

OCTOBER 14, 1991

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives / \$2.00 a copy; \$80 a year

© Entire contents copyright 1991 by
Crain Communications Inc. All rights reserved

California governor approves Prop. 103 rate rollback rules

SACRAMENTO, Calif.—Insurance Commissioner John Garamendi will begin to issue Proposition 103 rate rollback orders this week after Gov. Pete Wilson overruled an administrative court's blockage of emergency regulations proposed by the commissioner.

Mr. Garamendi "will announce the first of numerous individual company rollback amounts" on Wednesday, the Insurance Department said. The state Office of Administrative Law blocked Mr. Garamendi's

Continued on next page

Politics mires House debate on health care

By JERRY GEISEL

WASHINGTON—House Democrats and Republicans agree that reform of the nation's health care delivery system is needed, but they are miles apart on how extensive the changes should be.

At a House Ways and Means Committee hearing last week, congressional Democrats generally endorsed sweeping changes, including developing a national health insurance plan to assure health care coverage for all U.S. citizens.

"The American people want comprehensive reform, not a tinkering of the current system," argued Rep. Marty Russo, D-III.

Universal health care coverage is possible only through a single-payer system, like the Canadian national health insurance program, Rep. Russo said.

But House Republicans warned against radical changes, arguing that some changes—especially a federal takeover of the health care delivery system—would do more harm than good.

"In seeking to correct the shortcomings, we must not do so in a way that undermines all the benefits our system has provided and is

Continued on page 35

Broker liable for claims under Garamendi plan

By JOANNE WOJCIK

LOS ANGELES—California Insurance Commissioner John Garamendi wants to hold surplus lines brokers liable for claims not paid by insolvent or bogus non-admitted insurers.

Surplus lines brokers and others sharply criticize the idea, some labeling it an attempt to pass the buck for solvency regulation.

"The Department of Insurance is aggressively pursuing a strategy to hold surplus lines brokers financially responsible for the unlicensed products they sell," Mr. Garamendi told a standing-room-only crowd at the National Assn. of Professional Surplus Lines Offices Ltd. annual meeting earlier this month.

"Surplus lines brokers must take

responsibility for the integrity of the companies for whom you write insurance," the commissioner asserted. "It is your responsibility to policyholders and I am going to hold you to it."

No regulation has been proposed that would hold surplus lines brokers liable for a non-admitted insurer's failure to pay claims, an Insurance Department spokeswoman said. Any proposed regulation would have to be submitted to the state Office of Administrative Law for approval.

Such a proposal would be the latest in a string of actions by Cali-

fornia regulators to crack down on abuses in the surplus lines market.

"My underlying goal for the surplus lines system is that consumers' insurance needs are met and that their claims are paid by the non-admitted carriers they use," Mr. Garamendi said. The commissioner said his crack-down is designed to protect consumers from "unethical un-

licensed companies."

To support his claim that a growing number of insurers are "poisoning the surplus lines regulatory well," Mr. Garamendi cited

Continued on page 30



California Insurance Commissioner John Garamendi wants to hold surplus lines brokers liable for non-admitted insurers' failure to pay legitimate claims.

High court considers tobacco suit

Cigarette firms say labeling law pre-empts most liability actions

By STACY ADLER

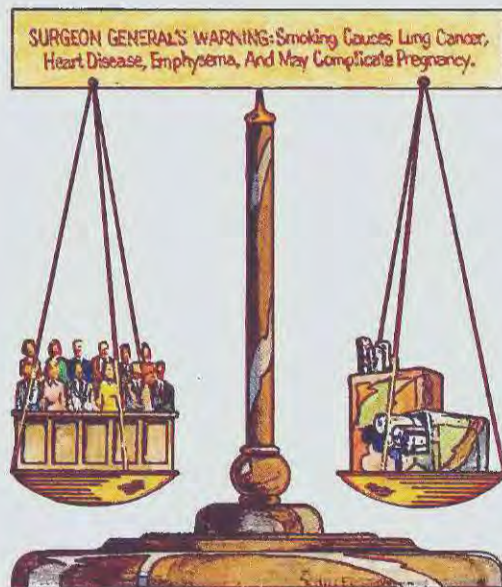
WASHINGTON—In a case with sweeping ramifications, cigarette manufacturers last week asked the U.S. Supreme Court to bar most tort lawsuits alleging injury from cigarette smoking.

At the same time, a plaintiff's attorney maintained during oral arguments before the court that the door should be left open for people injured from smoking to recover tort damages.

About 100 cigarette liability lawsuits are pending nationwide, most alleging that tobacco companies failed to warn consumers of the dangers of smoking and misrepresented that smoking was safe. Thousands more suits could be filed if the Supreme Court rules for the plaintiffs.

On the other hand, a ruling in its favor would immunize the tobacco industry from most tort claims. While plaintiffs could still bring strict liability claims, alleging that cigarettes are unreasonably dangerous, such an allegation would be much tougher to prove than failure to warn or misrepresentation.

Numerous legal theories could be used to try to hold tobacco companies liable. But the case before the Supreme Court focused on one narrow issue: whether the Federal Cigarette Labeling and Adver-



tising Act pre-empts state suits charging tobacco companies with failure to warn or misrepresentation.

The federal law requires all cigarette manufacturers to include a specific health warning on their packages and advertisements: "Warning: The Surgeon General Has Determined That Cigarette Smoking Is Dangerous to Your Health."

Now the companies are required to rotate four different warnings.

In addition, the act forbids the imposition of any health-related "requirement or prohibition... under state law" on cigarette makers beyond this specific warning.

Plaintiffs' attorney Marc Z. Edell told the high court that a jury verdict in a tort law case is different from a "requirement or prohibition under state law."

Therefore, the federal act does not pre-empt tort

Continued on page 40

Big punitive award unconstitutional: Appellate court

By MICHAEL SCHACHNER

BALTIMORE—In a first-of-its-kind decision, a Maryland appellate court has vacated a punitive damage award against Alexander & Alexander Inc., calling it unconstitutionally excessive based on the U.S. Supreme Court's landmark ruling on punitive damage awards.

A three-judge Maryland Special Court of Appeals panel on Oct. 4 ruled that a \$12.5 million award against Alexander & Alexander Inc. for deliberately harming a competitor "does not comport with due process" because the award is excessive compared with the harm the plaintiff suffered and because the jury was never told the purpose of punitive damages in the case.

The appellate court ordered a new jury trial to determine the amount of punitive damages A&A should pay.

While other appellate courts have asked lower courts to review punitive awards since the Supreme Court's March decision, the Maryland court is the first to vacate an award and order a new trial.

Tort reform advocates praised the Maryland court's decision. They noted that while the Supreme Court failed to establish uniform punitive damage award standards in its March decision in *Pacific Mutual Life Insurance Co. vs. Haslip*, lower courts are heeding its assessment that the Constitution requires:

- Trial court judges to properly instruct jurors on the purpose of punitive damages.

- Sufficient judicial review of punitive damage awards (*BI*, March 25; March 11).

"This is the first major breakthrough by an appellate court and it ought to give other courts guidance on this issue," said Ted Olson, a defense attorney with Gibson, Dunn & Crutcher in Washington, D.C. "I'm very, very pleased with this decision."

Mr. Olson said that since the Haslip ruling in March, the U.S. Supreme Court has remanded at least 13 punitive damage cases for reconsideration by lower courts. In all three cases that have been acted

Continued on page 47

Bidding war heating up for takeover of Executive Life
Page 3

More employers utilizing data from their health care plans
Page 3

Coleridge scolds U.S. market for failure to increase rates
Page 3

Update

Prop. 103 regulations reinstated

Continued from previous page

emergency request to approve formulas that would implement Proposition 103 rate rollbacks, including his proposal to allow insurers an aggregate 10% rate of return in determining rate rollbacks. The OAL said no emergency exists and that the department should follow the normal procedure of additional hearings and public comment before implementing the regulations (BI, Sept. 9).

Gov. Wilson said that "insurers and consumers are entitled to the swift determination of the insurers' rollback liability and to a comprehensive judicial determination of the viability of the initiative's central provisions."

Individual insurers will decide how they will continue to challenge the regulations once they are ordered to make rollbacks, said a spokesman for the American Insurance Assn. in Sacramento. Insurers have filed several suits challenging the regulations.

Fire creates huge fine arts loss

LONDON—A warehouse fire near England's Heathrow Airport that destroyed art valued at 30 million to 50 million pounds (\$51.4 million to \$85.7 million) could produce one of the largest insured fine arts losses.

The fire destroyed dozens of paintings and sculptures as well as furniture, silverware and glassware. However, 150 paintings, including works by Renoir and Matisse, were saved.

The extent of the damage will not be known for some time, say underwriters and a spokesman for James Bourlet & Son, the fine art packing and shipping company that owns the warehouse.

Estimates for the total loss of fine art ranged from 800,000 pounds to 100 million pounds (\$1.37 million to \$171 million). Bourlet estimates the loss at between 30 million pounds and 50 million pounds.

The loss "certainly is going to be the biggest loss that's ever affected the fine arts market worldwide," said Andrew McAdams, fine art and specie underwriter for Lloyd's of London syndicate 1009, managed by Octavian Syndicate Management Ltd. Syndicate 1009 leads Bourlet's legal liability coverage as well as the all-risk insurance that Bourlet makes available to fine art owners who use the warehouse.

The possibility of arson is being investigated, the police said.

Benefit fraud victims to recover

CHARLOTTE, N.C.—Three former officials of a North Carolina staff leasing firm and its affiliates will pay more than \$3.5 million in restitution to health insurers and others they defrauded as part of a plea agreement with the Justice Department.

According to earlier court filings by the Labor Department's Office of Labor Racketeering, Cap Staffing Inc. of Charlotte, N.C., and affiliated firms defrauded more than 120 businesses by causing them to believe they were covered by a Cap Staffing health plan underwritten by Travelers Insurance Co. Travelers, though, only provided administrative services (BI, May 7, 1990). Cap Staffing improperly diverted most premiums that were supposed to be forwarded to Travelers for claims payments, Labor Department officials said.

As part of the plea agreement, the Justice Department will recommend reduced sentences on the various charges, including fraud. In return, Michael Spieles, briefly president of Cap Staffing and its successor, Universal Staffing Associates Inc., will pay \$2.3 million in restitution; Michael Krebsler, an officer of Universal Staffing Associates, will pay \$1 million; and Jerry Wolicki, a vp of affiliate Cap Programs, will pay \$250,000.

With that restitution, it is expected "that plan participants eventually will have their health claims paid in full," said Tony Higgins, senior deputy commissioner at the North Carolina Insurance Department.

The exact amount of unpaid claims was not available, but federal and state officials estimate the amount is \$1 million to \$1.5 million.

Insurer ratings downgraded

NEW YORK—Moody's Investors Service has downgraded the financial strength ratings of two USF&G Corp. property/casualty and life insurance subsidiaries.

And, Standard & Poor's Insurance Rating Services has lowered the claims-paying ability and senior debt ratings of Massachusetts Mutual Life Insurance Co.; the senior debt rating of Kemper Corp.; and the senior debt rating of Continental Corp. and the claims-paying ability rating of Continental Insurance Intercompany Pool.

Moody's lowered the financial strength ratings for United States Fidelity & Guaranty Co. to Baa2 from Baa1 and Fidelity & Guaranty Life Insurance Co. to Baa3 from Baa1. Moody's also downgraded its ratings on other USF&G securities and debt. The downgrades reflect "increasing risks associated with USF&G's commercial real estate investments" and "reduced creditor and policyholder protection" resulting from increased operating expenses, Moody's said.

"We are outraged that Moody's would take such an action" despite USF&G's plans to restructure its portfolio and reduce operating expenses, said Norman P. Blake Jr., chairman, president and chief executive officer of USF&G. The restructuring should show up in 1992 results, he said.

S&P downgraded the claims-paying ability and senior debt ratings of Massachusetts Mutual to AA+ from AAA over concerns about its "surplus cushion" due to aggressive growth over the past five years.

"Asset quality problems"—including large real estate holdings—

Continued on page 46

Errors & omissions

• An incorrect logo accompanies stories reporting on the Council on Employee Benefits fall conference appearing on pages 10, 12, 13, 14 and 15. The correct logo appears on page 3.

• New York attorney Mark Scherzer is not a member of nor an attorney for the AIDS Coalition to Unleash Power as was reported in the Oct. 7 issue.

Latest fronting proposal eases rules for captives

By MEG FLETCHER

KANSAS CITY, Mo.—The latest proposal from the National Assn. of Insurance Commissioners to limit fronting arrangements is getting mixed reviews.

Some captive insurance company proponents say the latest discussion draft of the proposed model law, which contains significant changes from earlier versions, is a "vast improvement," while commercial insurance industry observers label it "a setback," particularly for non-captive fronting arrangements.

Among other things, the latest version would generally permit licensed insurers to front programs without prior approval from regulators and would allow captive reinsurers to retain underwriting authority for fronted business.

The proposal would, however, increase reporting and security requirements for fronted insurance programs.

It's "a vast improvement" over previous drafts, said Paul Brown, director of governmental affairs for the Risk & Insurance Management Society Inc. in New York.

It would cause only minimal disruption to existing fronting programs involving policyholders' captives, though extensive reporting and administrative requirements would probably increase the cost of such programs, he added.

Insurance industry representatives, though, are much more critical of this latest draft.

It is "a setback," said Edmond F. Rondepierre, senior vp, general counsel and secretary of General Reinsurance Corp. in Stamford, Conn. In an attempt to describe ac-

ceptable fronting arrangements, the new draft reintroduces vague wording that is neither workable nor enforceable, said Mr. Rondepierre, who chairs an industry advisory committee working with regulators to fine-tune the model law.

The draft is "a regression" and "would shut down much of the non-captive fronting arrangements," charged Franklin W. Nutter, president of the Reinsurance Assn. of America in Washington, D.C., and a member of the advisory group member.

The proposed model law calls for overly restrictive controls on fronting insurers in non-captive arrangements and "the net effect is a prohibition," said Lenore S. Marema, vp-legal and governmental affairs for the Alliance of

Continued on page 4

Canadian market outlook

Overcapacity to ensure low rates over long term: Consultant

By JUDY GREENWALD

EDMONTON, Alberta—The short-term forecast for Canadian commercial insurance is a tightening property market but stable liability rates, a consultant says.

Over the long term, though, overcapacity and market fragmentation will ensure a continued soft market overall, even if competition drives weaker players out of business, he says.

Edward T. Belton, a risk management consultant in Toronto with the Tillinghast division of Towers, Perrin, Forster & Crosby Inc., made his predictions last month at a session called "Insurance in an Ever Changing Land-

scape" during the Canadian Risk Management Conference, sponsored by the Northern Alberta chapter of the Risk & Insurance Management Society Inc.

"Insurance is indeed an ever-changing landscape," Mr. Belton said. But, it could be said that landscape is not changing fast enough, he added.

Fundamental problems have plagued the Canadian insurance market for 15 years and there is little evidence of solutions in place, Mr. Belton said.

One of these problems is oversupply. "The marketplace has suffered from surplus capacity for most of the last 15 years, and the problem has grown steadily worse since 1986," he said.

Given the mix of business underwritten in Canada, Mr. Belton said, a premium-to-surplus ratio of 2.5-

to-1 would be considered a relatively conservative calculation of total capacity.

But \$10.8 billion Canadian (\$9.56 billion at current exchange rates) in capital is now supporting just \$13.6 billion Canadian (\$12.04 billion) in net premiums, "which is exactly twice as much as what is needed," said Mr. Belton. "Clearly, as long as supply outstrips demand by such a wide margin, the market is going to remain soft and prices are going to remain under downward pressure."

Another problem facing insurers is fragmentation. Among the 135 active major property/casualty insurers in Canada, the largest holds just more than a 6% market share, according to Mr. Belton.

Both overcapacity and fragmentation have created an "undisciplined, hyper-competitive and very price-sensitive marketplace," he said. This in turn has created wide fluctuations in insurers' return on equity, but "the results have not been bad enough to drive surplus capital out of the industry," he said.

For the immediate future, Mr. Belton said property insurance rates should harden, while liability rates should remain stable.

The loss ratio for commercial property business has deteriorated to an eight-year high of 78.3%, he said. Meanwhile, claims are now growing at an 18.2% rate, while written premium growth is declining by 2%. "That class of business

Continued on page 15

Managed care directory deadline

Business Insurance is still accepting completed questionnaires for the fifth annual Managed Care Market Report to be published in December, which will list health maintenance organizations and preferred provider organizations nationwide.

The report will be published as a special issue in addition to the regular weekly edition of *BI*. All subscribers will receive this issue free of charge.

The directories are published as an editorial service. There is no charge to be included, but HMOs and PPOs must complete and return the *BI* questionnaire by the extended deadline of Oct. 28.

HMOs that have not yet received a questionnaire should contact Karen Armaganian at 312-280-3195. PPOs should contact Sarah Polster at 312-649-5279.

Inside

✓ Southwestern Bell Corp. expects that a voluntary early retirement program will save the company between \$60 million and \$110 million next year. **PAGE 6**

✓ Despite some shortcomings, state safety agencies still fill a need that cannot be served by federal OSHA, this week's editorial says. **PAGE 8**

✓ Many policyholders may find that none of the policies in their insurance portfolio covers losses resulting from employee arson or vandalism, warns risk management consultant Jim Marshall in Perspectives. **PAGE 27**

✓ A suit by members of Lloyd's syndicates underwritten by Richard Outhwaite marks the first time in memory that a court has heard a dispute between members and their managing and members agents. **PAGE 37**

Departments

Advertiser index 38
Ask a risk manager 28

Benefit beat	6
Bermuda	37
BI stock index	47
Classifieds	42
Insider trading	41
Insurance services guide	43
International	37
Letters	8
London	37
Opinions	8
Perspectives	27

Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611-2590, 312-649-5303. For reprints or reprint permission contact: Reprint Department, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017-5806, 212-210-0229, Fax 212/210-0704.

Vol.25, No.41—*Business Insurance* (ISSN 0007-6864) is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207-3185; 800-678-9595 or 313-446-1611. Copyright 1991 by Crain Communications Inc.

Two groups join last-minute rush in Executive Life takeover bidding

By JOANNE WOJCIK

LOS ANGELES—The bidding war for Executive Life Insurance Co. heated up prior to last week's deadline for offers to take over and rehabilitate the failed insurer.

One last-minute offer came from a group led by Hellman & Friedman, an investment bank in San Francisco. The group would infuse \$750 million in new capital into Executive Life to finance a new company named Sierra National Life Insurance Co. That company would be headed by John J. Byrne, chairman of Fund American Cos.

Another offer was announced late last week by Broad Inc., a Los Angeles financial services company headed by home building magnate Eli Broad. However, Broad is proposing only to acquire through an assumed reinsurance transaction \$5.5 billion of the insurer's policyholder obligations—or only about half of its total obli-

gations—and an unspecified portion of its assets, but none of its huge junk bond or its real estate holdings.

Broad officials could not discuss the proposal in detail because the company is currently in the midst of a stock offering.

In addition, French investor group Altus Finance announced last week that it plans to enhance its \$3 billion offer for the failed life insurer to make it more attractive to policyholders.

Those changes do not alter Altus' treatment of Executive Life's junk bonds, which other potential investors have maintained the Altus bid had undervalued.

Meanwhile, California Gov. Pete Wilson signed into law last Monday legislation limiting insurers' investments in high-yield, high-risk junk bonds to no more than 20% of their portfolios. S.B. 1135, sponsored by state Sen. Patrick

Continued on page 46

Agent Orange suits dismissed

Claimants bound by 1984 settlement

By STACY ADLER

NEW YORK—Producers of the defoliant Agent Orange do not have to pay more money to Vietnam veterans who claim they are not bound by a \$180 million settlement that precluded further lawsuits.

A federal judge dismissed two lawsuits brought by more than 40 Vietnam veterans and family members who claim they were not part of the original class action and therefore not bound by the 1984 settlement.

The veterans argued that because they were not aware of their injuries in 1984, they could not have chosen to opt out of the class-action lawsuit.

During the Vietnam War, thousands of troops were exposed to Agent Orange. In the 1970s and 1980s many veterans claimed injury from that exposure and sued companies that produced the herbicide, including Monsanto Co., Dow Chemical Co., and Diamond Shamrock Chemical Co., now a unit of Occidental Petroleum Corp. of Los Angeles. The claims were consolidated into a class-action

lawsuit, which was settled in May 1984 (*BI*, May 14, 1984).

The terms of the settlement expressly state that the class includes "persons who have not yet manifested injury."

As a result, U.S. District Court Judge Jack B. Weinstein of Brooklyn on Oct. 4 ruled that the plaintiffs were part of the class and, therefore, bound by the settlement.

Attorneys for the plaintiffs or the manufacturers could not be reached for comment last week.

The settlement, which was initially funded with \$180 million by seven manufacturers and their insurers, provides for two trust funds. One pays disability and death benefits to veterans and their families; another supports counseling programs for veterans.

The disability and death benefit fund as of Sept. 30 had received more than 50,000 applications for payments. The fund has so far paid 27,727 claims totaling more than \$86 million, court records show.

The veterans assistance fund has funded 134 grants in the past three years totaling more than \$24 million. These grants provide services to veterans in 46 states. ■

Employer turns to health data for leverage

By CHRISTINE WOOLSEY

CHICAGO—Employers increasingly are analyzing data from their group health care plans to aid in making decisions about how to design and better manage employee benefits.

Bethlehem Steel Corp. of Bethlehem, Pa., spends about \$250,000 annually to massage reams of data collected from Bethlehem's insurers, managed care vendors, claims

administrators, hospitals and pharmacies.

That expenditure is well worth it, given that Bethlehem spends about \$220 million annually on health care for its 27,000 active and 63,200 retired employees, said Jack Romeo, director of health care systems in Bethlehem's human resource department.

"The first thing you have to do is identify the data you want to examine," Mr. Romeo said during a session at the Council on Employee Benefits' 45th annual fall conference, held earlier this month in Chicago.



Photo by Kathryn McIntyre

While the leaves were turning colors at the NACSA/NACSE meeting, no turn in rates is expected.

No market turn seen despite Coleridge plea

By KATHRYN J. MCINTYRE

WHITE SULPHUR SPRINGS, W.Va.—Vivid autumn colors, frosty mornings and a feisty speech by the chairman of Lloyd's of London on the sorry state of the U.S. market punctuated the annual gathering last week of U.S. property and casualty insurance industry executives at The Greenbrier resort.

Lloyd's Chairman David Coleridge, addressing a full house of insurer and reinsurer executives and agents and brokers, admonished U.S. property/casualty insurers to raise their insurance rates.

"The only area of the world where rates are still pretty miserable is the United States. It amazes me. It's incredible you are prepared to go on offering security," he said.

"Our composite companies are putting rates up," Mr. Coleridge said, referring to multiline insurers in the United Kingdom. "I just pray that you will begin to put your rates up here. I don't see how you can go on."

Roundly criticizing mass media coverage of Lloyd's financial condition, Mr. Coleridge also as-

ured his audience that Lloyd's is secure and will have adequate capacity next year and beyond to serve its commercial insurance buyers and ceding companies (see story, page 44).

Agents and brokers in the audience, and most of the insurance company executives, applauded Mr. Coleridge's counsel quite enthusiastically. A few reinsurers, who later characterized Lloyd's underwriters as low-ball competitors and complained that Mr. Coleridge's remarks were merely a sales pitch for Lloyd's, applauded politely.

But as the agents, insurers and reinsurers headed for golf courses and tennis courts that had thawed in the morning sun during the speech, there was no more talk of rate increases than before Mr. Coleridge's lecture.

U.S. property/casualty insurers appear resigned to no immediate improvement in rates, aware that capacity among other insurers is plentiful enough to write any business they try to mark up.

Agents and brokers, however, complain that the soft market is making it tougher to earn a buck in the property/casualty business, and they are focusing on ways to restructure their agencies to deliver different types of service to clients.

Continued on page 42

Bendectin maker says award exceeds Texas cap

\$30 million punitive award

By JOANNE WOJCIK

CORPUS CHRISTI, Texas—Marion Merrell Dow Inc. plans to appeal a \$33.8 million jury award to the parents of a Texas girl born with defects allegedly caused by her mother's use of the anti-nausea drug Bendectin while she was pregnant.

The award, believed to be the second-largest ever in a Bendectin case, came in two parts: A county jury here awarded \$30 million in punitive damages on Oct. 3. An earlier compensatory award was

for \$3.8 million.

Cincinnati-based Marion Merrell Dow, a unit of Dow Chemical Co., will either seek a new trial or appeal the verdict to a higher court, a spokesman said.

Lawyers for the company also plan to immediately request that the trial judge reduce the punitive damage award to comply with a 1987 state tort reform law. That law limits punitive damages—which are insurable in Texas—to four times compensatory damages.

The company will seek to have punitive damages reduced to no

more than \$15.2 million, said George E. Berry, the lawyer coordinating its defense. Mr. Berry is with Dickson, Carlson & Campillo in Santa Monica, Calif.

However, plaintiffs' attorney Barry J. Nace with Paulson, Nace, Norwind & Sellinger in Washington, D.C., said he does not believe the tort reform cap should apply to this case.

"We think any kind of cap would be unconstitutional," he said.

Mr. Nace said his staff is also researching whether the tort reform

Continued on page 46



Fronting draft

Continued from page 2

American Insurers in Schaumburg, Ill.

Insurance regulators are drafting the model law to further ensure the solvency of fronting insurers. First unveiled last December, the NAIC proposal has gone through several revisions with the input of the industry advisory group (*BI*, June 24; April 29; April 8; Dec. 10, 1990).

Significant progress was reportedly made at a joint drafting session Aug. 13 in Washington, D.C. However, many industry observers were surprised when new, "major" changes to that draft were verbally outlined last month by Vincent Laurenzano, chief of the New York Insurance Department's Property Companies Bureau and chairman of the NAIC working group that is crafting the model law (*BI*, Sept. 30).

The written version of the latest draft, dated Oct. 4, states that the goal of the proposed model law is

"to identify, monitor and regulate" reinsurance transactions in which a licensed insurer cedes a substantial portion of its total book of business to unlicensed reinsurers.

The proposed law also is designed to limit transactions in which a licensed insurer cedes business to an unlicensed reinsurer simply to supply the reinsurer with a market.

Key provisions in the new fronting draft would:

- Eliminate the prior approval requirements for many types of individual reinsurance agreements that were contained in earlier drafts.

However, most fronting insurers would still be prohibited from giving non-captive unlicensed reinsurers the authority to underwrite, establish reserves, process claims or make settlements on their behalf.

- Allow a fronting insurer to delegate underwriting functions to a policyholder's captive reinsurer if the fronting insurer maintains an adequate degree of control.

For example, the captive must fol-

low underwriting guidelines and rating structures approved by the fronting insurer and confirmed annually by an independent audit.

- Allow a fronting insurer to use independent third parties to handle claims and establish loss reserves.

For example, a fronting insurer could rely on an independent actuary's opinion to set reserves and a third party to process and settle claims as long as the insurer conducts an annual claims audit.

- Limit the amount of business ceded to any single unlicensed reinsurer to a percentage of the fronting insurer's policyholder surplus.

A commissioner's prior approval would be required if a fronting insurer wanted to cede an amount exceeding 5% of its policyholder surplus to any one unlicensed reinsurer under a single contract.

And, prior approval would be required if the total amount of fronted agreements with unlicensed reinsurers exceeds 50% of an insurer's aggregate gross written premium, as

reported in its most recent annual statement.

However, a state could sign off on such agreements if already approved by an insurance department accredited by the NAIC.

- Require 11 minimum contract provisions in fronting agreements, as well as requiring recordkeeping and reporting to be conducted by the licensed insurer.

Among the 11 detailed contract provisions is a requirement that an unlicensed reinsurer provide and maintain with the fronting insurer acceptable collateral—including cash or letters of credit—equal to at least 100% of the liabilities ceded.

In addition, the reinsurer must provide further collateral equal to 25% of the liabilities ceded under the contract. Alternatively, for life business, the reinsurer could maintain policyholder surplus equal to 5% of the cedant's statutory surplus, while a property/casualty reinsurer could maintain surplus equal to one-third of its gross premiums written

on all business in the past 12 months.

Captive reinsurers, though, are given an additional option to posting the additional collateral: A corporate parent with at least \$50 million in net worth could agree to indemnify its captive for losses "resulting from failure of the captive to meet its obligations under the reinsurance agreement."

Another of the 11 provisions states that "the insurer must be provided with" an opinion from an independent actuary by May 1 annually "that the rates applicable to the policies reinsured under the reinsurance agreement are adequate to pay expected policyholder claims or losses and loss adjustment expenses."

And, an unlicensed reinsurer must submit to the fronting insurer on or before June 1 a copy of its annual statement with an opinion by an independent certified public accountant.

In addition, the model act calls for a fronting insurer to report on at least a quarterly basis all balances due under the reinsurance agreement that are payable within 30 days.

The fronting insurer could terminate the reinsurance agreement with 90 days written notice to the reinsurer. The fronting insurer also could draw on the reinsurer's collateral in the event that "any" provision of the reinsurance agreement is not followed.

The proposed model law also would require a fronting insurer to report detailed information quarterly to the state in which it is domiciled on any reinsurance agreement governed by the act.

Any violation of the proposed model law would result in penalties, including fines up to three times the commissions and fees earned by the insurer on the fronted transaction.

The proposed model law excludes intercompany reinsurance or pooling arrangements, as well as reinsurance agreements with an association, pool or organizations of insurers engaging in joint underwriting or joint reinsurance that are already regulated.

RIMS' Mr. Brown said the latest fronting proposal is "more workable," although not perfect.

He plans to recommend several changes, including allowing captives to perform claims handling as well as underwriting responsibilities.

In addition, he would like to reduce minimum contract requirements for captives so that a parent company with \$25 million in net worth—rather than \$50 million—could provide an indemnification agreement.

Mr. Brown said he also wants to clarify that a reinsurer would have to seriously breach contract terms before a fronting insurer could draw down on collateral.

Industry spokesmen find several other problems with the draft.

"It really appears more onerous than previous drafts," said the RAA's Mr. Nutter.

Specifically, he pointed to requirements for multiple audits as well as "low thresholds" for business allowed without a commissioner's prior approval. Such provisions increase the cost of business and subject reinsurers to regulatory delays.

"I think they tightened it up even more," said the Alliance's Ms. Marema. She objects to having all fronted arrangements regulated, and recommends that very small fronting arrangements be excluded if they are no threat to an insurer's solvency.

Mr. Laurenzano said he will accept comments on the model until Oct. 21. Comments should be sent directly to Mr. Laurenzano in New York and a copy mailed to NAIC General Counsel David M. Simmons at the NAIC's headquarters in Kansas City, Mo.

Mr. Laurenzano plans to meet with the industry advisory group Oct. 31 and hopes to have a final version of the proposal prepared by the NAIC's meeting Dec. 8-12 in Houston.

The industry advisory group expects to meet Oct. 15 in New York to discuss the draft. ■



WILL RUNAWAY EMPLOYEE MEDICAL CLAIMS TAKE THE SELF-INSURED FOR A RIDE?

NOT WITH A STOP LOSS CARRIER WHO KNOWS THE TERRAIN.

Employers Reinsurance Corporation is one of the largest writers of self-insured A&H.

We know the territory. The pitfalls. And we can carve out a custom plan no matter how intricate the client's needs.

We've been over this ground before. With a Best's A+ rating and financial strength that won't shrink from tough losses. ERC's sure-footed underwriting, claims support, and flexibility of coverage continue to lead the field. Call 1-800-255-6931 for information.

ERC. Taming runaway costs for over 75 years.

Employers Reinsurance

5200 Metcalf, Overland Park, Kansas 66201

A General Electric Financial Services Company.

All this talk about stability. No wonder you're so nervous.

Relax. Since 1924, our approach to retirement programs has been built upon the single-minded pursuit of quality.

Our unchanging philosophy of pursuing prudent risks plus our strict investment guidelines enable our clients to prosper, whether the

market rumbles or roars.

They are also why our Connecticut General Life Insurance Company has consistently earned among the highest ratings from Moody's, Standard & Poor's and A.M. Best.

To us, however, quality means more than having excellent financial ratings.

It means superior fixed income results, with guarantees backed by capital and surplus in excess of \$1 billion. An amount that puts us in the top 1% of all U.S. life

insurers. It means providing everything you need to run a 401(k) or pension plan. From plan design to ongoing management. All of which allows us to achieve a 93% client and asset retention rate year after year.

For further information, write Byron Oliver, President, CIGNA Group Pension, Dept. M-121, P.O. Box 2975, Hartford, CT 06104.

And we will make sure that you never get bent out of shape.

We get paid for results.® **CIGNA**

Southwestern Bell offers early retirement

Benefit beat

Southwestern Bell Corp. expects that a voluntary early retirement program will save the company between \$60 million and \$110 million next year even though the "Baby Bell" will be enhancing pension benefits by as much as 30% for those who participate.

St. Louis-based Southwestern Bell estimates that 1,200 to 1,900 of its approximately 17,700 management personnel will choose to retire under the program, which runs through Dec. 30.

If 1,200 managers accept the offer, Southwestern Bell stands to save \$60 million to \$70 million in benefits and salaries in 1992. Savings could reach as much as \$110 million if 1,900 participate in the plan, a spokesman said.

Regardless of how many managers retire early, layoffs of additional managers could follow the

early retirement plan as the company continues its effort to streamline operations, said Richard A. Harris, senior executive vp-human resources.

Under the plan, managers with 65 years of combined age and service will have five years of age and five years of service added to their defined benefit pension calculation formula.

Normally, an employee must have at least 75 years of combined age and service to be eligible for full pension benefits.

In addition pension benefits will be increased by 15% over five years for those who are off the payroll by Dec. 30.

Pension benefits can be taken

monthly or in a lump-sum under the program.

And, the five-year salary averaging period the company uses as part of its pension determination formula has been advanced by 30 months: The new period runs from January 1986 through December 1990.

The program is open to all 16,000 Southwestern Bell Corp. managers and approximately 1,700 managers who work for Southwestern Bell Telephone Co., its major subsidiary, and Southwestern Bell Yellow Pages.

Separately, managers who are 21 or older and have been with the company for at least one year can leave Southwestern Bell with whatever money has accumulated in their pension account rather than waiting until age 65 for monthly benefits.

All of the regional Bell telephone companies except U.S. West Inc. now are trying to cut their payrolls with early retirement programs for managers, the spokesman said. Southwestern Bell operates throughout Arkansas, Kansas, Missouri, Oklahoma and Texas.

—By Michael Schachner

Health care quality

Pennsylvania benefit managers' ideas on what constitutes quality health care vary widely, according to a recent survey.

Patient satisfaction was the most important indicator of health care quality, according to 24% of the survey respondents.

Twenty-three percent ranked providing the greatest accessibility for the greatest number of people as the most important feature of

quality health care; 20% ranked treatment success most important; 18% ranked cost effectiveness most important; and 14% ranked modern techniques and advances most important.

Benefits or health insurance managers from 100 central Pennsylvania companies were interviewed for the survey by HealthAmerica of Central Pennsylvania, a 50,000-member health maintenance organization serving seven counties in the state.

Most of the randomly selected employers were smaller firms: 76 had fewer than 100 employees.

In evaluating the quality of a health care program, the following factors were judged by the survey respondents to be very important:

- Employee satisfaction, 67%.
- Increased productivity of the workforce, 55%.
- General well-being of employees, 52%.
- Workdays lost or gained, 46%.
- Improved health status of employees, 40%.
- Success of smoking-cessation programs, 38%.
- Availability of preventive services, 37%.

The survey also found that 83% of the benefit managers use employee feedback and complaints as their primary method for evaluating health care quality; 41% use health care data analysis and evaluation; 39% relied on utilization reports; and 28% looked at the achievement of anticipated clinical outcomes.

Totals add to more than 100% because respondents could choose multiple responses.

Cost of coverage was the biggest problem that 39% of the benefit managers said they have with their health benefits program; timely payment of claims was the biggest problem for 26%; coverage exclusions was the biggest problem for 11%; and insufficient number of doctors and long waits were the biggest problems for only 6%. Other respondents listed many other problems.

More than nine out of 10 benefits managers felt that health care is somewhat or greatly overpriced, even considering its quality. Only 7% felt that health care costs are reasonable.

Sixty percent of the benefit managers believed that the quality of health care will become an even more important issue in the future. The remaining 40% said that the importance of quality health care will remain stable.

Other findings include:

- Forty-six percent said responsibility for monitoring the quality of employee health care lies with employers; 26% said health care providers; 12% said insurers; 9% said the employees themselves; 4% said government; and 3% gave some other response.

• Ninety-five percent of the respondents believe that the United States will eventually implement a national health care plan. Thirty-nine percent of the respondents said they expected a national program would be implemented in five to 15 years; 34% expect it in three to five years; 13% said it would happen in the next year or two; and 9% said it would take longer than 15 years.

And, 80% of benefits managers said that if a national health care system were inevitable, they would prefer a "public-private partnership" to a "Washington-based, single provider system."

Single copies of the survey results are available from F.G. Chip Merkel, President, HealthAmerica of Central Pennsylvania, 214 Senate Ave., Camp Hill, Pa. 17011; 717-763-9313.

—By Sara J. Hartly

SEA STUDIOS, INC./PETER ARNOLD, INC.



Over the years, First State has played an important role in the evolution of surplus lines coverage. Today we continue that tradition by

Just Because You've Never Seen It Is No Reason To Think It Doesn't Exist.

considering and delivering a wide variety of specialty products, even when these products can appear unfamiliar.

Our Product Development Committee, comprised of senior underwriting officers, screens new proposals. Many of our new products have originated from first-hand experience in the market to meet a unique insurance need. It's this kind of knowledge and involvement that enables us to develop a product that cannot be matched.

If you're a broker with an idea, talk to the company with a proven record of forming new ideas. Call us at any one of our offices coast to coast. Because sometimes you have to look a little harder to discover a different kind of animal.



60 Battery March Street,
Boston, MA 02110
617-357-8400 Telex 94-0013
Boston, Chicago, Los Angeles,
Atlanta, New York,
San Francisco



Do You Have Good Answers To These 7 Risk Management Questions?

- ① How can I determine loss trends when I don't know the full financial impact of recent years' accidents?
- ② Do the commonly used indicators accurately reflect how my company's approach to risk management is working?
- ③ How do I know which cases could benefit from medical management or medical coordination services?
- ④ How can I be sure my organization won't outgrow our RMIS?
- ⑤ What can a risk management department do to ensure the quality of a RMIS?
- ⑥ How can subrogation activities contribute to the control of my claim dollar?
- ⑦ I am concerned about the financial exposure of an environmental spill...How can I prepare for one?

