SEPTEMBER 23, 1991

Business Insurance®

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

Update

Work comp insurers conspired to repeal Maine rate limits: Suit

BANGOR, Maine—Thirteen Maine employers are charging that the National Council on Compensation Insurance and 14 workers compensation insurers have violated antitrust law.

The employers allege that the defendants conspired in 1987 to coerce the repeal of a 1985 state law limiting rate increases. The suit, filed on behalf of all insured employers in Maine, seeks class-action status.

"The conspiracy included an agree-

Continued on next page

MEWA fraud, abuse growing: GAO study

400,000 left without coverage since '88

By JERRY GEISEL

WASHINGTON—Fraudulent or mismanaged multiple employer welfare arrangements have left more than 400,000 workers and their dependents stuck with more than $132 million in unpaid medical claims since 1988, the General Accounting Office reports.

Of the unpaid claims left by the nearly 200 MEWAs since 1988, state regulators have been able to recover only about $10 million on behalf of beneficiaries, the GAO says.

"MEWA problems are both widespread and growing," asserted Gregory J. McDonald, the GAO's associate director for income security issues, as he released preliminary results of a new GAO study.

The study, based on phone interviews in May with state regulators and presented last week before the House Retirement Income and Employment Subcommittee, is the first to detail the scope of the problems created by fraudulent or mismanaged MEWAs.

After hearing the results of the GAO survey, angry subcommittee members blamed MEWA problems —especially those caused by self-funded or partially insured programs—on a "black hole" of regulatory uncertainty.

"These self-funded plans seem to have found refuge in a black hole of ambiguous authority between state and federal regulators," said Rep. Sherwood Boehlert, R-N.Y.

"The black hole has lured in numerous unsuspecting companies, leaving thousands of people with unpaid medical bills and insurance," he said.

Subcommittee Chairman William J. Hughes, D-N.J., who ordered the GAO study, worried that the damage caused by unscrupulous or poorly managed MEWAs may be even greater than indicated by the GAO.

"We don't know the full dimension of the problem," he warned.

Continued on page 59

35th Rendez-Vous de Septembre

Photo by Kathryn McIntyre

Reinsurers gathered in the Casino and other local landmarks.

From the cafes to seminars, gloom prevails

No major rate hikes seen until 1993

By GAVIN SOUTER and KATHRYN J. McINTYRE

MONTE CARLO, Monaco—Any significant increases in commercial insurance and reinsurance rates around the world are at least a year away, and many industry professionals don't expect significant increases until 1993.

Others, especially U.S. reinsurers, say they are operating as though market conditions will never change.

The huge increase in catastrophe reinsurance rates during the past 18 months has hardly nudged up direct insurance and lower-layer reinsurance rates.

Even if catastrophe reinsurance capacity shrinks even further at year-end, as some suspect, no one expects an immediate significant increase in insurance and lower-layer reinsurance rates.

These are the observations of reinsurers and brokers at a rather solemn Rendez-Vous de Septembre, held Sept. 9-14 in Monte Carlo.

With little prospect of improving profits, concern that adequate catastrophe protection won't be available in 1992 and the problems at Lloyd's of London on everyone's mind, there was little to celebrate at the 35th annual Rendez-Vous, the largest annual gathering of reinsurers worldwide.

"The mood is pessimistic," summed up Herve Cachin, general manager of Societe Anonyme Francaise de Reassurances in Paris.

Surprisingly, however, the conference organizers reported increased attendance.

The official attendance figure for the 1991 Rendez-Vous was 2,288 from 77 countries, an increase of 334 from 1,954 in 1990.

Most delegates, however, believed there were fewer people in

Continued on page 46

Ruling could cause premium hike

PBGC denied priority status in bankruptcy

By CHRISTINE WOOLSEY

NEW YORK—A federal court ruling may encourage employers to seek bankruptcy protection to avoid large underfunded pension liabilities, thus leading to higher pension insurance premiums for all employers with defined benefit plans.

The U.S. District Court for the Southern District of New York earlier this month ruled that the federal Pension Benefit Guaranty Corp. should not receive preferential treatment over the unsecured creditors of Dallas-based LTV Corp. LTV is seeking reorganization under Chapter 11 of the Federal Bankruptcy Act.

In a Sept. 13 decision, U.S. District Judge Kevin Duffy also declared that as long as LTV is in bankruptcy, the Department of Labor may not require the company to make minimum contributions to three underfunded pension plans.

LTV has been trying to avoid funding the plans for more than five years. LTV resumed funding the plans this spring (*BI*, May 6), but later stopped doing so when creditors objected.

The PBGC is appealing the district court decision to the 2nd U.S. Circuit Court of Appeals in New York.

In addition, the pension agency is calling on Congress to amend the federal bankruptcy code to, among other things, clearly give the agency priority status in bankruptcy proceedings and to require companies to continue contributing to underfunded plans while they seek reorganization.

Continued on page 58

Unusual ruling on pollution may aid many policyholders

By STACY ADLER

WASHINGTON—Policyholder attorneys nationwide are lauding a ruling by the U.S. Court of Appeals for the District of Columbia that cleanup costs are insured "damages" under the comprehensive general liability policy.

They say the unanimous decision, in which a three-judge panel interpreted Missouri law, is very unusual and highly significant because the court refused to follow a landmark ruling by the entire 8th U.S. Circuit Court of Appeals that cleanup costs are not "damages" under Missouri law (*BI*, March 7, 1988).

And, they are predicting that the decision will be influential nationwide because the District of Columbia Circuit is very well-respected.

Meanwhile, attorneys for insurers are considering whether they will seek review either by the entire appeals court or the Supreme Court.

But, Supreme Court review is highly unlikely because insurance contract interpretation is a matter of state law, attorneys for both policyholders and insurers agree.

In its sharply worded Sept. 13 decision, the District of Columbia Circuit said that while the 8th Circuit's decision in *Continental Insurance*

Continued on page 61

NEWSPAPER

Two employers take steps to cut retiree health liabilities
Page 3

Employers criticize proposal to limit employee surveillance
Page 3

Centre Re offers to acquire Bermuda financial reinsurer
Page 13

Update

Workers comp antitrust alleged

Continued from previous page

ment to withdraw from the Maine market and to intimidate and coerce other insurance companies to similarly withdraw from the market," charged Sidney St. F. Thaxter, an employers' attorney with Curtis Thaxter Stevens Broder & Micoleau in Portland, Maine.

The 1985 law reduced workers comp rates by at least 8% and froze rates through 1986. It also capped increases in 1987, 1988 and 1989 at 10% per year. But after that law was repealed, the employers charge, rates rose more than 25% in 1988 and 22% in 1989.

The employers filed suit Sept. 12 in U.S. District Court in Bangor.

Neither NCCI nor insurer spokesmen would comment until they could review the suit.

Employers have charged workers comp insurers in at least two other states with antitrust violation. Insurers in January agreed to pay $53 million to settle price-fixing charges brought by Minnesota employers (*BI*, Jan. 28). A pending Oklahoma suit charges insurers conspired to charge excessive premiums (*BI*, July 17, 1989).

Life insurers discuss safety net

NEW YORK—Executives of several life insurance companies are discussing the establishment of an industry-backed emergency fund to provide short-term help to life insurers facing cash flow problems.

The fund would be used to prevent insurers from being driven into insolvency by a rash of massive policy surrenders like the one that crippled Mutual Benefit Life Insurance Co. in July (*BI*, July 22).

The American Council of Life Insurance in Washington, D.C., confirmed that life insurance executives are exploring "yet another layer of protection through some type of liquidity mechanism," although the ACLI raised doubts about whether such a plan would succeed.

"Initial exploratory discussions of a liquidity mechanism by industry technicians have confronted obstacles that may well prove insurmountable," the ACLI said in a statement.

Asbestos cover trigger

ANNAPOLIS, Md.—Liability policies are triggered when a person first inhales asbestos fibers, Maryland's highest court has ruled.

In adopting to so-called "exposure" theory, the Maryland Court of Appeals on Sept. 12 joined the vast majority of courts nationwide that favor policyholders on this trigger of coverage issue.

In this case, Baltimore-based Maryland Casualty Insurance Co. argued that its policies were triggered decades after the initial exposure to asbestos, when asbestos-related diseases have become manifest.

The trial court agreed, and since all the Maryland Casualty policies expired before any of the claimants diseases' manifested, the court found there was no coverage.

Reversing that ruling, the Maryland high court said: "We align ourselves with the overwhelming weight of authority in the country and conclude that 'bodily injury' occurs when asbestos is inhaled and retained in the lungs."

Giving the Maryland high court ruling added significance is the fact that the nation's largest asbestos personal injury lawsuit, which combines 9,000 claims, is pending in Baltimore. If those plaintiffs are successful, the defendants may be able to tap more of their liability coverage as a result of this recent ruling.

For now, the ruling means that Maryland Casualty must provide a defense and indemnification to its policyholder, Lloyd E. Mitchell Inc., a mechanical contractor that was involved in the sale, distribution and installation of products containing asbestos.

Mitchell, which purchased comprehensive general liability coverage from Maryland Casualty from 1977 to 1978, has been named in dozens of lawsuits claiming bodily injury from exposure to asbestos products.

