

Business Insurance

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Jury holds distiller partly liable for death of Texas freshman

CORPUS CHRISTI, Texas—A distiller will appeal a Texas court jury's verdict that it was partially liable for the death of a college student who died of alcohol poisoning. The verdict was the first time a liquor company has been held liable in a product liability action for failing to warn the public about the dangers its product poses, said James Ragan, the Corpus Christi attorney who represented the student's mother. But, he conceded the verdict might not

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ITT to take big charge to bolster Hartford's reserves

By DOUGLAS McLEOD

HARTFORD, Conn.—ITT Corp. will take a \$1.15 billion pretax charge against third-quarter earnings to bolster the reserves of three loss-plagued ITT Hartford Group Inc. units and to cover the costs of defending pollution and asbestos claims. At the same time, Hartford will reorganize its surplus lines and reinsurance operations, closing the three units formerly managed by Cameron & Colby Co. Inc. ITT will assume ownership of the three insurers—First State Insurance Co., New England Insurance Co. and New England Reinsurance Corp.—while a Hartford unit will manage the runoff of their existing business. Partially offset by capital gains, the moves will result in a net aftertax charge of \$582 million. ITT will contribute \$680 million in cash and stock to Hartford to fund the restructuring. Ramani Ayer, president of property/casualty operations at Hartford, said Hartford made a strategic decision to separate the Cameron & Colby units, hammered by losses on pre-1986 business, from ongoing surplus lines and reinsurance operations.

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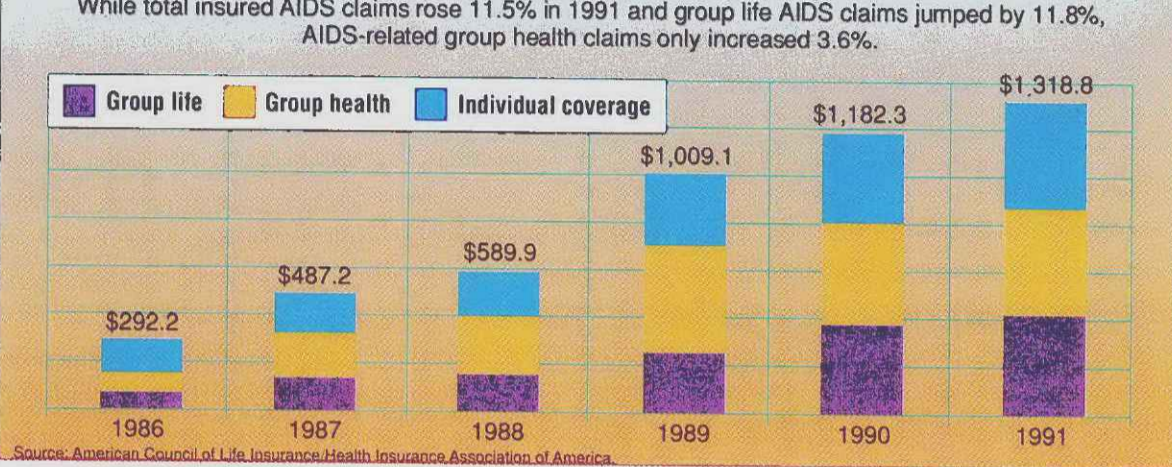
AIDS cost increase slows

Claims rise 11.5% in '91; smallest jump since 1986

By CHRISTINE WOOLSEY

WASHINGTON—The cost of AIDS-related group health care claims paid by insurers is increasing slightly, but AIDS-related group life claims costs continue to climb at a double-digit rate. Total estimated insured group accident and health claims for AIDS totaled \$455.4 million in 1991, up 3.6% from \$439.7 million in 1990. Meanwhile, estimated group life insurance claims rose 11.5% to \$419.3 million in 1991 from \$374.8 million the previous year, according to the survey by the American Council of Life Insurance and the Health Insurance Assn. of America. Including individual claims,

AIDS-related group health claims moderate



insurers paid more than \$1.3 billion in AIDS-related life and health insurance claims in 1991, the survey found. That represents an 11.5% increase over the 1990 total, the smallest rise in AIDS-related life and health claims paid since 1986, the first year the survey was conducted. By comparison, total AIDS-related life and health claims costs increased 17.2% between 1989 and 1990; 71.2% between 1988 and 1989; 21.2% between 1987 and 1988; and 66.7% between 1986 and 1987. The Washington-based trade groups surveyed 387 life and health insurance companies that account for 73% of the claims in four lines: individual and group life, and individual and group accident and health. Insurers and consultants attribute the slowdown to improved health care services for AIDS patients and life insurance underwriting practices that deny individual coverage to people who test positive for the AIDS virus. AIDS-related claims may still be understated due to insurance company misreporting and in-

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Insurers fear FAS 106 will cut surplus

By DOUGLAS McLEOD

KANSAS CITY, Mo.—An insurer group is urging state regulators to modify the new retiree health care liability accounting rule to prevent a major drain on insurers' surplus. The rule by the Financial Accounting Standards Board will force many corporations that prepare financial statements using generally accepted accounting principles to recognize

huge retiree health care liabilities on their financial statements for the first time. The National Assn. of Insurance Commissioners has told insurers that the rule, FAS 106, also should be used for statutory accounting purposes. But, insurers say that unless FAS 106 is modified, it could cause a serious erosion of policyholder surplus—and even threaten some insurers' solvency. One option under considera-

tion is letting insurers offset their FAS 106 liabilities with anticipated future tax benefits, a procedure that is not normally allowed under statutory accounting. While two NAIC officials said the group's position is to allow this tax offset, insurers say they have received no official word. A formal decision is expected in 1993. Another option is being offered by an insurer advisory group to

the NAIC: modifying FAS 106 to substantially cut the liability insurers would report in statutory statements. Implementing FAS 106 without change would cut insurers' surplus an average of 12%, a recent NAIC study found. But modifying the rule as the advisory group wants would reduce the surplus hit to 5%. FAS 106 covers retiree health care, life insurance and other

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London underwriters are raising United Airlines' hull insurance rates by 12% and its liability rates by 10%, brokers say.

Aviation rate increases much smaller than in '91

By GAVIN SOUTER

LONDON—Most of the world's major airlines can expect relatively small rate increases—and in some cases no rate hikes at all—when they renew hull and liability insurance in the next few months. Early renewals show that the 200% to 300% rate increases pushed through last year have not been repeated despite several large aviation losses this year. Overcapacity in the world market has frustrated underwriters' desire to obtain big rate hikes, even though reinsurers are forcing primary insurers to retain more risk, London brokers and underwriters say. And more insurers that normally follow the terms of lead underwriters now are offering their own terms and conditions in an effort to attract business, brokers say. However, several airlines, including United Airlines Inc. and Thai Airways, have had to find new lead insurers after Orion Insurance Co. P.L.C. stopped writing last month (BI, Sept. 7). About 70% of the world's airlines renew their insurance between Oct. 1 and Dec. 31. "On the Oct. 1 renewals, we were largely able to obtain coverage for the same price as last year," said Bill Smith, managing director of aviation at broker Leslie & Godwin International Ltd.

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Distiller held liable for death

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have substantial impact because federal law has required such warnings since 1987.

The jury last week found Brown-Forman Corp. of Louisville, Ky., 35% liable for the 1983 death of Marie Brinkmyer, a freshman at Texas A&I University. Ms. Brinkmyer died after reportedly drinking about 20 shots of Pepe Lopez tequila.

As a result of the verdict, the company is liable for about \$525,000.

The jury found that Ms. Brinkmyer was 65% responsible for her own death.

After the verdict, Brown-Forman said in a statement that "this case involves a tragic accident, but we believe the young woman herself was responsible for it."

Company officials would not return phone calls about insurance coverage.

Mr. Ragan said that determining the case's impact on liquor industry liability is difficult because of the case's unique characteristics. For example, Ms. Brinkmyer had a history of responsible action regarding use of drugs and cigarettes and had been warned about both.

American Re sale completed

NEW YORK—Aetna Life & Casualty Co. has completed the sale of its American Re-Insurance Co. unit to American Re Corp., a holding company formed by leveraged buyout firm Kohlberg Kravis Roberts & Co. and Am Re management.

Aetna received \$1.31 billion in cash at the closing and will receive up to \$20 million more in cash in December (BI, Aug. 24, April 20).

It also received \$70 million of American Re Corp.'s preferred stock and about \$30 million of its common stock. Aetna retains most of the reinsurer's U.K. operations.

Baseball owners safe at home

SPRINGFIELD, Ill.—A new Illinois law adopts a well-established principle in sports law that fans at baseball games assume the risk of being hit by a ball or bat and generally cannot sue because of resulting injuries.

The state's Baseball Facility Liability Act, which became effective Sept. 24, protects the owners and operators of any baseball facility—including major league teams, schools and parks that host amateur games—from such suits.

However, owners can be held liable if a fan is hurt because of equipment—like a backstop or screen—that is defective due to the owner's negligence or because of "willful and wanton" acts by owners or team members.

Some recent court rulings had begun to erode facility operators' traditional immunity, said Howard Pizer, executive vp of the Chicago White Sox.

For example, the Chicago Cubs several years ago lost a lawsuit brought by a fan who was injured at Wrigley Field when he was struck by a foul ball. The fan was seated behind home plate 10 seats outside of the area protected by a screen (BI, Dec. 4, 1989).

California small group reforms

SACRAMENTO, Calif.—A new California law prohibits health insurers from turning down small businesses seeking coverage.

The reform law, which takes effect July 1, 1993, covers companies with three to 50 employees.

Also under the law, signed by Gov. Pete Wilson last week, insurers must renew coverage for small businesses—except in specified circumstances like non-payment of premium—and must use a modified community rating to set rates.

Insurers can exclude coverage for pre-existing conditions only for a one-time, six-month period. However, the exclusion is prohibited when a business changes insurers or when employees covered by a group plan change jobs.

Gov. Wilson vetoed a bill proposed by state Insurance Commissioner John Garamendi that would have created a commission to establish a universal health insurance program (BI, Feb. 24).

In other action, Gov. Wilson also vetoed a package of workers compensation measures and announced he will call a special session of the Legislature Thursday to consider his workers comp reform proposal. A vote is expected on Friday.

But, Gov. Wilson did sign a bill that calls for establishing up to four "24-hour coverage" pilot programs (BI, Sept. 28).

He also signed into law a measure that repeals the state's earthquake insurance program (BI, March 2).

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Errors & omissions

• Yves Monmoton, deputy general manager of Scor Reassurance, was the skipper of the French boat that won third place in a race at the Rendez-Vous de Septembre. Mr. Monmoton was misidentified in a photo caption in the Sept. 21 issue.

• The Risk & Insurance Management Society's representative to the National Assn. of Insurance Commissioners had his badge color changed to green from gold at a recent meeting. The colors were transposed in a Sept. 28 story.

In a first, asbestos liability is based on market share

By JOANNE WOJCIK

A court for the first time says that companies' liability for asbestos-related injuries can be determined by their market share if the maker of the product causing the injury cannot be identified.

The Aug. 25 decision by California's 1st District Court of Appeal in *Wheeler vs. Raybestos-Manhattan* overturns a long-standing general order that barred the application of the market share theory of liability in asbestos cases in California.

Meanwhile, in Illinois, the state Supreme Court has adopted a "fiber drift" theory of liability. The court ruled that an asbestos manufacturer could be held liable for a worker's death even if only a small percentage of the asbestos fibers that drifted through his workplace were traceable to asbestos the defendant made.

Both decisions could increase the liability of some companies that produced asbestos or used the substance in their products.

The California ruling "relaxes

requirements for proving a particular product caused an injury," pointed out Irene C. Warshawer, an attorney with Anderson, Kill, Olick & Oshinsky in Washington.

And, the Illinois decision "liberalizes the proof necessary to show causation," said J. Timothy Eaton, an attorney with Coffield, Ungaretti & Harris in Chicago who specializes in toxic tort litigation.

The market share liability theory was banned in California as-

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N.J. court finds no cleanup cover for owned property

Insurer wins pollution case

By MARK A. HOFMANN

TRENTON, N.J.—The owned property exclusion in comprehensive general liability policies bars coverage for the cost of state-mandated pollution cleanups of the policyholder's property, the New Jersey Supreme Court has ruled.

Insurer attorneys say the decision is important because the New Jersey high court, in its first foray into pollution coverage disputes, is saying the insurance policy language should not be

interpreted liberally to favor policyholders.

But, policyholder attorneys say the decision does not break any new ground.

Policyholder and insurer attorneys agree, though, that the case takes is significant because New Jersey is a bellwether state regarding pollution coverage law due to the large number of coverage disputes filed in New Jersey courts.

Paterson, N.J.-based Morton Springer & Co. Inc. sought coverage for the costs of a state-

mandated environmental cleanup following an April 11, 1983, fire at a warehouse it owned in Newark.

When firefighters discovered that the warehouse contained hazardous materials, the New Jersey Department of Environmental Protection told Springer and its tenants, including Signo Trading International Inc., to clean up the site.

When the companies did not comply with the DEP's cleanup order, the state took control of-

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Environmental directory issue drawing near

The deadline is approaching for companies to return questionnaires to be listed in the *Business Insurance* directory of environmental risk management consultants, which will appear in the Nov. 23 issue. The issue also will feature a Spotlight Report focusing on environmental liability topics.

There is no charge to be listed in the directory. However, companies must fill out and return a BI questionnaire.

If your company is an environmental risk management consultant and you have not yet received a questionnaire, please request one by calling Kerry Dziubek at 312-649-5398.

The extended deadline for returning completed questionnaires is Oct. 19.

Conservation ordered for 'illicit' health insurer

By LOUISE KERTESZ

LOS ANGELES—A Bermuda captive owned by a claims administrator that writes group health insurance for small California employers is contesting a judge's order placing both companies in conservation.

California Insurance Commissioner John Garamendi charges that Dual Plus Insurance Co. Ltd. of Bermuda and its parent, Dual Plus Insurance Administrators of Long Beach, Calif., conducted "illicit" business in the state without the proper licenses. He also says the captive does not have adequate surplus.

While California business written by Dual Plus Insurance should have been placed through state-licensed surplus lines brokers, the insurer conducted operations directly from its parent's Long Beach office, the Insurance

Department maintains.

Some of the business written by the captive was formerly written by Physicians & Hospitals Benefits Trust, a multiple-employer trust for which Dual Plus Administrators was trustee.

PHBT, whose business was transferred to Dual Plus Insurance over the past two years, ceased operations Sept. 30. PHBT also has been placed under conservatorship.

Dr. Joseph Noble, president of Dual Plus and also operator of PHBT, said he phased out the MET and switched the business to the captive because of the hostile regulatory climate toward METs in California.

Dr. Noble is challenging the conservation order by Los Angeles Superior Court Judge Robert M. O'Brien.

The department's action is "a

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Surplus lines insurers face challenges

Risk-based capital may hurt non-admitted marketplace

By SARA MARLEY

CHICAGO—Risk-based capital standards are a good idea, but surplus lines insurers should prepare themselves now for a jolt when they are implemented, an insurer and analyst agree.

"Risk-based capital is a very good idea the industry can support," said Andrew S. Frazier, president and chief executive officer of Western World Insurance Group in Ramsey, N.J. "The logic behind it is so clear, it's hard to refute."

The question is not whether standards will be implemented, but when, said Herbert E. Goodfriend, director of insurance analysis at KPMG Peat Marwick in New York. "Alert management will (anticipate) what can happen to the marketplace even if your company is well-capitalized."

However, Messrs. Frazier and Good-

friend identified several areas where risk-based capital formulas could cause problems for the surplus lines industry in particular.

Because excessive growth is a factor in many insolvencies, penalties under risk-based capital likely will be imposed on companies that grow quickly.

As the "safety-valve" of insurance, premiums written by the surplus lines industry tend to fluctuate widely with market conditions, Mr. Frazier observed.

"During the last hard market, our company grew 400%," he said, noting that 33% annual growth is not unusual for a surplus lines insurer.

"When the market turns, there is no

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Federal solvency regulation may favor admitted insurers

By SARA MARLEY

CHICAGO—Sweeping federal insurance solvency legislation that would exempt many large standard lines insurers from state regulation would put surplus lines insurers at a competitive disadvantage, says a surplus lines industry association executive.

But that proposal would better insulate regulation from politics and would improve the currently inadequate regulatory system, contended an attorney for an insurance trade group.

A bill proposed by Rep. John Dingell, D-Mich., would allow insurers to choose either state or federal regulation for solvency. Those that choose federal regulation would have to be certified by a new

federal agency (BI, April 13).

Also under the bill, H.R. 4900, insurers with a net worth of more than \$50 million would be exempt from rate and form regulation on commercial policies sold to buyers with a net worth exceeding \$10 million.

Smaller standard lines insurers would be able to obtain a federal certificate but would still be subject to state rate and form regulation and would be required to participate in state residual risk pools.

Large policyholders would not be covered by a guaranty fund. But a new federal agency would pay claims filed by third parties against large policyholders if the policyholders are bankrupt and their federally certified insurers are insolvent.

The bill also calls for establishing a

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Democrats delay health reform: GOP senator

By JERRY GEISEL

WASHINGTON—A group of congressional Democrats are blocking even modest health care reform legislation, a Republican senator charges.

While many Republicans and some Democrats agree on some basic elements of health care reform, a powerful group of House Democrats favor an all-or-nothing approach, says Sen. John Chafee, R-R.I.

Since those Democrats can't agree among themselves on a comprehensive approach, health care reform legislation is not likely to be enacted this year, he says.

In fact, while a Senate-passed tax bill includes several reform provisions, including restrictions on pre-existing medical condition exclusions, House Democrats are unlikely to sign on. "I have a nagging feeling we will have a problem with the House," Sen. Chafee said.

Senate Minority Leader Robert Dole, R-Kan., is skeptical that

Congress will take action on health care reform soon.

Reform "will not be easy. All we have" from many members of Congress "are sound bites," Sen. Dole said.

Sens. Chafee and Dole spoke last week at the annual meeting of the American Academy of Actuaries. Other speakers discussed pension simplification legislation and the problems facing the Pension Benefit Guaranty Corp.

Several schools of thought now exist in Congress on the best approach to health care reform, Sen. Chafee said, with some favoring elimination of the entire system in favor of a government-run program.

But others, including Sen. Chafee, say the current system should be retained, but with reforms to improve access and control costs.

Among the elements Sen. Chafee said should be included in a basic reform package are:

- Increasing to 100% from 25% the tax deduction that self-employed persons can take for health



'I have a nagging feeling we will have a problem with the House' in passing health care reform.

—Sen. John Chafee

'The sooner reforms are enacted, the better for the PBGC and the defined benefit system.'

—PBGC's James Lockhart



insurance premium costs.

It isn't fair to allow employers to deduct 100% of their health care costs, while limiting to 25% the deduction the self-employed can take, Sen. Chafee said.

- Pre-empting state laws that mandate the benefits that health insurers must offer.

Mandates like requiring coverage for hair transplants inflate the cost of insurance, he said.

- Reforming medical malpractice laws.

- Reforming the small group health insurance market.

Insurers, for example, shouldn't be allowed to deny coverage for those with pre-existing medical conditions.

- Require more uniformity in billing and claims forms to reduce administrative overhead.

- Increasing research on the outcomes of medical procedures so providers have a better understanding of their effectiveness.

- Making it easier for small employers to fund health care coverage on a group basis.

Sen. Chafee acknowledges these changes are only a first, though necessary, step toward health care reform. And, it is important to be aware of some of these proposals' limitations, he noted. Savings reaped through greater uniformity in claims forms will not be enough to finance a major expansion of health care coverage, for example.

At the same time, the nation will

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Employee education can help reduce health care fraud

By SARA J. HARTY

MONTREAL—Educating employees about health care scams can go a long way toward holding down soaring health care costs.

"Believe me, fraud does impact on health care costs," said James L. Garcia, director of the health insurance tracking unit for Aetna Life Insurance Co. in Middletown, Conn.

"In the health care industry, there's big money, little controls and if you can rip off the insurance industry, you'll have a lot of people patting you on the back," he said.

Five percent of all health care costs is attributable to outright fraud, while 15% is tied to questionable activity, he said.

With U.S. health care costs in 1992 expected to total about \$800 billion, at least \$40 billion will be spent on fraudulent claims, he said. But, Mr. Garcia believes that fraud most likely will cost health care payers \$80 billion this year.

This lost money could make a real difference in health care, perhaps enough to provide coverage for the 37 million Americans that are currently uninsured, he suggested at the 38th

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Skandia offering delayed

U.S. unit's stock sale postponed to attract a higher price

By JUDY GREENWALD

Skandia Holding A.B. is postponing the public offering of its U.S. reinsurance unit's stock because it believes it can fetch a higher price if it waits.

In another industry stock development last week, Sears, Roebuck & Co. said it would sell Allstate Insurance Group stock to the public for the first time as part of Sears' massive corporate restructuring.

Insurance stock prices increased virtually across the board last week, as investors showed optimism that the property/casualty market could turn.

Under terms of a Sept. 9 preliminary prospectus, Skandia Group planned to sell 9 million common shares of Skandia America Reinsurance Corp. stock for an expected \$18-\$20 per share, raising \$162 million to \$180 million. Another 2.4 million

shares of preferred stock were to have been sold at \$25 each, for a total of \$60 million, with the proceeds used to repurchase common stock.

James Dowd, Skandia America's chairman and chief executive officer, said the offering was postponed because the stock market perceives a market turn is imminent in the wake of Hurricanes Andrew. Skandia Group therefore believes the stock could attract a higher price if it waits.

Mr. Dowd noted the offering had been oversubscribed at \$18 a share.

The withdrawal was a "pure economic decision," he said.

Mr. Dowd said he did not know when Skandia Group would make another offering. "Timing is everything in the business of selling stock, and we're prepared to go at a moment's notice."

Despite Mr. Dowd's contention

that the withdrawal was an economic decision, Michael Morrissey, a principal with Firemark Consultants in Parsippany, N.J., said he believes the postponement could be tied to the turmoil in the Scandinavian market.

The turmoil "reflects badly on Skandia America, so I think it's more motivated by troubles at home" rather than problems at Skandia America, Mr. Morrissey said (BI, Sept. 21). "The folks who run the Skandia America operation are very, very highly qualified people, and I hope they get their chance at the capital markets before too long."

Meanwhile, Sears announced last week it would sell up to a 20% stake in Allstate within the next 12 months. Sears will retain the remaining 80% or more of the Northbrook, Ill.-based insurer.

It is still too early to estimate how much Sears is likely to raise,

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Pollution nullifies product liability cover

By MARK A. HOFMANN

Post-1986 CGL policy exclusion affirmed by Ohio court

CLEVELAND—The absolute pollution exclusion contained in commercial general liability policies bars product liability coverage when damage is caused by a product's release of pollutants, a federal appeals court in Ohio has ruled.

While the ruling involves only Ohio law, the court's logic may carry some weight in cases "in which other insurance companies have a similar absolute pollution exclusion," said insurer attorney David Lester, a partner in the Cleveland law firm Janik, Lester & Dunn.

Mr. Lester represented Home Indemnity Co., a Home Insurance Co. unit that was sued by policy-

holder Park-Ohio Industries Inc. of Cleveland, an industrial manufacturer.

He added that the case is thought to be the first time a federal court has dealt with the impact of the pollution exclusion in the post-1986 CGL policy on product liability coverage.

"It's a very unhappy decision for manufacturers like (Park-Ohio). Our view is this is a product liability case," said Harold A. Madorsky, Park-Ohio's general counsel.

The court's interpretation of the facts of the case and the law may generate problems for businesses that potentially face product liability claims.

'It's a very unhappy decision for manufacturers,' like Park-Ohio, says Mr. Madorsky.

Mr. Madorsky said Park-Ohio is reviewing the decision before deciding whether or not it will appeal.

Park-Ohio bought a CGL policy from Home Indemnity to cover it and its Tocco Inc. subsidiary from Feb. 1, 1988, to Feb. 1, 1989.

According to the court decision, the insurance policy covered the companies for "damages arising from any defective product that they as insureds produced, subject to the terms, conditions and exclusions contained in the policy."

The case involved furnaces made by Tocco that, according to the decision, were "used to strip and burn rubber from the metal tracks of army trucks and armored personnel and missile carriers" at the Red River Army Depot in Bowie, Texas.

In January 1989, 48 Red River Depot workers filed suit against Tocco and a number of other defendants in a Texas state court.

The suit—*Fleenor vs. Goodyear Tire & Rubber Co.*—alleged that workers had contracted cancer and other diseases as a result of the depot's operations.

The suit against Tocco alleged that the furnaces "were defective, unreasonably dangerous and not reasonable for their intended use."

That case has not yet gone to trial.

The workers alleged that when the furnaces were operating, "certain rubber combustion products resembling soot, smoke, fumes, dust pollutants and other particulates, evolve from the incomplete combustion of organic materials." These rubber combustion products contain carcinogenic agents.

Park-Ohio notified Home of the suit. But on Oct. 26, 1989, Home informed Park-Ohio and Tocco that it wouldn't defend the furnace maker in the class action and wouldn't pay any damages awarded against Tocco.

The insurer said the CGL policy contained a pollution exclusion excluding coverage for "bodily injury or property damage arising out of the discharge, dispersal, release or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminants or pollutants into or upon land, the atmosphere or any water course or body of water."

Park-Ohio and Tocco filed suit against Home on June 8, 1990. Both the plaintiffs and Home filed motion for summary judgment, and the U.S. District Court for the Northern District of Ohio in Cleveland entered summary judgment for Home on Aug. 6, 1991. Park-Ohio appealed, and on Sept. 22 the lower court's ruling was upheld.