The answers to these questions (plus another 130 like them) are now available in a free booklet from Crawford & Company entitled "137 Questions to Ask Yourself Before You Next Renew." The most popular offering in Crawford's history, this completely revised series of questions and answers is designed to help you improve the service component of your risk management program.

Covering the key elements of effective risk management, the booklet includes pointers on...

- claims administration
- vocational/medical rehabilitation
- risk control
- risk management information systems
- finance

50
YEARS OF
Top Quality, Promptly

For all of the 137 Questions and their answers, send for our free booklet today!



Name: _____

Title: _____

Company: _____

Address: _____

Phone: _____

Barry LaFleur
Vice President
Risk Management Services
Crawford & Company
5620 Glenridge Drive, N.E.
P.O. Box 5047
Atlanta, GA 30302


Crawford
CRAWFORD & COMPANY
RISK MANAGEMENT SERVICES

Opinions

Don't kill state OSHA plans

THE WORD "OSHA" still makes many managers cringe. Tales of picayune harassment linked with government safety inspections continue to circulate despite increasing efforts by the agency and business leaders to work together.

But workplace catastrophes—like the fire last month at a North Carolina poultry processing plant that killed 25 workers and injured 55 other employees—drive home the point that government oversight of occupational safety and health is necessary and perhaps should be increased to protect employees. The North Carolina plant, which had never been inspected, lacked a sprinkler system, fire exits were unmarked and two doors leading out of the building were locked when the fire broke out.

That plant, however, did not fall under the purview of the federal Occupational Safety and Health Administration. Rather, North Carolina's federally approved job safety program was responsible for—but never carried out—inspections at the plant, partly because North Carolina only employed 37 inspectors, 27 fewer than recommended by federal OSHA.

In the aftermath of this tragedy, U.S. Labor Secretary Lynn Martin has ordered federal OSHA to review the North Carolina program and the programs operated by 24 other states and territories approved by federal OSHA to enforce job safety rules (BI, Oct. 7).

A knee-jerk reaction would be for Congress to order the consolidation of all workplace safety inspections under federal OSHA.

That would not be a wise decision.

Although some state programs are probably not up to snuff, neither, in many cases, is federal OSHA. The federal agency suffers from a lack of resources—both human and monetary—just like some state plans.

In addition, its sheer size makes federal OSHA slower than some state programs in reacting to emerging job safety problems.



"I'D LIKE TO SEE HIM
JUST TRY TO DO THIS JOB WITHOUT US!!"

For instance, the California workplace safety agency currently is studying occupational safety and health problems at newspaper offices. There currently is no federal ergonomic standard governing newspaper offices.

State agencies can also tailor their programs to their individual needs. In states that are home to many companies in a particular industry, for example, agencies can stress safety rules pertaining to that industry more easily than a monolithic federal agency could.

While it is proper that OSHA is reviewing how well state safety agencies protect workers—and indeed it may find that some states fall short—the state agencies still fill a need that cannot be served by federal OSHA.

Letters

COBRA premiums can be funded through FSAs

To the editor: In the Sept. 9 "Ask a Benefits Manager" column, Dennis Nirtaut left out the impact of the Consolidated Omnibus Budget Reconciliation Act of 1985 on medical flexible spending accounts. He stated: "An expense must be incurred while... employed... to be eligible..." A former employee may also be eligible if COBRA premiums for the FSA are paid. The COBRA FSA premiums are not pretax, but the claimed reimbursements would continue to be tax-exempt. The employee could also change his or her medical FSA on termination because of his or her change in employment status. These are minor points but could be expensive if overlooked.

Frank M. Arnall
President
Executive & Business Benefits Inc.
Orlando, Fla.

Mr. Nirtaut replies:

You are correct in stating that a former employee has COBRA rights under a medical FSA. As experience has shown under standard medical plans, COBRA administration can be time-consuming and expensive and can cost more than the 2% charge that is allowed by law. Although about 20% of terminating employees opt for COBRA coverage for medical plans, it appears that very few employees opt for COBRA for med-

ical FSAs. I checked with a COBRA administrator for FSAs who indicated that for all of the plans that the company administers, only two employees opted for COBRA coverage.

The reason employees usually opt for COBRA is that they have a large account balance at the time of termination and anticipate medical expenses that they can submit to the FSA. Because of the fact that COBRA contributions to an FSA are aftertax, the FSA loses its main purpose: tax savings on medical expenses.

With regard to your statement that the employee could also change his medical FSA on termination because of a change in

employment status, please note that:

- The regulations state that one may be allowed to change his or her medical FSA contributions due to a change in one's spouse's employment status. However, the regulations are silent with regard to the employee's employment status.

- The regulations also state that employees may be allowed to change their contributions to a medical FSA due to a "change in family status." There is no rule that requires that changes be allowed. Therefore, in order to minimize the additional administrative burden, you have the option not to allow changes at the time of termination or at any other time.

Physical therapists seek role

To the editor: The findings of the Health Insurance Assn. of America/Wyatt Co. managed care report lauded in your Aug. 19 editorial, "Defending Managed Care," are inconsistent with experience for physical therapy.

The report's key conclusion, that various legislative mandates to restrict managed care would increase costs, would be faulty if applied to physical therapy.

Such interpretation would be based on the fallacious premise that providers excluded from managed care networks are necessarily less cost-effective than affiliated providers. Rather, four other national and state studies have found that independent physical therapists charge less for per-service and per-episode care on average than competing providers.

The real issue in provider selection is not whether every individual practitioner should be allowed to affiliate but, rather, the exclusion of entire classes of providers.

Because of the four cited studies' findings of reduced costs for independent physical therapists, their blanket exclusion from managed care increases costs. Yet many managed care entities refuse to offer them affiliation. Hence the need for state legislative relief to maintain fair competition.

We recognize that state regulation may be idiosyncratic and its application to insurers is not on a "level playing field" basis due to ERISA's self-insured plan pre-emption. But the solution is not to create another problem of inequity that restrains competition by non-physician providers. Until all legally qualified provider types are permitted to maximize competition, managed care will neither substantially contain costs nor help assure quality.

Brian Rasmussen
Director

Department of Reimbursement
American Physical Therapy Assn.
Alexandria, Va.

Business Insurance®

Reporting weekly for corporate risk,
employee benefit and financial executives

Publisher: Alfred Malecki (New York)

Associate Publisher/Editor: Kathryn J. McIntyre, A.R.M.
(Chicago)

Managing Editor: James M. Burcke (Chicago)

Senior Editor: Jerry Geisel (Washington)

Assistant Managing Editor: Dave Lenckus (Chicago)

Assistant Managing Editor/Graphics: Jeanne M. Bartels
(Chicago)

CHICAGO: Karen Armaganian (Editorial Assistant)
Lori Block (Associate Editor)

Karen Brown (Assistant to the Editor)

Meg Fletcher, A.R.M. (Associate Editor)

Sara J. Harty (Staff Reporter)

Nancy Johnson (Copy Editor)

Kathryn M. Larrabee (Copy Editor)

Laura Mazzuca (Agent/Broker Topics Associate
Editor)

Sarah E. Polster (Directory Editor)

Roger Schillerstrom (Editorial Cartoonist)

Deborah Shalowitz (Associate Editor)

Timothy Stanton (Copy Editor)

Paul Winston (Copy Desk Chief)

Christine Woolsey (Associate Editor)

DALLAS: Michael Bradford (Associate Editor)

LONDON: Stacy Shapiro (International Editor)

Gavin Souter (Associate Editor)

LOS ANGELES: Joanne Wojcik (Bureau Chief)

Louise Kertesz (Associate Editor)

NEW YORK: Douglas McLeod (Bureau Chief)

Stacy Adler (Associate Editor)

Michael Schachner (Associate Editor)

SAN JOSE: Judy Greenwald (Associate Editor)

WASHINGTON: Mark A. Hofmann (Associate Editor)

Advertising Director: Martin J. Ross (New York)

Midwest Sales Manager: Robert L. Niesse (Chicago)

CHICAGO: Deborah D. Neale (District Manager)

Margaret Hikido (District Manager/
Classified Sales)

Elmer Kerstowske (Production Manager)

NEW YORK: Charles A. Horvath (District Manager)

Jack Forrest (District Manager)

Kathryn Premetz (District Manager)

Cynthia Bykowski (District Manager)

LOS ANGELES: Michael J. Sharpe (Western Advertising
Manager)

Director of Communications: Ronnie I. Drachman
(New York)

EDITORIAL: Chicago: 312-649-5398

Dallas: 214-363-1066

London: 71-608-1172

Los Angeles: 213-651-3710

New York: 212-210-0140

San Jose: 408-379-1790

Washington: 202-662-7200

ADVERTISING: New York: 212-210-0228

Chicago: 312-649-5276

Los Angeles: 213-651-3710

COMMUNICATIONS: New York: 212-210-0132

CIRCULATION: Detroit: 313-446-1611

Published by Crain Communications Inc., Chicago

G.D. CRAIN JR.

Founder (1885-1973)

MRS. G.D. CRAIN

Chairman

S.R. BERNSTEIN

Chairman-executive committee

RANCE CRAIN

President

KEITH E. CRAIN

Vice chairman

MARY KAY CRAIN

Treasurer

MERRILEE P. CRAIN

Secretary

WILLIAM A. MORROW

Executive Vp-operations

WILLIAM STRONG

Vice president-circulation

ROBERT C. ADAMS

Vice president-production

PENELOPE A. GEISMAR

Corporate communications mgr.

Published weekly at 740 Rush St., Chicago, Ill. 60611-2590, Telex 6871241, Fax 312/280-3174, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017-5806, Telex 640207, Fax 212/210-0704, CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231-6415, Fax 214/696-1936; Suite 814, National Press Building, Washington, D.C. 20045-1801, Fax 202/638-3155; 6500 Wilshire Blvd., Suite 2300 Los Angeles, Calif. 90048-4947, Fax 213/655-8157; 540 Latimer Circle, Campbell, Calif. 95008, Fax 408/379-3257; Cowcross Court, 2nd Floor, 75-77 Cowcross St., London EC1M 6BP, England, Fax 71/608/1173. \$2.00 a copy. \$80 a year in U.S. Canada and all other foreign add \$38 for surface mail. Europe and Middle East only add \$105 for air delivery. First-class mail to U.S., add \$95; to Canada add \$105. Bermuda only, \$180 per year expedited delivery. SHEILA GORMLEY, circulation manager. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich., 48207-3185, or phone 800-678-9595 or 313-446-1611, Fax 313/446-1650. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691.

A Publication of:

Crain 75th Anniversary Communications Inc.
1916-1991 75 Years of Publishing Leadership

BPA

Member of Business
Publications Audit of Circulation

ABP

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

THE ARGONAUT FORUM:

NINE HONEST, INFORMATIVE, HELPFUL, CONTROVERSIAL, AND ULTIMATELY UPLIFTING CONVERSATIONS DEALING WITH SUBSTANCE ABUSE IN THE WORKPLACE.



Please send for your free reprint of The Argonaut Forum—a series of nine conversations in which Argonaut clients, brokers, and executives frankly discuss substance abuse in the workplace. And offer concrete suggestions on how to deal with it.

THE SET IS YOURS, FREE.

For your free reprint of the entire Argonaut Forum series, mail this coupon to: Mr. Michael Crall, President, Argonaut Insurance Company, 250 Middlefield Road, Menlo Park, CA 94025. If it is more convenient, please call Mr. Crall's office at (415) 326-0900. Or FAX your request to (415) 858-6677. Name _____ Title _____ Company _____ Address _____ City _____ State _____ Zip _____

Argonaut

Data analysis

Continued from page 3
proved, he added.

"We've seen a reduction in costs as a result of this data examination," Mr. Romeo said, noting that Bethlehem's health care data is examined quarterly.

Bethlehem has analyzed its claims experience and compared it with steel industry norms provided by MEDSTAT Systems Inc., an Ann Arbor, Mich.-based company that collects and analyzes health care data for large employers and insurers.

Bethlehem also has analyzed the cost of its benefit plans based on different plan provisions—like maternity benefits.

For example, Mr. Romeo said Bethlehem analyzed the impact of its carved-out substance abuse and mental health benefit programs and found they were saving money. It also found that the steel industry is being hit with an increasing number of stress-related claims, he said.

"We also found a high incidence of cardiac problems in the steel industry," he added.

The company also has scrutinized claims filed by dependents to see whether some of the stress that occurs in the workplace is being taken home, he explained. The company did notice "an increase in the number of substance abuse claims being filed by dependents" in some of its smaller plant locations, he said.

That increase in claims seemed unusual, since most of the plants were located in rural areas that were not associated with high drug use. "We thought, 'Gee there are cows and trees around here. Why would these kids want to drink?' and found that" the kids drank because they had nothing else to do.

The company also used its data to develop "a hospital report card" that it uses, especially in small communities where competition isn't as keen. A similar report card was developed for physicians and claims administrators to assure the company that those entities were providing high-quality services, he said.

Through data analysis, the company was able to compare the cost of different laboratory and radiology service providers and found that tests ordered in doctors' offices were more expensive than those done by national labs. As a result, Bethlehem "is looking at developing a carve-out laboratory PPO" that would use a network of national laboratories, he said.

"You may want to take a look at your outpatient claims," Mr. Romeo suggested. "We've found that it's cheaper in some cases to have a procedure performed with an inpatient overnight stay than to do it on an outpatient basis."

Another area that produced savings resulted from a closer examination of ambulance utilization, Mr. Romeo said. "We looked to see whether the ambulance was taking patients to the emergency room and found that they weren't—they were taking patients to another hospital for a test" that for some reason could not be performed in the hospital to which they were admitted.

In addition, "we found our employees were taking ambulances, rather than cabs, to the hospital" in non-emergency situations "and we were paying for it," he said.

Collecting, disseminating and using health care data is not without its problems, he warned. The steel concern has had trouble with the quality of the data collected from hospitals and pharmacies by its insurers, health maintenance organizations and preferred provider organizations.

Data collectors should make sure that no coding errors have been made and that each claims record is complete, he said.

In addition, employers should pinpoint the parts of the group health plan that they want to scrutinize—especially if they are dealing with the high volume of information Bethle-

hem deals with. "It takes a lot of time to process, so you should know what you are looking for," Mr. Romeo said.

Timeliness also is important. "If the data is more than 3 months old" and there is a question about whether a claim should be paid or not, "that's no good, because you will have probably already spent the money on the claim," he explained.

Ernest J. Sessa, executive director of the Pennsylvania Health Care Cost Containment Council in Harrisburg, Pa., also spoke during the session. The council was created by the Pennsylvania Legislature to "encourage and promote market-based competition" among hospitals in the state and to provide cost and quality data to consumers.

Mr. Sessa discussed the success the council has had in collecting and disseminating to consumers information on hospital mortality rates and costs in the state.

Ross L. Coffey, vp of client services for MEDSTAT, moderated the session. ■

Unique health plans pose data comparison problem

By LORI BLOCK



CHICAGO—One critical challenge facing benefit managers attempting to evaluate their managed care programs is finding appropriate data with which their claims experience can be compared.

In the case of Allied-Signal Inc., this problem is particularly perplexing because the Morristown, N.J.-based conglomerate in March 1988 installed a then-revolutionary point-of-service health care plan (B, Feb. 18, 1991; March 19, 1990; Feb. 22, 1988).

Under Allied Signal's Health Care Connection program, the company's employees are enrolled in health maintenance organizations operated nationwide by CIGNA Health Plans Inc., explained Ronald S. McGurn, vp-labor relations and employee benefits. Employees can receive treatment from non-network providers, but their coverage will be sharply reduced.

The focus of the plan was to confine employees and their dependents to a primary care physician as much as possible as a means of reducing cost and ensuring that only those plan members who actually need increased care are referred to specialists, according to

Mr. McGurn.

The Health Care Connection program has been added to the collective bargaining agreements signed with 20 of the company's 21 unions, with the United Auto Workers being the lone holdout, he noted.

"Labor unions are not finding serious problems with managed care," Mr. McGurn said. "What they do have a problem with is increasing premiums."

And, what Allied-Signal now has a problem with is comparing the results of its health care plan with other companies' experience. Because its program is unique and its survey so comprehensive, Mr.

Continued on next page

Are renewals reflecting your or the market?

Acts of nature, unforeseen losses or just bad planning may have left some companies a little short. Unfortunately, your security could be someone else's cash flow.

As the market hardens, it's more important than ever to work with a reinsurer who is committed to your financial well-being. One with a record of solid investments, strong capacity and sound underwriting.

Since 1917, American Re has been known as a

stable market; last year alone, our assets totalled nearly \$3.8 billion. Our commitment to client service is proven every day with responsible underwriting, customized programs and fast claims payment.

In addition to our stability, we offer an innovative system we call the WHOLE ACCOUNT CONCEPT. It combines specialists from across divisional, corporate and geographic lines to focus on all the issues affecting your business. As proof of our

Continued from previous page

McGurn said he was unaware of comparable data at other companies.

"We are very anxious to have people who have a similar plan to do this kind of survey," Mr. McGurn said. "For all I know, this may be the first survey of its kind."

Among 4,000 Allied-Signal employees that were reached by telephone as part of the company's survey, 93% cooperated.

"If somebody had told me that before we took the survey, I probably would have had a coronary, thinking then that the survey was going to come out a lot more negative than it did," Mr. McGurn said.

Instead, the results of Allied-Signal's survey were quite favorable, Mr. McGurn noted. Since the program was adopted, 93% of the employees said they had used the network.

In addition, 65% of the surveyed employees said they had seen a

'We were absolutely thrilled with the results, with 86% saying they were very satisfied or somewhat satisfied with the quality of care' given by the primary care physician, says Allied-Signal's Ronald S. McGurn.

specialist affiliated with the CIGNA network during that time, while 42% said they had received treatment from a network hospital since the program was adopted.

However, "probably the most important question" the company asked concerned the employees' level of satisfaction with their primary care physician since the primary care physician was the linchpin of the plan design, Mr. McGurn said.

"We were absolutely thrilled with the results, with 86% saying they were very satisfied or somewhat satisfied with the quality of

care" given by the primary care physician, he said.

Similarly, the negative reaction to either the specialists or the hospitals used in the program was limited, Mr. McGurn said.

Just 8% of those surveyed said they were somewhat dissatisfied or very dissatisfied with the quality of care given by specialists, and only 3% expressed some degree of dissatisfaction with the quality of care given by the program's hospitals.

The employees also appeared satisfied with the pharmacy component of the plan.

However, 30% of the surveyed employees expressed some degree of dissatisfaction with the vision care programs provided by the CIGNA HMOs, prompting Allied-Signal to decide to adopt a nationwide vision care plan in the future.

As the plan administrator, CIGNA also earned satisfactory marks, with only a few exceptions, Mr. McGurn said.

"Now this is not to say that every one of the 27 health plans had the same profile," he said, referring to HMOs operated by CIGNA. "This is a national profile. There were some variations, and we're going to get at those this year," Mr. McGurn said.

Working with this data, Allied-Signal's next step was to make some outside comparisons.

"Since there was no normative data (from other employers), we said, 'Fine, let's take a look, at least within the CIGNA health plans, how those individuals rated their providers, those individuals

that had elected CIGNA HMOs.' The results are fascinating," Mr. McGurn observed.

For instance, Allied-Signal employees' overall satisfaction rate with physicians, which ranged from 86% to 91% depending upon the specific question being asked, was in keeping with the 88% satisfaction rate revealed in a 1989 survey of members of CIGNA HMOs.

Similarly, while Allied-Signal's survey indicated a 97% overall satisfaction rate with the plan's hospitals, CIGNA's survey revealed a 94% satisfaction rate.

Overall, Allied Signal employees' 91% approval rating for the Health Care Connection program compares with CIGNA's 86% rate.

However, as Mr. McGurn noted, employees are not uniformly satisfied in all locations. Similarly, the monetary success of the program—which has cut the company's per-capita costs from a projected \$5,003 under the former indemnity plan in 1991 to an estimated \$3,605 this year under the Health Care Connection—also varies by location.

In studying each of the 27 markets in which Allied-Signal employees are enrolled in the Health Care Connection, the survey results were compared against CIGNA's national trends, various regional trends, utilization statistics and employee satisfaction scores, and each market was placed in one of four general categories:

- Case I, in which both the financial results and employee evaluations were satisfactory.

- Case II, in which the financial results were satisfactory, but the level of employee satisfaction was unsatisfactory.

- Case III, in which employees said they were satisfied, but the financial results of the program were unsatisfactory.

- Case IV, in which both the financial results and employee evaluations were unsatisfactory.

As Allied-Signal prepares to renew the program with CIGNA, it is ready to discuss the performance of each of the regional plans. The company is not going to "macro bargain, it's going to micro bargain," addressing each regional plan on a case-by-case basis, Mr. McGurn said.

If the plan in a particular market is deemed a "Case I," the company plans to simply seek continuous improvement.

If a plan in a market is deemed a "Case II" or "Case III," Allied Signal is going to formulate "specific plans...to solve whatever the problems may be," Mr. McGurn said.

Using employee focus groups, Allied Signal plans to draw up a list of problems that CIGNA will be required, in the new contract, to fix. In some cases, that might mean adding more pediatricians to a network that lacks an adequate number. In other cases, this may require CIGNA administrators to become more responsive, Mr. McGurn said.

"But whatever (the problem) might be, it will be (addressed) as a separate portion of the contract," he said.

And, if a plan in a particular market is deemed a "Case IV," the company is "quite willing to go to market" to find another plan administrator, according to Mr. McGurn.

"It's not being vindictive, it's not being adversarial with your partner." Instead, it is a realization that no insurer can be the best in each region. "It's unreasonable to expect them to be," Mr. McGurn contended.

Mr. McGurn's discussion of Allied-Signal's program was part of a three-part seminar moderated by Joseph W. Duva, a partner with Ernst & Young in New York and formerly benefits manager at Allied-Signal.

premiums loss experience market's?

commitment to a close partnership, we've actually restructured our company to let you access the best minds in the business. With a flexible, coordinated response system that gives you products and services that are driven by your needs, not ours. So you can not only survive the next hard market, but maximize its opportunities.

Make sure you're not paying for someone else's mistakes. Talk to American Re.



**AMERICAN
RE-INSURANCE COMPANY**

555 College Road East, Princeton, NJ 08543-2411, (609) 243-4200

Atlanta, Bermuda, Bogota, Boston, Brussels, Cairo, Chicago, Columbus, Dallas, Hartford, Kansas City, London, Los Angeles, Melbourne, Mexico City, Minneapolis, Montreal, New York, Philadelphia, San Francisco, Santiago, Singapore, Sydney, Tokyo, Toronto

Basic data examination may fall short

By LORI BLOCK

CHICAGO—Analyzing managed care programs on a simple before-and-after basis may fall short of truly determining the success of such efforts.

Instead, benefit managers might consider more sophisticated methods of evaluating the success or failure of their managed care programs, said Ron Z. Goetzel, director of data analysis and evaluation services with Johnson & Johnson Health Management Inc. of Santa Monica, Calif.

"Many (companies) have embraced managed care as a cost-containment solution," Mr. Goetzel said during the Council on Employee Benefits conference held Oct. 3-4 in Chicago.

"But, very little research has been devoted to this area specifically. There are studies on health care experience that compare crude costs of 'time one' vs. 'time two.' But they are simple in structure, and they don't address a lot of the competing explanations as to why health care costs may rise or go down over time."

With that in mind, Johnson & Johnson evaluated CustomCare, a point-of-service plan at Southwestern Bell Corp. (BI, Sept. 23).

The purpose of the project, which focused on the experience of the company's primary operation, South-

western Bell Telephone Co., was to "guide the refinement of CustomCare, determine additional strategies to maximize savings while enhancing employee health, and provide essential information for negotiations with providers, union groups and insurance companies."

To that end, St. Louis-based Southwestern Bell and J&J sought answers to the following questions:

- What were Southwestern Bell's utilization and cost patterns during the five-year study period?

The study period included two distinct periods: from January 1985 to March 1987, before CustomCare was implemented, and from the program's inception in April 1987 through the end of 1989.

- Did CustomCare succeed in controlling health care expenditures?

- Was it effective across all geographical areas.

- How did it achieve its savings, if savings were achieved?

CustomCare's results in each of these areas were compared to a "baseline," which in this case was the pre-CustomCare experience, Mr. Goetzel said.

In addition, the CustomCare results were compared with results obtained outside the network as well as with "normative data," he said. In this instance, the normative data was

composed of the general medical cost trends in the nation during these years, Mr. Goetzel said.

But to make these comparisons effectively and answer the evaluative questions, Southwestern Bell's experience had to be distilled so only critical factors would be examined.

"In our case, we applied multiple regression technology to control for, or screen for, other competing forces... that may influence health care costs over time," he said.

"What (multiple regression analysis) essentially does is say, 'This was the effect of the managed care program subtracting out all the other issues that are out there at any given time,' he explained. "The way that savings are calculated is (the analysis) looks at actual experience vs. expected experience and then calculates the difference that caused that savings."

In Southwestern Bell's case, the evaluation accounted for the impact of demographic shifts in the plan's population, a heavy migration to existing health maintenance organizations, an increase in the number of retirees, changes in management mix, variations in network implementation, the seasons, and overall health care inflation.

Why go to all this trouble of accounting for, and factoring out, ex-

traneous circumstances? Why not just compare raw pre-plan costs with post-plan costs on a per-capita basis?

Mr. Goetzel explained that such techniques are fine until somebody observes, for example, that the company's demographics have shifted over time and, hence, claim costs per employee have shifted.

In addition, Mr. Goetzel pointed out that males and females have different medical expense patterns over their lifetimes and, thus, a shift in the company's male-to-female ratio would change its claims pattern.

"So, let's say you wanted to control for both... gender and age and you also want to control for other things," Mr. Goetzel said. One would end up with a large block of two-by-two tables with 77,760 different comparisons, so the actual effects of the managed care program could be examined "independent of all of the other factors that are playing a role in determining health care costs."

Multiple regression analysis simplifies this process while highlighting the impact of some of the extraneous factors, Mr. Goetzel said.

In Southwestern Bell's case, the evaluation based on multiple regression analysis indicated the company saved an average of 24.8% on inpatient care within the network. That was partially offset by an 8.3%

increase in the cost of outpatient care obtained within the network.

In all, following the installation of the CustomCare network, Southwestern Bell's annual per-capita health care cost inflation dropped to 6.3% from 11.8%.

Mr. Goetzel said there were several critical points of the CustomCare evaluation, including that:

- The evaluation examined all of Southwestern Bell's health care costs, not just those directly associated with CustomCare. These include existing HMOs, mail-order drug costs and administrative expenses.

- The evaluation relied upon multiple regression techniques to control for competing explanations for the observed changes in costs.

- Multiple comparisons of the plan were conducted.

- The evaluation included one data base representing a population that was a part of all the years studied.

- The evaluation was conducted by a party other than the company or the insurer.

From this analysis and employee surveys, the company is hoping to improve CustomCare's results.

The session was part of a three-part session, "Managed Health Care Programs: Results to Date," moderated by Joseph W. Duva, a partner with Ernst & Young in New York. ■

BellSouth evaluates self-designed plan

By LORI BLOCK

CHICAGO—By his own admission, Reezin Swilley's story is no run-of-the-mill testimonial to managed care.

Many companies are just now beginning to evaluate the managed care programs they have adopted from health insurers. Not BellSouth Corp., where Mr. Swilley is vp-benefits planning and administra-

tion. The Atlanta-based telecommunications company is faced with the challenge of evaluating a program completely of its own making.

And its assessment is far from uniformly rosy. While a financial success, the program has been an employee relations problem, Mr. Swilley concedes.

Mr. Swilley spoke at the recent Council on Employee Benefits conference in Chicago.

BellSouth responded to rising health costs by setting up its own network of doctors and hospitals

rather than contracting with an insurer.

It chose this route, Mr. Swilley said, because existing networks did not match the company's utilization profiles and offered only small savings. At the same time, establishing its own network would give the company greater control by giving it first-hand knowledge of the arrangements.

BellSouth began by outlining its philosophy and objectives. This led to a benefits plan design and data analysis. Only then did the company enter into direct negotiations with hospitals.

As part of the plan development, the company granted its employees "transition relief" or grace periods, which varied depending on individual circumstances, so that employees would not have to immediately terminate existing provider relationships.

In its dealings with hospitals, BellSouth sought a "win-win relationship" in the hopes of generating long-term hospital support, Mr. Swilley said.

"We wanted to be fair with the providers, and we wanted the providers to be fair with us," Mr. Swilley said. "We wanted to pay our fair share, but we did not want to overpay. We wanted to be able to deliver the additional volume, but we wanted to see (their) data and make sure they were quality institutions."

Direct contracting has definitely saved BellSouth money to the extent that it has been implemented.

BellSouth started its program by forming a hospital network designed to serve employees, their dependents and retirees in each of the 17 states in which it operates.

In 1988, its first year, the program reduced hospitalization costs by 20.2%. Costs were reduced 20.9% in 1989 and 21.1% in 1990, and a 21.4% savings is projected for 1991.

The company also has added a prescription drug program. But calculating the savings of this component of the program is difficult, because little data exists to indicate what the "retail" price for prescription drugs is, Mr. Swilley said.

Still, the company estimates that it has cut these costs by 2% in 1990 and 4% in 1991.

The company's latest venture has been to add a physician network.

"Ultimately, we'll have arrange-

ments in every city where we have a hospital network," Mr. Swilley said. BellSouth first added the physician component in South Florida and Alabama and is preparing to add it in New Orleans soon. The company estimates that the 3.5% savings that have been realized to date will rise to 20% once the program is fully implemented.

Overall, the company's hospital network is now established in 16 cities, where 85 hospitals are under contract. The company also has contracts with 26 stand-alone facilities. According to Mr. Swilley, 64% of the company's 100,000 employees are considered to be within the network's reach in that they live within a 25-mile radius of a facility.

Yet, despite these efforts, the results have been mixed. The program has helped contain rising costs. But employee satisfaction has been a problem, and it points up the fallacy of relying on utilization to gauge satisfaction.

If satisfaction were judged "by how people vote with their feet," as Mr. Swilley described it, then BellSouth would have no cause for concern. Nearly 80% of the employees within a network area are using the program. Such high utilization would indicate at least a modest level of satisfaction.

But an employee survey designed to address satisfaction directly indicated a dramatically different story. In 1986, before the new plan was put in place, benefit satisfaction among management employees was judged to be more than 90%. By 1990, this figure had fallen to about 65%. Similarly, benefit satisfaction among non-management employees was roughly 87% in 1986, but, with the adoption of BellSouth's direct contracting program, satisfaction has fallen to roughly 59%.

When BellSouth considered adopting such a program, one of its greatest concerns was employee satisfaction. Looking back, Mr. Swilley said, the question was: "Will the employees like (the program)?" "The answer is 'No.' No one likes to give up freedom of choice."

But, he added, "Will they accept it? The answer is, 'Yes.'"

Mr. Swilley's presentation was the final part of a three-part session, "Managed Health Care Programs: Results to Date," moderated by Joseph W. Duva, a partner with Ernst & Young of New York. ■

LARGE DOLLAR JUDGMENTS

You have paid your lawyer many thousands of dollars to receive a piece of paper that may be worth a lot of money. Do you want to find out if it is?

I investigate/evaluate and determine collectibility of judgments in the 9 contiguous western states with face value of \$250,000 upwards.

ROBERT A. WELLS
Licensed Financial Investigator
602-371-1720



The 16th Annual Bermuda Insurance and Reinsurance Forum

March 10 - 13, 1992
The Hamilton Princess Hotel

Offshore Insurance/Onshore Regulation is the theme of this year's conference.

More new captive insurance companies are being formed, more in Bermuda than anywhere else.

Owners of captives are finding new ways to defend against changes in the insurance environment, new organizations to work with and new applications for risk management.

Speakers representing captive owners, managers, reinsurers and technical expertise will cover:

- Offshore life insurance and reinsurance
- Regulation and its effect on captives
- Reinsurance: the state of the art
- Financial reinsurance for captives and their owners
- Tax issues.

Call today to receive a brochure for the longest-running, most successful of all the captive conferences.

Captives in Brief
Tuesday, March 10 - \$375.00

The Forum
Wednesday - Friday, March 11-13 - \$750.00

For further information, contact:
Eileen Callahan, Conference Director
Towers Perrin, 100 Summit Lake Drive
Valhalla, NY 10595 (914) 745-4611.

Tillinghast

a Towers Perrin company



Business, unions seek to cope with health care reform

By CHRISTINE WOOLSEY

CHICAGO—What kind of national health insurance scheme can guarantee access, quality and cost effectiveness in a nation that is being strangled by a huge deficit?



That question is a topic of continual debate among business, labor and medical groups. About the only thing they all agree on is that something needs to be done to halt runaway health care costs.

Corporate America has a significant stake in the debate because the current U.S. health insurance system is essentially employment-based. Labor, though, opposes efforts by employers to shift more costs to workers, while at the same time supports equal access to health care for all Americans.

Now there are some signs that both factions may be willing to meet halfway to forge a solution to the problems of health care costs and access.

Business and labor leaders presented their views on health care policy reform earlier this month at the Council on Employee Benefits' fall conference in Chicago.

One factor that has delayed a solution is a "40-year run of dominance by health care providers in the health care policy debate," said Gerald Shea, director of the health care division of the Service Employees International Union in Washington, D.C. The AFL-CIO-affiliated union represents workers in low-wage service jobs.

Employers were "conspicuously absent" from the health care policy debate that began in the early 1940s, Mr. Shea said.

But "that's changing now," he added. The change was spurred by President Carter's failed efforts to create a national health insurance program. Employers "were left on their own to deal with huge health care price increases," he said.

"The government has moved very quickly to solve its problems with health care costs," he noted. But Medicare and Medicaid cost controls have resulted in "a continual cost shift to private payers."

Employers "became more sophisticated health care purchasers in the 1980s," he said. "And purchasers—rather than providers—became more and more dominant in the health care policy reform equation."

Urging employers to "take control of the debate," Mr. Shea predicted that the debate in the 1990s will be characterized by "a clear dominance by purchasers."

But their expectations, he cautioned, should be realistic and include some form of government involvement. "Any health care policy reform requires major government action. Going it alone is not a viable strategy," Mr. Shea said.

Calling on business and labor to take an active role in the health policy debate, he said that "no one else is taking a leadership role, including providers and insurers."

Most of the ideas so far from insurers and medical groups "seem to be more damage controls than realistic solutions," Mr. Shea said.

Some employers agree that a solution will include government involvement.

"The feds are so involved now, we have to realize that is where the change will come from," said Barbara L. Decker, division manager

of health care planning and legislation at Southern California Edison Co. in Rosemead, Calif.

The federal government is currently the biggest payer of health care expenses—paying about \$1 out of every \$3 spent on health care in the United States, Ms. Decker said. She suggested that tax increases may be a necessary evil in health care reform.

Government also may be able to help curb the "technology arms race" that is driving up health costs nationwide, she contended.

Continued on next page

Editorial Index Service

The Business Insurance Editorial Index Service directs you to all news reports and feature articles published by Business Insurance newsmagazine.

The annual service includes 3 quarterly reports and a cumulative annual volume. In addition, article citations between publication of quarterly reports are available from BI's Information Centers in New York and Chicago. Complete alphabetical and chronological listings by company, person, subject and geographic location enables you to access data quickly and accurately.

Take advantage of this cost effective tool and fill out the coupon today or call 212/210-0137.



Editorial Index Service **Business Insurance**

220 East 42nd Street, New York, NY 10017

Please send me the following index(es):

Full Index Service at \$100* 1991

Softcover editions at \$100* each:

1986 1987 1988 1989 1990

Hardcover editions at \$150* each:

1981 1982 1983 1984 1985

* foreign postage additional

TOTAL ENCLOSED \$ _____

PAYMENT MUST ACCOMPANY ORDER —

Visa Mastercard Optima American Express

Check Enclosed (payable to Business Insurance)

Account # _____ Exp. Date _____

Signature _____

Name _____

Title _____ Phone _____

Company _____

Address _____

City _____ State _____ Zip _____

1991 | 1992

Business Insurance

DIRECTORY



of Corporate Buyers of Insurance, Benefit Plans and Risk Management Services

Updated and expanded, the 1991/92 Directory includes information on more than 13,000 executives from over 2,100 companies of all sizes located throughout the U.S. Plus, vital statistics on all companies listed include:

- primary type of business
- sales or assets
- number of employees
- name and title of chief financial officer
- names and titles of executives directly responsible for:
 - employee benefits — pension/retirement plans — personnel — risk & insurance management — property/casualty insurance — international employee benefits and/or risk management

Order the 1991/92 Business Insurance Directory of Corporate Buyers today — gain access to the executives who are directly responsible for the purchase of commercial insurance, risk management and employee benefits.

Order today! Complete the coupon and mail, or phone 313/446-1623. For tape sales or information call 313/446-1625.

Mail to:
Business Insurance Directory Single Copy Sales
965 East Jefferson Avenue Detroit, MI 48207

Reserve _____ copies

\$95 each

15% discount when you order 5 or more.

All orders must be prepaid.

Make check payable to:

Business Insurance Directory

Total enclosed: \$ _____

or charge my Visa Mastercard

American Express Optima

Account # _____

Exp. Date _____

Signature _____

print name _____

title _____

company _____

address _____

city _____ state _____ zip _____

phone _____

Health care reform

Continued from previous page

As an example, she cited the oversupply of costly advanced medical equipment in areas where health care providers are particularly competitive. That waste pushes up costs for payers, she said.

One lesson both business and labor learned in the 1980s was that it is unproductive to fight over who would pay the higher costs.

"There is just no winning under the current rules of the game," said Mr. Shea, the union representative. "But there is some success when labor and management work together to change the rules."

"We favor a social health care system and we are seeking to bring coverage to those who don't have it," Mr. Shea said. Yet, "most of our time is spent trying to put off cost shifts to employees."

Labor groups are willing to look at other reform proposals, though

most ideas now on the table are small "piecemeal approaches" that won't succeed, he contended.

Mr. Shea suggested that health care cost, access and quality be dealt with in one reform package. Those reforms need not be "government-run," but should probably be "government organized," he said.

Above all, the nation needs a "uniform set of rules about buying health care," Mr. Shea said. "The key lesson when you look around the world at other health care systems, you see everyone is put in the same system," he explained.

Achieving such uniformity will be difficult if not impossible, said Robert Hungate, manager of health care government affairs for Hewlett-Packard Co. in Washington, D.C.

"All of the platforms say health care access must be universal. But you need to define what you will give access to," Mr. Hungate pointed out. The cost, level and

quality of health care services that will be universally offered will have to be established.