N.Y. liquidation bureau blasted

NEW YORK—The New York Insurance Department's liquidation bureau lacks adequate controls to ensure the proper payment of claims against insolvent insurers, an audit by state Comptroller Edward V. Regan charges.

Errors and irregularities in payments have gone undetected due to inadequate bureau oversight, the audit says. The audit found that "thousands" of checks totaling $1.6 million—some as much as 10 years old—are listed as uncashed on bank reconciliations.

"We feel our claims operation is basically sound," said Deputy Superintendent Kevin Foley. "We have very, very sound controls over how and why we pay claims and where the money goes."

Many past management problems have been corrected, and improvements suggested in the latest audit already are being considered, Mr. Foley said. He added that the problem of uncashed claim checks was raised in two previous audits and corrected.

Mr. Regan also released a critical audit of the bureau last year as Superintendent James P. Corcoran was leaving office (*BI*, Jan. 15, 1990).

Bill limits bank insurance sales

WASHINGTON—Interstate insurance sales and underwriting by banks would be heavily restricted under revisions to a bill approved by the House Energy and Commerce Subcommittee.

H.R. 6 prohibits subsidiaries of state-chartered banks from selling and underwriting insurance nationwide if the states in which they are based had not allowed them to do so as of June 1.

The bill deals a blow to Citicorp and Chase Manhattan Corp., which attempted to sell insurance nationwide through their Delaware affiliates. While a federal appeals court upheld a Delaware law that allows subsidiaries of state-chartered banks to sell and underwrite insurance nationwide, it did not do so until after June 1 (*BI*, June 17).

Small town banks that sell insurance, as federal bank laws allow, would also not be allowed to sell insurance nationwide.

The panel also voted to prohibit diversified national bank holding companies or affiliates from writing insurance, except credit insurance.

Continued on page 62

Guaranty funds offer to buy Executive Life

By JOANNE WOJCIK

HERNDON, Va.—In an unprecedented move, the National Organization of Life & Health Insurance Guaranty Assns. is offering to purchase Executive Life Insurance Co. outright rather than simply pay benefits to policyholders.

Under the plan, Executive Life policyholders—including pension plans that purchase guaranteed investment contracts—would receive substantially greater benefits than under an earlier buyout proposal led by French investor group Altus Finance (*BI*, Aug. 12).

The move was triggered by an exhaustive financial analysis of the troubled insurer by a team of experts drawn from member guaranty funds, insurers and consultants that showed "the Altus proposal significantly understates the value of the company," according to NOLHGA President Eden Sarfaty.

This is the first time the guaranty fund organization has attempted to take over a failed insurer, but the plan makes good economic sense because it will ensure that its members "will have ample financial capacity for other insolvencies should they arise," Mr. Sarfaty said.

The plan, if approved by a Los Angeles Superior Court judge, would replace an earlier agreement NOLHGA had reached with the California Insurance Department to assess insurers an estimated $1 billion to make most Executive Life policyholders whole (*BI*, Sept. 2).

Under the new NOLHGA proposal, a new stock insurer, dubbed GALICO, would be formed to run off Executive Life's business. But, the new insurer may sell off some of the troubled insurer's business, Mr. Sarfaty said.

NOLHGA would be the only shareholder of the new insurer, which will not write new business, he said.

While GALICO initially would be capitalized at $300 million, NOLHGA member guaranty funds would be prepared to assess insurers up to $1 billion to provide additional capitalization if needed, Mr.

Continued on page 62

Judge sides with A&A

Orders employees who joined Hall to stop soliciting clients

By JUDY GREENWALD

OMAHA, Neb.—Alexander & Alexander Inc. plans to seek damages from Frank B. Hall & Co. Inc. and 11 employees who defected from A&A to Hall, following an A&A court victory earlier this month.

On Sept. 9, Judge Donald Hamilton of the Douglas County, Neb., District Court issued a permanent injunction Sept. 9 forbidding the 11 former employees of A&A's Omaha office from soliciting business from A&A clients until October 1992, or two years after they left A&A.

Judge Hamilton is expected to set a date for a hearing on A&A's efforts to obtain unspecified damages from both the 11 former employees and from Hall.

Meanwhile, related litigation between the two brokerages is now before a federal appellate court in St. Louis and a federal district court in Providence, R.I.

The complex legal proceedings are the latest in a series of lawsuits dating back to 1988 concerning the defection of A&A employees to Hall (*BI*, Dec. 24, 1990; Feb. 27, 1989).

Frank B. Hall & Co. Inc. has hired numerous executives from A&A, including Hall Chairman Donald W. Bell, who had been senior vp and Eastern regional manager at A&A (*BI*, May 22, 1989).

Judge Hamilton's 16-page decision follows a six-day hearing on the case that began July 8, according to Michael Gallagher, senior attorney with A&A in Owings Mill, Md.

"We are particularly pleased with the results for both our clients and our employees," Mr. Gallagher said.

A Hall spokesman said the brokerage does "not agree with the decision" and is "reviewing the

Continued on page 61

RIMS says NAIC proposal may imperil many captives

By MEG FLETCHER

PITTSBURGH—A regulatory proposal tentatively endorsed by the National Assn. of Insurance Commissioners could hamper risk managers' use of captives, the Risk & Insurance Management Society Inc. contends.

The so-called gatekeeper proposal, still in draft form, calls for Congress to authorize the NAIC's Non-Admitted Insurers Information Office to determine whether non-U.S. insurers not licensed in the United States can conduct business anywhere in the nation (*BI*, April 22).

In addition, non-U.S. reinsurers that assume business from U.S. insurers would be required to win NAIIO approval before ceding companies could take credit for the reinsurance.

The NAIIO now reviews the financial qualifications of non-U.S. insurers that want to write surplus lines business in the United States.

The proposal aims to restrict the ability of financially shaky offshore insurers and reinsurers to operate in the United States. But in doing so it would "wipe out" most offshore captives by forcing them to meet the same requirements as non-U.S. commercial insurers and reinsurers, said Paul Brown, director of governmental affairs for RIMS in New York.

The latest version of the proposal was discussed last week at the NAIC's quarterly meeting in Pittsburgh.

Also on the agenda were changes to a proposed NAIC model law to limit fronting arrangements. Critics of this proposal say that it would restrict the ability of captives to reinsure fronted programs (*BI*, April 15; April 8).

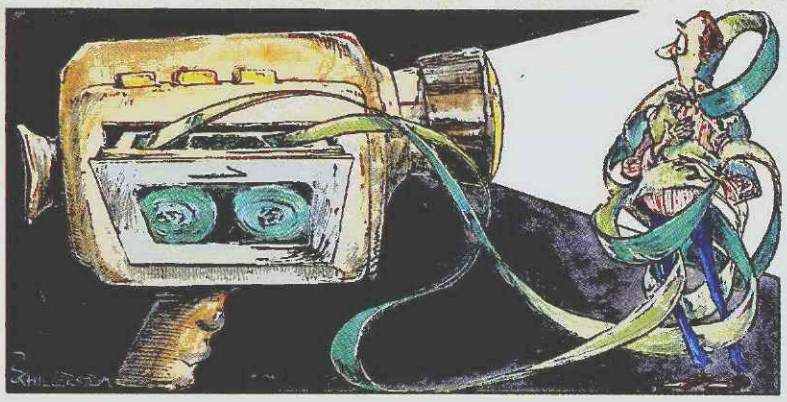
While the NAIC in April tentatively endorsed the development of the gatekeeper proposal into fed-

Continued on page 62

Inside

Departments

Vol.25, No.38—*Business Insurance* (ISSN 0007-6864) is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207-3185; 800-678-9595 or 313-446-1611.



Bill would limit surveillance of comp claimants

By MEG FLETCHER

WASHINGTON—Opponents of pending legislation to protect employee privacy say provisions restricting electronic monitoring and surveillance of employees could have broad, unintended consequences on workers compensation claim investigations and plant security.

The legislation could, for example, make it impossible for employers to videotape workers comp claimants in efforts to detect fraudulent claims.

The legislation also could prevent employers from using closed-circuit monitoring of the interiors and exteriors of company buildings, opponents of the bill say.

The bill's opponents are contacting employers and insurance industry representatives for help in lobbying legislators before a House subcommittee votes on the measure early next month.

The House bill, H.R. 1218, was introduced in February by Rep. Pat Williams, D-Montana. The proposal was referred to the House Labor-Management Relations Subcommittee, which is chaired by Rep. Williams.

The subcommittee is expected to mark up the bill and vote on it either Oct. 1 or Oct. 9, said Jon Weintraub, the subcommittee's staff director. He predicted that legislators would amend the bill's current language, but could not

Continued on page 17

Kentucky seeks to bar insurers

Suit names 15 offshore companies

By DOUGLAS McLEOD

FRANKFORT, Ky.—The Kentucky Insurance Department is trying to shut down 15 offshore insurers it charges are sham corporations operated by a businessman with offices in Lexington, Ky.

The Insurance Department filed suit earlier this month against Robert R. Campbell, charging that he has used the unlicensed offshore insurers to write business illegally across the country.

The suit, which also names the 15 insurers and two insurance holding companies as defendants, seeks a permanent injunction barring Mr. Campbell and the companies from further illegal insurance activity.