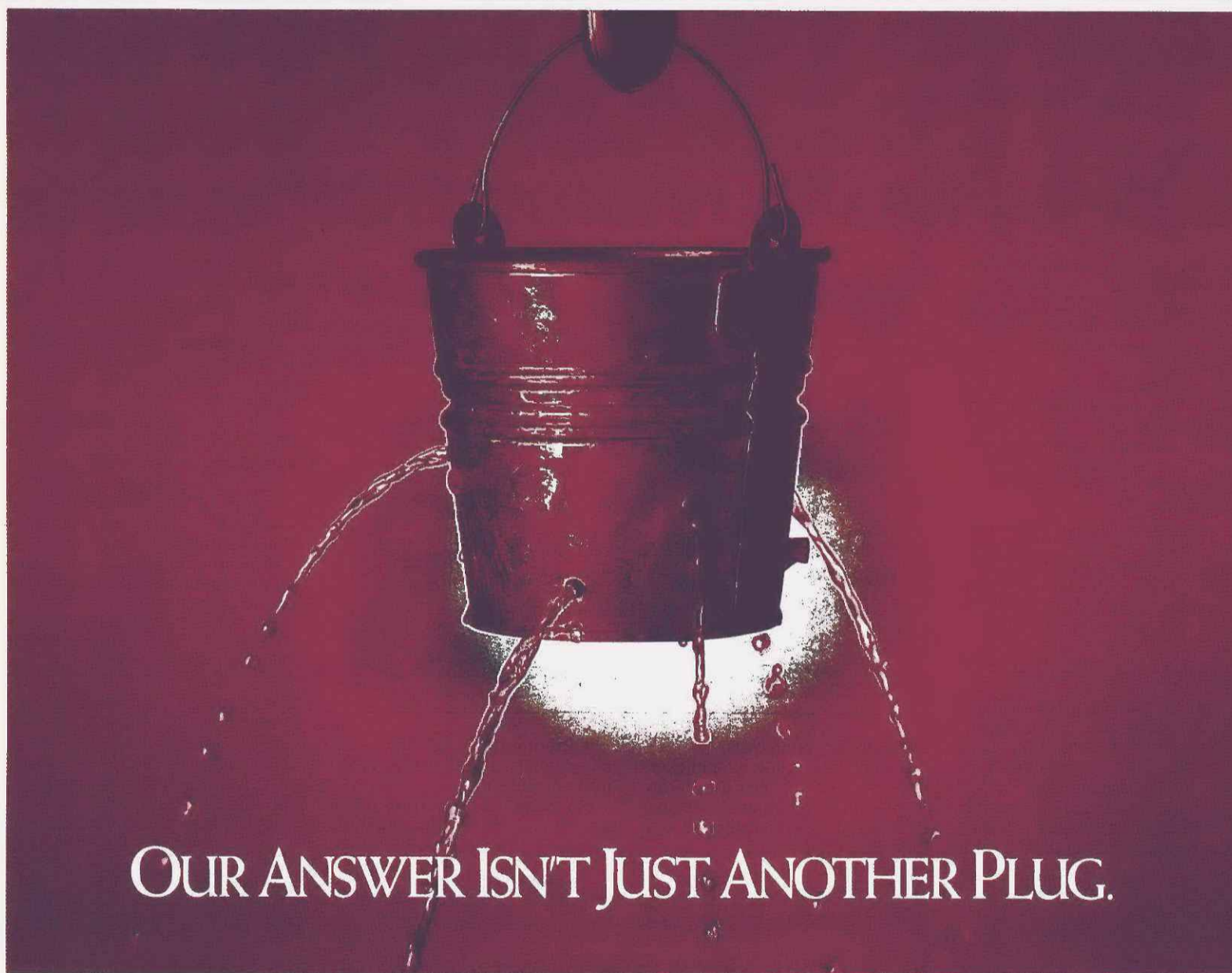
"Regardless of how one characterizes the plaintiffs' claims, the manufacturing defect allegedly resulted in the discharge of pollutants, and the pollution exclusion provision precludes coverage for this activity," wrote U.S. Circuit Judge H. Ted Milburn.

"There is no ambiguity in this situation. The pollution exclusion places no limitation on how the discharge is to be made or by whom. 'The discharge' applies to any discharge, and there is nothing in the facts of this case which bring into question the meaning of 'the discharge' or who must make the discharge. In a sense, the pollution exclusion follows the product, as do all terms of the policy," wrote Justice Milburn.

But in his dissent, Circuit Judge Ralph B. Guy Jr. held that the ruling could allow insurance companies to evade contractual obligations.

"Home's reading of the pollution exclusion would allow insurers to avoid defending any product liability case that fortuitously involves smoke, soot, fumes, liquids or vapors. For example, under Home's reading, the pollution exclusion would deny coverage to an automobile manufacturer for claims brought by motorists who had been injured, while in an automobile, by fumes from a defective exhaust system," wrote Judge Guy.

Park-Ohio Industries Inc. and Tocco Inc. vs. The Home Insurance Co., 6th U.S. Circuit Court of Appeals, No. 91-3826.



OUR ANSWER ISN'T JUST ANOTHER PLUG.

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

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

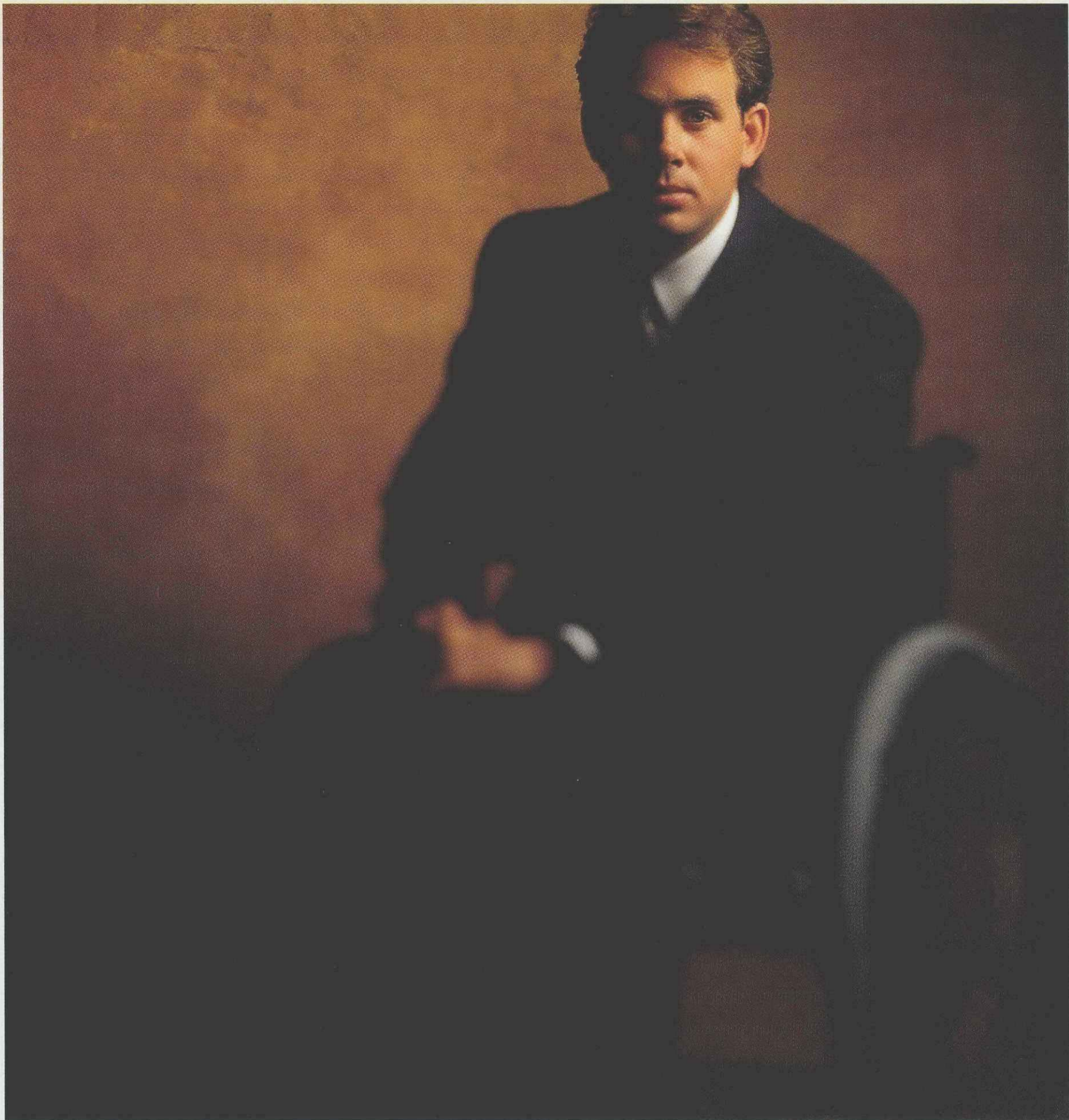
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On September 24, 1992, Wausau Insurance held a national satellite conference so its customers and other interested companies could learn about the employment perspective

of the Americans with Disabilities Act. A panel of experts discussed compliance with the law and how it may impact workers compensation.

Forty sites across the country received the satellite conference. In addition, many businesses and other organizations with satellite access received it at their own location.

We like to think of national satellite conferences like this as an innovative approach to something Wausau has been doing for years – supplying value-added service to its customers.

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Xerox aims to control mental health costs

To better manage mental health and substance abuse costs, Xerox Corp. has contracted with Preferred Health Care Ltd. to provide utilization review, case management, precertification and network providers for its employees.

Beginning Jan. 1, Wilton, Conn.-based PHC will manage mental health and substance abuse benefits for about 18,000 of Xerox's employees and their dependents who are currently covered under the company's self-insured fee-for-service plan.

American PsychManagement Inc. of Arlington, Va., will continue to provide case management, precertification and utilization review for mental health and substance abuse cases until January.

Xerox's other 38,000 employees and their dependents are covered by health maintenance organizations or other plans.

"Once the decision was made to move to a network model," Xerox searched for a network that emphasized effectiveness and outcomes, said Helen Darling, manager of health care strategies and programs.

With the addition of PHC's mental health network, Xerox hopes to "save some money in the short term" but to see greater savings over time, she said.

Xerox expects to spend less on inpatient care but more on outpatient treatments that are more effective in the long run, cutting back on the "recycling of employees through the same medical programs," she explained.

The office equipment giant spent approximately \$218 million on health benefits last year.

More than one-tenth of those overall health care costs were spent on treatments for substance abuse and mental health problems, said Ms. Darling.

Also disturbing, said Ms. Darling, was that 14% of total health expenses were on cases exceeding \$100,000—many of those involving either psychiatric or substance abuse treatment.

To cut that figure, Xerox had already established a \$100,000 lifetime maximum for mental health and substance abuse treatment, excluding prescription drugs.

Under the new plan, that limit will stay at \$100,000 for pre-authorized treatment with a network provider but will plummet to \$15,000 for pre-authorized treatment with a non-network provider.

Similarly, the annual maximum will remain at \$50,000 for network providers. If other doctors and hospitals are used, the maximum will be \$7,500.

—By Sara J. Harty

Mental health tab rises

Mental health and substance abuse costs average approximately 10% of a company's total health care expenses, up from an average of 5% a decade ago, according to a new survey.

However, the range of expenditures on behavioral health care costs varied widely, the survey found.

Twenty-one percent of the 350 companies surveyed by The Wyatt Co. reported behavioral health costs last year of 5% to 6% of total health claims costs. But even more companies—22%—said that their behavioral health costs represented 11% to 20% of

Benefit Beat

the total.

Of the companies surveyed by Wyatt, another 18% said behavioral health costs were 9% to 10% of the total; 18% said behavioral health care costs were less than 4% of the total; 16% said behavioral health care was 7% to 8% of the total; and 5% put the costs at more than 20% of the total.

"The cost spiral has prompted companies to adopt a range of cost-control initiatives," said Dr. John Bunker, a Wyatt consultant in Washington. "Employers are bringing managed care techniques from their medical bene-

fit programs to bear on mental health and substance abuse claims."

The vast majority of respondents use several utilization review programs to help control behavioral health care costs, the survey found.

Eighty-three percent, for instance, require precertification of inpatient days, 75% require medical case management and nearly that many—73%—require preauthorization for use of mental health services.

To better control behavioral health costs, a few companies are beginning to carve out these

benefits and administer them separately from other medical health benefits, the survey found.

Some 7% of those surveyed said they carve out behavioral health benefits.

More than two-thirds of those surveyed—70%—have an employee assistance program.

Of the surveyed companies that offer the programs, 53% use an outside administrator, 50% offer local face-to-face consultation off-site, 28% offer a local network of providers, 26% offer face-to-face consultation on-site and 12% offer telephone help.

Typically, companies require beneficiaries to pay both inpatient and outpatient deductibles and inpatient and outpatient

coinsurance for behavioral health benefits, the survey found.

The most popular funding method for behavioral health benefits was self-insurance with a stop-loss provision, used by 41% of those surveyed. The next most popular funding method was straight self-insurance, used by 37% of companies, followed by fully insured benefits, used by 12%. The remaining 10% used a variety of other methods.

The report, "Managing Behavioral Health Benefits: A COMPARE Survey Update," is available without charge from Gary Swegle, The Wyatt Co., 601 13th St. N.W., Washington, D.C. 20005; 202-508-4645.

—By Deborah Shalowitz

Is someone
else
profiting
from
your loss
experience?

NAIC gives states another option on dividends

By MEG FLETCHER

CINCINNATI—States have yet another way they can meet National Assn. of Insurance Commissioners' accreditation standards on extraordinary dividends paid by insurance companies.

About a year ago, the NAIC's Financial Regulation Standards and Accreditation Committee formally required states that sought accreditation to adopt the group's 1986 model act for insurance holding companies.

The model law essentially requires an insurer to obtain approval from its domiciliary insurance commissioner before

paying dividends that exceed "the lesser of 10% of surplus or net income," according to a complex formula.

That standard is more conservative—that is, requires approval at lower levels—than a pre-1986 standard that required approval for dividends exceeding "the greater of 10% of surplus or net income."

During the past several months, committee members evaluated requests from insurance companies that want liberal laws and from states that sought to have their rules on dividend payments approved so they could be accredited by the NAIC.

The committee already approved seven proposals, finding them "substantially similar" to

the model law (*BI*, Aug. 24; April 20).

An eighth alternative based on Illinois' regulation—which was approved by the committee earlier this month—is the first to reinstate "the greater of" language from the pre-1986 law. It was only approved after lengthy discussion, with committee members deciding that it con-

'I think it failed more because of the process it evolved from' than because of the content, says Gary Weeks, referring to a resolution emphasizing the serious problems in many state workers compensation systems.

tained adequate additional safeguards.

Among those safeguards: Dividends can be paid only out of "earned surplus," must be "reasonable" in light of the insurer's financial condition, and must be reported within a certain time.

In addition, Illinois regulators are required to have procedures to review both ordinary and ex-

traordinary dividends and to limit or disallow payment of any dividend if the insurer is financially troubled.

NAIC President and Committee Chairman William McCartney said he is willing to listen to still more alternatives, though he said the committee would like to close the discussion and move on to other topics, such as establishing standards for reviewing already-accredited insurance departments.

In related action, an NAIC subgroup deferred action on a model regulation that spells out how a commissioner should respond to an insurer's request to pay an extraordinary dividend.

In other action at the meeting, regulators:

- Certified the Texas department, making it the 14th one to be accredited.

- Refused during a closed plenary session to adopt a resolution emphasizing the serious problems in many state workers compensation systems.

"I think it failed more because of the process it evolved from," than because of the content, said Gary Weeks, director of Oregon's department of insurance and finance, and chairman of the NAIC's Workers Compensation Task Force.

During the NAIC's previous meeting, some regulators complained about the last-minute introduction of the resolution. Though the task force rejected it at that meeting, its parent committee adopted it (*BI*, June 15).

Some regulators also said they opposed it because they were afraid insurers could use the resolution's wording against them during rate hearings.

- Referred an accounting subgroup's recommendation to the Blanks Committee to change the annual statement so insurers must be more specific in reporting overdue reinsurance. Separate columns would be made for payments that are 90-120 days late and 120 or more days late. Currently, overdue reinsurance is reported in a single column labeled 90-180 days late.

- Established separate groups to discuss consumers' problems in seeking affordable auto, homeowners and commercial insurance policies, primarily for small businesses, in both urban and rural areas.

During a panel on redlining and other urban issues, consumer advocate Bob Hunter, president of the National Insurance Consumer Organization, urged regulators to seek information from insurers nationwide to determine areas where they sell all lines of property/casualty insurance.

Missouri Insurance Director Lewis Melahn, though, cautioned that regulators face several problems, including difficulty interpreting data, in investigating whether insurers are redlining. He added that a study in Missouri uncovered no illegal discrimination by insurers.

- Planned to continue drafting tighter rules to limit insurers' ability to transfer insurance policies from one insurer to another without the express approval of policyholders.

- Endorsed a bill pending in the U.S. Senate, S.B. 3092, that would allow the superintendent of insurance in the District of Columbia to fully regulate the district's Blue Cross/Blue Shield plan.

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Opinions

Family leave veto misguided

THE FAILURE of the House last week to override President Bush's veto notwithstanding, family and medical leave benefit programs are inevitable.

More employers are adopting family leave plans; states are enacting their own family leave laws; the Senate mustered enough votes to override the veto; and the House fell only 27 votes short.

Still, President Bush holds firm in his conviction that family leave decisions should be made by individual employers, not the government.

Critics of a family leave law point out that mandatory requirements would hurt small employers. However, the bill vetoed by President Bush would exempt employers with fewer than 50 workers. Larger employers likely would not face the problems of complying with the law that smaller, Mom and Pop firms would have.

And, the veto could work against big employers: As states enact their own laws in light of the federal vacuum, employers with multistate operations must comply with differing rules. The president and other Republicans cite this problem when advocating repeal of state health care benefit mandates; why wouldn't differing state laws be a problem when it comes to family leave?

And, we question President Bush's alternative to the legislation Congress passed. His proposal, which would grant tax credits to employers with fewer than 500 workers for each worker on leave, would cost the federal government money, a curious suggestion from a president committed to cutting the federal budget deficit.

Putting aside all the political rhetoric—by both supporters and opponents—we believe family leave programs benefit both employers and employees.

Demographic trends lead to a simple but fundamental conclusion: The workforce has changed. A huge number of women with young children has entered the workforce. The days when the average worker—meaning a married male with a wife who did not work—seldom had to think about family care responsibilities on the job are over.

Family leave programs address these problems. And, they build morale: Employees know they will have some flexibility should a family emergency arise—even if they never use the benefit.

It is likely that family leave legislation will one day become law. Either the president—whoever he or she may be—will realize that the benefits of a uniform national family leave law outweigh the



disadvantages, or enough support will be gathered in Congress to override a presidential veto.

Until that day arrives, employers that have not already adopted a family leave program would be wise to consider it—for their employees' sake.

A blow to consumer rights

WHAT CONSTITUTES a "consumer group"? That is a question that the National Assn. of Insurance Commissioners should ponder.

The NAIC recently stripped the Risk & Insurance Management Society Inc. of its status as a consumer group when RIMS officials attend NAIC meetings (*BI*, Sept. 28). The reason is a bit unclear (see letter below). What is clear is that the NAIC now classifies RIMS as an industry group, like the American Insurance Assn. or the National Assn of Insurance Brokers—organizations that represent the sellers of insurance products and services.

RIMS members are corporations that buy insurance. Yes, member companies operate captive insurers, but the vast majority of these are self-insurance vehicles that write only parent-company business.

If the No. 1 job of insurance regulators is to protect the consumer, it's a bit scary to think the NAIC may not know just whom it is supposed to be protecting.

Letters

'Will the NAIC ever get its story straight?'

To the editor: Correspondence has been fast and furious between the Risk & Insurance Management Society and National Assn. of Insurance Commissioners officials regarding the NAIC's decision to no longer recognize RIMS as a consumer organization.

Nevertheless, I am confused. When Paul Brown, RIMS director of governmental affairs, informed me of the NAIC's decision to arbitrarily rescind RIMS' status as a consumer organiza-

tion, he indicated that an NAIC official told him that the driving force behind the decision was RIMS' recent lobbying efforts on behalf of captives. When I mentioned this in a letter to NAIC President William McCartney, he responded that "the driving force behind the decision was not RIMS' recent activities geared toward ensuring the viability of the captive market."

Now I read in *BI* that Mr. McCartney said one of the reasons he decided to change RIMS' status was because "RIMS representatives primarily lobby on behalf of captive insurers at NAIC meetings." Will the NAIC ever get its story straight?

Frankly, why our status has changed is not particularly important. Whether it relates to our efforts on behalf of captives is not the issue. The real issue for RIMS is our stature as the voice of risk managers and commercial insurance consumers.

RIMS' membership is the single largest group of consumers of commercial insurance products and services in the world. In fact, our position relative to captive insurers is very much consumer-oriented. What are the owners of captives if not commercial consumers of insurance and insurance-related products and services?

This is merely another indication that some state regulators do not have a clue as to how the sophisticated commercial insurance market works. Instead of trying to learn more, they choose to simply lump all the players, buyers and sellers, into one common category. The NAIC has taken the easy road at the expense of commercial insurance consumers.

Suzanne H. Crager
President

Risk & Insurance Management
Society Inc.
New York

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Senate hopefuls look at benefit, risk topics

Business Insurance this week spotlights the major candidates running for U.S. Senate seats in Arizona, California, Colorado, Hawaii, Nevada and Utah.

The candidates were asked for their views on these pressing issues facing risk and employee benefits managers and the insurance industry: health care costs and the plight of the uninsured, tort reform, efforts to repeal insurers' antitrust exemption under the McCarran-Ferguson Act, and efforts to give the federal government a role in insurance regulation.

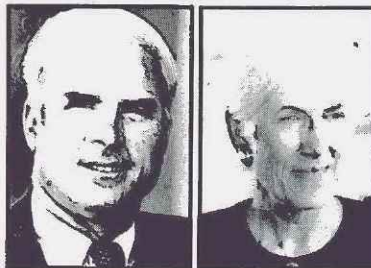
Arizona

Republican incumbent **John McCain**, 56, says that next to the economy and the budget deficit, health care reform is the most critical domestic issue the nation faces.

He favors reforming the health care system by, among other things, emphasizing managed care; providing tax credits for the poor and middle class to buy coverage; expanding access for children; increasing research into women's health issues; reforming medical liability coverage; and making long-term care coverage more affordable and accessible.

He also supports tort reform and co-sponsored the uniform federal product liability bill that the Senate recently killed (*BI*, Sept. 14).

Mr. McCain opposes efforts to repeal insurers' antitrust exemption as well as federal intervention in insur-



Sen. McCain Ms. Sargent

ance regulation.

Democratic challenger **Claire Sargent**, 58, worked in advertising and public relations before becoming a full-time mother and homemaker. She has been active in local and national politics.

Ms. Sargent supports the creation of basic universal health care coverage. She says Congress should closely examine the Oregon universal health care plan, which hinges on a system of rationing Medicaid services (*BI*, Aug. 31, Aug. 10), and Bill Clinton's "play-or-pay" plan (*BI*, Sept. 21) to see which could accomplish the most at the lowest cost.

Although she generally opposes laws to restrict the tort liability of businesses, Ms. Sargent would consider medical malpractice reform bills to improve access to health care.

Ms. Sargent said the federal government has an obligation to regulate the investment and solvency practices of all financial institutions on which the public relies, including the insurance industry.

California

Incumbent Republican **John Seymour**, 55, supports using tax incentives, both credits and deductions, to improve access to affordable health care. He also supports vouchers to let poor people select their health care plan.

He also would like to see greater emphasis on health promotion and efficiency in health care delivery.

Sen. Seymour has co-sponsored a bill, S. 2878, the Medical and Health Insurance Information Reform Act,



that calls for developing an electronic billing and patient information system. He envisions a system in which consumers carry a plastic card containing their medical history, insurance data and billing information. Health care providers could use the cards to link up to

an electronic network to retrieve records or transmit billing information.

Such a scenario would reduce administrative costs by \$4 billion annually and eliminate up to 10% of the unnecessary care provided in the system, saving an additional \$20 billion annually, he said.

The senator co-sponsored the uniform product liability bill that recently died. He called the bill a responsible approach to addressing the extremes and abuses of the tort system.

Sen. Seymour did not comment on reform of the McCarran-Ferguson Act or federal regulation of the insurance industry.

Sen. Seymour took office in 1991 after being appointed to fill the seat



Sen. Seymour Ms. Feinstein

left open when then-Sen. Pete Wilson was elected governor in 1990.

Democratic challenger **Dianne Feinstein**, 59, was mayor of San Francisco from 1978-88 and was the Democratic candidate for governor of California in 1990.

