

Business Insurance

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Arbitration panel orders reinsurers to pay Mission unit \$92 million

LOS ANGELES—An arbitration panel last week ruled that six reinsurers must pay more than \$92 million to Pacific Reinsurance Management Corp.—the defunct reinsurance pooling subsidiary of Los Angeles-based Mission Insurance Group, *Business Insurance* has learned.

That amount represents the reinsurers' total liability to PRMC, the panel ruled 2-1.

The reinsurers, which charged the
Continued on next page

Candidates split over corporate liability issues

By DEBORAH SHALOWITZ

WASHINGTON—The two presidential candidates disagree on several corporate liability issues but are not too far apart on others.

Vice President George Bush probably would oppose a federal high risk occupational disease notification law, while Massachusetts Gov. Michael Dukakis, heavily supported by organized labor, would support it.

And Mr. Dukakis is more likely to support repeal or modification of the insurance industry's limited exemption from federal antitrust laws than Mr. Bush is, observers say.

However, both candidates support beefing up environmental law enforcement and both support some tort reform efforts—although Mr. Bush's support of tort reform is far stronger than Mr. Dukakis'.

Mr. Dukakis views insurance as a "mechanism of social distribution," observed Peter Lefkin, federal affairs counsel for the American Insurance Assn. in Washington. As examples, he pointed to the governor's support for Massachusetts' new mandated health insurance bill and his calls for a federal law requiring employers to provide health insurance to employees.

Paula Gold, secretary of consumer affairs and business regulation for the state of Massachusetts, noted that although her department oversees nine state agencies—only one of which is the insurance department—80% of her time with Mr. Dukakis is spent on insurance issues.

Mr. Dukakis in 1986 convened a task force on liability issues chaired by Ms. Gold that recommended several tort and insurance reforms, including modifying the rule of joint and several liability and extending the theory of comparative fault to cases involving product liability.

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FASB proposal boosts retiree health plan bill

By DEBORAH SHALOWITZ

NORWALK, Conn.—Employers face an even larger hit to their pocketbooks than they expected under a proposed accounting standard requiring companies to recognize retiree health care liabilities and the cost of those liabilities on their financial statements.

Some benefit consultants expect the proposed accounting standard will force employers to consider ways to limit their retiree health care liabilities, including redesigning retiree health care plans and perhaps reducing benefits under those plans.

However, others say employers will attempt to contain health care costs instead of limiting their retiree health care plans.

Under the proposed accounting standard agreed to on Oct. 5 by the Norwalk, Conn.-based Financial Accounting Standards Board, employers would have to accrue as an expense against corporate earnings retiree health care liabilities from the date an employee is hired until the date the employee is first eligible for retirement health care benefits.

The board had previously tentatively concluded that employers would be allowed to expense these liabilities until the date of employees' expected retirement.

The accounting proposal would require companies to switch to accrual from cash accounting for post-retirement welfare benefits in fiscal years beginning after Dec. 15, 1991.

Employers now report only their pay-as-you-go costs for retiree health care benefits—such as the premium for a health insurance policy or claims costs if a company self-funds its retiree health care plan—as an expense item on their income statements.

Also under the proposal, employers would be re-

quired to amortize on a straight-line basis their accumulated retiree health care liabilities as of the standard's effective date over the average remaining service period of employees expected to receive the benefit or over 15 years.

Another provision of the proposal will require balance sheet recognition of a minimum liability beginning in calendar year 1997.

Employers will be required to record on their balance sheets at least the present value of retirement health care liabilities for current workers who are eligible to retire—called eligibles—as well as the liabilities for current retirees.

For example, if the unfunded obligation for retirees and eligibles is \$125,000 but the accrued liability to be reported on the balance sheet is only \$100,000, an additional liability of \$25,000 would be recorded with an offsetting charge to an intangible asset.

Under the previous tentative conclusions, the minimum liability employers would have had to disclose on their balance sheets was only the health care liabilities for current retirees. That was scheduled to take effect beginning in 1994.

The board chose to consider eligibles as well as retirees in the minimum liability because that was considered most consistent with the attribution approach, explained Diana Scott, FASB project manager.

FASB delayed the date employers would have to list these new liabilities on their balance sheets until 1997, hoping that with the five-year delay, recording an additional liability to meet the minimum requirement will not be very prevalent, Ms. Scott said.

FASB will release a final exposure draft of the proposed accounting standard for retiree health care lia-
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Australian market epitome of competition

By STACY SHAPIRO

SYDNEY, Australia—Australian insurance buyers, already accustomed to a highly competitive property/casualty insurance market, are seeing liability insurance capacity expand and property insurance rates plunge even further.

The Australian insurance market, which some observers say has been highly competitive since the mid-1970s, has softened even more since the July renewal season mainly because there are too many underwriters with not enough premium to justify their existence, as well as an overabundance of brokers.

Underwriters have been fighting for a piece of a smaller insurance marketplace over the past few years since state-controlled insurers began writing all workers compensation coverage in several of the country's largest states.

In addition, Australian underwriters face increasing competition from overseas insur-

ance markets.

Industry leaders agree that as a result of the soft—and smaller—market, some insurers and brokers are either reducing their staffs or are merging with other companies.

This "rationalization" of the market, as Australians call today's trend to merge, is a hot topic of discussion in the industry.

And, because risk managers can call the shots on broker services as a result of the fierce competition, brokers are offering their services for a fee, rather than basing their charges on commissions.

Members of the London market describe the Australian insurance industry as "tough."

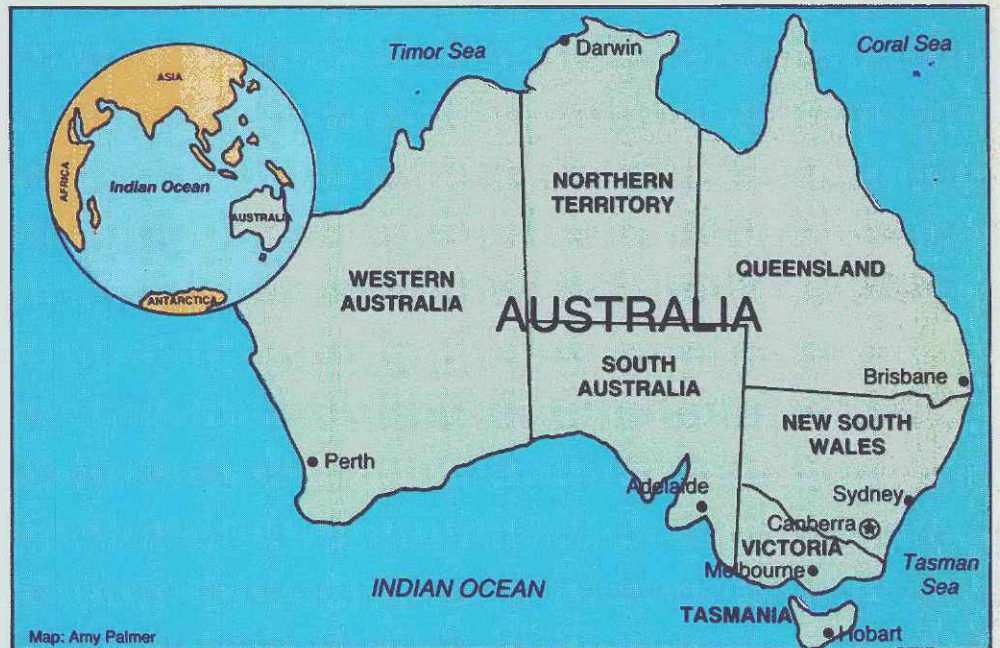
If an underwriter or a broker can survive in Australia, they can make it anywhere, they say.

Members of the Australian insurance market in Sydney, Melbourne, Brisbane and Canberra agree.

Australia "is a very competitive market, probably the most competitive market in the

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Exclusive market report



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Legislation easing HMO rules on its way to the president
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Computer claims processing begins in London next month
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PRMC awarded \$92 million

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pool with fraudulent management activities, had requested that the panel rescind the contracts (*BI*, July 18, May 2).

Instead, the panel concluded: "The agreements between the petitioners and the respondents remain valid. And both parties are directed to fulfill their respective obligations thereunder," according to a source familiar with the proceedings.

The reinsurers—Ohio Reinsurance Corp., Abeille-Paix Reassurances, Hamburg International Reinsurance Co., Hassneh Insurance of Israel Ltd., Seguros America S.A. and Compagnie Transcontinentale de Reassurance—must pay approximately \$11 million immediately and post the remainder in letters of credit or other securities. In addition, balances due to Mission's PRMC have to be paid in full; any amounts owed to reinsurers by PRMC cannot be used to offset the award.

Attorneys for PRMC at Buchalter, Nemer, Fields & Younger in Los Angeles said they were pleased with the panel's decision.

An attorney for the reinsurers, Elliott M. Kroll of Kroll & Tract in New York, said: "We don't believe this panel had any jurisdiction to award affirmative relief to PRMC, since the demands throughout the arbitration only made reference to the affirmative claims" by the reinsurers to rescind the contracts. "Any decision by this panel which would deny respondents' request and award anything to PRMC would be in manifest disregard for the law and could only be the result of bias or prejudice by the umpire," he said.

"The arbitration process has been tainted by the fact that someone has told *Business Insurance* that there is an award in chapter and verse before counsel for the respondent—i.e. myself and my firm—has either seen a signed award or the dissent of the respondents' arbitrator in the event of an adverse award."

Technical corrections bills

WASHINGTON—Congressional conferees were deadlocked last week in their attempt to work out employee benefit and other differences in Senate- and House-passed bills that would make technical corrections in several pieces of tax-related legislation.

Among the two bills' provisions to be reconciled are:

- The Senate bill, passed last week, calls for a 60% excise tax on pension reversions received from July 26, 1988, to May 1, 1989. The House bill lacks a comparable provision.

- The Senate bill retroactively restores the tax-free status of employer-provided educational assistance benefits to Dec. 31 and continues the prior law's tax-free limit at \$5,250 per employee. The House bill slashes the maximum limit to \$1,500 but would continue the tax-favored status of educational assistance benefits to Dec. 31, 1990. Both bills sharply curtail the availability of educational assistance benefits for graduate level work.

Section 127, which had allowed employers to provide educational assistance benefits to employees, expired on Dec. 31, 1987.

- The Senate bill would give companies with fewer than 10 employees more time before they have to include part-time workers in running Section 89's non-discrimination tests for welfare plans. The House bill lacks a comparable small business exception.

- The Senate bill would bar any provision of a tax treaty with Bermuda or Barbados that waives after Dec. 31, 1989, federal excise taxes on premiums ceded to reinsurers in those domiciles. There is no comparable House provision. A pending treaty with the United Kingdom on behalf of Bermuda would waive through Dec. 31, 1989, the federal excise tax.

Both bills, however, would tie the penalty for a single COBRA violation to length and severity of the violation.

C&B eyes TPF&C Reinsurance

NEW YORK—Corroon & Black Corp. in New York is negotiating with New York-based consultant Towers, Perrin, Forster & Crosby Inc. to acquire TPF&C Reinsurance, the fourth-largest U.S. reinsurance intermediary based on *Business Insurance* estimates.

If acquired, Philadelphia-based TPF&C Re would be merged with Corroon & Black's New Hyde Park, N.Y.-based G.L. Hodson & Son Inc., the eighth-largest U.S. reinsurance intermediary.

"We are indeed discussing with Towers Perrin the possibility of merging our two firms," confirmed Ronald J. Taylor, president and chief executive officer of Hodson. "There has been considerable discussion to date and we would expect there would be considerable additional discussion before any disposition is made."

"We are exploring a number of options now to determine what our best future is," said Robert F. Jones, senior vp of TPF&C Re.

Best to charge fee for ratings

OLDWICK, N.J.—A.M. Best Co. will charge insurers \$500 for their annual ratings beginning next year.

In an Oct. 11 letter to insurance company chief executives, Best President Arthur Snyder said the fee is necessary "to help us keep pace with an industry which is growing in size and complexity."

The number of insurers rated by Best has grown more than 50% to about 3,430 from 2,275 in the last 10 years, while concern over insurer financial stability has grown, Mr. Snyder explained in the letter.

The fee will be charged for Best ratings from A+ to C- but will be waived for Best's various "Rating Not Assigned" categories.

Best rated 1,963 property/casualty insurers and 1,470 life/health insurers in 1988.

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Errors & omissions

- A statement in the Oct. 10 issue attributed to Robert J. Vairo, president of Crum & Forster Inc., should have read: "Crum & Foster has 'walk-away' prices below which it will not write business even if it means losing business to competitors." A typographical error had changed the meaning of the statement.

Amendments to HMO Act permit experience rating

By JERRY GEISEL

WASHINGTON—Legislation that will give employers and federally qualified health maintenance organizations more flexibility is on its way to President Reagan for signature.

Passage of the legislation, which generally will take effect when President Reagan signs it, came after congressional conferees this month resolved a key difference that had been holding up final approval.

The compromise legislation includes a sunset provision that will end—effective Oct. 1, 1995—the current so-called "dual-choice" rule that requires employers with more than 25 employees to offer a federally qualified HMO if properly approached by the HMO.

The House bill would have retained the dual-choice rule, while the Senate bill would have eliminated the dual-choice rule in five years (*BI*, Aug. 22).

The conferees left intact the heart of the legislation: allowing federally qualified HMOs and employers to negotiate rates based on an employer's own past and projected claims experience.

The freedom to experience rate as well as other modifications made to the Health Maintenance Organization Act of 1973 will make federally qualified HMOs stronger players in the group health care market.

"The legislation will allow HMOs to become competitive as they never have been before," said consultant Elliot Segal, president of Managed Care Options Inc.

"Passage of the bill means HMOs and employers have a greater ability to respond to changing markets and demands," said James F. Doherty, president of the Group Health Assn. of America, an HMO trade group.

The legislation will allow federally qualified HMOs to set advanced, fixed rates based on an employer's past and projected claims experience. An HMO could

not, though, make retrospective adjustments if claims turned out higher than expected.

HMOs would be barred from charging experience-rates that are 10% higher than the HMO's community rate for employers with fewer than 100 employees.

Currently, federally qualified HMOs tend to use community rating under which rates are set based on the costs of the entire community they serve or a variation known as community rating by class. The legislation will allow HMOs to continue to use these rating methods if they so choose.

The legislation also modifies the so-called equal contribution rule, a requirement that employers had fought as protectionist for the HMO industry.

Under that requirement, employers have had to make the same contribution toward the premium charged by the HMO as the largest contribution made to the largest non-HMO plan, such as a companywide self-funded indemnity plan. Employers, noting that younger, healthier employees tend to select HMOs over indemnity plans, say the equal contribution rule has forced them to pay more for the HMO than their experience would justify.

Under the legislation, employers only would be required to make non-discriminatory contributions to HMOs. For example, the legislation would allow employers to make the same percentage contribution toward HMOs' premiums as for other health care plans, rather than paying equal dollar amounts to both types of plans.

Also under the legislation, federally qualified HMOs may:

- Sell a wide variety of benefits, such as dental and vision care, on a stand-alone basis.

- Provide up to 10% of physician services through non-affiliated providers.

BI collecting information for annual HMO/PPO issue

Business Insurance will publish in December its second annual special 53rd issue containing directories of health maintenance organizations and preferred provider organizations, along with reports on the state of the alternative health care market.

The directories will be published as a special issue in addition to the regular weekly edition of *BI*. All *BI* subscribers will receive this special 53rd issue of the year free of charge.

In addition to names, addresses and phone numbers of HMOs throughout the country, the HMO directory will provide a wealth of information on individual HMOs, including:

- Federal and state qualification.
- Operational date.
- Model type (group, staff, network, mixed model or individual practice association).
- Tax status (for-profit or non-profit).
- Number of participating primary physicians, and the percent board certified or board eligible.
- Average number of patients per primary physician.
- Number of specialists on staff and specialists available for referral.
- Number of administrative and marketing staff members.
- Number of participating hospitals, pharmacies and diagnostic labs.
- Areas serviced by the HMO.
- Rating options.

- Details on reporting and billing methods.
- Types of services offered, such as prescription drug, dental and vision programs.
- Number of employers contracting with the HMO; and the number of employees, as well as employees' dependents, covered.
- Gross revenues.
- Names and titles of top officers.

The PPO directory will contain similar information on each organization, including details on specialty services the PPOs may offer, how they negotiate hospital charges and methods of utilization review they offer to employer clients.

Along with the directories, the special 53rd issue will feature an in-depth report on the state of the managed care market, including a survey of benefit managers' opinions on HMO and PPO issues.

HMOs and PPOs throughout the United States are eligible to be included in the directories, which are published as an editorial service. There is no charge for companies to be included.

However, HMOs and PPOs that wish to be listed must fill out and return a *BI* questionnaire.

HMOs that have not yet received a questionnaire should contact Christine Woolsey, Editorial Assistant, at 312-649-5460; PPOs should contact Marilou Jones, Directory Editor, at 312-649-5279.

The deadline for alternative health care providers to return completed questionnaires to *Business Insurance* is Oct. 31.

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NACSA/NACSE
CONFERENCE
The Greenbrier

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London market revs up for computers

By CAROLYN ALDRED

LONDON—In a move expected to eventually reduce insurance buyers' costs as well as speed up claims payments, the London insurance market is gearing up to underwrite and place risks and handle claims via a marketplace computer network.

Lloyd's of London plans to centralize its claims-handling operations before joining up by 1990 with the new computerized London Insurance Market Network linking virtually all London brokers and insurance companies and syndicates.

And, as the London company market gears up for processing claims via the network beginning Nov. 7, several pilot programs initiated by several brokers and underwriting agencies to underwrite and place risks via the computer network are under way.

Not only will such a network radically change business in the London market—dramatically reducing the number of brokers scurrying around the city with files under their arms—it also is expected to increase the London market's efficiency and reduce its costs, thus making it much more competi-

tive. For policyholders, that initially means faster claims payments.

And, eventually, when risks are placed via the computer network, policyholders also can expect quicker placement of risks and more competitive rates, supporters of the system say.

In addition, since the system will be more cost-effective and more time-efficient than the current market system, underwriters and brokers can be expected to have more resources to attend to policyholder needs, such as restructuring insurance programs and developing new products and services.

The system also will allow brokers to seek placement for small commercial risks that brokers currently consider uneconomical to place because they generate small premiums.

There is no doubt that the "powerful new technology being introduced will affect our lifestyles," said Robert Mackenzie, a director

of DP Mann Underwriting Agency Ltd., during a series of three seminars last week held to explain the likely impact of electronic insurance trading in London.

More than 1,000 London market executives and employees attended the seminars, which were organized jointly by Lloyd's and the London Insurance Brokers Committee. That large turnout reflects the market's concern and interest in electronic trading.

"We cannot continue in the way we always have. It is a sad thing the market is changing in this way, but it is inevitable, and we have to go with it,"

Dennis Mahoney, chairman of Lloyd's broker Alexander Rowden Ltd., told seminar attendees, who ranged from chief executive officers to administration clerks for brokers, underwriting agencies and insurers.

Currently in the London market, claims are settled by claims brokers who personally visit underwriting claims managers. There is

some but not universal claim settlement coordination among underwriters.

In addition, in placing risks in the London market, brokers must stand in long lines to see every underwriter on a policy whether they are placing a massive risk for the first time or looking for an endorsement to an existing policy, Mr. Mackenzie said at the seminar.

When they get to the front of the line, "they have five minutes to present their case and, if unsuccessful, they go and join another queue," he said.

"If endorsements could be agreed (to) electronically, there will be more time in the (Underwriting) Room for negotiation," Mr. Mackenzie said.

For example, small commercial risks could be placed entirely electronically with no face-to-face contact between broker and underwriter, Mr. Mackenzie said.

This type of risk "lends itself to electronic dealing" because the placement costs are too expensive for brokers, he noted.

The network also would be useful for placing high value risks, agreed Mr. Mackenzie. *Continued on page 53*

'It is a sad thing the market is changing in this way, but it is inevitable,' says Dennis Mahoney.

Benefits forums Reagan official slams mandated care

By JERRY GEISEL

MONTREAL—Requiring all employers to offer health care coverage would be an economic disaster, a Reagan administration official warns.

Mandating health care coverage could force small firms that are unable to afford coverage out of business, while other companies, staggered by the costs, would lay off thousands of workers, predicts David Walker, assistant secretary at the Labor Department.

"In my opinion, mandated benefits are a prescription for disaster," Mr. Walker told the Council on Employee Benefits at its annual fall conference in Montreal Oct. 5-7.

Mr. Walker's views are at odds with those of Sen. Edward Kennedy, D-Mass., the chief congressional proponent of mandated health care coverage.

For example, Sen. Kennedy says businesses should support a federal health care mandate because it would reduce hospital cost-shifting. If all employers offer health care coverage,



hospitals would not have to shift care costs for uninsured patients to insured patients in the form of higher charges, Sen. Kennedy maintains.

But Mr. Walker contends that a health care mandate could actually increase health care inflation by stimulating the demand for health care services.

"You can't add \$27 billion to \$100 billion in health care costs to businesses" and not expect adverse effects, Mr. Walker said.

Sen. Kennedy repeatedly has said that his proposal would require employers to offer only a "minimum" and not a "Cadillac" plan.

But Mr. Walker says the Kennedy proposal gives new meaning to the word "minimum."

Under the Kennedy proposal, approved in February by the Senate

Labor and Human Resources Committee, employers generally would have to offer a plan with individual and family deductibles of \$250 and \$500, respectively. In addition, employers generally would have to pay 80% of the premium for individual and family coverage, and 100% of the premium for low-income workers (BI, Feb. 22).

And, Mr. Walker warns, once such a proposal is enacted, it could set the stage for additional benefit mandates.

"Once you mandate one benefit, where do you draw the line?" Mr. Walker asked. He added that legislators would be inclined to enrich required benefit packages as elections neared.

There already is evidence to support that scenario.

After promising business groups that he would not add to the basic health care package that employers would have to offer, Sen. Kennedy convinced the Labor and Human Resources Committee to accept a revised bill that added mental health care *Continued on page 26*

Asbestos firms launch facility to settle claims

By STACY ADLER

PRINCETON, N.J.—Asbestos producers and their insurers are launching a second attempt at joint claims handling.

Some 21 asbestos producers and about 10 insurers signed agreements last week forming what most observers say is the nation's last chance at handling mass tort claims outside the traditional judicial system.

The new Center for Claims Resolution—a successor to the failed Asbestos Claims Facility—is being run by the asbestos producers and partly funded by their insurers (see story, page 54).

The new claims handling organization is like "a phoenix rising from the ashes," said Scott Gilbert, an attorney with Covington & Burling in Washington, D.C., who helped create both claims-handling organizations.

Mr. Gilbert and other creators of the Center for Claims Resolution see this as the last chance for the massive number of claims to be settled through joint claims handling.

"The major reason that the Center will survive is because if the Center does not survive, there will be little prospect that anything like the Center can ever be developed to deal with this or any other mass tort problem," said Mr. Gilbert. "And for this reason not only will it survive; it has to survive."

Emmett W. Hines Jr., director of government relations in the Washington office of Armstrong World Industries Inc. of Lancaster, Pa., agreed: "It is very important for this organization to survive in order for other manufacturers who might face mass torts to have some hope" of handling their claims outside the tort system.

The former Asbestos Claims Facility was dissolved earlier this year after seven of the largest asbestos producers withdrew (BI, Aug. 1; May 30; Nov. 16, 1987).

The Asbestos Claims Facility was formed in June 1985 when 34 asbestos producers and 16 insurers signed the Wellington Agreement, named for former Yale Law School Dean Harry H. Wellington, who chaired the negotiations that led to the formation of the facility (BI, July 1, 1985).

The Wellington Agreement was the first attempt to resolve mass tort claims more quickly and cost effectively than through the traditional court system.

By signing the Wellington Agreement, insurers agreed to settle their coverage disputes stemming from asbestos bodily injury claims and to provide a joint defense against claims brought by asbestos victims.

Insurers that signed the Wellington Agreement still must pay the liabilities of the asbestos producers they insured regardless of whether those liabilities arise from court judgments or through settlements made by a claims-handling organization.

"Insurers' agreement (under Wellington) to pay liability payments and allocated expenses under the Wellington formulas is perpetual," explained Mr. Gilbert. "The Wellington Agreement explicitly provides that the coverage resolutions (between producers and their insurers) survives withdrawal by members and survives termination of the Asbestos Claims Facility."

In addition to paying for each producer's liability costs, insurers who are supporting the Center for Claims Resolution also have agreed to pay 60% to 70% of the Center's operating costs, said Mr. Gilbert. Producers will pay the remaining 30% to 40% of the operating costs.

One of the most notable difference between the Center for Claims Resolution and the former Asbestos Claims Facility is *Continued on page 54*

PPOs should polish image: Expert

By DONNA DiBLASE

DALLAS—Most employers view preferred provider organizations merely as discount health care arrangements and are skeptical that they really can control health care costs, says a PPO trade group chairman.

As a result, some employers and employer health care coalitions are bypassing existing PPO structures and negotiating their own preferred provider arrangements, which now mainly consist of negotiating discount prices with groups of providers, according to Douglas L. Elden, chairman of the American Assn. of PPOs and a partner with the Chicago law firm of Altheimer & Gray.

But, simply negotiating discount prices with providers is not enough to control health care costs while still providing quality care, warned Mr. Elden during a speech at the AAPPO 1988 Fall Forum, held Oct. 2-4 in Dallas.

In addition to negotiating discounts, PPOs provide utilization review, quality assurance and bill auditing that result in an integrated approach to managed health care, he said.

To avoid being shoved aside by employers who say the PPO industry can't deliver, Mr. Elden advised PPOs to

refine their own products.

If PPOs are going to survive in the managed health care marketplace, they must operate as well-managed, financially sound businesses that control costs by delivering health care in the most appropriate facility for the patient's illness—instead of just relying on discount prices to control costs, he told PPO officials.

"If PPOs are going to manage care and be the vehicle for the transition to completely managed health care, that's what we have to do. You have to deliver what the marketplace wants if you want to survive," Mr. Elden said.

"PPOs are managing care everyday. They're putting people in the right places to receive the appropriate levels (of care) and that's how we're saving money," he asserted.

"But, when I talk to people and say, 'PPOs are great and they are going to lead us to the future of managed care,' they tell me that I'm kidding them. They tell me that PPOs are just plain, old, ordinary discount pricing," he said.

"Employers think of PPOs as loose associations of physicians and hospitals that band together and sell medicine at a discount. And maybe, if you're lucky, (employers) give their employees an incentive to go to the so-called preferred providers," Mr. Elden added.

"The key word here is 'discount,'" he said, warning that "this discount medicine is not good for medicine. People are cutting corners.

"I don't believe in discounts, and I don't think you save *Continued on page 20*



FASB proposal

Continued from page 1

ilities in December, Ms. Scott said.

After the draft is issued, there will be a six-month comment period followed by two months of public hearings, Ms. Scott said.

FASB probably will issue its final regulations in mid-1990, she said.

Although it is too early to estimate exactly the amount of retiree health care liabilities that employers would have to recognize on their financial statements under the revised rules, "the numbers are just staggering—lots of zeros," said Samuel Berger, senior manager of the employee benefits services department of Price Waterhouse in Washington.

Consultants and benefits managers are particularly critical of the period allowed to expense retiree health care liabilities.

The proposed period "com-

presses costs into a shorter period of time, therefore making current costs higher than they would have been" under the tentative conclusions, explained Laura Watson, a partner in the Rowayton, Conn., office of benefits consultant Hewitt Associates.

Shortening the period "is going to add considerably" to employers' costs, agreed A. Herbert Nehrling Jr., assistant treasurer at E.I. du Pont de Nemours & Co. of Wilmington, Del.

Richard Raskin, a consulting actuary in the New York office of the Wyatt Co., opined that ending the period for expensing the benefit with the time an employee is eligible for retirement is "just not sensible from a benefits point of view."

"Benefits involve a lot of people and a lot of probabilities, and the law of large numbers should be applied," he said.

Mr. Raskin explained that when designing retiree plans, benefit

The rules are 'going to add considerably' to employers' costs, says A. Herbert Nehrling of Du Pont.

managers consider the probabilities of how many employees enrolled in the plan will eventually become eligible for benefits and the number of employees eligible for early retirement who will actually take that option.

However, FASB is not considering these probabilities under its proposed accounting rules, he said.

For example, Mr. Nehrling noted that Du Pont has an early retirement plan that allows 50-year-old employees who have worked at the company 15 years to retire with some medical benefits. Under the FASB proposal, Du Pont would

have to expense the cost of its retiree medical benefit plan by the time employees reach age 50.

However, "nobody retires at that time," Mr. Nehrling said. The average retirement age at Du Pont is 61, he noted. "This is why we object to what they're saying," he concluded.

Actuaries had predicted that under the former tentative conclusions, a typical Fortune 500 company with a generous retiree health care plan would expense annually about \$2,000 per employee. The pay-as-you-go costs for retiree health care typically are \$200 to \$400 annually per retiree.

"I don't think the cost is going to change that much in the first 15 years" under the proposal, said Ms. Scott, citing other mitigating factors.

Ms. Scott commented that in developing the proposal "the board members didn't feel comfortable developing an arbitrary practical approach" when dealing with ac-

counting rules.

Requiring retiree health care costs to be fully expensed by the time an employee is eligible for retirement is simply "accounting for a contract."

When the contract is fulfilled—when the employee has fulfilled the age and service requirements to be eligible for retirement—the accounting for that benefit should be complete, Ms. Scott explained.

"Every plan tells you when you are first entitled to receive benefits—that's the only thing that's certain," she said.

She also pointed out that "pensions and other deferred compensation promises are accounted for based on the contract" defining when the employee is eligible for the benefit.

"We can make pragmatic decisions in some areas," she said. However, because of the variations between all of the retiree health care plans offered by the nation's employers, the board had difficulty developing a condition that would require attribution beyond the eligibility date, she said.

She noted that the board met five times to discuss the issue and that the final vote was 4-3.

Mr. Raskin predicted that many employers will limit benefits under their retiree health care plans if the proposed FASB rules are adopted.

He predicted that some employers will "provide an allowance toward health insurance instead of outright health insurance, perhaps under a flexible benefits arrangement."

Some employers may reduce the benefits offered to employees eligible for early retirement or reduce their eligibility for early retirement, he said.

"Other employers may put 'inside limits' on the health insurance," such as limiting drug payments, Mr. Raskin also suggested.

And, some employers may set payment schedules for procedures, based on today's prices, regardless of future increases in the costs of those procedures, he said. In that case, Mr. Raskin quipped, "the employee is the winner": The employee "gets the booby prize—inflation."

Some employers, though, say they do not intend to change their retiree health care plans as a result of the FASB rules.

"The key is to try to contain health care costs" in general, said Mr. Berger of Price Waterhouse.

He added that the FASB rules "won't heighten concern (about costs) because it's already up there at a very high level."

Arthur Young, benefits manager at Hewlett-Packard Co., said the Palo Alto, Calif.-based company does not expect to change its benefits package in light of the revised FASB rules because the company already has changed its retiree health care plan several times in the last five years due to a "broader interest in controlling costs."

Fred Hamacher, vp of compensation and benefits for the Dayton Hudson Corp. in Minneapolis, said "the FASB rules are not going to affect us that badly."

He explained that the company's retiree medical plan is a defined contribution plan "so the liabilities for our company are not that bad."

"This is a big addition of liability," Ms. Watson of Hewitt observed. She explained that many workers eligible for retirement do not receive Medicare. As a result, an employer's retiree health care liabilities would be greater under the proposed FASB rules than the liabilities would be in later years after workers actually retire and become eligible for Medicare.

Furthermore, employers must take into account the high medical inflation rate when reporting these liabilities, she noted.

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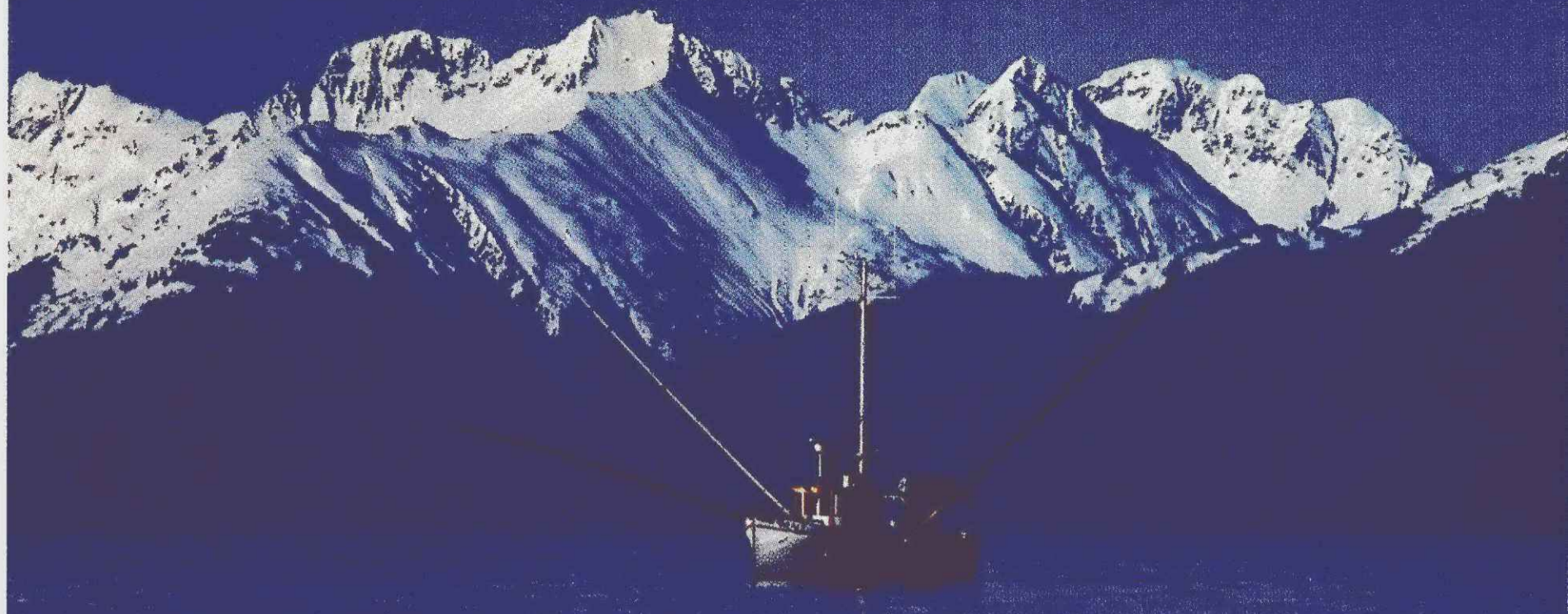
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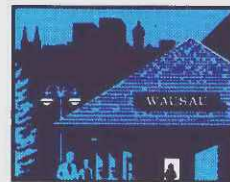
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INSURANCE**

ESOP to fund firm's 401(k) contributions

By GLENN HUNTLEY

A Texas natural gas and petroleum producer will use a leveraged employee stock ownership plan for making matching contributions under its 401(k) plan.

Under the plan, approved Sept. 29 by the board of directors of Houston-based Texas Eastern Corp., the company will purchase \$60 million of its common stock for the ESOP by the end of this year. The stock purchase will represent about 4% to 5% of the company's outstanding shares.

Texas Eastern will borrow the funds for the buyback from an asset-undetermined lender, the company announced.

Distribution of Texas Eastern stock will begin in January to participants in the company's 401(k) salary deferral plan as the employer's

matching contribution. The ESOP periodically will match employees' 401(k) contributions according to a formula based on the employee's length of service, Texas Eastern said.

More than 93% of the company's 7,000 employees nationwide participate in the 401(k) plan, a spokeswoman said.

There are no ESOP provisions for employees who do not participate in the 401(k) plan.

The purchase of stock for the ESOP will be made at the best possible price available before the end of the year, the spokeswoman said. The value of future matching contributions of company stock will be based on the original purchase price

of the stock.