Some reformers want a U.S. national health care system based on the Canadian model. Canadians enjoy free access to health care, but their system is not "monolithic," Mr. Hungate pointed out. The quality of services and equipment varies among the provinces, and research shows that provinces with higher incomes have higher health care prices.

The U.S. health care system is not much different, he said. On a per-capita basis, Massachusetts far outspends Mississippi on health care, so the question becomes which standard to use for the nation, Mr. Hungate explained. "As soon as you start talking about making health care available to all, you have to decide what level you'll make available. People are quite different in their spending patterns and that has to be figured in."

Furthermore, "we have managed our benefits programs very much based on individual benefits needs, not societal benefits needs," Mr. Hungate said. Some people may think that mammograms should be covered by any minimum universal benefit package, while others would say breast cancer is not as big a concern as cardiac problems and would demand that preventive services for heart disease should be included.

Mr. Hungate also pointed out that a successful health care system will include only the most cost-effective and highest-quality providers. As data on mortality rates at different hospitals and medical care facilities becomes available, it will have to be factored into any discussions about reform, he said.

All parties involved in the health care policy debate will have to make some trade-offs, Southern California Edison's Ms. Decker acknowledged.

Employers, for instance, may have to accept mandatory coverage to help even the playing field, while labor may have to accept more cost shifting, she said. "It makes sense for people to have a financial interest in the health care they receive," she noted.

Physicians and hospitals, too, will have to accept cost containment if reform is to succeed, she said. And insurers may have to swallow more regulation that would help eliminate inefficiencies, like duplicative administrative services.

Among the health care reform "building blocks" that Ms. Decker favors are:

- The creation of a national health care council to monitor health spending, propose non-enforceable expenditure targets and report annually to Congress on the causes of rising costs.

- Payment reform that would, among other things, eliminate cost shifting and improve access for the uninsured.

- Waivers of antitrust restrictions that would permit community multi-payer consortiums to negotiate with providers, increase market power of third-party payers—regardless of size—and modify the balance of power from providers to purchasers.

- Capital spending for a data base that would track significant health care capital purchases to help reduce costly duplication of resources and to improve geographic distribution of resources.

- Standardized claims forms used by all third-party payers that would provide data for an integrated health care data base and reduce administrative costs.

- The creation of a technology assessment agency that would help determine the effectiveness of new procedures and equipment, publish utilization and coverage guidelines for insurers, rationalize the introduction of new technology based on outcome research.

Moderating the session was John McMahon, director of employee benefits for TRW Inc. in Cleveland. ■



IF YOU'RE INTO HIGH RISK D&O BUSINESS, MAKE SURE YOU'VE GOT A GOOD NET.

From a broker's standpoint, the riskiest thing about writing high-risk D&O business isn't the clients.

It's the carriers.

Unfortunately, it seems that the companies most willing to take on the toughest risks are the toughest ones to find when it comes time to pay a claim.

There is one exception, however. It's the Executive Liability Division of Agricultural Excess

and Surplus Insurance Company (AESIC).

Our Non-Standard Risks Department can provide your high-risk clients with coverage up to \$5 million. And it comes with a couple of features many carriers can't touch.

Like an A.M. Best Rating of A+. And a reputation for responsive, cooperative D&O claims handling that's second to none in the industry.

So if you have D&O clients who are flying in high-risk territory, don't be afraid to go along for the ride. Just make sure they've got a good carrier to fall back on.

Like AESIC.

For more information, please call or write Agricultural Excess and Surplus Insurance Company, Executive Liability Division, P.O. Box 66943, Chicago, IL 60666. (708) 330-6750.

AESIC
Agricultural Excess and Surplus Insurance Company
A subsidiary of Great American Insurance Companies.

CEB's annual fall meeting attracts 200

CHICAGO—Attendance at this year's International Council on Employee Benefits fall conference held here Oct. 3-4



reached nearly 200. The 1991 fall conference was the 45th in the organization's history. The conference, dubbed "Benefits in Transition" featured sessions on managed health care programs, program effectiveness, developments in managed prescription drug programs, health care public policy and health care data management.

The CEB, founded in 1946, is composed of representatives from 183 companies interested in employee benefit planning. The organization's president is John K. McMahon, director of employee benefits for TRW Inc. of Cleveland. This year's general conference chairman was William E. Quarterman, manager-benefits planning and research for Ford Motor Co. of Dearborn, Mich.

The fall conference is the organization's only annual event that is open to both members and non-members. The next fall conference is scheduled to be held in Boston Sept. 30-Oct. 2, 1992 at The Westin Hotel Colony Place. ■

Pharmacy costs managed under network system

By LORI BLOCK

CHICAGO—Employers could better contain their prescription drug costs by adding a managed pharmacy network to their managed prescription drug plans, an insurer says.

Managed prescription drug plans have made great strides since their introduction more than two decades ago, but these programs fall short of actual cost containment, he said.

A managed drug program today may comprise "a well-designed and managed network of community pharmacies" that assure employees "the best quality and the lowest cost," said Perry Cohen, assistant vp-medical policy and programs for Aetna Health Plans, a unit of Aetna Life & Casualty Co. of Hartford, Conn.

The concept evolved over a 20-year history of managed drug programs, starting with prescription card programs in 1970, advancing to standardized pharmacy claim submissions in 1977, the arrival of mail-order drug programs in 1985, and the advent of on-line claim submissions in 1987.

Several trends are driving the move toward a complete managed drug program that includes a managed pharmacy program, Mr. Cohen said at the Council on Employee Benefits' 45th annual fall conference in Chicago earlier this month.

Those trends include:

- An increasing demand by employers to control the cost of their prescription drug benefits.

- The willingness of employers to carve out the outpatient drug portion of the benefit and manage it separately.

- The existence of technology that allows for the sophisticated management of pharmaceuticals in community pharmacies.

- The pharmaceutical industry's acknowledgment of the ability of managed care pharmacy programs to control utilization in the outpatient setting.

- Increased efforts by the federal and state governments to control the cost of pharmaceuticals for the elderly and the poor.

"My read of what's happening now is cost shifting, not cost containment," Mr. Cohen said.

Cost-containment efforts like mail-order prescription drug programs, which may improve access and lower costs when compared to indemnity programs, ultimately fall short, Mr. Cohen said.

Statistics on the actual savings generated by these programs are poor, he said.

And, Mr. Cohen added, mail-order drug programs can only effectively provide medication for chronic conditions like insulin-dependent diabetes or high blood pressure. He added that generally, such programs are unable to meet the needs of a patient suffering from a more acute condition, like an infection, that would require immediate treatment.

In addition, existing efforts to manage prescription drug costs fail to address a crucial problem: waste. Mr. Cohen reported that 40% of all prescription drugs are not taken to completion. Of course, 100% of these prescriptions are paid for, he said.

"There's an opportunity there for

some real cost savings," Mr. Cohen said.

And perhaps that is where the implementation of a managed pharmacy network can help, he said.

As with so many other managed care initiatives, the key here is data, Mr. Cohen said.

"You cannot manage what you cannot measure," Mr. Cohen observed.

With an electronically connected pharmacy network, benefit managers can obtain the most current utilization information at the time the drug is being dispensed, according to Mr. Cohen.

This data, when coupled with a three-part drug utilization evaluation program, should cut down on the waste and, hence, produce savings, he said.

Mr. Cohen explained that drug utilization should be evaluated by the physician prospectively, or before the drug is prescribed; by the pharmacist concurrently, or before the drug is dispensed; and by the physician, pharmacist and patient retrospectively, or after the patient has taken the drug.

The goal of this drug utilization evaluation program is to ensure that "the right drug is prescribed to the right patient in the right dose at the right time using the right brand at the right price," Mr. Cohen said.

However, "if no action is taken to change (inappropriate) patient or provider behavior," then all a company has done is add to the cost of its program, Mr. Cohen stressed.

The ideal managed pharmacy program should feature a master prescription data base that both physicians and network pharmacists could access, Mr. Cohen commented.

This data base should include not only claim and other information from all existing drug programs, but also a medical information data base consisting of medical, hospital and ancillary service claims data.

By combining prescription data with all the other medical data, employers can "see what works and what doesn't," Mr. Cohen explained.

When designing a drug benefit program, employers initially should cover only prescription drugs, he recommends.

In addition, the use of generic substitutes should be made mandatory, employee copayments should be required, supplies should be limited to just 30 to 60 days to cut down on waste, and the benefit should cover prescriptions obtained from network pharmacies only.

The ideal managed pharmacy program would provide coverage for necessary and quality drugs; ensure that pharmacies are reasonably accessible; offer appropriate financial incentives for both patients and pharmacists to participate in the program; and rely on on-line pharmacy claims submission for control.

Such a program should minimize waste, eliminate fraud, track abuse and ultimately would manage—rather than shift—costs, Mr. Cohen maintained.

Mr. Cohen's discussion was part of a two-part session on managed care developments.

The session's moderator was CEB President John K. McMahon, director of employee benefits for TRW Inc. of Cleveland. ■

Canadian market

Continued from page 2

obviously needs a very significant rate increase," he said.

The outlook for liability insurance is more encouraging from a risk manager's point of view, said Mr. Belton. The loss ratio for this business for the 12 months ending June 30 was 64.5%.

At that level, because of the relatively high investment income on claims reserves, liability business is still probably producing a satisfactory return on insurers' capital at risk, he said.

As a result, unless there is a dramatic increase in claims, liability rates are likely to remain stable, according to Mr. Belton.

Focusing on the longer-term picture, Mr. Belton said that overcapacity in the market will ensure that "hyper-competition" will continue "and the financial strength of the less agile, the less efficient, the less well-capitalized

insurers—and brokers, for that matter—will gradually deteriorate."

Weaker companies will eventually be weeded out, he added, but there is little likelihood of a major market crunch any time soon.

Instead, Mr. Belton foresees a "slow and stately" process, perhaps best described as "gradual attrition."

One of the possible consequences of this slow process is that European insurers are likely to become even more dominant in the Canadian market, Mr. Belton said. They seem to have capital and they are global thinkers, he said. On the other hand, he added, Canadian-owned insurers "don't have global horizons."

"We may see the Japanese enter the market in a significant way," added Mr. Belton. But, with capital now flowing back into Japan, he said he does not expect that to happen soon.

While the marketplace that emerges will have fewer players and be less fragmented, it will still be overcapitalized, "unless shareholders reverse their long-standing habit of parking their surplus capital."

If interest rates are low enough and the demand for capital grows, there would be opportunities for investors to put their capital elsewhere, said Mr. Belton.

However, even should the industry remain overcapitalized, a "more disciplined, less fragmented and more stable market" should eventually emerge, Mr. Belton predicted.

"During the transition, the risk manager will have to be alert to monitor developments carefully and be prepared to quickly adjust to the rapidly changing conditions in the marketplace," Mr. Belton warned.

Another speaker, Brian Johnston, president and chief executive

Continued on next page

The Only Corner You Have To Cut To Save On Health Claims Administration Is On This Page

If you are insured or self insured, we can show you how to reduce your monthly health claims administration costs to the lowest in the industry. Without cutting service or quality. So, if you feel you're paying too much, cut it out. Send this coupon to Amalgamated Life, 770 Broadway, New York, NY 10003, Attn. Sandy Reisman. For faster results, call **212-228-2391**.

Name _____

Company _____

Address _____

City, State, Zip _____

Telephone _____

ALICARE, INC.



Amalgamated Life
INSURANCE COMPANY SINCE 1943

Alicare is a wholly owned subsidiary of Amalgamated Life Insurance Company.

THE SPECIALISTS IN TEXAS ACT REJECTION

- As one of the leading risk management consulting firms, we can help you sort out the advantages and disadvantages of each option.
- Most knowledgeable in all aspects of non-subscriber consulting, offering the most comprehensive programs available in risk control, defense documentation, claims management, medical network, ERISA and tax deductibility issues, as well as specialized excess insurance.
- Unique feasibility study approach.
- Actuarial claims analysis and budget projections.
- Brokerage inquiries invited.
- Providing risk management advice to clients for 56 years.



Risk Analysts, Inc.

4828 Loop Central, Ninth Floor
Houston, Texas 77081
713/669-4771 FAX: 713/669-4724

Canadian market

Continued from previous page
officer of CIGNA Insurance Co. of Canada in Toronto, presented several predictions of the Canadian market's course over the next year.

Among his predictions:

- There will be some hardening of the market in 1992.

The shift will be felt more acutely in the energy sector because of the turbulent reinsurance market in the United Kingdom and Europe, he predicted.

Property rates "certainly have to increase," he added.

- There will be a reduction in the number of "pure" Canadian underwriters.

- Although there will be fewer players, the Canadian market's size will not diminish and capacity will remain stable.

- The ability of Canadian companies to retain larger portions of their risk will begin to see "a moderate increase."

Another speaker made a forecast of developments over the next decade in the Canadian market.

Gerald A. Wolfe, vp for General Reinsurance Corp. in Toronto, made several predictions for the course Canada's reinsurance market will take in the next decade.

Total reinsurance assumed in Canada was \$1.9 billion Canadian (\$1.64 billion at year-end exchange rate) last year, while total reinsurance ceded totaled \$2.6 billion (\$2.24 billion).

Mr. Wolfe said treaty business accounts for 80% to 85% of the business, with facultative making up the remaining 15% to 20%. A total of 85% to 90% of the Canadian reinsurance business is brokered, with the remaining 10% to 15% direct business. Of the facultative business, about 35% is brokered, while 65% is written on a direct basis.

Over the next decade, Mr. Wolfe predicted that:

- There will be fewer primary players because of withdrawal, consolidation and acquisition.

- There will be less of a demand for treaty reinsurance as a percent of the overall market, while facultative demand will increase. He attributed this shift to the development of the errors and omissions market for service industries.

- There will be more excess-of-loss and less proportional reinsurance for both treaty and facultative business.

- Larger reinsurers will garner a greater share of the market because of surplus and quality issues, as well as the consolidation of players.

"I think there will be more of a flight to quality," said Mr. Wolfe.

- There will be fewer reinsurers entering the Canadian market and perhaps more leaving or consolidating.

- The demand for higher catastrophe covers will continue.

- An increase in property reinsurance rates is coming soon, while casualty business will remain flat.

This is because the cost of catastrophe covers will climb, while retrocessional capacity is increasing, Mr. Wolfe said.

- Demand for financial reinsurance by Canadian cedants will grow.

- Canadian reinsurance regulation is unlikely to change.

- Long-term players will do well.

Also speaking at the session was Christopher R. Markwell, senior vp-insurance for the Royal Bank of Canada in Montreal, who spoke on the impact of proposed legislation on Canada's insurance industry.

Proposals expected to be enacted early next year will allow banks to purchase and wholly own insurance companies, he said. Bank holdings are now capped at 10%.

"Allowing Canadian banks to own property and casualty insurance companies can bring financial stability to the industry in at least two ways," Mr. Markwell said.

"First, Canadian banks will be able to inject Canadian capital into an otherwise foreign-dominated industry and, second, the destiny of Canadian-owned companies will be more determined and controlled in Canada by Canadians," he said.

"How many examples can we think of in recent years involving foreign-owned Canadian insurance companies that have departed, been cut back, sold, merged or have restricted writings because of the parent company's misfortunes or changes of strategy at home?" Mr. Markwell asked. "These decisions have had massive implications for the Canadian insurance marketplace."

Also speaking at the session was Bernard Rodrigues, superintendent of insurance for Alberta, who is based in Edmonton. The session was moderated by Richard Saylor, insurance and risk manager for Coca-Cola Beverages in Toronto. ■



**Prescription Service
by Mail**

Looking for a Prescription Plan That Makes Sense?

A remedy for the high cost of prescription benefits from RxAmerica,™ the home delivery prescription service of American Drug Stores.

- Are your prescription drug costs more than 8% of total health plan costs?
- Are your prescription drug costs rising at more than 15% per year?
- Is your plan's generic substitution rate less than 18%?

If you can answer "yes" to one or more of these questions,

RxAmerica™ can help:

- Cost Containment
- Increased Generic Utilization
- Flexible Plan Design
- Ease of Administration

Let us help you create a drug benefit plan that makes sense for you.

For more information, call
Wade Hall, National Sales Manager, at
1-800-999-1242.

RxAmerica

369 Billy Mitchell Road, Salt Lake City, Utah 84116



Everyone knows exactly who's responsible for the health care crisis.

What may be even worse than the skyrocketing cost of health benefits is all the finger pointing that goes with it.

It sometimes seems as though many people believe that fixing blame will somehow fix the problem. Meanwhile health care costs continue their upward spiral.

Yet it's clear, the only way we'll ever truly manage the cost of health care, and make care available to the greatest number of people, is for each of us to shoulder our fair share of responsibility. That, we believe, is the essence of managed care.

For our part, Aetna Health Plans has implemented a comprehensive managed care strategy founded on four key strengths.

First, superior medical management digs deeply into issues of utilization, pricing and quality management, looking beyond the typical cost containment and utilization review.

Second, insightful information management arms providers, customers and our own administrators with greater knowledge for making effective health care decisions.

Third, our formal quality management program, Operation Excellence, establishes baseline specifications against which we measure performance. The program enlists every Aetna Health Plans employee in identifying ways to improve customer service.

Finally, Aetna's full line of managed care products,

from managed indemnity to health maintenance organizations, affords employers unsurpassed flexibility in benefit design.

These initiatives effectively bring providers, employees and employers into the process of managed care. With tangible results. Last year we saved our customers a record \$1.95 billion.

Of course we're not promising an end to all your health benefits problems. At least not yet. But learn more about our approach to group health care and we think you'll agree: With Aetna Health Plans you're definitely pointed in the right direction. Call (800) 776-7602, ext. 22. Fax (214) 401-8562. **A policy to do more.**



Aetna Health Plans

Renaissance men rethink their 'function'

By JUDY GREENWALD

EDMONTON, Alberta—The risk manager's role has expanded beyond simply purchasing insurance to being involved in risk identification and risk control throughout a company, a consultant says.

However, risk managers must educate senior management about risk management's importance if they are to continue to evolve, a retired professor of risk management says.

These were among the views at a panel discussion titled "Risk Management Renaissance—Advancing the Art" during the Canadian Risk Management Conference held last month. That theme was also the theme of the conference, which was hosted by the Northern Alberta chapter of the Risk & Insurance Management Society Inc.

A departure point for much of the discussion were the thoughts of H. Felix Kloman, vp and principal of the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. in Stamford, Conn. Mr. Kloman, who was not present at the meeting, had written that: "Risk management should be seen more as a function than a specific position. It should be practiced by many levels of management, with coordination and guidance from the senior level."

David Warren, founder of consultant Warren, McVeigh & Griffin Inc. of Newport Beach, Calif., and now an independent consultant based in Orinda, Calif., noted that risk management can be the difference between a company's profitability and its bankruptcy.

Why, then, are risk managers not higher up in the corporate hierarchy?

One reason, Mr. Warren suggested, is that risk managers have reached their position from the "bottom up, not the top down." Two very good risk managers he knows, for instance, started out as secretaries in their departments. This shows that education is less important than a solid background in risk management, he said.

"Risk management is simply management," said Mr. Warren. The risk manager, in fact, does what the chief executive officer would do if the CEO were blessed with the risk manager's knowledge.

The risk manager must have a "holistic view" of his or her organization and must be knowledgeable in a wide variety of subjects, said Mr. Warren. The risk manager, in fact, is probably best suited to hold a top management job because he or she looks at the organization as a whole entity.

What kinds of risks should a risk manager address? "All of them," Mr. Warren said. Of course, the risk manager will not make decisions about areas like product design, but these factors could affect a risk management decision, he said.

Historically, risk managers have been part of the finance department, noted Mr. Warren. But, in light of the diminishing role insurance purchasing plays in risk management, is that still the proper place for them? he asked.

Theoretically, he said, the risk manager should report directly to the CEO. But from a practical standpoint, the CEO can only have a few people directly report to him or her.

In deciding to whom to report, Mr. Warren suggested that the determining factors should include which departments the risk manager contacts most often, which is the best position from which to contact people, and where will the risk manager have the greatest visibility.

Mr. Warren commented that only 36 years ago, no one held the position of risk manager within a corporation.

Obviously, he said, the discipline

has made great strides since then. But, to continue to achieve what it wants to achieve, risk management must take the initiative, said Mr. Warren. "Nothing is going to be handed to us."

For example, risk managers must take the initiative in selling management on the need to upgrade the function, Mr. Warren said. "The future does look bright, but only if risk managers take the initiative and make it happen," he said.

Wayne Snider, professor emeritus at Temple University in Philadelphia, said at the session that most in the profession are in agreement as to the desirability of a "renaissance" in risk management.

However, such developments take time, he said. For example, the concept of risk management was first outlined publicly in 1955, but it was

not until January 1965 that Douglas Barlow, who also spoke at the session, was appointed one of the first risk managers.

Mr. Barlow, who is now retired as risk manager of Toronto-based Massey-Ferguson Ltd., said at the meeting that if risk management is to evolve, it will be because it demonstrates it has survival value.

"The test of survival value is the opinion of the chief executive officer," he said.

Temple's Mr. Snider said that if a risk management renaissance is to occur, there must be an education program directed not at risk managers but at senior management, to change their perspective of what risk management is.

This program must be directed at business schools, "where the future leaders will come from," he said.

Risk management must be introduced now in management, financial and human resource courses, Mr. Snider suggested.

It will take 20 to 30 years before students exposed to risk management reach the top positions in business, he said. However, "you are laying the seed of a different perspective. This must be done."

Mr. Snider also discussed the importance of catastrophe management, whereby risk managers bring together senior management from every area within the corporation, tap their thinking on what risks the company faces and plan accordingly.

"If the renaissance is to occur, this is the crucial area of activity, and this is within your control," he said.

Also speaking at the conference was Robert W. Esenberg, president of the Risk & Insurance Management

Society Inc. and risk management director for the city of Virginia Beach, Va.

Mr. Esenberg said the risk management profession must be prepared to change because of the expansion of the global economy in Europe, the United States, Canada and elsewhere.

Other speakers at the session included Ward Ching, a senior consultant with Tillinghast in Irvine, Calif.; Michael L. Smith, associate professor on the faculty of finance at Ohio State University in Columbus, Ohio; and Paul A. Gray, manager-risk, safety and regulatory affairs at Nordion International Inc. of Kanata, Ontario.

The session was moderated by Michael Salter, manager-risk and insurance for Alberta Energy Co. Ltd. of Edmonton, Alberta. ■

"This is the only Claim Management Team fast and reliable enough for The Hertz Corporation."

Risk managers, audit committees should meet

By JUDY GREENWALD

EDMONTON, Alberta—Risk managers should be talking directly to their board of directors' audit committees, and not necessarily with their bosses present, says a retired banker.

Hal Wyatt, retired vice chairman of the Royal Bank of Canada in Calgary, Alberta, and a board member of several corporations, recommended that boards of directors take a more direct interest in risk management.

Mr. Wyatt spoke during a session at the Canadian Risk Management Conference, held here last month and sponsored by the Northern Alberta chapter of the Risk & Insurance Management Society Inc.

Retired banker suggests open talks without bosses present

"It is imperative that boards of directors include regular reviews of risk and insurance management matters as a part of their responsibilities," Mr. Wyatt said.

And, he suggested that boards of directors' audit committees play a key role in this process. While he said audit committees have dramatically increased the corporate matters they examine, "as far as I can ascertain, not many audit committees, or the full board, have concerned themselves nearly enough with the state of the company's risk and insurance management program."

Instead, they essentially have relied on management to evaluate insurance and how the company's risks are being managed, Mr.

Wyatt said. However, "more and more frequently they are coming to realize this falls far short of performing their duties," he said.

Mr. Wyatt said some of the boards he serves on receive an annual insurance report that is usually submitted by the chief financial officer, treasurer or corporate secretary, none of whom can necessarily give a well-informed opinion on coverage details.

Mr. Wyatt said there have been only two cases in his experience where there has been an opportunity for a face-to-face discussion with the risk manager. "In none of these cases has the risk manager been questioned independently of other senior officers of the company. And this is what I think

needs to change," he said.

Mr. Wyatt said as a first step, the audit committee should be more involved in studying at least these four elements:

- Identifying the company's exposure to accidental or fortuitous losses that could seriously impair its resources.

- Evaluating the risk in terms of past losses and potential future losses.

- Designing ways to control the risk by implementing measures to eliminate hazards, improve safety and heighten concern for the environment.

- Financing the risk to ensure there are sufficient funds to meet loss situations as they occur.

"It should not be difficult to gain

the interest and support of directors concerning the important role you play in enhancing and protecting a company's financial well-being," he said. "After all, aren't your objectives much the same?"

The question is how risk managers can communicate their concerns to directors, said Mr. Wyatt. "In so many companies the risk manager's reporting relationship shields him or her from the board if reporting through the corporate secretary or the chief financial officer," he said. "All too frequently it is the latter who attempts to explain insurance matters to the board. I question if this is adequate or even at times worthwhile."

Mr. Wyatt recommended that the audit committee comprehensively examine the company's insurance program at least once a year. "The risk manager should make a report to the board annually and respond to questions, which should take place without other senior company officers present," he said.

In addition to being questioned about the company's risk management program, risk managers should be given the opportunity to speak freely on all risk and insurance management matters, suggested Mr. Wyatt. The audit committee chairman should also be kept informed of any major changes in the program, he said.

Corporate structure also can hinder effective communication for risk managers, according to Bernard S.Y. Fung, global managing director in Toronto with Anistics, an Alexander & Alexander Services Inc. consulting unit.

There is an increased tendency for organizations to become more decentralized, with managers able to make more autonomous decisions, said Mr. Fung, who also spoke at the session. As a result, "you really have to go and persuade your colleagues" to follow risk management procedures.

"In a decentralized organization, risk management must also be promoted by everyone" from the top of the firm to the bottom, he said.

Mr. Fung warned also that "There is still a lot of confusion, certainly, in the minds of corporate management" between the concepts of insurance and risk management, he said. "Some of you are not helping" by focusing on insurance instead of on risk management with company managers.

Risk managers are still taking a "carrot and stick" approach, rather than telling management what they must do, he said. And they are using too much jargon and technical language, he said.

Among those with whom the risk manager should communicate, he said, are boards of directors, senior management, operational management, employees at large, financial institutions and the community.

And rather than adhering to a narrow focus in communication, risk managers should focus on general practices and guidelines that will guide the organization. The risk manager must provide guiding principles and overall strategic thinking to direct other employees in making the right decisions, Mr. Fung said.

A risk manager must also communicate in the context of enhancing company results, he said. "Every decision will have an impact on the value of the firm."

Also speaking at the session was Keith R. Gibson, risk manager for the Municipal Insurance Assn. of British Columbia, based in Richmond, British Columbia; and Michael L. Smith, an associate professor of finance at Ohio State University in Columbus.

The session was moderated by Peggy A. Stirrett, director-risk management for Calgary-based Petro-Canada Inc.

"Now, you can have them on your side."

Looking back, it was inevitable.

When The Hertz Corporation searched for a TPA that could combine the most reliable personal service with the fastest, most sophisticated computer technology, none measured up to their standards.

So, they created their own unique team. And Hertz Claim Management, a separate subsidiary of Hertz, was born.

Today, over a decade later, Hertz Claim Management provides complete claim management services for employee benefits, worker's compensation, and liability claims — to insured and self-insured corporations, municipalities and associations across the country.

They currently process claims amounting to over \$750 million yearly. And have become to the claim management industry what Hertz is to the car rental industry. The fastest, most reliable team in the business. ”

B.J. Shomer

HCM

Hertz Claim Management

Surplus Underwriters Casualty Insurance Company: Specialists in *all* areas of miscellaneous health care malpractice

Surplus Underwriters is a unique market for miscellaneous health care malpractice coverage. We are a stable, financially sound, 21 year-old company supported by A.M. Best "A"-rated reinsurers, and this is the *only* class of business we write. Because it is our specialty, we often write services and professions other companies refuse. Surplus Underwriters is an approved surplus lines insurer in most states.

For more information or a quote, call today:

713/522-6533

**SURPLUS UNDERWRITERS
CASUALTY INSURANCE COMPANY**

3121 Eastside • Suite 545 • Houston, Texas 77098
Fax: 713/639-6330

Canada's cleanup costs far exceed insurers' surplus

By JUDY GREENWALD

EDMONTON, Alberta—The estimated cost of cleaning up Canada's waste sites far exceeds the insurance industry's capital and surplus, warns a Canadian broker.

While estimated cleanup costs range from \$15 billion Canadian to \$210 billion Canadian (\$13.28 billion to \$185.91 billion at current exchange rates), Canadian insurers only have about \$9.5 billion Canadian

(\$8.41 billion) in capital and surplus, says Ronald Poole, senior vp at Reed Stenhouse Cos. Ltd. in Toronto.

Many Canadian insurers are foreign-owned, he said, and a large percentage of that total capacity could be repatriated, "because there is very little of it that we actually own."

Mr. Poole presented this gloomy scenario during a session of the Canadian Risk Management Conference, held in Edmonton last month and sponsored by the Northern Alberta chapter of the Risk & Insurance Management Society Inc.

He observed that finding funds to pay for pollution cleanup in Canada could be even more difficult than in the United States, where total cleanup costs are estimated to be between \$150 billion and \$2.1 trillion. Total capacity and surplus for the U.S. insurance industry, though, is estimated at \$150 billion.

Mr. Poole also said Canada tends to lag five years behind the United States in litigation trends. Some of the same environmental insurance issues that have been litigated in U.S. courts, including what constitutes a claim and what is equitable relief, are now surfacing in Canadian courts.

And he sees no reason to suppose that the drift of events will differ from what has occurred in the United States. "So much for our smugness," he said.

Mr. Poole said that with no practical way to purchase retroactive environmental liability coverage, risk managers must study past policies for possible coverage. Underwriters will pay an "enormous price" for having written policies in previous years that weren't as explicit in their exclusions as today's policies, he said.

Discussing the shape of the future pollution insurance market, he said, "I foresee a very difficult period which is going to cost all of us dearly."

However, for the time being, there will be a supply of environmental insurance products that is "prudently and selectively underwritten and tightly engineered," Mr. Poole added.

He predicted that some environmental liability coverage will become available, although it will be "subject to the swings of market capacity."

Mr. Poole said he expects the market to develop claims-made environmental liability policies under which a sudden, accidental and environmentally damaging event must be reported within 120 hours of the first occurrence.

In the short term, Mr. Poole believes a market will begin in specialty environmental liability coverage for financial institutions, architects and engineers errors and omissions and similar exposures. Limits will not exceed an aggregate of \$10 million, however, and the coverage will be "relatively expensive."

There also is the likelihood the alternative market will grow, he said. By definition, through the alternative market companies can become investors at the same time they are insurers. These facilities will become more numerous and will be an important element in Canada, he said.

In addition, Dennis Thomas, a senior partner with the Milner Fenerty law firm in Edmonton, said there is pressure in Canada to follow the same route as the United States by introducing laws like the Comprehensive Environmental Response, Compensation and Liability Act—or Superfund. However, as an attorney, Mr. Thomas said, "I just hope and pray we don't bring it to Canada."

Focusing on particular projects and getting sites cleaned up through

Continued on page 22

When a small miscalculation adds up to big litigation.



People make mistakes. A misplaced decimal point on an important financial document. A confusing telephone conversation that leads to mistaken action. A missed deadline. Unfortunately, in our suit-happy society, small mistakes can add up to big legal battles. And without proper errors and omissions coverage, they can prove disastrous to your client's bottom line.

In our service economy, more and more businesses are at risk. Like specialized computer software design, environmental testing labs, medical account management, credit reporting firms and marketing consulting companies.

Customized errors and omissions coverage from Media/Professional Insurance provides the protection today's service businesses can count on. Our staff attorneys and underwriters work as a team to handle applications and claims promptly and with expertise. And through A-rated Gulf Insurance Group, we can offer thorough coverage at realistic premiums.

Make sure your clients are protected from lawsuits they hadn't calculated on. Call the E&O experts at Media/Professional Insurance. Because nobody counts on making mistakes.



Media/Professional Insurance, Inc.
Two Pershing Square, Suite 800 • 2300 Main Street
Kansas City, Missouri 64108 • 816-471-6118

America's E & O Authority



OUR ANSWER ISN'T JUST ANOTHER PLUG.

Today's employee health care system is shot full of holes. Unnecessary surgical procedures, extended hospital stays, inappropriate diagnostic testing, over-utilization of psychiatric and substance abuse benefits, code gaming and the rubber stamping of claim payments can seriously drain a company's profits.

Insurers that address only one or two of these problems won't stem the flow.

At ITT Hartford, we take a total approach to cost containment. Managed care networks, utilization management (including psychiatric and substance abuse review), hospital bill audits, health care provider profiling and careful attention to monitoring and managing claims are all part of our process.

Everybody's plugging cost containment these days. The ITT Hartford difference is a strategy that's as comprehensive as it is conscientious.

For a program that holds water, talk to us.



ITT HARTFORD

For The Best In Life—And Health.

CAFETERIA PLAN SOFTWARE



If you're an employer thinking of bringing your flexible benefit plan administration in-house, or a TPA thinking of offering cafeteria plan administration service to your clients, we'd like to introduce you to the TravisFlex software system.

TravisFlex is a PC-based system which has been proven in the marketplace for four years. The system can handle plans as simple as flexible spending accounts (FSA's) to complex Full-Flex plans with several employee categories, benefit credits, vacation credits, etc., and is designed for any IBM PC or 100% compatible. And it costs as little as \$1,295.

TravisFlex can accept downloaded data about employees and their plan contributions, can print enrollment forms and has an optional Proceso module which can illustrate to an employee what he or she will save by enrolling in the flexible benefit plans.

FOR MORE INFORMATION ABOUT TRAVISFLEX SYSTEM OR OTHER TRAVIS PRODUCTS CONTACT TRAVIS SOFTWARE AT 1-800-521-5409 OR (713) 496-3737.

Other Travis Employee Benefit Systems Include: Corporate COBRA Manager, Group Premium Billing Manager, Retiree Premium Billing Manager and Travis/Comp.

NAME _____
 TITLE _____
 COMPANY _____
 STREET _____
 CITY, STATE, ZIP _____
 TELEPHONE _____

Travis Software

1001 E. Dairy Ashford, Suite 206 • Houston, Texas 77077
 Phone: 1-800-521-5409 or in Houston, call (713) 496-3737

PLEASE SEND MORE INFORMATION ON:

- Corporate COBRA Manager TravisFlex
 Retiree Premium Billing Manager
 Group Premium Billing Manager Travis/Comp

Waste sites

Continued from page 20
 prompt administrative action that addresses the problem, rather than getting "dragged through the courts," is key to avoiding some of the ongoing problems in the United States, he added.

Tom Fowle, an environmental engineer with the Insurers' Advisory Organization in Toronto who discussed legislation and regulatory activities in Canada, noted that every province has enacted its own pollution laws, and even within provinces, individual municipalities also have enacted their own laws.

In addition, enforcement practices will differ. Enforcers in one area come down hard on violators; elsewhere, violators benefit from a "blind eye," said Mr. Fowle, noting that this has created an "uneven playing field."

Mr. Fowle also discussed the scope of Canada's environmental problems. He noted, for instance, that Canadian

industries generate nearly 7 million tons of hazardous waste each year, half of that in Ontario. And about 20 million tons per year of municipal solid waste is generated, most of which ends up in landfills, he said.

In addition, acid rain seriously threatens the air.

Underground storage tanks are another problem. More than 10% of the 200,000 tanks in Canada may be leaking, said Mr. Fowle. The overflowing of tanks, which can spill over and pollute water supplies, also is a problem, he said.

Costs to upgrade USTs and for site remediation will average \$250,000 Canadian (\$221,325) per site. The cost of UST cleanup alone will amount to about \$5 billion Canadian (\$4.43 billion), or \$200 Canadian (\$177) per citizen, he said.

In addition, site remediation costs could also total \$5 billion Canadian, Mr. Fowle said. Cleanup costs of 400 hectares (988 acres) of Toronto harbor property alone are estimated at \$320 million (\$283.3 million), said Mr. Fowle.

Other speakers at the session were John Leeds, minister of the environment for Nova Scotia in Halifax; Doreen Henly, director of environmental affairs for the Canadian Manufacturers Assn. in Ottawa; Brian Farlinger, director of commercial affairs for the Canadian Bankers Assn. in Toronto; and Sally Hall, past president of the Edmonton, Alberta-based Consumers Assn. of Canada.

The session was moderated by Joseph MacDonald, manager-insurance for BP Canada Inc. in Calgary, Alberta.

Sometimes a second carrier is one too many.



To cover both property and boiler and machinery for larger insureds, Royal is the only source you need.

Few other carriers have the capability and expertise for handling both coverages, especially for larger accounts.

But Royal stands alone with Royal FlexSM, the uniquely filed property form that lets you combine coverages for uniquely customized policies.

With Royal, you deal with our underwriting specialists and in-house engineering loss control and claims handling.

Your clients benefit from one set of terms and conditions which helps them avoid coverage gaps. And eliminates the coordinating hassles of joint loss agreements.

For details, contact your local Royal Insurance branch office.

And let's get together, one on one.



Royal Insurance

Canadian conference attracts 573

EDMONTON, Alberta—A total of 573 people attended the Canadian Risk Management Renaissance Conference Sept. 22-25 in Edmonton and sponsored by the Northern Alberta chapter of the Risk & Insurance Management Society Inc.



"Risk Management Renaissance—Advancing the Art" was the theme of the conference, which featured a panel discussion on the past and future evolution of the field (see story, page 18).

During the conference, Gary G. Vamplew, manager-insurance and risk management for the Ministry of Government Services in Toronto, was presented with the Donald M. Stuart Award, which recognizes outstanding contributions to the field of risk management in Canada. The award was established and is maintained by the Ontario RIMS chapter, although it may be awarded to a member of any of the Canadian chapters.

The conference also gave a gift to Michael F. Steeler, who is retiring as publisher and managing editor of the Canadian Insurance Journal, which is published in Toronto.

Next year's conference, which will be held Oct. 4-7 in Ottawa, Ontario, has been named Ottawa Kaleidoscope, or OK '92, and will be hosted by the Canadian Capital Region chapter of RIMS.

For further information write to: Ottawa Kaleidoscope '92, P.O. Box 55032, Ottawa, Ontario, Canada, K1P 1A1, or call conference chairman Len G. Marks, Supervisor-Administrative Services for the Regional Municipality of Ottawa-Carleton at 613-560-1304.

Note: Royal FlexSM is available in most states.



OUR
MANAGEMENT
POLICY

Stability.
Pure and Simple.

 **National Re**
Our Policy Is Service.

Integrated departments: Not for everyone

By JUDY GREENWALD

Risk Management
Renaissance

EDMONTON, Alberta—Integrating loss control, safety, health and environmental functions along with risk financing within the risk management department is efficient and avoids unnecessary duplication.