Calling health care reform long overdue, Ms. Feinstein favors mea-

sures that would:

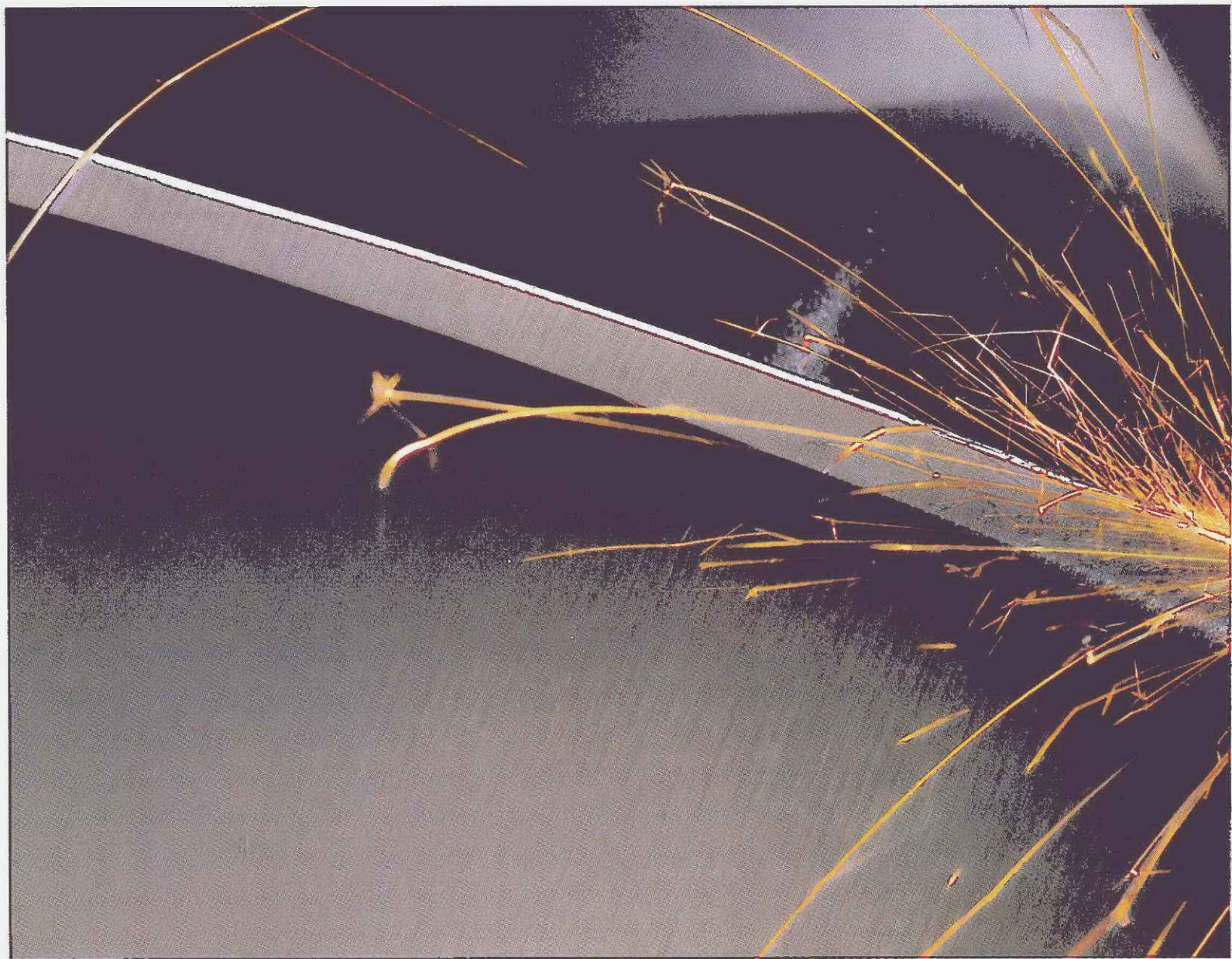
- Provide a minimum benefit package to everyone.
- Stress prevention and wellness.
- Prohibit exclusions for pre-existing condition exclusions and the cancellation of coverage for the elderly, disabled and ill.
- Control costs.
- Move the system from fee-for-service to managed care.
- Provide long-term care.

Ms. Feinstein did not respond to questions regarding tort reform, the McCarran-Ferguson Act or federal regulation.

The candidates are running for a two-year term, after which there will be an election for a six-year term for the seat.

Continued on next page

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Continued from previous page

The state's other Senate seat is open as well, because Sen. Alan Cranston is retiring.

Vying for the a six-year term is Republican **Bruce Herschensohn**, 60, a television commentator who ran for U.S. Senate in 1986 but lost in the GOP primary.

On health care, Mr. Herschensohn opposes House legislation, H.R. 1300, that would create a Canadian-style universal system. He supports elements of President Bush's proposal, except for its reliance on tax credits to help more Americans purchase health insurance (*BI*, Feb. 10). He supports a simplified tax code.



Mr. Herschensohn

Mr. Herschensohn supports tort reform and opposes both the repeal of insurers' limited antitrust exemption and federal insurance regulation.

Democratic challenger **Barbara Boxer**, 51, a U.S. congresswoman since 1982 and a former journalist, did not respond to repeated requests for her views.

Colorado

Sen. Timothy Wirth's decision to not seek re-election has left a Congressman and a former Colorado legislator battling for the Democrat's seat.

Running on the Democratic ticket is third-term Congressman **Ben Nighthorse Campbell**, 59.

Mr. Campbell said he believes the nation's health care system is in serious need of reform.

"A single payer or 'pay or play' national health insurance program may not ultimately be practical or

desirable in the U.S., but I believe we must move toward providing universal access to health care, emphasizing preventive care and reducing total health care costs.

"The health care insurance industry has to recognize this... and will most likely have to be changed in some ways to assist in this effort," Mr. Campbell said.

Some tort reform is needed to cut health care costs, he said. "However, a citizen's constitutional right of access to the judicial system cannot be summarily denied. We must do all we can to eliminate the practice, or necessity, of defensive medicine."

He also says he believes the McCarran-Ferguson Act can be reformed in a way to benefit both the insurance industry and consumers. The current system of state regulation is duplicative, and some federal oversight can be combined with permitting a national data bank to



Mr. Campbell



Mr. Considine

share loss cost data, he says.

"I believe a local understanding of insurance needs and the primary participation of the states in regulation continue to be warranted, but it seems to me that absent self-reform, mandated reforms or changes will occur through either tougher state regulations or wholesale revision of McCarran-Ferguson."

Mr. Campbell anticipates increases in the federal government's role in insurance regulation, because health care reform will require "na-

tional approaches to insurance coverage," he said. Mr. Campbell envisions a regulatory system consisting of "general guidelines, with the states continuing to handle the nuts and bolts of regulation."

Republican opponent **Terry Considine**, 45, is a businessman who led a successful fight to limit the time state and federal officials can spend in public office in Colorado.

Mr. Considine—who is recovering from a broken back suffered in a horseback riding accident last year—has developed a health care plan that would:

- Eliminate employer-sponsored health care plans and instead require all employers to give each worker \$4,500 annually to pay for health care. Of that amount, \$3,000 would go into a "Medisave" account that a worker would draw on to pay for health care. The remaining \$1,500 would be used to buy an insurance policy with a \$3,000 deductible.

Any funds that are not spent could be put into an Individual Retirement Account, which would encourage consumers to become better health care shoppers.

- Provide the same tax break to individuals who buy health insurance that is now available to corporations.

Regarding tort reform, Mr. Considine has formed a grass-roots organization called Coloradans Back in Charge that is calling for reduced civil litigation by using low-cost alternatives to court trials. The group also favors reimbursing successful litigants for a portion of their legal costs.

Hawaii

Democratic incumbent Democrat **Daniel K. Inouye**, 68, introduced the National Health Care Act of 1992, a proposal developed by the National Assn. of Social Workers.

"Like other single-payer national health care proposals, this bill would replace the patchwork of multiple public and private insurance plans with one publicly financed health insurance plan that is administered by the federal and state governments," Sen. Inouye said.

The plan would be financed by a personal income tax, an employer-paid payroll tax and corporate income taxes. States also would be assessed, and the cigarette and alcohol tax would be increased.

The plan would cover "expanded comprehensive care" and include primary care services, hospital care, dental and vision care, mental health and substance abuse treatment—with no "arbitrary limits"—rehabilitation services, prescription drugs and long-term care.

The plan calls for coordination of care by primary care providers as well as utilization review and quality control by "peer review organizations."

Republican challenger **Rick Reed**, 45, a six-year state senator, proposes giving each family a tax credit to buy the insurance policy of its choice.

He also favors requiring employers "to put the cash value of their existing insurance plan... into higher wages," according to a Reed campaign statement.

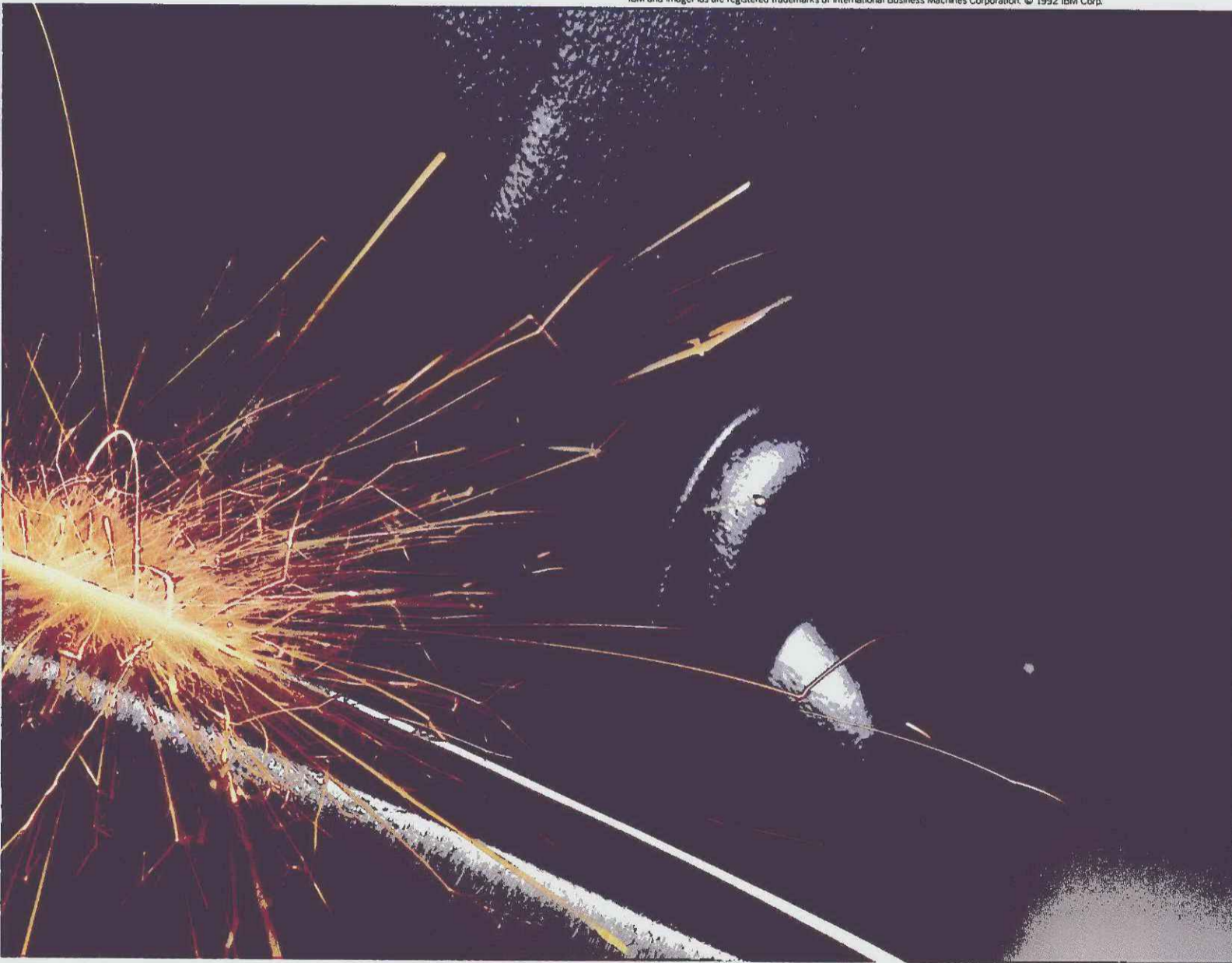
Each household receiving tax credits would be required to purchase a "minimum benefits insurance policy" that could cost as little as \$250 a month for a family of four, the statement said.

The plan also calls for guaranteed renewable insurance and caps on premium increases.

Neither candidate commented on tort reform, insurers' antitrust exemption and federal insurance regulation.

Continued on next page

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Senate candidates

Continued from previous page

Nevada

Democratic incumbent **Harry Reid**, 52, supports a national health care system that would provide "affordable, accessible, quality care to all Americans." He said reform should focus on prevention and maintenance.

Tort reform should be handled by the states, which have been crafting laws on this issue for many years, he said.

On the McCarran-Ferguson Act, Sen. Reid states that "as long as the rights and needs of the consumer are protected, there is no reason to make drastic changes to a law that has proven effective."

State insurance regulation is adequate for the most part, though solvency regulation "may need attention," he said.

The federal government should be involved as needed to protect consumer rights and needs, he said. "This level of involvement is directly correlated to the level of responsibility and integrity exhibited by insurance companies."

Republican challenger **Demar Dahl**, 50, a rancher and businessman who is making his first run for public office, did not respond to several requests for information.

Utah

A businessman and a congressman are battling for the seat being vacated by Republican Sen. Jake Garn.

Republican candidate **Bob Bennett**, 59, a businessman and son of a former U.S. senator from Utah, said tax policy should be changed to allow employers to pay, without penalty, directly to their employees the amounts they now spend on

health benefits.

Employees then could set up their own health savings accounts or buy their own health insurance.

Employers would have to contribute only \$1,500 to each account.

Under this system, policies belong to the individuals and would follow them when they change jobs or retire, Mr. Bennett explained. "Families would use their health savings accounts to pay for routine medical care, allowing the individual to bargain with his provider regarding costs and pay doctors directly," he said.

The entire system should be privately funded, except for federal subsidies for "those in need," Mr. Bennett says.



Mr. Bennett

Once in place, the system would abolish both Medicare and Medicaid, since everyone—including the elderly and poor—would have their own personal policies.

On tort reform, Mr. Bennett said he supports efforts to reduce the number of frivolous lawsuits and improve the way the civil justice system operates. He also supports caps on awards in medical malpractice suits, as well as efforts to promote alternative dispute resolution.

The federal role in insurance should be to provide a "level playing field for all insurance companies," he said. "The state should regulate the insurance industry at their level."

Democratic challenger **Wayne Owens**, 56, now serving his fourth term in Congress, has introduced legislation, the Health Care Protection Act, that is designed to combat "job lock," where people are afraid to change jobs for fear of losing

their health benefits.

"This act will guarantee individuals with a pre-existing condition retention of health care benefits when they move from one job to another," he stated.

Rep. Owens also says that any health care reform legislation passed by Congress should include benefits for long-term care. He said he would introduce legislation that would make long-term care services available to all who need them, regardless of age or income.

Rep. Owens also plans to introduce legislation that he says would improve health care access for rural residents. The legislation's primary focus will be recruiting physicians to rural areas.

Los Angeles Bureau Chief Joanne Wojcik and Associate Editors Judy Greenwald in San Jose, Calif., and Louise Kertesz in Los Angeles contributed to this report.

Reform outlook

Continued from page 3

face tough decisions in controlling health care costs, he said. It is possible, for example, that policyholders may have benefits and services reduced.

It may not be possible, if costs are to be controlled, for everyone to receive instant treatment on demand, he said.

But he rejects as invalid the assumption that lower health care costs in nations with government-run health insurance systems mean those countries are doing a better job in controlling costs.

Such comparisons are unfair, he says. Certain factors—like teen-age pregnancy and gun injuries, which drive up U.S. costs—are much less prevalent elsewhere, he said.

On the pension front, Rep. Rod Chandler, R-Wash., says simplification provisions included in House- and Senate-passed tax bills are a welcome change. Those provisions, among other things, simplify 401(k) non-discrimination tests.

For the longer term, he says, a blue-ribbon commission is needed to hammer out policy on many retirement issues, including, for example, recommendations to help improve the nation's very low savings rate.

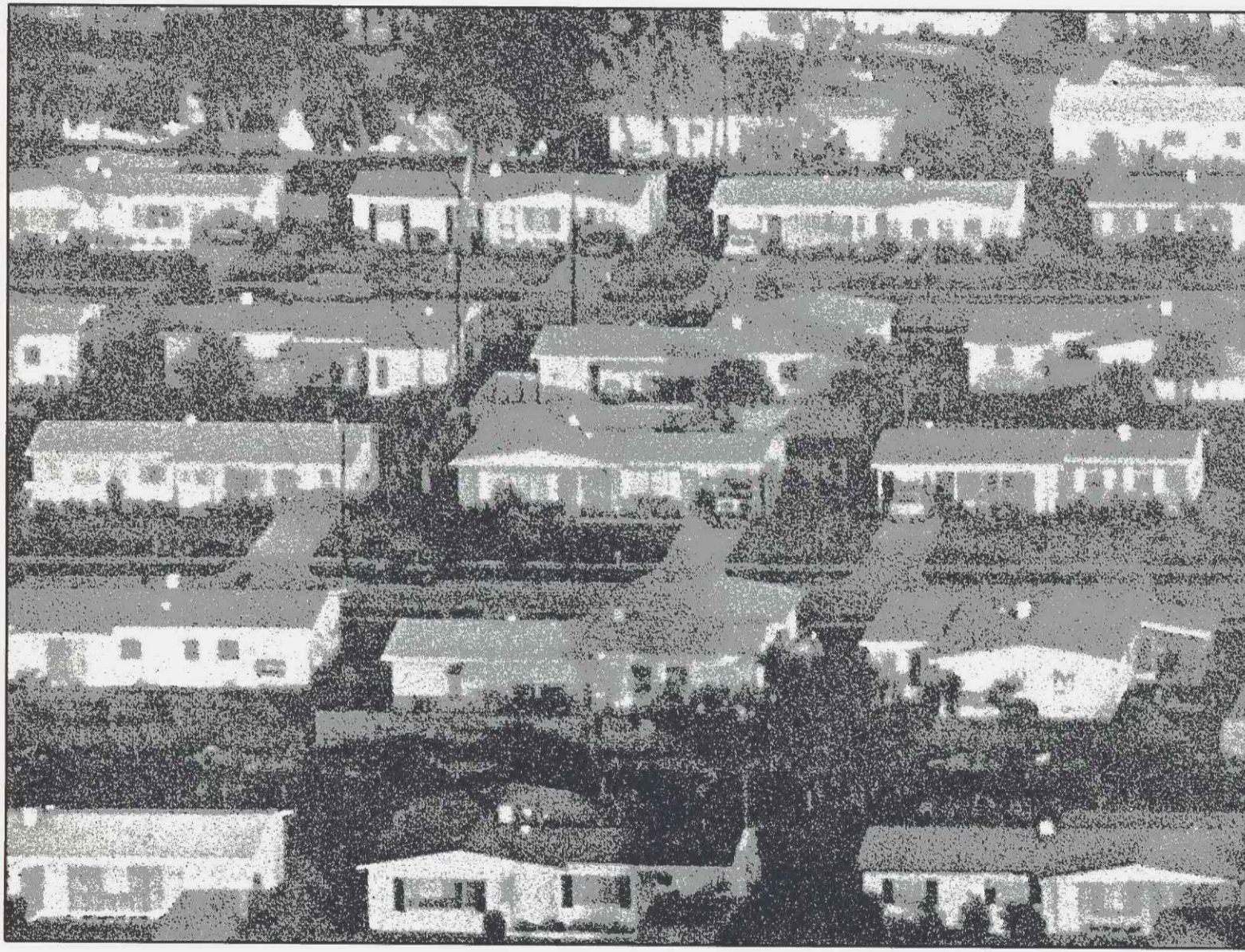
Pension Benefit Guaranty Corp. Executive Director James B. Lockhart III told the meeting that because he has warned about the PBGC's financial problems, "I have been called a Jeremiah, a Cassandra and have been accused of 'fear mongering' and crying 'wolf.'"

But, the problems are real, he said. Its current \$2.5 billion deficit could rise to \$18 billion by 1997. Without reforms, the \$19 annual per-participant PBGC premium paid by employers with well-funded defined benefit plans might rise to \$70, while premiums for underfunded plans—which now range from \$20 to \$72—could rise to "many hundreds of dollars."

Ultimately, employers with well-funded plans will rebel and terminate them in favor of defined contribution plans, which are not insured by the PBGC. Eventually, taxpayers would likely foot the bill when underfunded plans collapse.

But that gloomy scenario does not have to occur, Mr. Lockhart said. A series of reforms—including faster pension funding requirements, elimination of PBGC coverage of benefit improvements granted by underfunded plans and upgrading the PBGC's creditor status in bankruptcy proceedings—will give the agency better protection from losses and put it on a much sounder financial footing, he said.

"The sooner reforms are enacted, the better for the PBGC and the defined benefit system," he said. ■



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Asbestos rulings

Continued from page 2

bestos cases under General Order 21, issued by a San Francisco Superior Court shortly after the California Supreme Court's 1980 landmark decision in *Sindell vs. Abbott Laboratories*.

In the *Sindell* case, which involved women allegedly injured by the anti-miscarriage drug DES but who could not tell which company made the drug they consumed, the court allowed the plaintiffs to seek damages from companies that made the drug at time of the injury based on the manufacturers' market share.

Asbestos makers, though, were not held liable based on their market share. In its general order, the Superior Court explained that plaintiffs in asbestos cases could identify who made or supplied the asbestos-containing products that injured them.

The court also said that since many asbestos victims have been exposed to a variety of asbestos-containing products in various industries, it would be too difficult to devise a market share formula to determine damages.

The Wheeler litigation involved five personal injury cases that were consolidated for trial. The plaintiffs all said they had been exposed to asbestos fibers from a wide variety of asbestos-containing products.

While many of the manufacturers could be identified, the plaintiffs could not tell which companies were responsible for the portion of their injuries caused by their exposure to automotive brake products that contained asbestos.

The plaintiffs' only contact with the brake products occurred when they were replacing worn brake pads, when brands could no longer be identified.

The trial court dismissed the plaintiffs' claims, citing General Order 21.

That decision was reversed by the appellate court.

"Because of the peculiar facts presented by exposure to asbestos fiber from brake pads, we conclude that General Order 21 is inapplicable to the facts of the claim stated by plaintiffs," the court said.

Defendants Bridgestone/Firestone Inc. of Akron, Ohio; Morton International Inc. of Chicago; and Lear Siegler International Corp. of Stamford, Conn., are seeking review by the California Supreme Court and have asked that the appellate court decision be decertified so that it cannot be used as precedent.

Defense attorneys declined to comment pending the appeal.

Originally the decision was unpublished, but the court changed its mind after the plaintiffs requested that it be published.

Insurance defense lawyers are urging the state Supreme Court to "depublish" the decision.

"Wheeler distorts and greatly expands *Sindell* by equating 'identical' drugs with 'roughly comparable' brake products," wrote Raymond Coates of Low, Ball & Lynch in San Francisco in a letter to the high court. Mr. Coates, who filed an amicus brief in the Wheeler case, wrote the letter on behalf of the Assn. of Defense Counsel of Northern California, a group of about 2,000 insurance lawyers.

No other courts have used the market share theory in non-DES cases.

"In fact, I have explicitly seen it rejected," said Mr. Eaton.

"This ruling is an aberration and is unlikely to be affirmed on further appeal," he predicted.

The lawyer for the asbestos vic-

tims—Harry F. Wartnick of Borowsky, Wartnick, Moore & Harris in San Francisco—could not be reached.

The Sept. 21 decision by the Illinois Supreme Court stems from a 1982 suit against Manville Corp. by Lois Thacker, the widow of Les Thacker. Mr. Thacker died in 1981 from asbestosis and lung cancer.

Manville's 1982 bankruptcy filing delayed the case. Subsequently, the Manville Personal Injury Settlement Trust was created to assume liabilities for asbestos-related personal injury claims against the Manville entities. The trust was substituted as a defendant in the suit, and the case proceeded to trial.

Mr. Thacker allegedly contracted his illness from breathing in asbestos fibers that drifted throughout the work area at the Union Asbestos & Rubber Co. in Bloomington, Ill.

According to receipts introduced at trial, Union had purchased asbestos from Johns-Manville Corp., the predecessor of Manville Corp.

Union also bought asbestos from other manufacturers, many of which no longer exist. It was not shown at trial what percentage of the asbestos fibers that drifted through the plant where Mr. Thacker worked was attributable to the asbestos Manville produced.

A McLean County Circuit Court jury in 1989 awarded the widow \$280,830. The Manville trust appealed.

Initially, the appellate court reversed, finding that the plaintiff had failed to prove that asbestos sold by Manville entities was a proximate cause of Mr. Thacker's injury and death.

But then, after Mrs. Thacker sought a rehearing, the appellate court unanimously reversed its initial decision and affirmed the circuit court verdict.

The Manville trust then appealed to the state Supreme Court, which upheld the original jury verdict. No vote breakdown was made public.

An attorney for the Manville trust, Margaret S. Garvey of Freeborn & Oeters in Chicago, said she will ask the court to rehear the case.

But if the court decides not to, "the law made by the Thacker decision is likely to have a significant impact on other asbestos litigation in Illinois," Ms. Garvey said.

"The court did not require the plaintiff to show where Johns-Manville asbestos was used in the plant," she said. As a result, the decision "applies to cases where the plaintiffs didn't work directly with asbestos."

The Thacker decision could have broad implications outside of the asbestos context, said Mr. Eaton. "We could see it used by individuals suing smokestack industries in their communities or by non-smokers" harmed by exposure to second-hand smoke.

In a statement, Mrs. Thacker's attorney, James G. Walker of Bloomington, Ill., called the ruling significant not only for Mrs. Thacker but also for other asbestos litigation in Illinois.

"The Supreme Court's opinion puts to rest one of the few remaining arguments by which asbestos companies have attempted to avoid responsibility for the epidemic of asbestos disease caused in this community," he said.

Richard Wheeler et al. vs. Raybestos-Manhattan et al., California Court of Appeal, First Appellate District, Division Four; No. A054969.

Lois Thacker vs. UNR Industries Inc., et al., Illinois Supreme Court; No. 72095.



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Regulation

Continued from page 3
national "white list" of approved surplus lines insurers.

"I don't think the inevitability (of federal regulation) is there," said Richard M. Bouhan, executive director of the National Assn. of Professional Surplus Lines Offices Ltd.

If the Dingell proposal becomes law, many risks traditionally written in the surplus market would go with the federally licensed large insurers, Mr. Bouhan said at NAPSLO's annual conference last month.

"The big ones will always go to the area with the least regulatory intervention."

Some surplus lines insurers could also be hurt by the added burden of having to keep abreast of both regulatory systems, regardless of which they chose.

"A small regional carrier in the Midwest would have to have a staff and lawyers in Washington, regardless of their choice," Mr. Bouhan said.

The National Assn. of Independent Insurers, most of whose members are small to medium-sized companies, also is not convinced that federal solvency regulation would be prudent.

"Multiple regulation occasionally is a contributing factor to inefficiency," said David Brummond, assistant vp and assistant general counsel for the Washington-based trade group.

The NAII wants evidence that federal regulation would be more efficient, he said.

But the current state system of solvency regulation must be improved, said Craig A. Berrington, senior vp and general counsel of the American Insurance Assn. in Washington.

The AIA—most of whose members are large commercial insurers—has suggested granting federal licenses to property/casualty insurers to exempt them from state regulation for both commercial and personal lines (BI, Feb. 3).

Allowing insurers to select either federal or state solvency regulation would put "discipline back into the insurance purchasing decision," he said.

Even the National Assn. of Insurance Commissioners' state accreditation program, with its emphasis on uniform state laws, "back-handedly admits that national regulation is needed," he said.