Texas Eastern stock, which is traded on the New York Stock Exchange was trading at \$25.93 per share when the board approved the arrangement late last month.

Texas Eastern is a holding company involved in natural gas and petroleum products pipelines and international oil and gas exploration and production.

Union health benefit

A labor union representing workers in three states has turned to a regional preferred provider network to reduce costs of the union's self-insured health care

program that had been losing up to \$2,700 a day.

Kansas City, Mo.-based Operating Engineers Local 101 has selected HealthNet Regional Managed Care Network of Kansas City for its 4,000 members.

Under the preferred provider arrangement, union members pay lower copayments if they receive care from a preferred provider, said Ed Cosler, consultant with Cosler & Associates in Kansas City, who arranged the program.

In addition to HealthNet providers, some union employees in Kansas will be served by Preferred Health Care of Topeka and members in Southern Illinois and almost all of Missouri will be served by Health Link of St. Louis.

Other providers of health care and administrative services in-

clude American Benefit Plan Administrators, a third-party administrator based in Los Angeles; Kimberly Quality Care, a home health care provider; Medical Care International, a chain of free-standing surgical centers; ChiroNet, a chiropractic network; Preferred Mental Health, outpatient mental health services; Universal Home Care Inc., durable equipment services; and I-Care, home intravenous services.

HealthNet will act as the control plan for the participating PPOs.

The plan includes utilization review and quality assurance measures provided by other firms, Mr. Cosler said.

All of the providers have agreed to a common system of cost and quality controls, he added.

The network consists of 71 hospitals and more than 3,500 physicians located in Kansas, Missouri and Southern Illinois.

Under the new arrangement, the annual deductible is \$200 per covered individual for preferred or non-preferred provider services.

When preferred providers are used, the plan pays 85% of the next \$4,000 to a maximum out-of-pocket expense of \$1,000 above the deductible. It pays 95% of amounts above \$4,000 to a plan maximum of \$75,000 per individual.

For non-PPO services, the plan pays 70% of the first \$6,000 to a maximum of \$2,000; and 90% of the amount above \$6,000 to the plan maximum of \$75,000 per individual.

"We are excited that we were able to enhance the health care benefits of our members at an affordable cost in a time when many business and labor organizations are decreasing their benefits or, at best, leaving them the same," said Sam Long, Local 101 president.

The Operating Engineers union is the third labor group to join HealthNet since the provider created a pilot program for the Central States Teamsters in early 1987. The plan serves more than 21,000 people regionally.

Coalitions join forces

A coalition of employers and health care providers in New Britain, Conn., has joined forces with the larger, statewide Business Coalition on Health.

The merger of the South Central Connecticut Health Care Coalition, based in New Britain, with the statewide business group will boost the latter's representation to more than 150,000 employees.

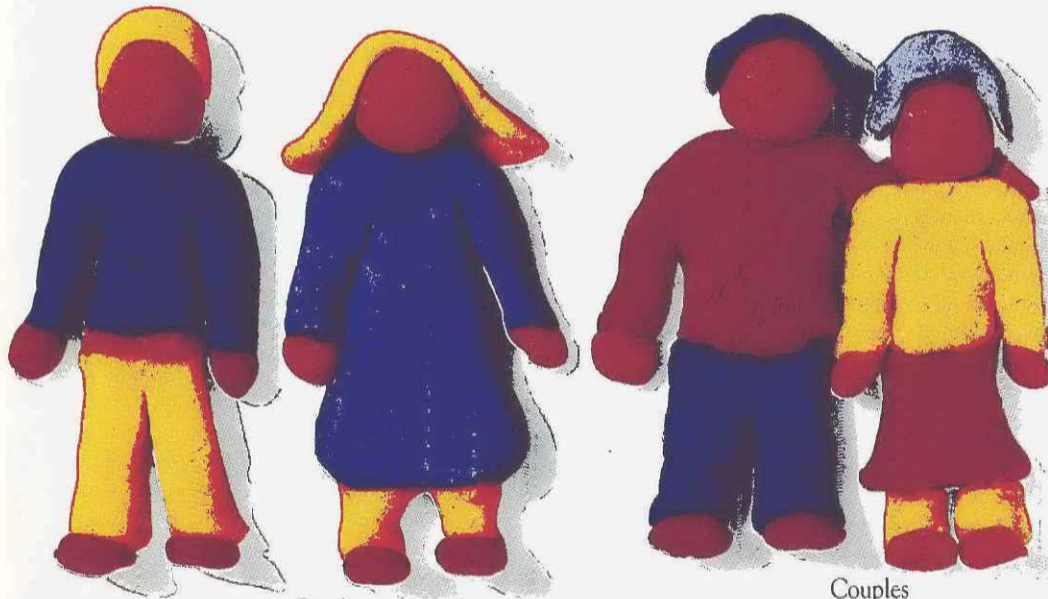
"The time is right to merge with the larger Hartford coalition. Our work in Central Connecticut has made a significant impact. Now we must be concerned with health care at the state level," said Richard Hines, SCCHCC chairman.

Projects conducted by the SCCHCC, which was founded in 1984, include an extensive study of local physician practice patterns and the development of company programs to help control escalating health care costs in the region.

The Business Coalition on Health's increase in membership "helps us represent the interests of all health care consumers on such key problems as rising hospital costs and access to affordable medical care," said Worth Loomis, the state coalition's chairman.

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

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Opinions

Improving annual statements

THE FINANCIAL HEALTH of property/casualty insurers and reinsurers will be somewhat easier to determine beginning in 1990.

That's when property/casualty insurers and reinsurers will be required to disclose for the 1989 year whether reinsurance payments owed them are overdue or in dispute (see story, page 12).

These changes in the content of statutory financial statements will reveal two important facts: how much in reinsurance payments owed a cedant are overdue or in dispute—and, thus, of questionable value—and which reinsurers are slow payers.

The new accounting rules requiring this change were approved earlier this month by the National Assn. of Insurance Commissioners' Blanks Task Force, which has rule-making authority over the content of statutory financial statements.

The amount of potentially uncollectible reinsurance at large is of great concern. To the extent that ceding companies claim credit for reinsurance recoveries they will never receive, they are overstating their net worth.

Advocates of the new rules say they will encourage more timely payment of reinsurance claims, and financial statements will more accurately re-

flect the amount of reinsurance payments ceding companies are likely to receive.

However, the new rules do not, unfortunately, require ceding companies to reduce their reported surplus by amounts of reinsurance overdue.

The NAIC's Blanks Task Force deferred action on a proposal that would require ceding insurers to write off 20% of reinsurance recoverables more than 90 days overdue.

We urge the NAIC to adopt a penalty to surplus for overdue reinsurance. And, we encourage the NAIC to adopt the earlier version of that proposal that called for the percentage of write-off to increase as the delinquency of the reinsurance due increases (*BI*, June 27).

A penalty to surplus for overdue reinsurance truly would result in a more accurate portrayal of a ceding company's financial strength.

Until such a penalty is adopted, however, careful readers of the statutory financial statements filed in 1990 and beyond at least will be able to determine how much reinsurance is of questionable value and do their own math. And, ceding companies will have a new source of information about which reinsurers are notoriously slow payers.

Letters

Subject of story disputes conclusions

To the editor: This letter is in response to Douglas McLeod's article, "Georgia Says Teale's Firm Cannot Write for Victoria" (*BI*, Oct. 10).

A review of the article reveals that it is highly inaccurate both by implication and in fact.

For example, the article's headline is incorrect because until Georgia issued the recent cease and desist order, which applied to all business written for Victoria, Georgia had never issued any ruling that in any way would be applicable to TRT Associates Inc. or any of its affiliates.

Your article also heavily relies upon quoting Charles Gordon-Seymour—who, incidentally, is no longer with Victoria Insurance Co. Ltd.—as stating "that TRT and Mr. Teale have no binding authority for Victoria." However, the long-established course of dealings between TRT and Victoria would indicate otherwise, but no reference is made to that fact in the article.

Your article also discusses the disapproval of an underwriting management agreement between TRT and Victoria, which had been submitted by Victoria for approval on Sept. 12, 1988, as part of seeking approval of a change of ownership.

It should be noted that the agreement in question was drafted by Victoria and submitted by Victoria for approval. It should also be noted that Georgia law only requires the approval by the insurance commissioner of contracts under which a person manages an insurer to the substantial exclusion of its board of directors or under which a person has the control or pre-emptive right to produce substantially all of the business for an insurer.

If one accepts only half of what Mr. Gordon-Seymour has been apparently quoted as saying, it would seem obvious that any agreement that he would have

considered and submitted on behalf of Victoria would not fall within the above categories in any case.

Your article also alluded to my previous connection with the Insurance Exchange of the Americas. Please be aware that I left the exchange in February 1984 upon completion of a three-year contract. The exchange was declared defunct three years later for reasons that have been cited as being related to underwriting. I was at no time an underwriter within the exchange. Your attempt to relate the two matters in your article cannot be understood.

In summary, after reading your article, one would think that Victoria's current regulatory situation arose out of some action or inaction on the part of TRT Associates Inc. However, a review of the actual and only order issued by the Georgia Insurance Department clearly indicates otherwise.

We have cooperated fully with the Georgia department in connection with the Victoria situation. While we recognize the importance of the press, we firmly believe that the Victoria situation can best be handled if innuendoes and inaccuracies are avoided by all concerned.

We would hope that in the future, if any organization with which I am connected elects to offer no comment to an inquiry from your publication that such action will not be construed to be a verification of information you may have received from some other source.

In this instance, it related to an undertaking given to an insurance company and my word is my bond. We have suffered at your hands in consequence because I would not break that undertaking.

Alan Teale
TRT Associates Inc.
Atlanta

■ *Editor's note: Business Insurance's article in the Oct. 10 issue was accurate, as a comparison of this letter with the article will show.*

Review which side you take in the fight

To the editor: The very enlightening perspective, "Catch-22: Insurers' Argument Would Make Coverage Worthless" (*BI*, Sept. 26), by Messrs. Saylor and Fram should serve to wake up the business community to the fact that the insurance industry will go to whatever lengths possible to run from paying

claims—even if they border on the ridiculous.

As I noted in my book, "Payment Refused," "the insurance industry has been pulling the same stunts against the big boys as it has been against the little guy."

As a consumer lawyer, I have been representing policyholders for 20 years who have been victims of insurance bad-faith claims practices. This article should be required reading for every business, small and large, that may have a claim someday. It should really be an eye-opener for any businessman or risk manager who thinks the insurance company is his friend.

Ironically, the business community has supported the insurance industry for years in its drive to reform tort laws. This means the business community has been partners with the insurance industry in attempting to narrow remedies for policyholders as well as individuals.

When will the business community join other consumer groups and help preserve and protect laws that give policyholders meaningful remedies?

William M. Shernoff
Shernoff, Scott & Bidart
Claremont, Calif.

Abortion 'benefit' cause for concern

To the editor: I was intrigued by Doug Palmer's letter, "Cover Photo is Personal Affront" (*BI*, Aug. 29). It is too bad that the fundamental human right to life has become a partisan issue in this presidential election; yet it has.

There is an even more important concern here for people who make their livelihood in the insurance industry. It is that many insurance companies do finance and promote the destruction of defenseless and innocent human life through health insurance contracts.

I would urge those employers who think they are providing an incentive by including unlimited abortion coverage as a health "benefit" in their employee benefit plans to be sensitive to the moral abhorrence that many people have to this procedure in many of the circumstances in which it is used.

Providing this coverage as a "benefit" just further legitimizes an action that a person may be tempted to consider during a time of darkness and despair.

Joe Theisen
Wausau, Wis.

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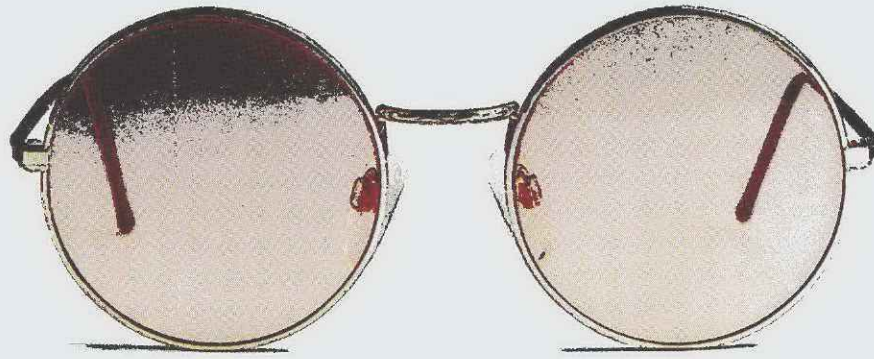
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Rules to spot slow-paying reinsurers

By MEG FLETCHER

NASHVILLE, Tenn.—Slow-paying reinsurers will be more identifiable under new accounting rules approved earlier this month by the National Assn. of Insurance Commissioners' Blanks Task Force.

In addition, the measure "will help identify ceding companies that may be overstating their net worth despite a body of uncollectible reinsurance," said Kenneth W. Smith, who heads the NAIC's Study Group on Property/Casualty Reinsurance.

The Blanks Task Force acts on behalf of the NAIC and its actions are final.

The amendment increases the annual statement disclosure requirements for property/casualty insurers that cede business to reinsurers. The measures go into effect for 1989 statements, which will be filed in March 1990.

Ceding insurers will be required to disclose the length of time that amounts recoverable

from reinsurers have been outstanding.

The amendment changes Schedule F, Part 1 A, Section 1 of the annual convention statement, which lists ceded reinsurance. Reinsurance recoverables not in dispute on paid losses will be reported in four categories: recoverables currently due; recoverables overdue 30-90 days; recoverables overdue 90-180 days; recoverables overdue 180 days and longer.

The determination of when a reinsurance payment is "due" will be based on the terms of the contract. Depending upon the contracts, reinsurance payments are due immediately, monthly, quarterly or even annually.

Ceding companies also will be required to disclose disputed reinsurance recoverables in footnotes if the amount in dispute with one reinsurer exceeds 5% of the cedant's surplus or if the amount in dispute with more than one reinsurer exceeds 10% of surplus.

Supporters expect the measure will encourage more timely payment of reinsurance

claims and result in financial statements that more accurately reflect the amount of reinsurance payments likely to be received.

However, the NAIC's Blanks Task Force deferred action on a proposal that would require ceding insurers to write off 20% of overdue reinsurance amounts against their capital and surplus. Such a write-off would be required only if the reinsurance was at least 90 days overdue, according to the proposal.

That proposal was referred to the NAIC's Accounting Practices and Procedures Task Force for further discussion, said Mr. Smith, who is deputy director for the Illinois Insurance Department's property/casualty division.

An earlier version of that proposal called for the percentage of write-off to increase as the delinquency of the reinsurance increased.

In another matter, the NAIC recently amended its accounting manual to deny a ceding company credit for reinsurance recoverable in a dispute with an affiliate.

Norad Re insolvent by \$50 million

By ROGER SCOTTON

HAMILTON, Bermuda—Norad Reinsurance Co. Ltd., a subsidiary of Philadelphia-based Berwind Corp., is insolvent by an estimated \$50 million and has entered voluntary liquidation.

Norad decided to liquidate earlier this month at a meeting of its creditors in Bermuda on Oct. 10, after it failed to negotiate a commutation of its liabilities with the insolvent Mutual Fire Marine & Inland Insurance Co. of Philadelphia.

That commutation agreement, which would have reduced Norad's \$22.7 million obligation to Mutual Fire to about \$3 million, initially was supported by Mutual Fire's rehabilitator, the Pennsylvania Insurance Commissioner.

The recommendation in January to the Commonwealth Court of Pennsylvania, which has jurisdiction over the Mutual Fire rehabilitation, to accept the commutation was withdrawn in August.

It was withdrawn "after concerns arose over the impact of the commutation as opposed to alternative courses of action and consideration of Berwind's potential liability for Norad's obligations," said Gregory Miller, an attorney for Mutual Fire's rehabilitator with the firm of Hoyle, Morris & Kerr in Philadelphia.

The Norad commutation had been premised upon an agreement by Mutual Fire to waive any rights it may have against Norad's parent, Berwind Corp.

Mr. Miller explained to the court that issues "exist regarding Berwind and its officers' and directors' possible liability in this matter."

Mutual Fire's committee of policyholders had objected to the commutation and urged legal action against Berwind directly to pierce the corporate veil.

According to the committee, Berwind formed Bryn Mawr Assurance Corp. as a Vermont captive in October 1986 and set up a new fronting arrangement with former Norad cedant, National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc.

"Berwind shifted its self-insurance program to Bryn Mawr, leaving Norad to collapse at the expense of Norad's third-party creditors once its continued existence no longer served Berwind's purposes," the committee said.

Norad was set up as a single-parent captive before it began writing commercial reinsurance, said Norad's liquidator, Christopher Whittle of the accounting firm of Ernst & Whinney in Bermuda.

"It appears that Norad stopped writing unrelated business around the end of 1985, but this business had a tail which seems to have since developed adversely for them," he said.

Mr. Whittle said Norad was managed by James (Bermuda) Ltd., a unit of Sedgwick Group P.L.C.

Neither James in Bermuda nor Norad President and Berwind Risk Manager Martin Hahn would comment on the insolvency.

Mutual Fire's rehabilitator last month sued Norad in Pennsylvania seeking recovery of amounts due plus interest.

Mr. Whittle declined at this time to release figures on Norad's assets and liabilities underlying his estimate of a \$50 million deficiency.

Mr. Whittle says he plans to report to Norad's creditors by the end of the year.

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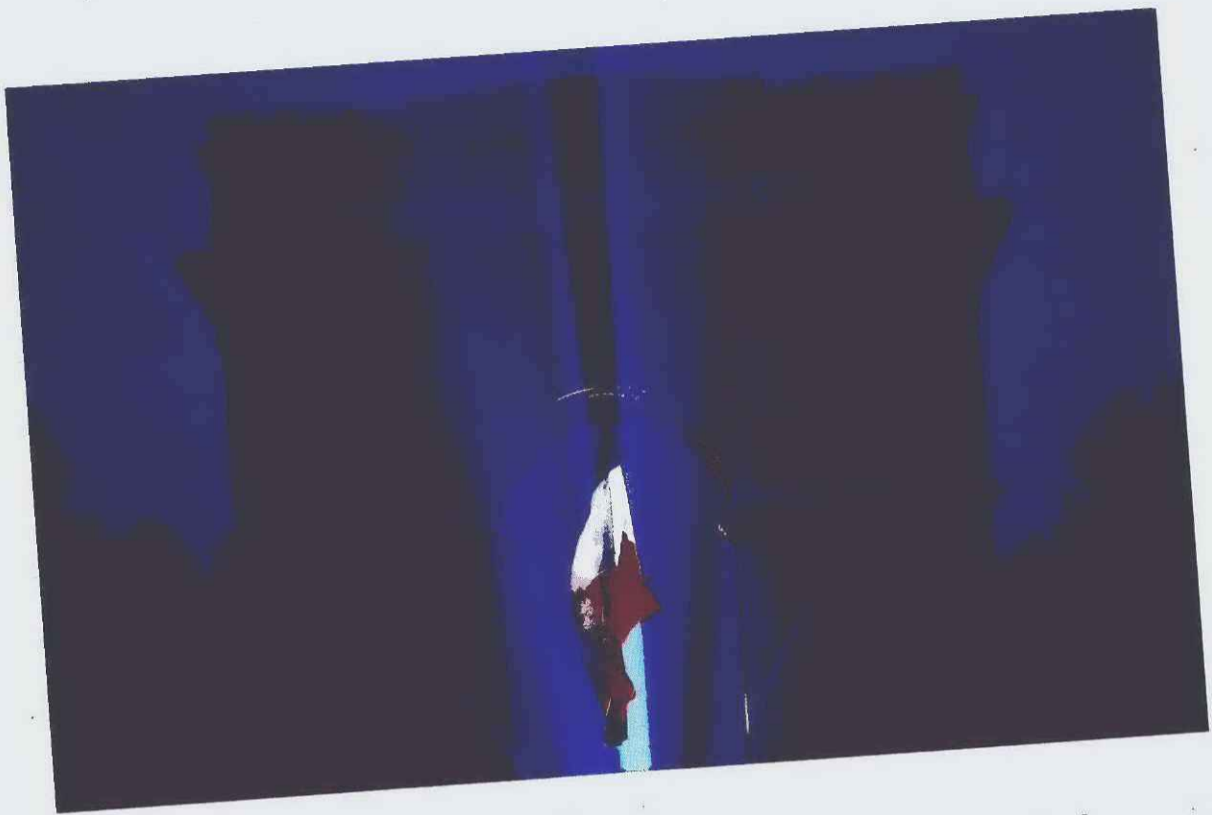
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Alternative markets offer risks, rewards

By KATHRYN J. McINTYRE

WHITE SULPHUR SPRINGS, W.Va.—Alternative risk financing vehicles can perform better than the conventional insurance market, contends a risk manager.

But, risk financing alternatives may find certain risks are unaffordable to insure under the current tort system, warns an insurance company executive.

Either way, insurance brokers must consider alternative markets, says a broker, because the traditional market is not always available and risk managers believe alternative markets can help stabilize rates.

These views were expressed during a panel discussion on "Alternative Markets: A Search for Stability?" during the joint meeting earlier this month of the National Assn. of Casualty & Surety Agents and the National Assn. of Casualty & Surety Executives at The Greenbrier (BI, Oct. 10).

Alternative markets—including captive insurance companies and risk retention groups—"create coverage where none existed," said Thomas D. Lewison, executive vp and chief operating officer of ICI Mutual Insurance Co. in Washington, D.C., an association captive.

"We're not looking for cheap insurance. We are funding them adequately and taking a conservative underwriting approach," he said. "We are looking to stabilize prices."

Alternative markets should be careful in assuming that they can fund risks that the traditional insurance companies have found they cannot, advised David A. Kocher, president of the Commercial Lines Division of Aetna Life & Casualty Co. in Hartford, Conn.

In the past, large companies that could afford to do so self-insured, or businesses with special needs and exposures too big for one insurance company sought alternative markets, he said. Today alternative markets are "driven not by the characteristics of the insured but by concerns with the liability system," Mr. Kocher said, and the traditional markets' "inability to respond to the changes in the liability system."

Large insurance companies, he pointed out, thought they knew the definition of occurrence and the definition of property damage when they issued policies, but the courts have changed the definition and held insurers liable for losses they did not think they had insured.

Insurers then found they couldn't handle some of the risks, Mr. Kocher said, and alternative markets were formed for risks such as medical malpractice, product liability, directors and officers liability other professional liability and environmental liability.

But, he said, "There are inherent limitations in any of these alternative mechanisms," because there are problems that can't be solved by new forms, higher retentions or pooling—the underlying problems in the liability system.

For alternative markets to believe they can fund these same risks is "a little dangerous," Mr. Kocher said.

"My concern is that the courts change the rules and medical society comes up with new definitions of injury," he explained.

And meanwhile, alternative market users think they have solved the underlying problems of the tort system. "This allows us to go back to sleep on what the courts are doing to this business," Mr. Kocher said.

Aetna, he noted, has paid \$1 billion gross and \$400 million net on asbestos bodily injury claims. "Most is behind us now," he added.

Mr. Kocher cited environmental liability as the most "striking example" of alternative markets funding a risk that traditional insurers believe only through "careful underwriting and restrictive coverages" can some policies be issued.

"The reality is that a lot of businesses will be living with the illusion of protection which isn't going to be there when necessary," Mr. Kocher said. "The liability system needs to be reformed" and without reform "real insurance protection for these risks will remain very problematical."

Mr. Lewison agreed that alternative risk financing markets are faced with the same tort system as

NACSA/NACSE CONFERENCE The Greenbrier

traditional insurers. But, he added, "It seems the insurance industry has found it necessary to back away from quite a bit" of business.

As a result, he said, risk managers had no choice but to use alternative risk financing vehicles.

"Essentially, we wanted stability and predictability," said Mr. Lewison, who was the risk manager for Rorer Group Inc. in Fort Washington, Pa., before recently accepting his post with the captive for mutual funds and investment advisers.

And risk managers are staying with their alternative vehicles be-

cause they are "tired of being whipsawed by the traditional market, he said.

"Risk managers have lost faith in the traditional market," Mr. Lewison said, pointing out that he has yet to find an insurer who is committed to writing particular types of coverage for the long-term.

Risk managers' expectations of insurers' commitment to markets is such that they consider a "long-term relationship any day beyond the 60-day cancellation notice," he quipped.

Timothy N. Thoelecke, president

of Great Lakes Agency Inc. in Chicago, agreed that risk managers "have found alternative funding mechanisms one method of solving their affordability and availability problems."

But, Mr. Thoelecke also pointed out, "Regulation is a problem." Illinois Insurance Director John Washburn, Mr. Thoelecke said, has commented that it is difficult to determine which groups are being formed for professional reasons and which are for profiteering.

The duty of agents and brokers, Mr. Thoelecke said, is to "seek whatever markets are available to our clients. This includes all aspects of the insurance mechanism."

But, he also advised, agents and brokers have to "analyze these markets" for their financial security.

Continued on next page



Mr. Thoelecke

How Fayrene Feinglas went



Mr. Kocher

Even when Fayrene Feinglas was in high school, it was easy to see she'd be going places. Her ability and determination had already earned her a "Most Valuable Player" award and a chance to compete in the Arkansas All-State Girls Basketball Championship.

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Continued from previous page

Mr. Kocher pointed out that "Aetna's first obligation is to return a reasonable profit to its shareholders."

Mr. Thoelecke agreed, commenting, "Without a philosophy of producing a return to shareholders, companies won't be around."

Mr. Kocher also pointed out that Aetna is participating in alternative markets.

By alternative markets, he said, he means "all the underwriting markets other than those provided by individual admitted carriers using essentially standard forms. This includes surplus lines carriers, service-only companies, risk retention groups, purchasing groups, single-company or association captives, excess or first-dollar pools, and so forth."

Mr. Kocher pointed out that, "together, these alternatives offer a significant amount of much needed flexibility in spreading insurance risk."

Aetna, Mr. Kocher said, has competed for this business in the past through service companies and syndicates and "in the future, we expect to do this more aggressively through our newly announced service company, Axia."

Axia Services Inc. will provide unbundled insurance-related services to companies that self-insure or are otherwise involved in the non-traditional market.

"I don't need to repeat for you that being unable or unwilling to provide coverage for your customers isn't

good business," Mr. Kocher said. "We have to find ways to accommodate our customers' needs."

"Part of the answer was tort reform, which I believe is absolutely essential. And we want to continue to pursue that reform," he said.

"Another part was developing innovative products and risk sharing approaches so we could provide the coverage we couldn't handle alone or in traditional ways."

Aetna is a member of the American Excess Insurance Assn., a consortium of insurers that provides high limits of general liability insurance. And, Aetna helped form Executive Risk Management Associates to write D&O coverage.

In addition, Aetna participated in the syndicate of insurance companies created to insure nurse-midwives.

Mr. Lewison also pointed out that "insurance in many cases is not the most economical vehicle," and accused business of "misusing the insurance industry in soft markets," by dropping deductibles below what businesses should maintain.

Panel moderator George C. Hill, executive vp of Rollins Burdick Hunter of Northern California in Oakland, Calif., observed that \$1,000 deductibles in the soft market were increased to \$5,000 or \$10,000 in the hard market and now insurers are offering \$1,000 deductibles again. ■

Pricing cycle problems confront insurers: Panel

By KATHRYN J. McINTYRE

WHITE SULPHUR SPRINGS, W.Va.—The property/casualty insurance industry must solve the problem of insurance pricing cycles, adjust its rates to reflect its higher tax liability and fend off federal regulation, according to a panel of industry leaders.

But, while the panelists agreed on the important problems confronting the property/casualty insurance business, they did not always agree on the best solutions.

Six industry experts were assembled for an open roundtable discussion during the joint meeting of the National Assn. of Casualty & Surety Agents and the National Assn. of Casualty & Surety Execu-

tives held earlier this month at The Greenbrier (BI, Oct. 10).

Joseph W. Hamilton Jr., chairman of Hamilton Dorsey Alston Co. in Atlanta, said commercial insurance buyers are confused by insurance pricing cycles, citing as an example the roller coaster in fleet insurance premiums a company can face.

A company that paid \$300,000 for fleet insurance in one year when the company had 20 bad drivers can get rid of the bad drivers and yet see its premium go up in a hard market.

If the company then gives up on loss control because its efforts do not seem to influence insurance prices, the premium can then drop to \$120,000 in a soft market, Mr. Hamilton said.

"He doesn't understand," Mr. Hamilton said of the insurance buyer, eliciting applause from the agents in the audience.

"Joe is right," said Morgan W. Davis, president of the Commercial Insurance Division of Fireman's Fund Insurance Cos. in Novato, Calif. "The customer wants capacity, stability and pricing they can understand. What confuses them is the cycle."

Mr. Davis suggested that certain changes in property/casualty insurance company accounting rules would help dampen the pricing cycles: requiring independent certification by actuaries of an insurer's loss reserves and requiring insurers to carry their bonds at market value.

Independent certification of loss reserves would temper insurers' tendency to understate loss reserves in a competitive market to maintain low pricing and then supplement those loss reserves in a hard market when higher prices can be charged, he said.

This approach "would help us keep some financial discipline," Mr. Davis said.

Fireman's Fund obtains this outside actuarial advice on how much it should maintain in its loss reserves, Mr. Davis said.

Carrying bonds at market value also would dampen the pricing cycle because it would reduce insurers' surplus at times of high interest rates when insurers otherwise are inclined to write more premiums for the cash to invest. Currently, bonds are carried at cost and, as a result, a reduction in their market value is not reflected in insurers' financial statements, allowing them to write more premiums for cash flow at times of high interest rates.

Robert J. Vairo, president and chief executive officer of Crum & Forster Inc. of Morristown, N.J., agreed with the need for "balance sheet discipline" among insurers, but disagreed with Mr. Davis' suggestions for achieving it.

Two different sets of actuaries will recommend different amounts needed for loss reserves because so much judgment is involved in setting loss reserves, Mr. Vairo pointed out.

In addition, "there are not enough actuaries in the country to even get at 3,500 companies' reserves more than once every five years," he said.

Furthermore, if insurers were required to carry bonds at market value, insurers probably would shift their portfolio to very short-

Continued on next page

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Mr. Vairo

Pricing cycles

Continued from previous page term investments, and that would create problems, he said. Insurers need to balance their portfolios against their cash needs, recognizing that long-tail liability line losses will be paid years in the future.

Instead of Mr. Morgan's approach, Mr. Vairo suggested that "balance sheet discipline is having enough money to pay claims and expenses we incur. That gets back to having an adequate price at the front end. You can't have adequate reserves if you cut prices below cost.

"To achieve balance sheet disci-

While ISO originally predicted that new tax law would cost the insurance industry \$7.5 billion in additional taxes over five years, 'That number is going to be exceeded significantly,' says Robert J. Vairo of Crum & Forster.

pline, each risk bearer has to know the adequate price and communicate that down to the desk underwriter," he said.

Richard M. Page, chairman and chief executive officer of Fred S. James & Co. Inc. in New York, called for a "blue ribbon panel of industry leaders, government peo-

ple and customers" to study the problem of insurance pricing cycles and recommend solutions to the industry and perhaps to Congress.

The McCarran-Ferguson Act of 1945 was the result of such a panel, he said.

"Our challenge and opportunity

is to make happen together what we want to happen to maintain this industry. We have the leadership capability," he said.

One factor that could curtail insurance industry price cutting is the new taxes the insurance industry owes under tax reform.

However, the panelists said they do not believe all insurers are taking their new tax liabilities into account when pricing insurance.

"Companies have not paid attention to the '86 tax act. This is going to impact surplus," said Dell G. Van Gilder Jr., president of The Van Gilder Insurance Corp. in Denver.

Mr. Vairo of Crum & Forster observed: "Although there has been a

lot written on the subject, it is not generally understood on the company side."

The Insurance Services Office Inc. originally predicted that the changes in the tax law would cost the insurance industry \$7.5 billion in additional taxes over five years, he said. "That number is going to be exceeded significantly. The number is \$16 billion to \$19 billion."

As a result, if insurers are targeting a specific return on equity, insurance prices will have to be increased to achieve the same return considering the higher taxes, he said.

"There is no evidence in the marketplace that the effect of the Tax Reform Act is being factored into pricing," he said.

Mr. Davis pointed out that Fireman's Fund paid \$100 million in taxes last year, which was more than the insurer had paid in its previous 124 years of business.

"We adjusted our pricing around the fourth quarter of 1987," Mr. Davis said. "I've heard not all companies have."

Mr. Page commented: "I've heard a number of people say they have adjusted their pricing, but rates continue to decline 15% to 20% across the board. I don't know where the two ends meet."

Mr. Davis responded: "Our revenues are off 15% because we're having a tough time writing business" at Fireman's Fund's rates.

In response to a question, Mr. Vairo noted that ISO "does not and should not take taxes into consideration" when calculating the indicated rate for various types of insurance.

The possibility of federal regulation of the insurance business also concerned the panelists.

"I appeal to agents on McCarran-Ferguson," Mr. Vairo said. "You may think it's our problem as insurance carriers. If it is repealed, it will be one big problem for you in day-to-day marketing. Each company will have its own forms, own rates. You'll have to sort that out."

Mr. Vairo pointed out that the insurance business was exempted from antitrust laws because "our business is significantly different from any other," in that it collects premiums today to pay claims years in the future. Insurers need "the ability to gather statistics to know the true cost of spreading risk," he said, calling the insurance market "disorderly enough today."

Repeal of McCarran-Ferguson, Mr. Vairo said, "will affect everyone in this room. I urge you to let your federal legislators know where you stand. We don't need federal regulation."

Jack S. Hupp, president of Seibels Bruce Group Inc. in Columbia, S.C., said that "as a regional insurer, repeal of McCarran-Ferguson would have more effect on our company than on the national companies."

But, he added, "I don't believe state regulation will be eliminated. If McCarran-Ferguson is done away with, we'll have state regulation in the long run but a harder process of doing business."

Mr. Van Gilder commented that the insurance industry may successfully defend against the anti-trust suits brought by 19 attorneys general, but the end of that case could be two to three years from now, just when the insurance industry may enter another hard market with rising insurance prices. Another hard market "could be significant to the attitude of legislators," he advised.

Mr. Page also warned that there is "great potential for harm" in the outcome of the attorneys general's suits, "particularly if we lose ISO as an information source."