Kentucky regulators also are seeking a court order that unpaid claims on existing policies must be paid by Mr. Campbell, his companies and anyone involved in placing business with the companies, including agents and brokers.

The offshore insurers are believed to have written tens of millions of dollars of commercial property/casualty premiums in several states.

Meanwhile, *Business Insurance* has learned that one of the offshore companies—Northern Commercial Fire & General Insurance Co. Ltd. of Anguilla—has tried to pay hundreds of claims totaling about $2.8 million with apparently worthless drafts issued by an entity called Eastech International Bank.

Although the drafts show a Dallas address for Eastech, at least two claimants who have sent the drafts to Dallas for collection have had them returned marked "addressee unknown," lawyers for the claimants say.

Information on the Eastech

Continued on page 18

Retiree health care costs

GE hopes to limit expenditures after 1994

By LORI BLOCK

FAIRFIELD, Conn.—A new labor contract will help General Electric Co. contain its retiree health care liabilities beginning in 1995.

The pact says that GE's contributions to its retiree health plan will be capped at their 1994 levels during subsequent labor negotiations.

Under the three-year collective bargaining agreement with two unions, the Fairfield, Conn.-based company will make regular contributions to its self-funded retiree health plan through 1994.

Beginning in 1995, the agreement establishes that the company's total per-employee contributions will be limited to its per-employee costs in 1994.

This agreement, which expires June 30, 1994, could be altered under a new collective bargaining agreement, but it gives GE a new bargaining chip.

GE and consultants expect the pact will help the company corral retiree health care obligations.

The retiree health care cap is "part of GE's overall efforts to manage health care costs," said Larry G. Cook, GE's consultant-insurance plans.

Consultants say the cap will help improve the company's finances as it begins complying with Financial Accounting Standards Board Rule 106 on recognizing retiree health care obligations on financial statements.

GE announced last week it will take a one-time charge—$1.8 billion in the first quarter of 1991 against restated earnings—to recognize accumulated retiree health care obligations under the new accounting rule. Taking the one-time charge, rather than amortizing the obligations over up to 20 years, will strengthen GE's long-term financial position, consultants say.

GE reached the labor agreement with the International Union of Electronic, Electrical, Salaried, Machine and Furniture Workers and the United Electrical Workers. Those union workers—along with other union workers—comprise less than 30% of GE's 235,000 domestic employees. However, the cap will cover "most" of its domestic employees, he said.

Through June 1994, retirees are actually to receive improved benefits, including additional preventive care, dental and life insurance coverage.

"What we have done is negotiate a limit on our future obligations," Mr. Cook explained.

GE's contributions are now based on what retirees earned while employed. "The more money you make, the more your contributions are," Mr. Cook said.

GE would not detail the financial impact of the cap on retiree health care liabilities.

But, Harry Purnell, a principal with A. Foster Higgins & Co. Inc. in Princeton, N.J., pointed out that the cap "eliminates the medical (inflation) trends assumption beyond the point benefits are capped. In an uncapped environment (the trend) extends for a very long time."

Mr. Cook stressed "the ultimate amount we contribute is still subject to (future) collective bargaining."

Even so, the pact still represents a significant

Continued on page 6

Media firm eliminates cover for new workers

By LOUISE KERTESZ

RICHMOND, Va.—Media General Inc. is eliminating retiree medical coverage for new employees and is capping its contributions toward medical coverage for future retirees already working at the company.

These changes, coupled with a voluntary early retirement plan, are expected to save the Richmond, Va.-based newspaper and broadcasting company about $6 million annually.

Media General is overhauling its retiree health care plan because it "just could not afford paying for that high level of benefits," considering "the inflation factors driving up costs," said Page Cooper, the company's assistant secretary and director of employee benefits.

In addition, the changes will allow the company to limit the amount of retiree health care liabilities it will be required to recognize on its financial statements beginning in 1993, Mr. Cooper said.

Had it not scaled back its retiree health care program, Media General would have had to recognize approximately a $9 million annual retiree medical liability beginning in 1993, Mr. Cooper said.

How much that liability will be lowered depends on how many people take the early retirement offer, he said.

Media General is among many companies, like General Electric Co. (see accompanying story), trying to limit their future retiree health liabilities, which will have to be reported on financial statements under new Financial Accounting Standards Board Rule 106.

The rule, which takes effect in 1993 for large employers, requires that companies accrue as an expense against earnings their retiree health care liabilities from the date an employee is hired until the employee is eligible for benefits. Differences between accrued expenses and actual benefit payments also will have to be recognized on balance sheets.

Media General is not altering the health care plan covering its current 1,050 retirees. The company pays the full cost of that self-funded plan, though retirees pay varying levels of deductibles and coinsurance.

However, beginning in January 1992, Media General will cease offering retiree medical coverage to new employees. And, the company will limit the amount it contributes toward medical coverage for current employees when they retire.

Under its new plan, Media General will contribute $15 per month for each year of service, up to a maximum of 25 years, for employees who retire before age 65.

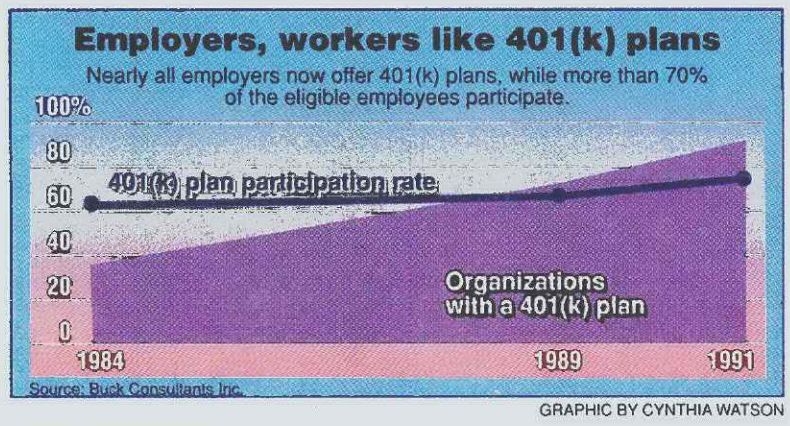
It will contribute $4 a month for each year of service for employees who retire at 65 or later, who are eligible for Medicare benefits.

Medical benefits are limited to retirees with at least 10 years of service.

In addition to limiting its contributions, Media General is offering employees who retire after January 1992 the choice of two plans. A high-option plan, with benefits similar to those retirees cur-

Continued on next page

Poll confirms rapid 401(k) plan growth



GRAPHIC BY CYNTHIA WATSON

By SARA J. HARTY

401(k) savings plans are approaching universal acceptance at U.S. companies, while the percentage of employees participating in the plans is growing.

However, employers responding to a survey by Buck Consultants Inc. point out that some government regulations have made 401(k) plans difficult to administer.

Some 91% of the 609 companies surveyed earlier this year by New York-based Buck offer a 401(k) plan, up from 72% of the employers surveyed by Buck in 1989 and only 36% in 1984.

"It's pretty clear that 401(k) plans have exhibited phenomenal growth. They have become a fixture in employee benefit schemes," said Fred Rumack, director of tax and legal services for Buck.

At the same time, the companies surveyed in 1991 reported that an average of 74% of the employees participate in their 401(k) plan, compared with a 66% participation rate in 1989 and a 62% participation rate in 1984, according to the survey.

According to the most recent survey, 63.1% of companies reported an employee participation rate between 71% and 100%, while 29.9% of the surveyed employers reported participation rates between 41% and 70% and only 7% of the companies reported less than 40% participation in their 401(k) plans.

Employees have learned the value of a 401(k) plan, Mr. Rumack said. When an employee leaves a company with a 401(k) plan, "he wants to make sure he can dupli-

Continued on page 20

Media General

Continued from previous page

rently receive, will require higher retiree contributions and a scaled-down plan will have "a lesser price tag for the coverage," Mr. Cooper said.

For example, the high-option plan has no deductible for care in a hospital or skilled nursing facilities and a 20% retiree copayment. For the low-end plan, the deductible is $500 and the copayment 35%.

Media General is reviewing its 1991 claims experience with the help of CIGNA Corp., its third-party administrator, "to determine what the premiums should be to generate the dollars to cover expected claims" in the two plans, Mr. Cooper said.

The overall Media General plan "evolved out of looking at a capped contribution approach by itself and low-option coverage by itself," said Alice Edmondson, a managing consultant with A. Foster Higgins & Co. in Washington D.C., who helped design the plan. The company feels the new arrangement "combined positive features of both" approaches, she said.

By offering retirees a chance to enroll in the low-option plan that requires a smaller retiree contribution, Media General has "actually tried to attack the cost-containment side as well. They've offered employees a chance to change their behavior a little and save themselves some money" Ms. Edmondson said.

"When you have higher deductibles, you're often less likely to use medical services than when you know it's paid for fully upfront," she said.

Media General "elected to bring costs under control by allowing employees access to roughly the same level of benefits" but increasing their cost burden, or allowing retirees to opt for a cheaper reduced benefit plan, said Steven Harrold, vp and principal with TPF&C, the consulting division of Towers, Perrin, Forster & Crosby Inc. in Atlanta. Mr. Harrold also worked with Media General on the plan.