Federal regulation would be better, because "state laws may look a lot alike on paper, but the same language can be interpreted differently," Mr. Berrington said.

Federal regulation would also be more insulated from political influence, he said. "State politicians see insurance-bashing as a way to the top. The state system is struggling to accommodate an increasingly political environment."

He added that, "No bill fulfills all of our goals, but the Dingell bill makes a good start."

Exempting large commercial policies from state regulation was also championed by Robert B. Shapiro, a lawyer who represents standard lines insurers and brokers.

"General Motors does not need rate and policy protection," said Mr. Shapiro, who is with the Law Offices of George K. Bernstein in Washington. "They have as much bargaining power as the insurer."

Illinois Insurance Director Stephen F. Selcke supported fed-

eral regulation of offshore insurers.

"As an insurance commissioner, I have more than a passing interest in preserving the effective, efficient tradition of state regulation," Mr. Selcke said.

But that does not mean that "the state regulation approach is perfect or there is no room for improvement," he said. "I don't agree that Washington or the federal government can overall do a better job regulating the insurance industry."

The Illinois regulator favors a federal "gatekeeper" law that

Federal regulation would be better, because "state laws may look a lot alike on paper, but the same language can be interpreted differently," says Craig A. Berrington, senior vp and general counsel of the American Insurance Assn.

would grant the NAIC authority to approve a list of alien insurers that can write in the United States.

"There are fraudulent activities by non-U.S. companies that state regulators are ill-equipped

to handle," Mr. Selcke said. "It is my opinion that some partnership seems inevitable in this particular area."

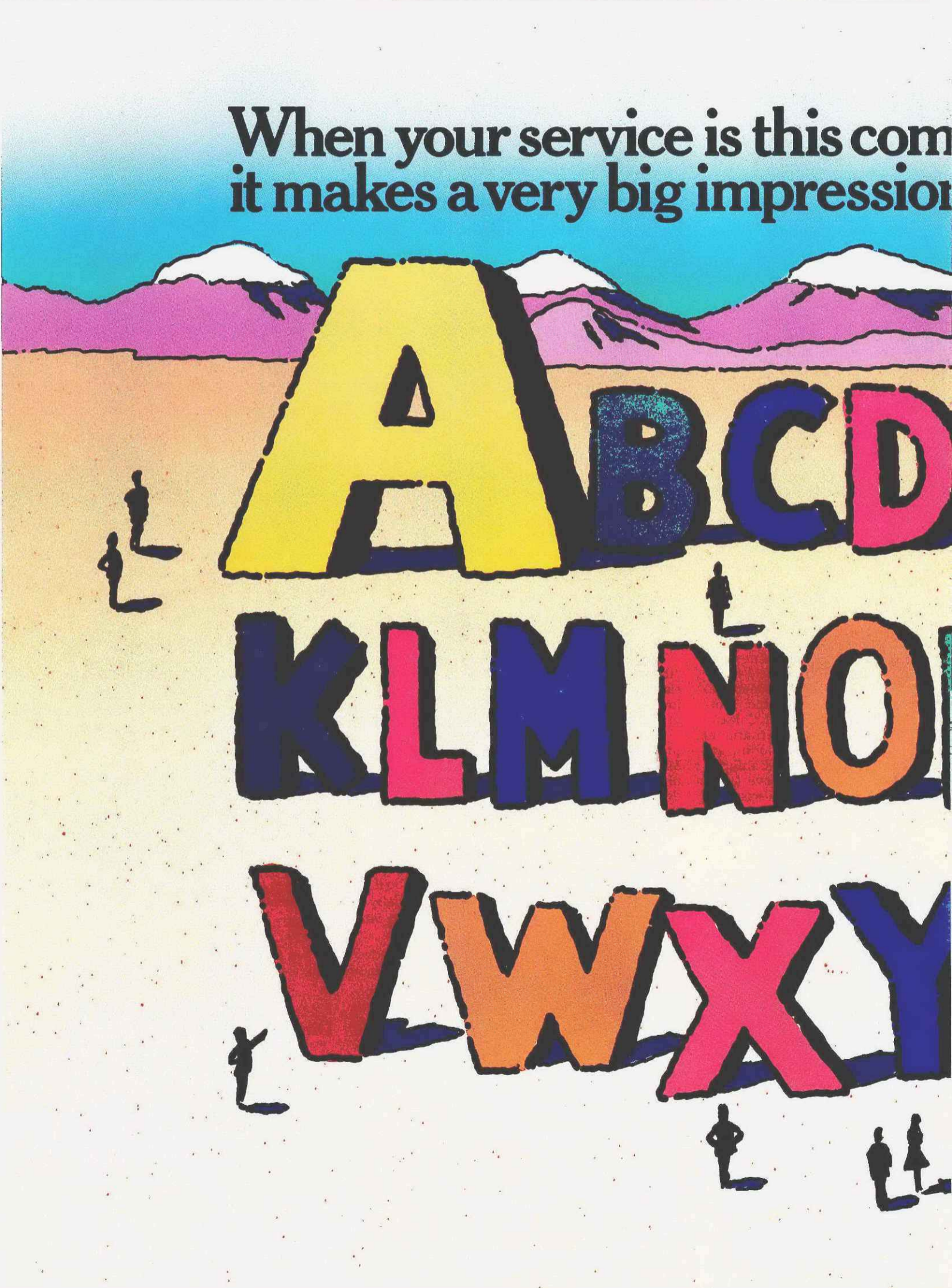
On one thing the panelists all agreed: Insurance regulation should be improved.

"The current system of regulation grew up with localized property risks," Mr. Shapiro said.

"It had nothing to do with global risk. Now you can have the same risk in fifty states and overseas."

For his part, Mr. Brummond of the NAII said he favored making regulation more efficient and competitive, but keeping it at the state level.

Moderating the session was Michael J. Snead, chairman and chief executive officer of Admiral Insurance Co. of Cherry Hill, N.J.



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NAPSLO meeting draws 1,700 people

CHICAGO—About 1,700 surplus lines insurance executives and wholesale brokers attended the annual National Assn. of Professional Surplus Lines Offices Ltd. meeting late last month.



Lloyd's of London Chairman David Coleridge gave the keynote address, while Stephen F. Selcke, director of the Illinois insurance department, made the introductory remarks. Panel discussion topics included federal regulation of the insur-

ance industry, risk-based capital requirements and solvency.

David R. Hartoch was elected the next president of NAPSLO, succeeding Kurt C. Bingeman. Mr. Hartoch is chief operating officer and president of Sherwood Insurance Services, a San Francisco-based unit of Frank B. Hall & Co. Inc. Mr. Bingeman is president and treasurer of Russell Bond & Co. Inc. in Buffalo, N.Y.

Next year's meeting will be held Sept. 29-Oct. 3 in Atlanta. For more information, contact NAPSLO Executive Director Richard M. Bouhan at 816-455-3210.

Risk-based capital

Continued from page 3
 reason that surplus lines growth be restricted if other risk-based capital requirements are met," he said. "The surplus lines industry can be the solution, not the problem."

"Clearly excessive growth is dangerous," Mr. Goodfriend warned. "Some companies have difficulty handling growth. Underwriting standards deteriorate, they have trouble processing claims. But it is the nature of excess lines to contract and expand."

Another hurdle for surplus lines insurers is stringent capital requirements for smaller companies.

Mr. Frazier fears that some insurers may be considered "too big to fail" by regulators. If that attitude prevails, well-capitalized small companies will have to compete against large companies that do not have to comply with such stringent risk-based capital standards. "It's a fact of life, but it's not in the best interest of the consumer or the industry."

Determining the proper capitalization for small companies is more difficult, Mr. Goodfriend explained. "Small companies are more variable. Data is less predictable."

"Niche players that perform well will not be penalized due to size" by risk-based capital standards.

How risk-based capital requirements will be applied to non-U.S. insurers is another concern to the surplus lines industry, Mr. Frazier said.

If offshore companies are not regulated as stringently as domestic insurers, "I can foresee circumstances where alien companies become the safety-valve," replacing U.S.-based surplus lines insurers.

Greater cooperation among insurance regulators worldwide should even the playing field, Mr. Goodfriend said.

Another threat that risk-based capital presents to surplus lines is that coverages with long tails become more attractive, Mr. Frazier said.

"Workers compensation and long-term lines appear to be less capital-intensive, but (they are) not less risky," Mr. Goodfriend agreed.

"My biggest concern is that (risk-based capital requirements) will inhibit the operations of strong companies without materially improving the performance of weak companies," Mr. Frazier said.

Rating agencies like A.M. Best & Co., Standard & Poor's Corp. and Moody's Investors Service Inc. already have implemented informal risk-based capital standards into their ratings, as illustrated by the rash of downgradings in the past year, Mr. Goodfriend said.

"They have their own ideas about minimum capital requirements based on risk. They may exceed those of the NAIC," Mr. Goodfriend said. The rating agencies "have their own battle on for market share, a battle to be the toughest guy on the block."

Risk-based capital is necessary because "most states' fixed minimum amounts are appropriate for startup (companies) but not adequate for established insurers," said Vincent Laurenzano, assistant deputy superintendent of the New York Insurance Department.

While a risk-based capital formula for property/casualty companies still is being developed, the risk-based capital requirement will be "significantly greater than the current minimum," he said.

The property/casualty formula should be ready for extensive testing in December and could be implemented in 1994, he said. An alternative formula will also be tested.

The life/health formula could be approved by the National Assn. of Insurance Commissioners later this year and likely will

Continued on next page

plete,



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Risk-based capital

Continued from previous page
 have to be used in conjunction with insurers' 1993 annual statements (BI, Sept. 28).

While risk-based capital is a good idea, it will only work if regulators are given the authority to enforce the standards, Mr. Laurenzano noted.

"Risk-based capital is not a rating system nor a magic formula," he said.

"It will not prevent all insolvencies, but it will prevent or mitigate many."

Commented Mr. Frazier: "Risk-based capital is a good idea whose time has come, but 'it will take the wisdom of Solomon to implement.'"

The panel was moderated by Thomas S. Bloom, chief executive officer of Heath Insurance Brokers Inc. in Dallas. ■

Changes at Lloyd's will pay off: Coleridge

By SARA MARLEY

CHICAGO—Lloyd's of London has learned from its mistakes, its top official says.



Hurricane Andrew stands as proof of that, says outgoing Lloyd's Chairman David Coleridge. Although Andrew cost insurers

twice as much as Hurricane Hugo in 1989, Lloyd's exposure will be far less, he said, explaining that the risk was spread over more of the Lloyd's market and

higher rates were charged for reinsurance.

Still, Lloyd's already has paid hundreds of millions of dollars to U.S. ceding companies through a newly merged and automated claims office, he said.

"We have a special settlement scheme in place which is designed to pay on brokers' advices, easing the cash flow of hard-hit U.S. insurers, with the differences settled later," he explained at the annual National Assn. of Professional Surplus Lines Offices Ltd. meeting.

Overall, "I hand Lloyd's to my successors better than when I received it two years ago," Mr. Coleridge said in his last U.S. appearance as chairman before he steps down at year end. "I am absolutely confident it will continue to be just as effective in the future.

"All the structural changes are more than matched by a change in attitude by all at Lloyd's," he continued. "We are determined not to repeat the mistakes of the past."

The next chairman, David Rowland, will preside over a new system of governance (BI, Aug. 31). As the first full-time chairman in Lloyd's history, Mr. Rowland will be "unencumbered by ties and duties to an underwriting firm or brokerage," the outgoing chairman said.

Among other changes in the works at Lloyd's cited by Mr. Coleridge: a new board—headed by Peter Middleton, Lloyd's recently appointed chief executive officer—that will address business development; and a high-level stop-loss coverage plan that will "limit members' exposure without effecting the security and solvency of Lloyd's as a whole."

The first steps toward corporate membership at Lloyd's have been taken, with "approval given for consortia formed between Lloyd's members and companies."

One sign of that cooperation is allowing syndicates to increase their capacity by 25% over premium volume limits by buying quota-share reinsurance, Mr. Coleridge said.

"Syndicates and agencies have merged, leading to greater efficiency; and the transfer from cost to benefit will have a real impact on the price we can charge for our products in a competitive marketplace, and improve our members' returns for the risks they accept," Mr. Coleridge said.

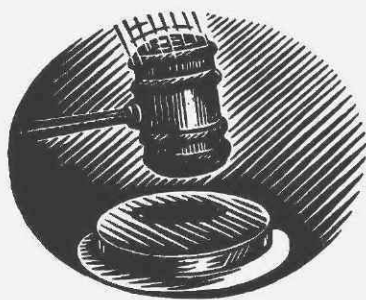
"As a member of a worldwide industry, Lloyd's has problems of its own. But it also shares with all other insurers the problems of the past," including long-tail asbestos and pollution claims, he said.

While exposures are mounting, policyholders are "unwilling to pay sufficient premiums to transfer (their risks) to insurers. They are increasingly looking to legal remedies.

"What I would ask is that we all try to help each other face these problems of change and turn them into opportunities," Mr. Coleridge said.

"Insurance is now such an inextricable part of everyone's lives on a global scale that in the future only global answers will do." ■

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Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

ELECTION '92

Stumpin' around: For these agents, voters may prove the hardest sell

By LAURA MAZZUCA

It's a well-known fact that politicians and salesmen have a lot in common. They both have a product to sell, and they both use "people skills"—a memory for names, faces and the gift of gab—to sell them.

So it should come as no surprise that a bumper crop of insurance agents—salesmen supreme—are running for Congress this year.

There's Jack Kingston, a Georgia Republican and a producer at Atlanta brokerage Palmer & Cay/Carswell Inc., fighting for the 1st District House seat vacated by Rep. Lindsay Thomas.

And Alfred Palermo, a second-generation independent agent, is waging an uphill battle against incumbent Democratic Rep. Donald M. Payne, in New Jersey's 10th District. So solidly Democratic is the district that a journalist once asked Mr. Palermo, "Why are you on this suicide mission?"

Among the agents turned politicians is Tim Holden, the Democratic candidate for the 6th District House seat in the heart of Pennsylvania's coal country. The insurance broker and licensed real estate agent has been Schuylkill County sheriff since 1985.

And Tommy Hartnett, a former agent who now conducts real estate appraisals, is taking on the powerful and well-financed incumbent Sen. Ernest F. Hollings, D-S.C.

Although independent agents are well-represented, the field is definitely not restricted to their ranks.

Terry Lee Moser, a Texas Democrat and a Mutual of Omaha Insurance Co. agent, is challenging incumbent Rep. Larry Combest for the House seat in the 19th District.

Steve Musselwhite, vying with Republican Bob Goodlatte for Virginia's 6th District seat vacated by Rep. Jim Olin, is a general agent for Shenandoah Life Insurance Co.

Where they come from, and why

What drives these scrappers into the fray? How do they balance their business responsibilities with the demands of running for office?

Most often, they don't; they simply turn over business to associates while they're on the campaign trail.

"You can't be a candidate and a professional agent in today's insurance market," Mr. Kingston said. "It's more than a full-time job just finding workers compensation coverage for your clients."

But insurance agents enjoy a distinct advantage over their competitors in their dual role as producers and aspiring politicians.

"Agents deal with churches, schools, hospitals and get to know a lot of people," Mr. Kingston said. "It makes it a lot easier to get a support base to run for office."

Agent trade groups say they will not back candidates solely because they are agents. But agents will get a "closer look," since the trade groups want insurance-savvy people in Congress, said Lynnea Olsen, director of federal affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va.

Having agents in Congress makes lobbying much easier, since the business is so hard to explain to members with no insurance background, agreed Joel Wood, vp of government affairs for the National Assn. of Casualty & Surety Agents in Washington.

Because of their varied client base, agents have a strong sense of the needs of "the real working world" and are well-suited to represent a cross-section of people, Mr. Wood said. "They understand the concerns of working people."

And because incumbents, who suffered record losses in the primaries, seem to be unpopular with voters in this election, Ms. Olsen of PIA believes that for insurance people, "this year is the year to give it a shot."

Continued on page 16G



While a small distance separates PIA and IIAA headquarters in Alexandria, Va., the gulf between the groups has widened.

Is iron curtain next step in trade group relations?

Animosity over failed merger talks pervades IIAA meeting

By LAURA MAZZUCA

NEW ORLEANS—Once the glow of democracy began to fade, the nations of Eastern Europe began squabbling. And once the glow of economic unity began to fade, their neighbors to the West began wrangling.

Now the glow of trade group unity has begun to fade and—you guessed it—the insurance agent associations have taken to squabbling.

Good feelings that had pervaded merger talks between the Independent Insurance Agents of America and the National Assn. of Professional Insurance Agents turned sour once the PIA unexpectedly pulled out of the talks early last month.

Those failed merger talks were the talk of the annual IIAA convention last month.

On Sept. 1, PIA President Daniel J. Blum had formally backed out, citing a lack of benefits from a merger and accusing IIAA of simply wanting to create "a bigger Big I."

Less than two weeks later, on the opening day of the IIAA convention, that group passed a resolution rejecting PIA's decision to end the talks and resolving to reopen talks when the PIA shows a "commitment" to them. Also in the resolution was a pledge to continue helping state chapters to merge.

In his opening address, R.C. Riley, outgoing IIAA president, reiterated what he thought the benefits of a proposed merger would be. Among them were greater efficiency, the "clout" of a united independent agent position, and better products and services.

"Since Sept. 1, when PIA ended two years of consolidation talks, I have been asked many times if I am disappointed," Mr. Riley said. "I am disappointed because it does not fulfill a mandate from you. It deprives you of the demonstrated benefits of one organization speaking loudly and clearly on your behalf."

Jeffrey M. Yates, the IIAA's executive vp, took a harder line. In his address, he accused the PIA of "deciding to serve two masters" by trying to include agents for direct-writing insurers in a new, merged association.

"PIA has said that they left the talks because they found no compelling reasons to consolidate," Mr. Yates said. "What about the nine states that have bit the bullet and made consolidation happen? They speak of the tremendous cost savings that have resulted from their consolidations, the increased legislative voice they have achieved, the streamlined education and public relations benefits, and on and on."

So far, local chapters have officially merged in Colorado, Kansas, Massachusetts, Michigan, Minnesota, Missouri, Oklahoma and West Virginia. Illinois chapters are set to merge Jan. 1.

Incoming IIAA President Eric G. Gustafson, chairman of Blake Insurance Agency Inc. in Portsmouth, N.H., vowed to dedicate his term to supporting each state association, whether merged or separate.

"Our job is to serve independent insurance agents," Mr. Gustafson said in his inaugural address. "It doesn't matter which decal you have on the front window of your shop; we support you and what you do."

At a press briefing during the convention, the IIAA's Mr. Riley said that the PIA was never truly committed to a consolidation. "PIA never got beyond just studying the feasibility of a merger," he said.

Before talks broke down, Mr. Riley suggested to Mr. Blum that both groups adopt a "statement of common commitment." This would have entailed that both boards express a commitment to merge, setting an April 1993 goal for completion and agreeing to represent independent agents "with room for participation" by others, including exclusive agents. But that proposal was never adopted.

"We started these negotiations in good faith, after surveying our members," Mr. Riley said. "If the members rise up and say that's what they want, there will be consolidation."

The subject of a merger was first broached in 1982. By 1990, the PIA lifted a 1983 "gag order" on discussion of consolidation. This action came in the wake of a push to merge by the Minnesota

Continued on next page

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Failed merger

Continued from previous page
chapters (A/BT, July 2, 1990; Dec. 3, 1990).

Formal merger talks began in August 1990. Only a year or so later, Mr. Riley and Mr. Blum were making association history by appearing together at the joint annual convention of the IIAA and PIA of Colorado, where they projected that a merger would be complete by the 1992 convention (A/BT, Nov. 4, 1991).

But talks continued to stall over membership and organizational structure, and an outside facilitator was introduced to the discussions in December 1991.

Although there was some friction on the subject of admitting exclusive agents as members—

which PIA favored—there was no indication of a disagreement before PIA finally axed the talks in September, Mr. Gustafson said. "What was done publicly and what was done privately were at variance," he added.

Breaking off the talks has left merged associations—and some planning to merge—in a state of confusion.

The governing boards of merged associations, which expected national consolidation by the end of this year, will now have to choose whether they will be affiliated with PIA, IIAA, both or neither.

"We just cannot afford to pay dues to both national associations," said Christopher J. Pallotta, president of the Professional Independent Insurance

Agents of West Virginia, which merged on Jan. 1, 1992.

Dues also are problematic for the Kansas chapters, with 70% of the members belonging to both the IIAA and the PIA.

The group proposed to the national PIA a dues structure based on membership before consolidation, rather than taking into account the "windfall" of new IIAA members, said Gene A. Elliott, director of the Professional Independent Insurance Agents of Kansas. But the national PIA never approved the dues structure or the merger, he said.

"We're in a mode of limbo," said Mr. Elliott, who is also a member of the PIA national board. "We can't afford to pay double dues, and we feel ours was a good compromise for both associations."

In August, the merged chapters in Michigan began withholding dues to both national associations "pending lack of movement on the part of the nationals toward a merger," said George Stancil, national director of the IIAA who represents the Professional Agents of Michigan. The group currently has about \$467,000 in escrow, he said.

But now that the talks are off, "we can't make a decision that won't make one segment of our constituency unhappy," added Frederick C. Lewis, executive director of the Michigan PIIA.

Members of the Michigan group and other consolidated chapters are concerned that the national associations' "family feud" will spill over into the "pleasant, harmonious" relationship at the state level, Mr. Stancil said.

If PIIA of Michigan affiliates with either the national IIAA or PIA, it runs the risk of alienating members who are affiliated with the slighted association. "This leaves us with a difficult dilemma. Speaking for Michigan, we resent and reject it," Mr. Lewis added.

Michigan members polled so far are voting 2-to-1 to affiliate with IIAA, Mr. Stancil said. "We're making a real effort to make sure this is a member-driven thing," he said.

Many state mergers have increased dues.

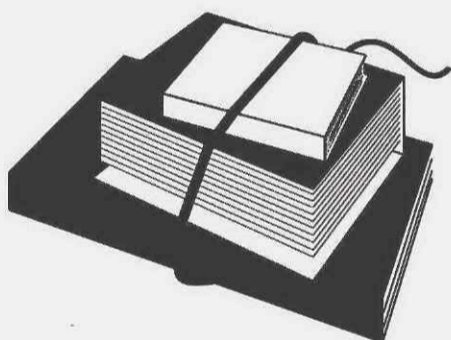
The merged Michigan group pays total dues of about \$460,000 to the national associations, Mr. Lewis said. Before the Jan. 1 merger, Michigan agents had approved dues for the proposed new entity that were higher than those for either individual association. But agents who had belonged to both groups are coming out significantly ahead. Since Jan. 1, dues have risen an average of \$50 a year for PIA members and \$75 a year for IIAA members, said Mr. Lewis. Agents who had been in both groups—512 of the 1,300 total—are saving \$500 annually on dues.

In West Virginia, dues have increased an average of \$70 a year for the 200-member merged group, said Gray Marion, executive director of the PIIA of West Virginia. The group pays about \$60,000 in annual dues to both national associations.

Members also are counted on a full-agency basis under the new organization. Before the merger, PIA members paid individual dues of about \$200 per year, while IIAA dues included all

Continued on page 16D

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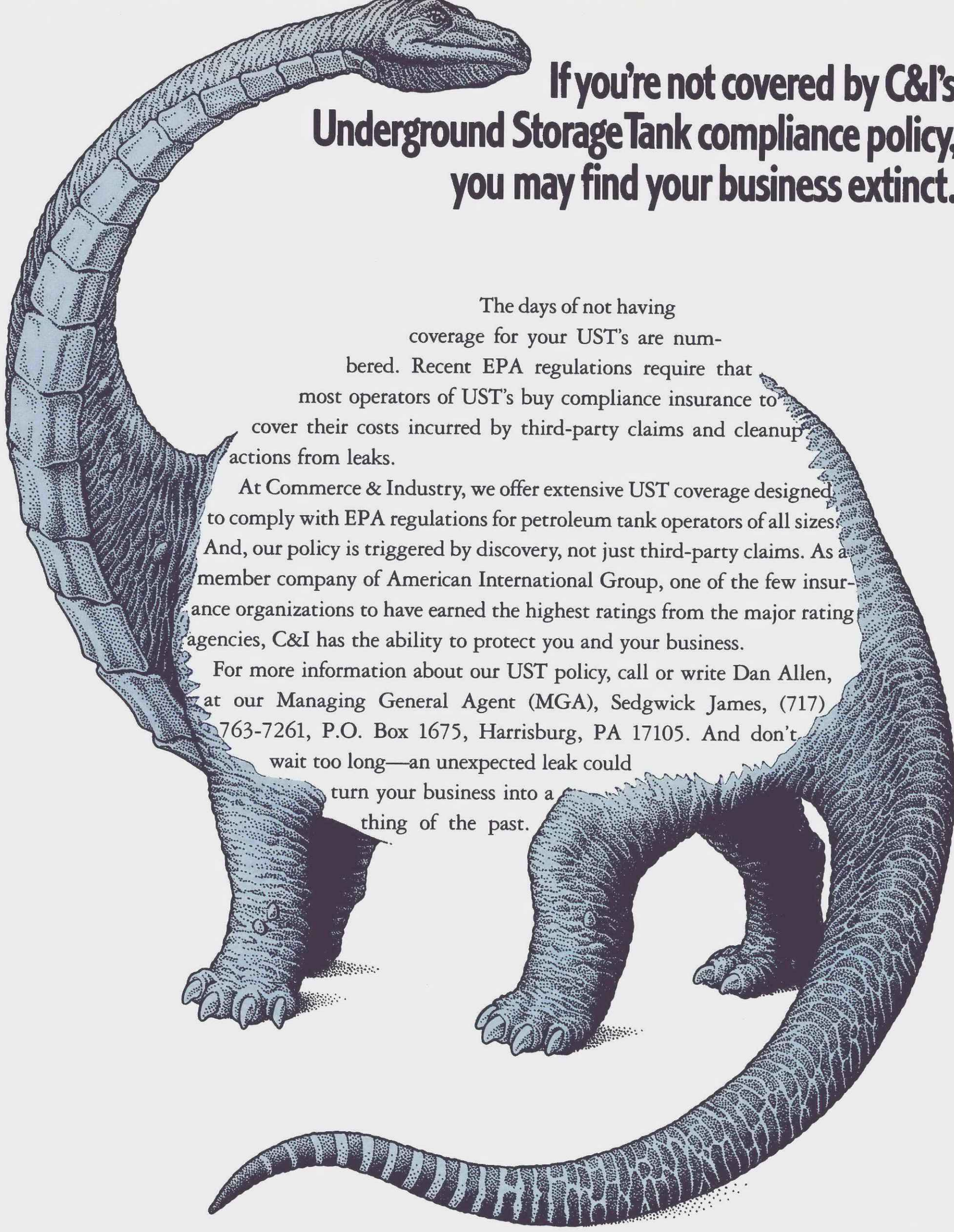


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Agent/Broker Topics

Failed merger

Continued from page 16B
agency employees, Mr. Marion said.