The panel was moderated by Harry F. Custis, chief executive officer of The CIMA Cos. Inc. in Alexandria, Va. ■

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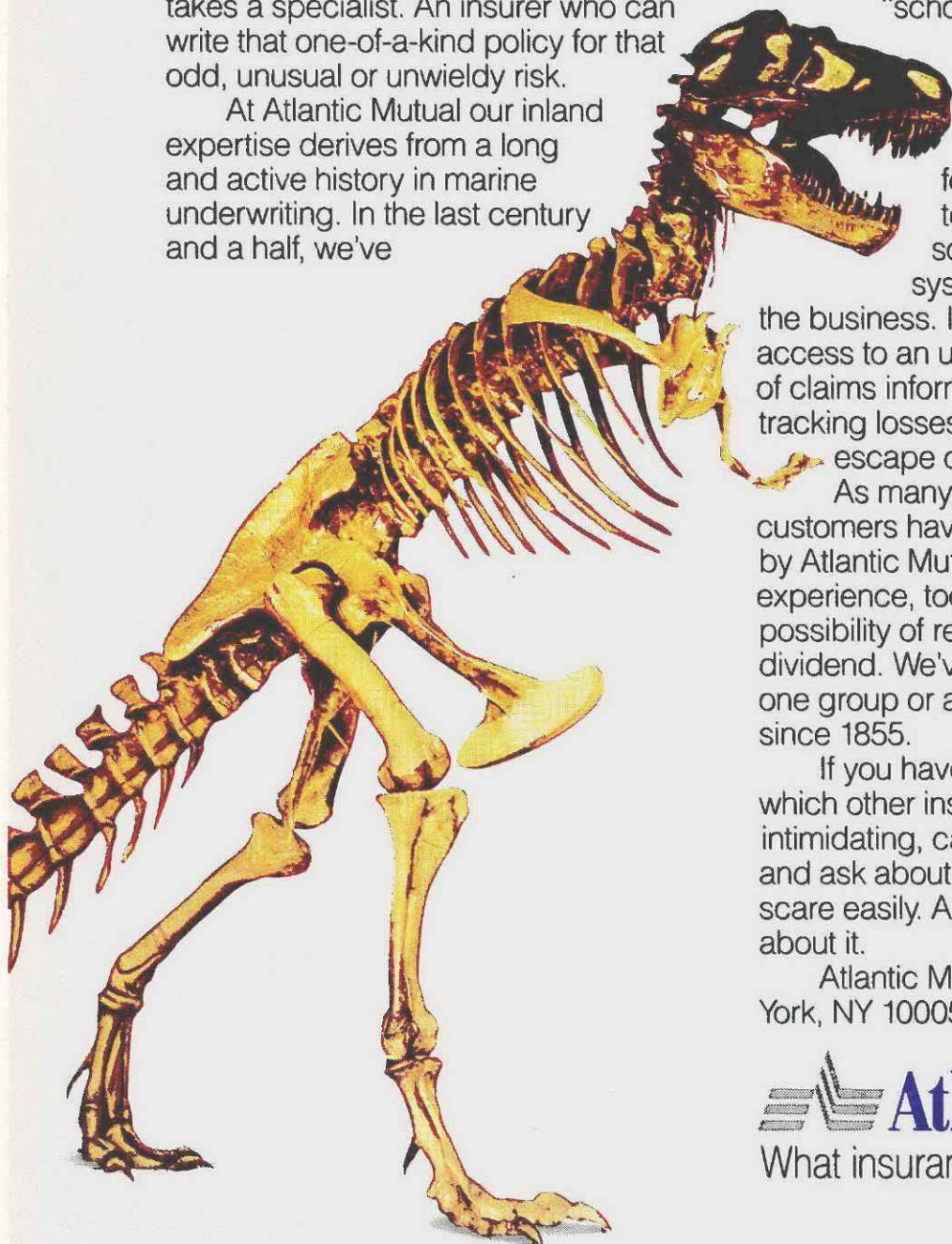
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Guaranty funds necessary: Regulator

By KATHRYN J. McINTYRE

WHITE SULPHUR SPRINGS, W.Va.—The state guaranty fund system neither hinders nor helps the regulation of insurers for solvency but is necessary to protect policyholders, maintains the president of the National Assn. of Insurance Commissioners.

"The guaranty fund system has had no impact on regulation," said John E. Washburn, NAIC president and Illinois insurance director.

"Regulation is what we do. We want to do the job the best we can. We are trying to get a better regulatory system. That wouldn't change with or without guaranty funds," he said.

Mr. Washburn participated in a panel discussion on "Guaranty Funds: Panacea or Curse?" during the joint annual meeting of the National Assn. of Casualty & Surety Agents and the National Assn. of Casualty & Surety Executives earlier this month.

In addition to asserting that guaranty funds do not affect the regulation of insurance companies for solvency, Mr. Washburn contended that "there is no way" to have a competitive insurance business without protection of the policyholders.

tion in the financial side of insurance companies that perhaps you think they do," Mr. Archer said.

"The commercial buyer is probably being taken monetary advantage of, but I don't have the answer."



Mr. Washburn

Mr. Comey noted that when guaranty funds were created in the late 1960s, they were designed to protect individuals whose auto insurers became insolvent. Now, insurance company insolvencies mostly involve commercial insurers.

As a result, the cost of funding the system has increased dramati-

The insurance buyer 'has got to wonder if there is rhyme or reason to price,' Mr. Washburn says.

cally. Insurers paid \$500 million in guaranty fund assessments in 1984 through 1986, compared with \$450 million in guaranty fund assessments from 1969 through 1983, Mr. Comey said. And, in 1987, the gross assessment before any recoveries was \$900 million.

Guaranty funds are both a panacea and a curse, Mr. Comey said.

They are a panacea because they have protected victims of insolven-

cies, but they are a curse because they do not provide an incentive to eliminate insolvencies, he said.

In addition, he said, the system "aids and abets instability of price and availability."

Hartford, he noted, paid \$18 million in assessments last year "for insolvent companies that took business away from us."

And, Mr. Comey said, the system is a curse because it is "unfair to companies that survive and are solvent and to the customers of solvent companies who pick up the tab in the long run."

Mr. Washburn countered that the system would be unfair if the competing company received the subsidy, but it is the policyholder who is subsidized.

Mr. Washburn also defended policyholders' decisions to buy insur-

ance from the insurer with the lowest price.

In a marketplace where insurance prices fluctuate, the insurance buyer "has got to wonder if there is rhyme or reason to price," he said. "How is he supposed to know he is taking advantage of something he shouldn't?" he asked.

"It's very difficult to pick among winners and losers," Mr. Washburn said.

Mr. Comey said insurers, regulators and brokers and their clients all can seek improvements in the operation of the guaranty fund system.

"From the company standpoint, there may have to be improved barriers to expansion in our business," he suggested.

For example, he said, an insurer

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NACSA/NACSE CONFERENCE The Greenbrier

When a consumer buys a car, if the auto manufacturer goes broke, the consumer still has the car, Mr. Washburn said. But, when buying insurance, the consumer is buying only a "promise of protection" and therefore a guaranty fund system is needed.

Mr. Washburn pointed out that the guaranty fund system is not absolute protection for policyholders of insolvent insurers because the funds cap claims payments to policyholders and impose deductibles.

In addition, policyholders of insolvent insurers have to find new insurers, he said.

But panelist Dale R. Comey, president and chief operating officer of Hartford Insurance Group in Hartford, Conn., suggested that guaranty funds encourage insurance buyers to buy the lowest priced insurance because buyers know if the insurer goes broke the guaranty fund will pay claims.

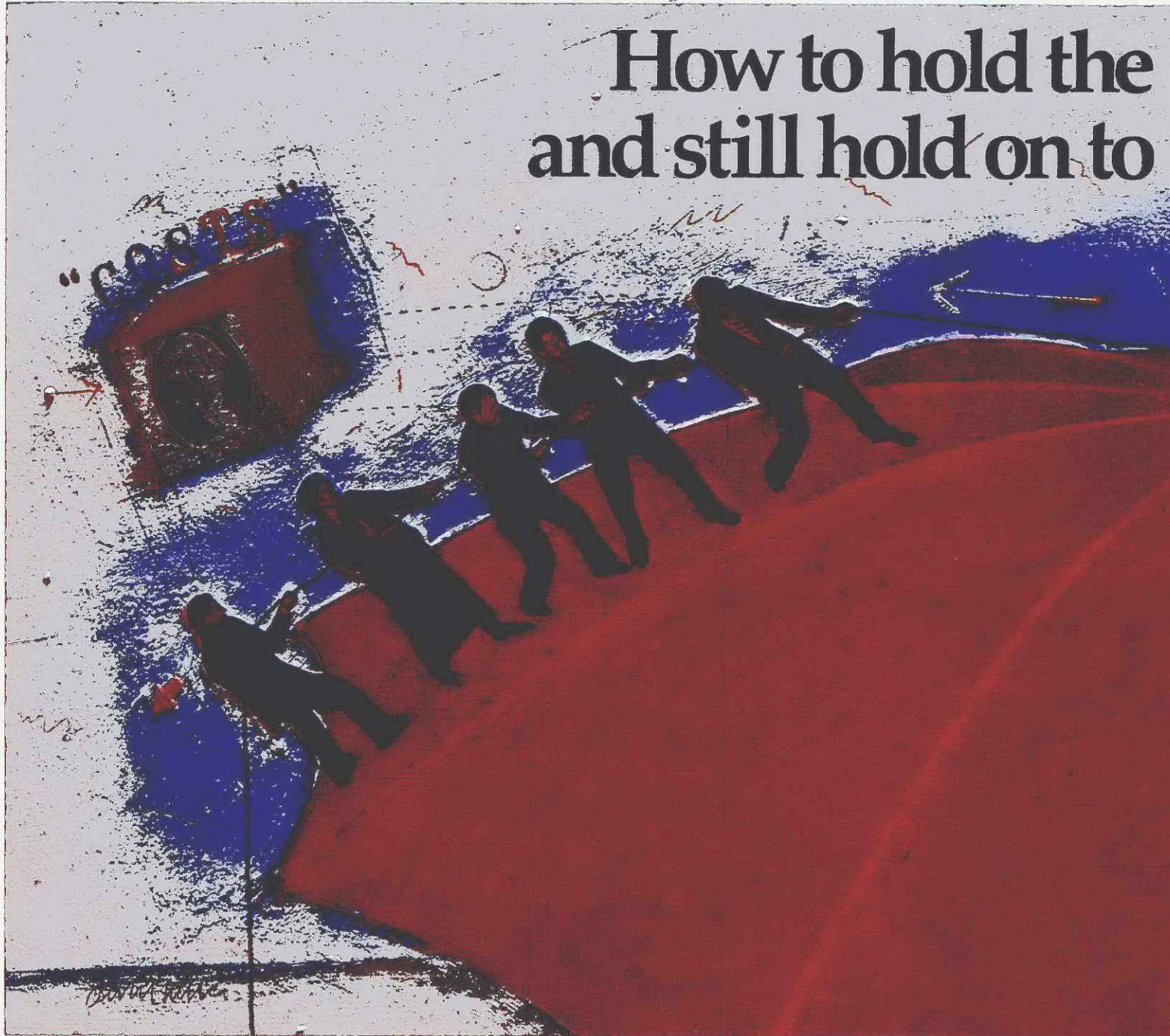
He recalled that Hartford "lost an account to Mission when it was known they were having difficulties," referring to the insolvent Mission Insurance Co. "There is no doubt in my mind that the buyer of insurance had his eyes wide open that he had access to the guaranty fund," Mr. Comey said.

An insurance buyer can purchase the first \$300,000 of coverage—which is generally covered by guaranty funds—at cut-rate prices and purchase excess insurance from other insurers, he said.

But Richard A. Archer, chairman of Jardine Emett & Chandler Inc. in Los Angeles, pointed out that commercial insurance buyers are "supporting a system where they have limited benefits," because the cost of guaranty funds is built into their premiums but they do not receive full coverage for their claims.

A higher cap on the claims paid by guaranty funds would be fairer to commercial policyholders, but what that would cost the industry in the aggregate has to be considered, he said.

"The commercial buyer is supposed to be sophisticated, but I can assure that many of the people we talk to don't have the sophistica-



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Continued from previous page
selling its product at half the market price should establish its reserves as if it were charging "100% of the price until events unfold that clearly demonstrate" that half the price is an adequate rate.

Regulators, according to Mr. Mr. Archer, not only need to run numerical tests on insurers' results, but also need a mechanism that would allow them to "underwrite companies," looking for such factors as underwriting controls, concentration of risk or inadequate reinsurance.



Mr. Archer

Regulators should be able to determine whether insurers have logical reasons to support their pricing structure, Mr. Comy pointed out.

'With a little creativity we can make buyers a little bit more sensitive to the long-term contracts they are purchasing,' and that if an insurer becomes insolvent the insurance was not such a bargain, says Dale R. Comey of Hartford Insurance Group.

And, the buyers and the placers of insurance "have to play a stronger role in this," he said.

"With a little creativity we can make buyers a little bit more sensitive to the long-term contracts they are purchasing," and that if an insurer becomes insolvent the insurance was not such a bargain, he said.

Mr. Comey also suggested that perhaps the buyer of insurance from an insolvent company should have to pay into the guaranty fund to the extent that its insurance premium was discounted.

"All three parties have to make a

contribution," Mr. Comey said.

Mr. Archer pointed out that "most producers do maintain their own system of measuring the financial stability of carriers.

"As a producer, we are really concerned about solvency because our errors and omissions insurance doesn't cover that."

Mr. Washburn rejected Mr. Comey's suggestion that regulators should "underwrite" insurance companies in regulating for solvency.

"For us to be out there underwriting this business means a large sophisticated staff involved in

nearly every transaction you are in. I don't think you want that or need that," Mr. Washburn said.

He did agree that insurers' reserving practices need to be better controlled. "I am going to try and push that reserves be based on exposure units," Mr. Washburn continued.

Pre-assessment guaranty funds might be a fairer approach, because with such a system the insolvent insurer will already have paid into the system, Mr. Washburn and Mr. Comey commented.

However, both Msrs. Washburn and Comey raised concerns that large pre-assessment guaranty funds may be tapped by states for other purposes, as occurred in New York (BI, May 23).

Mr. Washburn also took the opportunity to defend the system of state regulation of insurance against charges that it is uneven.

The varying levels of state regulation is inconsequential he said, because an insurer operating in any

one state is adequately regulated in its own state, while multistate insurers are regulated by all the states where they do business.

Collectively, the states employ 7,000 people and spend \$300 million to regulate insurers, Mr. Washburn said.

The NAIC is constantly analyzing whether those resources are being used correctly, he added.

In addition to assuring that if the price of insurance is too low that reserves also are not too low, Mr. Washburn said regulators want to know more about casualty lines because the catastrophe risk in insurance is now in casualty lines.

Previously, regulators were more concerned if insurers could pay claims after a large property catastrophe, he noted.

Questioned whether state insurance departments need more funding to better regulate insurers for solvency, Mr. Washburn answered: "There are some areas that we need help. One is travel. This is a national business," he said, but state legislators question why insurance department personnel need to travel to NAIC meetings.

Salaries paid by insurance departments also are too low to compete with the industry, Mr. Washburn said.

But, he noted, insurance departments can hire the outside resources they need when analyzing an insurer, and charge those costs to the insurer.

Mr. Washburn also warned against proposals for a federal guaranty fund system. "If the federal government does start doing a guaranty fund, there is no doubt that the regulation of solvency will flow with it.

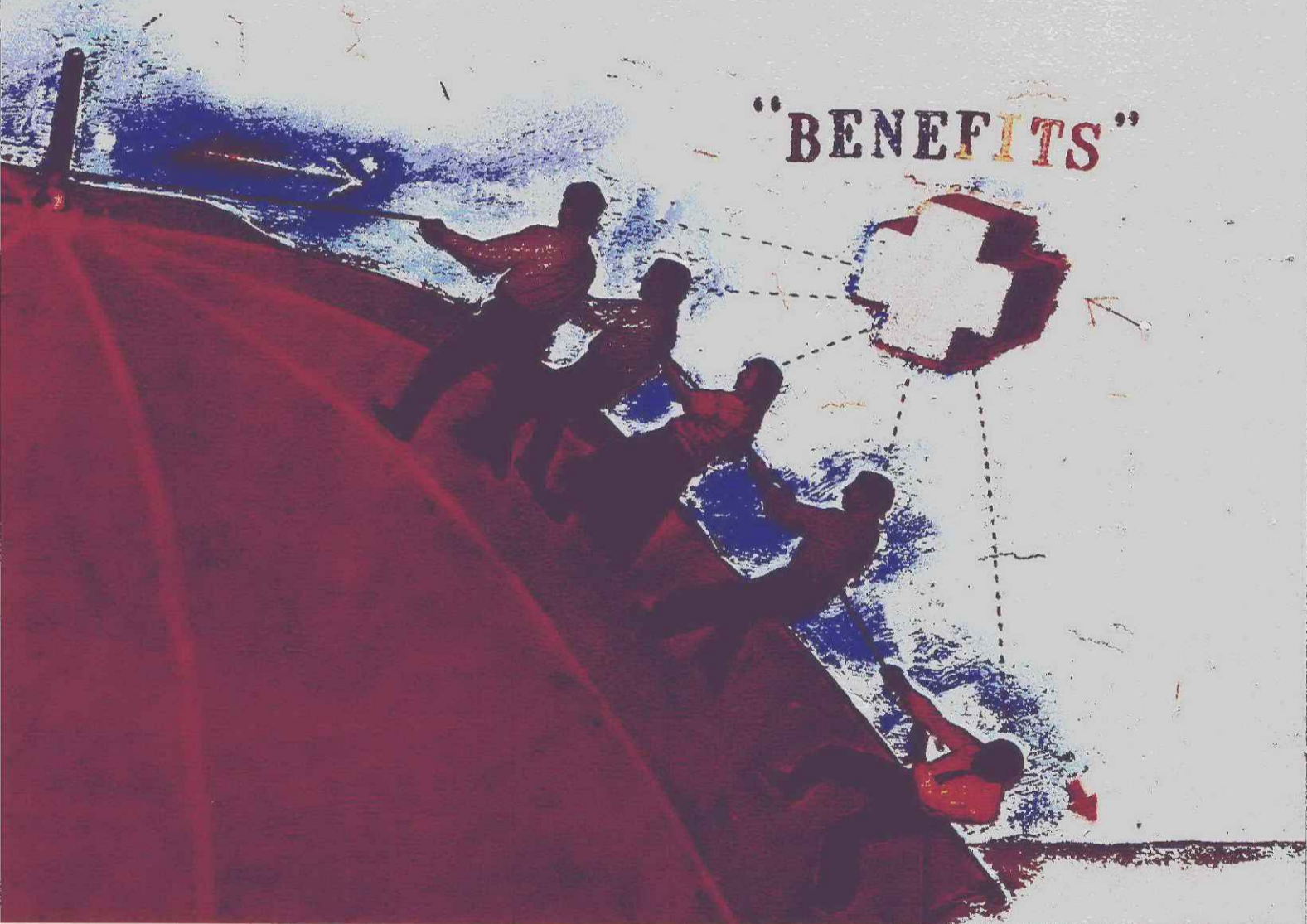
"You probably will have a dual structure," he said, because: "The states are never going to let go of a number of the things they do now. For sure they will never let go of marketplace regulation," referring to rating and market conduct.

Splitting these responsibilities between the federal government and the states would "be the worst thing in the world," Mr. Washburn said.

While the property/casualty insurance industry complains about the cost of guaranty funds, Mr. Washburn noted that two new types of guaranty funds are being developed: for life insurance and for health maintenance organizations.

The panel was moderated by Robert E. Vagley, president of the American Insurance Assn. in Washington, D.C.

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NACSA, NACSE announce their new presidents

John A. Kohler, chairman of Brandow Howard Kohler & Rosenbloom Inc. in Minneapolis, is the new president of the National Assn. of Casualty & Surety Agents.

He succeeds John F. Russell, president of Couper-Ackerman-Sampson Inc. in Binghamton, N.Y.

NACSA represents leading U.S. commercial property/casualty insurance agents and brokers and sponsors a political action committee.

Jack Moseley, chairman and chief executive officer of United States Fidelity & Guaranty Co. in Baltimore, is the new president of the National Assn. of Casualty & Surety Executives.

He succeeds John H. Brethrick Jr., president of The Continental Corp. in New York.

NACSE's membership includes leading U.S. Commercial property/casualty insurance and reinsurance companies.

PPO health care

Continued from page 3
 any money from discounts," he asserted.
 However, employers aren't far off the mark in their assessments of many PPOs as mere discount arrangements with no emphasis on utilization review or quality assessment, he said, adding that "that's what some PPOs are."
 But, the PPOs that are doing a good job of utilization review, quality assessment and physician and hospital bill audits have not "done a good job of broadcasting that to employers" to convince employers that PPOs are effective managed care mechanisms, he explained.
 So, some employers that have become frustrated in dealing with discount medicine arrangements and are doubtful of PPOs' ability to manage health care costs have set out to develop their own PPOs, he said. "Employers are sort of using their own people to reinvent the wheel," he said, explaining that some employers are engaging in "preferred provider arrangements."
 Under these arrangements, employers negotiate discount prices on services they perceive to be the highest cost portions of their benefit plans. For example, some employers might nego-

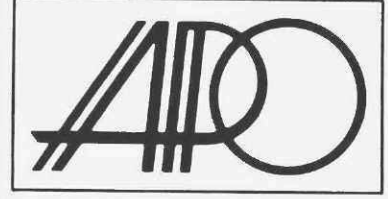
tiating a discount price with a physician group only if they believe that physician fees are gobbling up the biggest portion of their health care dollar. Others might negotiate discount prices with hospitals only, he said.
 The problem with these arrangements is that they don't effectively manage health care costs because there may be no utilization review or no emphasis on delivering the appropriate level of care in the right setting—such as placing a patient needing nursing care in a nursing home instead of in an acute care hospital, he said.
 Along with these special arrangements with certain providers, "sometimes, employers will make a deal with a PPO that does not include some services, like mental health care. So, the employer is left to contract separately with providers of these services," he said.
 But, the major disadvantage of both employers' preferred provider arrangements with certain providers and with existing PPOs offering limited services is that neither arrangement completely manages all aspects of a benefit plan, and thus does not really control costs, Mr. Elden said.
 "If you look at what employers in the marketplace are doing, they're not getting a managed PPO. They're acting like health care services are

not inter-related," he said. But, "if we as PPOs don't do this job for them, employers will form their own effective PPOs."
 And, "if more employers got together to form one PPO, they would be a potent force" in negotiating PPOs with providers, leaving many existing PPO firms in the dust, he warned.
 However, "if employers continue to negotiate discounts only, then we are safe," he said.
 PPOs must take steps to respond to employers' managed care demands to survive, he said.
 To assist PPOs in this endeavor, the AAPPO is developing a PPO credentialing process to be used by the PPO industry and employers to ensure that a particular PPO is a legally, financially and administratively sound managed care system (see story, page 24.)
 Under the process, a PPO would receive AAPPO accreditation if it meets certain criteria, such as having a complete provider network, including specialists like mental health providers, home health care providers, etc.; a utilization review program; a quality assessment program; legally sound contracts with providers in the network; and is financially sound.
 "A PPO is a business and the ones that run their operations this way will be the ones to survive," Mr. Elden said. ■

PPOs' goals for sponsors spark debate

By DONNA DiBLASE

DALLAS—Can provider-sponsored preferred provider organizations balance their business objectives of controlling health care costs for their employer clients with their need to guarantee patient revenues to their provider members?
 Not surprisingly, provider-sponsored PPOs say yes and other PPO sponsors say no.
 "I really think there are no conflicting business objectives in provider-sponsored PPOs simply because the marketplace will not allow it," according to Richard Mastaler, president and chief executive officer of Preferred Health Network, a Los Angeles-based provider-sponsored PPO.
 Health care purchasers demand cost-efficient health care, Mr. Mastaler explained.
 "This sounds like a solution from the people who brought you the problem: Rising costs resulting from ripping off third-party payers," rebuts Mark Jasper, chief executive officer of Benefit Panel Services Inc., an investor-sponsored PPO based in Los Angeles.
 Messrs. Mastaler and Jasper faced off in a debate on the issue



during the 1988 Annual Fall Forum of the American Assn. of Preferred Provider Organizations, held Oct. 2-4 in Dallas.

Provider-sponsored PPOs have repeatedly responded to the demands of health care purchasers and thus have proved their business objectives do not conflict, Mr. Mastaler contended.
 "At first, we had what is known as a first-generation PPO, in which doctors and hospitals got together to offer discounted prices on health care services to health care payers," he said.
 "Then, in the second generation of PPOs, we continued to offer the discounts, but we also added utilization review and quality assurance programs to our PPOs," he explained.
 "We did this because the market demanded it," he added.
 "Today, we are in the third generation, in which we are giving discounts, utilization review, quality assurance, data and information" as well as provider billing audits, in response to demands on the market, according to Mr. Mastaler.
 "We are now referred to as managed care companies. The word 'PPO' now refers more to the first generation of PPOs," Mr. Mastaler added.

But, Mr. Jasper of Benefit Panel Services argued that "provider-sponsored PPOs cannot resolve their conflicting business objectives and they cannot survive" in the managed health care marketplace.
 "A major conflict of these PPOs is their fundamental push to raise patient revenues. Their constituents are the providers, not the payers," Mr. Jasper emphasized.
 Provider-sponsored PPOs also "engage in anti-competitive actions in what is intended to be a competitive organization to lower costs. Network expansion is a problem for them because they have to contract with competing

Continued on page 22

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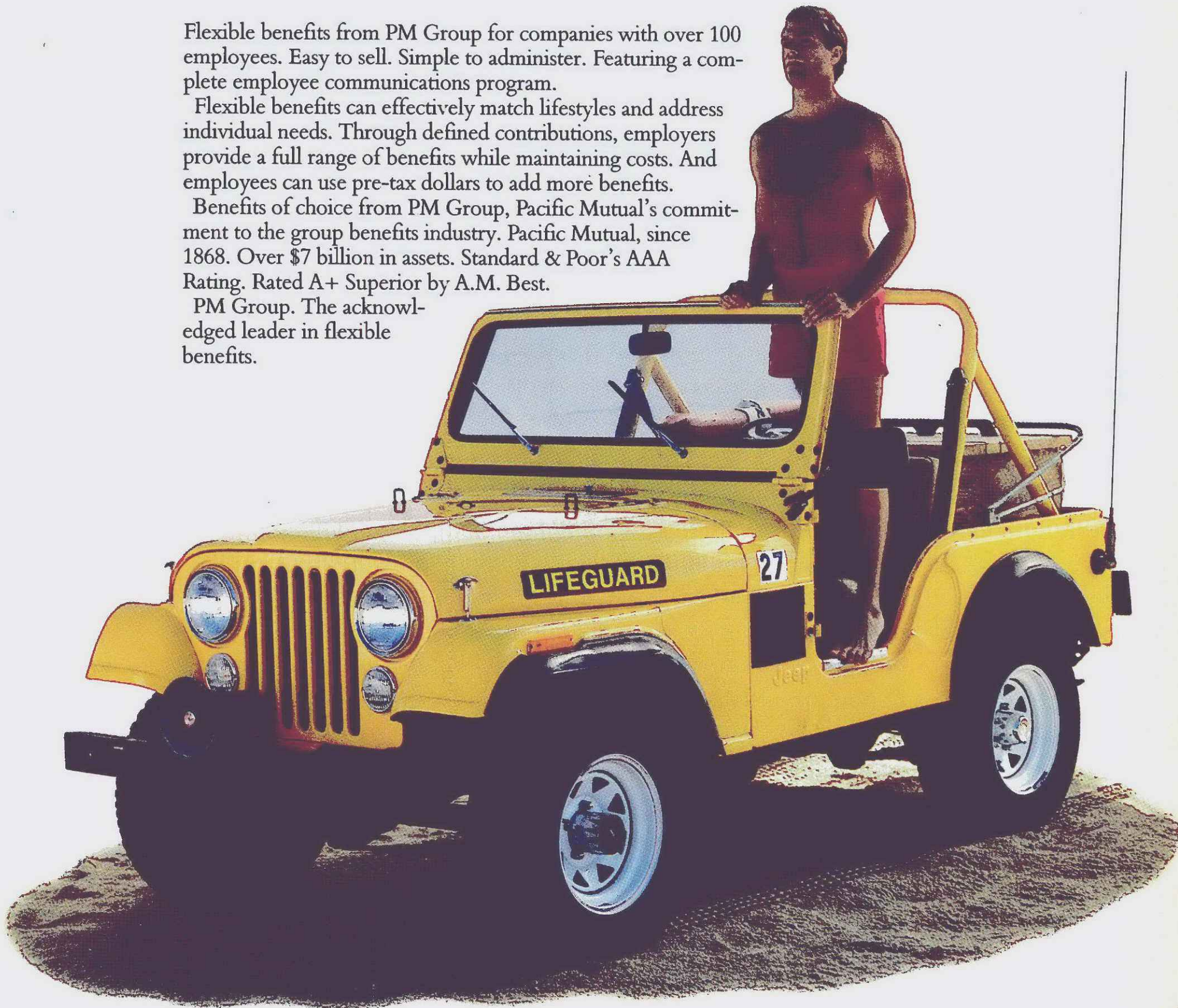
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PPO debate

Continued from page 20
providers," according to Mr. Jasper.

And, provider-sponsored PPOs "place their emphasis on scrutinizing hospital care, but there is very little, if any, scrutiny of outpatient providers," he charged.

Mr. Mastaler offered several counterpoints.

"I think provider sponsorship offers a distinct advantage in a number of areas," Mr. Mastaler commented.

First, since providers are negotiating rates with other providers in a provider-sponsored PPO, there is less of an adversarial relationship when it comes to setting prices for health care services, he said.

"The providers are prepared for risk pooling in these PPOs" since rates are not being negotiated by a third party who may have an unfriendly relationship with the providers, Mr. Mastaler explained.

"Employers are coming back to provider-sponsored PPOs for the very reason that they are tired of the rate-bashers and the adversarial relationship that results between providers and payers" when rates are negotiated by non-providers, he said.

The fact that Preferred Health Network is provider-sponsored "also allows us to make quick movements on pricing without being questioned by our provider members. They trust us" and do

The decision-making process is slow in provider-sponsored PPOs, Mr. Jasper contends.

not argue over price adjustments like providers might in a PPO sponsored by purchasers or by another third party, Mr. Mastaler suggested.

However, Mr. Jasper of Benefit Panel Services argued that "there is a lot of excess baggage and a slow decision-making process in provider-sponsored PPOs."

Mr. Mastaler of Preferred Health Network added that utilization review is more effective as a result of provider sponsorship of a PPO. He explained that because of Preferred Health Network's provider sponsorship, a multitiered utilization review program is in place to ensure that costs and care are efficiently managed.

"We have a hospital review program, plus six regional outside review organizations, plus a corporate utilization review program. This system of jurisprudence" enables the PPO to "throw out those physicians from our group" with whom payers have difficulties over costs or utilization, Mr. Mastaler said.

However, Mr. Jasper of Benefit Panel Services argued that "the strategy of a provider-sponsored PPO is unlimited access to all providers by patients. In these PPOs, there is patient self-referral" to specialists and surgeons.

In contrast, he said, in PPOs sponsored by independent investors or health care purchasers, "there are limits and controls on patient access to providers. There is no patient self-referral to surgeons."

Despite Mr. Jasper's arguments, "I think that this controversy is dead," said Mr. Mastaler, referring to the issue of conflicting business objectives in provider-sponsored PPOs.

However, "it will be in PPOs' best interest to restructure and limit the number of contracting providers involved in PPOs," Mr. Jasper said. ■

PPOs must deliver results: Experts

By DONNA DiBLASE

DALLAS—Preferred provider organizations must deliver results and be able to prove those results to their purchasers and members, according to health care experts.

"Remember, the transition to managed care requires quality, accountability and results," Douglas L. Elden, chairman of the American Assn. of Preferred Provider Organizations, told attendees of the AAPPO's Annual Fall Forum, held Oct. 2-4 in Dallas.

To employers, PPOs must deliver a product that meets the specific health care cost and quality management goals of each company, according to one health care consultant.

In addition, PPOs that have contracted with the federal Health Care Financing Administration, a government purchaser, to participate in a Medicare PPO demonstration project must deliver a product that controls utilization and cost while providing consistently

'You need to know what your customer's requirements are' and then develop a product to meet the needs of that employer, says Mr. Miller.

high quality care to Medicare beneficiaries, says one HCFA official.

Meanwhile, hospitals contracting with PPOs expect to be involved in managed care programs that will stand the test of competition by responding to provider concerns as well as purchaser concerns, explains an executive for a managed care joint venture between a hospital group and a health insurer.

And, physicians who remain skeptical about the ability of PPOs to deliver the patient share

claimed want PPO contracts that contain fair physician reimbursement arrangements in return for delivering cost-effective quality care, says one physician.

"You, as PPOs, must be ready well in advance not to sell employers something that they don't need but something that will work in the health care management programs," said Laird Miller, president of Health Systems Management Inc., a Minneapolis-based health care consulting firm.

"You need to know what your customer's requirements are and you have to identify the critical quality areas that relate to that particular customer" and then develop a product to meet the needs of that employer, he suggested.

And, "once you've identified those critical areas, define what quality is in those areas, establish performance goals and then consistently measure your results and improve your performance," Mr. Miller said.

Continued on next page

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Continued from previous page

But, he noted that "not very many of you are doing this right now."

Traditionally, PPOs have operated under the orientation of "following physicians around, finding the bad guys, beating up on them (eliminating them from PPO participation) and then everything is wonderful. But, this way, you don't prevent problems and in the future, preventing problems will be the only way to be successful," he predicted.

And, PPOs also must concentrate not only on what they do for the employer/customer but also for the employee/customer that is actually receiving health care from the PPO's providers, he said.

This means that PPOs will have to get more involved in things like assisting employers with workplace safety and disease prevention programs designed to improve the overall health status of employees and more effectively control health

Traditionally, PPOs have operated by following physicians around, finding the bad guys, beating up on them (eliminating them from PPO participation) and then everything is wonderful,' says Laird Miller, president of a consulting firm.

care costs, he said.

Along with assessing and meeting specific needs of employers, PPOs also must be able to provide employers with meaningful data and information about their health care cost and utilization status.

"Data is important because it's power," Mr. Miller added. "You have to know where you are before you can make changes to get to where you want to be."

In the future, employers also will demand performance-based contracts with PPOs, he said. That is, PPOs will be required to enforce certain performance criteria on

their provider members and eliminate providers that do not comply.

But employers are not the only health care purchasers interested in the results delivered by PPOs.

The HCFA, in its quest to control health care costs for Medicare recipients while maintaining a high level of quality, will select three PPOs by year-end to participate in a Medicare PPO demonstration project, explained C. Ross Anthony, associate administrator for program development in the HCFA's research and development department.

"In this program, we will require

PPOs to deliver high quality care, reduced costs in the long run and control over health care utilization" in the Part B portion—or non-hospital benefits portion—of the Medicare program, Mr. Anthony said.

"Medicare Part B is one of the fastest growing areas of the federal budget. So, our problems in the public sector led us to the best solutions in the private sector," he said, explaining Medicare's problems with high utilization and cost of health care.

Some of the basic objectives in the Medicare PPO demonstration project are:

- To reduce the annual percentage rate of increase in costs.
- To develop selection criteria for contracting with cost-efficient, quality physicians.
- To develop effective financial incentives to encourage beneficiaries to use PPO providers.
- To improve utilization review programs so that they effectively

and appropriately manage the delivery of health care to beneficiaries.

The HCFA will regularly evaluate the PPO projects to make adjustments as needed and to ensure that PPOs are delivering the results they promised, Mr. Anthony said.

"I think you as PPOs have a huge opportunity to extend into the public sector the best of what's going on in the private sector," Mr. Anthony predicted.

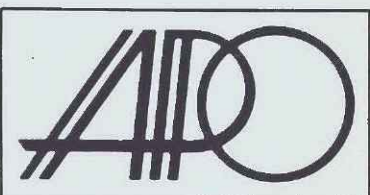
Along with purchasers of PPO products, providers participating in PPO arrangements have concerns about the results PPOs can deliver.

Hospitals, for example, are eager to participate in managed care programs but want those programs to be structured so that they respond to the changing needs of the health care market, said Robert L. Montgomery, executive vp of managed care for VHA Enterprises Inc. in Irving, Texas.

VHA Enterprises is the provider unit of Partners National Health Plans, the managed care joint venture between Voluntary Hospitals of America of Irving and Aetna Life & Casualty Co. of Hartford, Conn.

VHA and Aetna think that Partners will be able to respond to marketplace changes, he said.

First, the provider/purchaser



partnership aspect of the joint venture is one key to competing in the health care marketplace. Aetna's responsibility in the Partners joint venture is to be an advocate for the employer, or purchaser, and VHA Enterprises' role is to be an advocate for physicians and hospitals, he explained.

And, to "stand the test of competition, Partners' strategy in managed health care is long-term: to offer employers a spectrum of integrated managed health care products, such as PPOs, HMOs and indemnity plans under one experience-rated premium," he explained.

Partners currently operates 73 PPOs and 27 health maintenance organizations across the nation. In total, 115,000 physicians, 620 VHA hospitals and 180 independent hospitals participate in Partners' plans, he said.