But it can also create a department with muddled goals.

There is, in fact, no one answer to which approach should be taken; it all depends on the circumstances at a particular company.

This was the conclusion of a session on "fitting the pieces together" at the Canadian Risk Management conference held last month in Calgary and sponsored by the Northern Alberta Chapter of the Risk & Insurance Management Society Inc.

Speaking in favor of an integrated department was Paul A. Gray, manager-risk, safety and regulatory affairs for Nordion International Inc., a Kanata, Ontario-based manufacturer of radioisotopes used in the nuclear medicine industry.

Advocating a separation of risk financing from loss control and related functions were Graham Jackson, a director with consultant Independent Engineering Services Ltd. in Dallas, and A. Laird Wilson, visiting professor of safety and loss management at the University of Alberta in Edmonton.

Integrating risk management functions within a single department makes it easier to get things done, contended Mr. Gray.

He noted that risk management can be divided into two strategies: risk control and risk financing. The former includes activities like exposure avoidance, loss prevention and loss reduction. Risk financing includes risks that are retained by the organization, such as funded and unfunded reserves and captive programs, and those that are transferred, such as insurance.

"Insurance (alone) is not risk management," said Mr. Gray. It is just one aspect of it.

Any loss also has a net income or financial aspect, he said, and you cannot have risk control without risk financing. "It's got to be a consolidated approach."

He identified six distinct steps in the risk management process:

- Identification of risk exposures.
- Measurement and analysis of exposures.
- Determination of exposures that will respond to treatment by existing and available technology.
- Selection of appropriate technology based on cost effectiveness.
- Managing implementation of the program in the most cost-effective manner possible.
- Audit and followup.

Consistent throughout this risk management process, he said, is the same financial thread regarding cost effectiveness and the importance of appropriate actions being taken. But this approach is by no means limited to risk management. In advocating a consolidated approach, Mr. Gray pointed out that similar steps are taken in, for example, occupational health management.

There is also a "common sense" aspect to an integrating many functions into a single department, said Mr. Gray. Making a decision from only one perspective will not, in most cases, resolve an issue and will certainly not benefit the organization.

Coordinating the expertise within a company, though, assures the risk manager of greater success and acceptance of the ultimate recommendations produced, he said. This practice relates directly to the consolidated risk management department, he said.

Mr. Gray also delineated the advantages of a integrated risk man-

agement department:

- Coordination, including the ability to develop a detailed overview and plans to deal with exposures from all perspectives.

- Efficiency, effectiveness, cost and timeliness. By using a central focus, programs are efficiently and effectively implemented, said Mr. Gray.

- Accuracy and precision. "Everybody works together toward a common goal," he said.

- Credibility. This is gained with effective program implementation.

- Improved communication.

- Better teamwork.
- "Pro-activity." This approach permits a more active, rather than a reactive, response to events.

- Mutual respect, with everyone on the team recognizing what the other is doing.

- Underwriter awareness. This approach enhances the ability to answer underwriter questions regarding diverse loss exposures.

- Insurance. Knowledge of the details of the risk exposures enhances the ability to place the appropriate levels of insurance.

Health, safety, environment and

loss control functions as well as risk management all have the same basic structures, said Mr. Gray. "These functions are not only similar, but virtually identical in purpose, focus, philosophy, principle and mission."

But Mr. Jackson, the engineering consultant, countered that not only are the functions not virtually identical, they can't even "fit together."

Why, he asked, would risk managers "pay down the major contribution" they could make by taking on other issues like risk finance?

"That's something I've been trying to grapple with for all these

years," he said. "It's a fine theory, but does it work in practice?"

Many companies have found it doesn't. They are backing away from coordination after running into "paralysis by analysis," said Mr. Jackson. It has left risk management staffs analyzing a situation "while the operations guy has got the problem hanging down around his neck."

Another problem, he said, is establishing the department's focus. "Is its main focus financial, or loss control" or something else, like property protection? "To be effective, a de-

Continued on next page

When your clients come back after year, that's a very big deal

In this business, when you do the job, you get to keep the job. That's why our clients keep coming back to Affiliated and Appalachian, rated A+ by A.M. Best. Our clients know that no one offers faster, better or more complete professional service. Not to mention a complete property insurance product line that's simple, comprehensive and flexible—including an All Risk policy and a Combined Fire, Boiler & Machinery policy.

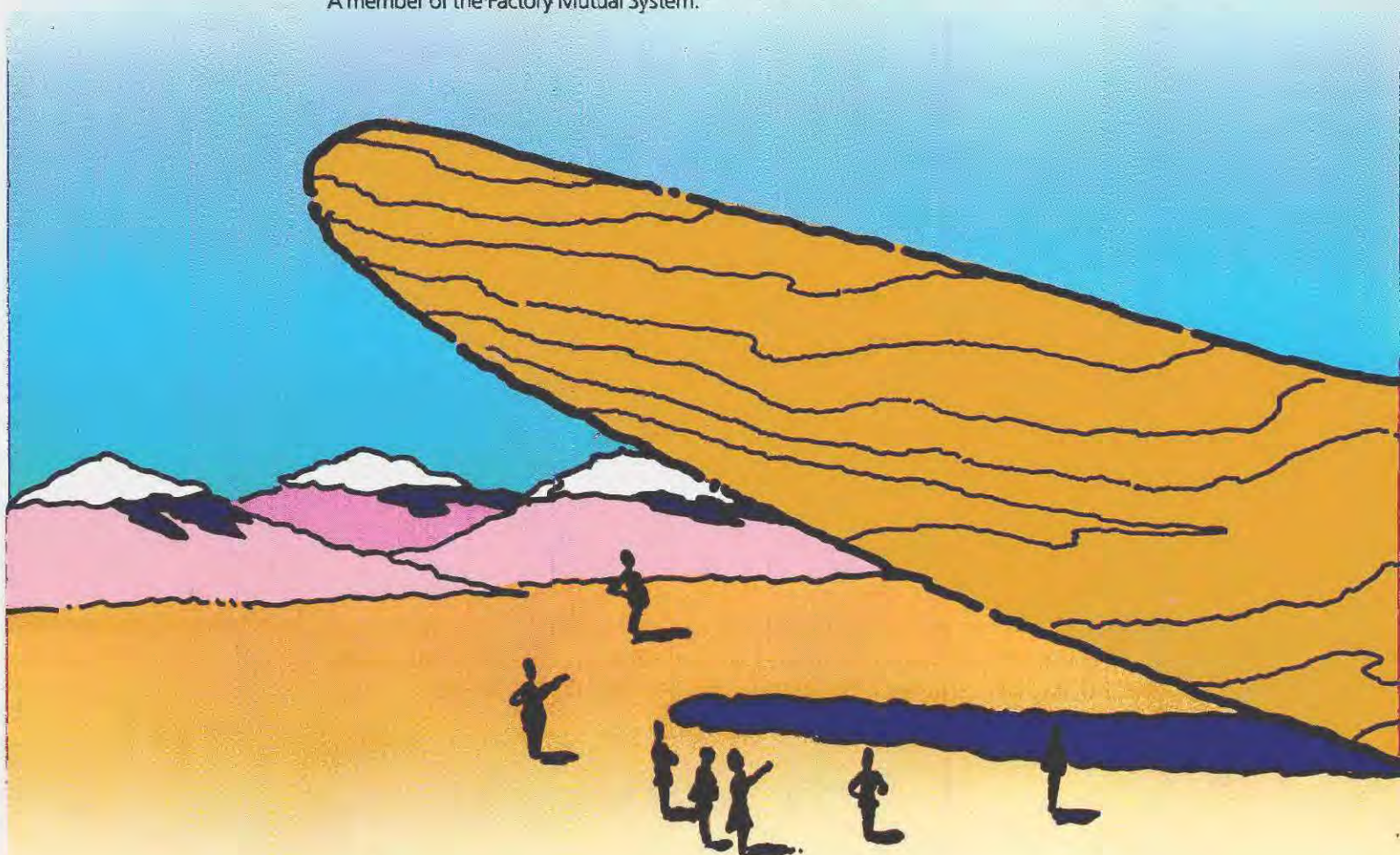
We put you directly in touch with experienced production underwriters who can tailor

a policy to meet your clients' needs, then get it out the door quickly. We've even been known to hand deliver a policy in a pinch. And our claims handling is just as fast, just as efficient, and certainly fair.

In addition, we can also make available our property engineering resources—resources that help reduce risk.

So if you want to start building a relationship with many happy returns, call 1-800-541-2276 and we'll put you in touch with your Affiliated/Appalachian representative.

Affiliated FM Insurance Company
Appalachian Insurance Company
Associated with Allendale Mutual Insurance Co.
A member of the Factory Mutual System.



Continued from previous page
 department needs to have a clear mission," said Mr. Jackson.

Furthermore, many of the functions of an integrated risk management department—like keeping on top of legislative activity—require considerable technical expertise. How, he asked, are people going to have a "true career path" if the department is under the influence of the financial part of the organization?

Resolving conflicts can also be a problem for integrated departments. A conflict between instituting safety measures and saving money, for instance, is best resolved by senior management, rather than by "filtering it through one department," he

said.

Mr. Wilson, the engineering professor, advocated a similar team approach. Both risk management and loss control require expertise that is both deep and wide, he said, adding that both activities are valuable, so "don't crunch them together."

These functions, particularly in large companies, should be managed by different departments, he advocated. There is no reason the risk manager and the loss control manager could not work together to a point, but then work separately on the individual details of their own work, said Mr. Wilson.

The bottom line on which approach to take depends upon the company's culture, its geographical location, its

employees' skills and its knowledge requirements, concluded Ross N. Collett, manager-risk management at Bow Valley Industries Ltd. of Calgary, Alberta, who moderated the session.

It is important, he added, that a company's structure provide value for its shareholders. The company cannot just rely on its insurance program alone. A plan that can work within each individual company is needed, said Mr. Collett, management must make a commitment to provide needed resources and people.

Also speaking at the session was Garry J. McDonnell, global director in Toronto with Anistics, an Alexander & Alexander Services Inc. consulting unit. ■

Sky not limit, yet, to liability awards

By JUDY GREENWALD

EDMONTON, Alberta—Significant procedural and substantive differences between the U.S. and Canadian legal systems help explain why Canadian court awards tend to be lower, says a Canadian lawyer.

Two key differences are the wider use of contingency fees and the greater number of jury trials in the United States, said E. David D. Tavender of the Milner Fenerty law firm in Calgary, Alberta.

Jury trials are almost the rule in major cases in the United States, but in Canada, juries do not hear complex and technical trials, said Mr. Tavender. And U.S. juries tend to punish large, wealthy defendants, he said.

"There's hostility toward concentrations of power," added Mr. Tavender.

Contingency fee arrangements, which allow readier access to the legal system, are common in the United States, but not in Canada, he also noted.

Mr. Tavender spoke at a session titled "Liability Insurance in Canada: Setting the Limits" during the Canadian Risk Management Conference held last month in Edmonton. It was sponsored by the Northern Alberta chapter of the Risk & Insurance Management Society Inc.

Among the other procedural differences Mr. Tavender cited are that:

- Court costs are generally not awarded against unsuccessful parties in U.S. litigation, as they are in Canada.
- Class-action lawsuits are, for now at least, more common and more easily prosecuted in the United States. Legislation proposed in Ontario, though, would make such suits easier to bring in that province.
- During pre-trial discovery, U.S. plaintiffs focus heavily on assessing defendants' wealth. In Canada, this is only possible in punitive damage claims.

Substantial differences in substantive areas of the law also result in lower awards in Canada, said Mr. Tavender.

In patent infringement cases, for example, Canadian plaintiffs are required to choose between having damages awarded on the basis of lost profits or by calculating the loss of royalty income.

U.S. courts can award damages on both grounds, and can also award treble damages for willful misconduct.

In Canada, it also is much more difficult to win a punitive damage award, he said.

But in contrast to this relatively positive view of the Canadian civil justice system, Mr. Tavender also had a warning. The concept of prejudgment interest has been introduced in Canada, he noted, and it could have the effect of almost doubling awards in cases that take six to eight years to come to trial.

"I do not think the sky is the limit in Canada, but I think there are some signals out there that risk managers should carefully heed," Mr. Tavender warned.

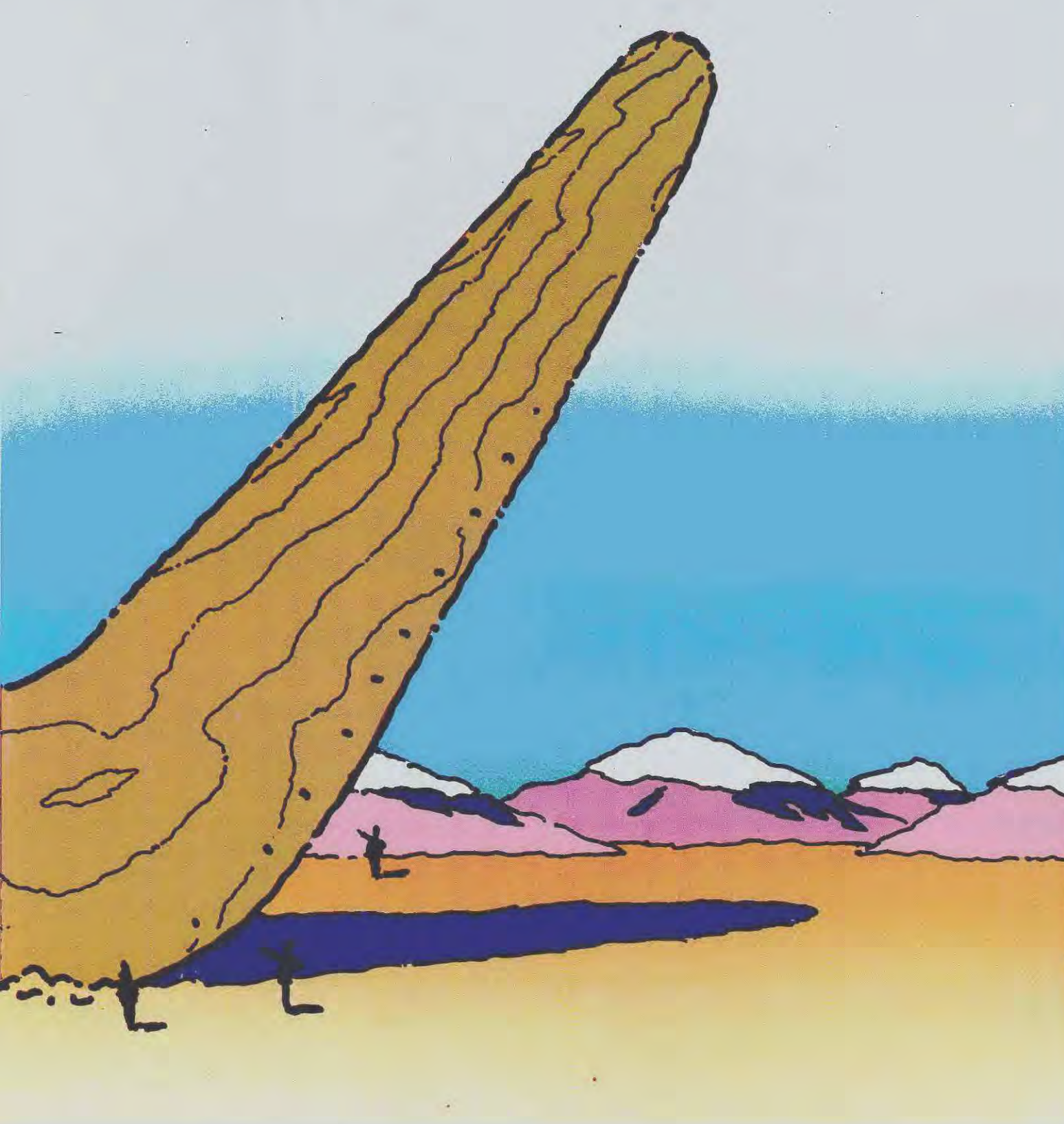
Other speakers included Gerald A. Wolfe, vp of General Reinsurance Corp. in Toronto, who discussed factors to be considered in deciding on liability insurance limits.

Mr. Wolfe said that among the factors Canadian companies should consider are their U.S. directors and officers' exposures and U.S. exposures in terms of the geographic distribution of products and operations.

In discussing solvency issues, Mr. Wolfe also said that federal solvency requirements in Canada are now stricter than those in the United States, although legislation now before Congress could strengthen U.S. requirements (BI, Aug. 12).

Also speaking at the session was Lorne Scully, managing director of Marsh & McLennan Ltd. in Toronto. The session was moderated by Catherine E. Dowdall, risk and insurance manager for Cadillac Fairview Corp. Ltd. in Toronto. ■

k year endorsement.





Is there a risk so complex we can't design a coverage for it? Probably not.

In fact, we've been doing it for years. So when it comes to special and unusual risks, with their demanding underwriting requirements, the long-tail nature of their exposures, and the absolute necessity for an insurer with financial stability, there's just one place to look.

The AIG member companies are known for skill in underwriting special

risks, for innovation in new products and for a willingness to write business others shy away from. In short, we have the experience, capacity, financial strength and stability you need in today's market.

You'll also discover at AIG a thorough understanding of the U.S. legal environment, a can-do attitude

and a long-term commitment to specialty risks, where the relationship between you and your insurer is so important.

For more information, ask your agent or broker to contact the AIG regional office nearest you. You'll find us ready to handle your special risks with experience, creativity and professionalism.

AIG World leaders in insurance and financial services.

American International Group, Inc., Dept. A, 70 Pine Street, New York, NY 10270.

Worker vandalism, arson

With dishonesty exclusion, all-risk property cover may leave gaps

By Jim Marshall

MANY POLICYHOLDERS assume that their all-risk property insurance will cover damage or destruction of their property resulting from employee arson or employee vandalism. Unfortunately, many policyholders may find that none of the policies in their insurance portfolio covers such losses.

Ironically, an all-risk property policy may afford less coverage than a basic or named-perils policy. This paradox results from the fact that all-risk policies often contain exclusions not generally found in named-perils policies.

For example, dishonesty exclusions are typically found in many property insurance policies. However, there are several ways to mitigate the potential effects of these exclusions.

There are a number of variations of the dishonesty exclusion found in all-risk policies. A common version would exclude coverage for loss caused by "any dishonest or criminal act of any proprietor, partner, director or employee of the insured, whether or not occurring during hours of employment."

With respect to employee arson or vandalism losses, the operative words or phrases included in such a typical exclusion might be "dishonest," "criminal," and "any employee." If the act of arson or vandalism were committed by an employee and deemed to be either dishonest or criminal, the resulting loss would be excluded.

There apparently is a dangerous perception among many insurance buyers and sellers that an act of employee arson or vandalism would not be deemed to be a dishonest act and, thus, would not be subject to the dishonesty exclusion.

This interpretation is based on the premise that dishonesty is essentially limited to employee theft, an exposure which customarily would be covered under employee fidelity coverage.

Agents, brokers and insurance company representatives have, on occasion, attempted to assuage our concerns about the dishonesty exclusion on the basis of this premise. We do not recommend reliance on this premise when there is no specific endorsement limiting the phrase "dishonest act" to "an act of theft."

The typical property insurance policy does not define the terms "dishonest" or "dishonesty." In the absence of a specific definition, most courts will interpret policy language in accordance with its commonly accepted meaning, i.e., in its plain, ordinary or popular sense.

Webster's Ninth New Collegiate Dictionary defines "dishonest" as characterized by lack of truth, honesty or untrustworthiness and defines dishonesty to include a lack of integrity.

We don't doubt the ability of

insurers' lawyers to persuasively argue that—based on the plain, ordinary or popular definition of dishonesty—employee acts of arson or vandalism of an employer's property should be considered dishonest and subject, therefore, to the dishonesty exclusion.

What constitutes a dishonest act in an insurance context has been judicially determined on a number of occasions, perhaps most frequently with regard to employee fidelity coverages.

In the absence of a specific policy definition of dishonesty, in the context of employee fidelity coverage, dishonest acts have been judicially defined as acts that involve bad faith, willfulness, a breach of honesty, a want of integrity or moral turpitude. Such acts may or may not amount to a crime.

Property insurers can, and will,

Property insurers can, and will, argue that under a typical judicial determination of what constitutes a dishonest act, employee acts of arson or vandalism of an employer's property should be considered dishonest acts and, thus, should be excluded.

argue that under a typical judicial determination of what constitutes a dishonest act, employee acts of arson or vandalism of an employer's property should be considered dishonest acts and, thus, should be excluded.

In most jurisdictions there would seem to be little question that an act of employee arson or employee vandalism would constitute a criminal act.

As a result, there would seem to be little argument that an exclusion of loss caused by criminal acts of an employee would be ambiguous with regard to loss resulting from employee arson.

The typical dishonesty exclusion applies to any employee without regard to particular status in the policyholder organization. The dishonesty exclusion might specifically state that it applies to a dishonest or criminal act of any employee of the policyholder "whether or not occurring during hours of employment."

The typical exclusionary language is drafted in a manner that will allow an insurance company to defend against an argument by a policyholder that, for the purpose of the dishonesty exclusion, acts by an individual are considered to be acts of an employee only if such acts occur during working hours.

The dishonesty exclusion in all-risk property policies is apparently a reaction by insurance companies to the difficulties they experienced in denying coverage on the basis of corporate arson.

There is an excellent article on this issue—from the perspective of

insurers—in the summer 1990 edition of Coverage, a publication of the Insurance Coverage Litigation Committee of the American Bar Assn. Section of Litigation. The article, "Corporate Arson and a New Tool—The 'Dishonest Acts' Exclusion," was written by John Waters, a partner in the New Orleans law firm of Bienvenu, Foster, Ryan & O'Bannon.

In his article, Mr. Waters observes that in cases of corporate arson, in the absence of a dishonesty or similar exclusion, the right of the corporate policyholder to recover would typically be dependent upon the degree of general control that the corporation had vested in the specific individual responsible for committing the arson.

In effect, in the absence of a dishonesty exclusion, courts have

typically looked to see whether the acts of the specific individual should be imputed to be acts of the corporation. Under the "control" theory, if the person who committed the arson did not possess the requisite degree of control over corporate affairs, the innocent corporation could recover in spite of the fact that the arson had been committed by an officer or an employee of the corporation.

However, as Mr. Waters writes in his article, in several cases the courts have essentially disregarded the control analysis where there was a dishonesty exclusion. Instead of the analysis of control, these courts have looked to the policy language to determine the intent of the parties.

One of these cases, *Minnesota Bond Ltd. vs. St. Paul Mercury Insurance Co.*, a 1985 case in Oregon, is particularly illustrative of the risks of a dishonesty exclusion.

In *Minnesota Bond*, although the arson was committed by a 50% shareholder, the corporate policyholder was denied recovery on its property policy on the sole basis that the policy contained an exclusion for loss caused by the willful or dishonest acts of the policyholder and, to quote the court: "There is no question that the act of arson was the willful and dishonest act by (the arsonist) who was an employee of the insured corporation." (Emphasis added.)

In *Minnesota Bond*, there was no evidence that the arsonist had acted on behalf of the corporation. Nor was there any evidence that the corporation had authorized or ratified the arson.

The 1989 Florida case of *State Farm Fire and Casualty Insurance Co. vs. Kane* illustrates that the scope of the dishonesty exclusion can go beyond the corporate employer. In *Kane*, the exclusion applied to the landlord, in addition to the tenant whose president had set a fire.

A common response from agents, brokers and insurers relative to the dishonesty exclusion found in property policies has been to defend the dishonesty exclusion on the basis that the coverage which is excluded from the property policy can be properly insured under the client's employee fidelity coverage.

Their conclusion is based on the premise that only employee theft would be excluded by the dishonesty exclusion in the property policy. The assumption that the employee fidelity coverage is an adequate replacement for coverage under the property policy suffers from a number of fatal flaws.

First, at least four courts have now held that the dishonesty exclusion in all-risk property insurance policies applies to more than just employee theft. In other words, the exclusion applies to arson.

Second, most employee fidelity policies do not provide coverage unless the act by the employee was committed with the manifest intent to cause the policyholder the loss and to obtain financial benefit for the employee or another person or organization.

Arson or vandalism committed by a disgruntled employee may not have been committed for the purpose of obtaining financial benefit for anyone and thus would not be covered by most employee fidelity coverage.

Third, even in the instances in which the employee fidelity policy does provide coverage, there is a substantial possibility that the scope and limits of coverage would be less than those which would be needed and available under the property policy, assuming an absence of the dishonesty exclusion.

The typical employee fidelity policy would not, as an example, respond to business interruption losses. In addition, the limit of employee fidelity coverage maintained by most employers is likely to be much less than the probable maximum loss of property that could result from employee arson.

To right this confusion, the first course of action is to carefully review the property coverage to determine whether there is some version of a dishonesty exclusion in the policy or policies.

If there is a dishonesty exclusion, the absolute remedy would be to eliminate entirely the dishonesty exclusion from the property insurance program.

If the insurer is unwilling to eliminate the exclusion in its entirety, the exclusion should be narrowed. At

Continued on next page

Dishonesty exclusion

Continued from previous page
a minimum, especially since many insurers represent that their policies are broader than the typical policy offered by other insurers, an insurer should be willing to adopt the approach taken by the Insurance Services Office in its special form, CP 10 30. The ISO form provides that: "This exclusion does not apply to acts of destruction by your employees; but theft by employees is not covered."

Another approach would be to limit the scope of the exclusion to those acts which would be covered by employee fidelity coverage, i.e., "acts by an employee committed with the employee's manifest intent to cause the insured the loss and to obtain financial benefit for the employee or another person or organization."

If the insurance company is unwilling to modify the exclusion but represents that the exclusion would not apply to employee arson or vandalism, the insurance company should be asked to provide a written confirmation of that point.

Finally, we would suggest that policyholders should not concede that loss resulting from employee acts of arson or vandalism is not covered, even in the face of a dishonesty exclusion.

As noted earlier, there is a reasonably prevalent opinion by brokers and insurers that the dishonesty exclusion is limited to employee theft. We believe that this interpretation is evidence that the intent of the dishonesty exclusion, at least as espoused by insurance companies and their representatives, is that the exclusion would not apply to

employee acts of destruction.

Even more telling is the fact that named-perils policies sold by most insurers probably specifically insure fire and vandalism and contain no dishonesty exclusion.

Insurance companies design and market all-risk policies to broaden rather than restrict coverage. We do not believe that it is the intent of insurance underwriters to make their all-risk policies narrower than the coverage which would be provided by their named-perils policies.

Many property policies contain exclusions for loss caused by any dishonest or criminal act of any proprietor, partner, director or employee of the policyholder. As the result of such exclusions, many policyholders may find at the time of loss that insurers will contend that their property insurance does not

cover employee arson or employee vandalism.

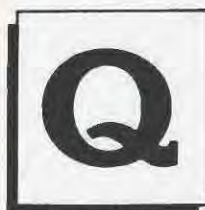
All policyholders should carefully review their property coverage to determine whether there is a dishonesty exclusion. If there is a dishonesty exclusion, a policyholder should first attempt to negotiate the narrowing of the exclusion toward its application only to losses caused by theft or, alternatively, to losses for which coverage is available under employee fidelity insurance. ■



Jim Marshall is senior consultant at Siver Insurance Management Consultants in St. Petersburg, Fla.

ASK A RISK MANAGER

Claims administration can be unbundled



We are preparing to market our casualty insurance program early next year and are considering unbundling the claims administration function. I understand you are using this approach. What are its advantages?



Yes, we do unbundle our claims administration program and have for the past 20 years. In fact, we unbundle all of our risk management services. Our history of unbundling goes back to the early 1970s, when our broker sold us on the concept by

demonstrating its advantages.

We were a small regional chain of fast food restaurants with a substantial amount of growth potential. Our broker, understanding the dynamics of our industry, told us that unbundling would give us the following opportunities:

- Internal control of our claims administration function.

Looking back, this thinking was way ahead of its time, because the whole business of risk management was just coming into vogue. We learned early on that our direct involvement with the claims adjusting process would generate savings for the company. Our understanding of the cause, nature and financial impact of claims enabled us to design and, over the years, modify our loss prevention programs.

Back in those early days, when the trend was for companies to buy full coverage and when safety issues were not as critical as they are today, we laid the necessary framework internally and externally to prevent and control our losses. When our unbundled claims adjusting program was initially designed, we set parameters with our third-party administrator on authority levels and reporting requirements. Then as now, our intent was to work directly with our third-party administrator on claim settlements.

- Flexibility to change the financial structure of our claims funding mechanism without disrupting the core of the structure: claims administration.

Over the years we have moved away from the fully insured-type program to one that blends several alternatives like self-insurance, utilization of a captive and large retentions. We accomplished our movement to these options without difficulty,

because the claims administration portion of the program remained intact.

Up until a year ago, when we centralized our claims reporting, our more than 1,200 restaurants reported accidents and incidents to the local office of the claims administrator, sending copies of forms to our department. If we had not unbundled, each time we changed insurers, the job of re-educating our field management on new claims reporting procedures would have been a monumental task.

- Geographic spread of claims administration offices needed to service our multi-location operations.

It was important for us to have branch offices within arms' reach, so to speak, of our restaurants. By placing the claims administration program with a national third-party administrator, we achieved this objective.

Over the years, our company has been involved in three major acquisitions of other restaurant operations. In each instance, having claims offices in virtually every city in which we operate a restaurant has been tremendous advantage for us.

Service is what counts. Don't make your decision strictly on price. The old saying, 'You get what you pay for,' is especially true of claims administrators.

The local adjusters have established a rapport with our field management, a relationship that has served us well. The local adjusters represent us at workers compensation hearings and provide the leg work for defense counsel on litigated claims. We also have called on them to attend local management meetings and share insights on topics like changes in workers compensation laws and the advantages of light-duty back-to-work programs.

It is important to view an unbundled claims adjusting program as a long-term commitment. I recommend making an initial commitment of at least three to five years. From personal experience, I find that the benefits of the program increase each year. We have enjoyed a solid business relationship with the same third-party administrator since the inception of the program in 1972.

When evaluating and selecting a third-party administrator, I offer a few additional considerations.

Service is what counts. Don't make your decision strictly on price. The old saying, "You get what you pay for," is especially true of claims administrators. The claims administrator should be familiar with your business and offer regular in-house training

programs to keep employees well schooled in workers compensation and liability issues.

Be sure the third-party administrator has an open ear to your concerns. You may want to schedule regular claim audits of files above a certain threshold.

And, you may have special requests regarding the format of claims data. Be vocal with your account representative on such matters. After all, a successful claims administration program does not operate on automatic pilot. Open communication between risk management and the claims administrator is a critical component of the relationship.

Make certain the claims administrator knows exactly what you expect of the program. Then, it's your responsibility to monitor the results and make changes as appropriate.

In addition, select a claims administrator that offers a wide spectrum of risk management services. A few important areas to consider are workers compensation cost containment programs, risk control services and a risk management information system. By consolidating these services with one vendor, administration of the program becomes simpler and more cost-effective.

Unbundling the claims administration program puts the risk manager in the driver's seat. It can prove to be an interesting and challenging ride. ■

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

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, president of Pacific Actuarial Resources (PAR) EXCELLENCE in Ashland, Ore.,



Ms. Werner

answers actuarial questions in the casualty field.

Ms. Werner's and Mr. Nirtaut's columns appear on the second Monday of alternate months. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month.

Ms. Werner's next column will appear in December. 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.

WHEN YOU TAKE AN ALTERNATIVE ROUTE, TURN TO US FOR REINSURANCE.



In today's marketplace, a financially strong and stable reinsurer is the only alternative. The experienced professionals at North American Re bring safe, secure reinsurance to your alternative structure. For more information on alternative markets, call Carla Shenkman, Director of Alternative Markets, at 212-907-8013.



California plan

Continued from page 1
these recent examples:

• On June 3, the department deemed Palisades National Insurance Co. of the British West Indies "unacceptable" for further placements. An investigation had found that \$72 million in securities claimed as assets were actually Indonesian war bonds issued to the Central Establishment for Trade Investment in Beirut and assigned to other entities (*BI*, July 29).

"Essentially, Palisades had no surplus," he said. "And, even if the company had owned these securities, bonds issued by a Third World country to finance war material does not qualify, in our view, as a sound investment."

• On June 4, Apex Placement Insurance Co. of the Turks & Caicos was barred from doing further business in California after regulators learned its primary assets included a yen note issued by a bankrupt Japa-

nese firm.

"I conserved the company and seized assets valued at only \$1.2 million," Mr. Garamendi said, although it claimed assets exceeding \$16 million.

Apex wrote more than \$2 million in premiums in 1990 and \$7.7 million in the first six months of 1991.

• On July 10, the department deemed Hibernian Insurance Co. "unacceptable" to underwrite business in California after an Insurance Department investigation revealed that the company had rented a purported \$141.8 million of Government National Mortgage Assn. bonds as surplus.

The company, which also is domiciled in the British West Indies, began writing business in California in March 1991.

California's problems with non-admitted insurers do not end there. More than a few non-admitted companies have "simply walked away from their obligations," said Mr. Garamendi. "They stop responding to

correspondence, they don't answer their phones, their doors are locked in the middle of the day, they stop paying claims, they stop paying return premiums, and so on.

This is the sort of "illegal activity I have committed to stamp out in this state," the state's first elected commissioner pledged.

Californians are expected to pay \$1.6 billion in premiums to unlicensed insurers this year, and to lose "hundreds of millions of dollars in unpaid claims and broken promises," he said.

"That's a lot of consumer dollars being thrown down a drain when there is a fully functioning admitted market that can meet their insurance needs right here at home," Mr. Garamendi said. He added that when non-admitted companies become insolvent, policyholders are not protected by state guaranty funds.

Mr. Garamendi acknowledged that "many alien or foreign insurance firms and their surplus lines brokers and agents play a useful role." But

abuses, he said, have left "tens of thousands of policyholders without legitimate insurance, forcing their claims not paid and little likelihood of recovering their lost premiums."

"I am going to shut the door on these abuses as far as is consistent with the law," he said. "And my regulatory powers will serve as a door jamb to make sure no one tries to push it open any further."

In fact, the Insurance Department has "already pulled the welcome mat and replaced it with a trap door" for those who come to California solely to cheat consumers, Mr. Garamendi said.

Since March, more than 20 offshore insurers have been blocked from writing business in California, more than double the number for all of 1990, the commissioner said.

Numerous cease-and-desist orders have also been issued to surplus lines brokers and agents that either wittingly or unwittingly have failed to sufficiently investigate the finances of offshore insurers, he said.

And tough new rules are now in place for non-admitted insurers that write business in California, he reminded the NAPSLO audience.

Under Insurance Department Emergency Regulation 15, which became effective Sept. 1, non-admitted insurers outside the United States that want to write business in California must have \$5.4 million in combined capital and surplus held in a trust fund somewhere in the United States. That trust fund must be composed of highly liquid assets, not letters of credit.

"These requirements will help to ensure that if the solvency of the offshore company is ever threatened, the consumer won't pay the price," Mr. Garamendi said.

The Insurance Department also plans to appeal to Gov. Pete Wilson the rejection of another emergency order. The Office of Administrative Law recently rejected an emergency regulation that prevented surplus lines brokers from placing automobile bodily injury, property damage liability or medical payment insurance with non-admitted insurers unless the business had first been rejected by the California Automobile Assigned Risk Program (*BI*, Sept. 16; Feb. 11).

And, under a program initially aimed at insurers, the department is assessing surplus lines brokers for the cost of responding to consumer complaints, Mr. Garamendi said.

Because "more than 50% of the complaints are (about) unlicensed insurers and the surplus lines brokers who sold the insurance," he said, "you are going to pay the bill for those complaints."

Regulators are also cracking down on the collection of premium taxes from surplus lines insurers by auditing surplus lines brokers responsible for those collections.

"We have a brand new team of auditors examining the tax liabilities of agents and brokers that have outstanding tax debts, and we have already collected over \$500,000 since April from just two surplus lines brokers," said Mr. Garamendi.

He declined to identify the brokers audited.

Industry officials were quick to fault Mr. Garamendi's proposal to hold surplus lines agents and brokers liable for legitimate claims not paid by non-admitted insurers.

Regulators are trying to hold someone responsible for insolvencies because "they want to blame somebody for the insolvencies (they) fail to catch," charged Philip Petronis, managing director of risk management services with Marsh & McLennan Cos. Inc. in New York, who spoke at the NAPSLO meeting.

The California proposal is merely one more attempt to "shift regulatory responsibility from the regulator to the intermediary," he said.

If California is having problems with non-admitted insurers failing to pay claims that is a problem that regulators—not surplus lines brokers—have to tackle, said Kurt C. Bingeman, the new president of NAPSLO.

Mr. Bingeman, who also is president of Russell Bond & Co. Inc. in Buffalo, N.Y., says regulators have the responsibility to set appropriate standards that non-admitted insurers must meet to do business in a state.

"The broker is not the guarantor of the financial stability of an insurance company. That is the responsibility of the state insurance department," Mr. Bingeman said.

"Some insurers will try to operate at the fringe. The role of the regulators is to try to prevent that from happening," Mr. Bingeman said. "The (surplus lines) industry wants the regulators to act forcefully to try to put out of business unscrupulous operators."

In addition, it is "absurd" to believe that surplus lines brokers have the assets to pay claims if a non-admitted insurer fails to do so, Mr. Bingeman said.

Surplus lines brokers do have an obligation not to place business with

Continued on page 32

Stallion infertility Special events liability Fine
High value vehicles International exporter pack
Unusual collections Memorabilia Exotic anim
Difference in conditions Group personal exces
Film and theatrical producers' errors and omissi
Trip transit Horse mortality Musical instrume
Cast insurance Negative film Unusual valuati
Commercial crime High value homes Fiduciat
Directors and Officers liability Tax interrup
Broadcast interruption Props, sets and wardrob
Product liability Fidelity Coupon over-redemp
Cancellation of event Parades Unique buildin
Adoption insurance Umbrella and excess liabi
Theatrical productions Faulty stock High valu
Kidnap, ransom and extortion Award presenta

It's really unusual if we can't insure it.

Chubb Custom Market, a department of Chubb & Son Inc., provides underwriting and insurance services for unique and unusual risks. We're able to combine the financial strength, stability and claim services of the Chubb organization with our expertise in non-traditional risks. By accepting only high quality risks and calling on the experience of our underwriters, we offer a custom approach that has made us a leading non-standard risk specialist.