What do members get in return for higher dues? Better state lobbying efforts, expanded educational programs and services, and improved committee systems, said Mr. Marion.

In fact, before the merger, no PIA office existed in West Virginia; the association was managed from PIA's office in Ohio.

"There's no downside to doing this. The benefits are realized immediately," said Mr. Marion.

Similar benefits are already evident in Kansas, said Mr. Elliott, where the associations merged Sept. 1. State lobbying has improved and duplicated education programs, which were lightly attended, have been eliminated, he said.

Merged state associations say they have also managed to avoid what many insiders have long blamed for failed merger efforts nationally: ego problems. At the state level, association officers have not necessarily parceled out authority among themselves, said Mr. Lewis of Michigan. Instead, whole new boards of directors have been created.

In fact, all that's needed for a state merger is a 12-month budget, a governance plan, and a financial and legal study, added

Stewart M. Borger, representative to the IIAA board of directors for West Virginia's PIIA.

Even the controversial issue of whether or not to accept exclusive agents as members—cited by PIA as a major stumbling block—need not derail mergers. Merged groups have taken up the

'There's no downside to doing this. The benefits are realized immediately,' says Gray Marion.

issue after consolidation, said Mr. Lewis.

Not all state chapters, though, see formal mergers as critical. Even without them, state groups can enjoy many of the benefits, said Judy Fletcher, executive vp of the PIA of Nebraska.

The PIA already cooperates with its IIAA counterpart on joint educational and legislative efforts, and will probably merge conventions, Ms. Fletcher said. "But we could do that anyway, even if our basic principles don't agree."

When the national talks broke off, the Nebraska groups had been studying consolidation for about a year. They dropped their

plans because they "had no plans to merge without national approval," she said. "If anything, people are just glad that some sort of a decision was made."

Associations in other states seem less willing to follow the nationals' lead.

Take the PIA of Pennsylvania, Maryland and Delaware. The group, which still plans to merge with its IIAA counterpart, issued a scathing statement blaming both national associations for failure to merge and vowing to continue its own merger efforts.

Or consider the Independent Insurance Agents of Texas. When the national talks collapsed, the IIAA chapter, which had been considering a state merger, called on PIA members to "force PIA leadership back to the negotiating table," or "join with IIAA to fight for the future of all independent agents."

Whether or not this battle cry will result in any disruptions or walkouts during the upcoming PIA national convention next month in Orlando, however, is still subject to speculation.

"Our intention is to continue to work with PIA and see if there's some way to work this out," said Mr. Elliott of the merged Kansas association. "But I think every state is going to have to weigh it and do what they think is best."

Even within the PIA, "there's a real split" over merging, said Mr. Marion of West Virginia's PIIA, pointing out that half of the PIA executive committee voted to continue talks.

In Michigan, where interest in merging predates interest at the national level, the groups will continue to act in the best interest of members, Mr. Stancil said. "If national (PIA) thinks it can come into Michigan and fly in the face of a 95% mandate, they're very naive."

"This was an idea whose time had finally come," agreed Mr. Marion of West Virginia PIIA. "I have no idea what will happen in Orlando, but it will be interesting."

By specializing, could insurers threaten agents?

Overreaction seen to direct writer threat

By LAURA MAZZUCA

NEW ORLEANS—With direct writers becoming an increasing competitive threat in commercial



lines, insurers must be careful to avoid crippling their distribution force through over-specialization, an insurance executive says.

James Cannon, president of SAFECO Insurance Cos., warned that there is a limit on how far insurers can go with specialization before they begin to weaken their distribution system by not providing enough markets for midmarket independent agents.

SAFECO, which maintains almost two-thirds of its business and \$1 billion in premiums in personal lines, has long been concerned about competition from direct writers.

But now direct writers are also beginning to take an increasing interest in commercial lines. "If you think commercial business is competitive today, just wait," he warned during a panel discussion at the annual Independent Insurance Agents of America convention last month.

In fact, State Farm Group employs the more Chartered Property & Casualty Underwriters than any other insurer, he noted.

Specialization, one of the industry's current fallback competitive strategies, will lead to subspecialization in the future, said Douglas W. Leatherdale, president and chief executive officer of The St. Paul Cos. Inc.

Insurers will see more niches they are willing to invest in, because "you simply can't be everything to everybody and do it well."

While "it's a certainty that our industry will continue its focus on what we do best," specialization will not just stop at product niches, said Fredric G. Marziano, vp of Continental Corp. and president of its agency and brokerage group. At Continental, specialization includes geographic regions and selectivity in producers.

Ten years ago the insurer had an agency force of 11,000. Now it gets most of its business—72%—from 1,100 "Circle" preferred agents. Continental, which is the second-largest commercial package writer after State Farm, will continue to focus on the preferred agents to reduce expenses and improve retentions, he said.

But pointing out the downside of specialization, Mr. Cannon said SAFECO must appoint six independent agents to get the volume that State Farm gets from one agent. This makes the case for diversification rather than specialization, he said.

Because "agents specialize in people in their community," many can't specialize in lines of insurance and must have contracts with insurers that can be all things to all people, added Eric G. Gustafson, chairman of Blake Insurance Agency Inc. in Portsmouth, N.H. Most of the IIAA's 280,000 members are small producers and need insurers to provide them with a wide range of products.

And while it's true that direct writers are making inroads into independent agents' market share, "It's not because the customers have left us, but we've left them" by not providing enough markets to place all of their business, he said.

In order to usurp the direct writers' market share, independent agents and insurers must cooperate to bring operating costs down, he said.

Maintaining the competitive edge was not the only survival issue the panelists discussed. Insurer chief executive officers speculated on how natural disasters like Hurricanes Andrew and Iniki—and man-made problems like insurer solvency legislation—would affect the industry.

While it's still too early to predict the magnitude of the effect of the hurricanes, "logic would suggest there has to be an impact, particularly on the property side," Mr. Marziano said.

The disasters will almost certainly affect reinsurance pricing and availability, beginning with January, April and July 1993 treaty renewals, he said. In fact, Continental Corp. announced late last month that it would stop writing reinsurance business and sell its Continental Reinsurance Corp. unit (BI, Sept. 28).

The St. Paul Cos., which has a

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Continued from previous page presence in reinsurance underwriting, is having difficulty finding retrocessional coverage, especially for catastrophic treaties, said Mr. Leatherdale.

The biggest impact on the primary market will probably be "some diminution of capacity," he said.

SAFECO, which sustained about \$125 million in losses from the Oakland, Calif., fires last year, is hoping not to be affected by the "precedent-setting string" of catastrophes, said Mr. Cannon.

However, insurance agents should pride themselves on the job they did in the wake of the hurricanes, commented Mr. Gustafson, the new president of the IIAA.

In fact, agents were on the scene in Florida even before the Federal Emergency Management Agency, he said. The insurance industry should "tell the public in a nice way what has been done," he added.

On legislative issues, the panelists agreed that the insurance industry must be more active in presenting its case to the public.

"The record shows that we understand what those key issues are, but we've failed miserably to get the insurance consumer to do something about it," said Mr. Cannon.

A "great object lesson" was the passage of Proposition 103 in California, when the insurance industry was not aggressive enough in mounting a campaign against the initiative.

Grass-roots efforts by the industry should communicate to the public that state legislatures are dominated by lawyers, whose own agenda is being promoted in the passage of legislation such as proposals involving rate roll-backs and freezes, said Robert L. Bailey, president and CEO of State Auto Insurance Co.

For example, the workers compensation system was originally devised as a no-fault program, "but it has deteriorated to a giveaway system," said Mr. Marziano of Continental, which writes about \$1 billion in workers compensation coverage per year.

In the 1920s, experts identified 59 forms of stress. Today, the types of stress have grown to include 292 categories, which are compensable in some states for workers compensation.

But the insurance industry must address its concerns "to someone other than insurance insiders," noted Mr. Marziano of Continental.

While agent associations and others are doing a good job of lobbying Congress, a personal letter to a congressman is just as important, he said.

The insurance industry needs to become more sophisticated in using the media "the way everyone else does" to get its message across—through sound bites, advertising and other forms of communication.

The agent's relationship with consumers puts them in a unique position to get the industry's message across.

"Money is not the key factor in this," Mr. Bailey told agents. "When you people get riled up about issues, things happen."

However, "no magic solution" exists for complex legislative issues, said St. Paul's Mr. Leatherdale.

The insurance industry should try to identify proposals that would reduce costs, "but not without seriously reducing access to the system," he said.

And while the push for fed-

tion," Mr. Leatherdale said.

Although Mr. Leatherdale said that the insurance regulation bill sponsored by Sen. John Dingell, D-Mich., is well-structured and "the best I've seen, addressing

Agents should pride themselves on the job they did in the wake of the hurricanes, says Mr. Gustafson, the new IIAA president. The insurance industry should 'tell the public in a nice way what has been done.'

eral regulation of insurer solvency is not as strong now as it was earlier in the year, "it's naive to assume that there won't be some form of federal regula-

tion," Mr. Leatherdale said. Although Mr. Leatherdale said that the insurance regulation bill sponsored by Sen. John Dingell, D-Mich., is well-structured and "the best I've seen, addressing key issues in a rational fashion," the panelists agreed the legislation's fatal flaw is the separation of solvency and rate regulation (BI, April 20). ■



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The PIA has stopped the consolidation talks—but not IIAA's commitment to the independent agent.

IIAA believes that independent agents should have their own unified, dedicated voice. Not only because it is in the best interest of its members, but also because over 90 percent of independent agents have demanded it.

After two years, PIA chose to end consolidation discussions with IIAA. The reason? Most notably, PIA wants to pursue the impossible task of serving two masters — independent agents and their competitors, the direct writers.

In addition, PIA says it could find "no compelling reasons" to consolidate with IIAA. This flies in the face of the success of those states that have achieved consolidation. Not only have they realized significant savings both in dollars and staff time, but they are also reaping the rewards of a strong, unified voice with consumers, legislators and regulators — a voice that is not fragmented or weakened by unproductive competition.

We "Reject" the PIA Action

On September 13, IIAA's National Board of State Directors unanimously "rejected" PIA's withdrawal from merger negotiations and restated its commitment to creating one organization advocating the unique interests of INDEPENDENT insurance agents.

One thing has not changed: IIAA's commitment to the independent agent. IIAA will continue to be the unrelenting advocate for independent insurance agents. It will continue to strive to give independent agents across the country the power and strength of a unified voice. And it will actively support and assist each of its state associations — merged or unmerged — to ensure the strength and prosperity of the independent agency system...now and into the future.



**INDEPENDENT INSURANCE AGENTS
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THE VOICE OF THE INDEPENDENT AGENT

Needed: Young, energetic producers

Cultivating new talent is vital to agencies' growth and success

By LAURA MAZZUCA

NEW ORLEANS—Many more independent agencies will fall victim to forced sale or bankruptcy unless agents become more aggressive and creative in hiring new producers, a consultant said.

"It's easy to start in the insurance business, but it may be the last creative thing you'll ever do," said Richard M. Womack, director of consulting services



for The St. Paul Cos. Inc. Too many agency principals believe they must keep a tight rein on their businesses, refusing to delegate authority or to think about perpetuation or shared ownership, Mr. Womack said at the annual Independent Insurance Agents of America convention last month.

Others who have children in the business may rely on them, even if they are unwilling or unable to carry the agency into the future. Still others cripple their children's efforts to find their own identity within the agency.

Indeed, one-third of today's agencies will disappear by the year 2000, victims of a constantly constricting business and agents' own lack of foresight, Mr. Womack predicted.

Because of this, Mr. Womack said, "You have to go after young people to take your agency to the next level."

Mr. Womack, who helped develop St. Paul's New Producer Program for its Top Brass preferred agents—composed of those who meet certain volume requirements—has based the new program on his own experi-

ence in the agency business.

His philosophy was: "I know I can't sell, so I'll find somebody who can," which fostered the success of Birmingham, Ala.-based McGriff, Seibels & Williams Inc., where Mr. Womack had been a principal since 1974. The brokerage ranked 23rd among *Business Insurance's* 100 largest U.S. brokers based on 1991 revenues (*BI*, June 29).

When Mr. Womack joined McGriff, its annual revenues were \$800,000. Today, that figure has grown to more than \$35 million, largely because "there was a base of people to carry the business forward," he explained.

St. Paul's program assists principals in recruiting and training new young producers. Since it was established in 1989, 25 producers have "graduated" from the program. Of that number, only four have left their agencies, and one simply changed agencies, Mr. Womack said.

None of the recruits had any insurance background, a requirement Mr. Womack believes is designed for filling the company ranks rather than selling insurance in an agency. Similarly, "He doesn't have to be a Phi Beta Kappa or a CPCU. That doesn't help you sell anything," he said.

The first step is for the agency principal to take a hard look at the agency's current sales culture. Are the principals—the agency's current owners—doing most of the selling? Is business produced using passive methods, like referrals and walk-ins? If so, the agency needs to shift its emphasis to more pro-active sales methods by actively soliciting referrals with target selling, sales centers, account rounding and plain old cold calling—which most agency principals don't have the time or the desire to do.

"Cold calling is anathema. Nobody wants to do it, so hire somebody who will," Mr. Womack said.

But agents shoot themselves in the foot before they even start recruiting if they discourage young people from entering the business by complaining about market conditions.

"It's a tough job recruiting because they don't like your industry," Mr. Womack said. "Yet we've got a great story to tell."

Principals must not settle for less than the best when hiring a producer, he said. This standard also means weeding out inferior producers already on staff who are dragging down morale and who will serve as a negative role model.

"The price for accepting weak

Continued on next page

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Continued from previous page
or marginal producers is a sick sales culture that spoils the entire agency" and results in low sales, low profits and no perpetuation, Mr. Womack warned.

The agency principal frequently doubles as the sales manager, and as such, must recruit quality producers, establish and maintain expectations, accept only top performances, help producers set annual goals, act as mentor, maintain a positive image and establish management culture, he said.

Principals can find prospective producers virtually anywhere: recent college graduates can be contacted, as well as direct writers, other independent agencies and brokers, recruiters and even the children of business associates and friends.

And now is a good time to hire because the poor job market is causing many graduates to leave college without jobs lined up. Direct writers also are a good source for recruiting because they are underpaid, Mr. Womack said. And, because an independent agency eventually can offer producers ownership, they actually have a hiring edge over alphabet-house brokerages.

When recruiting, principals should look for the "Four E's": ego, empathy, economic incentive and energy. "If they lack any one of these, throw them back," he said.

Plenty of personality profile tests are geared to the insurance industry, or a principal can even take the prospective recruit's profile results to a local psychologist for an evaluation.

The employer must also carefully interview the prospective producer and check references.

And the agency must provide its own "Four E's"—employment, education, empowerment and encouragement. "That's your part in the play. If you don't do that, you'll have a youngster who will leave, and if they succeed somewhere else they will hurt you."

Once you've identified a good potential producer, attract him or her with the right package, including good compensation, equity in the business, prestige and titles, and management input.

Also be sure to provide training after the producer is hired. At McGriff Seibels, Mr. Womack put new producers through a six-month training course in every department, then sent them to an insurer's home office school for three weeks of technical knowledge.

To get the producer on the right track from the start, "fire them the day you hire them" by making it clear that they must be producing three times their salary in two years, or they will be terminated, Mr. Womack said.

He also discourages principals from paying producers strictly on commission since they resent the percentage the agency takes and "they are never on the team. Put everybody on salary, and put salesmen on a bonus system."

When managing producers, sales managers should set high expectations and provide a supportive atmosphere by helping them with leads. But it must be made clear that every producer is expected to show growth.

"It's a long-term, never-ending process," Mr. Womack said. But if you successfully train one young producer, you will want to repeat the process. ■

Mardi Gras fever hits IIAA meeting

NEW ORLEANS—More than 1,000 people converged on the Crescent City Sept. 13-17 for the 97th annual convention of the Independent Insurance Agents of America.



Those attending the convention had to contend with unruly fans of the Chicago Bears (who played the New Orleans Saints that weekend) and drizzly weather if they wanted to stroll down Bourbon Street.

But to enjoy a taste of Mardi Gras they had to go only as far as the New Orleans Hilton Riverside Towers. The convention's opening party featured an elaborate parade—led by two New Orleans police officers on motorcycles—including a local marching band, a float featuring Swamp Thing and costumed ladies tossing out Mardi Gras beads and IIAA coins.

Featured speakers covered the spectrum, from Terry Anderson, the former Associated Press Beirut bureau chief who was held hostage in the Middle East, to Oliver North. Mr. North sat on a panel moderated by the IIAA's senior vp of government affairs, Paul E. Equale, which included Morton M. Kondracke, a "McLaughlin Group" regular and a New Republic editor.

Ex-NFL football referee Art Holst and college basketball analyst Dick Vitale rounded out the special speakers. Workshops topics included "Meeting Customers' Needs," "Securing a Company Appointment" and "The Truth About Flood Insurance." An exhibit hall featured 93 booths.

Next year's convention will be held Sept. 11-15 in San Francisco. For more information, contact Jeffrey Etzkin, director of conventions, 703-706-5406.

Agents' congressional bids

Continued from page 16A

They know the ropes

For most agents running this year, politics is nothing new. Many have been initiated through stints on school boards and charitable organizations.

Some even hail from political families. Mr. Holden's father, Joseph, served four terms as county commissioner. The younger Holden, in addition to serving two terms as county sheriff, also worked as a sergeant-at-arms for the Pennsylvania House of Representatives.

Mr. Palermo, president of Wm. G. Palermo Inc. in Linden, N.J.—the agency his father founded in

1944—credits his brother for getting him involved in politics in the early 1980s. Mr. Palermo has been commissioner of the Linden Housing Authority and chairman of the Linden Republican City Committee. He also lost a 1983 bid for the state Senate.

Mr. Kingston has been representing his district in the Georgia General Assembly since 1984 and has served on the insurance committee for four years.

Predictably, most of these agents hold pro-business views.

Mr. Musselwhite is a staunch believer in welfare reform through "workfare" and education, supports a constitutional

Continued on next page

Follow the money

The big agent trade groups—the IIAA, the PIA and NACSA—all sponsor political action committees. Among the biggest recipients of their largesse through August were:

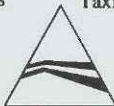
\$16,999 Sen. Bob Graham D-Fla.	\$15,500 Sen. Thomas Daschle D-S.D.	\$9,299 Sen. Don Nickles D-Okla.	\$7,000 Sen. Christopher Dodd D-Conn.	\$11,000 Sen. Bob Kerrey D-Nebr.
\$13,500 Rep. Richard Gephardt D-Mo.	\$13,000 Rep. Bill Paxton R-N.Y.	\$10,000 Rep. Jim Saxton R-N.J.	\$10,000 Rep. Dan Burton R-Ind.	\$7,750 Rep. Camille Collins D-Ill.

Source: Federal Election Commission

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Agent/Broker Topics

Congressional bids

Continued from previous page
 amend and favors "an immediate 5% cut in federal administrative spending."
 Mr. Palermo has been actively lobbying on insurance issues, especially auto insurance reform, in the New Jersey Legislature for years. He describes his opponent for the 10th District seat, Rep. Payne, as a "typical liberal Democrat," a "big spender" who voted for bills that would cost the taxpayers money.
 "We've got to overcome Democratic control of the House,"

warned Mr. Palermo, who favors limits on House and Senate terms, a line-item veto and the balanced budget amendment, which Rep. Payne voted against. "We should try to make some changes in the way Congress conducts business."
 Mr. Kingston, too, is a voice for free market economics, who calls the proposed mandatory family leave bill "anti-business."
 "I'm concerned about what laws do to business," he said. "We need more business people in office, and we have to have less regulation of business and let the market do its thing."

Kingston said.
 "Right now it's time for a change. This area is generally conservative, and we need business people in office."
 Like most agent-candidates, Mr. Kingston relies on agency associates to handle his book of business while he's out stumping.
 "I'm not even trying to do both," he added. If he wins, he plans to take a leave of absence from the business, but he intends to remain with Palermo when his political career ends.
 Mr. Palermo depends on his brother and son-in-law, both partners in the agency, to pick up the slack while he's campaigning. If he wins, they will carry the business until his term is up.

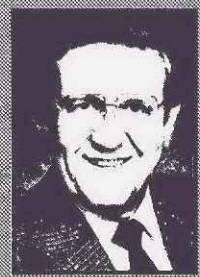
Agents on the ballot



Alfred Palermo
 ■ Republican, New Jersey
 ■ President of family-owned agency, Wm. G. Palermo Inc.



Jack Kingston
 ■ Republican, Georgia
 ■ Producer at Atlanta brokerage Palmer & Cay/Carswell Inc.



Tim Holden
 ■ Democrat, Pennsylvania
 ■ Insurance broker, sheriff of Schuylkill County

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Seeking to distinguish himself from some other Republicans, Mr. Kingston insists he is "not trying to define what is right and wrong," but he also supports a "return to traditional values and work ethics...like getting to work on time."
 His opponent is Barbara Christmas, a school board member who is "using her name to full advantage" in the campaign.
 Ms. Christmas supports and is supported by House Speaker Thomas S. Foley, D-Wash., and is endorsed "by all the other (Democratic) good old boys," Mr.

The name of the game: money
 But most candidates say that while their campaigns are going well, their main concern is monetary.
 Take, for example, Mr. Palermo, a Republican in a district where Democrats outnumber Republicans nearly 5-to-1. He has requested support from the agent associations but has not heard

from them. Well aware that most political action committee dollars will go to the incumbent or the clear favorite, Mr. Palermo has had to assemble his war chest mostly from family, friends and business associates.
 Even an endorsement is not enough. "Our work is appreciated and encouraged, but the most important thing I can do in the Beltway is raise money for these candidates," said NACSA's Mr. Wood.
 When evaluating a candidate for endorsement, PIA conducts its state affiliates for a perspective on the candidate and his opponent, Ms. Olsen said.
 "We give special consideration to those agents who come to town and seek to meet with us," she added.
 And the way lobbying works in Washington, agent candidates are not only supported by agent associations. Other PACs that have contributed to some of these candidates include those connected with energy, chain drug stores and convenience stores, and auto dealers, Mr. Wood said.
 Both the Independent Insur-

ance Agents of America and NACSA are supporting Mr. Kingston, who "not only knows the industry, but from a regulatory standpoint, understands the industry extremely well," Mr. Wood said. This knowledge would allow Mr. Kingston to "raise the quality of debate" on issues like the federal regulation of insurance.
 Not that NACSA and Mr. Kingston see eye to eye on everything. The candidate opposes all federal regulation of insurance; the trade group takes a "progressive stand" on some proposals for a federal oversight role.
 The organization has also set a "primary priority" on behalf of Mr. Musselwhite, a Democrat who represents "a key swing vote for us," Mr. Wood added.
 Despite its congressional endorsements, NACSA, as a matter of policy makes no endorsements in the presidential race. Mr. Wood noted, though, that the group planned a straw poll at its upcoming convention, and it was safe to assume that President Bush would win—at least in that race.

GRAPHIC BY A. TRANCHITA

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Issue of October 5

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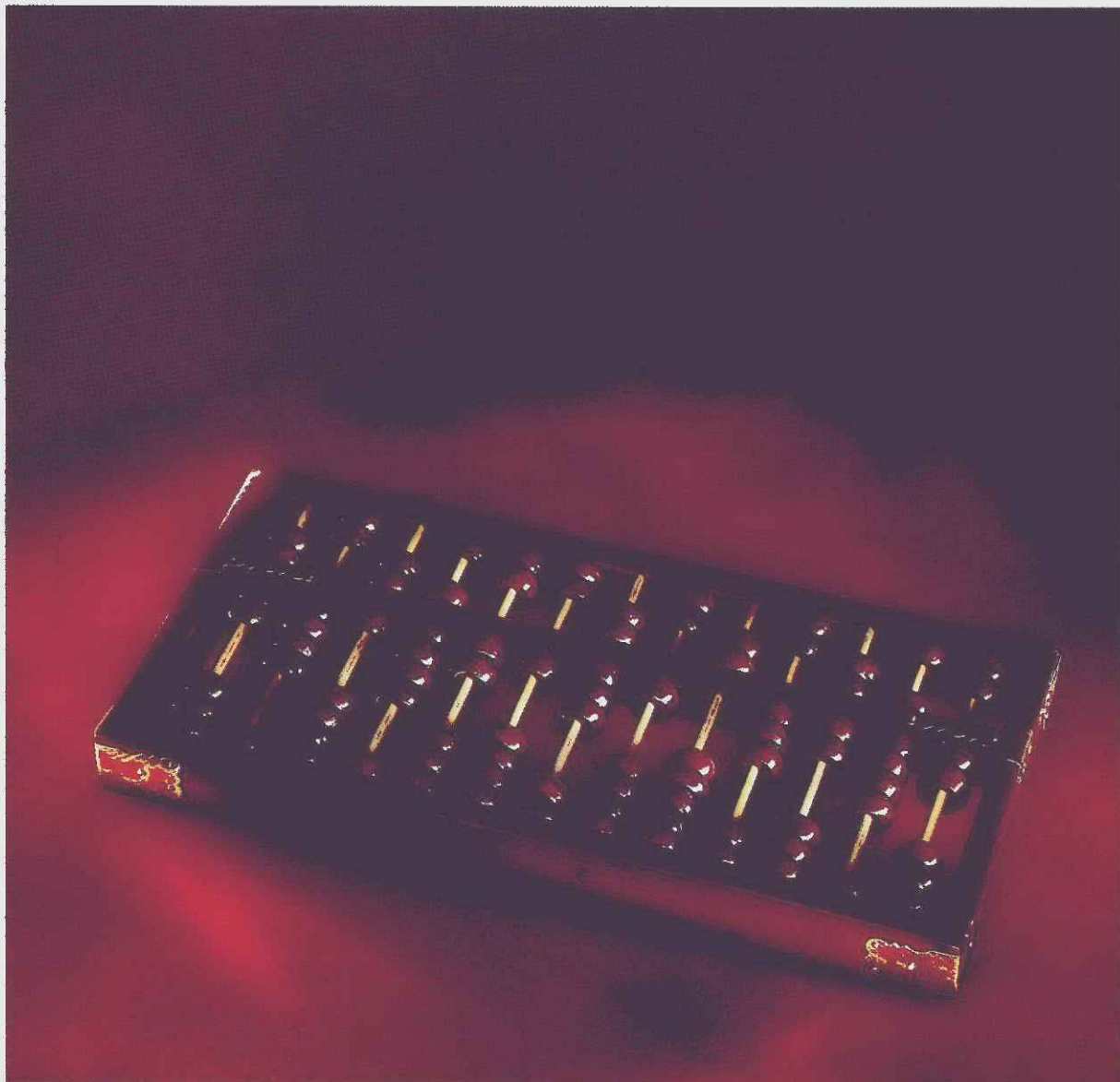
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ASK A BENEFIT ACTUARY

New Medigap policies are worth a second look

Q

Are Medigap policies an alternative for employer-sponsored retiree medical plans?