Partners plans are available to 1.2 million people.

While some hospital groups like VHA have aligned themselves with insurers or other PPO sponsors, some physicians still are unsure of their place in the PPO market, according to Dr. Joseph Boyle, executive vp of the American Society of Internal Medicine in Washington, D.C.

"I believe that over the past five to eight years, most physicians in this country have come to accept the fact that the future holds some form of managed care for them," he said.

"But, as they have viewed the changes before them, they have seen that the results of PPOs are a mixed bag," Dr. Boyle said.

Many physicians believe that the financial arrangements and physician risk-sharing aspects in PPO contracts leave them exposed to "unlimited liability and financial risk," he explained.

And, some believe that the PPO fee negotiations for some specialists are unfairly high compared with the fees negotiated with general practitioners and internists, he added.

Lynn Dowling, president of the Chicago-based AAPPO, moderated the panel.

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AAPPO offers accreditation guidelines

By DONNA DIBLASE

DALLAS—The American Assn. of Preferred Provider Organizations is offering preliminary recommendations for PPO evaluation and accreditation criteria.

The criteria are intended to assist both PPOs and employers in evaluating the performance and operations of PPOs.

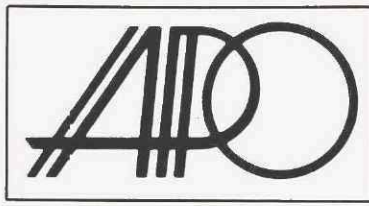
And, while the AAPPO does not support regulation of the PPO industry, the accreditation process is a step toward helping health care purchasers and PPOs weed out the bad apples and give the entire PPO industry a favorable image, say the creators of the criteria.

The preliminary AAPPO recommendations were unveiled at the organization's Annual Fall Forum, held Oct. 2-4 in Dallas.

"The AAPPO's involvement in this credentialing process has created a lot of controversy," said Brant P. Kelch, secretary-treasurer of the AAPPO and president of MedStrategies Virginia Inc., a health care consulting firm in Leesburg, Va.

"Some think the AAPPO should not be involved in credentialing at all. But in my opinion, all of us in the PPO industry have things to worry about and accreditation is coming whether we like it or not," Mr. Kelch asserted.

"Although the AAPPO is developing this accreditation process, it should be made clear that the AAPPO does not favor regulation," said Douglas L. Elden, chairman of the AAPPO and a partner with the Chicago law firm Altheimer & Gray. "It is not our job to reg-



ulate our members. But, if someone is going to regulate us, we want to be the first to educate them about what a PPO is and what criteria indicate a successful PPO," he explained.

In introducing the preliminary credentialing criteria, Mr. Kelch offered a few caveats.

For example, he explained that the credentialing process will not be completely revealed until it has been finalized. And, finalizing the process will include field testing of

the criteria and more input from PPOs, he added.

The credentialing process includes eight areas of PPO structure and performance that can be used to evaluate PPOs:

- The PPO's managed care network. Ideally, this should include physicians, hospitals, allied health professionals—like social workers and home health care providers—and ancillary facilities. A vast network is necessary for placing patients in the most appropriate setting to receive the necessary care.

- The provider selection criteria. This criteria should be consistently applied and enforced on all providers and ideally should consider historical performance by the provider.

- The payment methodologies and levels. Successful PPOs have

four characteristics in common in this area: competitive but equitable levels of payment to providers; monitoring and effective control of increases in payment levels; flexibility to respond to different levels of purchaser sophistication; and reimbursement mechanisms that create incentives for providers to deliver efficient services.

- The utilization management program. The program should: monitor quality and effectiveness of treatment; identify high quality, cost-efficient providers in the network; identify appropriate use of services and facilities; encourage cost-efficient, high quality behavior by physicians; and assist in the redesign of benefit plans that will encourage consumers to be cost-conscious and lead healthy lifestyles.

- The quality assurance program. Clinical and service quality indicators should be developed and enforced by the PPO.

- The capability of the PPO's management and administrative staffs. The PPO should be able to perform such tasks as data collection and reporting; claims processing; provider relations; and client services. The PPO should be able to demonstrate its results by having sophisticated data systems that interface with utilization management and quality assurance systems and that document cost savings, quality and inappropriate billing practices by providers, among other things.

- The legal structure of the PPO. Contracts with providers must contain all necessary provisions and be enforceable. And, the PPO must be structured to minimize antitrust risks, among other things.

- The financial solvency of the PPO. The PPO should have sufficient levels of capital to cover expenses and operate on a strong, rather than strained, financial basis.

Also working on the AAPPO's credentialing process are Dr. William L. Amos Jr., president of MedStrategies Georgia Inc. in Columbus, Ga.; Peter Boland, president of Boland Health Care Consultants Inc. in Berkeley, Calif.; and Ralph S. Pollock, executive director of the Business Coalition on Health, an employer coalition in Hartford, Conn. ■

PPO trade group holds conference

DALLAS—"Quality, accountability and results" were the most popular themes at the 1988 Annual Fall Forum of the American Assn. of Preferred Provider Organizations.

Some 460 executives of PPOs and insurance companies, as well as a few employee benefit managers, gathered Oct. 2-4 at the Dallas Fairmont Hotel to examine PPOs' viability and opportunities in the managed health care marketplace.

The AAPPO is a national trade association for PPOs, of which 440 PPOs are members. As of May 1987, there were 674 operational PPOs, according to the AAPPO's Annual Directory of Operational PPOs. The organization estimates there will be about 700 PPOs by year-end 1988.

Among its member services, the AAPPO provides an annual directory of operational PPOs, newsletters, regulatory updates and an educational conference. The AAPPO also is developing a credentialing process for PPOs.

For more information about the AAPPO, contact Lynn Dowling, President, American Assn. of Preferred Provider Organizations, 111 E. Wacker Drive, Suite 600, Chicago, Ill. 60601; 312-644-6610. ■

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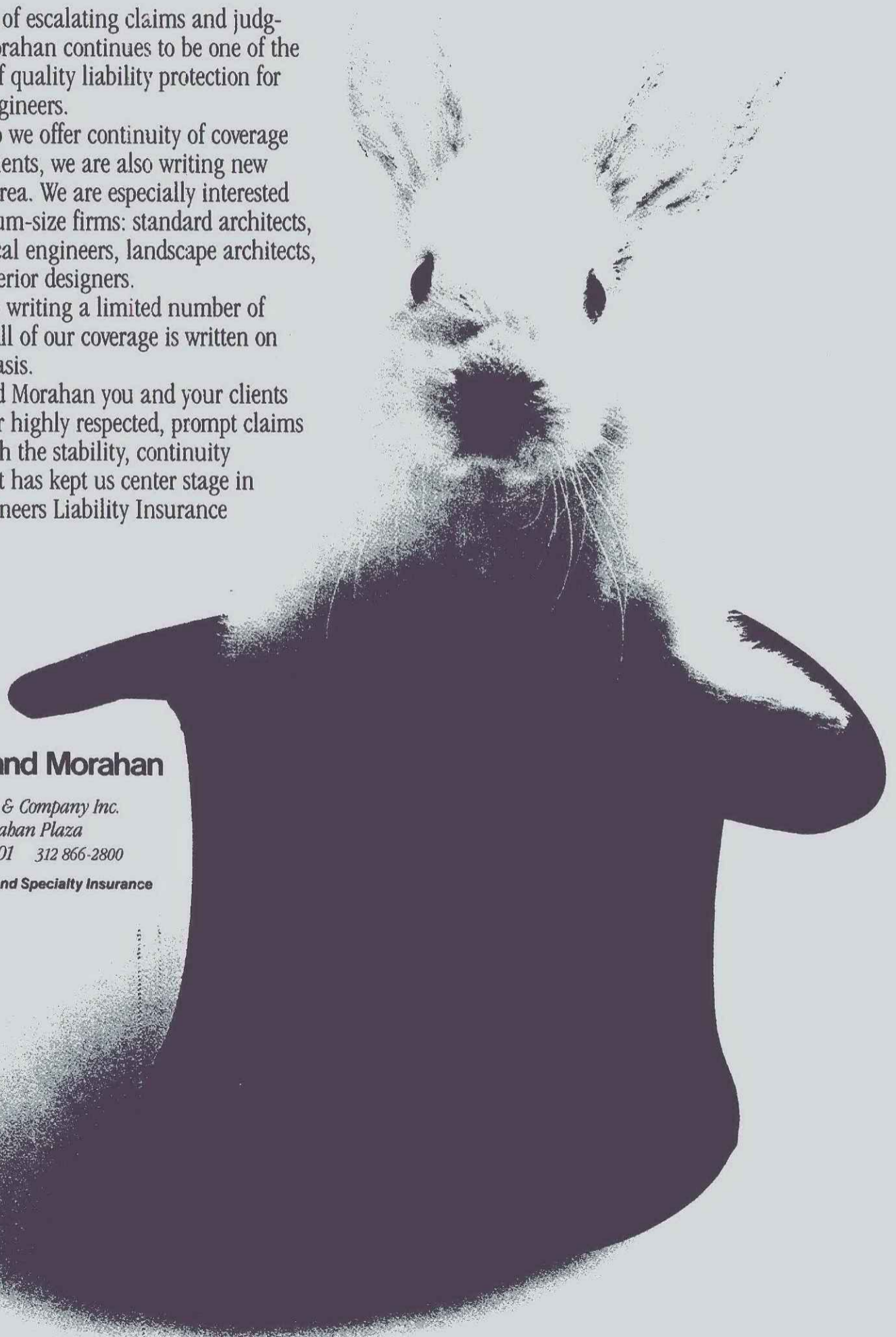
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Reagan aide's benefit views

Continued from page 3
coverage as a mandated benefit.

Mr. Walker acknowledged that access to health care is a serious problem: 37 million Americans lack such coverage.

At the same time, soaring health care costs and huge retiree health care liabilities also demand answers.

"Health care costs are close to 12% of the GNP, yet 37 million people are uninsured. That tells me something is wrong with our current system," he said.

But, until now, health care issues have been addressed in a "piecemeal manner," Mr. Walker said.

He recommends forming a national commission to study a broad range of health care issues and develop solutions.

Such a commission could be similar in structure to the 15-member blue ribbon panel that President Reagan established in 1982 to recommend ways to avert a financial collapse of the Social Security retirement trust fund, he said.

That commission's recommendations, including an acceleration in scheduled increases in FICA taxes, were largely accepted by Congress in 1983, and a crisis was indeed avoided.

Mr. Walker also believes Congress should establish a new joint committee on employee benefits to improve the way in which legislators consider benefits-related legislation.

Observers note that staff members of the tax and labor committees rarely talk to one another. As a result, when tax committee staffers draw up proposals affecting employee

benefits, they often only consider the revenue enhancement potential rather than social consequences.

Mr. Walker decried the way in which much recent benefits legislation has been developed and enacted.



Mr. Walker

Proposals, such as the complex and controversial Internal Revenue Code Section 89 non-discrimination rules for welfare plans, were developed behind closed doors, denying employers and consultants the opportunity to provide meaningful input.

"Benefits legislation must be considered in the sunshine," Mr. Walker said.

He added that the pace of legislative activity also must be slowed.

Benefits have had it rough on Capitol Hill because, among other things, the benefits community has not lined up influential legislators to back its cause, he said.

"We need champions on the Hill like Javits and Williams," Mr. Walker said, referring to the late Sen. Jacob Javits, R-N.Y., and former Sen. Harrison Williams, D-N.J., the prime movers of the Employee Retirement Income Security Act of 1974.

Mr. Walker also warned that restricting employers from capturing pension surpluses when they terminate overfunded defined benefit plans is an issue that will keep coming back.

"It will not go away. Liberals on the Hill want to change

the nature of the promise," Mr. Walker said.

Mr. Walker warned that reversion restrictions would be a blow to sound pension policy. He predicted that reversion curbs would discourage employers from establishing new pension programs and funding existing pension programs.

Instead of reversion penalties, Congress should be looking at ways to give employers access to pension surpluses without having to terminate plans, as is the case now.

For example, Mr. Walker advocates allowing employers to transfer a portion of pension surpluses into special accounts that would fund retiree health care benefits. The assets in those accounts would earn tax-free interest.

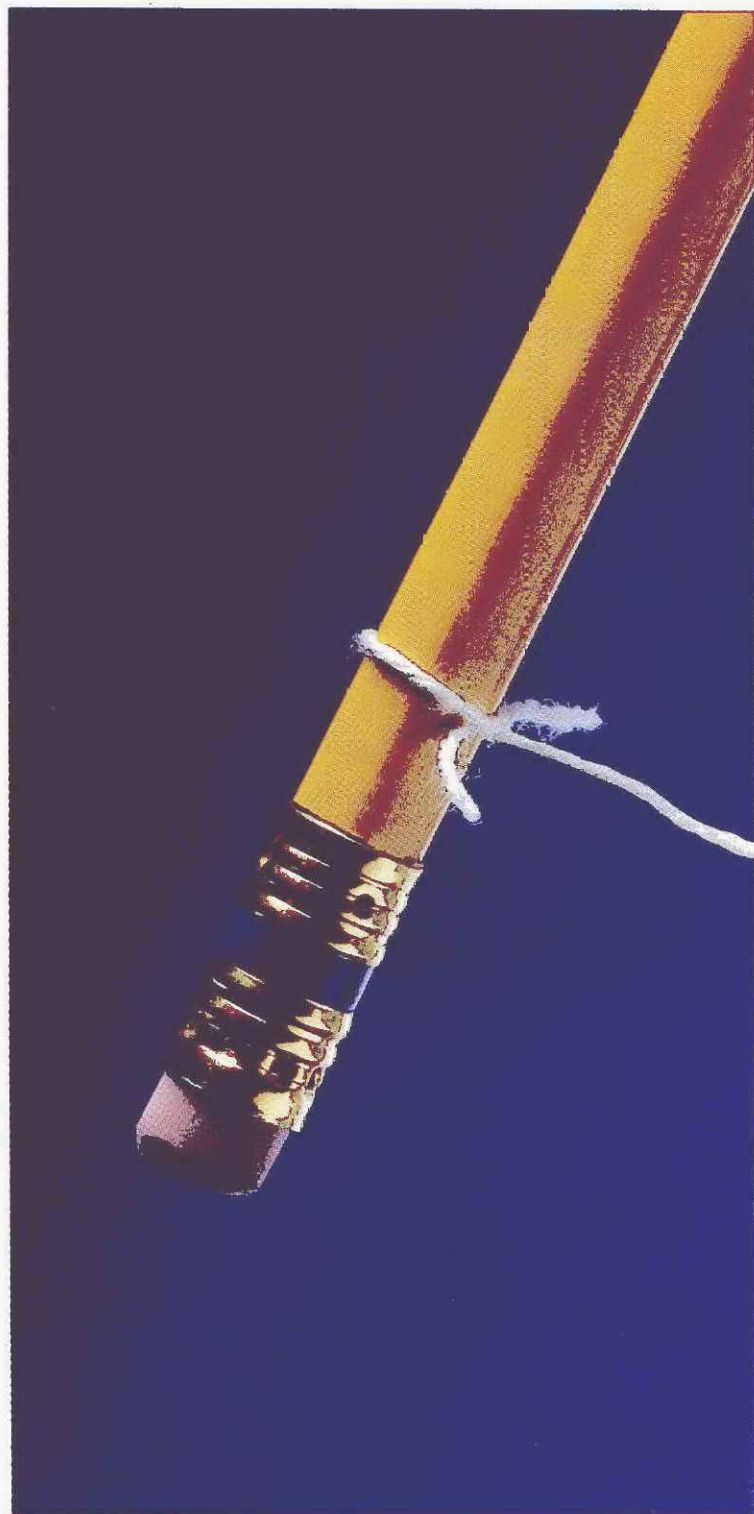
While the Reagan administration endorsed such a proposal in 1987, it was later defeated by the House Ways and Means Committee (BI, Feb. 23, 1987).

Mr. Walker said it is unlikely—regardless of the outcome of the November elections—that Congress would restore the old individual retirement account eligibility rules that allowed virtually any employee to make tax-deductible contributions of up to \$2,000 annually.

Under the 1986 tax law, the only employees who can take the full \$2,000 annual tax deduction for an IRA contribution are those not covered under a pension plan, or single taxpayers earning less than \$25,000 and those filing a joint return earning less than \$40,000.

Mr. Walker noted that research found that IRAs did not create any significant new savings. Instead, individuals generally transferred funds from existing savings accounts. ■

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Benefits are tax target: Consultant

By JERRY GEISEL

MONTREAL—Regardless of the outcome of the November elections, employee benefits will remain under congressional siege, a consultant warns.

As long as big federal budget deficits persist, employee benefits will be a vulnerable target as legislators look for new revenue sources, said Marjorie Kulash, a consultant in The Wyatt Co.'s Research and Information Center in Washington, D.C.

"Employee benefits constantly will be attacked as a means of tackling the deficit," Ms. Kulash told the Council of Employee Benefits at its fall conference in Montreal.

Indeed, a provision passed by Congress last month to limit tax

**Council on
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credits for employees who use reimbursement accounts to pay for child care expenses is an example of congressional "nibbling" at benefits to raise revenue, she noted.

Under that provision, tucked into a massive welfare reform bill, employees' child care expenses eligible for federal tax credits will be directly offset by the amount of contributions made to a dependent care reimbursement account (BI, Oct. 10).

The welfare legislation, which President Reagan is expected to sign, also will bar pretax contributions to dependent care reimbursement accounts and eliminate the federal tax credit for dependent care expenses for children older than 12.

Under current law, dependent care expenses for children under 15 can be funded through reimbursement accounts or be eligible for the federal tax credit.

These provisions, along with a new requirement for individuals to provide on their tax returns the name, address and taxpayer identification number of the child care service provider, will raise an estimated \$950 million over the next five years.

Those revenues are intended to partially offset the \$3.3 billion cost of the measure's other provisions, illustrating how the tax-favored status of employee benefits are

Continued on page 33



How to contain health care costs and still have a conscience.

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GAO misses point

Report shows failure to understand liability insurance crisis

By Robert L. Willmore

I READ WITH INTEREST Jerry Geisel's article, "Few Denied Coverage in Mid-80s: Study" (*BI*, Sept. 26), which summarized the Government Accounting Office's recently released report on the insurance crisis of 1985 and 1986. As the past chairman of the Reagan Administration's Task Force on Liability Insurance Availability and as the primary author of the two Tort Policy Working Group reports documenting that crisis and its relation to our tort liability system, I naturally was keenly interested in what the GAO had to say on this important subject.

I was disappointed but not particularly surprised to discover that the GAO has once again managed to miss the point by failing to understand the nature of the very phenomenon it is investigating.

While the report's authors do not expressly spell out their conclusions about the crisis, it is clear from reading the whole report that they are deeply skeptical that the crisis was really all that severe. This comes as a surprise to those of us who can well remember the shock and hardship many businesses, professionals, municipalities and non-profit organizations experienced during this difficult period. It must come as a particular surprise to the numerous state legislators and blue-ribbon commission members who, in fact-finding hearings throughout the nation, heard story after story on the devastating impact of this crisis—stories that the GAO dismisses as "anecdotal."

What the GAO does not seem to understand is that the insurance crisis did not hit every business, every profession, every municipality and every non-profit organization in every line of insurance. To the

Speaking out

contrary, some it hit exceedingly hard, others it barely touched. But, as the GAO has done in so many of its other reports on insurance, liability and litigation, it simply aggregates all its data and provides generalized averages that tell us next to nothing of significance.

Reading the GAO report, one is reminded of the tactic of plaintiffs' attorneys who seek to deny the existence of a crisis in medical malpractice insurance costs by aggregating the cost of such insurance for all physicians in all states. Looking at those figures, it indeed is difficult to see what the fuss is all about. But, if one focuses on specific, high-risk specialties like obstetrics/gynecology and neurosurgery, the existence of a severe problem in the cost of medical malpractice insurance is both obvious and irrefutable.

Perhaps most galling about the GAO report is its offhand conclusion that increasing insurance costs do not have a great effect on the costs of goods or services, or on the financial viability of business, since the large businesses responding to the GAO's questionnaire report that their 1986 premium costs constituted on the average only 0.6% of annual gross receipts (small businesses reported an average of 1.2%). This must be especially comforting to those judges, legal academics and liability activists who view the tort system as a ready vehicle for the redistribution of income in our society. After all, if insurance expenses are such a small percentage of the costs of products and services and businesses are not really threatened by increasing insurance costs anyway, then what is the harm in a little more

liability-driven income redistribution?

Of course, the GAO report fails to note that the price of a single dose of DTP vaccine increased to \$11 from 11 cents in four years—largely due to insurance and self-insurance costs—or that it now costs more for a manufacturer of a single-engine general aviation aircraft to purchase the necessary product liability insurance than to manufacture the aircraft. Nor does the GAO report document the new products withheld from the market because of the cost of liability insurance, or that many manufacturers increasingly find themselves at a substantial disadvantage to their international competitors because of the higher insurance costs they must bear.

One cannot help but wonder what conceivable justification the GAO has for aggregating together the insurance costs of all businesses—those engaged in high-risk activities as well as those engaged in low-risk activities—and from that meaningless statistic drawing the seemingly profound conclusion that the cost of insurance is not all that important.

Although it may sometimes seem that way, I do not believe the GAO has a hidden agenda. But I do believe that as long as the GAO fails to understand the issues it is investigating and continues to draw sweeping conclusions from meaningless aggregated data, the reports it issues with such fanfare will tell us virtually nothing.

Robert L. Willmore is counsel to the Washington, D.C., law firm of Arent, Fox, Kintner, Plotkin & Kahn, and until May was deputy assistant attorney general responsible for the torts branch of the U.S. Department of Justice.

ASK A BENEFITS MANAGER

Capping costs of health plan for the retired

Q I understand a number of employers are considering limiting their liabilities and cost of retiree medical benefits in light of expected Financial Accounting Standards Board requirements by switching to a defined-dollar approach. How does a defined-dollar approach work and what are the advantages?

A The Financial Accounting Standards Board has been studying the accounting treatment of retiree health care benefits for a number of years and is expected to release an exposure draft by November or

December that will require pension-like accounting for retiree medical benefits. These standards will require a charge to earnings and that a liability be included on a company's balance sheet.

Obviously, many of our more mature companies that are struggling with worldwide competition could be hurt the greatest. Some estimates indicate that annual income for some of the largest manufacturing companies could decrease by 20% or more—depending on final requirements—when they begin to recognize these liabilities on their balance sheets. Based on this significant financial impact, employers are now reviewing the alternatives they have in attempting to maintain these valuable benefits, particularly for their early retirees—who are not yet covered by Medicare—at more affordable and manageable costs so that they do not have a significantly negative impact on the short- and long-term viability of a company.

In my last article I reviewed a number of approaches that should be considered by employers in providing health benefits for retirees over age 65

in light of the catastrophic Medicare program that becomes effective Jan. 1, 1989 (*BI*, Aug. 22), and I reviewed the defined-dollar approach as one of those approaches. I will now review this approach in more detail so that you have an understanding of how it works and the advantages of this approach.

In a defined-dollar benefit plan, an employer indicates a specific amount it will contribute toward the cost of

retiree medical care. If the cost of the medical plan is more than the predetermined company contribution, the retiree pays the difference. The employer's cost is limited to the amount it indicated it would pay toward a retiree's medical coverage.

One way to design and implement this kind of approach is to communicate that, effective Jan. 1, 1990, we are going to grant a dollar
Continued on next page

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

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

This month's column on employee benefits issues is written by Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J. Susan M. Werner,



Mr. Duva

director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field. Mr. Duva's and Ms. Werner's columns usually appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Duva's next column will appear in November.

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.

The challenge of moving data

LAST MONTH I DESCRIBED the impact on a risk manager and risk management information system when acquiring another company (*BI*, Sept. 19). This month, I want to conclude with a discussion of two more situations: when the risk manager's firm spins off a division or subsidiary and when the risk manager's firm is divested or acquired.

The problems in divesting a division or company are less cumbersome and immediate to the risk manager. Chances are, the risk manager has been informed of senior management's intent to divest a division or company and, therefore, will have advance notice for effective planning.

In this situation, the major areas of concern to the divesting risk manager would be:

- **Transition phase.** The divested entity, whether it is now independent or owned by another firm, will need to extract the appropriate portions of its former parent's data base, such as claims and other exposure data. This data then would either need to be converted into an acquiring company's system or the divested firm's risk manager must now create a new system.

Either way, the transfer of data should be carefully planned by the two risk managers. Quick decisions should be avoided. For instance, a wholesale purge of the divested entity's information may not be wise, especially if the divesting firm is retaining the responsibility for running off existing claims. Furthermore, there may be certain sensitive data that senior management may not wish to part with, especially if the divestiture was under less-than-agreeable circumstances. Also, there may be contractual issues of which the divesting risk manager must be aware.

The subject of data ownership should be clearly established in the beginning so that there is no question as to who owns the data if and when a system or vendor is changed, or elements of a company are divested. A careful review of the contract—if there is a service relationship with the vendor—and discussions with the legal

department is highly recommended.

The risk manager should effect a smooth transition by coordinating the data transfer to the divested company. That process may be as simple as instructing the RMIS vendor to batch the divested company's data on a floppy disk or other media. In other cases, the process may be very time consuming for the vendors and risk managers.

- **Divestiture impact.** This is a foundational step. The risk manager must know what impact, both long and short term, this divestiture will have on his or her current system.

For those risk managers with large

In the event that you find your company the target of an acquisition, there are few, if any, RMIS implications. The problem, as we saw last month, lies in the hands of the acquiring firm's risk manager. The acquired firm's risk manager may either be looking for another job or determining if there is any way he or she fits into the acquiring firm.

If such an arrangement with the acquiring firm is possible, the "acquired" risk manager's priority will be to assist in the smooth transition of data and procedures to the new firm's risk management program. That risk manager also can

depending on the degree of similarity between the divested firm and the old firm. For example, the divested firm may have little, if any, claims management needs.

Either way, it would be an excellent time for the new risk manager to conduct a needs identification study.

During this needs identification process, he or she should also be aware of the following issues:

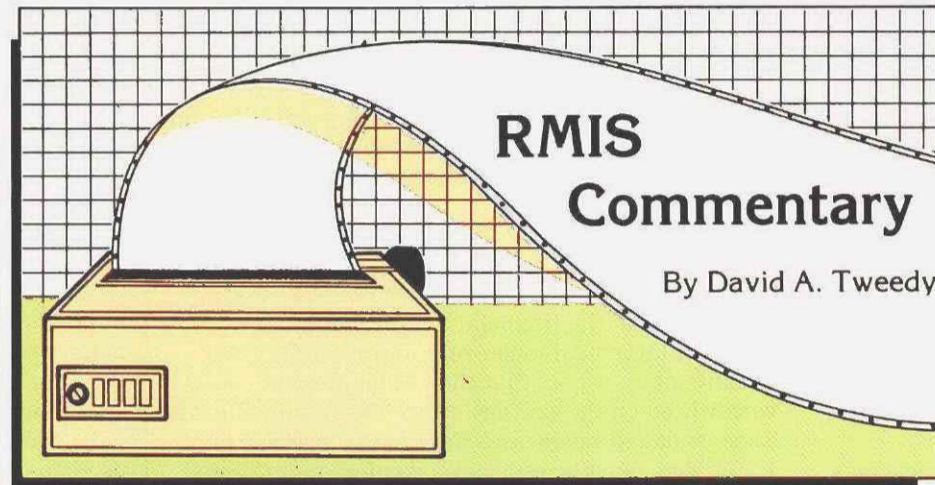
- **Data base construction.** The new risk manager must ensure that the appropriate elements of the old company's data base are extracted and input into the new system.

- **Communication channel establishment.** Fairly quickly, the risk manager must identify people within and outside the new organization who require risk management information, when they need it and how.

- **Contractual rights.** As mentioned above, the new risk manager should determine what contractual rights, if any, he or she has with the old RMIS vendor. It may aid in the data transfer/conversion stage in terms of cost savings.

- **Cost parameters.** The risk management budget will undoubtedly be different from under the old regime. Also, there may be other priorities that may tend to affect the kind of system implemented. This is an excellent time to perform a cost-benefit analysis.

Next month, I will conclude this series on mergers, acquisitions and divestitures with a look at the "ideal" RMIS—one best able to withstand these dramatic changes.



time-share RMIS or minicomputer systems, the divestiture of a unique subsidiary or company could mean the loss of 75% to 80% of all activity. For example, a conglomerate divesting a company with a self-administered workers compensation and general liability program that involves several thousand claims per year may no longer have need for a large claims administration-based RMIS. It simply may be easier to handle the remainder of the RMIS needs on a microcomputer.

Therefore, it would be a good idea for the risk manager to assess what kind of future activity is anticipated if one or more major divisions are spun off. It may signal a need to re-evaluate total RMIS needs. I recommend performing this assessment every three to five years; more frequently if your firm has a reputation for this activity.

assist in the data conversion process since the two systems are probably not immediately compatible.

My final example involves the experience of the firm or division being divested. We will assume that it becomes an independently operating firm instead of one acquired by some other firm.

Often, the problems faced by the risk manager in this situation are comparable to the one who has no RMIS at all. In past columns, I have enumerated the steps a risk manager should take in the design, selection and implementation of a responsive risk management information system.

The obvious first step that the new risk manager should take is to evaluate whether the RMIS and vendor of the old firm can efficiently meet the needs of the new firm. That could be a quick or extended process,

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



Defined-dollar retiree health plans

Continued from previous page

amount equal to the present cost of retiree medical care—say, \$725 per year, per retiree. Assuming that the actual cost remains at \$725 for two years, the retiree would not have to make additional contributions. However, in the third year, if the cost rises to \$850 per retiree, the retiree would then have to contribute the difference of \$125. This is how the plan would continue to operate unless and until the employer decides to pay more than \$725 per retiree.

In this type of program, the employer has the ability to design and manage its level of financial commitment to the various types of retirees (one of the problems with existing retiree medical programs is that they treat all retirees the same with no difference based on service, age, marital status, as is done in pension plans).

According to recent reports, two major

employers—TRW Inc. and Pillsbury Co.—have made moves to limit their retiree health care liability. Instead of guaranteeing a certain level of medical benefits, they will assume a fixed dollar limit for a retiree health plan. If health care costs continue to increase at the rates of 1987 and 1988—and the company does not increase the amount it provides for the coverage—the retiree will pay more.

Some of the advantages of a defined-dollar program for retiree health benefits are:

- ✓ Reducing long-term, overall corporate retiree health care costs.
- ✓ Shifting a greater percentage of health care costs to retirees over a period of time.
- ✓ Changing to recognizing service in allocation of benefits.
- ✓ Recognizing the higher cost of benefits prior to Medicare eligibility.

✓ In projecting the future liabilities of a program, you do not have to build in actual health care cost inflation.

Companies that implement a defined-dollar program must consider grandfathering existing retirees and those close to retirement for the program to be acceptable for these groups of employees, and it is imperative to ease the transition to this type of plan.

In reviewing the defined-dollar benefit approach, some companies may conclude that this is not the right approach for them. However, I believe that for a large number of companies faced with the double problem of escalating health care costs and the FASB accounting requirement, the defined-dollar approach is an attractive and practical way to stabilize costs and provide benefits on a more equitable basis than is currently being done.

Benefit laws

Continued from page 26
 being used to pay for other programs, Ms. Kulash said.

While benefits are likely to remain on the congressional hit list for some time, the outcome of the presidential election could affect the timetable during which some benefit issues are considered.

If Massachusetts Gov. Michael Dukakis wins, increasing access to health care coverage by mandating employer provided coverage is likely to be a major priority of his administration, she said.

With an advocate in the White House urging its adoption, legislation to mandate health care coverage would move through Congress much faster than if Vice President George Bush, an opponent of mandated benefits, captures the presidency, Ms. Kulash said.

If Mr. Bush is elected, Congress is much more likely to consider ways of expanding coverage for long-term health care expenses, an area the vice president has shown interest in, she said.

The election could affect benefit issues in other ways as well.

For example, if the Dukakis-Bentsen ticket wins the election, running mate Sen. Lloyd Bentsen, D-Texas, will vacate his position as chairman of the Senate Finance Committee.

Assuming that the Democrats retain control of the Senate, as appears almost certain, Sen. Spark Matsunaga, D-Hawaii, would be next in line as chairman of the Finance Committee.

Sen. Matsunaga is not known for strong leadership, making it likely that Rep. Daniel Rostenkowski, D-Ill., the powerful chairman of the House Ways and Means Committee, will play an even more commanding role in deciding the fate of benefits legislation.

Among their responsibilities, the chairmen of the House Ways and Means and Senate Finance Committees represent their respective branches of Congress when tax bills, which often include benefit issues, are hammered out for final approval in a joint conference committee.

In the past, Rep. Rostenkowski has taken a hard line on employee benefits.

In 1984, for example, his committee pushed for tough funding restrictions on Voluntary Employee Beneficiary Assns., a tax-favored vehicle used to fund a variety of benefit programs, especially long-term disability.

But Rep. Rostenkowski had to partially retreat when Sen. Bob Packwood, R-Ore., then-chairman of the Finance Committee, fought tooth-and-nail against VEBA restrictions during a House-Senate conference committee that considered the VEBA issue as part of com-

If Massachusetts Gov. Michael Dukakis wins the presidential election, increasing access to health care coverage by mandating employer provided coverage is likely to be a major priority of his administration, says Ms. Kulash.

prehensive tax legislation. Ms. Kulash said restrictions, such as higher taxes on pension reversions from terminated overfunded pension plans, will continue to be discussed by legislators.

The Senate, for example, is considering a proposal conceived by Sen. Howard Metzenbaum, D-Ohio, that would impose a temporary 60% excise tax on reversions received from July 26, 1988, to May 1, 1989 (BI, Sept. 12).

The 60% excise tax is, she said, a de facto moratorium on reversions since the excise tax, coupled with applicable federal and state taxes,

would eat up any surplus.

As a de facto moratorium, the excise tax is intended by its proponents to buy time until Congress considers more long-term approaches to handling the reversion issue, she said.

On the issue of tax incentives for prefunding retiree health care benefits, Ms. Kulash noted that a proposal advanced by Rep. Rod Chandler, R-Wash., has created a dilemma for employers.

While companies want more tax incentives to prefund, which the Chandler bill provides, they are concerned about another provision

in the proposal that would impose a 100% excise tax on pension reversions unless the excess assets are transferred to special accounts to fund retiree health care benefits (BI, Aug. 8).

"Some companies feel that this (100% excise tax on reversions) may be too high a price" for tax incentives to prefund retiree health care liabilities, Ms. Kulash said.

When Congress does consider proposals to give tax incentives for prefunding of retiree health care benefits, it also is likely to tack on vesting and participation rules, said Larry Leisure, national practice leader with TPF&C, the benefits consulting division of Towers, Perrin, Forster & Crosby Inc. in New York.

It is a "pipe dream" to believe that when Congress addresses funding issues it won't also deal with vesting and participation standards, said Mr. Leisure during the session.

Just as Congress will have its hands full tackling benefit issues

during the next session, which starts in January, the states also will be busy, Mr. Leisure said.

For example, if the financial problems of health maintenance organizations persist, more states are likely to establish guaranty funds for HMOs as well as increase minimum capitalization requirements for HMOs, he said.

In addition, if mandated benefit opponent Mr. Bush is elected President, the states could move on their own to enact legislation to require employers to offer health care coverages, he said.

At the same time, the states, to increase revenues, may move more aggressively to tax self-funded health care plans, Mr. Leisure said.



Ms. Kulash



Mr. Leisure

The top talent in the industry is being bought.

42nd annual CEB meeting

MONTREAL—Some 281 benefits professionals and invited guests attended the Council on Employee Benefits' 42nd annual fall conference Oct. 5-7 in Montreal.

The CEB, which is composed of 187 companies, was founded in 1946 to stimulate the development and improvement of the administration of employee benefit programs among its members.