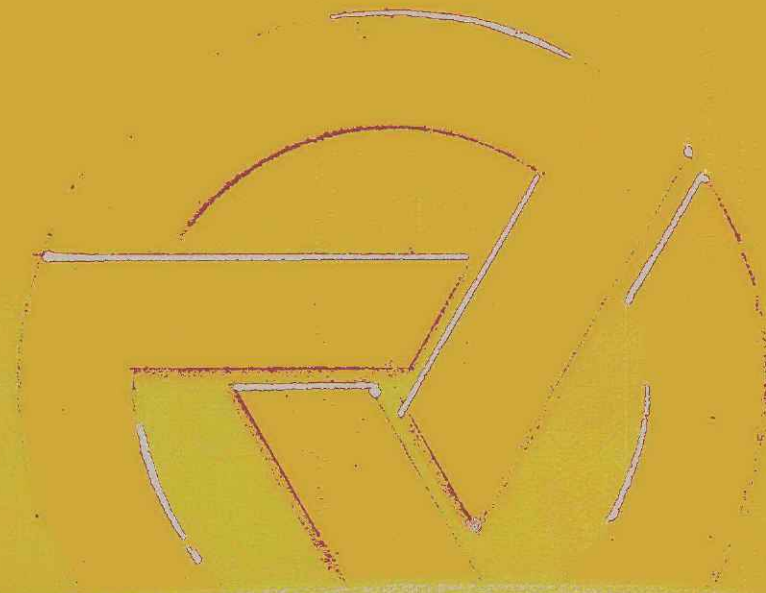
Because we can serve specialized brokers and wholesalers with units in Entertainment, Property, Umbrella/Excess Liability and Executive Protection, it really is unusual if it can't be insured through Chubb Custom Market. For more information, fax Chubb Custom Market at 1-908-580-7084.

Chubb Custom Insurance Co. is a member of the National Association of Professional Surplus Line Officers (NAPSLO). Chubb is proud to participate in "American Playhouse." Watch for it on PBS.



We're about to shed new light on insurance for transporters.

ECS Underwriting, the leader in hazmat transportation insurance, brings quality protection to the trucking industry.



Suddenly, business is looking brighter. For more than a decade, ECS Underwriting has been protecting transporters of hazardous waste and hazardous materials. Now we're bringing our expert coverage and service to haulers of industrial materials—to companies like yours. Day after day, you can count on the kind of strong programs and support that have earned ECS Underwriting a glowing reputation... and kept our customers on the road. Experienced underwriting, fast turnaround on filings, state-by-state certifications, and claims processing. Knowledgeable people who will go the extra mile whenever you need them. That's what you get with ECS Underwriting—and only with ECS Underwriting. Call us at 800-ECS-1414 now. And discover for yourself the value of insurance that outshines the rest.

OFFERING:

General Liability • Automobile Liability and Physical Damage including the MCS-90 Endorsement • Property and Inland Marine including Motor Truck Cargo

PROTECTING TRANSPORTERS OF:

Hazardous Waste • Hazardous Materials and Chemicals • Special Wastes including Asbestos, Low Level Radioactive, Waste Oil/Petroleum and Medical Waste • Sand and Gravel • Coal • Tar • Construction Material • Steel • Machinery • Equipment • Cranes and Concrete • Other Industrial Haulers



ECS
Underwriting,
Inc.

An ECS Company

Insurance protection for American industry.

Name _____

Title _____

Company _____

Address _____

City _____

State _____

Zip _____

Telephone _____

91-11-TRANS-10/14

ECS Underwriting, Inc.

One East Uwchlan Avenue, Suite 300
Exton, PA 19341

Or Call (800) ECS-1414 (In PA (215) 269-6731)
FAX (215) 524-5354

Brokers need one way to pay premium taxes

By LOUISE KERTESZ



LOS ANGELES—There should be a national, uniform method of collecting, reporting and paying surplus lines premium taxes, according to a panel consisting of surplus lines brokers, a surplus lines insurer and a risk management representative.

The current mechanism for paying those taxes is "an extremely confusing issue," said William Brecht, president of Hull & Co., a surplus lines broker in Santa Ana, Calif.

Mr. Brecht led the panel discussion on surplus lines premium taxes at the National Assn. of Professional Surplus Lines Offices Ltd. conference in Los Angeles earlier this month.

Because state surplus lines laws regulating tax payment mechanisms vary from state to state, "brokers are having a difficult time paying taxes on multistate risks. We need a uniform approach," asserted NAPSLO Executive Director Richard M. Bouhan.

Since the onus of paying the tax "is on the insureds, they need an efficient way to do that. If they can pay through their broker, they are well served," said Paul Brown, director of governmental affairs for the Risk & Insurance Management So-

California plan

Continued from page 30

an insurer that is in unsound financial condition and must exercise due diligence to ensure that does not happen, said NAPSLO Executive Director Richard Bouhan, noting a broker that fails to do so can be sued by the policyholder for unpaid claims.

But, it is another matter for the broker to be the guarantor of a non-admitted insurer, regardless of the situation, he added. "That would be a scary situation. That would be well beyond the standard of what is required today.

"Where else is a producer held to be the guarantor of a company?"

Donald Greene of the New York law firm LeBoeuf, Lamb, Leiby & MacRae also objected to the plan, suggesting such an action should be taken "through legislative review."

"The surplus lines market has always functioned better with less regulation," said Richard Smith of the Excess Lines Assn. of New York in a speech. "Why is it we are always treated shabbily during these soft markets?"

In a later speech, T.C. "Skip" Anderson, president of Skanco International Ltd., a surplus lines broker in Scottsdale, Ariz., unwittingly responded. "There is a lot of politics in the insurance market and we're going to be the whipping boy," he quipped.

David Bakst, a partner with Morrison, Mahoney & Miller in Boston, a law firm specializing in defense work for brokers and insurers, said in an interview that he is not aware of any other state that automatically makes a surplus lines broker liable for legitimate claims not paid by a non-admitted company. He noted, though, that surplus lines brokers have certain obligations to study the insurers with which they place business, such as checking ratings, asking the insurance department if there have been complaints against the insurer and reading the industry publications.

"The broker has to make the client aware of the situation. He has to make the client aware of all information that is reasonably available. Then the responsibility for selecting the insurer passes from the broker to the insured," he said.

Senior Editor Jerry Geisel in Washington, D.C., contributed to this story.

ciety Inc in New York.

Though problems involving the collection and payment of surplus lines taxes "are not a major concern of insureds," they "don't want a state to come up and say someday, 'You haven't paid your tax,'" Mr. Brown said in an interview.

The surplus lines tax is usually between 3% and 4% of the premium, Mr. Bouhan said in an interview.

"Regardless of how the surplus lines law is written in each state, the tax is passed through to the insured. It usually shows up as an identifiable item on the invoice from the surplus lines broker, Mr. Bouhan explained. The broker remits the tax to the state insurance department.

For the vast majority of risks using the non-admitted market, the tax revenue mechanism works well, Mr. Brecht said.

But the problem arises when, for

example, a surplus lines broker licensed in Missouri but not in California places coverage for a policyholder with risks in both states, Mr. Bouhan explained in the interview.

In many cases, the broker will remit all of the premium tax to the Missouri Department of Insurance, since the broker is not a licensed surplus lines broker in California, Mr. Bouhan said.

"Paying the tax to the home state" of the broker "is the easiest" route for brokers to take, conceded Maureen Caviston, branch manager of the New York office of Bryson & Associates Inc., another panelist.

That practice has caused state insurance departments to find discrepancies between the amount of writer premium reported to state insurance departments by insurers and the amount of premium tax collected by the individual departments.

"Some regulators believe they are being ripped off," Mr. Bouhan said during the panel discussion, because brokers unlicensed in their state are filing the taxes in other states.

"We try to interpret the spirit behind the surplus lines law" to see that "taxes are paid," explained Joseph Walsh, president of American Empire Surplus Lines Insurance Co. of Cincinnati, who also participated in the panel.

That involves insisting that brokers make "courtesy filings" with insurance departments on multistate risks. Courtesy filings are filings by a licensed broker on behalf of a broker not licensed in the state.

"But how do you allocate the premium on an umbrella risk or a product exposure?" he asked.

The amended tax section of the National Assn. of Insurance Commissioners model surplus lines bill,

which was designed to solve problems with the surplus lines tax, "needs a lot more work," conceded NAIC General Counsel David Simmons, also a panel participant.

The bill would be improved if it required the policyholder to pay a "self-procurement tax" equal to the surplus lines premium tax on that portion of the premium allocated to a state in which the policyholder's surplus lines broker is not licensed, Mr. Bouhan asserted. The policyholder would thereby pay the state insurance department directly, rather than through its surplus lines broker.

The NAIC, RIMS and NAPSLO should "continue to work together to straighten the situation out," Mr. Brown said. "But they can only do so much. It is up to state legislatures to put in whatever mechanism we need" to assure a uniform system nationwide. ■



If you find it difficult
to talk about, write:

Two-tiered regulation system touted

By JOANNE WOJCIK

LOS ANGELES—Regulation of the U.S. insurance industry should be divided into commercial and personal lines, much like new European Community directives provide for separate regulation of insurance for large and small commercial risks, a brokerage says.

Under such a split system, commercial lines should be regulated at the federal level, with the focus primarily on solvency, the brokerage proposes. Personal lines would continue to be regulated by the individual states.



This would allow large, federally chartered commercial insurers the freedom to write coverage in any U.S. jurisdiction, which would make it easier for risk managers of large interstate companies to assemble unified insurance programs, much like European multinationals can achieve using Europolicies, the brokerage contends.

The two-tiered proposal, which was initially developed by New York-based Marsh & McLennan Cos. Inc. (BI, June 10), has since gained the support of numerous other brokers, insurers and risk managers, according to Philip Petronis, managing director of risk management services at M&M in New York.

"The time is right to consider reform" of insurance regulation, Mr.

Petronis told a group attending the annual meeting of the National Assn. of Professional Surplus Lines Offices Ltd. held earlier this month in Los Angeles.

Mr. Petronis pointed to the latest insurer solvency study published by A.M. Best Co. of Oldwick, N.J., that showed there were more insolvencies among commercial insurers during the last decade than in the previous two decades.

The Best solvency study to which Mr. Petronis referred also predicted a surge in insolvencies among property/casualty insurers during the next two years (BI, July 22).

Insolvency is a "fundamental threat to our industry," because it violates the "promise to pay," on which insurance is based, Mr. Petronis said.

In addition, insurer failures contribute to the volatility of the market, according to Mr. Petronis.

"We don't want the cycle to repeat itself, although some firming would be welcome," he said.

Regulators already are looking "to other sources to be held responsible for insurer solvency" regulation, Mr. Petronis observed.

For example, during an earlier speech at the NAPSLO meeting, California Insurance Commissioner John Garamendi said he is exploring ways to hold surplus lines insurance brokers accountable when non-admitted insurers go broke or fail to pay legitimate claims (see story, page 1).

The recent failures of several large life insurers also have focused the spotlight on solvency regulation, with many Washington

politicians considering a proposal by Sen. Howard M. Metzenbaum, D-Ohio, and Rep. John D. Dingell, D-Mich., that provides for federal oversight of insurer solvency regulation (BI, Aug. 12).

"There is probably a greater likelihood today for a change in the way insurance is regulated," Mr. Petronis said.

But, rather than sitting back and waiting to see what measures lawmakers develop, the insurance industry should develop a plan of its own, he asserted.

M&M's two-tiered plan was developed by a coalition that included Alexander & Alexander Inc.; Sedgwick James Inc.; American International Group Inc.; and Dow Chemical Co.

Three basic components comprise the M&M plan:

- Large commercial insurers that meet minimum federal solvency standards would be issued federal charters.

Alien or surplus lines insurers that meet the minimum capital and surplus requirements also could apply for a federal charter.

However, applying for the federal charter would be optional. Insurers that opt not to do so would continue to be regulated by the individual states in which they do business.

- Federally chartered insurers would be exempt from state regulation, including rate and form regulation.

- Federally chartered insurers would not be required to participate in state guaranty funds. Policyholders of federally chartered insurers, therefore, would not be covered by the funds.

Federal regulation of large commercial insurers makes sense because "the state system is not suited to the regulation of large commercial risks," Mr. Petronis said.

For example, insurers that underwrite programs for multistate companies must comply with the rate and form regulations of each state in which the policyholder operates.

Because these programs are usually underwritten with manuscript forms, marketplace competition—not regulators—should govern form and price, according to Mr. Petronis.

"These buyers do not need nor do they want this regulatory protection," he said.

In addition, under the current system it is difficult for a regulator in one state to force a regulator in another state to halt the operations of an insurer that he or she knows to be insolvent, according to Mr. Petronis.

State regulation of large insurers should be pre-empted because "it makes no sense to separate solvency regulation from other regulation," like rate-setting, Mr. Petronis said.

Mr. Petronis also asserted that large commercial risks should not be protected by guaranty funds.

He said the funds provide a disincentive for regulators to seize a troubled company, because they create an "illusion" of a "backstop or cushion" that insurance buyers will be protected if the insurer fails.

By eliminating guaranty funds, risk managers would be forced to more carefully shop for financially strong insurers, Mr. Petronis suggested.

"Risk managers endorse this concept as long as they don't have to contribute (through premium taxes) to personal lines guaranty funds," he said.

The panel was moderated by David Hartoch, president of Sherwood Insurance Services in Los Angeles.

How to talk about AIDS
P.O. Box 303
Hartford, CT 06141



A policy to do more.

Surplus lines insurers balk at regulation

By JOANNE WOJCIK

LOS ANGELES—Insurance regulators' increasing attempts to favor residual markets over surplus lines insurers will only hurt consumers, the executive of a large surplus lines insurer contends.

But regulators maintain that restrictions on surplus lines insurance are intended solely to protect consumers in case non-U.S. insurers become insolvent.

"The surplus lines industry has never quarreled with the creation and operation of residual markets, since entry to these residual market plans historically has been contingent upon voluntary markets declining to accept the risk," said Michael Snead, chairman of Admiral Insurance Co. of Cherry Hill, N.J.

But today, the surplus lines segment of the voluntary market "is being pushed aside or, more accurately, placed behind the residual markets," Mr. Snead said during a panel discussion at the recent annual meeting of the National Assn. of Professional Surplus Lines Offices Ltd. in Los Angeles.

As examples of this activity, Mr. Snead cited both New York Insurance Department Regulation 41 and a new regulation issued by California regulators (*BI*, Sept. 16; Feb. 11) that was struck down by

the Office of Administrative Law.

New York Regulation 41, which was revised in August, prohibits surplus lines brokers from placing coverage with unauthorized insurance companies unless a risk has first been rejected by either an authorized insurer or the residual market.

The California regulation would have done the same thing, although it was restricted to automobile bodily injury, property damage or medical payment coverages. Insurance Commissioner John Garamendi is appealing the Administrative Law Office's decision to Gov. Pete Wilson.

Other states also are trying to require that risks be submitted and declined by residual markets before they can be placed in the voluntary surplus lines market, Mr. Snead added.

Such regulations, he asserted, are "contrary to the best interests of the consumer" because "a voluntary market always functions better than an involuntary market."

Because it is subject to market forces, a voluntary market is more efficient and responsive to the needs of the buyer than is an involuntary market that is based on forced or mandated participation, Mr. Snead added.

"The great travesty of these regulations is that they eliminate for the consumer the voluntary market choice and force the buyer into a state-mandated market regardless of price or service," he said.

"Simply, these types of regulations eliminate competition and are contrary to the free enterprise system," Mr. Snead charged.

Regulators counter that such restrictions are designed to protect consumers.

"We don't view the surplus lines market as 'evil,'" pointed out

The surplus lines market is being 'placed behind the residual markets,' says Mr. Snead.

Stewart Keir, assistant deputy superintendent and chief of the property and casualty insurance bureau of the New York Insurance Department.

"Regulators' intent is to protect policyholders to ensure benefits are paid in the event of legitimate claims," he said.

One advantage of placing business with admitted insurance companies, he said, is guaranty fund protection.

But if fear of insolvency is the reason that regulators don't want consumers to use surplus lines insurers, "they are attacking the problem from the wrong direction," Mr. Snead said.

"Admittedly, surplus lines companies are not covered by state guaranty funds except in New Jer-

sey," he said. "However, very few professional surplus lines companies have become insolvent over the years."

"Thus, a state policy to force business away from the voluntary surplus lines market to the residual market simply for guaranty fund protection (has) no validity," Mr. Snead said.

In addition, the solvency of residual markets could be threatened by these regulations because these markets generally charge cut rates to make coverage more affordable, Mr. Snead pointed out.

"The residual market works because, even in light of its failure to conform to basic market principles, it is supported by subsidies that are extracted from insurers and policyholders," he said.

Mr. Snead pointed to the recent experience of automobile plans in New Jersey and Massachusetts as "classic examples of the financial disaster that subsidized residual markets can create."

Several insurance companies withdrew from Massachusetts in the late 1980s, citing losses incurred in the state's residual auto insurance fund.

In New Jersey, the state Supreme Court earlier this year upheld a law assessing insurers in the state \$1.4 billion to help bail out the

state's defunct pool for bad drivers (*BI*, May 20).

But automobile residual markets are not the only such markets in dire financial straits, according to Mr. Snead.

"The medical malpractice JUA in New York is technically insolvent," he said. As of 1988, the balance sheet of this mandated residual market showed a shortfall of more than \$1 billion, according to Mr. Snead.

Eventually, such shortfalls will reduce the availability of insurance, he asserted.

"When insurance rates, or the price of any product, are set without consideration for underlying costs, companies will lose money and stop doing business, either voluntarily or through failure," he said.

"That means fewer choices for consumers, less competition for their business and high prices for their product."

Unfortunately, he said, "regulators understand the politics of cheap insurance a lot better than they understand the economics of a healthy voluntary insurance market."

The panel was moderated by David Anderson, president of Anderson & Murison Inc., a wholesaler in Los Angeles. ■

California wholesalers form lobbying group

LOS ANGELES—The formation of a new lobbying organization to represent insurance wholesalers in California was announced during the annual meeting of the National Assn. of Professional Surplus Lines Offices Ltd. earlier this month.

The new group, dubbed the California Insurance Wholesalers Assn., will provide a voice for wholesale brokers and other surplus lines servicing organizations

in California, according to Bill Brecht, president-elect of the new organization and president of the Western division of Hull & Co. in Santa Ana, Calif.

The group, which was formed in May, began soliciting members in midsummer and now has a roster of 74 insurance wholesalers, including surplus lines brokers and managing general agents.

Eventually the CIWA also will offer associate memberships to surplus lines insurers, according to Mr. Brecht.

While the CIWA plans to hire a lobbyist to represent wholesalers' interests before California legislators, initially it will use the services of the Agents & Brokers Legislative Council, a lobbying organization that represents the Independent Insurance Agents & Brokers of California, the Professional Insurance Agents of California & Nevada and the Western Assn. of Insurance Brokers, Mr. Brecht said.

The group also plans to "cooperate fully" with the Surplus Lines Assn. of California, a quasi-regulatory agency that checks the security of unlicensed insurers and files premium taxes and affidavits with the Insurance Department, according to Mr. Brecht.

In addition to Mr. Brecht, other officers of the new organization, all of whom will serve one-year terms, are:

- President David Anderson, president of Anderson & Murison Inc. in Los Angeles. Mr. Brecht, who was named president-elect of the CIWA, will become president of the group following Mr. Anderson's term.

- Secretary Marvin Uritz, president of Market Insurance Corp. in Encino, Calif.

- Treasurer Norm Levine, president of the Norco Agency in Van Nuys, Calif.

The CIWA plans to hold its first annual meeting before year end.

For more information, contact David Anderson at Anderson & Murison in Los Angeles at 213-255-2333.

—By Joanne Wojcik

To cut your rehabilitation costs, cut here.

Debra A. Keiser
Assistant Vice President

CRRSM Continental
Rehabilitation
Resources, Inc.

One Continental Drive
Cranbury, NJ 08570-0001
(609) 395-2020

Our personal touch makes the difference. CRR professionals can help you control and even cut expenses through timely selection and use of services that are case specific, targeted, highly practical and personalized. That means the best, most cost-effective rehabilitation. With close control from start to finish. And with all involved parties kept fully informed.

Get the cost benefits of our personal touch. Call or write Debra A. Keiser today.



National Assn. of Professional Surplus Lines Offices Ltd. earlier this month.

The new group, dubbed the California Insurance Wholesalers Assn., will provide a voice for wholesale brokers and other surplus lines servicing organizations

FINANCIAL INSTITUTION BONDS

- BANKS • THRIFTS • S&L'S • STOCKBROKERS •
- INSURANCE COMPANIES • FINANCE COMPANIES •
- MORTGAGE COMPANIES • ETC •
- PRIMARY, EXCESS OR CO-SURETY •
- ANCILLARY AND RELATED COVERAGES •
- INSURANCE OR FACULTATIVE REINSURANCE •
- DISTRESSED RISKS/CONVENTIONAL BUSINESS •
- STANDARD OR SPECIAL MANUSCRIPT FORMS •
- DOMESTIC OR LONDON MARKET POLICIES •
- IN-HOUSE FACILITIES OR OPEN MARKET •
- LIMITS TO \$50 MILLION AND BEYOND •



GARDNER MOUNTAIN BARR
A DIVISION OF HOGG INSURANCE BROKERS LIMITED,
LLOYD'S BROKERS

GMB INC.
17 STATE STREET
NEW YORK, NY 10004
ATT: MIKE FOGARTY
(212) 514-8100 FAX: (212) 514-8027

GMB (UK)
1 PORTSOKEEN STREET
LONDON, ENGLAND E1 8DF
ATT: TIM JAGGS
071 480-4683 FAX: 071 702-0544

Bingeman elected NAPSLO chief



LOS ANGELES—Kurt C. Bingeman, president of Russell Bond & Co. in Buffalo, N.Y., was elected president of the National Assn. of Professional Surplus Lines Offices Ltd. for 1992, replacing Joseph D. Timmons, president of the Midwestern General Agency Inc. in Kansas City, Mo.

Election of new officers took place at the end of this year's NAPSLO meeting, held Oct. 2-6 in Los Angeles and attended by more than 1,800 representatives of the surplus lines industry.

Other newly elected NAPSLO officers for 1992 are:

- Robert B. Angle, vp-marketing at Montgomery & Collins Inc. in East Hartford, Conn., as vp. He replaces Mr. Bingeman.

- David R. Hartock, president of the Southern division of Sherwood Insurance Services of San Francisco, as secretary. He replaces Mr. Angle, who was elected vp.

- Eugene J. Eisenmann, president of Stewart Smith Southwest Inc. in Dallas, as treasurer. He replaces Mr. Hartock, who was named secretary.

Next year's meeting will be Sept. 24-27 in Chicago.

For more information, contact Debbie J. Hill, Meetings Coordinator, National Assn. of Professional Surplus Lines Offices Ltd., 5746 N. Broadway, Kansas City, Mo. 64118; 816-455-3210.

—By Joanne Wojcik

Your life just got easier!

If you're not seeing Business Insurance every week — or are merely catching a dated pass-along copy now and then...you're missing important news and new developments in corporate risk and employee benefits management. Risky!
Make sure you have the business insurance news you need.

ENTER YOUR SUBSCRIPTION TO BUSINESS INSURANCE TODAY!

It will make your life a lot easier.

CALL TOLL-FREE on 1-800-678-9595. Fax your order in on 1-313-446-1650. Use the card in this issue, or if it's gone, use the coupon below.

Business Insurance gives you total news coverage of loss prevention, risk financing and benefit management. Every week. Annual subscription (52 issues) in U.S. dollars.

(Check here:)	Surface Mail	By Air
USA	<input type="checkbox"/> \$90	<input type="checkbox"/> \$175
Canada	<input type="checkbox"/> \$118	<input type="checkbox"/> \$185
Bermuda (air only)		<input type="checkbox"/> \$180
United Kingdom		<input type="checkbox"/> \$190 or £104
Europe/Middle East		<input type="checkbox"/> \$185
All other foreign	<input type="checkbox"/> \$118	Rates on request

new subscription. renewal. payment enclosed.
 bill me. bill company.
 Please send information on your special 20%-off group rate for five or more subscriptions.

name _____ (please print)

title _____ telephone _____

company _____

nature of business _____

business or home address

city _____ state/country _____ zip/postal code _____

I prefer not to receive information or advertising by mail from companies not affiliated with Crain Communications.

Mail to: Business Insurance, Circulation Dept., 965 E. Jefferson Ave., Detroit, MI 48207

4COU9

Health care

Continued from page 1

providing us as individuals and as a nation," said House Minority Leader Robert Michel, R-Ill.

"We do not intend to jump in with a grandiose proposal just for the sake of having a proposal," he said.

These differing opinions were expressed last week during the first in a series of House Ways and Means Committee hearings on proposals to improve access to health care.

About 34 million U.S. citizens currently lack health care coverage. More than two-thirds of the uninsured are either employed or dependents of uninsured employees.

And, health care expenditures now exceed 12% of the gross national product, the highest percentage of any country (BI, Oct. 7).

Committee members made clear that finding a bipartisan solution to improving access to health care will be an enormous political challenge.

The search for such a solution may be the "most singular daunting problem" over the next decade, said Rep. William Archer, R-Texas.

Indeed, the spirited debate at last week's hearing illustrates how far apart congressional Republicans and Democrats are in their search for that solution. For example, Democrats and Republicans disagree on how well the current health care delivery system is working.

Rep. Sam Gibbons, D-Fla., described the private health care delivery system as "an historic accident. We have let it go on, and it has brought disaster to our whole health care system."

For those without employer-provided coverage, the nation's health care system is a disaster, concurred Rep. Charles Rangel, D-N.Y.

But Rep. Michel said the United States has the world's best health care delivery system in most respects.

"In terms of quality of care, availability of care and timeliness of care, we are second to none," he said.

Republicans, though, agree that certain changes are necessary.

Rep. Archer, for example, said medical malpractice reforms and reduced paperwork burdens would make coverage more affordable.

"Real dollars can be saved through targeted reforms," he said.

In addition, Rep. Nancy Johnson, R-Conn., endorsed a modest approach to health care reform whereby federal law would be changed to make it easier for small employers to band together to purchase health insurance on a group basis.

Such an approach "would dramatically reduce the cost of insurance and make health care benefits more affordable to millions of people who work for small employers," Rep. Johnson said.

The Republican approach to improving health care access consists of trying to accomplish what is possible, said Rep. William Thomas, R-Calif.

Continued on next page

INSURERS?

When individuals leave your group health plan, they are at **risk** of becoming uninsured.

LET CELTIC REDUCE THE RISK.

Only Celtic offers a stand-alone
Post-Termination Benefits Program.

- Conversion Coverage for Long-Term Needs.

- Transition Coverage for Short-Term Needs.

For more information, contact Walter Roland.

Celtic Life Insurance Company
208 S. LaSalle Street
Chicago, Illinois 60604
(312) 332-5401

Celtic is A-Rated by A.M. Best Company

OCTOBER CLOSINGS

SET YOUR DATES

issue closing:	October 14	Bonus Distribution: SIAA
issue closing:	October 21	Reader Service Bonus Distribution: CPCU & Eaden-Baden
editorial feature: demographic section:	October 8	Specialty Risks: Environmental Liability — Directory: Environmental Consultants Insurer Topics: Automation: Claims
issue closing:	October 28	
issue closing:	October 16	
issue closing:	November 4	Bonus Distribution: NAII
issue closing:	October 22	
editorial feature: demographic section:		Reinsurance: Trends & Issues — Directory: Reinsurance Intermediaries Agent/Broker Topics: Tapping Surplus Lines Markets & IIAA Conference Report
issue closing:	November 11	
issue closing:	October 30	

1	2	3	4	5
6	7	8	9	10
11	12	13	14	15
16	17	18	19	20
21	22	23	24	25
26	27	28	29	30
31				

New York
(212) 210-0228
Fax: (212) 210-0704

Chicago
(312) 649-5276
Fax: (312) 230-3189

Los Angeles
(213) 651-3710
Fax: (213) 655-8157

Business Insurance
a publication of Crain Communications Inc

Health care

Continued from previous page

Republicans repeatedly recalled the political disaster that occurred the last time Congress tried to significantly expand health care coverage.

In 1988, legislation was enacted to expand the federal Medicare program by drastically reducing Medicare recipient's deductibles and coinsurance requirements (BI, June 6, 1988).

One year later, however, the Medicare Catastrophic Coverage Act was repealed following a wave of public outrage by middle- and upper-income retirees who objected to the higher taxes—initially \$1,600 a year for a married couple—to fund the benefits (BI, Nov. 27, 1989).

Many retirees also objected to the new program because they already received similar benefits at much lower costs from employer-provided plans.

The Medicare Catastrophic law was repealed "because we tried to do too much at one time. It sank under its own weight. It cost too much," said

Rep. Bill Gradison Jr., R-Ohio.

"We do not want to repeat that experience. It all fell down like a house of cards," Rep. Michel said.

But, Republicans were drawing the wrong conclusion from the Medicare debacle, Rep. Russo said. The 1988 law failed because the benefits were not rich enough, not because of public concern about the costs, Rep. Russo said.

In fact, some Democrats said the best way to improve access to health care would be to expand the Medicare program to cover the entire population. Medicare benefits currently are limited to retirees over age 65, as well as the disabled.

Medicare "is an American program. It is a proven program. It works. The hospitals know how to use it. The doctors know how to use it. The beneficiaries know how to use it," Rep. Gibbons said.

At the same time, an expanded Medicare program still would leave room for the private insurance industry, Rep. Gibbons said. Insurers could, for example, provide "Medigap" policies to cover deductibles and coinsurance not paid by Medicare, he said.

Some Ways and Means Committee Democrats want the government's role to go even further.

For example, Rep. Russo supports enactment of a single-payer government program that would provide first-dollar coverage for physician, hospital and dental care services as well as for prescription drugs. Benefits would be funded through new payroll taxes paid by employers and workers. The federal government would limit fees charged by physicians and limit the amount of funding provided to hospitals.

A single-payer program "is the only politically feasible option because it's the only plan that benefits all Americans," said Rep. Russo, who in March introduced a bill, H.R. 1300, calling for such a program (BI, March 18).

"This bill isn't about raising taxes: It's about giving people more services for less than they spend now on insurance company premiums," he said.

Rep. Russo said the administrative savings under a single-payer system would offset the cost of extending coverage to the uninsured and eliminating copayments and deductibles.

But Rep. Johnson, the Connecticut Republican, questioned putting so much power and trust in government to provide health benefits.

Political factors, like keeping the lid on taxes needed to support such a program, could unreasonably hold down how much the government would pay physicians and hospitals and lead to a deterioration in the quality of health care services, Rep. Johnson said.

Rep. Russo, though, said he was not proposing cutbacks in spending for health care services.

He said he is not trying to cut the percentage of GNP devoted to health care "to 9% or 8.5%. I'm just trying to keep it level."

But, Rep. Fred Grandy, R-Iowa, said individuals might lack incentives to use health care services wisely if a government plan—under Rep. Russo's proposal—paid all health care costs.

Rep. Russo countered that high deductibles and coinsurance requirements lead individuals to delay seeing their physicians. As a result of that delay, what initially is a problem that is simple and inexpensive to treat becomes much more expensive, he said.

Rep. Michel, echoing remarks made last month by Health and Human Services Secretary Louis Sullivan, said it would be ironic that as socialistic countries moved toward free enterprise, the United States would move in the opposite direction through a federal takeover of the health care delivery system. "Let us not make that mistake," he said.

However, Rep. Sander Levin, D-Mich., said it is possible to have a single-payer health care system and still have lots of free enterprise in other parts of the economy.

It is simplistic to say that a single-payer system "is not the American way," Rep. Levin said.

REINSURANCE Trends and Issues

Publishing:
November 4

Ad Closing:
October 22

Reinsurance. A puzzle?

How are reinsurers coping in today's market?

What is the outlook for rates and capacity in 1992?

Are there new rules and regulations affecting reinsurers?

What will year-end renewals mean for reinsurers as well as the primary market?

On November 4 nearly 150,000* readers — financial and administrative executives, risk and benefits managers, agents, brokers, insurers, reinsurers and consultants — will turn to Business Insurance for answers to these questions and more. To complement up-to-the-minute news and authoritative editorials, BI will detail developments and describe how they will affect corporate insurance buyers, insurers and reinsurers. Plus, editors will profile the 10 largest reinsurance intermediaries and provide readers with the most comprehensive directory of U.S. and Bermuda-based reinsurance intermediaries.

With so much at stake, can you afford to be the piece of the reinsurance puzzle that buyers can't find? Advertise in the only newsmagazine that puts all the pieces together. Advertise in Business Insurance.

*Includes pass-along readership.

REGULATION
RECOVERABLES
RELIABILITY
RATES
RETENTIONS
RISK
RELATIONSHIPS
REVENUES
RENEWALS

SURPLUS
SERVICE
STABILITY
SOLVENCY
SECURITY
SYNDICATE

NEGOTIATIONS
NET LINE
NON-ADMITTED

ADJUSTMENTS
ALTERNATIVE
MARKETS
ARBITRATION
ACCESS
ASSUME
AUTOMATIC
TREATY

CAPACITY
CONTRACTS
COVERAGE
CLAIMS
CATASTROPHES
CAPTIVES
COMMISSION

INTERNATIONAL
INTERMEDIARIES
INVESTMENT
INCOME
IBNR
INSOLVENCIES
INTEREST
RATES

UNDERWRITING
UBERRIMAE
FIDEI
UNDERLYING
PREMIUM
UNEARNED
PREMIUM

EXCESS
OF LOSS
EXPOSURE
EXCLUSION
EXPERTISE

REINSURANCE

Business Insurance
a publication of Crain Communications Inc

INTERNATIONAL

Names' suit against Outhwaite goes to trial

By GAVIN SOUTER

LONDON

LONDON—Members of Lloyd's of London syndicates underwritten by Richard Outhwaite charged during the first day of a landmark trial that Mr. Outhwaite wrote coverage outside of his field of expertise, thus subjecting them to horrendous losses.

According to Anthony Boswood, the lawyer for 987 syndicate members, "Never in the commercial history of the City of London has so much money been lost by the single-handed negligence of one man." In the opening arguments of the London High Court trial, Mr. Boswood alleged that Mr. Outhwaite broke the first rule of underwriting: Losses of the few should be shouldered by the many.

The losses at syndicate 317/£61,

managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., totaled \$456 million at the beginning of 1990. The losses stem from 31 run-off reinsurance contracts underwritten by Mr. Outhwaite in 1982. Those contracts exposed syndicate members to huge U.S. asbestos liabilities, Mr. Boswood said.

The trial marks the first time in memory that a court has heard a dispute between Lloyd's members and their managing and members agents.

Despite being a marine underwriter, Mr. Outhwaite chose to lead the risks as part of the incidental non-marine account under-

written by the syndicate, Mr. Boswood said. And he knew "virtually nothing" about U.S. casualty risks, Mr. Boswood added.

Besides Outhwaite, the suit also names as defendants 81 members agents that placed the members on the syndicate. However, the agents "are just as much victims of Mr. Outhwaite's negligence as the names themselves," Mr. Boswood said.

Neither the members nor the members agents had any idea that Mr. Outhwaite was exposing the members to such huge U.S. liabilities, he argued.

The syndicate's non-marine premium volume rose from 1.5 million pounds (\$2.2 million at applicable exchange rates) in 1981 to 18.1 million pounds (\$21 million) in 1982 and then fell to 3.1 million

pounds (\$4.5 million) in 1983.

To boost its premium volume during the soft market of the early 1980s, Mr. Outhwaite increased the syndicate's non-marine business, Mr. Boswood said.

However, the attorney charged, Mr. Outhwaite misled members and members agents into thinking that they were not heavily exposed to asbestos risks.

In reply to a letter from members agent Thomas R. Miller & Son (Underwriting Agents) Ltd. in 1982, Mr. Outhwaite had written that syndicate losses from asbestos claims would not be significant, Mr. Boswood noted.

Yet, the day before the reply was sent to the members agency, Mr. Outhwaite had accepted a runoff contract on an account that faced more than \$12 million in asbestos

losses, Mr. Boswood alleged, adding that the contract was just the beginning of a large runoff program that would expose the syndicate to further asbestos losses.

"Each of the plaintiff members knew that the membership of Lloyd's carried unlimited liability, but they were entitled to expect that those underwriting on their behalf would do so with a degree of skill and prudence appropriate to the world's most sophisticated insurance market," Mr. Boswood said.

Mr. Outhwaite's actions were akin to an investment manager ignoring a client's requests that funds be invested in British stock and instead investing the client's money in stocks in other countries, Mr. Boswood said.

Continued on next page

ACE posts first-ever underwriting loss

By ROGER SCOTTON

BERMUDA

HAMILTON, Bermuda—Less than a year after paying its first claim, high-layer excess liability insurer ACE Ltd. is reporting its first-ever underwriting loss—a \$10.9 million loss for the quarter ended June 30.

For the same period last year, Bermuda-based ACE reported a \$35.3 million underwriting profit.

For the six-month period ending March 31, ACE reported an underwriting profit of \$13 million (BI, June 17).

ACE Chairman and Chief Exec-

utive Officer Walter Scott attributed the underwriting loss to "increased frequency and severity of losses combined with the adverse development" of earlier claims.

"At this time last year, ACE had not yet paid its first claim," Mr. Scott observed in a report to shareholders. "In the ensuing 12 months, ACE has made payments on five claims aggregating to \$188 million."

Its provision for losses and loss expenses for the nine months

ended June 30 was \$160 million, compared with \$100 million in 1990.

Strong investment returns, though, more than offset what Mr. Scott called a "significant decline" in underwriting results. Realized gains and investment income on ACE's \$1.5 billion securities portfolio rose 125% to \$131 million from \$58 million for the nine months ended June 30, 1990.

The total return on the combined investment portfolio was 13.4%, leaving net income for the nine-month period at \$114 million, up 27% from \$90 million in that pe-

riod a year earlier, Mr. Scott said.

Written premiums rose 45.3% to \$209.3 million from \$144 million for the year-earlier period. Mr. Scott said the increase included \$39 million in new business and the purchase of three-year excess liability policies and additional limits by existing policyholders.

Earned premiums grew 9% to \$174.3 million, he said.

As of June 30, ACE had in force 389 excess liability policies and 229 directors and officers liability policies, compared with 381 and 212, respectively, as of June 30, 1990.

"While the total number of policies in force continues to grow, the increase is partially offset by the effect of mergers and acquisitions involving ACE insureds and the continued loss of a number of small excess liability policies due to our decision to no longer require the purchase of an excess liability policy before a D&O policy can be issued," Mr. Scott said.

By June 30, 103 excess liability policyholders had purchased the full \$200 million in limits ACE offers, he added.

Mr. Scott, who four months ago

Continued on page 39

Malta studies impact of product liability

VALLETTA, Malta—The Maltese government has issued a white paper detailing new consumer protection legislation that, among other things, would bring the island nation in line with the European Community's strict product liability law.