A

With the 1993 effective date of FAS 106 fast approaching, a benefits manager for a corporation that sponsors a retiree medical plan came to me to evaluate an interesting plan design alternative. The

corporation currently sponsors a retiree medical plan for current and future retirees and wants to get out of the retiree medical insurance business to the extent possible.

The benefit manager's idea is to provide future retirees who are Medicare-eligible with a fixed monthly amount (\$60, for example) to reimburse premiums incurred by the retiree for a Medigap policy. This is a health insurance policy that covers Medicare-eligible retirees and pays many of the medical expenses not covered by Medicare. The reimbursement would be provided for the retiree's lifetime, assuming the retiree continues to pay Medigap premiums. The Medigap policy would be purchased from an insurance company separate from the corporate plan sponsor providing the monthly reimbursement.

I had considered such an approach several years ago. At the time, this approach lacked appeal because of the state of the market for Medigap policies. Benefit coverages varied widely. Some policies had low scheduled benefits, while others paid nearly everything not covered by Medicare. Since the benefits under two policies were not comparable, a retiree had a difficult time purchasing a policy at a fair price. Consequently, it would have been unwise for a corporate plan

sponsor to build a retiree medical program around Medigap policies.

But the Omnibus Budget Reconciliation Act of 1989 has changed that. This federal legislation provides strong incentives to the states to adopt the National Assn. of Insurance Commissioners' model regulation for Medigap policies. This model regulation requires that Medigap policies sold in an adopting state must contain several highly desirable features for retirees:

- The regulation describes 10 model Medigap policies, labeled policies A through J. Each policy provides the same core benefits. Policy A provides only core benefits, while the remaining policies contain a mix of optional benefits such as reimbursement for certain prescription drugs and personal home care. A health insurer can only sell policies that are identical to those that the state has approved for sale. No other Medigap policies can be sold. Consequently, a retiree can make an "apples-to-apples" comparison of premiums from different insurers who are issuing the same model policy. This has created more of a price competitive market for Medigap policies.

- An insurer selling Medigap policies cannot refuse to offer coverage to an individual during the six-month period following the time the individual becomes eligible for Medicare. If an individual becomes eligible for Medicare while employed, the six-month window starts at employment termination.

- The model regulation specifies minimum claims loss ratios, limiting an insurer's profit on these policies.

- The insurer can exclude from coverage a person's pre-existing condition, but the exclusion must lapse after coverage has been in force for six months.

- The policies are guaranteed renewable, and cannot be canceled on account of an individual's health or claims experience. They cannot even be canceled on a class basis as long as an individual continues to pay the required premiums.

- The insurer has the right to increase premiums, but only for classes of individuals. Premiums cannot be increased only for individuals with high claims experience.

With these changes brought about by the 1989 budget law, a retiree medical plan sponsor might reasonably offer its employees incentives to buy Medigap policies and achieve several favorable results. By directing retirees to a third-party insurer, a corporation is able to discontinue its function as an insurance company for its Medicare-eligible retirees. By promising only a fixed monthly amount to reimburse Medigap premiums, a corporation has removed medical trend in the calculations of its post-65 liabilities. By offering premium reimbursement, the employer allows the retiree to choose the particular Medigap model policy that best fits the retiree's financial circumstances, and the reimbursement provided comes to the retiree as non-taxable income. This approach appears to offer both the corporate sponsor and retirees many advantages. ■

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

This month's column on actuarial issues in the benefits field is written by William J. Miner, an actuary with The Wyatt Co. in Chicago. Richard E. Sherman, president of Pacific Actuarial Resources (PAR) Excellence in Ashland, Ore., answers actuarial questions in the casualty field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions.



Mr. Miner

Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Ms. Werner's and Mr. Nirtaut's columns appear alternately on the second Monday of each month. Mr. Miner's next column will appear in December.

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

Court allows comp claim for chiropractic services

The Supreme Court of Mississippi held that chiropractic services as such were not excluded as compensable medical treatment under the Workers Compensation Act.

While employed, Earnestine White slipped and fell in February 1986, injuring her shoulder and lower back. She was then treated by her own physician, a general practitioner, until April 22, 1986. Ms. White also consulted an orthopedic surgeon who treated her from April 25 through June 17 of that year. She returned to work on June 2, 1986. Ms. White's general practitioner also referred her to an orthopedist who treated her from Feb. 23, 1987, to March 9, 1987.

In addition, during this period Ms. White saw a chiropractor from Sept. 18, 1986, until April 2, 1987. His bill was nearly \$3,000. The chiropractic service was disallowed in her compensation claim.

The administrative law judge also ruled that Ms. White's employer and insurer were not liable for payment of any services rendered by the chiropractor. The state compensation

Legal briefs

commission agreed. She appealed and lost again in the trial court.

The state Supreme Court said there "... is a broad public policy behind the Act to provide the necessary treatment to restore the injured worker to health and productivity." The court emphasized that the commission's focus should be to ask if the treatment was necessary and the charges were reasonable. According to the court, if both questions are answered in the affirmative, Ms. White could not be denied benefits solely because the service was rendered by a licensed chiropractor. The case was returned to the commission for further proceedings.

White vs. Hattiesburg Cable Co., Supreme Court of Mississippi, Oct. 30, 1991, Rehearing denied Jan. 15, 1992 (BI/04/O.-\$10).

Mental disorder not compensable

A mental disorder caused by the stress of attending a disciplinary

process was not a compensable occupational disease, according to the Court of Appeals of Oregon.

Katherine E. Thrash worked as a police officer for the city of Sweet Home. In 1986, she was diagnosed with multiple sclerosis and was reassigned to drive an ambulance. In March 1988 she became a full-time police department dispatcher. In May 1989 she received a call from a doctor requesting an ambulance for a comatose 90-year-old woman. She neglected to dispatch an ambulance until more than an hour later when the doctor called a second time. Ms. Thrash failed to report the incident on advice of her union representative, but the incident was investigated following a complaint from the doctor. This led to a disciplinary action resulting in Ms. Thrash being suspended without pay for an equivalent of three days.

Ms. Thrash filed a claim for workers compensation benefits alleging psychological and physical difficulties. The state compensation board denied her claim, but she

appealed that decision.

The appellate court agreed with the board's conclusion that although Ms. Thrash suffered from an adjustment disorder and had experienced real stress in her employment, her condition was not compensable as an occupational disease because she had not established that her employment was "a material contributing cause" of her mental disorder. The court emphasized that medical testimony supported the conclusion that it was the disciplinary aspects of the incident, particularly the suspension without pay, that were the significant factors in causing her distress.

Thrash vs. City of Sweet Home, Court of Appeals of Oregon, Jan. 22, 1992 (BI/02/)-\$10.

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a \$10 check payable to Mayo H. Stiegler to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

AIDS survey

Continued from page 1
complete or erroneous death certificate information, the survey authors note.

And, they note, the survey does not include claims paid by self-insured employers or by Blue Cross/Blue Shield plans. Nor

does it include deductibles and other out-of-pocket payments made by AIDS patients.

Also, consultants point out that the estimates do not take into account costs associated with lost work time and reduced employee productivity for workers suffering from acquired immune deficiency syndrome or

AIDS-related illnesses.

"We still haven't solved the problem of people dying of AIDS," pointed out Joel Kavet, a principal with William M. Mercer Inc. in Washington. "But improvements in our ability to manage the treatment of the disease" have helped moderate the cost of group health insurance

claims for AIDS.

Drug therapies that improve the quality of life for AIDS patients and enable them to forego hospitalization have helped temper group health claim costs, he said.

For example, the price of AZT, the most popular drug used to treat HIV-positive people, has fallen significantly over the last decade, Mr. Kavet explained. Lower doses are also being used to obtain the same effects, which also has cut costs.

Another factor in tempering AIDS-related group health claims has been the "increased use of large-case management," said John Hickey, a partner with Kwasha Lipton in Fort Lee, N.J.

Typical case management programs "assign patient advocates to certain diseases, like AIDS and cancer, that entail large purchases of medical care," he said. Those advocates are trained to direct patients to the most cost-effective, quality providers.

"The research leaves little doubt that costs have come down over time because we've gotten smarter about (treatment)," Mr. Kavet said.

Initial cost estimates were high because researchers knew little about how the disease would progress, he said. "It's important to know that earlier projections that AIDS would swallow the health budget whole are not true."

The trend toward self-insurance may also explain why AIDS-related group health insurance claims have moderated, pointed out Jude Payne, director of public health policy for the HIAA.

Nearly two in three U.S. employers self-insured their medical plans in 1991, according to A. Foster Higgins & Co. (BI, Jan. 27).

The ACLI/HIAA survey also reported that AIDS-related group health claims now account for 1.3% of overall claims costs, down slightly from 1.4% in 1990.

That moderation does not reflect trends among the uninsured population, though. Health costs probably are increasing at a faster pace for uninsured people

with the disease, said Mr. Kavet.

Health insurance costs have been moderating even though mortality rates for people with AIDS have not improved.

The federal Centers for Disease Control reports that of the 230,000 people diagnosed with AIDS since the beginning of the epidemic, 150,000—or roughly 66%—have died.

Individual life insurance claims are growing at a slower pace than group life insurance claims, noted Michael Cowell, vp and corporate affairs actuary for UNUM Life Insurance Co. in Portland, Maine. Individual AIDS-related life insurance

'Projections that AIDS would swallow the health budget whole aren't true,' says Mr. Kavet.

claims accounted for 2.3% of life insurers' total claims, up from 1.2% in 1987. Meanwhile, group AIDS-related life insurance claims totaled 3.9% of life insurers' total claims, up from 1.4% in 1987.

"The group life statistics of AIDS claims as a percent of total claims more closely mirror the epidemic in the general population, whereas in the individual life segment, we artificially control the number of claims through underwriting," Mr. Cowell said. Life insurers generally deny coverage to people who test positive for the AIDS virus, he said.

Individual copies of the 1991 "ACLI/HIAA AIDS-Related Claims Survey" are available without charge. Contact William Schreiner, American Council of Life Insurance, 1001 Pennsylvania Ave. N.W., Washington, D.C. 20004; 202-624-2000; or contact the Office of Publications at the Health Insurance Assn. of America, 1025 Connecticut Ave. N.W., Washington, D.C. 20036; 202-223-7808.

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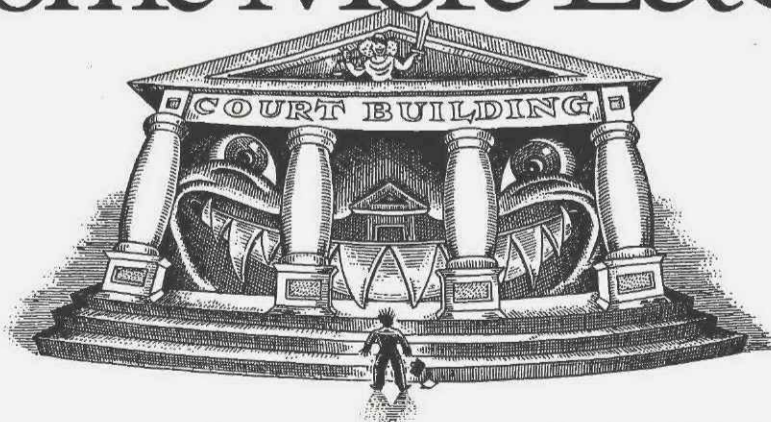
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INTERNATIONAL

Swiss Re to consolidate German operations

By DON LEWIS KIRK

ZURICH, Switzerland—Swiss Re Group is reorganizing to sharpen its competitive edge in Europe.

The reinsurer is consolidating its German operations under a new holding company, Vereinte Versicherungsgruppe. The Munich-based entity next year will absorb the direct life and non-life insurers Magdeburger Versicherung, Hannover Versicherung and Vereinte Versicherung A.G., in addition to Swiss Re Beteiligungen A.G., a German holding company.

Combined, the German group will have premium volume of 5.6 billion deutsche marks (\$3.85 billion at current exchange rates) and 10 mil-

lion contracts, the company said.

Of the group's 8,000 employees, 3,600 will be field agents.

"We are bundling our resources and strengthening on-the-spot decision making," says Werner Seifert, general director of Swiss Re Beteiligungen A.G. in Munich.

Swiss Re is trying to strengthen its direct insurance operations in Germany amid growing competition from other insurers and banks, Mr. Seifert said. Swiss Re's direct insurance operations are the fifth-largest in Germany and No. 9 in Europe.

The German consolidation will cut costs and increase efficiency, says Mr. Seifert. "Our goal is to be the lowest-cost producer in Germany. At the same time, we're hold-

ing on to our agents and locations.

"It's an illusion to believe price alone determines this market. We are not going to offer the lowest prices in town, but rather slim down operations to increase profits and become more flexible. If the market does lower prices, we can adjust more quickly."

Swiss Re also plans to set up a Zurich-based holding company to oversee all European operations. This centralization will make it easier to do business across the continent, Swiss Re said late last month. Raising capital, for instance, would be easier because the separate companies would not be hindered by the shareholding restrictions of their countries.

Moves similar to the German consolidation are planned in other European countries. Swiss Re plans to have a managing company or overall manager in each country. Last year, Swiss Re acquired Elvia Versicherung in Switzerland which oversees direct insurance operations there. Lloyd Adriatico S.p.A. will steer Italian operations, and Spanish operations will be overseen in Spain by Schweiz, Compania Anonima Espanola de Seguros y Reaseguros.

Mr. Seifert expects other insurers to make comparable moves to improve their competitiveness. "Only a small percentage of the 4,000 insurers that now exist in Europe will survive," he said. He predicts that 20 "European players" would ser-

vice the market and envisions a pan-European software system to facilitate brand-name distribution.

Swiss Re also plans to raise capital by allowing foreign investment. Legal hurdles once prevented foreign investors from holding shares in Swiss companies. But Swiss Re now hopes to raise 320 million Swiss francs (\$251.8 million) and increase the number of shares by 10%.

Swiss Re is the world's second-largest reinsurance company. Despite two very "bad years" with a large number of storm claims and losses from subsidiaries, Swiss Re's profits from direct and reinsurance last year increased 23.1% to 266 million Swiss francs (\$196.1 million at year-end 1991 exchange rates). ■

French flood losses to top \$300 million

By ALINE SULLIVAN

PARIS—Insured flood losses in southern France are expected to mount as heavy rain continued last week in the Vaucluse region.

The government was expected to declare the flooding a natural catastrophe after finance and interior ministries officials met Oct. 2 to assess the damage, said Gerard Toussaint of insurer trade group Federation Francaise des Societes D'Assurances.

The French government usually declares a natural catastrophe within weeks of the event if extensive damage has occurred, Mr. Toussaint said. Smaller incidents can take up to a year.

The storms and floods that battered regions of Southern France for two consecutive weeks resulted in at least 38 deaths and insured property damage of more than 1.6 billion francs (\$334.9 million at current exchange rates).

The trade association estimated that insured property damage from floods in the Vaucluse region alone will cost more than 1 billion francs (\$209.3 million). Extensive damage has also been recorded in the regions of Ardeche, Drome, Aude and the eastern Pyrenees.

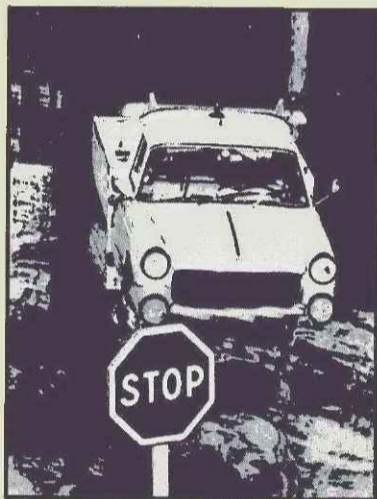
The declaration of a natural catastrophe will enable domestic and foreign insurers operating in France to recoup property damage claims through the state-owned reinsurer, Caisse Centrale de Reassurance. Insurers have three months from the declaration date to submit their reinsurance claims.

A CCR policy is not mandatory, but almost all insurance companies operating in France are reinsured for flood claims by the state facility.

Lloyd's of London syndicates insuring French property risk reinsurance through the Lloyd's market and not through the CCR, said Quentin Paillard, Lloyd's general representative in Paris.

"Lloyd's syndicates have chosen not to use the CCR" because foregoing that coverage "makes the prices of our policies more attractive," said Mr. Paillard. "It may well happen that there will be a catastrophic

Continued on next page



Rising waters in southern France damaged autos and buildings.

AP/Wide World Photo

MMI rescue plan collapses

By GAVIN SOUTER

LONDON—Municipal Mutual Insurance Ltd. has shut its doors to new business and clamped a seven-day moratorium on claims payments after a consortium of European insurers backed out of a deal to take over the troubled insurer last week.

"We have been negotiating with the French Group GMF to seek a satisfactory transfer of the business. Unfortunately, it is now clear that this will not be possible and discussions have been broken off," said Brian Wright, MMI chief executive.

MMI is now holding discussions about transferring some of its business to other British insurers or setting up other arrangements, Mr. Wright said.

If MMI goes into liquidation, its

LONDON

outstanding private policyholder claims will be paid through levies on all British insurers through the Policyholder Protection Act.

MMI is Britain's ninth-largest insurer by premium volume, according to the Assn. of British Insurers. Approximately two-thirds of the insurer's business is commercial lines, and 85% of that is insurance of local government authorities. It claims 60% of the local-authority market based on premium volume, covering 90% of all local authorities in some way. The remaining third of its business is personal lines.

Some of MMI's financial problems in recent years stem from the

soft market. Sources say another contributing factor has been large public liability claims suffered by its local authority policyholders, including compensation payments to victims of the Hillsborough soccer stadium disaster and their families.

In 1991, the company lost 238.6 million pounds (\$446.2 million at the year-end 1991 exchange rate) on net premiums of 784.9 million pounds (\$1.47 billion).

Rescue plans for MMI involving French insurer La Garantie Mutuelle des Fonctionnaires et Employes de l'Etat et des Services Publics and other European insurers were announced in July but were dropped last week.

MMI and GMF announced in July that MMI would be converted into a

Continued on page 23

Tanker claims loom large

By GAVIN SOUTER

SINGAPORE—The fourth major collision in four months in the Strait of Malacca will likely produce large insurance claims for international marine insurance underwriters.

But crude oil spilled from the tanker in last week's collision is unlikely to reach land, the tanker's manager and underwriters say.

The tanker Nagasaki Spirit and container vessel Ocean Blessing collided in the Strait of Malacca at 1 a.m. on Sept. 20.

Fires on both ships have been extinguished and 25 crew are still missing, according to Tim Fuller, claims manager at Tindall Riley and Co. That company manages Britannia Steamship Insurance Assn. Ltd. in London, which is the protection and indemnity club that insures the Nagasaki Spirit.

Jim Hood, a captain at the



GRAPHIC BY JOHN HALL

tanker's manager, Teekay Shipping (Canada) Ltd. in Vancouver, said the tanker, owned by a Liberian com-

pany, was carrying a partial load of 40,000 metric tons of crude oil from Ras al Khafji in the Persian Gulf to Brunei.

"The majority of the oil is still on board... only around 20% of it was in the tanks that were damaged," Capt. Hood said. And much of the oil that escaped has burned off, he said.

Pollution from the spill is unlikely to be serious, agreed Mr. Fuller. "The International Tanker Owners Pollution Federation is there monitoring the situation, but there does not appear to be any serious pollution."

Damage to the tanker's hull is limited to its port side, according to reports to London underwriters from Semco Salvage & Marine Pte. Ltd., the salvage company appointed.

The hull was directly insured with

Continued on next page

ACE offers executive compensation cover

By ROGER SCOTTON

BERMUDA

HAMILTON, Bermuda—High-layer excess liability insurer ACE Insurance Co. Ltd. is now offering coverages designed to protect senior executives against the risk of losing future compensation promised by their companies.

The executive compensation insurance is intended to ensure that executives receive the non-ERISA benefits they are owed under unfunded, non-qualified plans.

Executives covered under the

ACE policy would be protected against benefit loss or modification as a result of "bankruptcy or a unilateral change or refusal to pay by the corporation."

The policy will pay out subject to the terms and conditions of underlying plans as well as its own provisions. Plans that ACE is prepared to insure will include:

- Plans that provide pension ben-

efits to executives in excess of statutory limits.

• Other plans that fit ACE's underwriting criteria. These could include supplemental plans of all sorts, restricted stock plans, incentive compensation plans, performance unit plans, executive medical and accident plans, term life insurance plans, vacation plans and liability insurance plans.

Other new ACE coverages are designed to guarantee equity compensation, retiree medical benefits and "mezzanine" compensation—pen-

sion benefits that executives were promised but are not guaranteed by the Pension Benefit Guaranty Corp. and are not part of an unfunded, non-qualified plan.

Another new product is a differences-in-conditions policy under which ACE would make up the difference between benefits promised under earlier policies and those under its own.

The new product group fits ACE's marketing strategy in that it is catastrophic in nature and not labor-intensive, said Bill Loschert, senior vp

for underwriting. It is also the kind of product that ACE predicts will be much in demand among its Fortune 500 policyholders, though marketing will not be limited to current customers.

"Corporations will be able to have the advantage of being able to guarantee benefits to their senior management," said Mr. Loschert. ACE spent six months developing these products.

Typically, prepaid executive compensation policies issued by ACE

Continued on page 23

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French floods

Continued from previous page
flood in France, say in Nice, and we will be sorry we made this choice."

A CCR spokeswoman said property damage claims will only be reinsured if the original claim was filed by a French resident. And, the CCR does not reinsure claims on life and medical insurance policies.

Compensation for damage to standing agricultural crops is supposed to be reinsured by a fund financed by the French treasury and the farming industry. However, two years of drought in Southern France have depleted the fund, and the CCR may reimburse insurers for some agricultural claims.

Payments to direct insurers are made by the CCR's natural catastrophe guaranty fund, financed by levies on policyholders. The levy on

commercial fire and personal lines homeowners' insurance is 9% of premiums. The levy on auto insurance is 6% of theft premiums.

Flood damage accounts for about 85% of claims paid by the CCR. Storms that do not result in flooding or a landslide are not considered natural catastrophes.

The CCR reimbursed insurers for 2 billion francs (\$418.6 million at current exchange rates) in property damage claims after the city of Nimes was flooded in October 1988. Within a week, that flood was declared a natural catastrophe. Mr. Toussaint said the recent flooding is taking the government longer to assess because damage occurred over a wider area and in separate storms.

A flood on Sept. 26 in the Aude region and the eastern Pyrenees resulted in at least three deaths and extensive damage. ■

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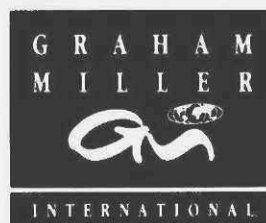
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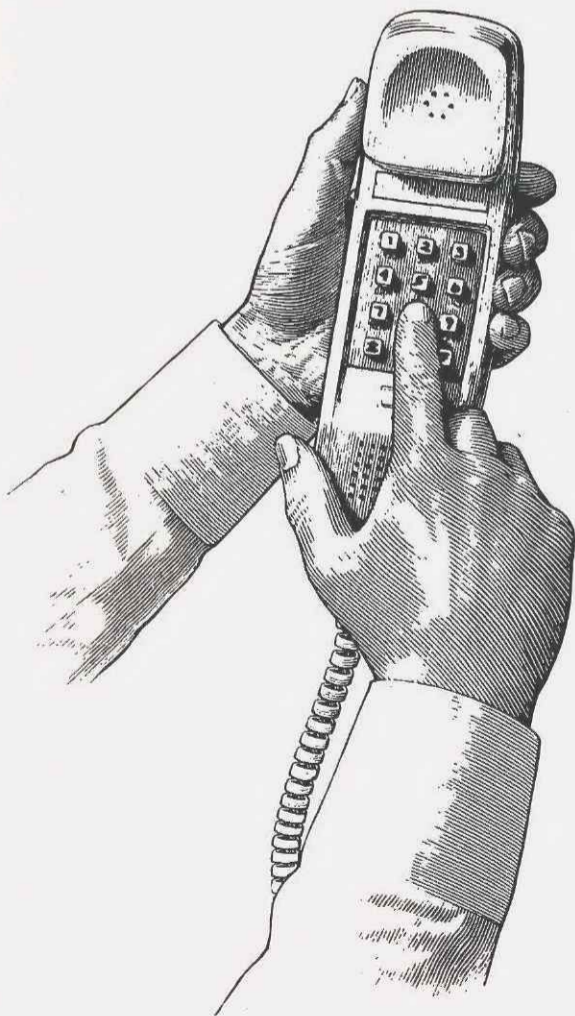
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Sinking ships

Continued from previous page
Nippon Fire & Marine in Tokyo and was largely reinsured with the London market through C.E. Heath P.L.C., the broker confirmed.