The company decided that employees "would be more receptive to the changes if you offered them some choices so they can help manage the process," he said.

Mr. Harrold noted that Media General also considered limiting future retirees' total lifetime medical benefit to $50,000.

But that idea was rejected and the lifetime maximum remains at $1 million under both health plan options.

A lifetime cap would have hurt the retirees "most in need" of health care benefits, Mr. Harrold said. Media General's thinking was, " 'We'd rather spread the risk a little bit and not have the reduction in cost fall on those least able to support it.' They thought it was a humane approach."

Media General is not alone in attempting to control its retiree health care liabilities, others point out.

"The vast majority of organizations are doing something" in response to looming FAS 106 requirements and the rising cost of retiree health care, explained John Bauerlein, a consulting actuary with Hewitt Associates in Santa Ana, Calif.

But most employers are "continuing their current arrangements for current retirees," Mr. Bauerlein noted.

Basing contributions toward retiree medical coverage on years of service is "becoming a very common approach," Mr. Bauerlein said.

Indeed, many of the 463 employers that responded to a 1990 Hewitt survey said that over the next five years they will "definitely consider using length of service as a method for varying retiree medical coverage, with 32% tying benefit levels and 39% tying retiree contributions to length of service."

But 63% of the survey respondents said they "definitely would not consider. . .eliminating the retiree medical plan altogether."

Meanwhile, about 290 of Media General's 6,400 employees are eligible for the early retirement program.

Mr. Cooper said that while eligibility in the early retirement program will vary slightly by site, employees between the ages of 57 and 64 with at least 10 years service generally are eligible to opt for early retirement with enhanced defined benefit pension plan benefits.

Under the plan, those opting for the program will have five years of age and five years of service added to their pension calculation formula. In addition, early retirees will receive a $200 monthly payment until they reach age 65 and become eligible for Social Security benefits.

Normally, Media General employees over age 55 with 10 years of service can retire early, but with reduced pension benefits. However, the added age and service credits will mean that early retirees will receive the same benefits as if they waited until normal retirement age, Mr. Cooper said.

•

Associate Editor Michael Schachner in New York contributed to this story.

Oregon OKs 11% decrease in comp rates

SALEM, Ore.—Oregon Insurance Commissioner Gary K. Weeks' approval of an average 11% reduction in pure premium rates for workers compensation coverage is being hailed by the National Council on Compensation Insurance as "an example of the rewards of workers compensation reform."

The reduction—in conjunction with a 10% rate reduction previously announced by SAIF Corp., Oregon's state fund—will save employers $66 million over the next two years, the Oregon Department of Insurance and Finance estimates.

The rate reduction will take effect beginning Jan. 1, 1992. It marks the second year that Oregon has lowered workers comp rates (*BI*, Sept. 16). Rates for 1991 were decreased 12.2%.

Pure premium rates reflect the projected cost of workers comp claims during the coming year and represent about 70% of the cost of insurance. The remainder is made up of administrative costs.

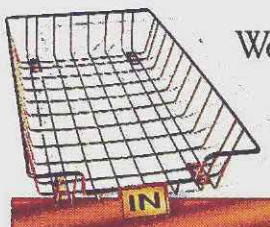
Major workers comp reform laws in 1987 and 1990 "tightened up the system to keep inappropriate claims out while increasing funding to those with legitimate injuries," said Mark Fryburg, executive assistant to Mr. Weeks. The laws also authorized the formation of managed care organizations for the treatment of injured workers (*BI*, May 28, 1990; July 20, 1987).

"The Oregon story is remarkable not only for the effort to contain workers compensation costs, but for preventing accidents from occurring in the first place," said NCCI President William Hager. "Over the last decade, even as the Oregon workforce rose by a quarter of a million, the number of disabling claims and fatalities actually fell."

"A vigorous enforcement effort" by Oregon Occupational Safety and Health, as well as efforts by employers and employees, is credited with reducing the number of accidents in the state's workplaces, Mr. Fryburg said.

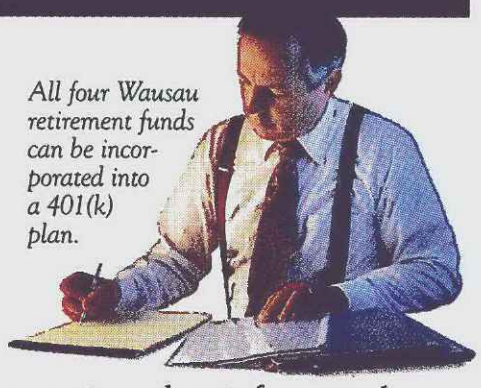
—By Louise Kertesz

TEAR OUT THIS PAGE FOR YOUR COMPANY RETIREMENT FILE. WITH A WAUSAU PENSION, IT MAY BE ALL THE FILING YOU'LL EVER DO.



We think business people have better things to do with their day than file paperwork and fill out complicated forms. Instead of handling questions about an employee's retirement fund, we assume they'd rather

be handling their own business. That's why more businesses are moving their companies' retirement funds to Wausau Insurance. Wausau handles the investing, the administration, the day-to-day bookkeeping, even those complicated IRS forms. But we don't stop there.



All four Wausau retirement funds can be incorporated into a 401(k) plan.

Our regional benefits specialists sit down with customers to pinpoint objectives. They make certain each plan is implemented properly — from conducting meetings that inform and familiarize employees, to assisting in the actual enrollment.

Wausau handles the retirement fund's paperwork, so you and your employees can look forward to retirement.

So, choose an employee retirement plan that emphasizes the growth of your company's pension fund, not the growth of its files. For more information, contact your Wausau account representative or Laureen Savage at the address below.

WAUSAU INSURANCE

Wausau Insurance Companies, 2000 Westwood Drive, Wausau, Wisconsin 54401-7881 Telephone (715) 842-6068 A Member of the Nationwide® Group

At issue

What are your risk management priorities for the new school year?

Mary C. Dewey
Acting Director, Department of Risk Management
The University of Vermont,
Burlington, Vt.

With ever-tightening budgets in higher education, we need to meet the ongoing challenge of controlling the cost of risk through aggressive claims management of self-insured claims, tough negotiation of insurance renewals, reevaluation of necessary excess liability limits and directing the most efficient use of funds toward internal loss control efforts.

Steven C. Holland
Director, Department of Risk Management
The University of Arizona,
Tucson, Ariz.

Many of the risk management issues facing business and industry today are also faced by institutions of higher learning. Our priorities include the steep escalation of environmental remediation costs and the prevention of future claims in this area. Another priority is addressing the variety of issues associated with new construction, renovations, and aging physical facilities.

Thomas R. Henneberry
Director of Insurance and Legal Affairs
Massachusetts Institute of Technology,
Cambridge, Mass.

Our basic risk management priorities are not unlike other private corporations'. Priorities include effectively positioning MIT with respect to insurance coverage and cost in anticipation of an approaching hard market; focusing on MIT's self-insurance of work comp; and ensuring that policies and procedures regarding alcohol are effectively understood by MIT's community.

Mary Breighner
Director, Risk Management
Columbia University,
New York

Our overriding priority will be to reduce the cost of risk. Employee safety training programs will be used to help decrease work comp accidents. Faster identification of claims that should be settled should help lower claim costs and expenses, including attorneys fees. Renewal negotiations, including competitive marketing, will be used to decrease overall premium costs.

Compiled by Sara Harty

Retiree health care

Continued from page 3

management victory because the issue of health care benefits is now on the negotiating table, consultants said.

"In general, there's probably an expectation by both employees and GE that contributions aren't going to be fixed forever," Mr. Purnell said. But now, management has more control over any future increases, he said.

The agreement is a relatively new cost containment tool for GE, he said. Traditionally, the idea of cutting benefits or boosting employee contributions has been kept off the negotiating table, he explained.

While the cap has other financial implications, "the real dollar impact is it positions (GE) so well in future negotiations," agreed Richard Ostuw, a vp in Cleveland with TPF&C, a unit of Towers, Perrin, Forster & Crosby Inc.

With the cap, GE's contributions are fixed. The only portion of future retiree health care cost inflation that GE will have to pick up is that amount the unions can negotiate, he explained.

GE has set the stage for passing on "automatic and open-ended increases" in retiree health care costs, said Stewart D. Lawrence, senior vp of Martin E. Segal Co. in New York. Any cost increases "will automatically flow through to the employee."

The cap was a "workable agreement," particularly since it will be subject to future negotiations, said Joseph Cowell, secretary of the IUE-GE Conference Board in Lexington, Ky.

But, regardless of the outcome of future collective bargaining, the cap will still help GE "put forward a more attractive bottom line" in the face of FAS 106, Mr. Purnell said.

Under FAS 106, which takes effect in 1993 for large employers, companies will have to accrue as an expense against earnings their retiree health care liabilities from the date an employee is hired until the employee is eligible for benefits. Differences between accrued expenses and actual benefit payments also will have to be recognized on balance sheets.

But, Mr. Cook stressed that the "cap was not established solely in response" to FAS 106, even though GE announced last week it would take a one-time, $1.8 billion aftertax charge against first-quarter earnings in response to FAS 106. The one-time charge represents less than 10% of the company's equity.