Local insurers predict the legislation would have a major impact on the domestic market for liability insurance (BI, Oct. 7), although they add that the measure is unlikely to become law soon.

In its paper, the government

GLOBAL BRIEFS

contends that Roman law, which is the conceptual basis for the Maltese legal system, inadequately protects consumers by giving the manufacturer, seller and buyer equal rights.

"The position has not altered much since the Code Civile, the Napoleonic model for our civil code, was being polished into its near perfect formulation. Our code

has not yet reflected a society where economically powerful industrial setups or distribution chains are confronting a myriad of individual consumers acquiring in haste," the report said.

A key part of the government's proposal is to adopt the E.C. Product Liability Directive. That 1985 measure is designed to shift the burden of proof in product liability litigation to the producer of a product rather than a consumer.

The Maltese consumer protection legislation would change the 100-

year-old civil code in three main areas, according to the report: statutes regulating the supply of goods and services; the law of contracts; and the statutes governing liability for damage caused by defective products. Specific legislative reforms have yet to be introduced in each of the three areas.

Another key feature of the government's proposal is the establishment of a Consumer Protection Council, which would:

- Monitor all commercial activities relating to the supply of goods

and services.

- Investigate and identify products, services or trade practices that harm consumer interests, and recommend alternatives.

- Guide, assist and educate consumers.

- Foster development of consumer and fair trade associations.

- Monitor consumer law and practices in other countries.

The council also would have executive power enabling it to intervene directly in the marketplace.

—By Maria Kielmas

Hull rates for Aussie fleets at low ebb

By KATE McILWAINE

BRISBANE, Australia—Marine insurers are trying to hike hull rates for Australia's commercial fishing fleets, particularly Queensland-based boats, after incurring numerous losses in the past three years.

Underwriters say the waters off Queensland, which include the Great Barrier Reef and Cape York, are the most hazardous for fishing boats, but insurer competition has kept rates low.

The three largest fishing fleet underwriters in Australia together reported claims from Queensland waters totaling \$7.4 million Australian (\$5.7 million at year-end 1990 exchange rate) last year, but gross premiums written for that business totaled only \$4.25 million Australian (\$3.3 million).

Sunderland Marine Mutual Insurance Co. Ltd., a unit of Sun-

derland Insurance U.K., insures about 40% of Australia's national fishing fleet, industry observers say. Switzerland General Insurance Co. Ltd. also writes about 40% of the fleet's coverage. Most of the remaining 20% is covered by Marine & Aviation Management Services Ltd.

The Australian commercial fishing fleet consists of about 9,000 boats, ranging in length from 18 feet to more than 100 feet, according to David Townsend, secretary of the Canberra-based National Fishing Industry Council.

Fishing is Australia's fifth-largest industry with annual gross production valued at \$850 million to \$1 billion Australian (\$675 million to \$794 million). Around 70% of the Australian fleet's catch is exported.

Mr. Townsend said shellfish like prawns, lobster, scallops and abalone are the primary catch.

Some tuna, salmon and mullet are also harvested.

The predominant species caught in the Great Barrier Reef waters off Queensland are prawns and scallops, which are dredged from the ocean floor by trawlers.

Underwriters say their losses on hull coverage for Queensland operations are disastrous.

David A. Roberts, Australian manager of Melbourne-based Sunderland, said the insurer's loss ratio on this class of business in 1990 was 170%. It was 120% in 1989, and is likely to be around 120% again this year, he added.

Sunderland's rates vary from 2% to 7% of the value of the hull, according to Mr. Roberts. But, for business to be profitable, an average rate of at least 3.5% is needed, he said.

"We've been looking for 15% to

Continued on next page



GRAPHIC BY CYNTHIA WATSON

INTERNATIONAL

LONDON

Continued from previous page

"It could be argued that the position of an underwriter (demands even more care) because an investment manager can only lose the money he has been given, but an underwriter can lose everything his names have," he said.

Some famous figures are among the members suing Mr. Outhwaite and the members agencies. Included in the original writ are an Anthony Jacklin, thought to be the former professional golfer Tony Jacklin; Patrick Sheehy, thought to be the same Mr. Sheehy who is president of B.A.T Industries P.L.C.; and Edward Heath, thought to be the former British prime minister. None has denied the numerous press reports that they are involved in the suit.

Mr. Boswood's opening arguments are expected to last one week. The trial is expected to last at least two months.

Open account

Uncertainty over the size of fu-

ture claims from U.S. pollution and asbestos risks and a huge drop in capacity have forced one of the oldest Lloyd's of London syndicates to leave a year of account open for the first time ever.

Marine syndicate 367, managed by F.L.P. Secretan & Co. Ltd., which can trace its origins back 200 years, will leave its 1989 year open, confirmed Peter Edwards, Secretan's chief executive.

And although the syndicate has reserves of \$153 million to meet future claims, it will not be able to ascertain whether this will be adequate until next spring, when more notices of pollution claims have been filed, Mr. Edwards said.

Fear of future losses has caused the syndicate's capacity to be cut in half as members agents advise Lloyd's members to steer clear of syndicates with long-tail pollution and asbestosis exposures, he said.

The syndicate's 1989 capacity was 142 million pounds (\$257 million at appropriate exchange rates), but capacity this year had dropped to 101 million pounds (\$194.9 million). And prospective 1992 capacity is only 42 million pounds (\$72.7 million at current exchange rates), Mr. Edwards

pointed out.

"Obviously, we are extremely disappointed at the drop in capacity, but it is not just a problem for 367. There are a number of marine syndicates with pollution liabilities which are suffering similar problems," he said.

Less than 10% of syndicate 367's premium income was derived from its incidental non-marine account, and of that, a "tiny percentage" was related to pollution and asbestos risks, Mr. Edwards said.

Loss review

Lloyd's has set up an independent loss review into the huge loss suffered by syndicate 421, managed by Merrett Underwriting Agency Management Ltd., for its 1983 account year.

The syndicate, which ceased writing new business in 1990, is reporting losses equaling 570% of its 3.4 million pounds of capacity (\$5.5 million at appropriate exchange rates) stemming from asbestos and pollution claims from runoff contracts it wrote in 1983.

The underwriter at the time was John Emney, now chief underwriter at Charter Reinsurance Co. Ltd. Merrett underwriter Dennis Purkiss became underwriter of syndicate 421 in 1986 and remained underwriter until 1990.

"The losses stem from similar runoff contracts to those written by the Outhwaite syndicate only on a much smaller scale," Mr. Purkiss said.

The loss review is made under the Loss Review Bylaw, which is triggered when syndicate losses top 100% of stamp capacity.

Review panel members are: Roger Whewell, a partner at KPMG Peat Marwick McLintock; David Lowen, chairman of ARIG Insurance Co. Ltd.; and Nick Thomson, underwriter for syndicate 33 managed by Hiscox Syndicates Ltd.

Meanwhile, Lloyd's has revoked an order made in May that syndicate 575, managed by J.H. Chappell (Underwriting Agencies) Ltd., cease underwriting.

The order to stop underwriting was originally made because the syndicate had underwritten more premium volume than it was permitted to write, due to automatic reinstatements of catastrophe coverages (BI, May 27).

Lloyd's says it is now satisfied that the syndicate has taken sufficient measures to ensure that it will not exceed its capacity again.

Agency in liquidation

Troubled Lloyd's underwriting agent Gooda Walker Ltd. has gone into liquidation and the Corporation of Lloyd's has been left to manage its affairs.

Syndicates managed by the agency have been subjected to huge losses from Hurricane Hugo and other catastrophes which have battered the insurance market in the past four years (BI, Sept. 2).

Four of the six syndicates managed by Gooda Walker have produced losses totaling 221 million pounds (\$382.3 million at current exchange rates).

The decision to place the company in liquidation followed Lloyd's refusal of a proposed rescue plan for the company and the company's inability to renew its errors and omissions coverage.

Lloyd's is trying to find new agencies to manage the Gooda Walker syndicates. The management of syndicate 1052 already has been transferred to RGB Underwriting Agency Ltd., and Lloyd's is negotiating with other agencies regarding syndicates 295 and 299.

Lloyd's will arrange for the runoff of syndicates whose management cannot be transferred.

Fishing fleets

Continued from previous page

30% increases in Queensland and more for some vessels if necessary," he said.

Rates in Queensland were "misjudged" in past years and need to be increased more than in other Australian states to catch up, he said.

Although there is "more sense" in the market now, from 1986 to 1988 underwriters had tried to "cut each other's throats," he explained. "We've all been brought up with a jolt—we bit off more than we could chew."

Mr. Roberts said there has been "a fair bit of resistance" to attempts by hull insurers to increase rates, but fishermen "recognize the risks of their industry."

In 1990, Sunderland's fishing boat losses totaled \$11 million Australian (\$8.5 million), of which \$4 million Australian (\$3.1 million) was in Queensland waters. The insurer's gross premiums written in 1990 for fishing boats nationwide was \$8.9 million Australian (\$6.9 million), while it was only \$2 million Australian (\$1.5 million) for Queensland risks.

The insurer's claims included groundings, sinkings, fires, major machinery breakdowns, collisions and heavy weather damage, Mr. Roberts said.

Written premiums are about \$8 million Australian (\$6.4 million at current exchange rates) this year, with \$9.5 million Australian (\$7.6 million) so far in claims, he said.

Chris Kelsey, assistant national marine manager for Sydney-based Switzerland General, said the past three years "haven't been kind to (fishing fleet) underwriters."

Michael Matthews, the insurer's Queensland marine manager, added that the past four years "have been 'chronic' for fishing fleet underwriters."

The insurer's 1990 premiums written for Queensland fishing boats were \$1.5 million Australian (\$1.2

million), with losses of \$2.4 million Australian (\$1.9 million). The insurer's 1991 experience has been "tracking pretty well so far" with \$1.6 million Australian (\$1.3 million) in premiums and \$1.1 million Australian in claims (\$873,950).

Switzerland General is trying to raise rates at least 10%, Mr. Kelsey said.

Rates have been driven downward by companies that "dabble in the market" but do not stay in it for the long term, he said.

For example, while rates should be between 2.5% and 3% of value, some insurers are prepared to charge 1% or 1.5%, he said. Switzerland General has a policy of not writing business for less than 2% of the hull value, Mr. Kelsey said.

Warren Holmes, Queensland manager of Melbourne-based MAMS, which writes on behalf of the Australian Hull Pool and the Australian Marine Underwriting Agency, said most companies writing fishing boat fleets are losing money, particularly in Queensland.

MAMS raised rates 15% last November and expects to increase them again by around 7.5% this November, he said.

Some underwriters may even look carefully at whether they will continue to underwrite fishing boat business in Queensland, he added.

"We still write the business, but we don't actively pursue it," he said.

Mr. Holmes said Queensland fishing boat rates are the highest of all Australian states.

Queensland losses for MAMS in 1990 were almost \$1 million Australian (\$772,500), while gross premiums written were about \$740,000 Australian (\$571,650), Mr. Holmes said. The sum insured is \$30.9 million Australian (\$23.8 million), meaning the average rate is about 2.4%.

John Green, Queensland marine manager for Property Marine Insurance Co. Ltd., a Sydney-based specialist marine and motor underwriter that underwrites fishing fleets in

Continued on next page

Motel 6 was losing sleep over its benefits program...

...until QicClaim/2[®] put their problems to rest.

Human resources personnel at Motel 6 were lodged in a health benefits administration nightmare.

"We found ourselves bogged down in paperwork and claims resolution...stuck between our insurance company and our employees," said Tom Higgins, vice president of human resources.

The QicClaim/2
advantage for Motel 6?
"It works."

Then they woke up to the fact that they could serve their 6,000 covered employees better—and more economically—by self-insuring and self-administering their group health program.

So they talked to other human resources executives. They consulted software experts. They sent for information and they reviewed several products. Most software programs left them with reservations.

All but one—QicClaim/2 software from Resource Information

Management Systems, Inc. (RIMS).

Higgins quickly discovered what he calls the major advantage of QicClaim/2: "It works."

Even the installation was easy. The program came in four small boxes and plugged right in to Motel 6's existing PC hardware.

When it came to actually paying claims, the motel chain didn't lose any sleep, either. That's when RIMS top training and support staff checked in.

"I could almost run the program just from watching the demonstration, so you know it's easy," Higgins said.

As for QicClaim/2's efficiency, Motel 6 expects a 15-month return on their investment.

Now, when Motel 6 employees have health claims questions, they call their co-workers. And that's a dream come true for staff and the human resources department alike.

If you have a benefits administration nightmare of your own, call us toll-free at 1-800-950-0099

for more information or for a free copy of our video.

© 1991 Resource Information Management Systems, Inc. RIMS is a registered trademark of the International Business Machines Corporation.

RIMS The Leader in Benefits Administration Software

Resource Information Management Systems, Inc. • 500 Technology Drive
P.O. Box 3094 • Naperville, IL 60566-7094 • 708/369-5300 • FAX: 708/369-5168

Advertiser

Index

Issue of October 14

Advertiser	Page #	Advertiser	Page #
Aetna Health Plans	17	Environmental Compliance	31
Aetna Life & Casualty	32-33	First State Insurance	6
Affiliated FM/Appalachian	24-25	Gardner Mountain Barr Inc.	34
AIG Corporate	26	Great American Insurance Co.	14
Alicare	15	HCM Claim Management	18-19
American Drug Stores	16	Insurance Intelligence	12
American Reinsurance	10-11	ITT/Hartford Insurance Co.	21
A.M.E.V. Holdings Inc.	41	Kirkpatrick & Lockhart	40
Argonaut Insurance Co.	9	Media/Professional Ins.	20
Business Insurance	13,36	Mutual Med., Inc.	39
Celtic Life Insurance	35	Mutual of Omaha	48
Chubb	30	National Reinsurance	23
CIGNA	5	North American Reinsurance	29
CMG Health	40	Resource Inform. Mgmt. Systems	38
Continental Agency, Inc.	34	Risk Analysts Inc.	16
Continental/Rehab Resource	44	Royal Insurance	22
Cover X	39	Surplus Underwriters Casualty	20
Crawford & Company	7	Tillinghast	12
David Corporation	41	Travis Software	22
Employers Reinsurance Corp.	4		

Business
Insurance

INTERNATIONAL

Continued from previous page
Queensland and New South Wales, said 1987 was the last "reasonable year" for his company's book of fishing fleet risks. He estimated Property Marine's share of the Queensland fishing market is about 15%.

"Overall... it's one of the worst lines to get involved in," he said.

Mr. Green said fishermen's incomes are falling because of government limits on catches and, as a result, some cannot afford to keep up the regular maintenance on their boats. "It's hard to lift rates when they don't have the money," he said, noting that some fishermen already are borrowing funds to pay their insurance premiums.

James McDonald, marine underwriting manager for Sydney-based Lumley General Insurance Ltd., said his company writes only a small portion of Australia's fishing fleet business and is "extremely conservative" with its underwriting.

For example, he said Lumley will not write coverage for boats that operate in waters above Rockhampton, about halfway up the Queensland coast.

"We target vessels in less geographically hazardous zones," he said. "Ours is a thin slice of the premium pie but a large slice of the quality pie."

As a consequence, Lumley made a profit on its fishing boat business last year, "but we're perhaps the only insurer who did," Mr. McDonald said.

The Fishing Industry Council's Mr. Townsend said he did not think losses in recent years had been "abnormally high" but said Queensland's poor loss record could be attributed to the cyclones in northern Queensland, the Great Barrier Reef and a larger number of wooden vessels.

"It's riskier territory," he said, not-

ing that most underwriters set premiums accordingly.

Switzerland General's Mr. Kelsey said Queensland waters are "hostile territory."

Mr. Matthews, also of Switzerland General, said there are a lot of wooden and fiberglass boats operating in Queensland waters, noting they are more easily damaged than steel-hulled boats if they hit a reef. He said rough weather also contributes to losses.

"A wave through the wheelhouse is common and it can be a \$50,000 Australian (\$39,725) loss if electronic equipment is damaged," he said.

MAMS' Mr. Holmes could not say why losses in Queensland were higher than in other states, but speculated that the length of its coastline may contribute.

"Vessels travel further afield, and once you pass Cairns, facilities are basically nil," he said.

MAMS has higher deductibles on policies for boats that operate above Princess Charlotte Bay, 200 miles north of Cairns, Mr. Holmes said. The usual deductible is \$5,000 Australian (\$3,973) or 1% of the ship's value, but that increases to \$10,000 Australian (\$7,945) for vessels operating around the Cape York Peninsula, he said.

Major fishing boat claims to hit insurers in 1990 and 1991 include:

- \$1.4 million Australian (\$1.1 million at current exchange rates) for the Julia Percy, an 80-foot trawler that ran aground on Kangaroo Island, South Australia, in December 1990 after its anchor chain broke.

- \$1.3 million Australian (\$1 million) for the Bounty Hunter, whose hull was pierced by rocks in Queensland waters on Dec. 27, 1990.

- \$1.3 million Australian (\$1 million) for the Crystal Voyager, which sank off Fraser Island, Queensland, in March 1991.

- \$1.25 million Australian (\$993,125) for the Aqua Enterprise, a sister ship to the Julia Percy that sank in April 1990 off southern Tasmania.

- \$1 million Australian (\$794,500) for the Karina G, a 100-foot tuna boat that ran aground off South Australia January 1990, after its anchor chain broke.

- \$750,000 Australian (\$595,875) for the Phoenix Czar, an 80-foot prawn trawler that sank in the Gulf of Carpentaria in June 1990.

- \$410,000 Australian (\$325,745) for the Apache after a fire broke out on board while in north Queensland waters Sept. 13, 1991.

- \$285,700 Australian (\$226,845) for the Mercedes, which caught fire in Queensland waters on May 9, 1990.

- \$250,000 Australian (\$198,625) for the Kekenni, which sank June 17, 1991, after its hull was pierced by a Chinese bulk carrier off Cairns, north Queensland.

- \$229,000 Australian (\$181,941) for the Polaris, which sank off Townsville, north Queensland, in August 1991.

- \$176,000 Australian (\$139,832) after a fire on board the Koorelah in Queensland waters, Jan. 1, 1991.

- \$130,000 Australian (\$103,285) for the Enterprise, which sank off Moreton Island, south Queensland in August 1991. ■

BERMUDA

Continued from page 37

announced the company's first excess liability rate increase in its history (BI, June 17), also reminded shareholders that ACE is not "market-share driven" and will not write policies at rates it considers to be too low.

In a separate development, ACE last week announced the appointment of its first full-time in-house lawyer, Bradford W. Rich.

Mr. Rich had been senior vp-claims and general counsel with Crum & Forster Inc. of Basking Ridge, N.J., and was its chief litigation counsel for the past five years.

Mr. Rich said his appointment was only partly a recognition of increasing claims. It was predicated more on the desire of the company's Philadelphia-based legal consultant to cut down on his travel, Mr. Rich said.

Economy buoyed

Insurance-related companies continue to inject more money into the Bermuda economy than any other sector of the island's international business community, a survey by the local Chamber of Commerce found.

Forty-nine insurance-related

firms, including brokers and captive managers, with operations in Bermuda pumped \$110.4 million into the local economy in 1990, or three-quarters of the total \$148 million spent by all 93 companies responding to the survey.

Last year's Chamber of Commerce survey found that 107 international companies spent \$154.4 million in 1989, with 52 insurance-related companies accounting for \$104 million—or two-thirds—of that total.

Although the figures would appear to show that fewer insurance-related firms are spending more, the results are "not strictly comparable" year to year, warned Andrew Carr, a Chamber of Commerce official. Mr. Carr also is head of Marsh & McLennan Cos. Inc.'s captive management operation in Bermuda.

The number of reporting companies fluctuates, and the confidentiality the Chamber offers to respondents make it impossible to tell whether the same firms are taking part in the survey, he pointed out.

Half of the total spent by all respondents in 1990, or \$73.8 million, was attributable to salaries and benefits for 1,378 employees, 1,029 of whom—or nearly 75%—were employed by insurance-related firms, according to the survey. ■

Sell more group by selling it self-funded

Today's high health insurance costs demand a hard look into alternatives. Such as self-funding. It can save important money. And it's feasible even with employee groups as small as 25.

Why not be the person who points the way?

We'll put you in the business. We're a full-service, fully automated third-party administrator, and we can do it all for you. We'll help with the selling, but the clients you have stay *your* clients. Our job is mainly administration — providing plans, documentation, underwriting, claims service, etc. Call for information...on self-funding and other alternatives.

800-747-4126

MutualMed_{INC.}

Benefit Administrators

1225 E. River Drive, Davenport, IA 52803

NEW POLICE PROFESSIONAL LIABILITY

- Wide Range of Limits of Liability
- Wide Range of Deductible Options
- A Highly Respected Insurer, A' Prime Rated
- A Broad Definition of Insured
- Jail Facilities Coverage
- Full Civil Rights Coverage Optional
- First-Aid Coverage Included
- Coverage for "Moonlighting" Included
- Occurrence and Claims Made Forms Available
- Retroactive Dates for Claims Made and Occurrence
- Insured's Right to Select Legal Counsel
- Insured's Right to Reject Settlement

PUBLIC OFFICIALS LIABILITY also available

Our years of experience and research and development in this class of business assures you a quality product. Our professional underwriting and claims staff assures you of service both before and after the sale.

ASK US TO FAX YOU AN APPLICATION TODAY!



COVER X CORPORATION

P.O. Box 5096, Southfield, Michigan 48086

Telephone: (313) 358-4010

Facsimile: (313) 358-2459

COVERAGE MAY NOT BE AVAILABLE IN ALL STATES

High court refuses to review cases

WASHINGTON—The U.S. Supreme Court last week refused to review a product liability lawsuit brought against five pharmaceutical firms by the granddaughter of a woman who took the anti-mis-carriage drug DES 30 years ago.

The New York Court of Appeals dismissed the lawsuit in February, ruling that the manufacturer's liability extended only to the daughter of the woman who took the drug, diethylstilbestrol, not to the granddaughter (*BI*, Feb. 25; Jan. 14).

The plaintiff had alleged that her grandmother's ingestion of DES set in motion a chain of events that resulted in the plaintiff's cerebral palsy.

The high court also refused to review a libel suit brought by entertainer Wayne Newton against the National Broadcasting Co. The 9th U.S. Circuit Court of Appeals last year overturned a \$5.3 million libel award against NBC.

In 1986, a federal court jury awarded Mr. Newton \$22.8 million after finding the network defamed him in 1980 and 1981 broadcasts that tied him to organized crime. A federal judge later cut the award to \$5.3 million (*BI*, Sept. 3, 1990; Jan. 23, 1989; Nov. 23, 1987).

—By Stacy Adler

Tobacco lawsuit

Continued from page 1
lawsuits brought under state law for failure to warn or misrepresentation, he argued.

"If a jury was to find a cigarette manufacturer failed to adequately inform consumers of the hazards of smoking, what regulation or prohibition does this force on manufacturers? None," he said.

But H. Bartow Farr III, an attorney representing the tobacco industry, argued that jury verdicts based on cigarette warnings are exactly the type of "requirement or prohibition" Congress intended to pre-empt with the Federal Cigarette Labeling and Advertising Act, which took effect in 1966.

"Congress recognized that this was a national problem that needed a national solution," said Mr. Farr, who is with Klein, Farr, Smith & Taranto in Washington, D.C.

While justices pressed both attorneys with difficult questions during the oral arguments, no clear picture emerged of how the court is likely to rule.

The court is reviewing a 1990 decision by the 3rd U.S. Circuit Court of Appeals that found that the federal act pre-empts state law tort claims (*BI*, Jan. 15, 1990).

The 3rd Circuit held "that the act pre-empts those state law damage actions relating to smoking and health that challenge either the adequacy of the warning on cigarette packages or the propriety of a party's actions with respect to

the advertising and promotion of cigarettes."

"We further hold that where the success of state law damage claims necessarily depends on the assertion that a party bore the duty to provide a warning to consumers in addition to the warning Congress has required on cigarette packages, such claims are pre-empted as con-

Mr. Edell insists that a jury verdict that finds a cigarette manufacturer liable for failing to adequately inform consumers about the dangers of smoking is different from a state 'regulation or prohibition,' which is barred by the act.

flicting with the Act," the appellate court ruled.

The dispute stems from a lawsuit brought by Antonio Cipollone and his wife, Rose, against three tobacco companies: Liggett Group Inc. of Durham, N.C.; New York-based Philip Morris Inc. and Lorillard Inc., a unit of New York-based Loews Corp.

The lawsuit was filed in 1983 in U.S. District Court in Newark, N.J., before Mrs. Cipollone, a long-time smoker, died of lung cancer at age 58. Since then, her husband has carried on the lawsuit as executor of her estate.

Mr. Cipollone charges the tobacco companies with breach of an "express warranty" in their advertising that smoking was safe and with failing to warn smokers of the

dangers of smoking.

Ads for Liggett's Chesterfield brand appearing in 1952, for example, told smokers, "Play Safe: Smoke Chesterfield."

The lawsuit also alleged that cigarettes are inherently dangerous products subjecting the manufacturers to claims of strict liability.

After the 3rd Circuit rendered its

decision that the federal act pre-empts claims based on post-1966 warnings, it remanded the case for a new trial.

After a four-month trial a federal jury in Newark found that Liggett breached express warranties in ads for brands Mrs. Cipollone smoked before 1966, the year the federal act took effect. The jury awarded Mr. Cipollone \$400,000 in damages, the first such defeat suffered by a cigarette maker in more than 300 tobacco liability cases (*BI*, June 20, 1988).

While the jury also found Liggett liable for failing to warn of the dangers of smoking, the jury awarded no damages on this issue after concluding that Mrs. Cipollone was 80% responsible for her injuries and Liggett 20% responsible. Under New Jersey law, a plaintiff found more than 50% responsible cannot recover damages.

Mr. Cipollone then appealed the 3rd Circuit's pre-emption ruling to the U.S. Supreme Court.

His attorney, Mr. Edell, tried to persuade the high court that the federal act does not pre-empt state tort law claims.

The act permits state tort law claims for failure to warn, fraud, deception and misrepresentation, said Mr. Edell, who is with Budd, Larner, Gross, Rosenbaum, Greenberg & Sade in Short Hills, N.J.

"At no time during hearings on the act did the industry ask for a

protection from these cases," said Mr. Edell. "Nor is there any suggestion that Congress created pre-emption from state tort law claims."

Chief Justice William H. Rehnquist interrupted Mr. Edell to ask: "Cannot the language Congress used be read more broadly than you are suggesting? Can it not be read to pre-empt state tort law claims?"

"No," Mr. Edell answered. He insisted that a jury verdict that finds a cigarette manufacturer liable for failing to adequately inform consumers about the dangers of smoking is different from a state "regulation or prohibition," which is barred by the act.

"While a jury verdict may have indirect regulatory effect, it is different from a regulation," said Mr. Edell.

However, Justice Sandra Day O'Connor said that "tort suits do appear to impose a state law prohibition" in conflict with the federal act.

She asked Mr. Edell: "What alternative does a manufacturer have but to cease using a warning" that a jury later finds inadequate?

A manufacturer can choose to pay a verdict and not change its behavior in any way, responded Mr. Edell.

Justice Antonin Scalia bristled: "Why isn't this the same as a regulation? You violate the tort law and you pay damages."

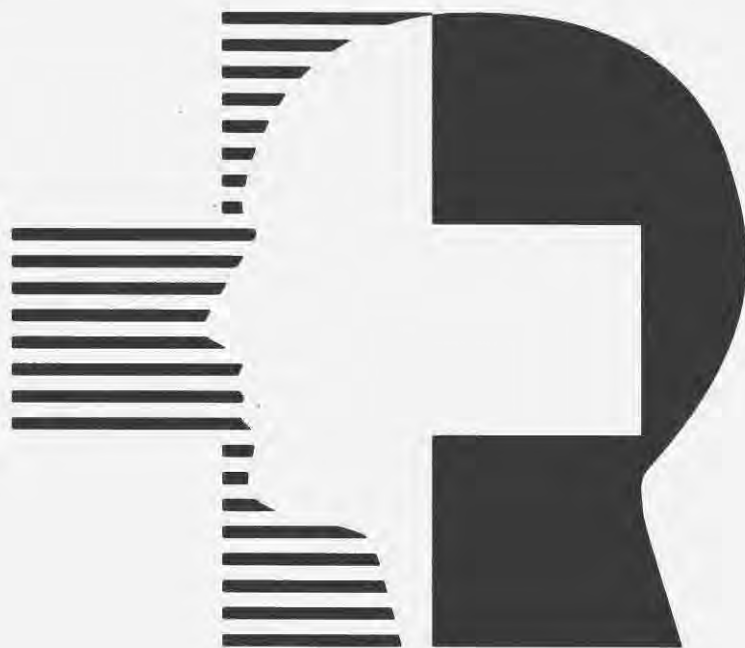
Mr. Edell replied that in a tort case a manufacturer is not found guilty of violating the law, but rather of violating a duty of care owed to the plaintiff.

And, he said, "Congress was well aware of these tort actions." Had Congress intended to pre-empt tort lawsuits, it could have done so expressly, said Mr. Edell.

"The burden is not on us to show Congress intended that these actions continue," said Mr. Edell. "Rather, the burden is on the defendants to show with crystal clarity that Congress intended to do away with these actions."

But defense attorney Mr. Farr argued that "it was the judgment of Congress that it... should set the

Continued on next page



CMG Health A national leader in quality and cost control for mental health and chemical dependency

CMG Health's collaborative approach to care involves patients, families, attending physicians, employee assistance programs, and customers. We provide flexible, customized services that reflect our customers' needs:

- Utilization Management Programs
- Preferred Provider Arrangements
- Full or Partial Risk Programs
- Employee Assistance Programs

Our customers include insurers, employers, HMOs, PPOs, TPAs, and other providers of healthcare services.

For further information, please call Wayne Feest, Vice President, Sales and Marketing, at 1-800-776-2466.



Continually Improving Behavioral Healthcare®

Corporate Offices
25 Crossroads Drive
Owings Mills, Maryland 21117

Legal Notice

DOCKET NO. CV-88-352383-S
CARRIER CORPORATION,
Plaintiff,
v.
THE HOME INSURANCE COMPANY,
et al.,
Defendants.

NOTICE TO ALL INTERESTED PARTIES RELATING TO INSURANCE COVERAGE FOR ENVIRONMENTAL LIABILITIES OF CARRIER CORPORATION

Carrier Corporation, a subsidiary of United Technologies Corporation, has filed a lawsuit in the Superior Court for the state of Connecticut against many of its comprehensive general liability insurers, for the period 1955 to the present, seeking insurance coverage for actual or potential liabilities of Carrier arising out of the environmental claims and hazardous waste sites listed below.

If you believe that you may have an interest in the subject matter or outcome of this lawsuit and you desire to participate in the action, you must seek to participate by December 1, 1991, or you may be foreclosed from so participating. If you would like to receive a copy of the most recent Complaint in this action, please contact Plaintiff's counsel, John M. Sylvester, Esq., of Kirkpatrick & Lockhart, 1500 Oliver Building, Pittsburgh, Pennsylvania, 15222-5379, (412) 355-6500. Other papers filed in this action are available for your review at the office of the Clerk of the Superior Court of Connecticut, at Hartford, 95 Washington Street, Hartford, Connecticut, 06103, (203) 566-3170.

ENVIRONMENTAL CLAIMS AND HAZARDOUS WASTE SITES

- | | |
|---|--|
| Carrier Corporation Facility | — City of Industry, California |
| Carrier Corporation Facility | — Collierville, Tennessee |
| Carrier Corporation Facility | — DeWitt, New York |
| Carrier Corporation Facility | — McMinnville, Tennessee |
| Carrier Transicold Facility | — Miami, Florida |
| Carrier Transicold Facility | — Montebello, California |
| Carrier Corporation Facility | — Tyler, Texas |
| Elliot Company Facility | — Springfield, Ohio |
| Bioecology Systems | — Grand Prairie, Texas |
| Butter Mine Tunnel | — Pittston, Pennsylvania |
| Capri Pumping Service | — East Los Angeles, California |
| Edgewater Terminals, Inc | — Edgewater, New Jersey |
| Enviro-Chem/Northside Landfill | — Zionsville, Indiana |
| Envirotech II Site | — Tonawanda, New York |
| Fisher-Calo Chemicals & Solvents Site | — Kingsbury, Indiana |
| Great Lakes Asphalt Site | — Zionsville, Indiana |
| Industrial Solvents & Chemical Company Site | — Newberry, Pennsylvania |
| New York City Landfills | — Brookfield, Staten Island |
| New York City Landfills | — Edgemere, Queens |
| New York City Landfills | — Fountain Avenue, Brooklyn |
| New York City Landfills | — Pelham Bay, Bronx |
| New York City Landfills | — Pennsylvania Avenue, Brooklyn |
| New York City Landfills | — Review Avenue, Long Island City |
| Old Forge Landfill | — Old Forge, Pennsylvania |
| Pollution Abatement Services | — Oswego, New York |
| Pollution Abatement Services | — (Clothier Site) Granby, New York |
| Pollution Abatement Services | — (Fulton Terminals Site) Fulton, New York |
| Pollution Abatement Services | — (Holbrook-Mexico Site) Mexico, New York |
| Pollution Abatement Services | — (Holbrook-Parish Site) Parish, New York |
| Pollution Abatement Services | — (Irwin Site) Oswego, New York |
| Pollution Abatement Services | — (Lybault Site) Richland, New York |
| Pollution Abatement Services | — (Rice Road Site) Parish, New York |
| Pollution Abatement Services | — (Volney Landfill) Volney, New York |
| Pottstown Abandoned Trailer Facility | — Pottstown, Pennsylvania |
| Quanta Resources/Lodi Street Plant Site | — Syracuse, New York |
| Saad Waste Oil Site | — Nashville, Tennessee |
| San Gabriel Valley Sites | — San Gabriel, California |
| Solvent Savers | — (Pompey Site) Pompey, New York |
| Solvent Savers | — (Lincklaen Site) Lincklaen, New York |
| Solvent Savers | — (Novak Farm Site) Novak Farm, New York |
| Spectron, Inc. Site | — Elkton, Maryland |
| Stringfellow Acid Pits | — Glen Avon, California |
| Tri-Cities Barrel Site | — Port Crane, New York |
| York Oil Site | — Moira, Pennsylvania |

Continued from previous page standard of conduct," said Mr. Farr. "States were pre-empted from setting their own standards of conduct. Likewise, it follows that Congress intended to pre-empt states from enforcing their own standards of conduct through damage suits."

Justice O'Connor asked Mr. Farr if Congress, in requiring the health warning on cigarette packages and advertisements, "set a ceiling on the amount of information consumers could receive?"

"Or, did Congress set the lower limit of the warning so that additional warnings are allowed?" she

'Congress did not want the states to impose different warnings,' Mr. Farr says.

asked.

Mr. Farr replied: "Congress set both the minimum and maximum. It is both the floor and the ceiling."

Justice O'Connor did not give up. "Does this mean manufacturers are prohibited from adding additional warnings?" she asked, adding: "Can a state through its tort law establish a duty to provide additional warnings?"

Mr. Farr replied: "Congress said quite explicitly we do not want the states to impose regulations or prohibitions in this area; Congress did not want the states to impose different warnings."

Then Justice Scalia posed a hypothetical case in which a manufacturer printed the congressionally mandated health warning along with information suggesting "the surgeon general's report is not worth the

paper it is written on."

Justice Scalia asked if this type of fraud and misrepresentation also is pre-empted by the federal statute.

Mr. Farr replied simply that the Federal Trade Commission would regulate this type of activity.

The Supreme Court has a number of options as to how to rule in the Cipollone case.

The justices could rule that plaintiffs can bring tort suits challenging the cigarette maker's advertising claims and the adequacy of their health warnings. That would be the best possible outcome for smokers, who would then be free to sue cigarette manufacturers for fraud, failure to warn and misrepresentation.

Or, the court could rule that plaintiffs cannot challenge the health warnings or the advertising, which would bar most suits against cigarette manufacturers that allege fraud, failure to warn or misrepresentation. This is the best possible outcome for the tobacco industry.

Defense attorney Victor Schwartz was optimistic that the court would take the latter approach.

"The suggestion that the tort law is not a 'requirement' is frivolous and I think the judges recognized this," said Mr. Schwartz of Crowell & Moring in Washington, D.C.

Others, however, predict the court will find a middle road.

"A middle ground, which is most likely, would be for the court to rule that if plaintiff can show the tobacco companies tried to undermine the (required) health warnings through advertising, they can recover," said John Banzhaf, executive director of Action on Smoking & Health, an anti-smoking group in Washington, D.C.

Thomas Cipollone vs. Liggett Group Inc., Philip Morris Inc. and Loews Theatres Inc., United States Supreme Court; No 90-1038.

Insider trading

Humana Inc.: James D. Bohanon, divisional officer, exercised an option for 31,250 shares of common stock and sold 30,000 common shares at between \$11.42 and \$32.83 per share from July 1 to July 30 and now directly holds 2,768 common shares.

Patricia P. Davis, divisional officer, sold 17,025 shares of common stock at \$32 per share on July 1 and now directly holds 2,768 common shares.

Thomas J. Flynn, vp, sold 15,000 shares of common stock at \$32 per share on July 18 and now directly and indirectly holds 60,197 common shares.

Philip B. Garmon, divisional officer, exercised an option for 26,250 and sold 20,635 shares of common stock at between \$13.63 and \$31.42 per share from July 1 to July 12 and now directly and in-

directly holds 13,448 shares.

Humana stock was trading at \$29.38 per share on Oct. 4.

Transamerica Corp.: Burton E. Broome, vp, exercised an option for 3,620 shares of common stock at \$22.57 per share on Aug. 15, and now directly and indirectly holds 9,378 common shares.

Kent L. Colwell, vp, indirectly exercised an option for 4,572 shares of common stock at \$22.57 per share on Aug. 13, and now directly and indirectly holds 20,694 common shares.

Richard A. Finn, officer, indirectly exercised an option for 3,000 shares of common stock at \$22.57 per share on Aug. 8, and now directly and indirectly holds 34,310 common shares.

Transamerica stock was trading at \$36.88 per share on Oct. 4.

UNUM Corp.: Stephen B. Center, officer of subsidiary, exercised an option for 9,250 shares and sold

2,500 shares of common stock at between \$30.31 and \$64 per share from Aug. 8 to Aug. 9, and now directly and indirectly holds 16,356 common shares.

Richard B. Dalbeck, retired, exercised an option for 2,000 and sold 2,000 shares of common stock at between \$24 and \$65.11 per share on Aug. 1, and now directly and indirectly holds 9,380 shares.