It has hull, machinery and disbursement coverage up to 6.4 billion yen (\$54.5 million). C.E. Heath placed 3.9 billion yen (\$32.6 million) of reinsurance on the risk in the London market. The reinsurance is led by Lloyd's of London syndicate 62 managed by Barder & Marsh.

Further reinsurance coverage for Nippon is also placed in the London market, sources say. However, the Nagasaki Spirit is unlikely to be a total loss, Capt. Hood said.

The Panamanian-registered Ocean Blessing was beached and will be towed to Singapore, said a spokeswoman for the vessel's managers, Orient Overseas Container Line Ltd. in Hong Kong. The Ocean Blessing, which is owned by Lomita Shipping Co., was on charter and en route from Dubai to Singapore.

The management company would not comment on hull coverage.

The Ocean Blessing's liability cov-

Ships in the Strait of Malacca 'have just had bad luck lately,' a Salvage Assn. spokesman says.

erage was written by P&I club Steamship Mutual Underwriting Assn. Ltd. in London.

The body of one crew member of the Nagasaki Spirit has been recovered, and two survivors have been picked up. Twenty other crew are still missing, Capt. Hood said.

Late last week, bodies of 16 of the 21-member Ocean Blessing crew had been found on the ship. The vessel was still on fire, and inspection of the starboard was impossible, the OOCL spokeswoman said.

The crash is the fourth major collision in four months in the 600-mile long strait, the main route for ships between Asia and Europe.

In June, the U.S. destroyer Ingersoll collided with Matsumi Maru 7, a Japanese merchant ship. In July, two super tankers, the Radwan and the Argo Hebe, collided. And in August, cruise liner Royal Pacific sank after colliding with a Taiwanese fishing trawler (BI, Aug. 31).

However, the Strait of Malacca is not normally the site of a large number of collisions, according to the Salvage Assn. in London.

"They just seem to have had a bit of bad luck lately," a spokesman said. ■

INTERNATIONAL

LONDON

Continued from page 21

joint stock company and absorbed by GMF and Belgian insurer Societe Mutuelle des Administrations Publiques in Liege, Belgium (BI, July 27).

MMI was to become the British partner in Eurosafe, an association of companies insuring local authorities in Europe.

But then GMF declared that the deal was "no longer financially interesting," a company spokeswoman said.

MMI will make a further statement Thursday regarding the payment of outstanding claims.

Some of its personal lines business has already been transferred to General Accident Fire & Life Assurance P.L.C. and Norwich Union Fire

Insurance Society.

Some local authorities have found coverage from other British insurers at premiums similar to those charged by MMI.

But for others, finding alternative coverage has been difficult, said Martin Pilgrim, finance director for the Assn. of Metropolitan Authorities. "One authority could not even get third-party coverage for its vehicles."

If MMI went into liquidation, some local authority claims for compulsory coverages, like third-party automobile liability and employers liability, might be paid under the Policyholders Protection Act along with private policyholders' claims. However, the Policyholders Protection Board would have to seek legal advice, said Derek Wright, the board's financial representative. ■

BERMUDA

Continued from page 21

could not be canceled, would insure named executives for a period of 10 years and could be renewed annually at ACE's discretion. Corporations are expected to pay the premiums, but the insurance would actually be owned by the named executives, who would be given insurance certificates.

Limits are \$150 million for any one corporation in any one year.

Rates will depend on each company's "historical and prospective financial strength," said Mr. Loschert. Premium rates are to be governed by each corporation's Standard & Poor's credit rating and will differ from company to company. ACE is charging \$5,000 per application and says it will only consider companies with at least an "A" rating, though the insurer may consider lower ratings in certain risk categories like, for example, U.S. utility holding companies.

Because these coverages will require more credit analysis than other ACE policies, Mr. Loschert is putting together a two- or three-member executive compensation department.

Only a few other insurers write so-called ECI policies, and Mr. Loschert predicts "explosive growth" at ACE, with net premiums for the coverages hitting \$40 million by the end of 1993.

Meanwhile, ACE posted an underwriting profit of \$4.7 million for the nine months ended June 30 compared with an underwriting loss of \$10.9 million for the same period last year. Net premiums earned after three quarters were up 14% at \$199.1 million vs. \$174.3 million last year, while losses and loss expenses were \$169.2 million compared with \$160 million previously.

New business growth, which had picked up in the second quarter, continued strong in the third, said Walter A. Scott, chairman and chief executive officer.

Since Sept. 30, 1991, ACE has added 40 new excess liability accounts, a third of them with non-U.S. clients, and 20 new directors and officers liability accounts.

Reporting to shareholders, he said, "We expect the above average growth in new business to continue at least through the calendar year end, due principally to the reduced excess liability capacity available in the London market."

Investment income was \$81.9 million for the nine-month period, while net income rose 20% to \$136.4 million from \$113.6 million in 1991. Shareholders' equity increased to \$1.21 billion from \$1.11 billion last year. ■

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Larry Worrall, co-founder of E&O Professionals, pioneered Agent's E&O defense strategies in the early 1960's.

Bermuda captive

Continued from page 2

not very responsible attempt to address the public trust," said Aaron Liberman, president of HSR Inc., a licensed surplus lines broker in El Toro, Calif., that represents Dual Plus.

A state-appointed conservator is now working in Dual Plus' offices informing policyholders—some of whom are hospitalized—to seek other coverage and that existing valid claims would likely not be paid, said Dr. Noble.

Dual Plus policies cover 4,000 people employed by about 1,000 firms.

According to an unaudited financial statement filed by Dual Plus Insurance with the California department in late August, the insurer had capital and surplus of \$753,008 as of March 31.

However, the department has re-

duced that amount to \$156,468. It reduced assets by about \$130,000, alleging that intangibles and other items were not acceptable as assets. And, the department increased liabilities by \$470,000 because claims reserves were not reflected in the financial statement.

Dual Plus Insurance has written about \$7 million in premium so far this year, Dr. Noble said.

Under the current Insurance Code, an "unlicensed" insurer is required to maintain a minimum capital and surplus of \$5.4 million, a department spokeswoman said. That would be raised to \$15 million under a proposed regulation known as Section 2174.

The department's action was not spurred by any policyholder complaints, Dr. Noble noted.

"The most bizarre part of all of this is that there have been no consumer complaints" to the department about Dual Plus, Dr.

Noble said. "In any seizures I've been aware of in the past, the central fact was consumer complaint.

"Our customers were not being hurt, but they sure as hell are now," Dr. Noble asserted.

The department has removed from the payroll Dr. Noble; his wife, who is chairwoman and director of the claims department; and three family members.

"The DOI is not acting like a conservator but like a wrecking ball," Dr. Noble said.

PHBT and subsequently Dual Plus have been operating for six years, during which time department staffers have conducted audits on the premises, Dr. Noble said. But, the department did not consider the company's operations "illicit" until he testified at a hearing on a proposed surplus lines regulation, he said (BI, Aug. 3).

At those hearings, Dr. Noble and John B. Cumming of Los Angeles,

Dual Plus' consulting actuary, argued that non-admitted insurer's reinsurance should be taken into account when assessing whether it is adequately protected against insolvency.

"My commentary at the hearings was probably the trigger" for the proceedings against Dual Plus, Dr. Noble said. "Me and my big mouth."

Insurance Department staffers attending the hearings were apparently surprised that Dual Plus maintained an office in Long Beach, he said.

For a captive "to maintain a physical presence" in another jurisdiction may be "a technical violation," he added. "Had we had only a shingle in Bermuda," the department might not have taken its action. "But why wait six years to call it to our attention? We weren't operating in a closet."

Dr. Noble conceded that Dual

Plus Insurance Administrators is operating without a certificate of registration from the department.

"We applied for one twice—the last time in 1989—and were told each time the application got lost. We also figured the certificate might be redundant, since as the parent of a Bermuda captive, we have the right to administer it," he said.

Dr. Noble contends that the term "unlicensed" should not be applied to Dual Plus, which is licensed in Bermuda.

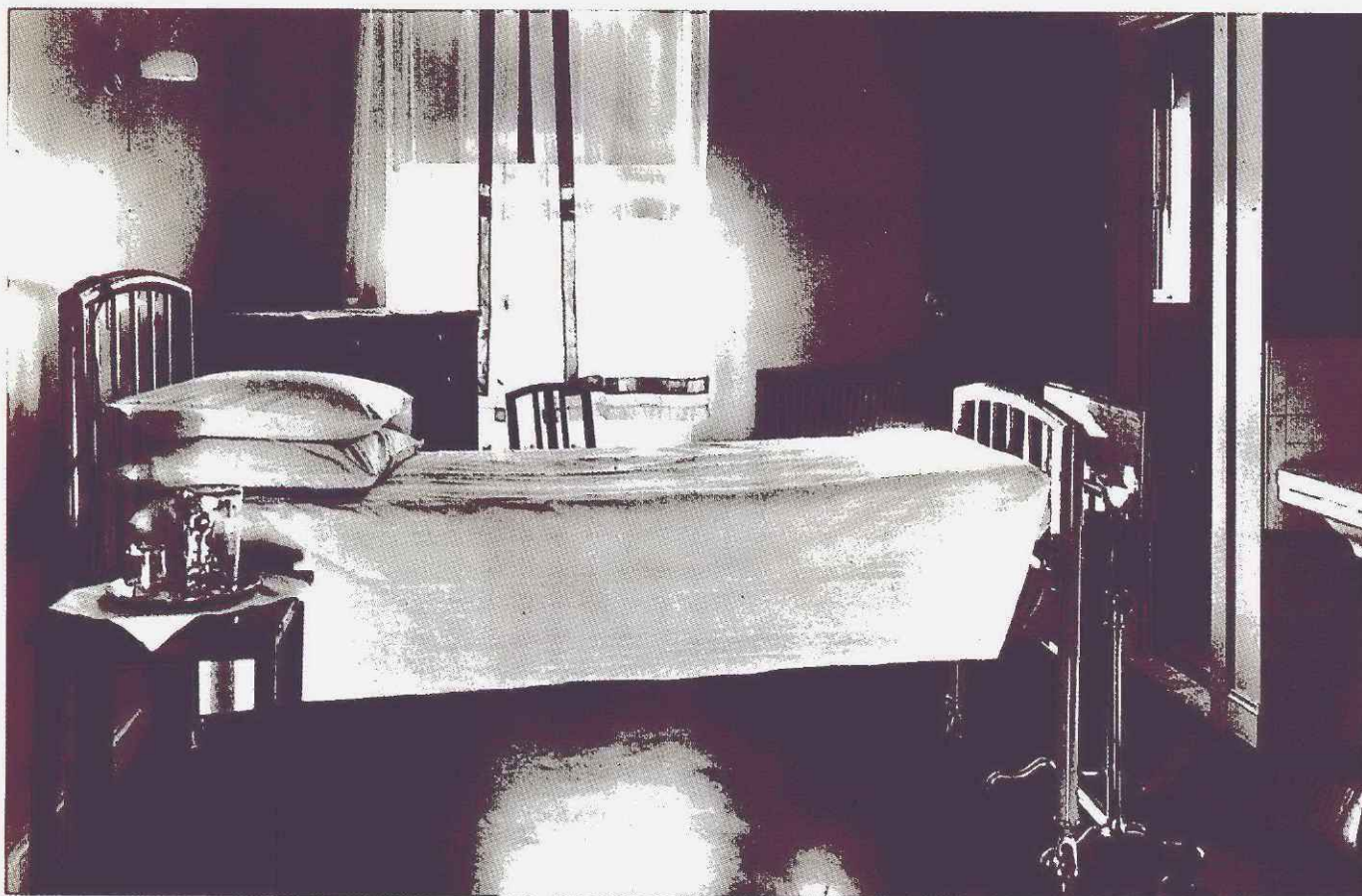
Bermuda law requires captives to maintain a "rather modest" capital and surplus of \$200,000. "But they are mindful of your (premium volume to capital) ratio and mindful of your reinsurance," Dr. Noble said.

Dual Plus purchases \$1 million in specific stop-loss insurance from Lloyd's of London syndicates in excess of \$50,000 per person annually. Lloyd's syndicates also write Dual Plus' aggregate stop-loss coverage, which limits the insurer's maximum claims exposure to \$692,000 a year, he said.

"We have been light years from ever having an aggregate penetration," Dr. Noble said. Dual Plus has filed only \$230,000 in specific stop-loss claims in three years, he said.

Despite Dual Plus' arguments, Mr. Garamendi might have "a strong position to issue a cease and desist order" against the insurer, said Jon Harkavy, general counsel and vp of Vermont Insurance Management Inc., a captive manager in Arlington, Va.

Dual Plus has not operated like "a classic captive." Most domestic and offshore captives are "very cautious" to avoid the appearance of doing business in a state, he added. ■



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Business Insurance

New Jersey ruling

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the site and spent about \$3.6 million decontaminating it.

Meanwhile, Springer had filed a complaint against its CGL insurer, Federal Insurance Co., holding that the Chubb Corp. unit was obligated to defend and indemnify it against the New Jersey agency's claims.

Federal wrote a primary comprehensive general liability policy with \$500,000 limits per occurrence and an umbrella policy with similar terms.

Each policy specifically barred coverage for damage to the policyholder's own property.

However, Springer argued that even though the damage was confined to its own property, there had been damage to the air, land and water overseen by the state of New Jersey and there had been a threat of damage to third-party properties.

In the New Jersey Supreme Court's 4-3 ruling on Sept. 23, Associate Justice Robert Clifford wrote for the majority that "under its clear terms, the policy does not cover the costs of cleanup performed by or on behalf of an insured on its own property when those costs are incurred to alleviate damage to the insured's own property and not to the property of a third party."

The decision marked the court's "first excursion into the thicket of environmental pollution coverage," Justice Clifford noted.

But in a dissent that was longer than the majority opinion, Associate Justice Daniel O'Hern wrote that "even had the event or occurrence of the fire been confined exclusively to the insured premises, the insured has nonetheless become liable to a third party—DEP."

Justice O'Hern continued, citing an Idaho court decision: "When the broad definition of 'property damage' in a CGL policy is read together with the 'owned property' exclusion and the policy's introductory paragraphs on liability, it is clear that coverage is expressly provided when the insured becomes liable to third parties for events confined exclusively to the insured's premises."

The ruling "can be regarded as an admonition to the appellate division not to go too far in finding coverage for corporate insureds for their environmental cleanup costs," said Federal attorney William J. Brennan III, a partner with Smith, Stratton, Wise, Heher & Brennan in Princeton, N.J.

Mr. Brennan used the word "bellwether" to describe New Jersey's place in environmental law. "New Jersey has become the jurisdiction of choice for corporate insureds seeking coverage" for environmental cleanup costs, Mr. Brennan said.

"The case indicates that the New Jersey Supreme Court is prepared to uphold and enforce insurance contract limitations in the environmental context," said Laura A. Foggan, an insurer attorney with Wiley, Rein & Foggan in Washington.

Ms. Foggan said that New Jersey's appellate courts often take a liberal reading of policy language to find "deep pockets" for environmental cleanup costs.

But, Springer attorney Robert Rose of Pitney, Hardin, Kipp & Szuch in Morristown, N.J., disagreed on the impact of the case.

"It may, on a long-term basis,

not have a lot of importance," he said. The case was "very fact-sensitive" and should not be regarded as any sort of landmark decision, he said.

William Greaney, a policyholder attorney with Covington & Burling in Washington, agreed.

"Let's face it, it's an extremely important state" for environmental rulings, he said. But, the case itself "doesn't break a whole lot of new ground."

"From a policyholder's standpoint, it says as long as you have some offsite migration," the policyholder will be covered, he said.

Mr. Greaney added that such offsite migration probably applies to 99.9% of pollution cases.

State of New Jersey, Department of Environmental Protection, et al vs. Signo Trading, et al, New Jersey Supreme Court (A-72).

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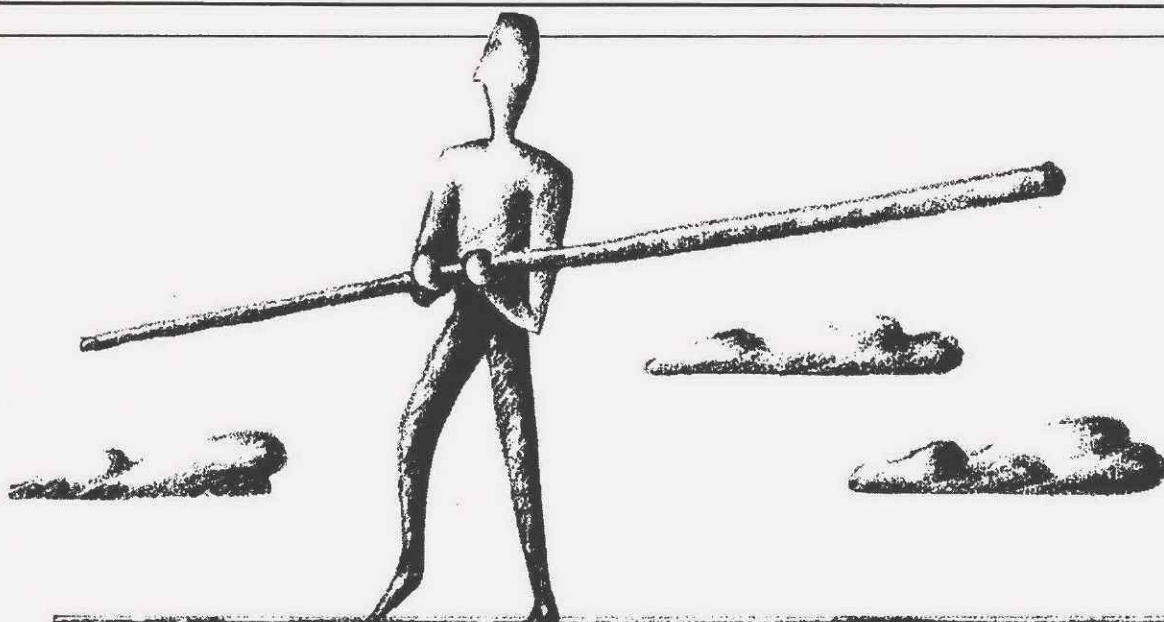
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Health care fraud

Continued from page 3
 Annual Employee Benefits Conference, sponsored Sept. 18-23 in Montreal by the International Foundation of Employee Benefit Plans.

Employers can protect themselves and their workers from fraud through education programs, Mr. Garcia said.

For instance, gullible patients are attracted to clinics offering "new health care alternatives." The clinics specialize in everything from high blood pressure and diabetes to heart disease, weight control and depression.

These outfits advertise that no matter what is ailing someone, this is the place to go for health care.

The clinics' advertising also snares healthy people by stressing that "prevention is important—by the time you feel the symptoms it may be too late," he said.

In addition, such advertising points out: "Best of all, services are free—we accept your insurance as full payment."

But these clinics will provide and bill for extensive unnecessary care, Mr. Garcia said.

Employers should warn their employees about these setups, he said: There is no such thing as something for nothing, and if it sounds too good to be true, it probably is.

Other examples of fraudulent setups include:

- The dishonest pharmacist who fills a prescription for a generic drug but bills the insurance company for the full cost of a brand-name drug as well as additional drugs that the patient did not receive.

- Health care providers who habitually perform somewhat routine procedures regardless of whether they are needed.

In one podiatrist's scheme, the feet of patients who were seeking care for problems like corns were routinely X-rayed in a relaxed po-

sition. The positioning of the feet made it look as if there were something wrong with the patients' arches.

The doctor would show each patient the X-ray and assure him or her that a routine surgical procedure—performed right in the office—could fix the problem before it causes pain.

After the "procedure" is completed, the doctor takes another X-ray, this time with the foot in a different position. As a result, the X-ray shows that the arch has been "fixed."

This scheme was discovered when a patient's foot later developed gangrene because of the podiatrist's sloppy work. The foot had to be amputated, Mr. Garcia said, noting that the foot was not injured before the podiatrist performed the procedure on the arch.

- The provider who always "up codes." This type of provider always bills for treating a complex fracture rather than a simple fracture, for example.

And, instead of submitting one charge for performing a surgical procedure, these providers unbundle charges for a surgical procedure and charge for each individual step in the procedure.

- The care giver who prescribes a "therapeutic" vacation, convincing the patient that he or she is suffering from an ailment like depression. The provider then bills the patient's insurer for services that are never provided, making enough money to pay for the patient's vacation and rake in a profit.

The best way to fight depression is to relax in the therapy of the patient's choice—perhaps golf or horseback riding, these "therapists" argue, Mr. Garcia said.

This depression—even if the patient has had no prior indication of mental illness—can recur every year, the provider tells the patient. As a result, the patient is told to consider an annual therapy session.

These operations, which in the past have promised to accept the patient's insurance as full payment, have had to modify that promise to accept only "qualified insurance coverage," since some insurers with fraud units are onto the scam, Mr. Garcia said.

To fight fraud, everyone must realize that it exists and that anyone can become a victim, he said.

At the least, health care consumers should ask their providers some basic questions for their own safety.

"If a car mechanic told you you needed new tires, you would at least look at the old ones," Mr. Garcia observed.

Employees should be instructed to sign and date only one claim form. Health care consumers should realize that signing a claim form amounts to signing a blank check. "There's nothing wrong with giving a blank check to a family member, but you would check to see how much that family member wrote the check for," Mr. Garcia said.

Likewise, after receiving care, patients should check their bills to verify that they are being charged only for care that was provided, he said.

Employees can be taught to help identify fraud as well, Mr. Garcia said. If there is a discrepancy in a bill, both the provider and insurer should be informed. It may be an accident, or there may be a pattern that the insurer can flag.

Employers also should make employees aware of what they stand to lose if they participate in a fraudulent scheme: In addition to a criminal record, health care fraud can lead to the loss of a person's job and a court order to reimburse the health care payer for the cost of unnecessary care.

The session was moderated by Joe J. Thomas, business manager and secretary-treasurer of Local 942 of the Laborers International Union of North America in Fairbanks, Alaska. ■

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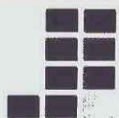
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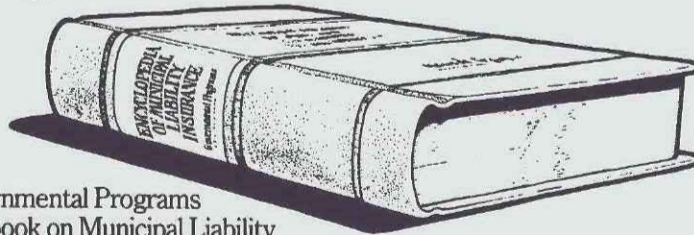
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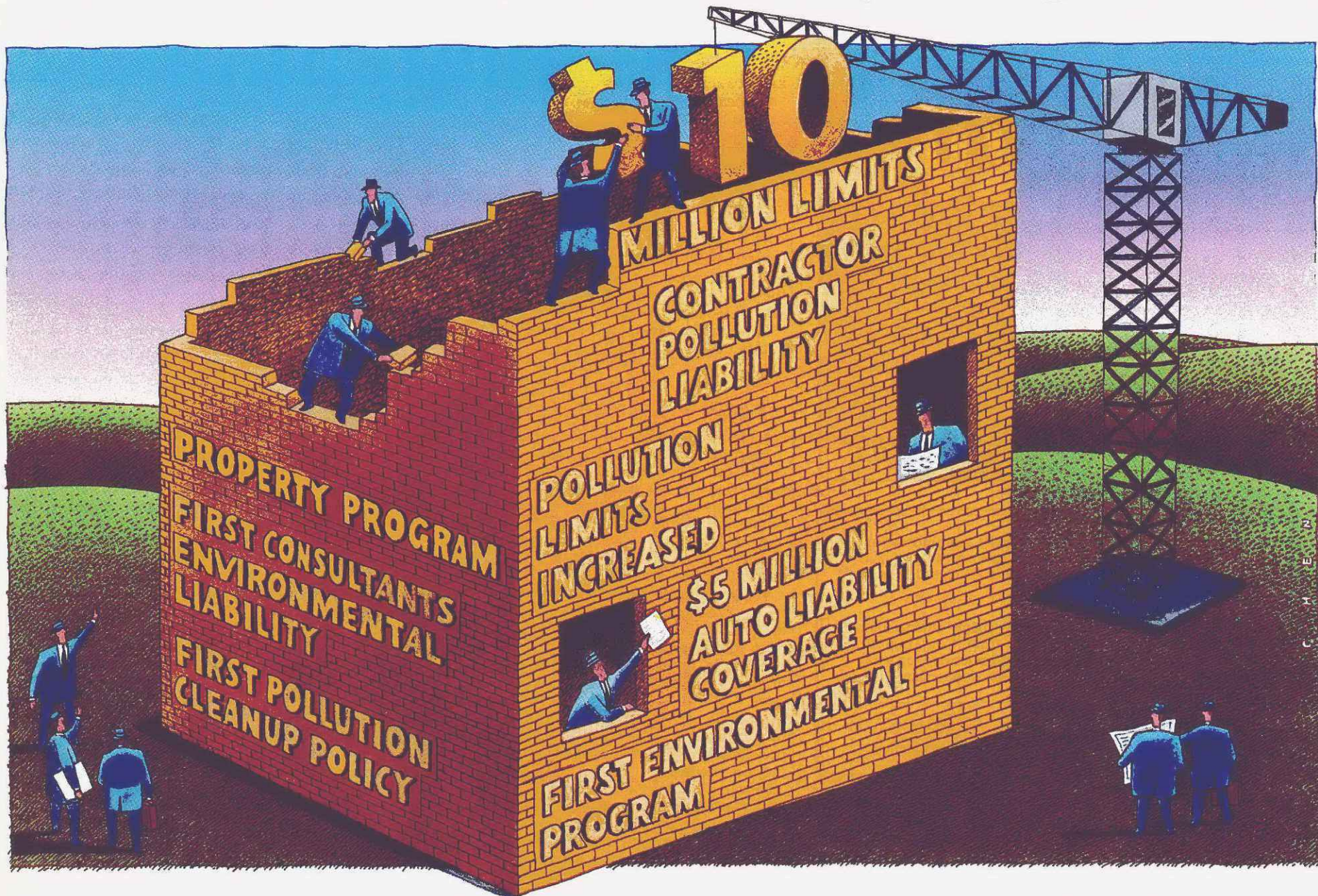
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Aviation renewals

Continued from page 1

The average increase in rates for business placed through London brokers has been moderate, about 12% for hull coverage and 11% for liability coverage, Mr. Smith said.