Restating its first-quarter earnings will turn a $999 million profit into a net loss of $801 million.

But, GE says the charge will not hurt cash flow, and it already has been informed by rating agencies that the adjustment will have no impact on its triple-A debt ratings.

In its statement, GE said that "despite a difficult economy, GE's wide diversity of businesses and continuing strong productivity gains should result in earnings per share increases for the third quarter, fourth quarter and full year 1991 before the effect of this accounting change."

International Business Machines Corp. of Armonk, N.Y., took a one-time $2.3 billion charge against its first-quarter earnings to recognize its accumulated retiree health care obligations (*BI*, April 1).

By taking the charge and putting the cap in place, GE has done about all it can to "minimize the long-range impact (of FAS 106) on its income statements," said Patricia Wilson, a principal with A. Foster Higgins & Co. Inc. in Philadelphia.

"Without the caps, it is still probable—almost certain—that the accounting expense will be higher than what it was before 106 because you are reflecting the long-range implications of rising health care inflation."

TPF&C's Mr. Ostuw predicted that more companies in strong financial positions, like GE and IBM, will take the one-time charge since they can "absorb it with little impact."

And, companies in severe financial straits also may opt for a one-time charge to "get it out of the way while (the company) looks bad." ■

Get on the winning T.R.A.C.

with Reliance National

Reliance National introduces the Technical Risk Account Concept (T.R.A.C.) to the oil and gas industry.

Products Available:

- Property
- Worker's Compensation
- General Liability
- Automobile Liability
- Boiler & Machinery
- Marine

THE CHOICE

Reliance National
A Reliance Group Holdings Company
77 Water Street, New York, N.Y. 10005

For further information, please call us at 212-858-6356

Reliance National underwrites through: Reliance National Insurance Company, Reliance Insurance Company, Planet Insurance Company, United Pacific Insurance Company, Reliance Insurance Company of Illinois, and Reliance Insurance Company of New York.

Opinions

Funds' rocky state

STATE WORKERS compensation funds can play an important role in assuring that employers can find affordable coverage in an ever-tightening market. But, the funds also create other problems and cannot be viewed as a panacea for the nation's workers comp problems.

As we reported last week in a special issue on workers compensation, proponents of the state funds point out that they provide many policyholders—especially small businesses that commercial insurers shun—a chance to buy coverage in the voluntary market. In addition, they point out that their rates are often lower because state funds do not incur many of the expenses—like the necessity of producing a profit for shareholders—that commercial insurers must face.

We're in favor of anything that can reduce the bulging number of employers that are insured in the residual market, which is one of the biggest problems in the workers compensation system. And at a time when workers comp premium rates are spiraling across the nation, any savings for policyholders is an important factor.

However, state funds face many problems that could hurt rather than help policyholders. First and foremost, like many skeptics, we question whether some funds charge realistic rates. For instance, the Colorado fund is still trying to make up a nearly $200 million deficit created by unrealistically low rates in the early 1980s.

Secondly, some state funds are suffering because they are indeed state agencies, subject to interference from legislators and bureaucrats. West Virginia's monopolistic state fund, for instance, reported a $400 million deficit at year-end 1989 because of a 30% rate cut mandated by the governor in 1985 and a subsequent rate freeze.

In addition, the huge piles of cash held by state funds—necessary to pay future claims to injured employees—often prove irresistible to state legislators looking for new ways to balance the budget. Oregon's state fund nearly became insolvent after the state removed $81 million in reserves in 1982. And cash-hungry New York legislators have "borrowed" $1.3 billion from that state's fund since 1981. The fund likely will need that money to pay claims, and we suspect it will be forced to raise rates to cover the shortfall rather than collect the entire loan from the state. Or, if that does not

occur, the fund must have been charging excessively high rates to build up such a surplus. Either way, policyholders are losers.

With such controversy surrounding state funds, we also wonder whether the state funds that Texas and Louisiana officials envision will really help ease the grave residual market problems in both states. While commercial insurers, and thus their policyholders, are no doubt overjoyed at the prospect of being released from the huge residual market losses in both states when the state funds take over that role for the future, how will the funds be able to cover the residual market deficit that commercial insurers find unbearable?

Proponents of the funds argue that shifting the residual market burden from commercial insurers will entice more insurers to voluntarily write workers comp business, thus reducing the number of policyholders in the residual market. While this sounds reasonable, there still will be employers in both Texas and Louisiana insured by the fund whose losses exceed their premiums due to the nature of their risks and the fundamental problems that still exist in both states' workers comp systems. And, while, presumably, the funds could ask legislators for a bailout, how likely is that, given the current budget problems of all states?

Letters

Gentlemanly ideals far cry from gloves-off reality

To the editor: As an attorney who handles both reinsurance arbitration and litigation, I was surprised to read Ronald A. Jacks' Perspective article, "Arbitrating Reinsurance Disputes," in which he argues that, despite a "great deal of errant nonsense being perpetrated these days," arbitration is superior to litigation for settling reinsurance disputes (*BI*, Sept. 2).

Maybe it ought to be so, or even once was, but the stated idealistic views of the arbitration process are a far cry from the way it is.

Yes, reinsurance arbitration can work on a gentlemanly level as described in the article, when the parties to the dispute are not particularly adversarial, but those disputes are mostly going to settle anyway. In the more usual, hard-fought, protracted situation, the arbitration war is no less expensive than litigation, no quicker and, unfortunately in many cases, a lot less fair.

Part of the difficulty with arbitration lies in the realization that it is not a judicial process at all.

In hotly contested disputes (and which one isn't?), it becomes much more of a political process, as evidenced by the fact that the most important event in many an arbitration is the selection of the umpire, an event that frequently far overshadows the presentation of the legal issues of the dispute. Indeed, selection of the umpire can often be the point at which an arbitration is really won or lost.

Every lawyer who practices in this area can cite examples of outrageous injustice in the results of one or more big reinsurance arbitrations. Although injustices can also occur in litigation, at least a court is forced to justify a decision and have it subject to appellate review. In arbitration, you have no appeal and may not even know why you lost.

I am not convinced that the parties entering into a reinsurance contract containing an arbitration clause are always fully aware of just what they are giving up.

While the judicial process is far from perfect (and reinsurance companies in particular seem to be taking some real judicial beatings as of late), the level of fairness in court is generally far higher than what intensely adversarial parties will come up with on their own, away from the courthouse.

The traditional arbitration trade-off of litigation's guarantees of fairness in exchange for the supposed expediency, convenience and low cost of the proceedings is now just a myth, particularly in light of the rather ugly way in which the reinsurance arbitration creature has grown up. While arbitration certainly still has a valid place in the reinsurance world, it frankly has been way oversold.

John H. Haley
Bickford Hahn & Haley
New York

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

Business Insurance®
Reporting weekly for corporate risk, employee benefit and financial executives

Publisher: Alfred Malecki *(New York)*

Associate Publisher/Editor: Kathryn J. McIntyre, A. R. M. *(Chicago)*
Managing Editor: James M. Burcke *(Chicago)*
Senior Editor: Jerry Geisel *(Washington)*
Assistant Managing Editor: Dave Lenckus *(Chicago)*
Assistant Managing Editor/Graphics: Jeanne M. Bartels *(Chicago)*
CHICAGO: Karen Armaganian *(Editorial Assistant)*, Lori Block *(Associate Editor)*, Karen Brown *(Assistant to the Editor)*, Meg Fletcher, A.R.M. *(Associate Editor)*, Sara J. Harty *(Staff Reporter)*, Nancy Johnson *(Copy Editor)*, Kathryn M. Larrabee *(Copy Editor)*, Laura Mazzuca *(Agent/Broker Topics Associate Editor)*, Sarah E. Polster *(Directory Editor)*, Roger Schillerstrom *(Editorial Cartoonist)*, Deborah Shalowitz *(Associate Editor)*, Timothy Stanton *(Copy Editor)*, Paul Winston *(Copy Desk Chief)*, Christine Woolsey *(Associate Editor)*
DALLAS: Michael Bradford *(Associate Editor)*
LONDON: Stacy Shapiro *(International Editor)*, Gavin Souter *(Associate Editor)*
LOS ANGELES: Joanne Wojcik *(Bureau Chief)*, Louise Kertesz *(Associate Editor)*
NEW YORK: Douglas McLeod *(Bureau Chief)*, Stacy Adler *(Associate Editor)*, Michael Schachner *(Associate Editor)*
SAN JOSE: Judy Greenwald *(Associate Editor)*
WASHINGTON: Mark A. Hofmann *(Associate Editor)*

Advertising Director: Martin J. Ross *(New York)*
Midwest Sales Manager: Robert L. Niesse *(Chicago)*
CHICAGO: Deborah D. Neale *(District Manager)*, Margaret Hikido *(District Manager/ Classified Sales)*, Elmer Kerstowske *(Production Manager)*
NEW YORK: Charles A. Horvath *(District Manager)*, Jack Forrest *(District Manager)*, Kathryn Premetz *(District Manager)*, Cynthia Bykowski *(District Manager)*
LOS ANGELES: Michael J. Sharpe *(Western Advertising Manager)*

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

EDITORIAL: Chicago: 312-649-5398; Dallas: 214-363-1066; London: 71-608-1172; Los Angeles: 213-651-3710; New York: 212-210-0140; Washington: 202-662-7200
ADVERTISING: New York: 212-210-0228; Chicago: 312-649-5276; Los Angeles: 213-651-3710
COMMUNICATIONS: New York: 212-210-0132
CIRCULATION: Detroit: 313-446-1611

Published by Crain Communications Inc., Chicago

G.D. CRAIN JR. Founder (1885-1973)
MRS. G.D. CRAIN Chairman
S.R. BERNSTEIN Chairman-executive committee
RANCE CRAIN President
KEITH E. CRAIN Vice chairman
MARY KAY CRAIN Treasurer
MERRILEE P. CRAIN Secretary
WILLIAM A. MORROW Executive Vp-operations
WILLIAM STRONG Vice president-circulation
ROBERT C. ADAMS Vice president-production
H.L. STEVENSON Corporate editor
PENELOPE A. GEISMAR Corporate communications mgr.