CEB's 1989 fall meeting will be held Oct. 11-13 in St. Louis.

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Unions seek improved defined pension plans

By JERRY GEISEL

MONTREAL—Organized labor will place more emphasis on improvements to defined benefit pension plans during its next round of contract negotiations, a union official says.

"There will be more emphasis on defined benefit plans, especially improvements in early retirement benefits," said David Beier, benefits director for the United Auto Workers' General Motors Department in Detroit.

Mr. Beier, speaking before the annual fall conference of the Council on Employee Benefits in Montreal, also said the UAW supports mandated health care coverage as well as increasing the use of

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managed health care programs.

From the perspective of the worker, defined benefit plans offer several clear advantages over defined contribution plans, according to Mr. Beier.

For example:

• Defined benefit plans provide participants with a promised benefit based on salary and years of service.

By contrast, an employer with a defined contribution plan agrees only to provide a certain contribution. As a result, if assets decrease in a defined contribution plan because of poor investment performance, employees suffer the loss.

• Workers' and retirees' basic benefits provided through a defined benefit plan are insured by the federal Pension Benefit Guaranty Corp. However, the PBGC does not insure benefits provided by defined contribution plans.

While the PBGC's multibillion-dollar deficit has cast some doubt on its ability to pay future benefits to participants in plans it has taken over, legislation passed late last year will shore up the financial base of the PBGC, Mr. Beier said (BI, Dec. 28, 1987).

• Because workers often collect defined contribution benefits in one lump sum before retirement, there is a tendency to spend the money on non-retirement income purposes, Mr. Beier said. By contrast, defined benefit plans typically provide monthly benefits after a worker retires.

Mr. Beier rejected arguments frequently heard in employer circles that companies have the right to reversions from terminated overfunded pension plans.

At least some of that money belongs to participants, according to Mr. Beier. He also noted that reversions frustrate the retirement income expectations of workers.

In addition to supporting curbs on employers' ability to recapture pension surpluses, the UAW backs legislation to require employers to offer health care plans, Mr. Beier said.

Mr. Beier cited Canada's government-sponsored health care program as an example of national health care that works.

Health care costs under the program, which is administered by Canada's 10 provinces and two territories, are substantially less than those in the United States.

And, the program has allowed Canada to achieve universal health care coverage for its population, while across the border more than 37 million Americans still lack health insurance.

And, Mr. Beier dismissed employer arguments that mandated health care legislation, S. 1265, proposed by Sen. Edward Kennedy, D-Mass., is anti-business.

The Kennedy legislation, which would require employers to offer workers health insurance, "is not anti-business. It is pro-business," he argued.

Mr. Beier said the Kennedy bill, if enacted, would be a boon to employers already providing health care coverage.

For example, an estimated 23 million of the 37 million uninsured Americans would gain health care insurance under the Kennedy bill. That expanded coverage would mean hospitals would not

Continued on next page

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Continued from previous page
have to shift as much of the cost of caring for the uninsured to insured patients in the form of higher charges, he said.

Also, if more people had coverage through employer plans they would seek earlier treatment of health care problems. By contrast, those without coverage tend to wait until illnesses develop into medical emergencies, often requiring costly hospitalization, he said.

And, the Kennedy legislation would pre-empt state-mandated benefit requirements, a thorn in the side of multistate employers.

These mandated state benefit requirements drive up the cost of health insurance and put administrative burdens on employers that operate in many states while generally not providing meaningful benefits to workers, he said.

Mr. Beier dismissed employer arguments that a federal benefit mandate would rob employers and employees of the ability to develop a health care package to meet each other's needs.

While the Kennedy bill lays down basic health care plan requirements, employers can deviate from the federal minimums if they provide actuarially equivalent benefits, he noted.

For example, an employer might offer a dental care program in exchange for imposing deductibles

A change in the health insurance system of the United States is inevitable, Mr. Beier says.

higher than the \$250 individual and \$500 family limits mandated by the bill (BI, May 25, 1987).

Mr. Beier says a change in the health insurance system in the United States is inevitable.

While the UAW fully supports the expanded use of managed health care programs to help reduce health care costs, Mr. Beier urged employers to get more health care data from providers and do a better job of analyzing the data.

"Moses did not come down from the mountain with an 11th commandment saying 'Thou Shalt Not Question Doctors,'" he said.

Once employers get their hands on the data, they'll be shocked at the abuses in the health care delivery system, he said.

Mr. Beier cited examples of abuses, including several hundred cases in which doctors prescribed two weeks of rest in hospitals for workers with back problems.

"If that is all that was wrong, they could have stayed at home" to rest, he said.

Indeed, the key to curbing health care inflation is for employers to identify health care providers who provide high quality service at cost efficient prices and then give workers incentives to use those providers, he said.

Such an approach makes a lot more sense than jacking up deductibles and coinsurance requirements, which only shifts costs to workers.

"All the copays will not work" to reduce health care inflation, he said.

Another area of employee benefits for which Mr. Beier sees a growing need is child care services.

Expanded child care programs are a necessity because of the rise in the number of women in the workforce, he said.

Last year, for example, 57% of women with children under age 6 were working, up from 19% in 1960.

Expanded referral systems are needed to help employers and employees find good quality child care centers, he said. ■

Canada nearing universal health care

By JERRY GEISEL

MONTREAL—A combination of public and employer-sponsored programs provide many Canadian workers with richer benefits than their U.S. counterparts, a consultant says.

"We may be the most insured people in the world," observed Robert McKay, a partner in the Toronto office of Hewitt Associates.

Canada has achieved nearly universal health care coverage with health care costs amounting to about 9% of the gross national product, he said. By contrast, about 37 million Americans lack health insurance coverage, while health care consumes close to 12% of the nation's GNP.

The government-sponsored health care programs administered by Canada's 10 provinces and two territories, along with supplemental plans offered by employers, result in tiny out-of-pocket expenses for employees.

For example, when Mr. McKay's wife had a baby several years ago, the total out-of-pocket expense for health care services amounted to just \$6, he said.

Canadian benefit programs also are more generous in other areas, Mr. McKay said during the annual fall conference of the Council of Employee Benefits in Montreal earlier this month.

For example, Canadian employers tend to provide richer dental, life insurance and long-term disability benefits, he said.

Canadian dental programs usually provide first-dollar coverage with employers picking up the full premium, he said.

In addition, Canadian companies provide more generous vacation benefits than American employers.

For example, a Hewitt survey found that four weeks of vacation were provided to employees with 10 years of service by 73% of Canadian employers, compared with just 30% of U.S. companies, he said.

The survey also found that six weeks of vacation were provided to employees with 25 years of service at 27% of Canadian firms, while just 6% of U.S. employers provided that vacation benefit to 25-year veterans.

The biggest difference in benefit practices be-

tween employers in the two countries is the delivery of medical care benefits.

In the United States, most employers provide comprehensive medical care benefits to their employees; public programs are available only for the very poor, disabled and the elderly.

In Canada, however, programs administered by the provinces provide comprehensive health care coverage to nearly all Canadians. The role of employer plans is a secondary one, providing such supplemental benefits as prescription drugs, dental care and semi-private rooms, instead of a ward, for hospitalization.

Since the bulk of health care coverage is provided through provincial plans, the direct benefit costs for Canadian employers are low.

A Canadian employer's monthly costs for supplementary health care programs typically ranges from \$8 to \$20 for an individual, while the monthly cost of family coverage ranges between \$20 to \$50, he said.

"That is probably what a U.S. company paid 25 years ago" for health care, Mr. McKay said.

Continued on next page

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Canadian plans

Continued from previous page

With costs so low, health care cost containment has not yet emerged as a major issue for Canadian employers, Mr. McKay said.

However, employer concern is beginning to develop as costs increase for prescription drug and hospital room upgrade programs, he said.

While flexible benefit programs are beginning to grow rapidly in Canada, the sole impetus behind them has been to increase employees' benefit choices rather than to give employers a weapon to control benefit costs, Mr. McKay said.

"Employers that opt for flex do so because they want to be more innovative," he said.

In some benefit areas, though, U.S. workers have an edge over their Canadian counterparts.

For example, under Section 79 of the Internal Revenue Code, U.S. workers are not taxed on em-

ployer-paid premiums on the first \$50,000 of group term life insurance. In Canada, though, only employer-paid premiums for the first \$25,000 Canadian (\$20,695) is tax-free to employees.

In addition, salary reduction arrangements, under which U.S. employees make pretax contributions for uncovered benefit expenses through arrangements like flexible spending accounts, are not authorized under Canadian tax law, Mr. McKay said.

While Canadian employers providing supplemental health care plans do not face non-discrimination rules, U.S. companies starting Jan. 1 will have to comply with the dreaded Section 89 non-discrimination rules for welfare plans.

"We gave up Wayne Gretzky, but don't have Section 89—a good trade-off," Mr. McKay quipped, referring to the recent trade of the superstar hockey player by the Edmonton Oilers to the Los Angeles Kings.

MARAD to rule on applications by hull insurers

By MICHAEL BRADFORD

WASHINGTON—European underwriters are lining up to write hull insurance on U.S. government-subsidized ships after a ruling earlier this year opened the market to non-admitted marine insurers worldwide.

Prior to the June ruling by the Maritime Administration, an agency of the U.S. Transportation Department, only U.S. and British insurers were allowed to write the coverage.

But since that ruling, nine European insurers have applied with MARAD to write hull insurance for U.S. government-subsidized ships.

Five of the insurers are French:

- Assurances Generales de France.

- La Concorde S.A.

- Groupe des Assurances Nationales Incendie-Accidents.

- La Reunion Francaise S.A.

- Cie D'Assurances Maritimes, Aeriennes & Terrestres S.A.

The other four insurers that have applied with MARAD are:

- Uni Mutual General Insurance Co. of Norway.

- Skandia Insurance Co. Ltd. of Sweden.

- Hansa Marine Insurance Co. Ltd. of Sweden.

- Sirius Insurance Co. Ltd. of Sweden.

"The applications have been published in the Federal Register but no action has been taken yet," said a spokeswoman for MARAD in Washington. Decisions on whether the insurers will be approved to write the coverage are expected sometime next month.

MARAD's proposal to open the market for the coverage initially drew sharp criticism from the American Institute of Marine Underwriters, which charged that the new regulations were not stringent enough with regard to the foreign underwriters (BI, Feb. 1), thereby allowing them an unfair competitive advantage over American and British underwriters.

However, AIMU said after the passage of the regulations that it was pleased some of its recommendations were incorporated into MARAD's final ruling.

Following passage of the regulations, AIMU President Ward L. Mauck said that his group was especially pleased that MARAD expects U.S. government-subsidized vessel owners to place their insurance in the American market when rates and coverage conditions are favorable.

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Australian market

Continued from page 1
world," summed up R.A. (Bob) Scott, the Sydney-based chief general manager of Auckland, New Zealand-based NZI Corp. Ltd., Australia's third-largest insurer (see story, page 48).

"This market is terrible," observed Robert G. Harrison, chief executive officer of Frank B. Hall Australia Holdings Ltd., in Sydney, a subsidiary of Frank B. Hall & Co. Inc. of New York.

"Nobody can tell us in New York how to broke. We have to learn the local rules—that there are too many brokers and too many insurance companies," he said.

However, industry sources do not agree on when the Australian market turned soft.

For example, Lawrence J. Adler, chairman and chief executive of FAI Insurances Ltd. in Sydney, who started Australia's second-largest insurance company in 1960, says the Australian insurance market always has been competitive.

"I have never been of the opinion that there's not been fierce competition," he said.

But, "you can be successful even in a competitive market," he added.

Terry J. Paradine, chairman and chief executive of Marsh & McLennan Pty. Ltd. in Australia, a unit of New York-based Marsh & McLennan Cos. Inc., said the last hard Australian insurance market was in 1974, when Cyclone Tracy swept through the coastal city of Darwin in the Northern Territory, causing insured losses of \$541.4 million Australian in 1987 terms (\$391.2 million at year-end 1987 exchange rates) (see story, page 46).

At that time "we couldn't place 100% of a property insurance policy anywhere in the world at any price," said Mr. Paradine.

Even when the worldwide property/casualty insurance market hardened dramatically in the mid-1980s, the Australian market did not follow suit, Mr. Paradine pointed out.

"In 1985 and 1986 when the U.S. and Europe went hard, the market here instead of shooting up nudged up 10%," Mr. Paradine said, referring to rate hikes. "Now this year the (property/casualty) rates are down an average of 15%. We're all chasing the same small barrel of apples."

Many brokers, underwriters and risk managers agree that the Australian market has further softened since July—the key renewal date for the many Australian companies that end their fiscal year on June 30.

"At the present time, the market is very soft," said W.S. (Bill) Mansfield, managing director of National Commercial Union Ltd. in Melbourne. "In the last six months there's been an escalation of competition."

"The soft market only happened this June," said Ross McKenzie, managing director and chief executive officer of Alexander Stenhouse Ltd., a unit of New York-based Alexander & Alexander Services Inc.

"The market follows along the lines of North America, with kick-in influence by the London market," he noted. There once was a two-year lag between when Australian market conditions followed North American market conditions, but the lag time is now a matter of months, he pointed out.

"So what happens at Dec. 31 in the U.S. happens in London, then here by June 30," he said. "You saw the softening in December. We saw the most severe softening in June this year."

For example, he said, there was greater liability insurance capacity. Insurance buyers easily could find \$100 million Australian (\$79.8 million) of general liability insurance during renewals. Previously,

buyers sometimes had trouble arranging that much coverage, although it could be found, he said.

In addition, buyers saw 20% to 40% discounts in rates for certain classes of business, such as industrial special risks insurance packages, which are all-risk property coverages.

"A lot of premium disappeared in June due to softening rates, maybe \$100 million to \$200 million in premiums, but that is not a scientific figure," Mr. McKenzie said.

The Government Insurance Office of N.S.W. in New South Wales saw some serious competition for liability coverages, according to Charles A. Pollock, assistant managing director of general insurance of GIO in Sydney.

The state-owned GIO, for example, quoted a \$235,000 Australian (\$187,694) premium to a food manufacturer for product liability insurance, said Mr. Pollock, who would not specify the amount of

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Australian market

Continued from previous page limits the GIO would have written for the premium. But a U.S. insurer quoted an \$80,000 Australian (\$63,896) premium for the same coverage, he said.

"And, there was a claim on the policy," Mr. Pollock pointed out.

In another case, GIO quoted a \$40,000 Australian premium (\$31,948) for product liability coverage, but the same U.S. insurer quoted a premium of \$7,000 Australian (\$5,591).

In an attempt to keep another policyholder with a large property risk whose coverage renewed during the June 30 renewal "mania," GIO quoted the company a sharply lower premium, Mr. Pollock said.

GIO negotiated the property coverage for \$2.7 million Australian (\$2.16 million), nearly a 23% reduction from the \$3.5 million Australian (\$2.5 million at year-end 1987 exchange rates) premium GIO

charged last year. The policyholder had a \$2 million Australian (\$1.6 million) deductible last year.

To cut the premium further, the policyholder decided to increase its deductible to \$7 million Australian (\$5.6 million), so GIO cut its premium to around \$1.6 million Australian (\$1.28 million), Mr. Pollock said.

However, GIO lost the coverage to a European insurer that quoted a premium of \$1.4 million Australian (\$1.12 million).

National Australia Bank in Melbourne considers its property insurance placed in the Australian market a bargain.

The coverage is written as an industrial special risk policy that covers all property risks. The bank's premiums for the coverage have increased 20% in nine years, but the bank's assets have increased much more, so in fact the property rates "are so cheap that we wouldn't mention it," said John A. Hale, senior manager of delivery

risk for the bank.

Over the same nine-year period, the bank has increased its deductible to \$100,000 Australian (\$79,870 at current exchange rates) from \$5,000 Australian (\$3,994).

"It would cost more to put the property coverage into a captive," Mr. Hale said.

The bank finances its bankers blanket bond insurance through a new captive based in Singapore (see story, page 40).

The bank also insures general liability risks for up to \$100 million Australian (\$79.87 million), with the coverage placed by Alexander Stenhouse, Mr. Hale confirmed.

Among risks that the Australian market does not write completely are mining operations.

"Mining insurance" has been prevalent since the 1960s and 1970s, when mining activity began to increase significantly in Queensland, the leading mining state, said Paul H. MacDermott, chief executive and managing

director of Sedgwick MacDermott Pty. Ltd. in Brisbane, a unit of Sedgwick Group P.L.C. in London.

"The rapid development of mining in Queensland generated a need for much greater scope of insurance expertise and availability," he said. Coverage originally was written primarily by the London and U.S. insurance markets but later, the Australian market provided capacity as well.

In recent years, however, because of major losses, such as underground collapses, about 50% of coverage is placed in London and 50% in the Australian market.

During this time, the first industrial special risks package was developed to cover all risks of a mining company, Mr. MacDermott said. The IRS package is now a standard insurance policy purchased by many Australian corporations.

Mining property package limits can range from \$10 million Australian (\$7.9 million) for a single loss

at a gold mine to \$500 million Australian (\$399.4 million) for a single loss at a major mine, Mr. MacDermott estimated.

There currently is a minor gold rush going on in Queensland, he said. With new technology, miners are reopening old gold mines in search of new veins of ore.

Gold mining, however, "is less hazardous" than other mining operations and "underwriters see the style of operations as simple," Mr. MacDermott said. As a result, the typical property package for a gold mining project would not provide limits of much more than \$10 million because the insured values are less than those of a coal mine, he said.

Altogether, 172 general, or non-life, insurance companies were registered by the Insurance and Superannuation Commission to write business in Australia as of June 30, according to the commission's 1987/88 annual report.

Together, the insurers wrote \$6.2 billion Australian (\$4.5 billion at year-end 1987 exchange rates) in gross premiums as of Dec. 31, 1987, the commission says, up about 9.9% from \$5.6 billion Australian (\$3.7 billion at year-end 1986 exchange rates) in 1986.

The growth rate of the commercial insurance industry has fallen behind the growth of the country's gross national product, however, as a direct result of the removal during the last three years of workers compensation coverage from the private sector. State-controlled insurers have taken over writing the coverage in three major Australian states—Victoria, New South Wales and South Australia.

Workers compensation moved into the state-owned sector in Victoria and South Australia in 1985 and into the state-owned sector in New South Wales at the end of 1986.

Meanwhile, state-controlled insurers have been the exclusive underwriters of workers compensation coverage in Queensland for many years.

The "nationalization" of workers compensation in Victoria, New South Wales and South Australia has cost the private insurance sector between \$2.5 billion Australian and \$2.8 billion Australian (between \$2 billion and \$2.24 billion) in gross premiums, according to a market survey report on Australia published in May by Axco Insurance Intelligence Services Ltd. in London.

In the last 12 months, the loss of workers compensation premiums has cost Australian insurers around \$800 million Australian (\$639 million), Mr. Scott of NZI estimated.

There now are 13 state-owned insurers in Australia, and these insurers are not controlled by the federal Insurance and Superannuation Commission. These companies had total 1987 gross written premiums of \$3.6 billion Australian (\$2.6 billion at year-end 1987 exchange rates), up approximately 9.6% from \$3.3 billion Australian (\$2.2 billion at year-end 1986 exchange rates) in 1986, according to the commission.

The largest and the newest of these state-owned companies include the Accident Compensation Commission of Victoria, which runs a workers compensation schemes known as Workcare, and the Workers Compensation Board of New South Wales.

The workers compensation state funds, however, are having difficulties, industry sources say. Some of the schemes are believed to be underfunded, and there is talk in some states about moving workers compensation back to the private sector following elections there.

As a result of workers compensation premiums moving to the state sector, insurers are fighting for business in a smaller market.

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Business Insurance

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To gain a competitive edge, some insurers are merging.

And, many observers expect this trend to continue.

The Insurance and Superannuation Commission notes that there are four fewer authorized insurance companies this year than there were at June 30, 1987.

The most prominent of these mergers occurred earlier this year when General Accident Fire & Life Assurance Corp. P.L.C. in Scotland purchased 51% of NZI and withdrew the name General Accident from the Australian market.

Before the merger, General Accident was the 16th-largest insurer, and NZI was the eighth-largest insurer. The combined company is now the third-largest insurer, according to commission figures.

The merger stopped the volatility of the NZI's shares, which were affected by the October 1987 stock market crash, according to the company's annual report for the fiscal year ended March 31, 1988.

NZI, like other insurers, had been hurt by the loss of workers compensation premium, which accounted for 15% of the insurer's gross premiums when the coverage was taken over by state-controlled insurers, Mr. Scott said.

The merger with General Accident "is welcomed," said Mr. Scott. "We are very happy." The

the broker previously placed. Sedgwick Ltd. has since reduced its staff by 20% through attrition, he said.

"All brokers have suffered equally as a result of the loss of workers compensation," said Mr. Harrison of Frank B. Hall. "It was a start for a lot of belt-tightening in Australia. I think we will see more marriages of convenience."

As a result of the loss of workers compensation, however, brokers are becoming more innovative. Many are offering their services on a fee basis. And many are offering risk managers other services besides insurance brokering.

For example, Frank B. Hall is offering special environmental engineering studies through the company's Technical Risk Insurance Management department in Sydney, Mr. Harrison noted.

Other brokers, such as Alexander Stenhouse and Sedgwick, also have risk management divisions.



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The loss of workers compensation premiums also is affecting Australia's 894 general brokers.

two businesses are being integrated in Australia, Southeast Asia and New Zealand, but it has not been decided how to integrate the companies in London.

As part of the plan to recoup from the loss of workers compensations, the new NZI group is developing other areas of business, including linking up via a computer system with NZI representatives based in brokerages throughout Australia and London.

The loss of workers compensation premiums also is affecting Australia's 894 general brokers.

"Brokers took a caning from (the loss of) workers compensation," said John C. Green, deputy chairman and group deputy manager of Hogg Robinson Australia (Holdings) Ltd. "They had to tighten up."

Workers compensation only accounted for 15% of Hogg's brokerage, but the company still reduced staff to 90 people from 135 because of the competition between brokers that resulted from the loss of workers compensation, according to Mr. Green. Hogg also shut down its Perth office and is currently looking for a new chief executive.

"There is little doubt that we (as brokers) found it necessary to step back and look at our whole business at the time" workers compensation became state-controlled, said Robert Piper, chairman of Sedgwick Ltd. in Melbourne, a unit of London-based Sedgwick Group P.L.C., and chairman of the National Insurance Brokers Assn. of Australia.

Workers compensation at one point accounted for 35% of Sedgwick Ltd.'s business, he said. But the company had advance warning and pulled out of workers compensation and developed other business before workers comp became state controlled.

"We are now far more effective and profitable and we realize how much work was involved without making as much money as we thought," he said, referring to the workers compensation coverage

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Australia presents unusual risk issues

By STACY SHAPIRO

SYDNEY, Australia—While Australian risk managers face many of the same issues as U.S. risk managers—workers compensation claims, product liability costs, continuing risk management education and insurance availabil-

ity—risk management in the land “down under” is different from anywhere else in the world, industry observers say.

“The whole financial environment is entirely different here,” said Faith W. Lamberts, executive director of risk management consultants Anistics Pty. Ltd. in Syd-

ney, a division of Alexander & Alexander Services Inc. of New York.

“There are higher tax rates and cost (of doing business); you don’t have the claims frequency here as in the U.S. because workers compensation is substantially a social system and the claims frequency

here doesn’t show the same liability trends as in the U.S.,” Ms. Lamberts added.

So in Australia, “you have low frequency losses with high catastrophic potential,” she said. Anistics, which has been in Australia for two years, is therefore building data bases here that don’t exist in any of its operations in either the United States or the United Kingdom, she said.

One of the major issues confronting Australian risk managers is the “variety and complexity” of the workers compensation system, said Kevin Knight, president of the First World Congress on Risk & Insurance Management to be held in Brisbane next week.

The system is complicated because four of the six states have state-controlled workers compensation insurance programs, he explained.

Work comp insurers 'were looked on as cowboys; so the government moved in,' says Bruce Bow.

Queensland has had a state system for some time, while state legislation was passed to create state-run systems in Victoria and South Australia in 1985 and in New South Wales in 1986.

The state-owned workers compensation insurers were created “to curb the dramatic increases in premiums that (insurance) companies were charging,” explained Bruce Bow, a consultant with Trowbridge Tillinghast, a Towers, Perrin, Forster & Crosby Inc. risk management consulting subsidiary in Sydney.

The loss of workers compensation premiums has had a dual impact on Australia’s commercial insurance market: It not only is creating fierce competition, but it also is spurring mergers and acquisitions among brokers struggling to survive in the soft market.

“Ten years ago I got into risk management, and the biggest ques-

tion was how to get the workers compensation premium down,” Mr. Bow said.

Premium escalation was accelerated in 1984 and 1985 when Australia experienced an epidemic of “repetitive strain injury” claims, such as those from office workers who sat in front of computer screens each day, explained Mr. Bow and many other industry sources.

“RSI became a disease, like getting measles. It took a lot of management to control,” Mr. Bow recalled.

As a result of the RSI claims and increased workers compensation premiums, many Australian employers self-insured their workers compensation exposures and improved working environments.

“Workers compensation became the largest premium cost for a company,” said Mr. Bow. “And the insurers were looked on as cowboys; so the government moved in to regulate.”

Like other employers in Australia, the postal system experienced an “epidemic” of RSI claims, “but our work practices changed that,” said Mr. Knight, who is the manager of Australia Post Security, the security arm of the postal system, in Queensland.

“Workers compensation is a major concern to us,” Mr. Knight said.

Australia Post, which employs 35,000 workers throughout the country, changed the work environment to reduce the frequency of workers compensation claims, he explained.

To reduce the incidence of RSI claims, the piles of mail to be sorted were reduced in size so that workers could “see their progress,” Mr. Knight said. In addition, workers now perform a variety of duties throughout the day to use different muscles, he added.

“This keeps the level of skill up and overcomes absenteeism and workers compensation problems,” Mr. Knight said.

In addition to workers compensation, Australian risk managers also are concerned that their companies’ product liability exposures will increase if two pieces of legis-

Continued on next page

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lution proposed by the Australia Law Reform Commission are passed.

The bills, which will permit class action suits and lawyers' contingency fees for the first time, also will impose strict liability on product manufacturers (see story, page 44).

"The game is fairly stable at the moment," said Mr. Knight. "But if we start down the road of class actions like you have in the states, it would be a whole new ball game for us."

Increasing litigation "is going to be a worry" for Australian companies that already consider the country to be the second-most litigious society outside of the United States, said Stuart W. Bassett, international risk manager for Mayne Nickless Ltd., a multinational firm based in Melbourne.

"It is not good for business. But the attitude of the law is becoming increasingly consumerist," Mr. Bassett said.

Australian risk managers also are concerned about the education of risk managers in their country, which up until a year ago was strictly a matter of learning on-the-job.

Risk management consultants, members of 11-year-old Assn. of Risk & Insurance Management in Australia, insurance brokers and

**AIRM is 'struggling'
to put together a
correspondent
course for risk
managers.**

other companies interested in risk management have set up the Australian Institute of Risk Management to try to "develop a benchmark for Australian risk management," said Ms. Lamberts of Anistics, who is on the AIRM board.

The institute, which started almost a year ago, already has initiated a course for 180 people on the basics of risk management. The course is designed for 20 people at a time and is held in Sydney, Melbourne, Brisbane and Perth.

However, AIRM is currently "struggling" to put together a correspondent course for risk managers because Australia "is too vast a country not to have one," said Ms. Lamberts.

Although risk management education programs are just emerging, many Australian companies have formal risk management departments.

For example, nine years ago, National Australia Bank Ltd. of Melbourne—which is one of the country's top three banks with between \$60 billion and \$70 billion Australian (\$47.92 billion to \$55.91 billion) in assets—launched its "delivery risk division," which encompasses insurance and property loss control for both lending and non-lending risks.

And, Mayne Nickless, which supplies such diverse services as courier services and security vans, has had a risk management program in place for 15 years.

Just this past June, Westpac Banking Corp. in Sydney, Australia's largest banking and financial services group with more than 1,400 branches and more than \$84 billion Australian (\$67.1 billion) in assets, established a strategic operational risk division to coordinate the management of its non-lending risks.

In addition, Australian risk managers have handled mining and ranching risks for decades, since minerals and wool are the two largest exports from this Southern Hemisphere nation.

At National Australia, the pri-

mary purpose of the bank's delivery risk division "is to look at the pure risk and see them in the delivery systems of our products," said John A. Hale, senior manager of the division.

Among its other duties, the department tracks via computer the company's non-lending losses.



For example, after a check of automated teller machine losses found that most losses occur after a check is deposited but before the funds have been transferred, the company installed a mainframe computer system that only allows withdrawals after checks have cleared.

"We probably reduced our total loss pattern from where it was going by 50%," said Mr. Hale.

Continued on next page



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Australian risks

Continued from previous page

National Australia also uses a computer to administer its self-insured workers compensation claims.

The bank's workers comp software, known as infORM, was developed by Objective Risk Management in Sydney for National Australia Bank five years ago. The system, which is now sold in the open market, can divide claims into 85 different injury classifications.

National Australia six months ago formed a single-parent captive in Singapore managed by Sedgwick Ltd., a division of Sedgwick Group P.L.C. of London, to provide bankers blanket bond and computer crime coverage.

The company retains between \$10 million and \$15 million Australian (\$8 million and \$12 million) of its risk. This includes a per-branch deductible of \$100,000 Australian (\$79,870) and the amount insured by the captive, according to Robert I. Ridduch, in-

While there are no inherent risks from mining bauxite, the refineries and smelters where the mineral is turned into aluminum can pose special risks, according to Michael D. Guilmartin, insurance manager for Alcoa of Australia Ltd.

urance manager for the bank. Lloyd's underwriter Alec Sharp leads the layer above the captive's retention, he said.

Another long-established risk management program is run by Mr. Bassett, international risk manager at Mayne Nickless.

"I have never seen an organization more committed to risk management than Mayne Nickless," said Mr. Bassett.

There's been a risk manager in the company for 15 years now, he pointed out.

The company, which is more than 100 years old and employs more than 30,000 people in 11 countries, operates numerous subsidiaries under different names,

including: Armaguard in Australia, Loomis Armored in the United States and Metropolitan Security Services in Australia.

Mr. Bassett described the use of different names for the company's subsidiaries as "commercial risk management," explaining that if one company does badly and has to shut down, a customer may go to another Mayne Nickless-owned company down the street that is doing well and operating under another name.

"They are leaving one of our companies but not leaving Mayne Nickless," he said.

Mayne Nickless has risk managers in Australia, the United Kingdom, the United States and Canada, all of whom report to their respective finance controllers and to Mr. Bassett.

"I coordinate the programs," he said, describing himself as "a glorified consultant."

Mr. Bassett also manages the company's Bermuda captive and its recently formed Singapore captive.

Westpac's risk management division, which was developed in response to a 1986 study of its non-lending risks, currently employs two people—David A. Williams, head of the division, and Richard E. Tarlinton, manager of risk and

loss control.

Eventually, the division may grow to four employees, but "it would be self-defeating to have a big bureaucratic structure," said Mr. Williams.

Among the division's current projects are crisis management and setting up contingency plans in case of a fire, similar to a plan implemented by First Interstate Bank in Los Angeles during a blaze earlier this year (BI, May 9).

The division also is soliciting information on the types of risk management plans being employed at its overseas offices.

The bank has overseas branches in many cities, including London, New York, Tokyo, Hong Kong and Beijing.

Before the risk division was created, there was no way for risk managers at Westpac branches to circulate their ideas throughout the company.

For example, while Westpac's New Zealand branch already has a contingency plan in case administrators there cannot get to work, such as during natural disasters, Westpac's London branch is just developing such a plan.

London could have used a contingency plan twice last year: during the October 1987 windstorms and when an embassy was seized and the roads to the bank were blocked off.

"These are realities which have to be brought out into the open," Mr. Williams said.

On the insurance side of Westpac's risk management program, Westpac has 13 policies, all of which renew on Oct. 1 to coincide with the company's Sept. 30 fiscal year-end, said Mr. Tarlinton.

The coverage is brokered by Sandeman & Co. Ltd. in Australia.

Among its insurance programs, the bank has a bankers' blanket bond, which includes computer crime coverage, with limits of \$100 million Australian (\$79.9 million) and a deductible of \$12.5 million Australian (\$10 million) led by Lloyd's of London underwriter Colin Spreckley.

Westpac also is learning when not to spend money on contingency plans.

For example, last year when the bank experienced problems with its automated teller machines that allowed depositors to make withdrawals without sufficient funds, the loss turned out to be less than the cost to install a 24-hour computerized back-up system, according to Mr. Williams.

Fortunately, the incident only affected the 5% of Westpac's business related to personal banking. The vast majority of Westpac's business—95%—is in corporate banking.

In total, the bank lost \$600,000 Australian (\$433,500 at year-end 1987 exchange rate), of which all but \$60,000 Australian (\$43,350) was never recovered and was self-insured, he said.

Mr. Williams chalked it up as a learning experience.

"Any organization with computer processing is going to go through that (kind of loss), and we learned through the exercise the low cost," he said.

"It changed our approach to risk planning," said Mr. Williams. "It's what I have said for two years. You don't need 100% backup for all computer systems."

One of the country's largest aluminum operations is Alcoa of Australia Ltd., which operates a totally integrated system in which bauxite is mined, refined and smelted to produce aluminum.

"The bauxite is mined only for our consumption, but it is a major activity" said Michael D. Guilmartin, insurance manager for Alcoa of Australia.

While there are no inherent risks from mining bauxite, the refineries and smelters where the mineral is turned into aluminum can pose

special risks, according to Mr. Guilmartin.

Bauxite is "just a type of dirt with an aluminum content," explained Mr. Guilmartin. As a result, the mining risks "are not a large concern."

"There are explosives involved, large ore-carrying vehicles, fire and machinery risks but no special risks to the employees. Explosives are safe until they are primed and there are only a handful of employees involved in the blasting activity," he said.

The refineries and smelters, where the mineral is turned into aluminum, "from a risk point of view, are more complex," Mr. Guilmartin said.

There are large boilers, turbine generators, pressure vessels and very important electrical rooms. The company, however, has not had a single loss that exceeded \$2 million Australian (\$1.6 million), he said.

Alcoa Australia's property coverage is insured by highly protected risk insurers, particularly Kemper Group of Long Grove, Ill., and members of the Factory Mutual System, said Mr. Guilmartin.

These insurance companies offer a full range of inspection and fire safety services to the company, he said.

Alcoa Aluminum insures the first \$30 million Australian of its primary liability insurance policy in the Australian market and Alcoa U.S.'s umbrella liability policy provides cover above that level, Mr. Guilmartin said.

Alcoa Australia's insurance administrator, Brendan M. Ryan, is this year's chairman of the Assn. of Risk & Insurance Management in Australia, which is hosting the First World Congress of Risk & Insurance Managers next week (see story, page 47).

Alcoa Australia is 41% owned by Aluminum Co. of America of Pittsburgh and 42% owned by Western Mining Corp. Holdings Ltd. of Victoria, with the remainder of the company held by others.

"We have insured assets of \$2.5 billion Australian (\$2 billion) and have a whole range of insurance requirements: public liability, business interruption, workers compensation, directors and officers liability," he said, although the company self-insures its workers compensation exposure.

Australia's ranchers are faced with a unique problem when it comes to purchasing insurance: the great distances between cattle ranches and Australia's coastline cities.

Australia's cattlemen cannot always walk into their local insurer's or broker's office to obtain coverage because the ranches—called cattle stations—may be located hundreds or thousands of miles from the nearest town.

To meet ranchers' special insurance needs, Hogg Robinson Australia (Holdings) P.L.C., a unit of Hogg Robinson Gardner-Mountain P.L.C. in London, offers comprehensive property/casualty packages through the Cattleman's Union, which provides insurance for 3,500 cattlemen, according to John C. Green, deputy chairman and group managing director of Hogg Robinson Australia in Sydney.