However, the average includes some large increases for airlines that have suffered major losses over the past year, he said, noting that about half of the airlines that renewed Oct. 1 received the same rate as last year.

"The Oct. 1 renewal increases were substantially less than they have been" because of overcapacity, said Chuck Laible, senior vp at Willis Corroon Corp. in New York.

"There have been some modest increases in rates but no increases in deductibles," said Richard Maylam, underwriter for Lloyd's of London syndicate 270 managed by A.J. Archer & Co. Ltd. A typical hull deductible for a jumbo jet remains \$1 million.

The moderate rate increases will mean that aviation underwriters will continue to lose money on airline accounts, Mr. Maylam said.

"The premiums are simply not sufficient to pay for the claims that we are having," he said.

Aviation underwriters have fallen far short of an underwriting profit over the past 12 months, said Jean-Michel Giquel, a director of insurer La Reunion Aeriennne in Paris.

"Over the past 12 months, we have had claims of \$1.25 billion, and that is far away from the total premium received of \$750 million," he said. Estimated rate increases of between 10% and 20% for fourth-quarter renewals are insufficient, Mr. Giquel said.

However, it appears that underwriters could make a profit on airline coverage this year.

Through July 31, aviation underwriters have paid \$228.5 million in hull claims in excess of \$10 million and have reserved \$141.4 million for liability claims, according to the latest report by John Chapman, a director of Bain Clarkson Reinsurance Brokers Ltd.

Mr. Chapman projects that airlines will pay premiums of \$480 million for hull coverage and \$395 million for liability coverage in all of 1992.

The \$369.9 million in 1992 losses does not include the \$35 million hull claim and as-yet undetermined liability cost connected with the crash of a Pakistan International Airlines jet last week (see related story). In addition, hull claims of less than \$10 million—which are not

tracked by the survey—push the total loss figure higher.

Mr. Chapman said the market overcapacity will curtail 1992 rate increases. "Overcapacity seems to haunt the aviation market constantly. It has somehow survived five years of rate cutting, and is without doubt the aviation market's most erosive element."

Most major direct insurers have remained in the market for the past six years without substantially reducing their capacity, he said.

"Quite simply, every major insurer and reinsurer wants to be involved," Mr. Chapman said.

Currently, there is double the capacity needed in the market, said Steve Anderson, a director in Sedgwick Group P.L.C.'s aviation department in London.

However, Orion's withdrawal from the market last month could indicate that aviation insurance capacity will contract soon, said Archer's Mr. Maylam. Some aviation underwriters may be forced out of the market due to losses on other lines of business, he said.

"Orion's aviation department was very well-organized and is a loss to the London market, but Orion stopped writing all business, not just aviation business, and this may be what will happen with other underwriters," he observed.

In the United States, Aviation Office of America Inc. stopped writing airline insurance as of July 1, an official said. However, the insurer still writes general aviation business.

Excess capacity in the world market convinced AOA to "take our assets and apply them to the non-airline area," he said. In addition, "our primary role had been as a following market. We preferred to have more control over our own destiny."

AOA wrote between \$7 million and \$10 million in airline premiums last year, he said.

Capacity in the world aviation market will drop substantially in 1993, predicted Mr. Giquel.

"The cost of excess-of-loss reinsurance will increase substantially at the year-end renewal, and some direct underwriters will be forced to withdraw from the market as a result," he said.

Aviation insurers will pay a larger share of losses themselves rather than pass the risk on to reinsurers, agreed Christopher Cook, chief executive for aviation and aerospace at Johnson & Higgins Ltd. in London.

"Last year, the direct underwriters could buy reinsurance down to a burst tire if they wanted to, but since the Jan. 1 renewal this

year, the typical retention has been around \$50 million" per loss, divided among all the insurers on a risk, he said.

Under such a scenario, reinsurers would not pay any claims if a loss was less than \$50 million. If a loss exceeded \$50 million, each insurer on the risk would receive a pro rata portion of the payment by the reinsurer. For instance, if there was a \$75 million loss, an insurer writing a 10% line would have to pay out \$7.5 million gross, but would receive \$2.5 million from its reinsurers.

In some cases, retentions have risen to \$100 million per loss, Mr. Cook said.

"It is doubtful if many of these markets are fully aware of the colossal exposure they have elected to retain," said Mr. Chapman of Bain Clarkson.

For example, on last year's total major losses of \$830.1 million, a \$50 million retention per loss would have meant that insurers would have retained \$556 million in losses, with reinsurers paying the rest. A \$100 million retention would have increased insurers' share of the losses to \$680.2 million, he said.

For the 1992 losses up to July 1, insurers would have had to pay all claims under a \$100 million retention since there was no crash prior to July 1 whose losses exceeded \$100 million.

"These are admittedly market figures, and some underwriters' results may be proportionately better, but for every one of those, somebody's must be worse," he said.

Some of the large losses that have hit the market this year have led to higher than average rate increases for some airlines.

In particular, according to underwriting and brokerage sources:

- China Airlines' hull rate increased by 41%, and its liability rate increased 30% this year. China Airlines filed a \$75 million hull claim after a Boeing 747 crashed last December in Taiwan (BI, Jan. 6).

- Trans World Airlines Inc.'s hull rate increased by 47% and its liability rate increased by 53%. TWA had a \$20 million hull loss in New York in July (BI, Aug. 3).

- Thai Airways' hull rate increased 21% and its liability rate increased 19%. Thai Airways had an \$87 million loss in Nepal in July (BI, Aug. 10).

But other airlines with better loss records have not suffered the same increases. For example, Malaysian Airways' rates remained unchanged, though its premiums increased because its exposure increased 25%.

\$35 million hull loss in Nepal crash

KATMANDU, Nepal—Aviation underwriters face a \$35 million hull claim and unspecified liability claims after a Pakistan International Airlines jet crashed in Nepal, killing all 167 aboard.

Hull and liability coverages for PIA were placed in the local Pakistan market but most of the risk was reinsured into the London market by C.T. Bowring & Co. Ltd.

Leading the reinsurance was Lloyd's of London syndicate 960, managed by Sturge Aviation Syndicate Management Ltd. The coverage is due to renew Oct. 15, sources say.

No liability reserve has been established. The Airbus A300 hull had an insured value of \$35 million.

The jetliner was en route from London to Katmandu via Karachi, Pakistan, when it crashed into mountains on its approach to Katmandu airport, said a spokeswoman for the Pakistani airline.

The reason for the crash has not yet been determined, she said. On board were 16 crew members and 151 passengers—37 Britons and others including European nationals and North Americans.

The crash comes two months after a Thai Airways A310 crashed on its approach to Katmandu (BI, Aug. 10).

The crash also comes at the beginning of the renewal season for most major airlines. Quotes for PIA already had been issued in London but were subsequently increased to reflect the loss, sources said.

—By Gavin Souter

And the hull rates for the London portion of United Airlines' coverage increased by about 12%, and the liability rate increased by about 10%, brokers estimate. Its total premium increased by about 32% because of an increase in its fleet value, sources say.

United officials couldn't be reached for comment.

United also has changed its lead underwriter. Because Orion is no longer underwriting, the airline's new lead in London is British Aviation Insurance Group.

Another account that Orion formerly led is Thai Airways, whose coverage is now led by Brian Beagley, underwriter for Lloyd's of London syndicate 960, managed by Sturge Aviation Underwriting Management Ltd.

Orion also was the lead insurer for the KSSAF group, the largest single insurance buying fleet, whose coverage renews on Nov. 1. KSSAF consists of 54 airlines headed by a group of European air carriers with a fleet value of \$19 billion.

South African Airways is another major airline that has changed its lead underwriter. Last year the risk was led by Lloyd's syndicate 824 managed by Murray Lawrence & Partners Ltd.

However, the South African account moved to La Reunion Aeriennne, in Paris, sources say.

The change in lead underwriters is coupled with the increasing trend toward following underwriters offering their own terms and condi-

tions, said Mr. Smith.

"Whereas before an airline might be placed with three or four different markets and their separate terms and conditions, now it might be placed with six or seven markets all offering their own terms and conditions," he said.

"Anybody that can put down a 2% to 3% line is prepared to quote for his own share," Mr. Smith said.

This trend reflects the competitive nature of the market, said Mr. Cook. "People are concerned about market share, and they have to show that they are giving something for the business they take on. You have to sing for your supper now."

Soft market conditions have also forced London underwriters to drop the demands for quicker premium payments which they imposed last year, said Sedgwick's Mr. Anderson.

Last year, London underwriters demanded that airlines pay 50% of the premium within 60 days after the beginning of the policy, 25% within 90 days and the final 25% within 120 days.

However, the tighter payment terms were not followed by other major markets, and London underwriters have reverted to the previous system where airlines pay 25% of the premium every 90 days, Mr. Anderson said. But all underwriters are keeping a tighter rein on credit control and demanding prompt payment on the due date, he said.

● Associate Editor Sara J. Harty contributed to this story.

Hartford reorganization

Continued from page 1

"This was a drag on earnings. We feel we have resolved this issue and put it behind us," Mr. Ayer explained, noting that Hartford now is better positioned to achieve ITT's goal of a 15% return on equity.

"Reinsurance and surplus lines management can really focus on the future now," he said.

Mr. Ayer also denied that the timing of the move was affected by Hartford's \$95 million in aftertax losses from hurricanes Andrew and Iniki (BI, Sept. 28). "You don't do something like this in one or two days," he said, adding that the plan has long been in the works.

Insurance analysts applauded the moves and said other underreserved insurers should take similar steps.

"These are not the only guys with a problem, but you have to give them credit for belling up to the bar," said Myron M. Picoult, managing director and senior insurance analyst with Oppenheimer & Co. in New York. Whether other insurers follow the lead "depends on how brain-dead they are. The sooner

they face reality, the better."

"The industry has to recognize some of the deficiencies in reserves," agreed Michael A. Smith, an analyst with Shearson Lehman Bros. in New York. "This is one step by one company," he said, adding that it "certainly makes it easier for other companies to follow now that one company has done it."

Reserve bolstering would have to become far more widespread to trigger any turn in the property/casualty market, he said. "This is a nice first step, but it's going to take a lot of cumulative trauma, and that's going to take some time."

ITT and Hartford announced the charges and restructuring last Wednesday. The charges comprise:

- \$900 million pretax to bolster reserves and fund the runoff of pre-1986 surplus lines and reinsurance business written by First State, New England Insurance and New England Re. Much of the widening loss stems from asbestos and pollution liability claims, Hartford said.

Some of the reserve additions also relate to potential unrecoverable re-

insurance—including amounts owed by the H.S. Weavers (Underwriting) Agencies Ltd. line slip—though Mr. Ayer declined to comment on the extent of the uncollectibles.

The charge amounts to \$594 million aftertax.

- \$250 million pretax to build defense cost reserves for asbestos and pollution claims. This charge amounts to \$165 million aftertax.

Meanwhile, Hartford will report \$177 million in aftertax realized capital gains. That reduces the total aftertax charge to \$582 million.

The \$680 million ITT is contributing to Hartford to help fund the reserve bolstering and reorganization includes \$300 million in cash and \$380 million in common stock of Alcatel Alsthom, a French telecommunications company with which ITT was involved in a joint venture.

The restructuring of Hartford's surplus lines and reinsurance operations include these changes:

- First State, New England Insurance and New England Re will cease underwriting at year end and

will run off their existing business.

- First State Management Group, Hartford's wholesale underwriting management arm, will begin writing non-admitted business through Pacific Insurance Co., another Hartford unit. Pacific's policyholder surplus has been increased to \$200 million from \$47.5 million at year-end 1991, Mr. Ayer said.

First State Management also will now report to the same management overseeing Hartford Specialty Co., Hartford's specialty lines retail arm. First State Management and Hartford Specialty will work together "to strengthen ITT Hartford's competitive position in the specialty, excess and surplus market," the company said.

- All of Hartford's reinsurance operations will be consolidated under Hartford Reinsurance Management Co., which will underwrite for Hartford Fire Insurance Co.

Meanwhile, Lawrence S. Doyle resigned as Hartford senior vp and director of international property/casualty operations in a move he and Mr. Ayer said is unrelated to the

restructuring. Mr. Doyle will continue until March 1 as an executive assistant to Mr. Ayer.

Since 1986, Mr. Doyle has also been chief executive officer of First State, New England Insurance and Cameron & Colby, the Boston-based underwriting manager that was phased out of existence last year.

"I've been doing four jobs for the last seven years and basically decided to do one job going forward," he said.

Hartford's ratings were placed under review.

Standard & Poor's Corp. placed the AAA claims-paying ability rating of the Hartford property/casualty intercompany pool and Hartford Life Insurance Cos. on CreditWatch with negative implications. S&P said it is reviewing the restructuring but does not expect the rating will drop below AA.

A.M. Best Co. also placed the Hartford group's A+ pooled rating under review, and Moody's Investors Service Inc. put both ITT's and Hartford's credit ratings under review.

FAS 106

Continued from page 1

welfare benefits. Most companies previously accounted for these costs on a pay-as-you-go basis in their income statements.

But, the new rule requires employers to accrue retiree benefit liabilities as an expense against earnings from the date employees are hired until they become eligible for benefits.

Employers also will now be required to set up a balance sheet liability for the obligations as they are accrued.

The new rule will require employers to either fully recognize their accumulated retiree liabilities in the first year after the rule takes effect or amortize them over up to generally 20 years.

FAS 106 goes into effect for most large companies in GAAP financial statements for fiscal years beginning after Dec. 15.

Because of the sting of recognizing huge retiree health care liabilities, many companies are revising their benefit programs to try to contain retiree health care costs (*BI*, Aug. 17).

The accounting board last year softened the impact of FAS 106 by adopting FAS 109, which allowed employers to offset retiree benefit liabilities with a "deferred tax asset." This asset represents anticipated future tax deductions, primarily those generated by payment of retiree health benefits (*BI*, May 20, 1991).

The NAIC has since concluded that insurers should comply with FAS 106 in preparing their statutory financial statements. But it is not clear whether the regulators will recognize FAS 109 or whether they will modify FAS 106 to soften its impact.

The NAIC currently plans to follow GAAP implementation of the accounting rule, including allowing insurers to recognize deferred tax benefits, say NAIC officials Darren Cook and Robert Solitro. Mr. Cook is the group's director of financial services, and Mr. Solitro, the deputy New Hampshire commissioner, heads an NAIC working group on

accounting rules.

But, insurers say matters are not so clear. Because the NAIC has not formally advised insurers to adopt FAS 109, it is not clear that retiree health care liabilities may be reported net of deferred taxes, said D. Keith Bell, manager of accounting policy for Aetna Life & Casualty Co. and a member of the advisory group.

Allowing the offset would open a "Pandora's box," forcing regulators to explain why offsets should be allowed in this area but not in others, like reporting of unrealized capital gains and losses, said Alan Close, associate controller with Northwestern Mutual Life Insurance Co. Mr. Close also is a member of the industry advisory group.

Concerned about the rule's impact on surplus, the advisory group instead has proposed modifying FAS 106 in several ways that it says would better reflect insurers' legal benefit obligations.

These modifications include:

- Requiring insurers to recognize postretirement benefit liabilities only for retirees and fully eligible or vested employees, rather than requiring them to recognize their accrued liabilities for all active employees in the period in which they provide services, as FAS 106 requires.

But that modification could make it difficult to tell what an insurer's obligations actually are. Benefit programs do not always spell out when employees are fully eligible or vested and courts have not settled the issue in many cases, explained Mr. Cook of the NAIC.

- Using a general long-term inflation rate in estimating future retiree health care obligations rather than the much higher health care cost trend rate that FAS 106 requires employers to use.

- Limiting the period that insurers may amortize postretirement benefit liabilities to 10 years, rather than to 20 years as in FAS 106.

The advisory group proposal would become effective Dec. 31, 1993, for statutory statements, a little more than a year after FAS 106 takes effect.

At the advisory group's request,

the NAIC ran a "field test" comparing the impact of FAS 106 with the advisory group's proposal.

Of the 126 insurers surveyed, 28 said they had no postretirement benefit obligations and 55 said they had potential liabilities but lacked specific data.

The NAIC report is based on the remaining 43 companies—20 stock insurers and 23 mutuals or fraternal organizations with total assets of \$816 billion, or 38% of total industry assets of \$2.1 trillion. Nineteen of the companies were life/health insurers, 13 were property/casualty insurers and 11 were multiline companies.

The survey found that under FAS 106, the insurers' average balance sheet liability would grow from \$10.8 million in the first year the accounting rule was in effect to \$40.8 million in the third year.

If a deferred tax offset were allowed with FAS 106, the average liability—reduced by a 34% effective tax rate—would grow from \$7.2 million in the first year to \$26.9 million in the third year, the survey found.

Using the advisory group proposal, though, the average liability would start at \$5.1 million in the first year and grow to \$23.3 million by the third year.

Examining FAS 106's impact on surplus, the survey found that surplus would decline 12% on average if an insurer recognized its accumulated postretirement benefit obligation immediately rather than amortizing it.

By contrast, the advisory group plan produced an average 5% reduction in surplus.

Aetna's Mr. Bell conceded that allowing FAS 106 liabilities to be reduced by tax offsets would "remove a lot of the urgency" from the debate over the advisory group proposal.

The surplus hit under FAS 106 would be reduced to approximately 8% if tax offsets were allowed. That impact "is not as severe," Mr. Bell noted.

Mr. Cook said he expects the NAIC will adopt a "statement of concepts" and resolve the FAS 106 issue by the middle of next year. ■

Stock offerings

Continued from page 3
analysts noted.

Allstate reported \$10.02 billion in revenues for the first half, up 4.5% from \$9.59 billion in the first half of 1991. Profits increased 40.5% to \$496.4 million from \$353.4 million.

About 10% of Allstate's business is commercial lines, with the remainder life insurance and personal lines.

The Allstate offering is "a wonderful idea, because Allstate is never going to get the value it deserves when it is buried under Sears," said Joyce Culbert, an analyst with Chicago Corp. in Chicago.

Charles Ronson, an analyst with Balestra Capital in New York, said: "I think it's an excellent idea." Shareholders now have a choice: "Do they want to own Sears, or do they want to own Allstate?"

The stock sale will benefit Allstate, Mr. Ronson said. "It will make them directly responsible, theoretically, to the market, and it might make them a little more aggressive in hustling profits."

Bruce Ballentine, an analyst with Moody's Investors Service Inc., agreed. "Public ownership should promote more of an arm's-length relationship between Allstate and Sears," which would benefit Allstate. However, William Cavanaugh,

director at Standard & Poor's Corp. in New York, said that S&P's "overall view is that it's basically neutral for Allstate."

Sears will still own 80%, he noted. "They will obviously be the controlling shareholder. They will have great influence in setting things like dividend policy."

"I don't think it will make a lot of difference as to how Allstate operates," said Russell R. Miller, chairman of Russell Miller Inc., an investment bank specializing in insurance issues.

Moody's on Sept. 25 lowered the insurance financial strength rating for Allstate Insurance Co. and Allstate Life Insurance Co. to Aa2 from Aa1 and left them under review for possible future downgrade after Allstate announced it would take a \$700 million aftertax loss as a result of Hurricane Andrew.

"Moody's remains concerned about Allstate's ultimate losses for Hurricane Andrew," Mr. Ballentine said. The agency will continue the review in light of Sears' restructuring.

S&P also has placed Allstate Insurance Co.'s AA+ and Allstate Life's AAA claims-paying ability ratings on its CreditWatch list.

But, observers say they do not believe that the insurer's hurricane losses will have an impact on the sale.

"I don't think the stocks respond to that at all," said Chicago Corp.'s Ms. Culbert.

Mr. Cavanaugh noted that by the time of the offering, the true cost of Andrew "should be pretty well determined. It's not going to have a significant impact on the sale or the price."

Meanwhile, property/casualty and brokerage stocks posted solid gains last week, with several companies reaching 52-week highs (see chart, page 31).

Stocks that hit 52-week highs on Thursday included: American International Group, \$106.63, up 62.5 cents; Aon Corp., \$49.63, up \$1; Chubb Corp., \$86.25, up 75 cents; Arthur J. Gallagher & Co., \$28.50, up 50 cents; General Re Corp., \$106.50, up \$2.625; Hartford Steam Boiler & Inspection Co., \$59.25, up 87.5 cents; Lincoln National Corp., \$67.50, up 75 cents; Marsh & McLennan Cos. Inc., \$90.50, up 25 cents; Old Republic International Corp., \$25.50, up \$1.125; Transamerica Corp., \$27, up 50 cents; and Transatlantic Holdings Inc., \$46.25, up \$1.25.

Among the stocks that hit 52-week highs on Wednesday were: Aegon U.S. Holding Corp., \$41.875, up \$1.125; and National Re Corp., \$24.25, up 75 cents. AIG, Chubb, Gallagher, Gen Re and Old Republic also hit 52-week highs on Wednesday. ■

Update

Defense pension add-ons killed

WASHINGTON—Congressional conferees last week killed a provision in a House-passed defense spending bill, H.R. 5006, that would have added hundreds of millions of dollars to major defense contractors' pension costs (*BI*, May 25).

Companies doing more than \$100 million in business with the Defense Department would have been required to provide special benefits to workers age 55 and older with at least 10 years of service who were laid off because of defense budget cutbacks.

The Senate bill, S. 3114, did not include such a requirement.

Wyatt settles with liquidator

NASHVILLE, Tenn.—The Wyatt Co. has agreed to pay \$2.75 million to settle a suit by the liquidator and receiver of Petroleum Marketers Mutual Insurance Co., a risk retention group that wrote underground storage tank liability coverage.

The lawsuit, filed by the Tennessee insurance commissioner, sought damages allegedly caused by services Wyatt provided to Petromark. An early 1990 Wyatt review found that the risk retention group was underreserved and needed to increase its reserves to \$33 million from \$10 million to meet outstanding claims (*BI*, Feb. 19, 1990). In quarterly reviews over the preceding two years, Wyatt had recommended only minor reserve increases.

Liquidation proceedings began in May 1990 after Petromark, then the second-largest market for petroleum tank coverage, failed to raise sufficient new capital (*BI*, April 16, 1990).

Under the settlement agreement, the receiver will release all claims against Wyatt relating to its service to Petromark. In addition to the \$2.75 million Wyatt will pay to the receiver, the consultant will release all claims against Petromark's estate and the commissioner and relinquish claims for \$156,404 in unpaid services.

EPA waste proposal withdrawn

WASHINGTON—The Environmental Protection Agency last week withdrew its proposal to relax its definition of hazardous waste.

The agency proposed last April to no longer consider as hazardous waste certain waste mixtures containing only a small amount of hazardous material.

But, the EPA withdrew the proposal because it "was severely criticized by all parties, including industry," a spokeswoman said.

The proposal was prompted by a December 1991 ruling by the U.S. Court of Appeals for the District of Columbia that "dismissed a major component" of the EPA's hazardous waste regulation introduced in 1980. The court ruled the agency did not provide a sufficient comment period when it introduced its so-called "mixture and derived rule." That rule states that all mixtures containing any amount of hazardous material are considered hazardous.

After the appellate court ruling, the EPA reinstated the rule on an emergency basis. But, in April it proposed adopting its relaxed rule in 1993.

The EPA now plans to meet with representatives of "environmental groups, industry and the states to solicit their input" on promulgating a rule governing hazardous wastes in mixtures.

Briefly noted

Dennis H. Chookaszian took over as chairman and chief executive officer of CNA Insurance Cos. last week, succeeding Edward J. Noha. Mr. Noha was named chairman of parent CNA Financial Corp., succeeding Laurence A. Tisch. Mr. Tisch is now CNA Financial Corp.'s CEO. . . . Congressional conferees were meeting over the weekend to hammer out a **compromise tax bill**. Tax bills passed last week by the Senate and earlier by the House contain numerous pension simplification and other employee benefit provisions. . . . The House failed by 27 votes last week to override President Bush's veto of **family leave legislation**, S. 5 (*BI*, Sept. 21). The Senate had earlier voted to override the veto. . . . First Insurance Co. of Hawaii Ltd., the state's largest insurer, estimates its gross losses due to **Hurricane Iniki** at \$275 million. The company said it had a "comprehensive reinsurance program". . . . Pennsylvania's General Assembly will convene today for a special session to consider pending bills on **workers compensation** and health care for uninsured children. . . . The Illinois Insurance Department has notified George E. Foundos, president of Chicago-based **Quill Marine Insurance Brokers Inc.**, that it will not renew his agent's license. Mr. Foundos—who has 30 days to request a hearing—is involved in litigation with Royal Insurance Co. of America over a block of excess liability business on which Royal claims it was defrauded (*BI*, July 20). . . . A Tennessee administrative law judge has denied the **25% workers compensation rate hike** requested by the National Council on Compensation Insurance. But, the judge acknowledged that current rates are too low. . . . The NCCI is seeking an average 17.1% increase in pure **workers compensation premium** in Maryland. . . . American International Group Inc. has sold its **Paul Napolitan Co.** reinsurance brokerage unit to Marsh & McLennan Cos. Inc. M&M's Guy Carpenter & Co. Inc. unit is the largest U.S. reinsurance broker. . . . The Virginia State Corporation Commission has approved a state insurance department plan under which Hartford Life Insurance Co. will assume up to 184,000 annuity contracts and life/health insurance policies previously written by the defunct **Fidelity Bankers Life Insurance Co.** of Richmond, Va. . . . A Pennsylvania judge has ordered the liquidation of Pottsville, Pa.-based **National Security General Insurance Co.**, an accident and health insurer that wrote only in Pennsylvania. The insolvency is estimated at between \$1 million and \$4 million.

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