Published weekly at 740 Rush St., Chicago, Ill. 60611-2590, Telex 6871241, Fax 312/280-3174, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017-5806, Telex 640207, Fax 212/210-0704, CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231-6415, Fax 214/696-1936; Suite 814, National Press Building, Washington, D.C. 20045-1801, Fax 202/638-3155; 6500 Wilshire Blvd., Suite 2300 Los Angeles, Calif. 90048-4947, Fax 213/655-8157; Cowcross Court, 2nd Floor, 75-77 Cowcross St., London EC1M 6BP, England, Fax 71/608/1173. $2.00 a copy. $80 a year in U.S. Canada and all other foreign add $38 for surface mail. Europe and Middle East only add $105 for air delivery. First-class mail to U. S., add $95; to Canada add $105. Bermuda only, $180 per year expedited delivery. SHEILA GORMLEY, circulation manager. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich., 48207-3185, or phone 800-678-9595 or 313-446-1611, Fax 313/446-1650. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48013. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691.

A Publication of: Crain Communications Inc
1916-1991 75th Anniversary 75 Years of Publishing Leadership

VBPA Member of Business Publications Audit of Circulation ABP

We cover more disasters than the networks.

A disaster needn't be world-shattering to rate our attention. For every insured who suffers a loss, there is an impact on the balance sheet of a ceding company.

As a world-class reinsurer dedicated to supporting our clients and their commitment to their insureds, we strive to help ceding companies as quickly as possible.

Allstate Reinsurance provides sophisticated Underwriting, Actuarial, and Surety services upfront. After a property, casualty or surety loss, we stand ready to help with claim consultants — expert professionals whose personal involvement and counsel can assist you in reaching fair and proper settlements.

We aim to meet claims payment expectations, often within 48 hours, frequently via direct wire transfer to ceding companies or intermediaries.

No other non-direct writer can match our combination of financial strength, technical knowledge and superior professional services.

A fact that may not make the evening news. But could be very important to your business.

Allstate®
REINSURANCE

2 Allstate Commercial Plaza, 51 West Higgins Rd., South Barrington, IL 60010 (708) 551-2500 Telex: 283513 or 253177 Fax: (708) 551-2844


K
I
J
C
L
B
A
N
NETHER LAND
LOAD

WE'D LIKE TO CLEAR UP SOME FAR-FLUNG MISCONCEPTIONS ABOUT FINANCIAL REINSURANCE

Everywhere you turn, it seems, someone is launching a new financial reinsurance product.

While this dramatically increases an insurer's reinsurance options, it also breeds confusion. Centre Re would like to clear the air.

Since 1988, we've written $1.2 billion in finite risk reinsurance.* While we are proud of this achievement, it is our creativity and ability to complete complex transactions that distinguishes Centre Re as the leading financial reinsurer in the world.

"Finite risk" doesn't mean "no risk." We look for opportunities where risk is ample, but clearly defined and fairly priced. Often, these can be complicated situations that traditional reinsurance cannot adequately address.

We structure contracts that are flexible and efficient, so that our clients derive, over the term of our relationship, the most financial stability and capacity their reinsurance premium can buy.

We limit our liability in these transactions but, in exchange, offer our clients the possibility of sharing in the profitability of a contract.

These and other financial benefits of finite risk reinsurance are explained in our 1990 annual report, "The Changing Face of Reinsurance." For your copy, please call us at 809-295-8501. In London, call 071-283-8049.

**Reinsurance volume for 1990 totalled $617 million. Assets at 6/30/91: $1.6 billion.*

Centre Re

Innovation in Reinsurance

For more information, contact us through your reinsurance intermediary.

Prospects for product liability bill cloudy

By MARK A. HOFMANN

WASHINGTON—Federal product liability reform legislation will win Senate approval—if it ever reaches the full Senate, predicts Sen. John D. Rockefeller IV, D-W.Va.

However, Sen. Rockefeller, one of the co-sponsors of S. 640, the Product Liability Fairness Act of 1991, made clear that he does not necessarily expect the proposal to reach the Senate floor any time soon.

Harkening back to the federal Medicare law, the Clean Air Act and other legislation that took years or even decades to pass, Sen. Rockefeller noted "a lot of things take a lot of time."

His remarks came during a Sept. 12 hearing on the product liability bill before the Consumer Subcommittee of the Senate Commerce, Science and Transportation Committee.

But, after listening to an exchange during the hearing between U.S. Commerce Secretary Robert Mosbacher and Commerce Committee Chairman Sen. Ernest F. Hollings, D-S.C., another senator expressed doubts that the bill would win Senate approval.

Sen. John McCain, R-Ariz., said wistfully: "I wish I could share the optimism of my friend from West Virginia."

Sen. Hollings made clear at the hearing that he felt enough time had been spent on the bill and on the whole issue of product liability reform.

"We've been on this thing for nine years," Sen. Hollings said. Time had not improved proponents' arguments, the senator said, asserting that some provisions of S. 640 represented a step "back to the Star Chamber." The Star Chamber was an infamous 17th century English secret court that decided the fate of defendants without benefit of a jury.

The subcommittee heard testimony on the possible impact of current product liability law on, among other things, manufacturers' ability to compete with foreign firms.

S. 640, introduced in March by Sen. Robert Kasten, R-Wis., is identical to S. 1400, which died without full Senate action during the 100th Congress (*BI*, March 18; July 31, 1989).

Like its predecessor, S. 640 would:

- Eliminate joint and several liability for non-economic damages in product liability cases.
- Place time limits on when a product liability suit can be filed. Those limits would depend on the age of the product and when the injury or its cause was discovered.
- Give greater protection to wholesalers and distributors as well as federally certified products.
- Make it tougher to recover punitive damages.
- Encourage expedited settlements through the use of alternative dispute resolution mechanisms like arbitration.
- Provide that if a plaintiff declines a defendant's settlement offer, the plaintiff must pay the defendant's legal fees if a judgment of less than the settlement offer is returned.

Similarly, defendants who refuse offers from plaintiffs would have to pay plaintiffs' legal fees when awards were higher than such offers.

This provision led Sen. Hollings, a consistent opponent of federal product liability reform legislation, to charge that the act would amend the Seventh Amendment of the Constitution, which provides the right to a jury trial.

Sen. Hollings called this provision "absolutely outrageous." The bill "undertakes to punish the citizen" who takes his case to a jury rather than accept a proposed settlement, he said.

Sen. Hollings also used his opening remarks to blast charges made recently by Vice President Dan Quayle and others that the United States has too many lawyers and too few engineers (*BI*, Aug. 19).

"I can tell you there were a lot more engineers in Adolf Hitler's Third Reich than there were lawyers," Sen. Hollings said.

Mr. Mosbacher, speaking for the Bush administration, made clear that he did not share Sen. Hollings' assessment.

"I hope and pray that this gets a chance to be debated by the full Senate," he said. "This is certainly not a panacea, but it's one more important step toward making us more competitive worldwide," Mr. Mosbacher said.

Small businesses are hurt the most by product liability laws, which now vary from state to state, he contended. Small firms pay proportionately more for product liability insurance and court costs than their larger counterparts, Mr. Mosbacher said.

He also charged that the current system discourages innovation.

Sen. Hollings replied that differing state product liability standards were not the cause of U.S. companies' difficulties with foreign competition.

"Let's get to the real problems in this country," he said, citing the federal deficit as one.

Mr. Mosbacher replied that "almost all" the business people he has spoken to recently agree that the lack of a uniform product liability standard "is a cost that's hurting U.S. business." He told the panel, "We've got to make some changes."

Sen. John Breaux, D-La., asked the commerce secretary if it were not true that foreign companies doing business in the United States were subject to the same product liability laws as their U.S. counterparts.

Mr. Mosbacher replied this indeed was true. However, he pointed out that a foreign company doing business in the United States probably sells a far greater percentage of its goods in a foreign market, where U.S. laws do not apply. The U.S. company, selling most of its goods domestically, thus has a greater chance of being hit with a product liability suit, he said.