The cattlemen and the corporations that run the stations are often too far away to talk face to face, said Mr. Green.

"These accounts we can't see. They're too far away. So we mail the coverage proposal to them," he said.

The coverage insures "their home, farm building, equipment, motor vehicles, liability, aircraft and their investment properties, computers, personal accident and pleasure craft," said Mr. Green.

Their biggest risk is bush fires, but "they're insured for that," he said.

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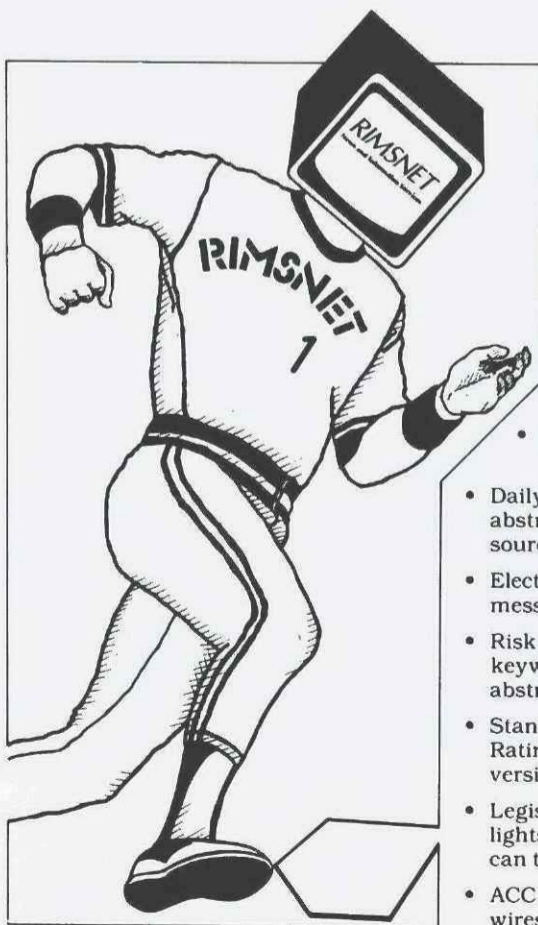
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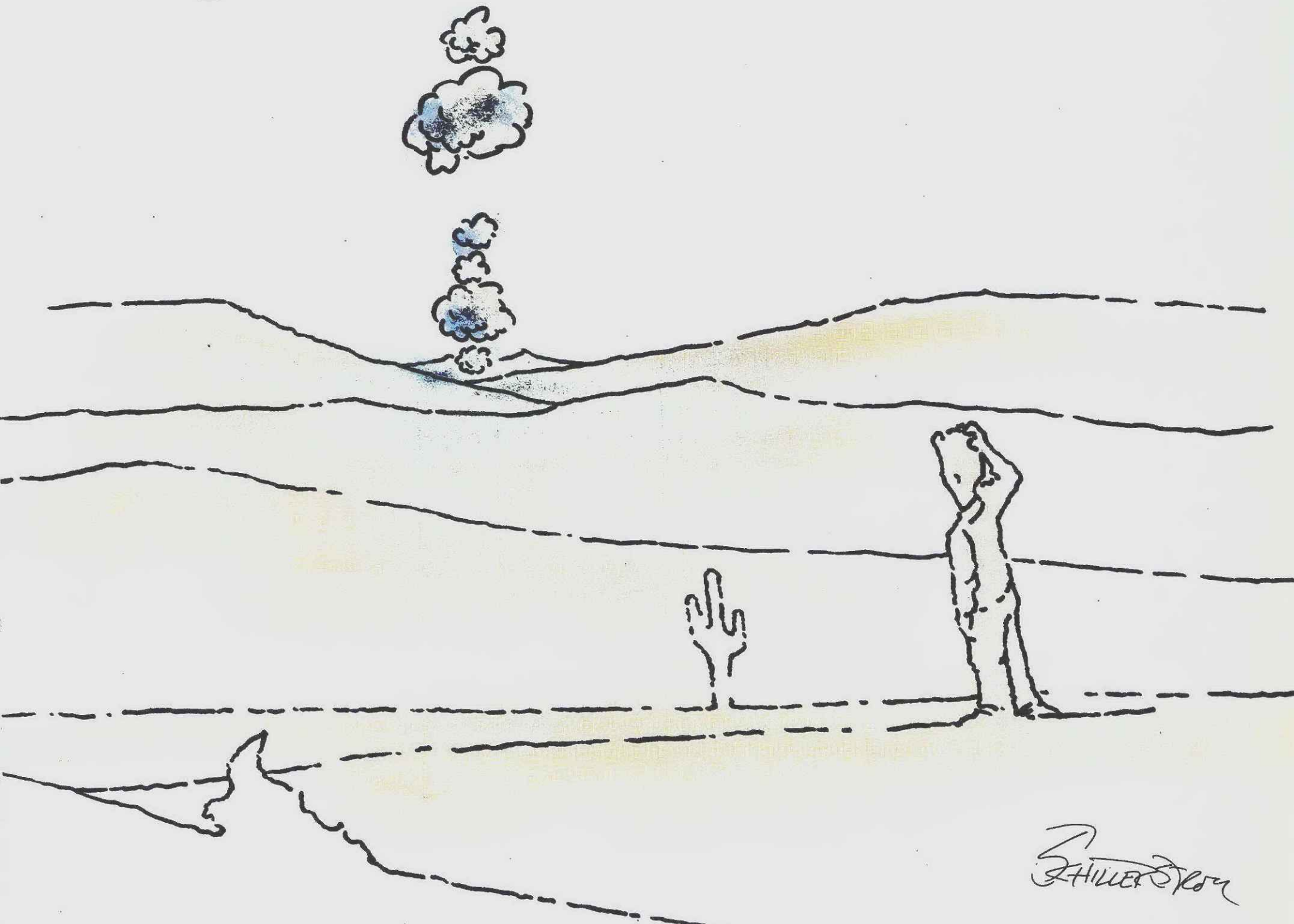
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Australia follows litigious Yankee lead

By STACY SHAPIRO

SYDNEY, Australia—Australia's legal climate is becoming more like the U.S. civil justice system each day, which soon could lead to higher liability insurance premiums and reduced capacity for the country's insurance buyers, observers say.

Damages that Australian courts have assessed against manufacturers, municipalities and schools already mirror damage awards imposed by U.S. courts.

In addition, the Australia Law Reform Commission—which examines the country's legal system and drafts legislation for Parliament to consider—is drafting legislation that would permit claimants to file class-action lawsuits, allow attorneys to charge contingency fees and impose strict liability on manufacturers and importers for products that cause injury.

Most brokers, underwriters and risk managers in Australia fear that modifying Australia's civil justice system to reflect the U.S.

system will lead to a tighter liability insurance market.



limits of between \$100 million and \$200 million Australian (\$79.9 million and \$159.7 million).

"It's a dangerous trend for Aus-

tralia to become more litigious, showing signs of following unhealthy U.S. practices," summed up Robert Piper, chairman of Sedgwick Group P.L.C. subsidiary Sedgwick Ltd. and the Asia/Pacific region based in Melbourne, Victoria.

"If that happens, the changes will be reflected in the cost and availability of liability protections as experienced in the U.S.," predicted Mr. Piper, who also is chairman of the National Insurance Brokers Assn. of Australia. "It

would be a very sad day if that happened."

Many Australians already consider their country the second-most litigious society outside of the United States, and some say even outside the state of California.

For example, they point out the recent case in which a school was ordered to pay \$2 million Australian (\$1.6 million) to a boy who suffered an injury during a sports activity.



Mr. Piper

Another example, they said, is the case in which a transportation authority was ordered to pay \$65,000 Australian (\$51,916) to a bus driver who claimed he contracted cancer from passengers who smoked on the bus he drove.

And, in a landmark decision last month, Victoria's Supreme Court upheld a punitive damage judgment awarded by a lower court—the first time a punitive damage award has been upheld by a supreme court.

The lower court had awarded \$250,000 Australian (\$199,675) in punitive damages and \$426,000 Australian (\$340,246) in compensatory damages to Klaus Rabenalt, a former asbestos miner dying of cancer.

CSR Ltd., a major sugar producer, was ordered to pay the award on behalf of its now-defunct subsidiary Micalco Pty. Ltd., which ran a blue asbestos mine in Wittenoom between 1943 and 1966, when the mine was closed.

CSR faces 288 additional claims that could total \$50 million Australian (\$39.9 million) in losses from former mineworkers and residents of the surrounding area, according to the company.

The company is asking its insurer, the State Government Insurance Commission of Western Australia, a state-owned insurer, to pay \$30 million Australian (\$24 million) of the estimated \$50 million Australian in losses.

However, the SGIC has stated publicly that CSR's coverage is "inoperable." SGIC Managing Director Frank Michell said the Supreme Court in the Rabenalt case "placed direct responsibility on CSR for the Wittenoom mine."

The Australian insurance market is "probably in the same position" that the U.S. market found itself in 1977 or 1978, when asbestos bodily injury cases began proliferating, said Ed Harris, a U.S. insurance consultant, during an Oct. 3 seminar on class-actions lawsuits, contingency fees and product liability given by the Australian Insurance Law Assn. in Melbourne.

To give seminar attendees an idea of what to expect if asbestos bodily injury cases reach the level they have in the United States, Mr. Harris pointed out that eight U.S. law firms are handling 65,000 such cases, and the average settlement ranges from \$8,000 to \$438,000, depending on the illness of the claimant.

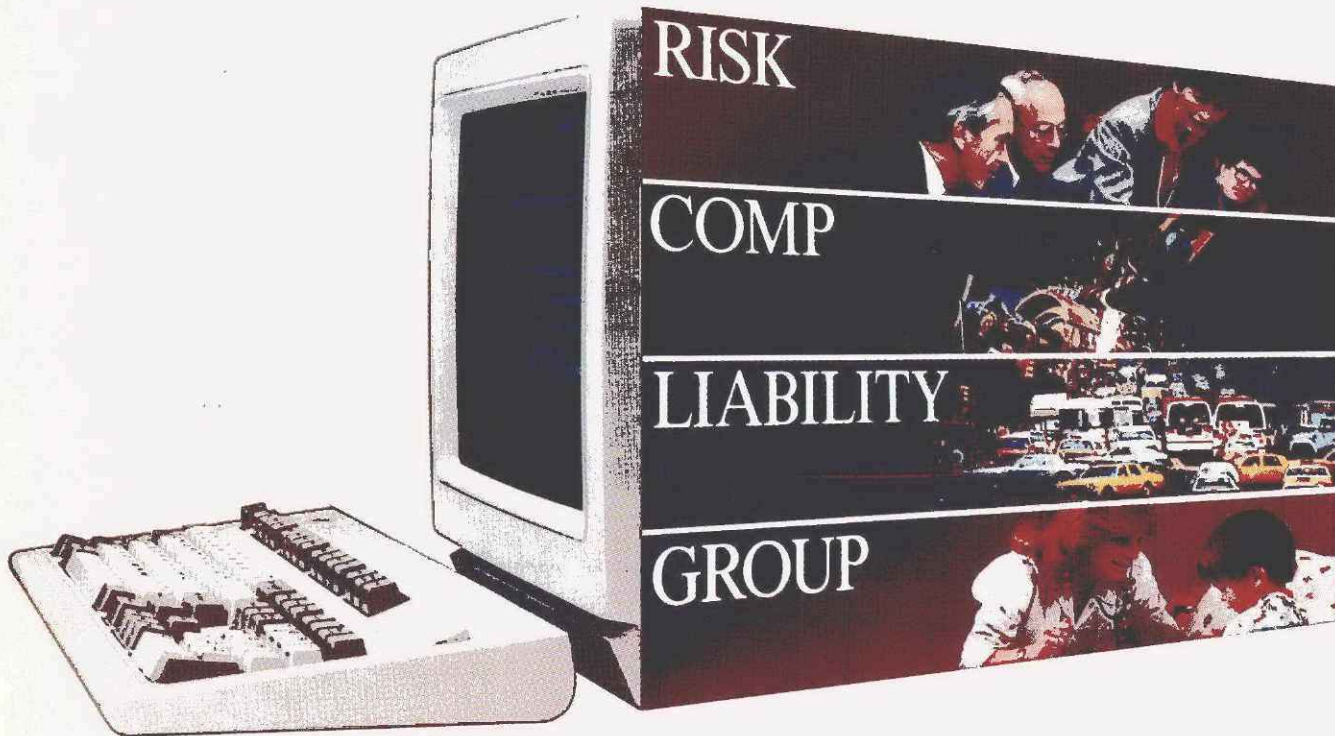
"Thank God we are nine years behind the U.S.," said John A. Hale, senior manager of delivery risk at the Melbourne office of National Australia Bank.

The changes in Australia's civil justice system sought by the Australian Law Reform Commission would further fuel the transformation of Australia's civil justice system into a more litigious system if adopted.

The commission plans to introduce its Federal Court (Group Proceedings) Bill 1988 next month to Parliament. The bill would permit claimants to file class-action law-

Continued on next page

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Continued from previous page suits and allow attorneys to charge contingency fees.

Justice Elizabeth Evatt, president of the Law Reform Commission in Sydney, and her colleague, John Goldring, commissioner in charge of product liability, explained the changes at the Australian Insurance Law Assn. seminar.

The legislation defines "class actions" as a procedural device in which one person can, on behalf of a group, seek legal action against a single correspondent.

Class actions would make it economical for claimants with small losses to seek recovery by banding together and sharing the legal expenses they could not afford individually, Justice Evatt explained.

For example, if 1,000 people suffer damages of \$1,000 Australian (\$799) each, they may not seek recovery because it would not be cost effective, she said. "A class action can help redress the imbalance of this but do no more than that," Justice Evatt said.

Under the proposed legislation, a court would distribute awards to each claimant in a class action only after making a "reasonably accurate assessment of the total monetary relief recoverable in the proceedings," says information on the legislation distributed by the commission.

This kind of "aggregate assessment" would be unique to Australia, Justice Evatt said.

The court also would be able to order that the entire award be placed in whole, in part or in installments in a special Grouped Proceedings Assistance Fund. The fund, a mechanism that also would be created by the legislation, would make payments to claimants based on the court's decision. The fund could retain the money for six years.

The contingency fee aspect of the legislation is intended to make class-action lawsuits attractive to attorneys, Justice Evatt said. "It is the only incentive left for lawyers to take class actions," she said.

However, the fees would be subject to court approval, according to Justice Evatt.

The commission also is drafting separate product liability reform legislation that would allow claimants who charge they suffered injuries as a result of using a product to seek compensation from the manufacturers or importers of those goods, Mr. Goldring said.

The commission released a discussion paper on its product liability legislation proposal in August and is soliciting comments from the public, businessmen and trade associations until Dec. 1. Public hearings also will be held in each state during November.

The commission will report on its proposed legislation to Australia's attorney general in June.

The commission's product liability reform proposal is "controversial," acknowledged Mr. Goldring.

He compared it with the European Community's product liability directive that imposed strict liability on all manufacturers in the EC as of July.

For example, like the EC directive, the commission's proposal says a plaintiff would have to prove only that loss or damage was caused by an identified characteristic of the product used. The burden of providing proof of the product's inherent safety rests with the defendant, who could be the manufacturer or, if the manufacturer cannot be readily identified, another supplier of the goods.

The commission's proposal is tougher than the EC directive in some respects, however. For example, manufacturers under the commission's proposal would not be allowed to use the "development risks" or "state-of-the-art" defense, Mr. Goldring said. Under such a defense, a defendant could provide evidence that the product was as safe as possible when it was produced considering the state of technology at that time.

No such defense is permissible under current Australian law, and the lack of it "does not appear to have restricted innovation or (to have) adversely affected industry in Australia," he said.

In addition, the legislation would not allow the defense that the goods complied with a statutory standard, he said.

The legislation also will not set a limit on the amount of damages that can be awarded in all cases against a manufacturer involving a single product defect, Mr. Goldring said. Any lawsuit, however, would have to be filed within three years of the time that the injured person became aware of the loss.

Many Australian insurers and businesses are concerned the legislation would not be uniformly enforced if enacted, because under Australian law, individual states must approve a federal law for it to be followed on the state court level.

This could result in forum shopping, said Ron Beazley, senior litigation partner at Sly & Weigall in Melbourne.

There also are concerns the legislation would lead to frivolous suits and clog up the court system.

"I am against contingency fees," Mr. Beazley said. "I am worried about liability premiums increasing," he said.

"I am violently opposed to contingency fees," said W.S. "Bill" Mansfield, managing director of National Commercial Union Ltd., a Melbourne-based insurer.

Lawyers who charge contingency fees would be tempted to bring frivolous actions that would abuse and clog up the courts, he said.

"Class actions we don't like" either, Mr. Mansfield said. "You can see some justification, but in principle, I oppose it."

"Class actions and contingency fees are more of Americana and a move toward a more litigious society," said Ross McKenzie, managing director and chief executive of Alexander Stenhouse Ltd. in Sydney, New South Wales. "It will change the price of liability insurance, which is relatively inexpensive here compared with the U.S."



Mr. McKenzie

Lawrence J. Adler, chairman and chief executive of Sydney-based FAI Insurances Ltd., one of Australia's largest liability underwriters, said class-action lawsuits would "not be good news for insureds because rates will have to go up. . . . We are pretty litigious but not as great as in the U.S."

"I have a sense of impending change," observed Faith Lamberts, executive director of risk management consultant Anistics Pty. Ltd. in Sydney, a subsidiary of New York-based Alexander & Alexander Services Inc. "There is a general unease in the public sector, as if maybe a liability fiasco will really strike."

The Insurance Council of Australia Ltd., the insurance trade association based in Melbourne, is studying the commission's proposals before taking a stand, said Grahme C. Bond, chief executive of the ICA.

However, he said: "We are concerned that a change in the law may widen the legal system so that we will have the same problems here as you have in the U.S. We are still investigating the situation. But class actions don't sound good, al-

though we are not quite sure. However, many business associations are strongly opposed to it, and we are the end users of the system.

"If our members pay more claims, we will charge more premiums and the cost will go back to the businesses," Mr. Bond said.

However, Mr. Bond, like most Australians, believes that consumers should have the right to their

day in court without being barred by cost.

Australians should be aware of the "social cost" that will be involved if the country's civil justice system moves closer to the U.S. system, said Stuart Bassett, international risk manager for Mayne Nickless Ltd. in Melbourne. "The social cost is not being properly explained to society," he said.

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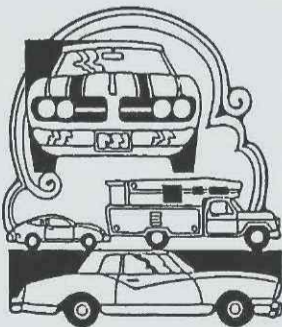
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Mother Nature tests Australian stamina

By STACY SHAPIRO

SYDNEY, Australia—Cyclones, bush fires, floods, earthquakes and other natural disasters are the major risks Australians face.

Over the past 20 years, natural disasters have caused about \$2.53 billion Australian (\$1.83 billion at year-end 1987 exchange rates) of insured losses, in 1987 monetary terms.

"Australia is prone to most of the weather perils you can name—fire, floods, earthquake," said Tom J. Brown, operations director of Royal Insurance Australia Ltd. in Melbourne, Victoria, a unit of Royal Insurance P.L.C.

"What we fear worst here is the weather," said John Cloney, managing director of Sydney-based QBE Insurance Group Ltd., one of Australia's largest commercial insurers.

"We have never seen a country so green, but it will turn to dry grass in the summer and then you will have bush fires. And there are hail storms and cyclones, all very damaging. Mostly, it is the weather we have to worry about. It's the biggest enemy



Mr. Cloney

'We have never seen a country so green, but it will turn to dry grass in the summer and then you will have bush fires. And there are hail storms and cyclones. It is the weather we have to worry about. It's the biggest enemy we've got,' says Mr. Cloney.

we've got," Mr. Cloney said.

For example, much of the country's coastline is prone to cyclones, floods and major storms, which can seriously damage the major Australian cities located on the coasts.

And, because of the country's arid climate, fires destroy thousands of acres of bushland each year.

Royal estimates insured losses caused by natural disasters average about \$133 million Australian (\$106.2 million) per year. While that figure may not appear large by U.S. standards, where natural catastrophes regularly tally more than \$1 billion in annual losses, it is significant in relation to sparsely populated Australia, which has roughly one-fifteenth the population of the United States.

The worst loss occurred in 1974, when Cyclone Tracy hit the Northern Territory coastal city of Darwin, causing insured losses of \$541.4 million Australian in 1987 terms (\$391.2 million).

"Tracy is the most famous loss

here from one event," said Charles Pollock, assistant managing director of general insurance for state-owned insurer Government Insurance Office of New South Wales in Sydney.

Most insurers agree that Cyclone Tracy caused the Australian insurance market to harden, but subsequent insurance cycles on the continent were more influenced by worldwide market trends.

Other major losses, according to Royal, include:

- The 1974 floods in Brisbane, which cost insurers \$211.6 million Australian at 1987 prices (\$153.5 million).

- The 1985 storms in Brisbane, which cost underwriters \$192.6 million Australian at 1987 prices (\$139.2 million).

- The 1970 cyclones, including Cyclone Ada, that hit Queensland and cost insurers \$50.8 million Australian in 1987 terms (\$36.7 million).

- Cyclone Althea in 1971 in Queensland, which cost \$94.7 million Australian in 1987 terms (\$68.4 million).

- The 1986 cyclones that hit Queensland, which cost \$42.8 million Australian in 1987 terms (\$30.9 million).

Australia also fears bush fires, especially in the summertime.

"An earthquake in Adelaide would be a big problem, or a cyclone in Brisbane would be major, but bush fires in Victoria are still the biggest problem," said Terry J. Paradine, chairman and chief executive of Marsh & McLennan Pty. Ltd. in Sydney, a subsidiary of New York-based Marsh & McLennan Cos. Inc.

The worst of these fires occurred on Feb. 16, 1983, in Victoria, a state in Australia's Southeastern

corner, on the ominous day known as "Ash Wednesday." Insured fire losses topped \$165.4 million Australian in 1987 prices (\$119.5 million), according to Royal.

On that same day in South Australia, fires cost insurers an additional \$45.5 million Australian in 1987 terms (\$32.9 million).

The Southern Electricity Commission of Victoria was blamed for causing eight fires in Victoria near Melbourne.

The SECV conceded liability for two of the fires.

The SECV fought a coverage battle with its primary and excess liability insurers in London's High Court. Insurers, including nearly 40 companies worldwide and four Lloyd's of London syndicates, charged that the SECV's loss experience was misrepresented and not disclosed to them before they accepted the risk (BI, March 26, 1984; Jan. 30, 1984).

The insurers claimed that SECV's Australian brokers, Sedgwick Ltd. and Sedgwick International Ltd., units of Sedgwick Group P.L.C., should have paid the loss.

However, the SECV reached an out-of-court settlement during the trial with its insurers and Sedgwick Group, which placed coverage for the SECV in the London market.

The SECV remains a client of one of the Sedgwick units, Sedgwick Ltd. in Melbourne, confirmed Rober M. Piper, chairman of Sedgwick's Asian/Pacific and Australian operations.

The SECV continued its relationship with the broker because the litigation that concerned London operations "did not affect our relationship," Mr. Piper said.

Lloyd's investigated any possible wrongdoing "and did not take any action against anybody," showing that there was no malfeasance, he added.

"Parts of the world have higher

bush fire risks, but Australia is a big country and it's dry and there's a lot of bush around. As housing spreads, the risk will remain with us," Mr. Piper pointed out. "And, we also have eucalypt trees that tend to explode" when they catch fire.

"On Ash Wednesday, you would never have experienced those kind of conditions in your lifetime," he said, referring to the fierce, hot winds that spread the fire swiftly across the dry bushland.

"It is not unusual to have fire, but not of such intensity and size. There is no evidence that we are likely to have that kind of situation again," Mr. Piper said.

Since the SECV loss from the Ash Wednesday fires, however, other electrical utilities have been hit with claims charging that the utilities had caused fires, noted Geoff Atkins of Trowbridge Tillinghast, a Towers, Perrin, Forster & Crosby Inc. management consulting and actuarial firm in Sydney.

Since the SECV case, "there have been a lot of liability claims to electricity companies, which has caused its own liability crisis," Mr. Atkins said.

For example, the GIO is currently negotiating to settle a \$20 million Australian (\$16 million at current exchange rates) claim against an electric company for a December 1986 farmland fire, said Mr. Pollock of the GIO, who noted that London insurers are also on the risk. The claim "hasn't gone to trial yet. We are currently negotiating," he said. "We are hoping to get it into arbitration."

But, Ross McKenzie, managing director and chief executive officer of Alexander Stenhouse Ltd. in Sydney, pointed out that the insured losses in Australia caused by natural disasters must be kept in perspective. He pointed out that insured losses caused by natural disasters "are not unique to Australia. We have certain zones with cyclones, but you (in America) have hurricanes. We have bush fires, and so do you. We have earthquakes, but they are nothing like those in the U.S."



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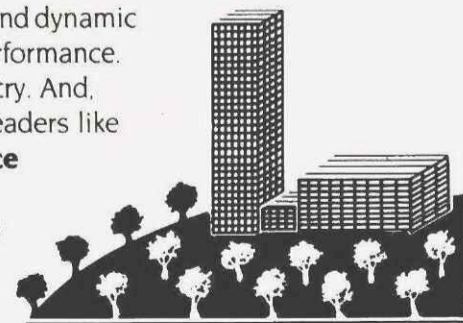
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IFRIMA sets sights on global credentials

By STACY SHAPIRO

BRISBANE, Australia—Risk managers around the world may be able to obtain an "international risk management" designation in the future following the First World Congress on Risk & Insurance Management to be held here Oct. 23-28.

The executive committee of the International Federation of Risk & Insurance Management Assns. will discuss during the five-day conference an outline for an international risk management course that would transcend national boundaries, Kevin Knight, president of IFRIMA, said recently.

Once the members agree on an outline, IFRIMA members will begin drafting a course that could be approved at the 27th Risk & Insurance Management Society conference in Atlanta next year, said Mr. Knight, manager of Australia Post Security, the security division of the Australian Post Office in Brisbane.

Risk managers who successfully complete the course would earn an "international risk management" designation, he said.

The World Congress, which was the brainchild of Mr. Knight, was approved at the 1986 Risk & Insurance Management Society conference in Toronto.

The Congress is being held in conjunction with the annual meeting of the Assn. of Risk & Insurance Managers in Australia, which was moved up a month from its usual November date.

More than 350 risk managers—more than 20% from overseas—are expected to attend this first World Congress, said Mr. Knight.

Risk managers will be coming

primarily from the United States and Europe and will join participants from Japan, India, Malaysia and Singapore.

The focus of the conference is "Leisure and the Age of Technology," which parallels the major tourist attractions around Brisbane, noted Mr. Knight.

For example, one session will feature a report by Sir Llew Edwards, chairman of the World EXPO '88, on the risks at the year-long event closing at the end of the month in Brisbane.

"EXPO's poured more beer than any place in Australia and there's been no serious problems," said Mr. Knight.

"The queues (lines) to get in are up to three hours long, and there's been no punch-ups (fights). The staff are well-trained to nip any problems. And it could also be the Brisbane attitude—there is hardly any crime here," he added.

In addition, conference members will visit area tourist attractions to see risk management programs in action.

"All people of all ages risk the high-tech rides in these parks, and they watch high-tech shows, and eat and drink and the owners hop like billio (hope like hell) that they don't get a power cut (electricity failure). Then the owners hope they can get liability insurance. They are also looking heavily at risk identification and analysis," he said.

Also speaking at the conference will be Graham Butchard, commissioner of the New South Wales Workers Compensation Commission, which was set up last year after the New South Wales government made workers compensation a state-controlled program. ■

Australian insurers wrestle with regulatory problems

By STACY SHAPIRO

MELBOURNE, Australia—Run-off of workers compensation claims, standardized insurance accounting and fire brigade taxes are the primary regulatory issues of concern to Australia's insurance industry.

The insurance industry is currently negotiating with the Accident Compensation Commission of Victoria and the Victorian government over liability for workers compensation claims that occurred before the work comp system was taken over by the state in 1985 (BI, Jan. 6, 1986).

The Victorian government is seeking \$900 million Australian (\$719 million) from insurers for incurred-but-not-reported workers compensation claims stemming from policies issued prior to 1985 when the state program, known as "WorkCare," was imposed.

The insurance industry has countered that the sum is "a ridiculous figure" and has not paid it, said Grahme C. Bond, chief executive of the Insurance Council of Australia Ltd., the industry's trade association in Melbourne.

Currently, insurers and the Victorian government are negotiating a settlement whereby the insurance industry would pay a one-time lump sum settlement for the IBNR claims, according to John A. Clarke, manager of public affairs and a liaison with the Victorian government for C.E. Heath Underwriting & Insurance (Australia) Pty. Ltd. in Melbourne, a subsidiary of C.E. Heath P.L.C. in London.

Heath Underwriting wrote about 23% of the Victoria workers compensation market before it came under state control.

"Negotiations are continuing, but we believe that our assessment is correct that private insurers should pick up about \$200 million Australian (\$160 million)" of the IBNR losses, said Mr. Clarke.

Insurers also are concerned about a recent report issued by the Accounting Research Foundation on standardizing insurance accounting. The report

could be adopted by the federal government's Insurance and Superannuation Commission, which regulates all insurance companies, brokers and superannuation (pension) funds.

"We need to develop accounting standards in the insurance and superannuation industries," said Frank Keenan, senior assistant commissioner of the policy group of the Insurance and Superannuation Commission.

The Insurance Council of Australia agrees that insurance accounting should be standardized, but the industry "wants to make sure it depicts the true position of the company and is not onerous to enforce," said Mr. Bond.

The ICA has submitted its views on the foundation's report to the foundation, according to Mr. Bond.

Among the ICA's concerns, Mr. Bond said, is that "there is a tremendous amount of disclosure required. If the standards are kept as they are, the Australian insurance industry will be the most disclosed companies in the world, anytime, anywhere."

Some insurers also would like to change the collection of fire brigade tax on every fire insurance policy for the state governments, said R.A. "Bob" Scott, chief general manager of NZI Insurance Co. in Sydney, a subsidiary of NZI Corp. of Auckland, New Zealand.

The fire brigade tax finances the operations of local fire departments.

For every property policy in New South Wales, for example, all policyholders pay insurers a \$27.50 Australian (\$22) fire brigade tax for every \$100 Australian (\$79.9) premium and 25% of every \$127.50 Australian (\$101.8) in premium as stamp duty, said Robert G. Harrison, chief executive officer of Frank B. Hall Australia Holdings Ltd. in Sydney, a unit of Frank B. Hall & Co. Inc. of Briarcliff, Manor, N.Y.

"This is not a good way to collect money" for the fire brigades, said Mr. Scott.

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Australian insurers' premiums up 9.9%

By STACY SHAPIRO

BRISBANE, Australia—Australia's general insurance companies' gross premiums rose 9.9% in 1987, according to a report by the Insurance and Superannuation Commission.

The commission reported that general insurance (non-life) companies wrote \$6.2 billion (\$4.5 billion at year-end 1987 exchange rates) in premium volume in fiscal years that ended in 1987, up 9.9% from \$5.6 billion Australian (\$3.7 billion at year-end 1986 exchange rates) in fiscal years that ended in 1986.

The report includes figures for companies' fiscal years that end within the calendar year in its report. For example, if a company's fiscal year ends March 31, 1987, it would be included in these 1987 figures.

The report does not indicate how many companies were included in the 1987 figures. However, as of June 30, 172 general insurance companies and 52 life insurance companies were authorized to operate in Australia, according to the Insurance and Superannuation Commission's 1987/1988 annual report.

The report is the first the commission has issued since it was formed last year, said Frank Keenan, senior assistant commissioner of the policy group of the Insurance and Superannuation Commission.

In addition, there are 13 state-owned insurers not governed by the commission with total premiums of \$3.6 billion Australian (\$2.6 billion) in 1987, up 9.6% from \$3.3

billion Australian (\$2.2 billion) in 1986.

The 172 general insurers that are not state-owned showed an improved net underwriting loss of \$717 million Australian (\$518 million) for 1987, from a record \$800 million Australian (\$532.4 million) loss for 1986.

In contrast, the 13 state-owned insurers' net underwriting loss worsened after workers compensation was moved into the state-controlled sector. The state-owned insurers' net underwriting loss reached \$2.5 billion Australian (\$1.8 billion) in 1987, compared with \$1.8 billion Australian (\$1.2 billion) in 1986.

Altogether, the privately owned general insurers' net aftertax profits were down slightly to \$353 million Australian (\$255 million) in 1987, compared with \$369 million Australian (\$245.6 million) in 1986.

The Top 10 general insurance companies in Australia, based on 1987 premium volume and published by the New York-based accounting firm Deloitte Haskins & Sells, are:

- N.R.M.A. Insurance Ltd. of Sydney, with premiums totaling \$520.1 million Australian (\$375.8 million) and aftertax profits of \$40.6 million Australian (\$29.3 million).

- FAI Insurances Ltd. of Sydney, with premiums totaling \$451.6 million (\$326.3 million) and aftertax profits of \$67.1 million Australian (\$48.5 million).

- The New Zealand Insurance Co. Ltd., which merged with General Accident Insurance Co. of New Zealand Ltd. after General Acci-

dent's Scotland-based parent company bought 51% of Auckland-based NZI's stock earlier this year. NZI has \$344.6 million Australian (\$249 million) in total premiums and total profits of \$43.3 million Australian (\$31.3 million).

- MMI General Insurance Ltd., with a total premium volume of \$338.1 million Australian (\$244.3 million) and aftertax profits of \$2.3 million Australian (\$1.7 million).

- National Commercial Union Ltd. of Melbourne, with \$304.8 million Australian (\$220.2 million) and a profit of \$740,000 Australian (\$534,650).

- Norwich Winterthur Insurances (Australia) Ltd., which merged earlier this year with CIC Holdings Ltd., with total premiums of \$215.6 million Australian (\$155.8 million) and an aftertax loss of \$8.5 million Australian (\$6.1 million).

- QBE Insurance Group Ltd. of Sydney, with a total of \$214.6 million Australian (\$155 million) in

group premium volume and aftertax profits of \$4.5 million Australian (\$3.3 million).

- GRE Insurance Ltd., a unit of Guardian Royal Exchange Assurance P.L.C. of London, with total group premium volume of \$187.7 million Australian (\$135.6 million) and aftertax profits of \$4.5 million Australian (\$3.3 million).

- Mercantile Mutual Holdings Ltd. of Sydney, a unit of Nationale-Nederlanden Group, with premiums totaling \$167.4 million Australian (\$120.9 million) and an aftertax loss of \$4.1 million Australian (\$3 million).

- Royal Insurance Australia Ltd. of Melbourne, a unit of Royal Insurance P.L.C. of London, with total premiums of \$148.7 million Australian (\$107.4 million) and profits of nearly \$21 million Australian (\$15.2 million).

One company that had been in the Top 10 but slipped as a result of the state-controlled workers compensation programs is C.E. Heath Underwriting & Insurance

(Australia) Pty. Ltd. in Melbourne, a unit of C.E. Heath P.L.C. of London (see related story).

Australia's Insurance and Superannuation Commission requires insurers to meet minimum capital and surplus requirements as well as prove that they have adequate reinsurance before they can operate. The commission mandates that companies have paid-up capital of not less than \$500,000 Australian (\$399,350); assets must at least \$1 million Australian (\$798,700) in excess of liabilities or 20% of the previous year's premium volume, whichever is greater; and acceptable reinsurance arrangements, which the insurance company must submit for review.

Because of the stock market crash last October, there was "a substantial decline of Australian and international share markets (which) resulted in a number of companies being requested to furnish additional financial information to the commission," said the commission's annual report. ■

Heath recovering from lost business

MELBOURNE, Australia—C.E. Heath Underwriting & Insurance (Australia) Pty. Ltd. of Melbourne is setting sights on independence and expansion after suffering huge losses when state-controlled insurers became the exclusive underwriters of workers compensation coverage in Victoria in 1985.