James F. Orr, chairman, exercised an option for 13,250 and sold 11,000 shares of common stock at between \$26 and \$64.75 per share on Aug. 14, and now directly and indirectly holds 47,263 common shares.

UNUM stock was trading at \$59.13 per share on Oct. 4.

Insider Trading, compiled by Invest/Net Trading Group Inc. of Fort Lauderdale, Fla., from reports filed with the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry directors and officers.



AMEV HOLDINGS, INC.

the U.S. holding company
of the \$40 billion combined operations of
N.V. AMEV in the Netherlands and Groupe AG in Belgium

Welcomes

MBL GROUP

to our premier group of
speciality insurance and financial services companies

Time Insurance

Western Life Insurance

American Security Group

Superior Insurance

United Family Life Insurance

AMEV Financial Group

AMEV Venture Management

Allen R. Freedman

Allen R. Freedman
Chairman, Chief Executive
Officer

M. Gordon Gaddy

M. Gordon Gaddy
President, Chief Operating
Officer

For more information contact Corporate Communications at (212) 323-9806

N.V. AMEV's ADRs trade over-the-counter on the NASDAQ system

DAVID will save the day (and save you money).

Those endless stacks of claims administration paperwork have terrorized you long enough. DAVID brings you CompPlus and P&CPlus, the inexpensive, effective weapons for Risk Managers.

CompPlus and P&CPlus are truly formidable. These complete systems for workers' compensation and liability claims and risk management will bring the paperwork Giant to his knees. And all without Giant costs.

CompPlus and P&CPlus are versatile programs, allowing adaptability in a multitude of industries. That's why DAVID is the fastest growing and most competitive company in the marketplace. DAVID has helped slay Giants nationwide.

Call today and let DAVID help reduce your losses and cut your costs.



1(800)55-DAVID

DAVID Corporation
One Sansome St., Suite 950
San Francisco, CA 94104
1(800) 55-DAVID
FAX (415) 362-5010

© 1991 DAVID Corporation
DAVID Corporation is a subsidiary of
Wyatt Software

Mail this coupon and cut your
claims processing down to size

YES! I'm interested in more information and a free demo diskette.

NAME _____

TITLE _____ PHONE _____

COMPANY _____

STREET _____

CITY _____ STATE _____ ZIP _____

See Us at SIIA
booth #504

U.S. market

Continued from page 1

The effect of depressed profits in the property/casualty insurance business was not only audible but also visible at this year's joint annual meeting of the National Assn. of Casualty & Surety Agents and the National Assn. of Casualty & Surety Executives. The meeting, which always begins on the first Saturday in October, allows the top executives of the largest U.S. property/casualty insurers to meet with their best producers.

Tennis courts, where the captains of the insurance industry and their wives compete for crystal trophies, were only half as full as in past years. And there was plenty of room at cocktail parties that previously had been jammed wall-to-wall.

And, all attendees had rooms at

The Greenbrier, unlike prior years when some had to stay in nearby hotels.

The official attendance was 1,134, down only 60 from 1990's attendance, but most agreed the meeting looked emptier this year.

In his speech on current insurance rates last Tuesday, Mr. Coleridge warned U.S. insurance industry executives: "We cannot allow this state of affairs to continue. We simply cannot allow insurance to be traded like a low-value natural commodity, such as guano, and expect to retain any credibility or anyone's respect, especially our customers'."

He suggested that when confronted by extreme fluctuations in the price of insurance, commercial insurance clients "will eventually abandon us and arrange the transfer of their risks by other methods, bypassing us or

leaving us only the catastrophe levels to fight over, like dogs over a bone."

"I am not advocating rate-fixing, cartels or agreements" Mr. Coleridge emphasized. "I am looking for common, commercial sense to prevail to enable a healthy, competitive market in international insurance to survive, grow and prosper."

Outside of the United States, he said the insurance business appears to be coming out of the current cycle of underpricing. But "this itself could be a major danger," he added.

"As our client base emerges from global recession, the demand for insurance will increase rapidly. If the insurance industry cannot meet this demand, our clients will start looking at alternative methods of risk transfer."

"To guard against this eventuality and to maintain a balanced book

of business, the insurance industry as a whole needs to increase its skills in both underwriting and investment management," Mr. Coleridge said. "This will ensure financial strength through adequate reserves, thus enabling us to offer continuity of cover at reasonable premium rates over time, avoiding cyclical overreaction in rating as capacity moves from feast to famine and back during the inevitable insurance cycles."

Quoting from his preface to Lloyd's 1988 global results released earlier this year, Mr. Coleridge said: "What the world's insurance industry must address is the fact that premiums have become outrageously uneconomic. Profitability is the key to solvency, without which there is no insurance."

Mr. Coleridge asserted: "Our clients, the oil and energy companies,

the global conglomerates, can do nothing without insurance. They are prepared to pay a realistic price to sleep easily at night and enjoy continuity of insurance cover, year on year.

"And what do we do? We expend the intellect and effort of hundreds of thousands of people worldwide—underwriters, brokers, investment managers—yet we allow the ultimate price of our product to be determined, not by demand or a realistic bargain, but by available capacity and thus, often, by willingness to supply the product at any price," he said.

The state of the U.S. property/casualty business was on everyone's minds—and lips—during the annual NACSA/NACSE meeting.

The industry executives met for
Continued on next page

The professional marketplace

RATES AND CLOSING TIME:

Rates: Display classified is \$123.75 per column inch, minimum of one inch. Straight classified is \$11.00 per line, minimum of 5 lines. Count 34 characters per line (include each space and punctuation as a character). Additional \$17.50 charge for all blind box ads. Only those responses which fit into a business size envelope will be forwarded. Responses are forwarded daily.

Closing: Published every Monday. Copy must be in typewritten form by noon Tuesday, 6 days preceding publishing date. No verbal phone copy accepted. Prepayment required for all advertisements. Mail ads to Margaret Hikido, Classified Advertising, 740 N. Rush St. Chicago, IL 60611. For more information call 312-649-5340. FAX 312-280-3189.

MARKETING REPRESENTATIVES
Excellent career opportunity with a rapidly growing Company in Central New York. A third party payor of group health, dental and worker's compensation claims is seeking experienced marketing representatives. Ideal candidates will possess a Bachelor's degree and at least 3 years sales experience. Experience in group health benefits is desirable. Package includes an attractive salary plus incentive, medical, dental, life and LTD insurance and a 401(k) plan. **Please reply in confidence to Box 2703, Business Insurance, 740 N. Rush St. Chicago, IL 60611-2590**

FREE LANCE WRITER
To report on workers' compensation cost control, managed health care, and other disability matters. National journal. Published monthly to large readership. Excellent reporting and writing skills as well dependability are essential. Call Micheal at 617-737-2084.

BI Classifieds assure top quality results!

VICE PRESIDENT RISK MANAGEMENT SERVICES
Maclean, Oddy & Associates, a leading independent international insurance broker seeks individual for position of Vice President, Risk Management Services. Primary position responsibilities include planning, developing and administering a risk management function designed to provide a full array of services including brokering, claims management, risk control and information management. The ideal candidate will have a college degree, 8-12 years experience as a risk manager or risk management consultant, CPCU and ARM designations, be highly professional and possess excellent communication skills. Excellent company benefits and salary commensurate to experience. For confidential consideration, qualified candidates should forward resume and salary to:
**Chief Administrative Officer
Maclean, Oddy & Associates
1445 Ross Avenue, Suite 3900, LB200
Dallas, Texas 75202**

BUSINESS INTERRUPTION/CPA
Nation's leading Public Adjusting firm has immediate opening for a CPA in its Business Interruption Claims Department. Minimum 3-4 years experience required. Must be willing to travel. Send resume including **SALARY REQUIREMENTS** to:
**Don Dragony CPA, MBA
Corporate Controller
Alex N. Sill Company
6000 Lombardo Center
Suite 600
Cleveland, Ohio 44131**

Advertise in The Professional Marketplace and reach Top Professionals!
Call 312/649-5340 for details.

HELP WANTED PRODUCER WANTED
Lamb, Little & Co., a 43 year old Chicago area Insurance Agency, now based in Rolling Meadows, is looking for a Producer to fill a vacancy in their downtown branch office.
Producer should have an established book of business and would retain exclusive ownership of all expirations. Most overhead expenses paid for. Generous commission split, plus profit sharing. Send inquiries to:
**LAMB, LITTLE & CO.
5301 Keystone Ct.
Rolling Meadows, IL 60008
ATTN: Robert Power**

INSURANCE POLICY DEVELOPMENT
A Delaware County Life Insurance Company is seeking an individual for its Policy Development Department. The successful candidate should have a college degree plus a minimum of 5 years experience in the insurance industry of which 3 years should be related to insurance contracts and compliance. The successful candidate will be responsible for the drafting of policies along with compliance and filling with state regulatory agencies.
We offer a competitive salary and benefits package plus a 401(K) savings plan. Please send resume and salary requirements in confidence to **Insurance Company, Executive Offices, 401 Parkway Boulevard, Broomall, PA 19008.**

HELP WANTED RISK MANAGEMENT ANALYST
Memphis based national corporation experiencing rapid growth has an immediate opening in its corporate insurance staff for a highly qualified and motivated risk management professional. This position offers qualified candidates the opportunity to exercise creativity and imagination as a member of an innovative risk management team which has become widely recognized as an industry leader.
Reporting directly to the Vice President-Risk Management, this highly visible position has responsibility for risk identification, risk reserving, risk analysis, risk financing with emphasis on coverage analysis and administration of retro plans. Additionally, the risk management professional selected will have regular interaction with underwriters, claims professionals and other service providers.
Qualified candidates will have a minimum of a Bachelor's degree in business, Finance or Insurance and 2-5 yrs. experience in underwriting/claims analysis.
This excellent opportunity offers a very attractive salary commensurate with experience, bonus opportunity and corporate benefit package. For prompt, confidential consideration, fully qualified candidates should send their resume and complete salary history to:
**Human Resources
P.O. Box 45
Memphis, TN 38101-0045**

FRESNO UNIFIED SCHOOL DISTRICT DIRECTOR, BENEFITS AND RISK MANAGEMENT
MINIMUM QUALIFICATIONS:
1. Graduation from college with a major in Business Administration, Public Administration or closely related field.
2. Five years of experience in management, investigation and adjustment of California Worker's Compensation claims, general and vehicular bodily injury and property damage claims, general liability claims, group medical plans and thorough familiarity with appropriate California statutes and common law precedents. (The training and experience indicated describes an desirable combination. Additional supervisory or management experience may be substituted for part of the education.)
**SALARY: \$50,270 - \$62,840
DEADLINE: NOVEMBER 4, 1991
CONTACT: JAN KALPAKOFF AT: (209) 441-3486**

RISK MANAGER
Large building materials and transportation company located in the Dulles Airport area of Northern Virginia needs a Corporate Risk Manager. Candidates should have a college degree in finance or business. Must also have experience in claims, dealing with third-party claims administrators, preparation of insurance bid specifications, negotiation with underwriters, property and casualty insurance, bonding, group insurance and pension plans. Good communication skills are critical. Candidate should have attained the Associate in Risk Management professional designation. Submit resume and salary history to:
**B. E. Pittman
V.P. Human Resources
Tarmac America, Inc.
P.O. Box 2016
Norfolk, VA 23502
EQUAL OPPORTUNITY EMPLOYER**

HELP WANTED ATTORNEY
Medium-size law firm seeks attorney with at least five years intensive experience in monitoring Director/Officer claims for underwriters, including negotiation of settlements and structuring of same. Must have strong academic background and be willing to locate in Boston area. Please submit resume, including identity of clients to **Business Insurance, Box 2701, 740 N. Rush Street, Chicago, IL 60611-2590.**

FOR SALE FLORIDA MANAGING GENERAL AGENT FOR SALE: Profitable, good company representation. Principal to remain. Terms available to right buyer. Principals only need reply to: **A JAMES, 1425 NW 97 TERR, PEMBROKE PINES, FL 33024**

MARKETING RESOURCES MOTOR CARRIER X-DATES
With Policy #, Ins. Co, and More Custom Format is Available Most State's are Available
Call us at (714) 546-7465

Business Insurance Circulation Breakdown*

Commercial Consumers

Administrative:
CEO's Presidents, and Owners .2,500
Vice-Presidents, General Managers and Other Administrative Personnel .4,263

Financial:
Chief Financial Officers and Vice-presidents of Finance .2,972
Secretaries, Treasurers, controllers and other Financial Personnel .4,406

Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations .10,976

Sub-total .25,117

Associations .458
Government, Unions and Educational Institutions .1,234

Commercial Consumers

Sub-total .26,809

Insurance Agents and Brokers .9,430
Insurance Companies .8,045
Accountants, Actuaries, Attorneys & Consultants .3,405
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers .1,392
Others Allied to the Field .1,518

TOTAL .50,599

* Source Business/Occupational breakdown of qualified circulation, May 27, 1991 issue, as submitted to BPA for June 1991 BPA Publisher's Statement.

Discover Samaritan Style

Claims Manager

Samaritan Health Services, a nonprofit multihealthcare system, serves 24 hospitals throughout Arizona and California. We are currently seeking a claims management professional to join our Risk Management team.

The responsibilities of this position will entail leading a team of experienced claims staff in our professional, general and workers' compensation liability self-insurance program. Qualified candidates must possess a related degree and 10 years management/supervisory experience in multiple insurance lines of which 5 years must be in hospital liability. Litigation management experience also required. A working knowledge of data base management systems is necessary.

In return for your expertise, we will provide an excellent salary and benefits package to include healthcare insurance, 401(k) retirement plan, relocation assistance and much more. For more details, please call 1-800-395-4343 or send a resume to: **Samaritan Health Services, Human Resources/Recruitment, 1441 N. 12th Street, Phoenix, AZ 85006.**

Equal Opportunity Employer
We support a drug-free work environment.

Samaritan Health Services

U.S. market

Continued from previous page
formal presentations and roundtable discussions in the mornings and continued informal talks in the afternoons, while enjoying the mountain scenery and sporting activities offered at The Greenbrier. Evenings were filled with cocktail receptions and private dinners.

Despite Mr. Coleridge's dire warnings, the consensus on the U.S. market from the gathering: no foreseeable change.

The only exceptions seen are in marine and aviation insurance and catastrophe reinsurance.

Marine and aviation insurance rates, though, are going up from very depressed pricing, observed Robert C. Nevins, managing director-global marketing for Alexander & Alexander Services Inc. in San Francisco.

"Otherwise, we won't see any changes in 1992," he said.

"I don't think we're anywhere close to a genuine turn in the market—except marine, aviation and some directors and officers liability insurance," commented J. Bransford Wallace, chairman of brokerage services at Willis Corroon Corp. in New York, during a Wednesday morning roundtable discussion.

"We may see some moderation, but we had better prepare ourselves for a protracted soft market," he said.

Edwin L. Overmyer, president of Berwanger Overmyer Associates in Columbus, Ohio, and another roundtable participant, agreed that "the soft market is the playing field we are dealing with."

"I don't see it changing for the middle market," he added.

"There won't be a return to a hard market," according to Michael G. Repoli, president of Maryland Casualty Co. in Baltimore, who also participated on the panel. "Changes in the market will be more gentle."

In addition, insurance regulators are determined to force insurers to reduce their expenses before they will approve rate increases for regulated lines of insurance, Mr. Repoli said.

As a result, there is little prospect for insurers to obtain higher rates, with plenty of capacity to write commercial insurance—which some insurers have increased by withdrawing from personal lines insurance—and not enough demand in a stagnant economy, he said.

"We have educated our customers to buy on one thing: price," Mr. Repoli complained.

Insurers, he suggested, must "distinguish ourselves so that price is not the determining factor" when a policyholder selects an insurer.

During another panel discussion on Tuesday, retired insurance executive Bernard J. Daenzer was one of the few to suggest that an upturn in rates is near. He predicted the insurance industry will have "banner years" in 1992 through 1994, but that profits will slide in 1995 through 1997.

Now a consultant based in Key Largo, Fla., Mr. Daenzer predicted that "one frightened chief executive officer will be the leader" in increasing rates, and added with a chuckle that "April 17, 1992, is the exact date for the change in the cycle."

But others on the same panel were not so optimistic.

Bernard H. Mizel, chief executive officer of broker American Business Insurance Inc. in San Francisco, commented that "in the middle market segment of the business, we do not contemplate any hardening."

And A&A's Mr. Nevins warned that if rates go too high, too quickly for major accounts, the insurance industry will "chase that business away" to alternative risk financing mechanisms.

After the panel, Timothy Thoelecke, president of Great Lakes Agency in Chicago, quipped that the only line of insurance that never sees rate cutting is insurance agents errors and omissions coverage.

The agents and brokers attending the annual NACSA/NACSE meeting

admitted that current market conditions are hurting their businesses.

One agent commented privately that he had just renewed a package policy for \$78,000 off the expiring \$160,000 premium. The lost commission income can be estimated at \$8,200 on one account, he said.

As Peter T. Pruitt, president of New York-based Frank B. Hall & Co. Inc., observed, brokers are being squeezed by smaller commissions on cheaper renewals, falling interest rates depressing investment income and the recession constricting their clients' need for insurance.

"Profitability is a problem in these conditions," Willis Corroon's Mr. Wallace said during the Wednesday morning roundtable.

"The easiest money any of us make is interest income, but interest rates are heading south," Mr. Wallace said.

Quantifying how much renewal premiums are falling, he reported that at Willis Corroon in the first six months of 1991, renewal premiums were off 9% to 10%. That reduction followed premium reductions of 11% in the first six months of 1990 and 13% in the first half of 1989.

"That starts you in a significant hole," Mr. Wallace observed.

One agent in the audience complained that insurers hold prices relatively firm on renewal quotes, but cut prices more to obtain new clients.

Maryland Casualty's Mr. Repoli responded that "not every account will be the same for the new carrier or agent" in terms of the premium re-

quired.

"We all have success stories," he said, referring to how a new insurer or agent can assist a client in reducing its losses.

Agents and brokers, for example, can help clients control their workers compensation costs said Robert R. Parks, president of Alton Insurance Agency Inc. in Arlington, Va.

'Brokers are not making the money they were. They need capital investment,' Mr. Mizel says.

His agency employs an engineer whose advice to clients on loss control has helped them improve their experience modification factors and, thus, reduce the cost of their workers comp insurance.

Mr. Overmyer of Berwanger Overmyer Associates suggested that property/casualty insurance brokers must "diversify to transcend" declining revenues. His firm, he noted, now earns 40% of its revenues from other products and services, including group life and health insurance, claims administration and other financial services.

Agents and brokers certainly can't afford to deliver the same level of service to all their property/casualty

insurance clients regardless of size, several experts agreed on the Tuesday morning panel.

"Forget the term 'agents and brokers' for personal lines and small business," advised Mr. Daenzer, the independent consultant.

Instead, he suggested these accounts be handled by customer service representatives who have "heart and soul," but not necessarily advanced training in insurance. And, they will have to "double the volume of business" handled to make it economical to service these accounts, he added.

Accounts require different treatment depending on which of three categories they fall into—personal lines and small commercial accounts, jumbo risks and the middle market—said A&A's Mr. Nevins.

William C. Cohen Jr., chief executive officer of Insurance Management Associates Inc. in Wichita, Kan., suggested that accounts be defined by whether they require special service, not by volume. Those that do not require special service—and don't want to pay for it—are really commodity business, he said.

The dynamics of the distribution system are changing dramatically," observed ABI's Mr. Mizel.

"The long soft market has weakened our industry," he said. "Brokers are not making the money they were. They need capital investment."

"We have to change and we have to listen to our customers," he advised. "We have to determine what

they want and then we can determine how we can improve our profitability."

Small accounts present "tremendous opportunities" for the agent or broker to handle all the insurance needs of the account, not just one segment, he suggested.

A&A's Mr. Nevins noted that clients are asking brokers to provide specific services on an unbundled basis because "they have been dissatisfied with bundled services."

This client demand "will drive more consolidations, because it is very expensive to offer a multiplicity of services," Mr. Mizel said.

The insurance industry leaders at The Greenbrier last week also expressed concern about other issues confronting the industry, including the adequacy of regulation.

"It's scary that our business is so politicized," observed Frank J. Coyne, president of General Accident Insurance Co. of America in Philadelphia. "There is so little understanding of the role we play."

Mr. Daenzer complained that the "consumer advocacy groups are kidnapping the commissioners."

He advised agents and brokers to spend more time talking to insurance commissioners and explaining the industry's problems, especially the need to better regulate insurers for solvency rather than control rates.

Mr. Mizel suggested that the "situation in California is really dreadful." *Continued on next page*

Insurance services guide

Advertise in
The Insurance Services Guide
FAX your advertisement for the next issue
FAX: 312/280-3189
PHONE: 312/649-5340
Contact Margaret Hikido
to reserve space.

FRONTING
We're specialists in fronting arrangements and mergers/acquisitions. In the industry since 1960.
Corporate Intermediaries
W.F. "Bill" Vest
Box 816124, Dallas, TX 75381
PHONE/FAX 214-620-2581

Reach For The Stars

Investigate this new generation of quality software solutions for health benefits management, workers' compensation claims, general liability, medical cost containment, and first injury reporting, including:

ISP HealthStar • ISP CompStar • ISP MultiStar
ISP MediStar • ISP FirstStar

For more information about the many ways you can benefit from Insurance Software Packages, Inc. write to us at
3625 Queen Palm Drive
Tampa, FL 33619
or call (800) 237-8133 in the U.S.,
(813) 621-6069 in Florida.



Cognac-Plus The Total Life & Health Administration & Claims Processing Software for Insurance Carriers, Associations, Self-Insured Groups, TPA's, even Start-up Organizations from a single desk-top P.C. or Local Area Network.

If you are seriously looking for a way to manage your programs and cut the cost of administration and claims processing, we're waiting for your call. Ask how Cognac Plus can put you in control.

APEX DATA SYSTEMS
6464 E. Grant Rd., Tucson, AZ 85715 (602) 298-1991

Visit us at our SIA booth #217

AUTOMATED HEALTH CARE CLAIMS MANAGEMENT SYSTEMS

- Claims Processing
- PPO Management
- Section 125/Cafeteria Plan
- Utilization Review
- Cobra Administration
- Billing & Administration

For Self Insureds, TPA's, Associations, Insurance Companies

COMING SOON...
Managed Care Review System
Including Bundling, Un-Bundling and Out-Patient Review



ELDORADO
COMPUTING
INC.

2880 East Northern Ave. Suite 4
Phoenix, Arizona 85028
(602) 493-0288



WLT

Software of Florida, Inc.

NEED TO REPLACE YOUR EXISTING CLAIMS SOFTWARE???

MEDICLAIMS - \$35,000*
Health Claims Administration System

COMPCLAIMS - \$15,000*
Workers' Compensation Administration System

- * Average Installed Price Through 1991
- * No Charge for Added Workstations
- * No Add-On Modules Needed
- * No Charge for Retraining and Enhancements
- * No Hidden Costs

PC AND NETWORK BASED SYSTEMS
12 YEARS COMMITMENT TO QUALITY SOFTWARE

CALL 813-797-7814
and find out why so many companies are turning to WLT!

WLT Software of Florida, Inc.
ANYTHING ELSE IS A COMPROMISE.
24671 U.S. 19 N., SUITE 460, CLEARWATER, FLORIDA 34623

Visit us at our SIA booth #616

U.S. market

Continued from previous page

There are a couple of companies that should be shut down. They are writing business way under the market and nothing is being done."

Insurance Management Associates' Mr. Cohen complained that the industry has failed to present its facts on the underlying cost of claims in a form easily understood and believed by regulators and politicians. He suggested the industry has failed when, for example, it allows workers comp coverage to become so underpriced that insurers seek a 51.8% rate hike in Pennsylvania. Requests for such large hikes create confusion, he said.

Industry leaders also expressed concern about tort reforms. General Accident's Mr. Coyne called on the industry to support tort reform efforts. Mr. Parks of Alton Insurance Agency agreed, saying "now that the vice president has come out in favor of tort reform, this is a good time to press forward."

Vice President Dan Quayle in August called for changes in the tort system in an address to the American Bar Assn. (BI, Aug. 19).

Mr. Parks cautioned that the push for tort reform "has to come from other than the insurance industry, because the perception is, if it comes from the insurance industry, it's bad."

Joseph L. Marcum, president of Ohio Casualty Insurance Co. in Hamilton, Ohio, agreed that tort reforms are needed. He noted that legal costs eat up 19 cents out of every dollar in automobile claims costs in California. ■

Coleridge to buyers: No worries

Chairman defends Lloyd's health against media reports

By KATHRYN J. MCINTYRE

WHITE SULPHUR SPRINGS, W.Va.—Commercial insurance and reinsurance buyers need not worry about the continuity of their programs

at Lloyd's of London, despite critical articles in the mass media, its chairman asserts.

"Lloyd's will have sufficient capacity, probably about \$18 billion, in 1992 and beyond to provide continuity of cover to large risks and insurers," David Coleridge said last week in a speech intended to "set the record straight" on Lloyd's.

He also called on U.S. insurers to increase their property/casualty rates and warned them that they face stiff competition from other insurance markets (see related stories, page 3 and this page).

"Lloyd's is a byword for innovation and security in insurance and it will remain so," Mr. Coleridge declared. "You may all have confidence in Lloyd's as a reinsurer at a time when the reinsurance market is hardening—and very markedly—and the search is on for quality of assets and high solvency ratios."

Mr. Coleridge made his remarks at the annual joint meeting of the National Assn. of Casualty & Surety Agents and the National

Assn. of Casualty & Surety Executives, which is the largest gathering of top executives in the U.S. commercial property/casualty insurance marketplace.

In a speech highly critical of general media reporting on Lloyd's record \$983.7 million loss for the 1988 underwriting year, Mr. Coleridge commented that "I can only react with amazement to much of the inaccurate rubbish which has recently been printed and said, literally around the world, about the Lloyd's market."

Allowing that Lloyd's has "a high public profile and therefore attracts more comment than a conventional insurance company," Mr. Coleridge complained that "this year's crop of comment surrounding the announcement of our results was hyperbole by any yardstick."

Mr. Coleridge emphasized that while as a whole the Lloyd's market reported a loss for 1988, two-thirds of the syndicates made profits and one-third, or 10,000, of its 32,000 members actually made money. Furthermore, only 318

names suffered losses in 1988 greater than 100,000 pounds (\$193,000 at the appropriate exchange rate), he said.

A large reason that the market suffered an aggregate loss was an increase of \$2 billion compared with 1987 in loss reserves, or what Lloyd's calls "reinsurance to close" an accounting year, Mr. Coleridge said.

That "quite proper" increase in loss reserves included reserves for "American long-tail liabilities arising from policies covering companies exposed to pollution and asbestosis claims," he said.

"A large influx of possible pollution claims" was reported to Lloyd's at the end of last year, he said. As a result, syndicates had to establish loss reserves for these "potential claims," he said, emphasizing the word potential.

Mr. Coleridge called on insurers to continue to fight demands for coverage to clean up past pollution, calling it a "deep-pocket" solution to the problem of decades-old industrial pollution.

The most recent increase in loss reserves at Lloyd's brought its aggregate assets to \$32 billion, Mr. Coleridge pointed out. With \$19 billion reserved to cover losses, "our declared resources are 156% of liability provisions."

And those assets are invested in "high-quality securities of various types with the majority of our U.S. dollar funds in U.S. government securities. Unlike our competitors, we have no junk bonds or volatile property holdings in our in-

vestment portfolio."

Furthermore, Lloyd's assets of \$32 billion do not include the "undeclared assets of our members, all of whom have unlimited liability to pay claims. Neither do we add to reserves from existing capital. It is all new money called from names."

"This, I venture to suggest, belies the rantings of the media that we are either fundamentally bust or about to be so," he said.

Indeed, he continued, as Lloyd's "enters 1992, we will be a leaner, fitter and supremely secure and solvent insurer, eagerly looking for opportunities in the years ahead."

Mr. Coleridge acknowledged that in addition to news of a record loss at the close of the 1988 underwriting year, some syndicates have called on their members for cash to cover catastrophe losses that occurred in 1989 and 1990. Generally, under Lloyd's three-year accounting system, names would not expect cash calls until the end of those underwriting years.

"Claims have already exceeded premiums received or reinsurance recoveries within the Lloyd's market," he said, especially excess-of-loss or catastrophe business.

Those two years saw the "longest and mostly costly run of natural and man-made disasters in the record books," he remarked.

And, the catastrophes occurred "at the low point in the insurance cycle when premium rates were depressed, there was too much capacity worldwide and everyone was chasing cash flow."

Continued on next page



Mr. Coleridge

NACSA/NACSE CONFERENCE The Greenbrier

U.S. an island, Coleridge says

WHITE SULPHUR SPRINGS, W.Va.—The U.S. insurance industry is ignoring globalization and deregulation of the industry worldwide at its peril, warns the chairman of Lloyd's of London.

Deregulation and globalization are "of major importance for us in Britain, Europe and the Pacific Rim, but they still seem not to excite the American industry," David Coleridge observed.

"If you do not want your insurance industry to follow your automobile and electronics industry down the road to domination by Europeans and Japanese, you need to look carefully at your present position," he told U.S. insurer executives meeting here at The Greenbrier resort last week.

"In continental Europe, there are some of the world's largest, most secure and best reserved insurance companies hungry for acquisition and expansion. A similar industry exists in Japan," he said. These insurers are financially strong, he said, "because of their governments' attitudes toward insurance and the fiscal and taxation treatment of their insurers' reserves."

"These differ markedly from the attitudes toward insurance shown by my government and yours," he said.

Not only competitors but also clients will change as trade barriers come down around the world, Mr. Coleridge predicted.

Clients will merge and become larger, "which will improve the central professionalism of what will be very large purchasers of insurance. They will operate on a truly global scale."

These global buyers will demand a global response from insurers, Mr. Coleridge predicted. "There must be greater willingness to offer cross-border covers where appropriate, such as those currently offered by Lloyd's and its brokers."

"To maintain and increase our share of core business, insurers will have to respond with more innovative thinking, and the industry as a whole will have to add value to the products and services it offers," he said.

To succeed in this new global economy, the industry must address personnel recruitment and training, Mr. Coleridge said. "Not only must we be able to attract the ablest and brightest people, we must develop them through a real commitment to training, which, certainly in London and especially at Lloyd's, we have," he said.

The insurance industry also must "get its products and pricing right, especially with new products, if it is to remain viable, and it must keep its solvency and reserves under constant review," Mr. Coleridge said.

This "will be especially important in a climate of freedom where there will be fewer restrictive trading agreements, tariffs and government controls over products and pricing," he said.

—By Kathryn J. McIntyre

To cut your downtime, our specialists handle both the appraisal and adjusting. And they have experience-based expertise in such areas as construction, mining, logging, precision machinery, farm and marine equipment.

To give your claims a fast start, report them to one of our four conveniently located regional offices, for referral to the nearest adjuster with the right expertise.

Ask for our Claims Directory and more information. Please contact:

Michael J. O'Malley
Assistant Vice President
Continental Loss Adjusting
One Continental Drive
Cranbury, NJ 08570-0001
Tel: (609) 395-2368
Fax: (609) 395-6303

WHY DEAL WITH JUST AN APPRAISER WHEN WE'LL GIVE YOU A HEAVY-EQUIPMENT ADJUSTER?

 **Continental Loss Adjusting** SM

There when it counts.

'In 1965, 1966 and 1967, Lloyd's last made losses in circumstances very similar to today's. "The End of the Line for Lloyd's" and "Unlimited Liability Must Go" were the two most popular headlines. Neither happened,' Mr. Coleridge says.

Continued from previous page

"We thus have the situation where at least \$675 million of 1989's and 1990's losses have already been called from members. Thus, some of the predicted losses for the Lloyd's market for the next two years of account have, in fact, been paid."

Mr. Coleridge noted that "unhappily for some names, they have been presented with bills for the aggregate losses on their syndicates for the three-year period 1988 to 1990. And they have, very publicly, made their unhappiness clear to the newspapers and television, at the same time suing all and everyone in an attempt to recoup their losses."

Dozens of U.S. members facing huge losses are trying to sue Lloyd's alleging violations of Securities and Exchange Commission rules in recruiting U.S. members (BI, Oct. 7; Sept. 2).

Mr. Coleridge called their litigation efforts "sad" and pledged that Lloyd's will fight litigation in the United States.

Members of Lloyd's "sign endless agreements saying that actions must be brought under British law," he pointed out.

Mr. Coleridge also criticized members who said "thanks" when they made profits but sued when they suffered losses.

Lloyd's is ready, he said, to coop-

erate with the SEC. "We've worked closely with the SEC over many years. If the SEC wishes to see anyone at Lloyd's, we are available. We will cooperate 100%. We have nothing to fear or hide."

With this explanation of recent developments at Lloyd's, Mr. Coleridge asked: "So why did the world's media use up acres of newsprint to pillory Lloyd's for incompetence and to predict our imminent demise?"

His answer: "When the news from Lloyd's is about profits, moderate trading losses, reserving methods and changes in market practice, then it is largely the province of the financial and business writers who have some understanding of our structure and operations and can put the news in a realistic context.

"However, when the story is of a Lloyd's name losing money to the extent of selling his castle in Scotland and moving to a cottage, which is, as we call it, a rich man

made poor story, it becomes the province of the feature writer, gossip columnist, general news reporter and what have you. Such people have little or no knowledge of insurance, let alone Lloyd's, and they tend to sensationalize all and everything. It was precisely this media coverage which has led to the present public debate about the future of Lloyd's.

Mr. Coleridge noted that Lloyd's has been through this media attention before: "In 1965, 1966 and 1967, Lloyd's last made losses in circumstances very similar to today's. 'The End of the Line for Lloyd's' and 'Unlimited Liability Must Go' were the two most popular headlines. Neither happened and, indeed, the market returned aggregate profits for the next two decades."

Mr. Coleridge conceded that Lloyd's will lose more names for the 1992 underwriting year and that Lloyd's capacity will "decrease perhaps by 10%."

Industry must come to grips with problems, agency exec advises

WHITE SULPHUR SPRINGS, W.Va.—The insurance industry should be "our own worst critic," an agency executive maintains.

"It is time we realized that we need to make improvements in our products and services," urged William T. Huntley III, senior vp of Pritchard & Jerden Inc. of Atlanta.

"We must face the sobering truth that the public is not happy with our responses to their problems or the explanations we give for our shortcomings."

Mr. Huntley made his remarks as the outgoing president of the National Assn. of Casualty & Surety Agents at its annual joint meeting with the National Assn. of Casualty & Surety Executives last week.

"The industry is under unprecedented attack," Mr. Huntley said, observing that "public confidence is at an all-time low. Insurance insolvencies are becoming more frequent and more costly by the day.

"Federal regulation of insurance is more likely than ever. And globalization of the economy is forcing major changes in the financial services industry, including insurance."

The insurance industry, Mr. Huntley pointed out, "has made mistakes. It is not fair to blame the consumer for losing confidence in us when from their perspective they can't get affordable insurance, or their life savings just happened to be in Executive Life."

As a result, "it is time we realized that we need to make improvements in our products and services. It is time to begin to make changes that will restore confidence in our industry and the products we sell and ensure our place in a rapidly changing marketplace."

While conceding, "I don't pretend to have the answers," Mr. Huntley said, "I think that our industry has the raw talent and heart and can make the commitment to effect changes that will benefit us as well as our clients and the national community."

Mr. Huntley stressed that he did not intend to "chastise the industry" with his remarks.

"I still believe strongly in what we do. We provide a public service to our economic system by providing insurance products that ensure that products and services necessary to sustain our high quality of life can continue to be developed and produced, without the fear of random disaster."

The Soviet Union's efforts to develop a free market economy include "talking with experts from the United States to help them establish an insurance system," Mr. Huntley noted. "It's rather unfortunate that we have not done a better job of explaining the importance of insurance to our own American public," he quipped.

Mr. Huntley warned his audience: "We can anticipate change and adapt to the future, or resist and become the dinosaurs of the insurance marketplace."

"As the leaders of the Soviet government learned, if you don't meet the needs of your public, they will find someone who will," he said.

William P. Wallace, deputy chief executive officer of Wallace, Welch & Willingham Inc. in St. Petersburg, Fla., was elected president of NACSA for the coming year.

—By Kathryn J. McIntyre



Mr. Huntley

Regulators must guarantee rate adequacy, insurer says

By KATHRYN J. MCINTYRE

WHITE SULPHUR SPRINGS, W.Va.—Proposed federal oversight of insurance regulation must include constraints on states' ability to roll back insurance rates, contends an insurer executive.

Regulatory change, "with a strong emphasis on solvency controls and strengthened oversight, is imminent," forecast Kenneth J. Duffy, president and chief executive officer of Commercial Union Insurance Cos.

But, a federal regulatory role should not be limited to "promulgation of standards with delegation of implementation to the states," he said.

"Solvency standards will lack comprehensiveness if they ignore the political suppression of adequate rate levels," Mr. Duffy said.

"Minimum standards for regulation should specify that regulators have a responsibility to set rates with some reasonable degree of accuracy over a period of time. Rate setting should not consistently result in rate inadequacy as it has in many states," he asserted.

Mr. Duffy made his remarks here last week at the joint annual meeting of the National Assn. of Casualty & Surety Agents and the National Assn. of Casualty & Surety Executives as the outgoing president of NACSE.

Noting that federal legislation is expected to "set some minimum standards for state regulatory performance," Mr. Duffy suggested that the legislation also include a "mechanism to lessen the impact of political influence in rate setting."

The only protection for insurers against inadequate rate setting by the states is for insurers to file suit claiming the rates are confiscatory, he noted.

"History indicates that applying this standard to a specific rate set by a state is rather hopeless. One rate for one line of business for one year is so subject to normal and expected variation that courts are rightly hesitant to substitute their judgment for that of the regulator," he explained.

Federal reform legislation, Mr.

Lloyd's capacity this year was \$21.4 billion.

"While we are not complacent about any of this, neither are we unduly panicked," he said.

Due to low rates in the last few years and the capacity added to Lloyd's in the last 10 years, the market has not fully used its capacity, he said.

In addition, "many of those who are staying (members) are increasing their premium limits to take advantage of the upturn when it comes," he said, predicting a market turn in the next 18 months.

In response to a question, Mr. Coleridge said that he personally does not think that unlimited liability at Lloyd's will be abandoned.

However, recognizing how difficult it is for a Lloyd's member to know that he "may wake up and find that (he) is bust," Mr. Coleridge predicted that Lloyd's may adopt "some form of mutualization for a loss of considerable size" suffered by an individual member over a four-year period.

Mr. Coleridge declined to speculate how large the loss would have to be, but emphasized it could not be so small as to mutualize all losses or so high as to make it meaningless.