Sen. Slade Gorton, R-Wash., a co-sponsor of S. 640, asked Mr. Mosbacher whether he believed that enactment of the proposal would enhance U.S. firms' ability to compete, promote innovation and encourage the manufacture of certain goods, like general aviation aircraft.

The Commerce secretary said that would indeed be the case, adding that enactment of S. 640 would create new jobs as well.

However, Mr. Mosbacher's remarks drew further scorn from Sen. Hollings. The senator said the real reason for the inability to compete is the lack of a U.S. national trade policy, "not this little old product liability." ■

INTERNATIONAL

Centre Re to acquire Pinnacle

Finite risk reinsurer to pay $63.7 million

By ROGER SCOTTON

HAMILTON, Bermuda—Centre Reinsurance Holdings Ltd., the Bermuda-based finite risk reinsurer, is offering to pay $63.7 million for the business of Pinnacle Reinsurance Co. Ltd., the Bermuda financial reinsurer owned by Lloyd's of London broker C.E. Heath P.L.C.

Although Heath's board of directors has approved the deal, it still must be approved by Heath's shareholders.

If the deal goes through, Centre Re's asset base will grow to more than $2 billion. Centre Re reported assets of $1.32 billion at year-end 1991, while Pinnacle reported assets of $738.5 million at the same time.

To "facilitate" the sale, Pinnacle has reached an agreement with the liquidators of Mentor Insurance Ltd. to settle litigation against Pinnacle filed by the liquidators in 1986 (see related story).

Pinnacle Chairman Bruce Swann said he hoped the two companies would be fully integrated by the end of the first quarter of 1992. Pinnacle clients will be asked "to convert their contracts with the company and replace them with the obligations of Centre Re."

Pinnacle will not accept new business, since "all new business will be written with the Centre Re group of companies," he said.

Centre Re specializes in finite risk reinsurance, which incorporates substantial underwriting risk while still capping the reinsurer's ultimate risk and profit. Pinnacle specializes in time-and-distance coverage, which guarantees the ceding company specific payments at specific future dates, based on the initial premium and the investment returns expected by the reinsurer. However, the reinsurer bears no underwriting risk.

The acquisition of Pinnacle was motivated by two key factors, said Centre Re President and Chief Executive Officer Steven Gluckstern: the desire to write a larger share of the time-and-distance market for London underwriters and the chance to acquire added expertise through Pinnacle's team of financial reinsurance underwriters, marketing specialists and actuaries.

About 75% of Pinnacle's $155 million book of business is composed of reinsurance written for Lloyd's syndicates and London insurers, Mr. Swann noted. The bulk of this business is time-and-distance policies that will be reinsured by a newly formed Centre Re unit, CentreLine Ltd., of which Mr.

Continued on next page

Pinnacle acquisition prompts settlement

HAMILTON, Bermuda—The liquidators of Mentor Insurance Ltd. are settling their claims against Pinnacle Reinsurance Co. Ltd., one of 11 defendants the liquidators sued in connection with Mentor's collapse.

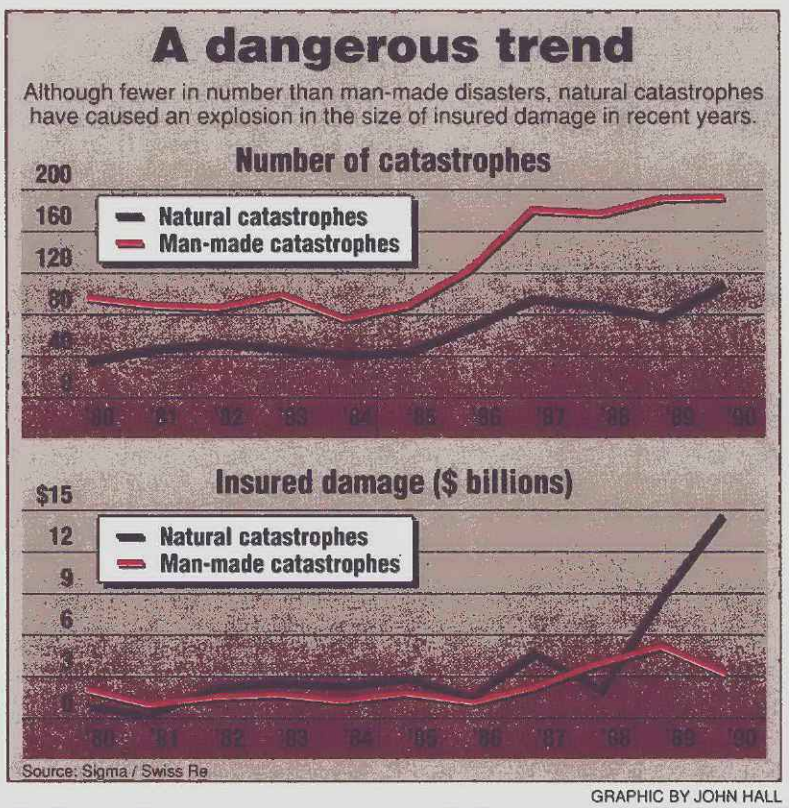
The liquidators alleged that Pinnacle helped "conceal and misrepresent" Mentor's true financial condition by drawing up "secret side letters" to three stop-loss contracts written by Pinnacle (*BI*, March 24, 1986).

Pinnacle breached the fraudulent trading rules of Bermuda's 1981 Companies Act and failed to meet a common law fiduciary duty to Mentor, the liquidators charged.

However, to "facilitate" the sale of Pinnacle to Centre Reinsurance Holdings Ltd. of Bermuda, Pinnacle and Mentor liquidators Charles Kempe and Nigel Hamilton have agreed to settle the litigation. The settlement, whose terms were not released, is conditional on the sale of Pinnacle to Centre Re.

Originally filed in federal court in New Orleans in 1986, the litigation is working its way through the Bermuda courts. If the ac-

Continued on next page



GRAPHIC BY JOHN HALL

1990 catastrophe losses highest in history: Study

By DON LEWIS KIRK

ZURICH, Switzerland—Last year was the worst in modern history in terms of disaster losses, a new report shows.

A total of 298 natural and major man-made disasters worldwide produced $17 billion in insured losses last year—the highest toll ever registered by Swiss Reinsurance Co.—up from 265 catastrophes that caused $13 billion in damages in 1989.

More than three-quarters of all damages, or $13.03 billion, was caused by storms, the Swiss Re study found. In Western Europe alone, eight winter storms caused total insured damage of $10.1 billion.

In addition, compared to historical trends, there has been a disproportionate increase in the number of natural disasters over the past several years, according to Swiss Re.

"Considering the frequency and extent of loss of catastrophes with damage exceeding $1 billion, the following statement can be made: the return period has become significantly shorter," Swiss Re observed. "Whereas in the 1970s there were usually several years separating insurance damage of this magnitude, there has been at least one such catastrophe per year since 1987.

"The concentration of catastrophes of this magnitude. . .(separated by) short periods of time represents an immense challenge to the insurance system. If the storm damages in 1989 and 1990 turn out to be statistical freaks, then the reserves can be replenished. If, on the other hand, they mark the onset of a trend toward losses of this magnitude on the one hand and increasingly shorter periods on the other, then the insurance industry is in grave danger," Swiss Re warned.

Of the 298 catastrophic events tallied by Swiss Re in 1990, 107 were natural disasters, up from 76 in 1989.

"In the last two years there has been an alarming explosion of insurance damage from natural catastrophes," according to the report. "Following a rise of $6.3 billion in 1989, it increased in 1990 by a further $5.7 billion to the cur-

Continued on page 16

Halvanon liquidation in U.K., Israel to be split

LONDON—Liquidators of Halvanon Insurance Co. Ltd. of Israel plan to ask creditors next month to formally approve splitting the liquidation into separate proceedings in London and in Israel.

Until now, the defunct insurer—which went into liquidation in 1985—has been maintaining separate liquidations in England for international reinsurance written by its London office and in Israel for its domestic business.

However, any decision by either set of liquidators has had to be agreed upon by all of Halvanon's 35,000 Israeli creditors and its 3,100 London creditors.

The split would be "practicable" and allow the British and Israeli liquidators to pursue their distinct claims in their own jurisdictions, documents sent by the liquidators to creditors late last month contend. The liquidators feel that the split would allow more money to be paid to the creditors as dividends.

A creditors' meeting has been called in London on Oct. 23 by accounting firm Cork Gully, which is acting as the U.K. liquidator, to approve a "scheme of arrangement" that would create the split. Approximately two-thirds of Halvanon's business was carried out in London, according to the documents sent to creditors last month.

A meeting of Israeli creditors has been called by liquidator Amihud Doron in Tel Aviv at about the same time.

If creditors approve the split, liquidators hope to start paying dividends within two years. So far, London liquidators have collected about 5.1 million pounds ($8.9 million), although liquidation expenses now total about 2.3 million pounds ($4.1 million).

—*By Stacy Shapiro*

GLOBAL BRIEFS

New Gerling chief

COLOGNE, Germany—Adolf Kracht has been named chief executive of Gerling-Konzern Versicherungs Beteiligungs A.G., Germany's third-largest insurance company.

Mr. Kracht was elected earlier this month to replace Hans Gerling, who died Aug. 14 at the age of 76 of heart failure. Mr. Gerling had led the insurance group his father founded in 1904 for the past 40 years.