Until 1985, when the state of Victoria moved workers compensation coverage from the private sector to state-controlled insurers in an effort to stall climbing workers comp premiums, Heath Underwriting had been the country's largest workers compensation insurer and second-largest private insurer.

In 1984, Heath Underwriting reported \$320 million Australian (\$255.6 million at current rates) in gross premiums. But, Heath Underwriting lost \$200 million Australian (\$159.7 million) of premium volume following the move of workers compensation to state-controlled insurers in Victoria, said John A. Clarke, manager of public affairs and a liaison with the Victorian government for Heath Underwriting.

As a result, Heath Underwriting dropped from the ranks of Australia's 10 largest insurers to No. 13 in 1987 with total premium volume of \$114.5 million Australian (\$82.7 million at year-end 1987 exchange rate).

Heath Underwriting plans to boost its premium volume back to 1984 levels by the end of 1989 by restructuring and expanding to write business outside of Australia, Mr. Clarke said.

Heath Underwriting's parent, broker C.E. Heath P.L.C. of London, announced earlier this month that Heath Underwriting will become a separate company with a \$45 million Australian (\$36 million) capital in-

fusion from Hambros Bank in London, a 16.8% shareholder of C.E. Heath.

Heath Underwriting will be 90% owned by C.E. Heath P.L.C. and 10% owned by Heath Underwriting management, Mr. Clarke explained.

Heath Underwriting began as an underwriting agency for Lloyd's of London underwriter Michael Payne in 1968. C.E. Heath P.L.C. in London took over the underwriting operation in 1971 and Heath Underwriting became an autonomous insurance company.

Heath Underwriting's run-off of workers compensation claims will continue to be "owned" by C.E. Heath P.L.C., which will pay an administrative fee to Heath Underwriting in Australia to administer the run-off, according to Mr. Clarke.

Heath Underwriting eventually hopes to be listed publicly, but the insurer has not selected a stock exchange for its listing, Mr. Clarke said.

Heath Underwriting also hopes to expand in California through subsidiary C.E. Heath Compensation & Liability Co., which it established in January 1987 after Heath Underwriting acquired and renamed Falcon Insurance Co., licensed in Delaware and California.

The California company, which specializes in workers compensation and general liability coverages and has 30 employees, plans to write less than \$25 million in premiums during the 1988 calendar year.

"We hope to achieve \$40 million by 1990," said George O. Sturesteps, deputy chairman of Heath Underwriting. But the company will not grow quickly or write anything but workers compensation until it receives a rating from A.M. Best Co., he said.

—By Stacy Shapiro

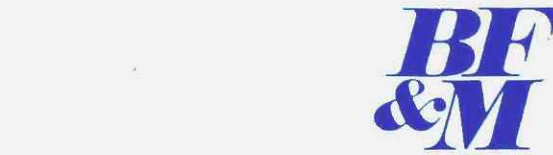
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The land 'down under': A mix of cultures

By STACY SHAPIRO

SYDNEY, Australia—A mixed influence of American and European cultures abound in this country.

In many ways, for example, Australia's major cities look like American cities with clusters of high rise office buildings, major shopping and financial districts and multilane streets.

Sydney looks similar to Denver with very modern buildings mixed among the older buildings—which, in Sydney, date back to the late 18th century when Australia was founded as a British penal colony. Sydney's sparkling harbor, however, is reminiscent of San Francisco.

Melbourne, on the other hand, has a downtown shopping district—Collins Street—which is comparable to Chicago's Michigan Avenue. And Melbourne is perched on the sea coast, similar to Chicago's location on Lake Michigan.

Australia's metropolitan areas also have franchise strips with numerous fast-food chains, including such American chains as McDonald's and Pizza Hut,

as well as miles of used and new car dealerships.

The former British penal colony also maintains English customs, such as driving on the left side of the road, occasionally adding milk to tea and eating lunch later in the afternoon.

More importantly, however, Australia, as part of the British Commonwealth, has a Parliamentary government on both a federal level and in the country's six states.

Australia also has adopted the British legal system, complete with trial lawyers known as "barristers" wearing wigs and gowns to court.

Also part of its British heritage, Australia declares Queen Elizabeth II as the country's sovereign, represented by her Gov. General. The queen's portrait, as in the United Kingdom, is on all coins, although the nation's monetary unit is called a dollar rather than a pound.

"Although our heritage is English, all of our own styles have a very American influence," summed up Ross McKenzie, managing director and chief executive officer of Alexander Stenhouse Ltd., one of Australia's largest insurance brokerages.

Australia, however, has its own unique characteristics.

In particular, Australians must cope with the vast distances between their cities, said Faith W. Lamberts, executive director of Anistics Pty. Ltd. in Sydney. Ms. Lamberts is an American citizen who has lived in Australia for several years.

Australia is the world's sixth-largest country in terms of land mass, with an area of nearly 3 million square miles, but it is sparsely populated beyond its coastline where its five key cities are found:

- Sydney, in New South Wales, the principal port of the country, has about 3.3 million people.
- Melbourne, in Victoria, has 3 million people.
- Brisbane, in Queensland, has 1.1 million people.
- Adelaide, in South Australia, has 960,000 people.
- Perth, in Western Australia, has around 1 million people.

About 90% of Australia's 16 million citizens live within 100 miles of a coastline, according to a Market Survey Report on Australia

published in May by Axco Insurance Intelligence Services Ltd. in London.

Australia's coastline, bordering the Pacific Ocean on the east and the Indian Ocean on the west, spans nearly 23,000 miles.

In addition, nearly all Australians are of European origin, while only about 1% of the population are native Aborigines.

"This country has the largest percentage of its population (of

any country) in urban areas and yet it has one of the world's lowest densities," said Ms. Lamberts. "It has five key commercial centers and nothing else. And each one of them is unique. I can even hear different accents."

Australians also are much more aware of the international climate than are most Americans and Europeans because they frequently travel for work or vacation.

"Australians are outward-look-

ing," said Ms. Lamberts.

Many Australian companies are expanding into other countries, creating multinational media or brewery conglomerates and getting involved in all industries.

And in the insurance industry, many Australian executives are sought for insurance and brokerage posts in New York or London.

For example, John Hatton, former head of Marsh & McLennan

Pty. Ltd. in Sydney, has moved to New York to be managing director of M&M's Pacific Basin operations, said Terry J. Paradine, chairman and chief executive of M&M Pty. in Sydney.

And Lloyd Mills, who preceded Mr. McKenzie at Alexander Stenhouse, is now senior vp and director of Alexander & Alexander International Inc. in New York.

"It's part of our advance party

Continued on next page



1988 Results **RLI** Even Stronger

Consolidated Statutory Financial Information

RLI Insurance Company and Mt. Hawley Insurance Company

STATUTORY SURPLUS *(000 Omitted)*

1983	— \$12,238
1984	— \$16,739
1985	— \$37,037
1986	— \$53,063
1987	— \$57,243
*1988	— \$64,951

COMBINED RATIO

1983	— 94.9
1984	— 97.0
1985	— 99.7
1986	— 84.1
1987	— 84.2
*1988	— 93.9

5 YEAR
COMBINED RATIO: 89.8
(1983-1987)

ASSETS *(000 Omitted)*

1983	— \$ 35,156
1984	— \$ 48,719
1985	— \$105,993
1986	— \$159,568
1987	— \$168,859
*1988	— \$173,861

LOSS RESERVES *(000 Omitted)*

1983	— \$ 4,985
1984	— \$ 9,150
1985	— \$22,784
1986	— \$46,243
1987	— \$59,712
*1988	— \$63,544

*Six months results ended June 30, 1988

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Australia's history

Continued from previous page
to rule the world," quipped Mr. Paradine. "And you thought Crocodile Dundee was light entertainment," referring to the popular film in which a character from the Australian Outback "conquers" New York City. Seriously, he added, it should not be regarded as unique for Australians to move to any English-speaking country.

This year, Australia has been celebrating the 200th anniversary of the arrival of the first "settlers," who actually were British convicts who landed in January 1788 after King George III decreed Botany Bay—later renamed Sydney—a British penal colony.

On those ships were 759 convicts, 43 women and children and 740 officials, says Axco's report, along with the colony's first

It currently is spring in Australia, with the daffodils in bloom and temperatures already in the 80s and 90s in the Northern part of the country where rain forests abound. Toward the middle of the country, where cattle, sheep ranches and mining are prevalent, the temperatures already are topping 100 degrees.

governor, Capt. Arthur Phillip. During the next three years, two more fleets arrived, bringing 3,000 more convicts found guilty of minor offenses. In 1793, the first free emigrants from England arrived in Sydney. But it wasn't until more than a century later, on Jan. 1, 1901, that the Commonwealth of Australia was proclaimed an inde-

pendent federation of six states, namely: New South Wales, Victoria, Queensland, South Australia, Western Australia and Tasmania. The Australian Capital Territory was acquired from New South Wales in 1911 to build the nation's capital, Canberra. Also in that same year, Australia gained control of the Northern Territory.

It currently is spring in Australia, with the daffodils in bloom and temperatures already in the 80s and 90s in the Northern part of the country where rain forests abound. Toward the middle of the country, where cattle and sheep ranches—called stations—and mining are prevalent, the temperatures already are topping 100 degrees as summer in the Southern Hemisphere is approaching. As the country's year-long Bicentennial celebration and the 1988 World Expo in Brisbane winds down, Australians are looking ahead rather than backward, with several cities bidding to host the 1996 Summer Olympic Games. "Australians may have an initial reticence about doing something, but when they accept an idea they go for it hook, line and sinker," summed up Ms. Lamberts.

The professional marketplace

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Business Insurance Circulation Breakdown* Commercial Consumers

Administrative:	
CEO's Presidents and Owners	2,621
Vice-Presidents, General Managers and Other Administrative Personnel	3,657
Financial:	
Chief Financial Officers and Vice-presidents of Finance	2,993
Secretaries, Treasurers, controllers and other Financial Personnel	4,454
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	10,994
Sub-total	24,719
Associations:	
Government, Unions and Educational Institutions	477
Commercial Consumers	979
Sub-total	26,175
Insurance Agents and Brokers	
Insurance Companies	10,557
Actuaries, Attorneys, Adjusters, Appraisers and Consultants	7,380
Others Allied to the Field	3,843
TOTAL	50,946

* Source: Business/Occupational breakdown of qualified circulation, May 30, 1988 issue, as submitted to BPA for June 1988 BPA Publisher's Statement.

Agents, brokers may face new regulations

By STACY SHAPIRO

CANBERRA, Australia—The Australian federal insurance authority may tighten its control over insurance brokers and agents, based on a review of 1984 federal regulations.

The Insurance and Superannuation Commission is considering amending the Insurance (Agents and Brokers) Act 1984 to bring the regulation of agents closer in line with broker regulations; to extend the powers of the commission to investigate brokers' accounts; and to require brokers to keep "appropriate" accounting records for the commission to review.

The commission earlier this year issued its proposed changes in a 15-page document distributed to most brokers and agents for comment. The commission is reviewing the market's responses before it drafts an amendment to the insurance act.

"The whole review has sprung up in light of the operations experience" of the act, said Stephen Curley, assistant commissioner of general insurance at the Insurance and Superannuation Commission in Canberra, Australia's capital.

If the commission decides following the comment period that its proposed changes are necessary, the commission will have to ask Parliament to amend the 1984 law.

In Australia, the federal government oversees all brokers, agents and insurance companies. The Insurance (Agents and Brokers) Act 1984, which the Australian Law Reform Commission proposed in 1980, outlines the supervisory role of the commission and the duties of brokers and agents.

The act became effective on a state-by-state basis between Jan. 1, 1986 and August of this year.

According to the act, brokers must be registered by the commission to conduct business. The brokers must abide by strict audit requirements, carry professional liability insurance and file annual reports to the Insurance and Superannuation commissioner.

The act also requires brokers to release premiums to insurers within 90 days of their receipt from policyholders.

However, the regulation of insurance agents is much less stringent: Agents do not have to be registered, follow the audit requirements that a broker must, or release premiums to insurers within a specified period after receipt.

But, as soon as the act was implemented, a "number of complaints of relevance to the provisions of the act were received and investigated," according to the commission.

"By late 1987, it was apparent that a review of the operations of the act was appropriate in order to identify areas in which amendment may be necessary to ensure that the objectives of the act were being met in the most efficient manner."

The commission has identified 13 areas of regulation that

The brokers must abide by strict audit requirements, carry professional liability insurance and file annual reports to the Insurance and Superannuation commissioner.

need attention.

For example, the commission particularly wants to address the unequal treatment of brokers and agents, noted Frank Keenan, senior assistant commissioner of policy group for the commission.

"There is concern from brokers that they must meet the cost of registration, but an agent does not," even though an agent may conduct similar business, he said. "We haven't come up with a solution yet, but we have canvassed views."

Among its proposals, the commission recommends that agents be required to hand over premiums to underwriters within a certain amount of time, possibly as short as a week, rather than the 90-day requirement now in force for brokers.

The commission also proposes extending its power to inspect or audit the accounts of agents as well as brokers.

The commission, among other changes, also proposes:

- Extending the powers of the Insurance and Superannuation commissioner to refuse, suspend or cancel broker registration, including when the commissioner believes the broker is unable to meet its obligations or is involved in another brokerage business that fails to meet requirements. Revocations of broker registrations would be made public.

- Requiring brokers to maintain appropriate accounting records and explain their transactions and financial position to the commissioner.

Current practice "has created difficulties for the accounting profession and has hampered investigations by the Insurance and Superannuation Commission," the review document said.

- Allowing brokers to self-insure a portion of the professional liability insurance they are required to carry.

The law currently states that brokers must carry professional liability insurance limits of at least \$500,000 Australian (\$399,350) or that equal to 15% of premium volume in the previous financial year, whichever is greater, up to a maximum of \$5 million Australian (\$4 million).

- Allowing inspectors appointed by the commission to investigate a broker's books and demand that documents be produced on request. This is mandated by the Insurance Act 1973 for insurance company investigations but is not addressed in the brokers and agents law.

In general, the National Insurance Brokers Assn. of Aus-

tralia agrees with most of the changes the commission seeks.

However, the NIBA made some alternative recommendations in its Sept. 19 response to the commission.

For example, while NIBA welcomes the expansion of the commission's power to refuse, suspend or cancel brokers' registration, NIBA believes that "it is important that a degree of specificity be given to the Insurance and Superannuation Commissioner so that he still has certain guidelines to act within."

NIBA encourages the commission to be even stricter with agents. For example, the association claims that fees paid by policyholders to agents should be charged on a separate invoice from a premium invoice, if the commission allows agents to make such charges.

The commission reports that 894 general insurance—or non-life—brokers and 65 life insurance brokers were registered as of June 30, down from 989 general brokers and 76 life brokers as of June 30, 1987.

The commission received 100 new applications for registration for general brokers and 827 renewal applications in 1988. Of these, 857 have been granted, nine have been refused, 52 were pending as of June 30 and nine applications were withdrawn.

In addition, 120 general insurance brokers did not apply for renewal of registration, and 42 general insurance brokers' registration were canceled voluntarily.

The decrease in registered brokers shows that "the industry is undergoing a process of rationalization and consolidation," the commission's report says.

Most insurers and brokers say the loss in three states of workers compensation premiums, which state-owned insurers have been exclusively writing since 1985, has fueled competition. These changes are causing an increase in mergers and acquisitions in the Australian market.

The commission reports that the 778 brokers that filed financial statements to the commission showed an aggregate operating profit of \$36.4 million Australian (\$29.1 million at current exchange rate) from general brokerage business and an operating loss of \$239,000 Australian (\$190,889) from life insurance brokerage on total premiums of \$3.2 billion Australian (\$2.6 billion). Brokers' assets totaled more than \$1 billion Australian (\$798.7 million).

As of June 30, the commission had received 75 complaints alleging breaches of the brokers and agents act. The act details more than 40 offenses with penalties ranging from \$5,000 Australian to \$25,000 Australian (\$3,994 to \$19,967).

Six cases involving criminal allegations were referred to the state police, which led to the prosecution and conviction of one insurance intermediary. Other police investigations are continuing, according to the report.

Two insolvencies were reported to the commission during the year: Business Insurance Consultants (Aust.) Pty. Ltd. and Hunter Loth Insurance Brokers Pty. Ltd., according to the report.



Sedgwick leads Australia's brokers

The largest insurance broker in Australia is Sedgwick Ltd., based in Melbourne.

The subsidiary of Sedgwick Group P.L.C. in London placed premiums of more than \$450.4 million Australian (\$359.7 million) in 1987, according to the New York-based accounting firm Deloitte Haskins & Sells.

Deloitte, which ranks the largest insurance brokers in Australia according to premium volume in the September 1988 edition of its Insurance Directions, gleans its figures from the Insurance and Superannuation Commission.

The gross gross revenues and profits of all Australian brokers are not public.

Sedgwick in Australia has evolved through mergers and acquisitions and internal growth since at least 1953. It now employs about 600 of the 1,000 Sedgwick people in the Asia/Pacific region, said Robert Piper, chairman of both the Australia and Asia/Pacific region. Revenues totaled about \$45 million Australian (\$35.9 million) at the end of last year, he said.

About 60% of its brokerage is paid in fees rather than commissions, which "is a growing trend" in Australia, he said.

Although Sedgwick considers itself to be an "all-around" kind of broker, some of its specialties include marine hull, construction, professional indemnity and financial institution placements, said Mr. Piper.

Sedgwick is also the largest captive management company in the region with a "strong operation" in Singapore, Mr. Piper said. The group manages 17 Australian captives in Singapore, including those of Westpac Banking Corp., National Australia Bank Ltd. and Qantas Airways.

The second largest broker is Alexander Stenhouse Ltd., a subsidiary of Alexander & Alexander Services Inc. in New York, with a premium volume totaling nearly

\$386 million Australian (\$308.3 million) last year, according to Deloitte.

Stenhouse, based in Sydney, has its origins in 1876 with the Reed Stenhouse Group and 1886 with Alexander & Alexander Inc. Group, which merged in 1985 following the merger of the two parent companies.

Stenhouse has 500 employees in 23 offices in Australia and Papua New Guinea with total revenues of between \$40 million Australian (\$31.9 million) and \$50 million Australian (\$39.9 million), said Ross McKenzie, managing director and chief executive of Stenhouse.

"We promote to our clients integrated services," said Mr. McKenzie. Together with A&A unit Anistics Pty. Ltd., Stenhouse offers a range of risk management services.

The third-largest insurance broker is Marsh & McLennan Pty. Ltd. of Sydney, with a premium volume of more than \$237.3 million Australian (\$189.5 million) at year-end Dec. 31, according to Deloitte.

The company is mainly "a hybrid" going back 60 or 70 years when the Baillieu family started a company in Melbourne, which was acquired by C.T. Bowring & Co. Ltd. and in 1981 merged with M&M.

There are three units of Marsh & McLennan Cos. Inc. of New York in Australia: the retail broker M&M; employee benefits consultant Mercer Campbell Cook & Knight; and C.T. Bowring Reinsurance, said Terry Paradine, chairman and chief executive of M&M Pty. Ltd. in Sydney.

Although Mr. Paradine would not comment, industry sources say the retail broker's revenues are around \$35 million Australian (\$28 million) with all three companies posting total revenues of \$65 million Australian (\$52 million).

M&M Pty. Ltd. employs 340 people and reports to London's Marsh & McLennan Bowring as of July 1 this year under M&M's global restructuring, Mr. Paradine confirmed.

The other top 10 brokers, according to Deloitte, include:

- Fourth-ranked Willis Faber Johnson & Higgins Pty. Ltd. with a premium volume of nearly \$173.5 million Australian (\$138.6 million) in 1987.

The company posted a net loss of \$343,000 Australian (\$273,954) after the merger with Stewart Wrightson Holdings P.L.C. group last year.

- Fifth-ranked Jardine Australian Insurance Brokers Pty. Ltd. with a premium volume of \$162.4 million Australian (\$129.7 million) in 1987.

Based in Sydney, the company has 285 employees with revenues last year of about \$20 million Australian, said Dennis Guy, chief executive.

The company is 60% owned by Jardine Insurance Brokers in London, 20% by the company's chairman, Brian Coppin, based in Perth, and 20% by the Australian company Westfarmers.

In Australia, Jardine is heavily involved in 400 local municipal authorities' insur-

ance programs in Victoria, New South Wales and South Australia.

The group also is involved in the construction industry.

- Sixth-largest is the Minet group, which is a unit of the U.K.'s Minet Holdings P.L.C., with about \$124.4 million Australian (\$99.4 million) in premium volume in 1987.

The company showed a net loss of \$847,000 Australian (\$676,498) at year-end.

- Seventh-ranked is Bain Clarkson Pty. Ltd., which is a unit of U.K.-based Bain Clarkson Ltd., with a premium volume of about \$91.3 million Australian (\$72.9 million) in 1987.

It reported a net loss of \$81,000 Australian (\$64,694) in 1987.

- Ranked eighth is Westpac Insurance Services (Brokers) Ltd., the first Australian broker in the top 10, with a premium volume at year-end Sept. 30, 1987 of \$67.4 million Australian (\$53.8 million).

Westpac Insurance Services showed a net profit in 1987 of \$706,000 Australian (\$563,882).

- Ranked ninth is Hannan group, made up of six registered Australian brokers, including Hannan & Co. Insurance Brokers Pty. Ltd., with about \$59.4 million Australian (\$47.4 million) in premium volume and net profits of \$548,000 Australian (\$437,687) at year-end June 30, 1987.

- Ranked as the 10th-largest is the Lowndes Lambert group, made up of six companies including Lowndes Lambert Australia Ltd., with about \$55.8 million Australian (\$44.6 million) in premium volume and \$179,000 Australian (\$142,967) in net profits for its year-end March 31, 1987. The broker is a unit of U.K.-based Lowndes Lambert Group Ltd.

—By Stacy Shapiro

Sedgwick is the largest captive management company in the region with a 'strong operation' in Singapore, according to Sedgwick's Robert Piper.

Candidates' views

Continued from page 1

Mr. Dukakis has long been interested in insurance and related issues.

Almost 20 years ago, Mr. Dukakis, as a representative in the Massachusetts Legislature, led the state to adopt in 1970 the country's first no-fault automobile insurance law.

Based on interviews, the Democratic and Republican national platforms, campaign position papers and responses to questions submitted to each campaign by *Business Insurance*, the two presidential candidates' views on several corporate liability issues emerged, including:

- High risk occupational disease notification.

Mr. Dukakis would support and Mr. Bush probably would oppose a federal law requiring workers to be notified if they have been at high risk of contracting an occupational disease because of workplace exposure to certain hazardous materials.

Earlier this year, a high risk occupational disease notification bill was passed by the House and debated but withdrawn from the Senate floor (*BI*, April 4).

"Clearly, the bill will be back," noted Susan Spangler, director of risk management for the National Assn. of Manufacturers in Washington and the leader of the business coalition that lobbied against the bill. And "it may be even more broad and more onerous," she said.

For example, organized labor favors a federalized workers compensation program in addition to a federal high risk occupational disease bill, she noted.

Mr. Dukakis would support these initiatives, she speculated.

Furthermore, because Mr. Dukakis favors mandated benefit programs, he may also favor a federal high risk occupational disease notification program, both of which benefit the worker, pointed out Charles Fritzel, assistant vp of government relations in the Washington office of the National Assn. of Independent Insurers.

However, Mr. Bush "would continue to be very strongly opposed to" a high risk occu-

pational disease notification bill, Ms. Spangler said.

Business "can expect the same type of help from" a Bush administration that it received from the Reagan administration during congressional consideration of the notification bill, Ms. Spangler speculated. Several Cabinet secretaries lobbied against the bill and advised President Reagan to veto the bill if it passed the Congress.

A Bush administration would be "antagonistic toward" a high risk occupational disease notification bill, predicted Tom O'Day, associate vp in the Washington office of the Alliance of American Insurers.

However, the AIA's Mr. Lefkin predicted that "labor would have a higher degree of acceptance under Mr. Bush than it did under Mr. Reagan."

Neither candidate responded to questions on the issue.

- Repeal or modification of the McCarran-Ferguson Act.

Mr. Dukakis believes the limited antitrust exemption granted to the insurance industry by the McCarran-Ferguson Act of 1945 warrants review, and Mr. Bush's position on the issue is not clear.

"The Dukakis administration would be more likely to look closer at the insurance industry" than the Bush administration, because the Democrats on a whole tend to favor federal solutions to problems, Mr. Fritzel said.

Mr. Dukakis would "have more of an activist, federalist approach," he said.

The Dukakis campaign, in response to questions, said: "The breadth of the antitrust exemption for the insurance industry is a legitimate source of concern and should be re-examined to see if it is still consistent with the public interest."

Mr. Lefkin pointed out that Mr. Dukakis as governor of Massachusetts "has not disassociated himself" from state Attorney General James Shannon, one of the most vocal opponents of McCarran-Ferguson and an active leader in the antitrust litigation filed by 19 state attorneys general against the insurance industry (*BI*, June 20).

However, a Republican administration might be more hesitant to change the status

quo than a Democratic administration, Mr. O'Day speculated.

Mr. Bush probably would lend a "more sympathetic, understanding ear" to the insurance industry than Mr. Dukakis would, Mr. Lefkin said. "A Bush administration probably will have interests that coincide more closely with the insurance industry" than a Dukakis administration would have.

Furthermore, repeal or modification of the insurance industry's antitrust exemption seems to be more of a Democratic issue than a Republican one.

For example, all of the Democrats except one on a House subcommittee voted earlier this year for a bill that would virtually gut McCarran-Ferguson. All of the Republicans on the panel opposed the measure (*BI*, June 20).

But, both candidates seem to oppose federal regulation of insurance.

The Republican platform, while not addressing the issue directly, says on the issue of federal vs. state regulations: "We are committed to further return power from the federal government to state and local governments, which are more responsive to the public and better able to administer critical public services."

Mr. Dukakis, in response to questions, stated: "The regulation of the insurance industry appropriately rests with the states, and I oppose any change" in that area.

Whatever the candidates' stance on the issue, both Mr. Lefkin and Mr. O'Day agreed that the Justice Department antitrust chief under either a Democratic or a Republican administration probably would support repeal or modification of the antitrust exemption.

"The outlook on the federal level under either administration is rocky" for the insurance industry, Mr. O'Day said.

- Environmental liability.

Mr. Bush and Mr. Dukakis both can be expected to be tough on environmental issues.

The Democratic platform states that the federal government must "aggressively enforce toxic waste laws and require polluters to be responsible for future cleanup costs."

The Republican platform basically agrees: "We support strong enforcement of our en-

vironmental laws and will accelerate the pace of our national effort to clean up hazardous waste sites and to protect our groundwater."

"Both parties have been making that a key issue" in their campaigns, noted Jon Harkavy, director of governmental affairs for the Risk & Insurance Management Society Inc.

Neither candidate "bodes well for business," observed Les Cheek, vp of federal affairs in the Washington office of Crum & Forster Corp. "Either administration would favor more extensive environmental legislation."

Under either a Dukakis or a Bush administration, businesses and insurers "are going to face significant difficulties," Mr. Lefkin agreed.

Given the limited resources of the federal government, both administrations would say companies should pay to clean up toxic waste, Mr. Lefkin continued. He added that if companies do not have enough money to finance cleanups, insurers also will have to pay.

Mr. Bush, previously not thought of as an environmentalist, is "clearly trying to distance himself from the record of the early Reagan years" and establish himself as a candidate sympathetic to environmental issues, Mr. Cheek noted.

Mr. Dukakis comes from a state that has among the most stringent environmental laws in the nation, Mr. Cheek pointed out.

Furthermore, Mr. Dukakis has had direct experience with environmental impairment liability insurance.

The state created a fund in 1985 to pay third-party claims in the event of a hazardous waste spill if a waste facility did not have insurance to cover the claim, explained Timothy Gailey, assistant secretary of consumer affairs and business regulation for the state of Massachusetts.

After the state approves a claim, all waste-generating businesses in Massachusetts would be assessed a fee to pay the claim, based on the amount of hazardous waste the companies generate, Mr. Gailey continued. Claims would be limited to the maximum

Continued on next page

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amount of insurance required by the federal government for hazardous waste facilities—\$3 million occurrence/\$6 million aggregate.

So far no claims have been submitted to the state-sponsored program.

- Tort reform.

Both Mr. Bush and Mr. Dukakis support tort reform, but Mr. Bush's support for the issue is much stronger than Mr. Dukakis'.

"We propose to return the fault-based standard to the civil justice system," the Republican platform says. "We support enactment of fair and balanced reforms of the tort system at the state level."

Responding to questions, the Bush campaign stated: Fairness, balance and predictability must be restored to this nation's liability system through the consideration of such important reform as: restoration of a fault-based standard of recovery; elimination of the 'deep pocket' rule under which defendants only minimally responsible for an injured party's damages can be forced to pay 100% of a plaintiff's claim; and expanded use of alternative dispute resolution mechanisms such as binding arbitration and mediation to encourage early resolution of disputes.

"Already more than two-thirds of our states have enacted some form of tort reform, and I believe public officials must do all they can to ensure appropriate reforms are enacted in all our states and in the federal system," the Bush campaign response concludes.

Mr. Bush is "completely committed to the issue" of tort reform, said Blair Childs, executive director of the American Tort Reform Assn. in Washington.

However, while Mr. Dukakis has supported tort reform in Massachusetts, "we would like the governor to have been much more active and more of a leader" in the drive to enact state tort reforms, Mr. Childs said.

Also, Mr. Dukakis' view "is 'states rights' on this," Mr. Childs noted. Mr. Dukakis would not support reform at the federal level, he speculated.

Mr. Dukakis, in response to questions, said: "In general, I support full compensation. However, I supported the Massachusetts Medical Malpractice Reform Act of 1986 which set a \$500,000 limit on the amount which a jury can award for non-economic damages, i.e., pain and suffering.

"This cap is intended to strike a balance between the real needs of an injured patient and the very legitimate problems occurring in the medical community as a result of the increases in the number and size of malpractice claims. The law provides that, in extraordinary circumstances, a jury may exceed the \$500,000 limit. There is no limit on the amount recoverable for economic damages."

In addition, Mr. Dukakis endorsed several tort reform recommendations made by the Massachusetts liability task force, including modifying the rule of joint and several liability.

The report recommended that the contribution to a damage award by each defendant be based on its relative share of liability under the comparative negligence or fault scheme.

Other recommendations in the report that Mr. Dukakis endorsed include: requiring advance notice of policy non-renewals; increasing insurance company disclosure requirements; increasing funding to insurance departments; and adopting a flex rating system for some commercial liability lines.

Mr. Dukakis proposed legislation that would have made these recommendations law, but the bill did not pass, Ms. Gold said.

London computers

Continued from page 3

enzie and Mr. Mahoney.

"On larger risks, face-to-face negotiation will still be necessary. Brokers will still see the first three or four leading underwriters" to set the terms of the policy before offering the risk over the network, Mr. Mahoney said.

The "potential rewards are enormous, and the consequences could be dire if we let someone else use the technology against us," Mr. Mackenzie concluded.

The first claims to be handled electronically over the LIMNET system will be non-marine claims processed through the Policy Signing and Accounting Centre Ltd., a policy signing and accounting bureau for more than 130 London insurance companies.

London brokers next month will be able to send claim notifications to PSAC members via the network, allowing underwriting claims managers to agree, question or settle the claims via the computer network by entering information on a computer terminal.

Before linking up with LIMNET, Lloyd's plans to unify its claims system. And, Chairman Murray Lawrence has instructed all syndicates to join LIMNET by the be-

ginning of 1990.

"It has become increasingly apparent that Lloyd's needs to improve the claims service it provides to both brokers and insureds. It is felt that, if improvements can be made in this area, it will lead to a reduction of costs and thus an improvement in the competitive position of the marketplace leading to an increase in business," Mr. Lawrence wrote in a Sept. 28 letter to senior market personnel.

As a result, "all Lloyd's syndicates will be required to be a member of the claims office which serves the syndicate's principal market by March 1, 1989. Membership will be mandatory for the central recording, advising and taking down of all claims," he said.

A working group appointed by the Committee of Lloyd's, chaired by former Lloyd's Chairman Sir Peter Miller, is investigating how "the current claims agreement processes operating within the Lloyd's market can be built upon and streamlined into a set of efficient and speedier procedures and to make recommendations to the Committee of Lloyd's by March 31, 1989," the letter continued.

Lloyd's currently has separate claims processing facilities for its

"A good point of difference (between the two candidates) will lie in judicial appointments," Mr. Lefkin said.

Increasingly, tort reform will be fought in the courtroom, so judges' appointments will influence tort reform, he said.

- Federal product liability reform.

Mr. Bush probably would support federal product liability reform, while Mr. Dukakis' position is unclear.

A Bush administration would be "supportive and helpful" in the fight to enact a federal product liability reform law, said Victor Schwartz, counsel to the Product Liability Alliance and an attorney with Crowell & Moring in Washington.

The Republican platform calls for "a reasonable state and federal product liability standard that will be fair to small businesses, including professional and amateur sports, and to all who are in liability contests."

"Jobs are being lost, useful and sometimes lifesaving products are being discontinued, and America's ability to compete is being adversely affected" by the current liability scheme, the platform says. "Reform will lower costs for all and will return fairness to the system for the benefit of everyone."

However, in response to a question submitted to the Bush campaign on whether product liability reform should be enacted at the federal level or left to the states, Mr. Bush responded that he "support(s) individual state authority."

He continued: "Consumers have generally been well served by the regulatory structures developed by the states. As president, I would urge states to continue to take the lead in product liability regulation. I would encourage the drafting of a uniform state code as a model for the states."

Mr. Schwartz noted, though, that "we've had many situations where political leaders at first blush think federal product liability laws should be left to the states."

However, after politicians understand the interstate commerce and national insurance ratemaking aspects of the issue, "most people agree... that product liability should be handled by the federal government," he continued.

Mr. Dukakis' position on product liability is not defined.

"We just don't know whether a Dukakis administration would support a federal product liability law," Mr. Schwartz said.

Mr. Schwartz pointed out that Rep. Bill Richardson, D-N.M., the original sponsor of H.R. 1115, the federal product liability reform bill passed by the House Energy and Commerce Committee earlier this year (BI, June 20), served on the Democratic platform committee. However, the platform does not mention the issue of product liability, and the Dukakis campaign did not answer questions on the issue.

- Increasing taxes on property/casualty insurance companies.

Still reeling from the tax increases imposed on property/casualty companies by the Tax Reform Act of 1986, insurers may be hit again for higher taxes under the next presidential administration, observers warn.

While both candidates say they are opposed to raising taxes, observers think future tax increases are likely.

"We are a ripe target with the budget deficit as it is," Mr. Lefkin said. "Either administration is going to have to go to some lengths to find revenue. We as a large business entity are going to be a large target." ■

aviation, marine and non-marine markets. However, syndicates are not required to process claims through these facilities. Syndicates that do not process claims through market claims processing offices must settle claims with brokers individually.

All claims then must be processed by Lloyd's central accounting office.

In addition, "by early 1990 all syndicates will need to join the London Insurance Market Network either directly or through a computing services bureau so that claims information can be passed electronically," Mr. Lawrence also said in his letter.

The Institute of London Underwriters, an association of marine and aviation underwriters representing more than 100 London companies, plans to handle claims via the network by June 1989, an ILU spokesman said.

More than 80 of a total of 240 Lloyd's brokers already are connected to LIMNET, and the Lloyd's Insurance Brokers Committee has instructed all Lloyd's brokers to be connected to the system by 1990, according to Mike Anstee, systems director for the committee.

Continued on next page

Update

Iowa may take Chubb licenses

DES MOINES, Iowa—Insurance Commissioner William D. Hager announced he may seek to revoke all of the licenses of Chubb Corp. subsidiaries in Iowa as a result of the insurer's failure to bind some \$400 million in drought insurance its agents sold nationwide.