The fund to cover an individual member's large loss would be created by a "small levy" on all

Duffy suggested, should include the "concept of 'predictive accuracy'" to allow a review of rates for adequacy or redundancy.

"A federal oversight body could review rate setting in a particular line and state and determine whether rates had been consistently inadequate or redundant," Mr. Duffy explained.

"If the oversight body had the authority to initiate a review, or could do so upon petition, a new and more equitable standard would apply to state rate setting," he said.

"This would not completely de-politicize rate setting, but it would be better than the present situation," Mr. Duffy maintained.

The current system of insurance regulation in the United States not only is the victim of "political expediency," according to Mr. Duffy, but also is "parochial, unpredictable (and) unduly expensive."

In contrast, "good regulation should be cost-effective, fair, focused on prevention and predictable to both the regulated and the public," he said.

"Current insurance regulation fails to meet these reasonable standards," according to Mr. Duffy.

As examples of recent regulatory failures, he cited:

- Recent insurance company insolvencies, and their cost to the public and solvent insurers.

- The "tremendously expensive regulatory examination process," with too much emphasis on trivia, creating jobs and raising revenue.

- The massive costs of "patently groundless lawsuits initiated by agencies of our government to advance political ambitions at the expense of insurers," and the "cost of company-instituted litigation, which we are compelled to incur to avoid the confiscation of our property."

The first is an obvious reference to the antitrust litigation pending against insurance industry defendants and the second refers to insurers' objections to regulations re-

names. The central fund, which exists to pay claims if a syndicate cannot, would not be involved, he noted.

Commenting that he did want to "second guess" the recommendations of a 14-member task force that is due to report by year-end on the issue of unlimited liability and other Lloyd's market concerns, Mr. Coleridge said, "I have a feeling that they may recommend this."

Were it to eliminate completely the unlimited liability of members, Lloyd's would become "no more than a small insurance company" that "would not merit any excitement," Mr. Coleridge said.

If Lloyd's adopts mutualization of individual member's large losses, the society as a whole retains unlimited liability, he explained after his speech.

Mutualization of large losses suffered by individual members possibly could be adopted for the 1992 underwriting year, Mr. Coleridge said. It would not be retroactive, however.

Commenting that he has "tremendous sympathy for any individual member that suffers a large loss," Mr. Coleridge also pointed out that actual losses suffered by names may be less than the cash members have been called to pay because they may be able to offset their individual losses against other income for tax purposes. ■

lated to Proposition 103 in California.

- The failure of regulators to exercise responsibility in their public pronouncements on insurance issues and to speak out when the public is being misled.

"Most often, the public statements of our regulators are politically motivated rather than factually based," Mr. Duffy said.

- The inability of regulators to agree on policies and practices, "causing 50 different requirements ranging from slight to great, but always consistent in requiring reams of paper and great expense."

The current state system of regulation "was conceived at a time when distances were great, communications slow and attitudes and practices were characterized more by differences than similarities," he said.

In the current review of the U.S. insurance regulatory system, "we could learn much from the regulators in other countries," he said.

"Their principal regulatory focus is on solvency. They have in the main recognized the social purpose of insurance without losing sight of economic realities," he said.

Foreign governments tend to "be supportive" of their insurance industries, while U.S. regulators have a "fundamentally anti-business attitude," he observed.

"Insurance is a vital part of the economy in a free society, but this does not appear to be recognized by our government, as our laws, accounting requirements and tax codes impose constraints upon us in our home market which are not borne by our major foreign competitors in their home markets.

"The governance of insurance in other countries is designed to ensure the strength of the industry with a resultant economic benefit to the nation," Mr. Duffy said.

As a result, he said, U.S. insurers are badly positioned to meet foreign competition. "The challenge of international competition can only be met by an industry which produces profit at a level which will attract capital to fuel essential growth."

Joseph C. Eanes Jr., president of Fidelity & Deposit Co. of Maryland in Baltimore, was elected president of NACSE for the coming year. ■



Mr. Duffy

NACSA/NACSE
CONFERENCE
The Greenbrier

Update

Insurer ratings downgraded

Continued from page 2

"partially offset strong statutory earnings" in 1990 and may continue to do so, S&P said.

"We've done very well on our real estate investments, historically," a Massachusetts Mutual spokesman said.

The rating on Kemper senior debt was lowered to A from AA, which S&P said was due to "aggressive investment policies" at units Kemper Investors Life Insurance Co. and Federal Kemper Life Insurance Co.

Kemper disagreed with S&P's action, arguing that several factors plus "Kemper's conservative capital structure warrant a higher rating."

S&P lowered the Continental pool's claims-paying rating to AA from AA+, citing "mediocre underwriting results" and singling out the commercial multiperil line as "extremely competitive with heavy cost-cutting." Also, the senior debt rating of parent Continental Corp. was lowered to A from A+

John P. Mascotte, chairman and chief executive officer of Continental, said, "We are disappointed that a change in S&P's outlook for the insurance industry has triggered a lowering of Continental's ratings."

CIGNA weighs offers for unit

PHILADELPHIA—CIGNA Corp. says it is considering selling its property and casualty reinsurance division.

Several parties in the reinsurance business have made unsolicited inquiries about the division, which generated close to \$591 million in net premiums worldwide last year, according to Philadelphia-based CIGNA. "We have interested parties on both sides of the Atlantic," said a spokesman, who would not disclose the asking price.

The division writes treaty, facultative and financial reinsurance. About 56% of its revenues come from outside the United States, according to the insurer.

Moody's Investors Service placed the A1 financial strength rating of CIGNA Re under review after the proposed sale was announced.

TPA charged with MEWA fraud

GREENSBORO, N.C.—A North Carolina third-party administrator and its president have been indicted on charges that the firm embezzled approximately \$1.2 million from more than 1,300 multiple employer welfare arrangements that it administered.

Following a one-year investigation by the U.S. Labor Department and the FBI, Calvin Banks Finger and his firm, American Institute of Management Services Inc. of Winston-Salem, N.C., were indicted Oct. 1 by a federal grand jury in Greensboro.

The indictment charges that from January 1987 through November 1989, Mr. Finger and AIMS embezzled the funds from three different AIMS-controlled bank accounts designed to hold employer payments until they were forwarded to insurers. The money was used for purposes other than funding benefits and defraying reasonable administration expenses, the indictment charges.

Mr. Finger, whose company administered MEWAs that provided health, life and other benefits to workers and dependents of multistate employers, faces up to 15 years in prison and \$750,000 in fines if convicted on all three counts of embezzlement. AIMS, if convicted on all counts, faces a fine of \$1.5 million.

Mr. Finger was arraigned Oct. 7 in Winston-Salem and pleaded not guilty. He was released on \$25,000 bond.

Jardine offering to aid growth

LONDON—Jardine Insurance Broking Group Ltd. plans to offer shares representing 32.3% of the company on the London Stock Exchange to finance expansion, especially in Europe.

The broker, wholly owned by Jardine Matheson Holdings Ltd. of Hong Kong, also is changing its name to JIB Group P.L.C.

The offering price will be announced this week, but sources estimate the value of the 33 million shares to be offered at about 65 million pounds (\$111.2 million at current exchange rates).

Half of the shares will be placed with institutional investors and half offered to the public. Trading will begin in London Nov. 7.

John Barton, chief executive of JIB, said the offering will allow it to pursue other acquisitions, including its current negotiations for a minority stake in a "major continental European broker."

Briefly noted

U.S. District Judge H. Russel Holland approved Exxon Corp.'s new settlement with Alaska and the U.S. Justice Department over the 1989 **Valdez oil spill**, even though Exxon will pay a lower criminal fine than under the earlier settlement. Judge Holland said he accepted the latest deal because it provides more money to rehabilitate Prince William Sound and because of Exxon's cleanup efforts (BI, Oct. 7; April 29). . . . The Senate this week is expected to vote on a measure approved by the House that would require the secretary of transportation to develop new rules for employers to conduct **alcohol and drug testing** of more than 4 million aviation, rail, motor carrier and mass transportation employees. The bill, H.R. 2942, would require rules to be developed for pre-employment testing, reasonable suspicion, random and post-accident testing. . . . A House subcommittee has defeated an amendment to legislation to refinance the Resolution Trust Corp. that would have outlawed the **regulatory and insured vs. insured exclusions** contained in directors and officers liability insurance policies. The Federal Deposit Insurance Corp. called on Congress to prohibit the exclusions (BI, Sept. 30). . . . Michael J. Mullen will resign at the end of the year as executive director of the **National Assn. of Insurance Brokers** in Washington, D.C. A successor has not been named. . . . The Senate Permanent Subcommittee on Investigations is conducting a "preliminary inquiry" into **Lloyd's of London** following allegations of securities law infringements and financial problems. "We have nothing to hide," a Lloyd's spokesman said of the investigation. . . . The High Court in London has postponed an action to wind up four insolvent insurers owned by **London United Investments P.L.C.** LUI administrators are expected to distribute documents outlining schemes of arrangements for the four companies at the end of this month.

Bendectin award

Continued from page 3

excludes damages related to toxic torts.

A Nov. 15 hearing has been scheduled to record the judgment, after which the company can file its motions and appeals.

Among 35 previous Bendectin suits that have gone to trial, the company ultimately has lost only two. Only one Bendectin award has been larger than the Texas award, the Marion Merrell Dow spokesman said.

In 1987, a federal jury in Washington, D.C., awarded \$75 million in punitive damages and \$20 million in compensatory damages to an 8-year-old boy who was born with deformed hands and elbows.

The trial judge, though, later disallowed the punitive damages and a federal appeals court overturned the compensatory award in 1990.

Mr. Nace, who also represented that plaintiff, said he is attempting to reopen the case based on evidence in the Texas trial.

Bendectin was introduced in 1956 by Richardson Merrell Inc., which Dow Chemical purchased in 1981 and renamed Merrell Dow Pharmaceuticals Inc. The name was changed in 1989 to Marion Merrell Dow.

And at least 1,150 Bendectin suits against Merrell Dow were dismissed in 1989. In a single case, the U.S. Supreme Court let stand a federal court's dismissal of the bodily injury claims.

Once widely prescribed, Bendectin was taken off the market in 1983.

Executive Life bids

Continued from page 3

Johnston, D-Stockton, also restricts insurer investments in mortgages and real estate.

With the value of its junk bond holdings deteriorating, Executive Life was seized by California regulators earlier this year (BI, April 15).

As of late last week, the Altus and Hellman & Friedman bids were the only two that had been formally submitted to the court.

Several other offers were expected by last Friday's 4 p.m. EDT deadline:

- Texas investor Richard Rainwater, recording industry mogul David Geffen and San Francisco-based Bechtel Investments, a unit of Bechtel Group Inc., were reportedly preparing a bid (BI, Sept. 30).

- A plan by the National Organization of Life & Health Insurance Guaranty Assns. to take over and liquidate the insurer was announced in mid-September (BI, Sept. 23).

- A group of municipal guaranteed investment contract holders who are not included in any of the other offers are expected to assemble a bid of their own.

Meanwhile, a trial is continuing in Los Angeles on an issue that could affect any eventual Executive Life deal: whether municipalities that invested the proceeds of bond issues in Executive Life GICs are policyholders entitled to the same claim priority as annuitants and other GIC holders.

If the muni-GIC holders are found to be policyholders, rehabilitation plans for Executive Life will have to account for \$1.85 billion in additional liabilities.

The latest Executive Life offer was presented to Los Angeles Superior Court Judge Kurt Lewin on Friday by Hellman & Friedman, the Zell-Chilmark Fund, a Chicago-based limited partnership, and Fund American Enterprises, a wholly owned subsidiary of The Fund American Cos., the former owner of Fireman's Fund Insurance Cos.

Of the \$750 million in new capital that would be committed to the new company, \$300 million would be in cash and \$450 million would be available on a standby basis in the form of a letter of credit from Bank of America.

The new company, called Sierra National Life Insurance Co., also would use as capital Executive Life's extensive junk bond portfolio. Ana-

ly that time, sales had fallen sharply and numerous product liability suits had forced up the company's insurance costs (BI, June 20, 1983).

The subsidiary was invoiced directly for its share of Dow Chemical's overall product liability coverage costs.

At the time, Dow Chemical purchased primary product liability coverage from its captive insurer, Dorinco Reinsurance Co. Dorinco is managed from Dow Chemical's Midland, Mich., headquarters.

Excess layers were placed with Lloyd's of London syndicates.

Dow Chemical would not reveal its coverage limits, but attorneys in 1984 estimated that as much as \$2 billion in coverage was available to pay Bendectin-related claims.

Bendectin has been targeted in suits by at least 1,800 women who used the drug during pregnancy. It was used in more than 33 million pregnancies from 1956 to 1983.

In 1984, more than 700 claimants alleging injuries from the anti-nausea drug agreed to settle their claims for \$120 million (BI, July 23, 1984).

That pact, though, was soon voided by the 6th U.S. Circuit Court of Appeals. The appeals court ruled that the judge presiding over the case had exceeded his authority in certifying a mandatory class of plaintiffs in an effort to facilitate the settlement.

Plaintiffs' attorneys initiated the action that resulted in the 6th Circuit opinion.

Many of the appellate rulings favorable to the drug company have focused on scientific evidence. These

courts have concluded that the data presented at trial did not prove a significant connection between the use of Bendectin and birth defects.

In addition, more than 35 epidemiologic studies and reports by the U.S. Food and Drug Administration and foreign drug enforcement agencies support Marion Merrell Dow's claim that there is no connection between the drug and birth defects, its spokesman contends.

However, plaintiffs' attorney Mr. Nace said that a 1983 study by the National Institute of Health showed that Bendectin interferes with the development of cells while limbs are forming in the womb.

In addition, four animal studies completed since the drug was taken off the market showed a direct relationship between use of Bendectin and limb deformity, he said.

Bendectin's active ingredients were vitamin B-6 and doxylamine succinate, an antihistamine.

While the FDA since 1976 has required that over-the-counter antihistamines carry a warning against their use during pregnancy, no such warning was required on Bendectin.

Marion Merrell Dow is appealing the two cases it has lost.

In one case, a Washington, D.C., Superior Court in 1983 awarded \$750,000 in compensatory damages to a 12-year-old girl for disfigurement, mental anguish and pain and suffering.

And, in 1987, a federal court in Washington, D.C., awarded \$300,000 in compensatory damages in another birth defect case. ■

lysts estimate the portfolio is worth \$4.2 billion.

The Hellman & Friedman offer, said Mr. Byrne, is expected to offer policyholders 83 cents on the dollar, compared with 81 cents under the Altus plan.

Also, like the Altus bid, the Hellman & Friedman offer would rely on state guaranty funds to make policyholders whole, he said.

The investment group initially hesitated in submitting its offer after receiving word that the guaranty fund association was considering submitting a bid of its own.

However, "after studying the bid and talking to the NOHLGA people, we now think they played a constructive role" in the preparation of the Hellman & Friedman offer, Mr. Byrne said.

Other provisions of the Hellman & Friedman offer include:

- Policyholders would receive 50% of the first \$200 million in profits earned by the new company, or 15% of total profits, whichever is greater.

- Policyholders—including pension plans that hold GICs—would receive interest payments tied to five-year Treasury bond rates plus 50 basis points. As of today, that return would equal about 7.8%.

Under the Altus proposal, interest earned would be tied to five-year Treasury bond rates minus 100 basis points. At today's rates, that would amount to approximately 6.3%.

- A five-year moratorium on cash-outs—the same ban included in the Altus proposal.

Altus announced early last week it was enhancing its offer after other bidders said the French investor group had undervalued Executive Life's extensive junk bond portfolio.

Under its original offer, Altus Finance, a division of Paris-based bank Credit Lyonnais, would pay \$2.7 billion for the junk bond portfolio and a liquidating trust would be set up to sell off the company's real estate holdings, valued at \$380 million.

A separate group led by insurer Mutuelle Assurance Artisanale de France of Paris, would capitalize the new company with an additional \$300 million in cash (BI, Aug. 12).

The junk bonds, which had a face value of \$6.6 billion when purchased by Executive Life, are now valued at \$4.2 billion by securities analysts.

While the new Altus offer prom-

ises enhanced benefits to policyholders, it does not change the \$2.7 million price tag on the junk bond portfolio.

"Any bid which leaves the junk bond portfolio in Executive Life is just another high-stakes roll of the dice with policyholders' money, and the investor group has no interest in subjecting policyholders to those kinds of risks and uncertainties," said John F. Hartigan, director of transition planning for the French investor group and a senior partner in the Los Angeles law firm of Morgan, Lewis & Bockius.

The latest Altus proposal includes the following provisions:

- A liquidity provision that would permit life insurance, annuity and pension GIC holders to immediately borrow up to 50% of the net cash value of their contracts in the form of policy loans without imposition of surrender or moratorium charges.

- A policy will be established to assist hardship cases to access the value of their policies without moratorium or surrender charges.

In a development related to Executive Life's failure, Gov. Wilson signed into law S.B. 1135, a bill that limits insurer investments in junk bonds, mortgages and real estate.

Basically, the new law makes sure that insurers' operating capital is held in more conservative investment vehicles, said Wayne D. Wilson, vp of the western regional office for the American Insurance Assn., which supported the legislation.

Currently, he explained, insurers investments are divided into two categories: general investments, where operating capital is stored; and excess investments, which holds all funds that exceed paid-in capital.

Under the new law, some investments that had been considered general investments, such as mortgages and real estate, will be transferred into the excess investments category.

While smaller insurers may be forced to alter their investment practices, Mr. Wilson does not think the new law will have a dramatic impact on large insurers.

The Altus bid would immediately comply with the new statute, but the Hellman & Friedman bid would not comply until 1996 because the new company would maintain the junk bonds, which comprised as much as 65% of Executive Life's portfolio. ■

Punitive damages

Continued from page 1
on so far, the lower courts have reaffirmed the punitive damage awards.

Mr. Olson noted, though, that if lower courts continue to "place a rubber stamp on the original awards, the Supreme Court will likely feel inclined to take another case."

However, federal and state appellate courts throughout the country that have relied on *Haslip* have not been so quick to uphold initial punitive damage awards, the Maryland appellate court decision notes.

In six cases cited in the Maryland appellate court opinion, two state appellate courts have reduced awards and two federal appellate courts have remanded punitive awards to trial courts for further consideration. Another two state appellate courts have sustained punitive awards, the decision noted.

Those cases clearly show that the nation's highest court has effectively spread the message to lower courts that punitive damage awards must be reasonable to stand, said Martin Connor, president of the American Tort Reform Assn., a business-backed advocacy group based in Washington, D.C.

"It appears as though courts are finally getting the message that the 14th Amendment does place limits on a jury's discretion" for awarding punitive damages in consideration of actual damages suffered, Mr. Connor said.

However, the Supreme court ruled 7-1 in *Haslip* that the due process clause in the 14th Amendment does not mandate such limits on juries.

"While *Haslip* is not a model of clarity, it does call for clear instructions for juries and requires that punitive damages be rationally related to harm done and compensatory damages. It seems that the law is finally moving this way," observed Pacific Mutual attorney Bruce Beckman of Adams Duque & Hazeltine in Los Angeles.

"This is the first time a court has ordered a retrial to reconsider punitive damages on the grounds that an original award was unconstitutionally high," said Victor Schwartz, a tort law specialist with Crowell & Moring in Washington, D.C.

"I commend the Maryland court for following constitutional guidelines established by the Supreme Court, however vague those guidelines might be. Plaintiffs' lawyers said earlier this year that the Supreme Court's *Haslip* ruling was meaningless because it set no standards. This ruling shows it wasn't," Mr. Schwartz said.

Plaintiffs' attorneys say the Maryland appellate court decision is not a complete surprise.

"Each case should be looked at on its own merits," said William Shernoff of Shernoff, Darras & Bidart in Claremont, Calif. "It sounds like the Maryland court is saying that based on the guidelines set by the Supreme Court, the award was out of whack and that it should be sent back for a jury to come up with something more in line with the actual damages," he said.

"There's clear hostility toward punitive damages in the appellate world," said Linda Lipsen, an attorney with the Consumers Union of the United States in Washington, D.C.

But, Ms. Lipsen does not give the *Haslip* decision much credit for this trend.

"The public relations campaign against punitive damages is affecting all cases. It's not the Supreme Court ruling that is causing punitive damages to be reversed or reduced. There's nothing instructive in the *Haslip* decision. It doesn't limit punitive damages, it only says to act reasonably, which has always been the case," she said.

The dispute in the Maryland case involves a broker-of-record agreement that now-defunct independent broker B. Dixon Evander & Associates Inc. in Baltimore held from 1975 to 1986 with Mutual Fire, Marine & Inland Insurance Co. through the insurer's managing general agent, Shand, Morahan & Co. Inc.

Evander alleged that A&A encouraged Shand Morahan, which was then an A&A subsidiary, to terminate the agreement with Evander and place coverage directly with Mutual Fire for the University of Maryland Medical Group.

The trial jury originally awarded Evander \$40 million of punitive damages, but the trial judge in August 1990 reduced that award, which he called excessive, to \$12.5 million (*BI*, Sept. 10, 1990; May 7, 1990).

Although the Maryland appellate court vacated the \$12.5 million punitive damage award, the court left standing a judgment against A&A for actual damages exceeding \$250,000.

Dixon Evander, president of the now defunct brokerage, which recently won an \$8.7 million judgment against Maryland's largest medical malpractice insurer for defamation (*BI*, Oct. 7), withdrew his claim for punitive damages against Shand Morahan and Mutual Fire but not Mary Scheeler, an A&A vp who was in charge of the account.

Both A&A and Evander still have the option of appealing the appellate decision to Maryland's highest court. Neither Ronald J. Roessler, A&A's general counsel, nor Evander's lawyers said they had not decided whether to appeal.

If no appeal is made, a trial court jury in Baltimore will again decide whether A&A must pay Evander punitive damages.

A&A is "pleased" that the \$12.5 million in punitive damages was viewed as unconstitu-

tional by the Maryland appeals court, Mr. Roessler said.

However, "it's our position that this is not an appropriate case for the award of any punitive damages, and we will stress this point at retrial," he said.

Edward J. Birrane, Evander's lead attorney and a partner with Birrane, Harlan & Cooke in Baltimore, said he is "not totally unhappy with what's happening. Personally, I'd prefer to have a jury hear our case again than more judges. To my understanding, the jury will be instructed that A&A is guilty of leading a malicious conspiracy to damage my client. The only question they'll have to answer is what punitive damages they should pay."

In vacating the punitive damage award and calling for a retrial, Judge Alan Wilner, writing for the three-judge appellate panel, noted that the issue of punitive damages became muddled during the original trial.

Judge Wilner said that the trial court judge failed to provide the jury with any instruction on punitive damages with respect to A&A nor was the jury told about the purpose of punitive damages.

"On this, we do not believe that a \$12.5 million award comports with due process," the court said.

Not only was the \$12.5 million punitive award allowed by the trial court excessive in terms of Maryland history, "it is far in excess of the actual harm caused to Evander, representing nearly 50 times the compensatory damages. Until the end of the case, Evander himself sought no more than \$5 million," Judge Wilner wrote.

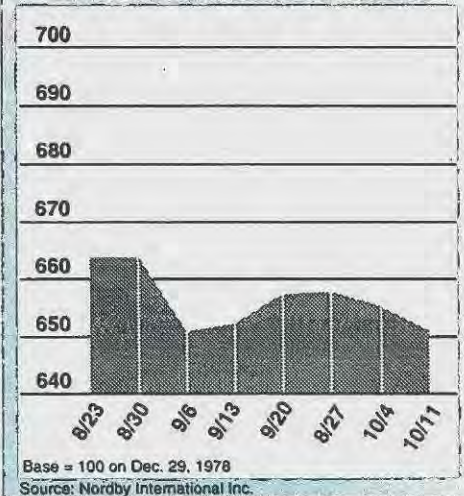
The court called A&A's actions "excessive, ill-motivated and, in retrospect, stupid." However, Judge Wilner wrote that the broker's scheme did "not strike us as very high on the scale of reprehensibility."

The court compared the punitive damages awarded in the A&A case with the previous highest punitive damage award in the state. In that case, the family of a child electrocuted by downed power wires was awarded \$7.5 million. The court emphasized that A&A's actions caused "nothing like the harm" done to that child.

The court accepted that A&A "set out to cause economic harm to a competitor, that it used inappropriate means to achieve that goal, and that it should be punished for, and others deterred from, engaging in that conduct. But, nothing approaching \$12.5 million is necessary to achieve either goal."

Alexander & Alexander Inc., et al vs. B. Dixon Evander & Associates Inc., Court of Special Appeals of Maryland, No. 1920, September term 1990.

BI Insurance Index



Insurance industry stocks slipped again last week as the *Business Insurance Index* fell 3.9 points to 651.8 on Oct. 11, from 655.71 on Oct. 4. Advancing issues for the week were led by Nobel Insurance Ltd., up 8.9%; UNUM Corp., up 7.0%; and USLICO Corp., up 5.0%. Declining insurance issues for the week followed Provident Life, down 10.4%; Selective Insurance Group, down 10.1%; and Fremont General Corp., down 9.7%. The most active insurance issue for the period was Sears (Allstate), with 6.9 million shares traded. The *BI Index* was down 0.6%; the Standard & Poor's 500 rose 0.05%; the Dow Jones 30 Industrials were up 0.7%; and the New York Stock Exchange Composite fell 0.07%.

British Issues

Oct. 10 Companies	Price pence	P/E	Div. pence	Yield %	1 Week	
					High	Low
Comm'l Union	485	N/M	30.7	6.3	485	484
Gen'l Accident	515	N/M	35.7	6.7	528	513
Gdn Royal Exch	169	N/M	15.7	9.4	177	169
Royal	328	N/M	34.7	10.6	339	328
Sun Alliance	354	N/M	18.7	5.3	358	349
Brokers						
Bradstock	171	19.5	6.0	3.5	172	171
CE Heath	497	17.3	34.5	6.9	500	497
Hogg Group	220	13.1	10.7	4.9	225	220
Lloyd Thompson	431	21.7	12.0	2.8	431	430
Lowndes Lmbrt	337	17.2	15.3	4.5	341	337
PWS Holdings	84	10.3	4.7	5.6	85	84
Sedgwick Grp	249	23.6	16.0	6.4	268	249
Steel Brl Jones	334	17.5	16.3	4.9	334	334
Willis Coroon	294	15.5	17.6	6.0	301	294

Source: Philip Olsen, Insurance Industry Analyst, London

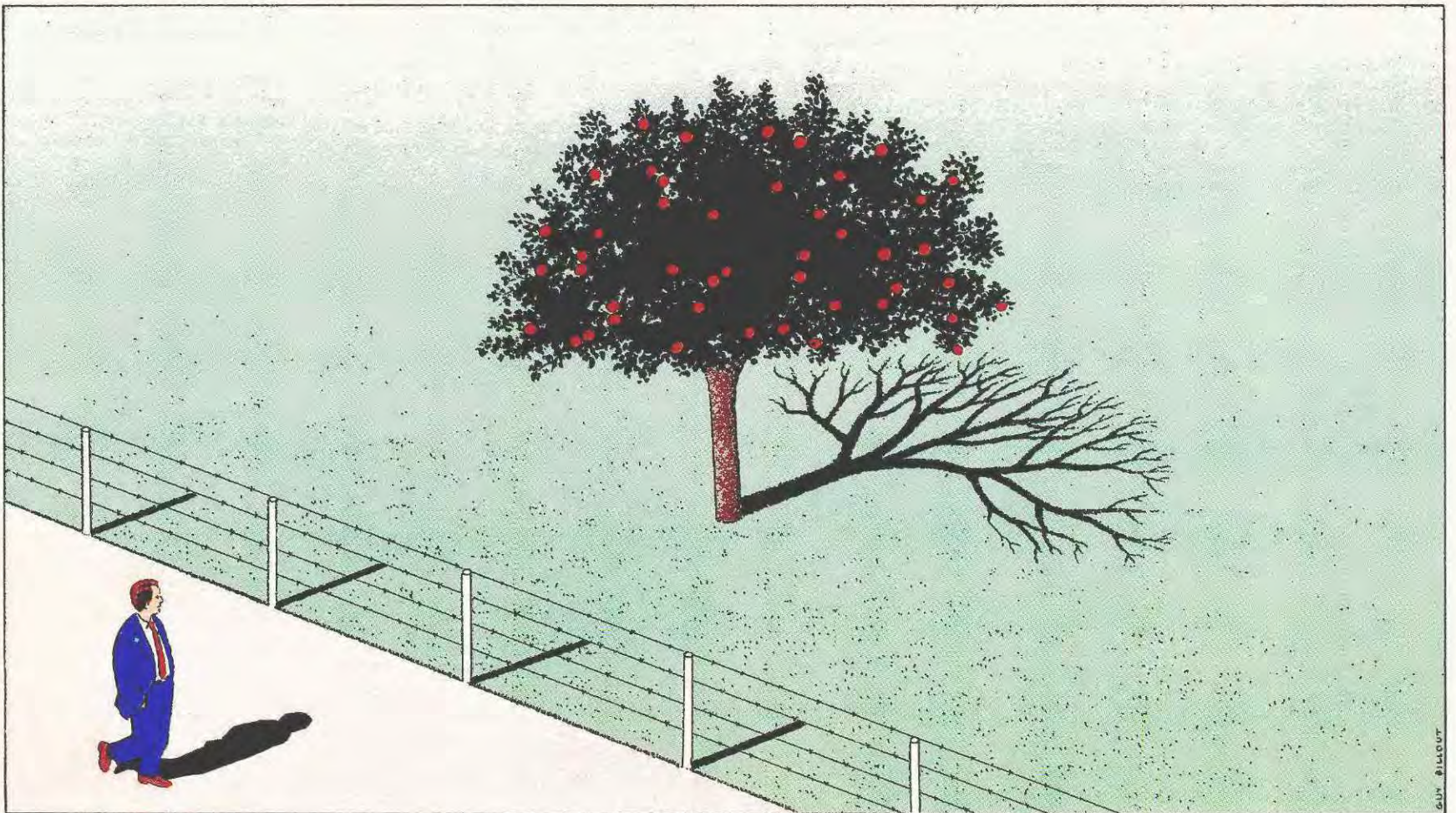
BI Industry Stock Report

OCTOBER 7, 1991 THROUGH OCTOBER 11, 1991

	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value																							
				High	Low										High	Low																													
BROKERS																																													
Alexander & Alexander	NYS	19.75	-1.25	-14.59	27.63	16.75	362	1.00	5.06	16	9.77	2.02	18.50	2.78	57.45	19.50	10.25	112	0.00	0.00	9	3.22	5.75																						
Gallagher Arthur J. & Co.	NYS	19.13	-1.92	-17.74	28.38	19.00	8	0.64	3.35	15	5.88	3.25	22.50	-1.64	-	26.75	17.00	23	0.40	1.78	23																								
Frank B. Hall	NYS	3.88	3.35	6.90	4.38	2.00	52	0.00	0.00	-8	-5.24	-0.74	28.34	1.69	-31.82	28.34	17.84	899	0.16	0.71	12	18.90	1.19																						
Hibb, Rogal & Hamilton	OTC	14.25	3.64	-3.39	17.50	11.25	101	0.36	2.53	22	3.56	4.00	31.25	-3.85	43.13	35.00	16.50	4	0.00	0.00	18	13.52	2.31																						
Marsh & McLennan	NYS	74.38	-2.76	-4.65	87.25	65.75	314	2.60	3.50	18	14.77	5.04	3.81	8.94	27.10	4.38	2.50	9	0.00	0.00	5	7.76	0.49																						
Poe & Associates	OTC	11.50	-4.17	79.69	12.50	6.25	163	0.32	2.78	14	2.29	5.02	28.88	2.21	71.11	32.88	11.75	328	1.40	4.85	7	42.73	0.68																						
BROKERS AVERAGE																																													
CONGLOMERATES & HOLDING COMPANIES																																													
Berkley W.R. Corp.	OTC	25.25	3.59	-32.67	32.25	20.88	324	0.32	1.27	14	23.89	1.06	44.50	-2.27	44.54	22.50	11.75	54	0.84	3.91	9	16.29	1.32																						
Berkshire Hathaway Inc.	NYS	8475.00	-0.99	26.97	8475.00	175.00	1	0.00	0.00	-30	4612.00	1.84	18.38	-10.37	5.00	24.50	12.00	335	1.00	5.44	5	25.88	0.71																						
ITT (Hartford Group)	NYS	54.88	-1.13	14.32	63.00	40.25	1617	1.72	3.13	8	64.01	0.86	14.88	1.71	15.53	18.63	11.75	30	2.00	1.34	10	15.05	0.99																						
Sears (Allstate)	NYS	36.13	-2.36	42.36	43.50	22.88	2768	2.00	5.54	12	37.38	0.97	4.88	0.00	5.41	7.50	4.25	15	0.32	6.56	-8	1.32	3.69																						
CONGLOMERATES AVERAGE																																													
INSURERS/REINSURERS																																													
Aetna Life & Casualty	NYS	34.38	-0.36	-11.86	49.13	29.00	1595	2.76	8.03	7	64.23	0.54	15.50	-1.61	23.23	16.50	8.38	31	0.24	1.57	9	11.19	1.36																						
American General	NYS	41.88	3.08	36.18	41.88	23.50	684	2.00	4.78	10	37.14	1.13	6.00	0.00	223.93	5.88	1.25	124	0.00	0.00	-169	2.48	2.04																						
American Heritage	NYS	30.38	2.53	44.64	32.25	19.63	17	1.08	3.56	13	19.25	1.58	52.25	-0.48	10.58	56.50	40.50	6	0.00	0.00	-	70.93	0.74																						
American Indemnity(Fin'l)	OTC	6.25	-3.85	92.31	7.75	2.75	43	0.08	1.28	3	12.93	0.48	50.13	1.26	2.56	58.50	38.00	131	1.60	3.19	12	16.70	3.00																						
American International	NYS	80.25	-0.77	4.39	102.00	59.25	1917	0.48	0.60	11	45.34	1.77	36.13	-2.03	10.73	38.38	24.25	320	2.00	5.54	13	36.56	0.99																						
Aon Corp.	NYS	35.50	-3.73	2.16	41.75	27.63	198	1.60	4.51	10	18.50	1.92	29.63	-8.49	8.22	39.38	20.50	155	2.00	0.68	10	18.38	1.61																						
Argonaut Group	OTC	23.75	3.26	11.33	33.38	17.75	166	0.68	2.86	7	48.26	0.49	18.38	-1.34	10.53	25.38	11.50	747	1.60	8.71	-9	41.44	0.44																						
AVEMCO Corp.	NYS	25.50	-3.77	51.49	26.75	14.13	11	0.40	1.57	19	9.55	2.67	25.50	-0.97	10.27	30.00	17.75	72	0.60	2.35	9	21.71	1.17																						
Baldwin & Lyons Inc.	OTC	24.00	0.00	28.00	25.25	17.00	0	0.28	1.17	8	24.29	0.99	46.50	0.00	32.38	58.00	28.75	0	1.32	2.84	12	35.39	1.31																						
Belvedere Corp.	ASE	3.00	-4.00	20.00	3.38	1.75	30	0.04	1.33	20	7.65	0.39	7.38	-3.28	-1.67	14.25	6.13	1424	2.00	2.71	-1	11.96	0.62																						
Chandler Insurance	OTC	2.50	-4.76	-63.64	7.25	2.13	50	0.00	0.00	-2	5.95	0.42	63.25	6.98	35.66	70.25	33.88	492	1.04	1.64	11	37.25	1.70																						
Chubb Corp.	NYS	61.13	-1.61	12.67	75.25	35.75	1022	1.48	2.42	9	35.19	1.74	39.13	-2.19	39.73	42.75	23.25	105	1.64	4.19	9	60.34	0.65																						
CIGNA Corp.	NYS	46.50	4.49	13.76	56.75	33.63	485	3.04	6.54	11	73.15	0.64	35.13	-2.43	14.23	41.50	26.00	94	1.00	2.85	13	30.70	1.14																						
CNA Financial Corp.	NYS	86.25	1.77	25.68	92.50	49.50	41	0.00	0.00	12	70.23	1.23	15.00	3.45	37.93	15.50	9.38	35	1.08	7.20	-5	26.86	0.56																						
Continental Corp.	NYS	25.00	3.09	0.50	30.63	15.75	558	2.60	10.40	9	37.83	0.66	18.38	5.00	15.75	21.00	14.75	24	1.00	5.44	10	29.44	0.62																						
Durham Corp.	OTC	31.00	-0.40	10.71	34.25	23.00	10	1.00	3.23	17	28.04	1.11	16.00	-1.54	17.43	18.50	9.88	16	1.00	6.25	-84	13.14	1.22																						
Fremont General Corp.	NYS	65.63	0.57	26.51	65.88	42.63	123	0.88	1.04	19	36.11	1.82	15.50	3.45	37.93	15.50	9.38	35	1.08	7.20	-5	26.86	0.56																						
Frontier Insurance Group	NYS	24.25	1.04	27.63	25.88	15.69	11	0.00	0.00	10	11.20	2.17	18.38	5.00	15.75	21.00	14.75	24	1.00	5.44	10	29.44	0.62																						
Gaisco Inc.	ASE	11.50	-7.07	50.82	12.88	4.25	116	0.04	0.35	15	3.37	3.41	16.00	-1.54	17.43	18.50	9.88	16	1.00	6.25	-84	13.14	1.22																						
General RE Corp.	NYS	88.00	0.00	-5.38	102.50	75.50	827	1.68	1.91	13	37.50	2.35	15.50	10.14	16.98	18.00	12.50	108	1.04	6.71	8	18.91	0.82																						
Hanover Insurance Co.	OTC	28.50	0.44	7.55	30.75	21.00	6	0.44	1.54	10	37.44	0.76	5.06	0.00	223.93	5.88	1.25	124	0.00	0.00	-169	2.48	2.04																						
Harleysville Group	OTC	27.75	-1.77	21.31	32.00	14.25	4	0.64	2.31	8	22.99	1.21	52.25	-0.48	10.58	56.50	40.50	6	0.00	0.00	-	70.93	0.74																						
Hartford Steam Boiler	NYS																																												

Knowledge Without Action Is Wasted. Every group insurance company promises

the fruits of its knowledge and resources. But we put our knowledge and resources to work on practical ideas for employers and employees. ♦ For example, we identified early one of the great



emerging issues in employee benefits -- the provision of practical, economical group long-term care coverage -- and moved to implement it. Today, those we serve have this coverage available to them -- because our experience and the resources we command made it possible early. ♦ Clients who depend on your advice want to know how well group insurance companies know the industry. Now you can tell them how we make our experience and expertise work for them. For more information, call Patrick Moeschler, Director of National Accounts, at 1-800-877-1052.



The Managed-Cost Professionalssm