A Dec. 5 hearing before an administrative law judge is scheduled to consider whether to revoke the license of Federal Insurance Co., a Chubb unit that issued drought insurance through underwriting manager Good Weather International Corp. of Jericho, N.Y.

"We are simply not going to have an insurer in this state collect premiums and not pay claims," said Mr. Hager.

After the hearing, the commissioner will investigate revoking the licenses of other Chubb units in Iowa including: Alliance Assurance Co. Ltd., Great Northern Insurance Co., Pacific Indemnity Co., The Sea Insurance Co. Ltd. and Vigilant Insurance Co.

"Chubb sold the products in Iowa under the Chubb name," said Commissioner Hager. "We are concerned there may be involvement of other Chubb companies and we may consider revocation of the licenses of all Chubb companies."

Chubb already is immersed in litigation in federal and state courts nationwide where it is being charged with fraud for attempting to return double the premiums to the farmers who bought drought policies (BI, Aug. 8; July 25; July 18).

Fireman's Fund fights regulator

BOSTON—Fireman's Fund Insurance Cos. is protesting an attempt by the Massachusetts Insurance Division to revoke the license of an Illinois-based insurer it recently acquired.

The division filed a complaint last week seeking to revoke the Massachusetts license of Lisle, Ill.-based Warner Insurance Co., alleging that its "proposed" sale violates an agreement reached last November that permitted Fireman's Fund to withdraw from writing business in the state (BI, Nov. 23, 1987).

However, attorneys for Fireman's Fund contend the Insurance Division's complaint is "without legal foundation," because the sale was completed before the complaint was filed.

Richard J. Underwood, a partner in the Boston law firm Finnegan & Underwood, said that Fireman's Fund completed its purchase of Warner from Employers Insurance of Wausau on Sept. 29, and that the sale was approved by Illinois Insurance Director John E. Washburn. The Massachusetts department was notified of the acquisition on Sept. 30, Mr. Underwood said. In addition, he said he met with Commissioner Roger M. Singer the following week to discuss any potential legal concerns, none of which was voiced at the time.

Warner has written no business since 1985.

The division has scheduled a Nov. 29 hearing on the complaint.

Outhwaite, 2 syndicates settle

LONDON—Lloyd's of London underwriting agency R.H.M. Outhwaite (Underwriting Agencies) Ltd. has settled two more disputes involving claims of \$10 million over runoff reinsurance policies that underwriter Richard Outhwaite wrote in the early 1980s.

Mr. Outhwaite has agreed to pay all claims filed by syndicate 406, underwritten by Seamus Cowley and managed by Wellington Underwriting Agencies Ltd., plus an additional sum for incurred-but-not-reported losses. In return, Mr. Cowley will reassume all future liabilities stemming from the unlimited runoff reinsurance policy.

In addition, syndicate 28, underwritten by J.J.S. Birrell and managed by Murray Lawrence & Partners, has agreed to raise the point at which Outhwaite will be responsible for claims in return for a lump sum payment, the Outhwaite spokesman confirmed.

Court eases watch of insurers

PROVIDENCE, R.I.—The Rhode Island Superior Court has lifted the temporary receivership on two property/casualty insurance subsidiaries of Resolute Holdings Inc. (BI, Oct. 3).

American Universal Insurance Co. and Canadian Universal Insurance Co. Inc., both members of American Universal Insurance Group, had been placed into receivership earlier this month because of questionable investments.

While lifting the receivership, Superior Court Judge Thomas H. Needham also issued a consent order putting these investments under the control of a specially appointed trustee, attorney Allan Shine of Winograd Shine & Zacks in Providence, according to Earl C. Ostroff, chief executive officer of the two companies.

Mr. Ostroff, who was asked by Mark A. Pfeiffer, director of the state Department of Business Regulation, to run the companies while it was under receivership, will remain there. He replaces Charles Christopher, who resigned in September.

Briefly noted

Sanus Health Plan, a New York-based HMO, is negotiating to purchase **Mxicare of New York Inc.** and Mxicare Health Plan Inc.'s Houston organization for an undisclosed sum, according to *Crain's New York Business*. . . **Alexander & Alexander Services Inc.** sold its 5% ownership in Priceforbes Federale Volkskas Ltd., a South African insurance broker, and is dissolving its dormant South African subsidiaries that have not conducted business for 2½ years. . . The California State Automobile Assn., a not-for-profit American Automobile Assn. affiliate, has launched a statewide **campaign to support Proposition 104**, a no-fault auto insurance initiative sponsored by the insurance industry (BI, Feb. 29). . . President Reagan last week signed welfare reform legislation that will limit tax breaks for employees who use dependent care reimbursement accounts to fund **child care expenses** (BI, Oct. 10). . . The **Victoria Insurance Co. Ltd.** President Charles Gordon-Seymour has been replaced by Bharat Shah, who had been vp-finance, treasurer and secretary, a Georgia Insurance Department spokesman confirmed. The Insurance Department last month suspended Victoria's license (BI, Oct. 10).

New asbestos claims facility

Continued from page 3

that insurers will not take part in the day-to-day operation of the Center.

However, insurers will be able to affect how the Center is run through their non-voting board member and by having the right to audit the claims files of the Center.

In addition, if, after the first year, insurers do not believe the Center is well-run, they can withdraw their support.

None of the voting members of the Center's recently elected board of directors represents insurers. The board consists of three members selected by the three largest producer members of the Center; one member elected by majority vote; and the president.

Members of the Center's first board are:

- Lawrence Fitzpatrick, formerly acting chief executive officer of the Asbestos Claims Facility, and recently elected chairman, president, chief executive officer-elect of the Center for Claims Resolution.

- Glenn W. Bailey, chairman and president of Keene Corp. of New York.

- Samuel J. Heyman, chairman and CEO of GAF Corp. of Wayne, N.J.

- Mr. Hines of Armstrong.

- Christopher J. McElroy, senior corporate counsel for United States Gypsum Co. in Chicago. Mr. McElroy was elected by majority vote.

The board of directors also includes two non-voting members: Curtis M. Pontz, senior counsel and assistant secretary for CertainTeed Corp. in Valley Forge, Pa.; and Keith Rayment, non-marine director responsible for claims at Sturge Holdings P.L.C., a Lloyd's of London underwriting agency.

In addition, Center members elected William R. Jacobi, director of claims for the Asbestos Claims Facility's Eastern regional claims office, vp-claims elect and treasurer; and Peter Coleman, director of law at the Asbestos Claims Facility, vp-law elect and secretary.

"We have eliminated to a certain extent some of the internal conflicts that led to dissolution of the Asbestos Claims Facility," said Irving Kagan, senior vp and general counsel for GAF.

The producers that abandoned the Asbestos Claims Facility were frustrated because smaller producers could side with insurers to create voting blocks against the larger producers, explained Mr. Gilbert.

"We no longer expect to have bitter fights between the members and the directors at the board level as to how claims are to be settled," agreed Mr. McElroy of USG.

Insurers also are pleased with the structure of the new facility because they are relieved of some of their claims-handling obligations and do not have to get tied up in the day-to-day activities of the Center, explained John F. Shea Jr., vp and claims counsel for Aetna Life & Casualty Co. of Hartford, Conn. He said it is more appropriate for producers to run the facility because they are named in the litigation.

With the benefit of experience from the Asbestos Claims Facility, the framers of the Center For Claims Resolution say they have created a more enduring organization.

"With a clearer mission and stronger organizational structure than that of the Asbestos Claims Facility, a smaller and more unified membership and a refined and more flexible method by which to share liability among its members, the Center should provide the best opportunity for private industry to address the asbestos crisis," said Mr. Fitzpatrick.

"This is a group that has three years' experience together and has discussed in detail what they want to do," said Mr. Gilbert. "Every conceivable issue that could cause a rift has been put on the blackboard and been resolved. We have also built in flexibility."

Inflexibility was the main reason the Asbestos Claims Facility died, observers say.

For example, under the Wellington Agreement the percentage of liability costs paid by each producer was based on historical data on claims paid until 1983 and could not be changed significantly. The Center for Claims Resolution has created a more flexible system for allocating liability costs.

The Center's liability formula is based on several time periods and different occupational categories to reflect the changing mix of asbestos cases, said Mr. Gilbert. In addition, there is no cap on changes in a producer's liability costs.

The members of the Center also have a more unified claims handling philosophy than did the Asbestos Claims Facility. The members of the Center for Claims Resolution unanimously are dedicated to the "fair and expeditious" settlement of meritorious claims, and they have set their sights on eliminating the backlog of claims, said Mr. Gilbert. Currently more than 60,000 asbestos claims are pending.

"We want to resolve these claims well in advance of the time they go to trial, and we want to resolve them ultimately using claims-handling staff and not outside lawyers," said Mr. Gilbert.

The Asbestos Claims Facility had only a handful of in-house counsel, but the new Center for Claims Resolution hopes to eventually have a greatly expanded in-house legal staff, he said.

An agreement also was expected to be signed last week that allows asbestos producers—both those that joined the new organization and those that didn't—to share counsel for routine tasks such as discovery.

However, unlike under the Asbestos Claims Facility, in the new facility "joint counsel will not represent all producers in settlement and they will not represent producers in conduct-related trials," explained Mr. Gilbert.

Each producer can be represented by its own counsel when it believes it has different interests.

The Center for Claims Resolution also has an improved system of governance in which each producer's vote is weighted according to amounts paid on its behalf to the Center. Therefore a larger asbestos producer that faces more claims will have a more heavily weighted vote than a smaller producer that faces fewer claims. In the Asbestos Claims Facility, each producer and insurer had one equal vote regardless of size.

"We have tried to provide those producers who have a more significant stake in the center, in terms of payment of their assets, more of a say in governance, and, at the same time, preserve for smaller producers a say in how things are run," Mr. Gilbert explained.

"It is a hard balance to achieve."

21 unite in claims handling

The 21 producer members of the Center for Claims Resolution include: A.P. Green Industries Inc., Armstrong World Industries Inc., CertainTeed Corp., C.E. Thurston & Sons Inc., Dana Corp., Flexitallic Inc., GAF Corp., IU North America Inc., Keene Corp., Marmont Corp., National Gypsum Co., NOSROC Inc., Nutum Corp., Pfizer Inc., Quigley Co. Inc., T&N P.L.C., United States Gypsum Co.

Insurers supporting the new organization are: Fireman's Fund Insurance Cos.; Royal Insurance Co.; Liberty Mutual Insurance Co.; Crum & Forster Inc.; Hartford Insurance Group; Aetna Life & Casualty Co.; CIGNA Property & Casualty Insurance Co.; Lloyd's of London; and several London market insurers.

London computers

Continued from previous page

The IBM LIMNET system began operating last year for simple data and accounting transfers, and the number of underwriters and brokers linking up with the system is growing dramatically, said Bob Perry, manager of IBM's LIMNET operations in London. It currently links about 160 organizations, including companies, brokers and Lloyd's underwriting agencies.

And, several insurance companies and brokers already are examining the practicalities of computerized risk placement, *Business Insurance* has learned.

For example, PSAC expects to introduce computerized risk placement for some excess-of-loss reinsurance renewals by the end of next year, said Roger Foord, PSAC's market relations and planning manager.

Lloyd's underwriting agencies and brokers also are examining electronic risk placement, said Peter Rawlins, managing director of Sturge Holdings P.L.C.

"We are talking to brokers about how to make better use of the electronic network, including risk placement. We also are getting underwriters comfortable with the idea," he said.

Some agencies, including Sturge, currently are experimenting with different underwriting functions via electronic links with brokers, he noted.

In addition, Lloyd's broker C.T. Bowring & Co. Ltd. is working on a prototype risk placement program with D.P. Mann, said Roger Townsend, Bowring's group controller of management services.

Both Mr. Townsend and Mr. Rawlins predict that some insurance renewals will be placed electronically in the London market during next year.

Meanwhile, network facilities to deal with other underwriting functions, such as excess-of-loss reinsurance premium adjustments, placing syndicates' outward reinsurances, and accounting for proportional treaties, likely will begin, Mr. Townsend said.

"Networking is an opportunity for the market to realize massive cost savings. It will reduce the cost of doing business for both the broker and the underwriter as well as developing the quality of the product," explained Mr. Mahoney of Alexander Howden.

The electronic network, for example, will handle the more tedious and routine elements of transactions, such as repetitive storage of data, he explained. In addition, the network likely will increase the quality of information available to underwriters, he said.

"There will be a consistency of records and a greater assimilation of data," said Mr. Mahoney.

In addition, brokers no longer will have to wait in long lines to see every underwriter prepared to write a percentage of the risk—a very wasteful process, other supporters of the system say.

Underwriters and brokers will be able to further reduce costs by moving much of their staff out of London's expensive financial district to administration offices located outside of London, he added.

Already, some London insurance companies are considering retaining only a few key staff in a central underwriting building (*BI*, Sept. 19).

By reducing underwriters' and brokers' costs, the network will enable the London market to offer faster, more efficient and more innovative service, even to the point of 24-hour trading if required, sources say.

However, the advent of "technology will change nothing unless we change the way we do business," Mr. Mahoney said, referring to the fact that there is some resistance to the LIMNET system.

Many underwriters and brokers in the market remain doubtful about the effectiveness of an electronic network. There is an underlying fear that people will lose their jobs and that machinery will take over some underwriting and brokering decisions to the detriment of the market, sources say.

The thought of electronic trading is causing a "very healthy debate," said Mr. Mahoney, admitting that the network will mean a reduction in the number of people involved in each transaction.

"The cost savings are going to come about because we will be making our industry less people-intensive," he said.

Until now, the market members linked to the system have concentrated on non-controversial applications, such as data transfer.

However, the uses now being planned, such as electronic risk placement, likely will be "controversial, (initially) expensive and entirely voluntary. There will be a lot at stake," said Mr. Mackenzie of DP Mann.

"The relationship between brokers and underwriters is endowed with old customs. It is traditional, highly sensitive and very controversial," Mr. Townsend of C.T. Bowring and chairman of the network's steering group told the seminar attendees.

As a result, "people will find it difficult to accept" the role of a computer in placing risks, he said.

However, electronic trading is vital for the survival of London as the world's premier insurance market, the speakers argued.

"Lloyd's competitive edge is being eroded by the growth of its competitors and its increasing overheads. Our profitability is shrinking," said Des Lee, head of systems and communications at Lloyd's.

But Mr. Mahoney said there are "encouraging signs" of a changing attitude toward the computer system.

"A lot of people believe electronic trading will come sooner rather than later. Having hundreds of thousands of people dashing around London is costly and inefficient," Mr. Mahoney explained.

"The brokers have woken up to the fact business is changing. The chief executives of the broking houses will push for electronic risk placement," said Mr. Anstee of the LIBC.

"London will blend technology in quicker than other insurance centers," he predicted.

"The market is becoming readier, the pace of recognition is accelerating," Mr. Townsend agreed.

"Getting LIMNET right is vitally important for the London market. If it doesn't get it right it will be damaging for the market as a whole," said Cees Schrauwers, director of insurance consultancy for Coopers & Lybrand Associates Ltd. in London.

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By **LEONARD M. WILSON**
Special to Business Insurance

INSURANCE BROKERAGE has traditionally ranked as one of the most profitable industries as measured by profit margins or return on shareholders' equity. The generous returns stem from the highly specialized nature of the professional service rendered, barriers to entry for new competitors and strong underlying growth that fosters profit opportunities. Last month, we addressed the issue of commercial premium growth as the ultimate determinant of the brokers' longer-term prospects (*BI*, Sept. 19). We concluded that despite the soft rates prevalent during most years of the past decade, insurance premiums would continue to expand at—or modestly above—the rate of increase in the gross national product. From our vantage point, we anticipate a favorable backdrop for brokers as the current soft market runs its course.

If growth prospects seem solid, what about profitability? We know from the experience of the past decade that brokers' margins fluctuate with the shifts in the insurance cycle. Soft markets degrade profit spreads as commission realizations per unit of insurance effectively decline. Hard markets, associated with rising realizations, generate wider margins.

In addition to the issue of the cyclical impact, there is the question of structural changes in profitability. By structural, we mean changes that take place over a long period of time and that may not be easily discernable to the industry participants except through close examination of operating performance over an extended time frame.

We think that self-insurance falls into the category of a structural change in insurance brokerage. Much increased sophistication through such techniques as risk management and the vastly improved organizational approach to serving the client also are factors that we count as structural. Each, in our

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view, has tended to erode profit margins. The wider acceptance of self-insurance has likely diverted revenues from brokerage, while greater technical expertise tends to raise the cost of doing business.

The slippage in insurance brokerage profitability seems evident over a decade's time. In 1975, average pretax profit margins for our universe of public brokers amounted to 23%. Marsh & McLennan Cos. Inc. posted the highest spreads at almost 30%. This, incidentally, was not an optimal year because margins continued to expand moderately with the upswing in premium rates over the next three years.

In 1985, a year of recovery in earnings, the average profit margin was 18.3%. M&M and Arthur J. Gallagher & Co. were able to maintain profitability over the 10-year period, while Alexander & Alexander Services Inc. experienced a steep decline caused to a large degree by problems in the United Kingdom. Corroon & Black Corp. recorded profit slippage from, we believe, a change in mix and rapid growth that raised overall earning power appreciably.

Even if we allow for varying performance within the group, we think that it is probably reasonable to conclude that, at least in the aggregate, insurance brokerage is not quite as profitable a business as it had been in the 1970s. At the same time, we believe that the structural impact on profitability has run its course. Whatever present concerns arise over brokerage profit margins now are provoked by the soft market.

We can observe the effect of a soft market by comparing average profit margins in 1978—when the market was at a cyclical peak—with those in 1984—at the depth of a cyclical trough. In 1978, average pretax margins reached an exalted 28%, with all brokers achieving handsome returns. By 1984, prosperity had retreated, and average margins shrank to 15%.

Clearly, the longevity of the soft market and the depth of price cutting determine the

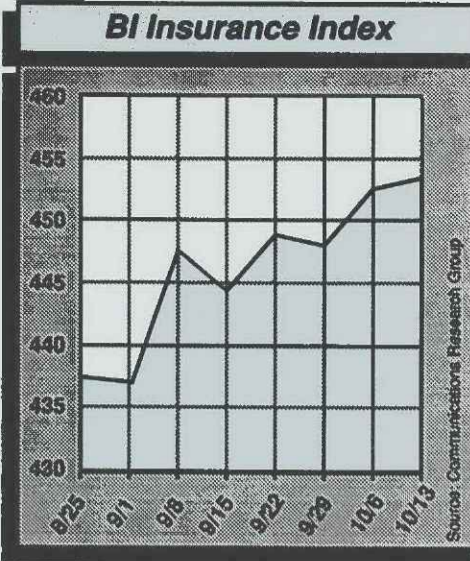
extent of margin shrinkage for brokers. But brokers faced high inflation during much of the last soft market. They were confronted with the strongly rising costs over which their control was limited at the same time that revenue growth weakened markedly.

The current soft market is destined, we think, to bring about some degree of slippage in profit spreads once again. How far the erosion proceeds will depend upon the soft market's configuration. We would not be surprised if commercial rates remained soft into 1990. The state of reinsurance markets is another factor that will influence margins importantly for some brokers.

We believe that the soft market could shave 2% to 4% from the peak pretax margins achieved in 1987. We base this relatively optimistic forecast on our expectation that the quality of cost controls has improved appreciably. It also appears that the rate of inflation will not much exceed 4% to 5%, though this seemingly modest rise impedes cost control in a people-intensive enterprise.

If our postulated margin decline is correct, then earnings may be quite well-sustained in the present soft market. Moreover, the publicly owned brokers would be well positioned to regain or match 1987's cyclical peak in profit margins once the market hardens. Such performance would validate our earlier conclusion that the structural easing in profitability already has occurred, and that the profit margins principally will fluctuate with the underwriting cycle.

Among the publicly held brokers, there are bound to be varying results. For example, A&A has significant opportunity to widen profit margins and may outperform its peers, given currently below-average spreads. M&M, on the other hand, is likely to experience only a modest cyclical amplitude in its profit margins, which are the highest in the group. As always, management expertise will count for a good deal, but on balance the general outlook for brokerage margins seems far better today than it did in 1982 or 1983.



Insurance industry stocks continued to climb last week, as the *Business Insurance Index* rose 1.4 points to 454.4 on Oct. 13, from 453 on Oct. 6. Advancing issues were led by Tokio Marine & Fire Insurance Co. Ltd., up 12.9%; Selective Insurance Group Inc., up 7.4%; Sears, Roebuck & Co. (Allstate), up 7%; Argonaut Group, up 6.5%; and United States Fire & Casualty Co., up 6.4%. Declining issues were led by Berkshire Hathaway Inc., down 20.2%; Baldwin & Lyons Inc., down 5.6%; Phoenix Re Corp., down 3.8%; Alexander & Alexander Services Inc., down 3.7%; and Arthur J. Gallagher & Co., down 3.6%. The most active issues were: Sears, Roebuck & Co. (Allstate), 5.4 million shares traded; Farmers Group Inc., 2.5 million shares traded; and ITT Corp. (Hartford Group), 1.3 million shares traded. The *Business Insurance Index* gained a slight 0.3% for the period, trailing the leading market indicators: The Standard & Poor's 500 gained 1.3%; the Dow Jones 30 Industrials were up 1.2%; and the New York Stock Exchange Composite rose 0.9%.



Mr. Wilson

British Issues

Oct. 13 Companies	Price pence	P/E	Div. pence	Yield %	1 Week	
					High	Low
Comml Union	351	100	25.3	7.2	356	350
Genl Accident	887	8.1	58.0	6.5	894	889
Gdn Royal Exch	185	100	13.1	7.0	187	183
Royal	389	8.0	30.0	7.7	391	384
Sun Alliance	1027	7.8	54.7	5.3	1027	1012

Brokers	Price	P/E	Div.	Yield	High	Low
Bradstock	226	12.2	8.0	3.5	231	224
CE Heath	438	14.1	34.5	7.8	438	435
Hogg Robinson	152	12.9	8.0	5.3	152	149
Lloyd Thompson	210	16.5	8.0	3.8	210	209
PWS Holdings	143	20.4	6.0	3.6	144	143
Sedgwick Grp	232	19.3	16.0	6.9	233	227
Steel Bri Jones	219	19.6	13.3	6.1	220	218
Willis Faber	242	13.5	16.0	6.6	244	237

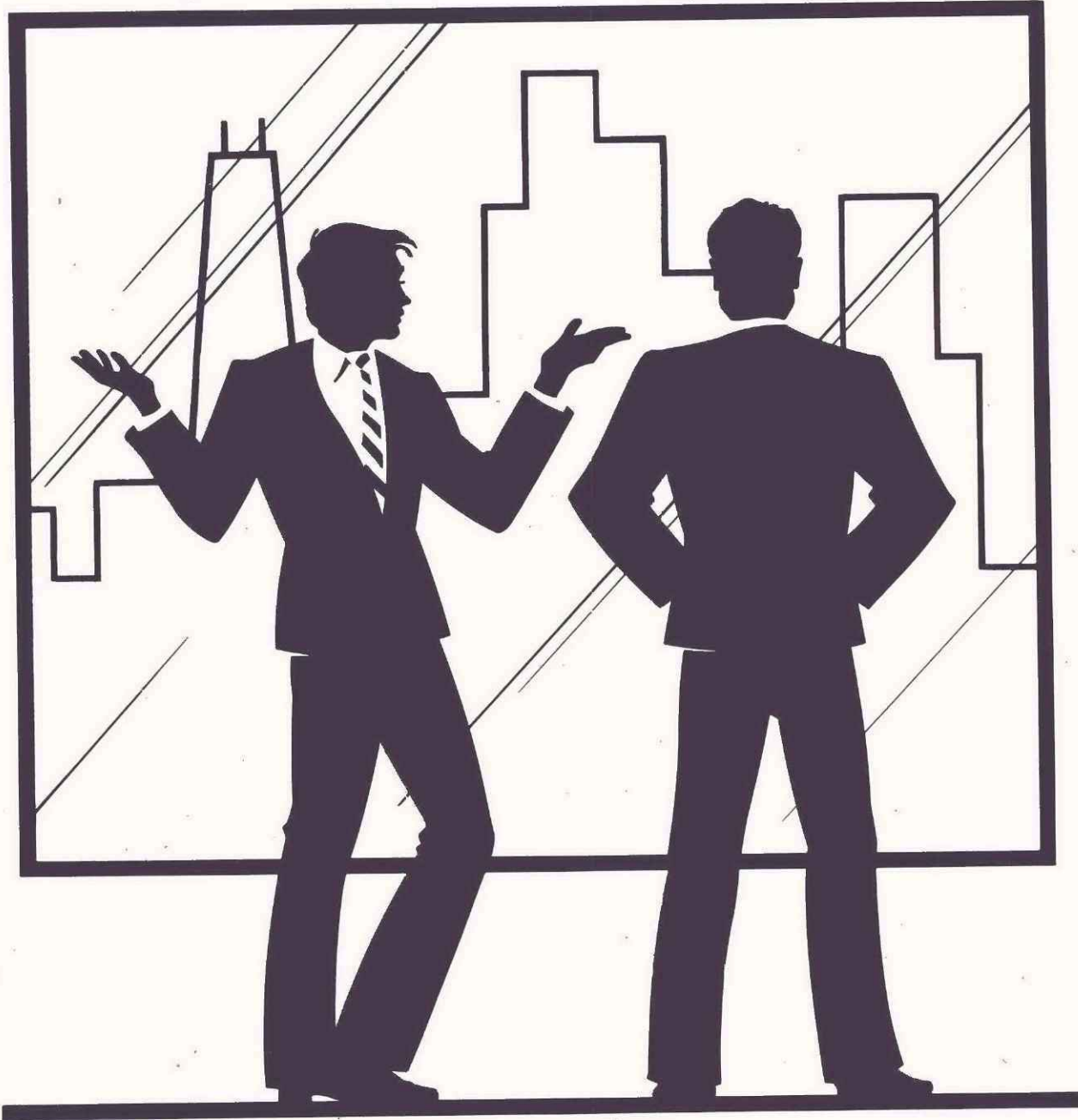
Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

OCTOBER 13, 1988 10/7/88 THRU 10/13/88

	Weekly Price	% change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Weekly Price	% change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value		
				High	Low										High	Low								
BROKERS																								
Alexander & Alexander Svcs	NYSE	26.00	-3.7	46.5	28.13	17.75	458	1.00	3.8	18.6	3.71	7.01	11.63	2.2	20.8	13.50	8.75	154	0.60	5.2	-1.2	16.24	0.72	
Baldwin & Lyons Inc	OTC	17.00	-5.6	41.7	18.00	12.00	0	0.20	1.2	6.7	18.31	0.93	57.25	-0.7	2.5	59.38	45.50	1016	1.20	2.1	12.3	26.21	2.18	
Corroon & Black Corp.	NYSE	31.13	-2.7	10.2	34.75	28.00	58	1.08	3.5	4.7	5.43	5.73	11.00	0.0	-7.4	14.38	10.75	296	0.20	1.8	2.6	17.75	0.62	
Gallagher Arthur J. & Co.	NYSE	17.00	-3.6	6.3	18.88	13.88	31	0.48	2.8	12.2	5.16	3.29	26.75	-0.9	15.1	27.75	20.50	12	0.36	1.3	5.6	25.10	1.07	
Hall Frank B. & Co.	NYSE	3.63	0.0	26.0	5.50	2.88	19	0.00	0.0	12.2	0.00	N/A	15.50	-0.8	18.1	16.38	13.38	15	0.48	3.1	6.6	16.65	0.93	
Hilt. Rogal & Hamilton	OTC	12.00	1.0	23.1	12.75	9.75	16	0.00	0.0	12.2	0.00	N/A	31.50	1.6	37.0	32.75	22.50	94	1.20	3.8	11.4	10.65	2.96	
Marsh & McLennan Cos. Inc.	NYSE	57.38	1.1	15.9	58.50	45.25	366	2.50	4.4	14.0	6.74	8.51	30.00	-0.8	14.3	32.00	25.25	0	0.00	0.0	11.4	29.60	1.01	
Poe & Assoc Inc.	OTC	8.25	0.0	17.9	9.25	6.75	0	0.40	4.8	12.7	0.27	30.56	26.25	-1.9	28.0	27.50	20.75	229	0.72	2.7	8.2	26.50	0.99	
BROKERS AVERAGE			-1.7	23.5					2.6	11.4			10.88	-1.1	141.8	11.63	4.50	4	0.24	2.2	17.8	2.90	3.75	
CONGLOMERATES & HOLDING COMPANIES																								
Berkley W R Corp.	OTC	27.50	0.0	14.6	29.00	23.50	18	0.36	1.3	6.1	17.63	1.56	26.25	-1.1	141.8	11.63	4.50	4	0.24	2.2	17.8	2.90	3.75	
Berkshire Hathaway Inc.	NYSE	3850.00	-20.2	30.5	5000.00	2755.00	67	0.00	0.0	17.0	69.38	10.42	40.00	0.0	0.0	40.00	0.00	0	0.00	0.0	0.0	0.00	0.00	0.00
ITT (Hartford Group)	NYSE	50.88	2.8	13.1	53.38	43.25	1316	1.25	2.5	7.0	52.23	0.97	32.75	4.8	43.1	32.75	22.63	141	1.12	3.4	7.7	35.05	0.93	
Sears, Roebuck & Co. (Allstate)	NYSE	42.25	7.0	25.6	40.75	32.25	5386	2.00	4.7	10.5	34.74	1.22	35.25	0.0	-2.8	38.25	32.25	119	1.88	5.3	7.0	27.86	1.27	
CONGLOMERATES AVERAGE			-2.6	21.0					2.1	10.1			24.63	-1.5	23.2	25.88	19.13	270	0.74	3.0	5.8	27.82	0.89	
INSURERS & REINSURERS																								
Aetna Life & Cas Co	NYSE	51.00	0.0	12.7	52.50	39.50	963	2.76	5.4	7.9	53.56	0.95	16.63	1.5	23.2	17.63	13.13	53	0.76	4.6	5.3	9.34	1.78	
American General Corp.	NYSE	34.50	1.8	8.7	36.38	27.50	856	1.40	4.1	9.3	28.04	1.23	9.50	0.0	-32.8	9.50	4.50	34	0.44	7.5	28.0	9.37	0.63	
Amer Heritage Life Inv	NYSE	27.00	0.4	11.3	27.00	24.00	1	1.08	4.0	11.8	20.98	1.29	5.88	0.0	0.0	5.88	0.00	0	0.00	0.0	0.0	0.00	0.00	
Amer Indly Fin'l Corp	OTC	10.00	-2.4	11.1	12.00	8.25	2	0.56	5.6	38.5	15.26	0.66	32.75	4.8	43.1	32.75	22.63	141	1.12	3.4	7.7	35.05	0.93	
American Int'l Group	NYSE	67.63	0.9	12.7	68.25	49.00	1147	0.40	0.6	10.5	33.56	2.02	35.25	0.0	-26.7	5.56	3.13	52	0.05	1.5	5.7	3.48	0.99	
Aon Corp.	NYSE	27.63	0.5	20.8	28.25	21.88	222	1.28	4.6	9.4	15.13	1.83	12.00	-2.0	6.7	14.25	11.00	17	0.80	6.7	8.0	12.51	0.96	
Argonaut Group	OTC	45.00	6.5	51.3	49.00	29.50	156	0.00	0.0	6.2	29.19	1.54	25.50	7.4	34.2	26.25	19.25	94	1.24	4.9	5.7	19.52	1.31	
AVEMCO Corp	NYSE	25.00	-2.0	27.4	28.75	17.88	17	0.34	1.4	12.1	7.74	3.23	12.00	-2.0	6.7	14.25	11.00	17	0.80	6.7	8.0	12.51	0.96	
Belvedere Corp	AMEX	4.75	5.6	8.4	6.00	4.00	6	0.04	0.8	6.6	7.87	0.60	25.50	7.4	34.2	26.25	19.25	94	1.24	4.9	5.7	19.52	1.31	
BMA Corp	OTC	30.00	3.4	12.1	36.75	25.50	131	1.20	4.0	27.8	24.45	1.23	36.75	-0.4	16.8	36.75	29.75	573	1.88	5.4	7.3	24.94	1.39	
Chubb Corp	NYSE	57.50	-0.9	2.9	63.38	51.25	357	2.16	3.8	6.7	46.13	1.25	36.75	2.5	2.8	40.00	33.00	1024	2.40	6.6	12.5	45.28	0.80	
CIGNA Corp	NYSE	53.00	-0.7	20.8	55.38	42.75	433	2.96	5.6	8.6	49.19	1.08	13.13	0.4	9.2	34.38	28.88	832	2.64	8.5	7.8	19.53	1.59	
CNA Fin'l Corp.	NYSE	63.00	-3.6	13.2	66.13	51.00	234	0.00	0.0	9.4	46.40	1.36	31.13	0.4	9.2	25.75	17.88	519	0.48	1.9	11.4	28.53	0.88	
Continental Corp.	NYSE	39.50	0.6	1.9	41.63	34.75	331	2.60	6.6	8.2	42.10	0.94	37.38	-1.6	31.2	40.13	28.00	157	1.28	3.4	9.7	46.77	0.80	
Durham Corp	OTC	35.00	-1.4	62.8	36.25	21.50	19	0.92	2.6	33.0	26.00	1.35	27.75	1.8	16.2	28.75	24.00	35	1.08	3.9	12.9	32.33	0.86	
Farmers Group Inc.	OTC	71.50	0.2	77.6	71.75	40.50	2470	1.44	2.0	17.0	22.02	3.25	17.88	0.0	19.2	23.88	15.00	71	0.80	4.5	8.6	12.53	1.43	
Fireman's Fund Corp	NYSE	32.50	-0.8	25.0	33.50	25.75	208	0.50	1.5	11.4	26.17	1.24												
Forum Re Group	OTC	0.69	0.0	-24.2	1.19	0.63	0	0.00	0.0	-1.2	0.51	1.35												
Fremont Gen Corp.	OTC	11.63	2.2	20.8	13.50	8.75	154	0.60	5.2	-1.2	16.24	0.72	50.75	0.2	26.5	53.50	40.25	144	2.36	4.7	9.8	36.62	1.39	
General Re Corp.	NYSE	57.25	-0.7	2.5	59.38	45.50	1016	1.20	2.1	12.3	26.21	2.18	31.00	1.2	74.6	30.88	18.50	124	0.00	0.0	15.8	19.92	1.56	
Home Group Inc.	NYSE	11.00	0.0	-7.4	14.38	10.75	296	0.20	1.8	2.6	17.75	0.62	31.00	-0.8	14.3	32.00	25.25	0	0.00	0.0	11.4	29.60	1.01	
Hanover Ins Co.	OTC	26.75	-0.9	15.1	27.75	20.50	12	0.36	1.3	5.6	25.10	1.07	26.25	-1.9	28.0	27.50	20.75	229	0.72	2.7	8.2	26.50	0.99	
Harleysville Group Inc.	OTC	15.50	-0.8	18.1	16.38	13.38	15	0.48	3.1	6.6	16.65	0.93	10.88	-1.1	141.8	11.63	4.50	4	0.24	2.2	17.8	2.90	3.75	
Hartford Steam Boiler	OTC	31.50	1.6	37.0	32.75	22.50	94	1.20	3.8	11.4	10.65	2.96	2											

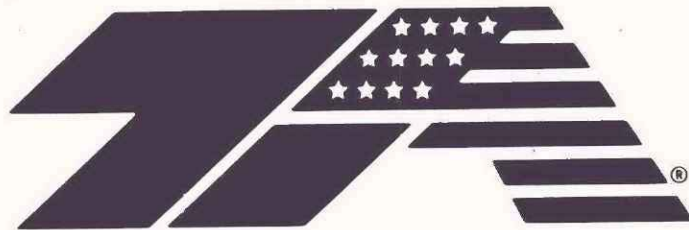
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