The Gerling group has been a major power in shaping industrial insurance worldwide. Last year's

Continued on page 16

Rome syndicate's capacity to shrink in '92

By STACY SHAPIRO

LONDON—Member dissatisfaction is forcing one of Lloyd's of London's leading marine underwriters to lower his syndicate's capacity by about one-third in 1992.

Chris Rome said that his marine syndicate 662, managed by C.W. Rome (Underwriting Agency) Ltd., would reduce its capacity about 36% to somewhere around 50 million pounds ($86.9 million) in 1992 from 78 million pounds ($150.5 million) this year.

This reduction is "in common with the whole marine market," according to Mr. Rome. Stung by horrendous losses for 1988 to 1990, members are leaving Lloyd's in record numbers (*BI*, Sept. 2).

But members agents single out Mr. Rome, saying that his syndicate is rapidly losing capacity for 1992 because members are so discouraged with its overall results. A number of members have insisted that they be withdrawn from the syndicate, agents say.

One members agent, for example, says that Mr. Rome's performance as a "well-known, leading underwriter remains below expectations." Some members agents have been convinced over the past few weeks, however, that Mr. Rome is an important ambassador for Lloyd's and should continue to be supported. A former chairman of Lloyd's Underwriters' Assn., Mr. Rome is one of the most vocal leaders in the market.

The market generally is jumpy following the losses that have hit many syndicates and have cause several to shut down, he said. He noted that he took a day off work a few weeks ago, prompting a rumor that he had resigned.

But Mr. Rome says he has no plans to shut down his syndicate. "We have lost some of our capacity (as many in the market have) but I have no intention to stop underwriting," he said.

Mr. Rome's syndicate 662, has been the leading syndicate in a number of high-risk areas though it has not been a major player in the excess-of-loss reinsurance market, an area in which huge losses have been suffered by Lloyd's syndicates.

The syndicate leads many off-

Continued on page 16

LONDON

Pinnacle

Continued from previous page

Swann expects to be named chairman. Pinnacle's risk-bearing business would be reinsured by Centre Re, he said.

"Pinnacle's penetration of the U.K. market was undoubtedly a primary reason for our interest," said Mr. Gluckstern, who described Centre Re's current share of Lloyd's business as "modest."

"A substantial portion of Lloyd's liabilities are on Pinnacle's books. By acquiring it, we will become, overnight, a major reinsurer of Lloyd's of London. And when you look at the kind of restructuring that's taking place there, and I think it will continue to take place, that's the right environment for us to be marketing the Centre Re type of finite risk or financial reinsurance products," Mr. Gluckstern said.

"By acquiring the Pinnacle business, we're also getting a substantial increase in assets, and this is going to be important to us in helping to enhance our investment returns."

Mr. Gluckstern said Pinnacle's management and staff will add substantial expertise to an existing proven base operating within the financial reinsurance industry, which he said was still in its infancy.

"The demand for finite risk and financial reinsurance products will continue to grow, and I think you are going to see Centre Re taking a more visible role in the field of financial insurance products as well as reinsurance. They're broadly similar products bought by different clients. These are products that make sense economically all over the world, in Asia, the Far East or Australia. It's just a matter of when we're going to be ready to set our sights on these markets," he said.

C.E. Heath, which founded Pinnacle 12 years ago with paid-in capital of $20 million, was interested in a combination with Centre Re for financial reasons. Recognizing the need to develop new financial reinsurance products and at the same time increase Pinnacle's $55 million capital base, Heath said in a statement that it had been interested in "disposing of Pinnacle" since the beginning of the year.

Heath said that it already had earmarked 20 million pounds ($35.7 million at current exchange rates) of the proceeds of the sale to reduce debt and to strengthen its balance sheet. Any remaining funds will be used to finance "future broking acquisitions, should suitable opportunities arise."

Pinnacle's management says it is excited about merging with Centre Re, particularly because Zurich Insurance Co. of Zurich, Switzerland, increased its stake in Centre Re to more than 75% from 40% last month by buying the shares held by Fluor Corp. and J.P. Morgan & Co. Inc.

"We're tremendously excited at the prospect of involvement with a publicly traded, AAA-rated company like Zurich," Mr. Swann said. "We're also looking forward to the challenge of being part of a group with a much larger capital base than ours because this will open up new business opportunities for us," he said, adding that Pinnacle's capital had not grown much over the past several years under Heath's ownership.

J.P. Morgan, which advised on the formation of Centre Re in 1988, said last week that it will record about a $50 million pretax gain in the third quarter from the sale of its Centre Re shares to Zurich.

Mr. Gluckstern noted that CentreLine will emerge as a "highly formidable competitor and among the biggest in the business" in the time-and-distance market.

Pinnacle reported capital and surplus of $55.5 million at year-end 1990, while Centre Re's surplus stood at $312 million as of June 30.

The acquisition of Pinnacle will mark the first time Centre Re has acquired a portfolio of ongoing business, Mr. Gluckstern noted, though it has acquired runoff business.

Initial overtures were made to Pinnacle in May, Mr. Gluckstern said.

The complicated mechanics of the proposed acquisition have been designed to meet the requirements of Centre Re, which did not want to take on Pinnacle's corporate structure. The acquisition will involve the formation of a Bermuda company, Vertex Holdings Ltd., that is being set up by Pinnacle's eight-member management team to purchase Pinnacle from Heath's U.K. subsidiary, Risk Management Holdings Ltd.

Vertex's acquisition of Pinnacle will be funded by a loan from a Centre Re subsidiary. Pinnacle will simultaneously enter into a 100% quota-share reinsurance agreement with Centre Reinsurance (Bermuda) Ltd.

According to Heath, the sale is conditional upon shareholder approval, the release of a charge by Lloyd's Bank P.L.C. over Heath's shareholding in Pinnacle and the approval of the Bermuda Monetary Authority, which supervises the island's foreign exchange controls. Heath expects the transaction to be completed by the end of October. ■

Settlement

Continued from previous page

quisition proceeds, a November hearing before the Bermuda Court of Appeal, at which Pinnacle would have sought a dismissal, will probably be canceled.

Although neither side would discuss the settlement, it is known to include mutual releases from all outstanding claims along with a commutation of the three stop-loss contracts. The contracts—which were due to mature in June 1992, December 1992 and December 1993, respectively—guaranteed that Pinnacle would pay Mentor a total of $54.3 million.

Pinnacle Chairman Bruce Swann said he believes that acquisition of Pinnacle would have proceeded without the settlement of the litigation. But his counterpart at Centre Re is not so sure.

"Certainly, our interest in wanting to acquire the Pinnacle business would not have been changed by the litigation," said Steven Gluckstern, the president and chief executive. "Mentor settlement or not, we would have still wanted the business. But if the settlement had not been worked out satisfactorily, it would have been questionable as to whether we'd been able to reach an acceptable agreement to acquire the Pinnacle business."

Some Pinnacle directors, meanwhile, are convinced that the liquidators' suit against Pinnacle would never have gone to trial.

"We were always a bit player in an action that I doubted would have ever got as far as being tried on its own merits," said Pinnacle Vp Richard Black.

And while Mr. Swann says that the litigation held down Pinnacle's earnings initially, the financial reinsurer's business soon picked up, largely as a result of its response to the suit.

"We're going to miss the action in a rather perverse sort of way," Mr. Swann said. "We had to be far more aggressive about winning business than we might have been without this suit hanging over us. It was as though we were operating with one hand tied behind our back. And there was a certain intellectual stimulation from it all that I personally will miss.

"Certainly, the experience has not been wasted on us," he said.

Many of Pinnacle's managers say they would have welcomed the company having its day in court.

—By Roger Scotton

We listen.

You have unique reinsurance needs. The more we know about your needs, the better we can work together toward meeting your objectives.

Give us a call today.
1-800-7-GENRE-1

General Re®

Reinsurance at its best

INTERNATIONAL

GLOBAL BRIEFS

Continued from page 13

consolidated gross premium volume—both foreign and domestic—exceeded 8.2 billion deutsche marks ($5.49 billion at year-end 1990 exchange rates), up from 7.7 billion ($4.56 billion at year-end 1989 exchange rates) in 1989.

As head of one of the world's leading industrial insurers, Mr. Gerling's name was synonymous with innovation. He was responsible for spearheading the insurer's foreign expansion and promoted the idea of intensive safety management for large industrial risks.

Mr. Gerling was considered a visionary in German insurance. He anticipated an enormous rise of risk among commercial policyholders. As a result, his company became a leading underwriter for major German industries. In the past five decades, he also helped form post-war government policy on insurance.

Mr. Kracht had been vice chairman of Gerling-Konzern Versicherungs Beteiligungs. He directed all corporate dealing at the time of Hans Gerling's death.

Before joining Gerling at the beginning of this year, Mr. Kracht was managing director of Munich bank Merck, Finck & Co.

The banker-turned-insurance-executive has already signaled his willingness to cooperate more closely with leading German banks to distribute the insurer's products.

Gerling-Konzern Lebensversicherungs-A.G., the Gerling group's Cologne-based life insurance subsidiary, is already engaged in a joint marketing venture with Germany's largest bank, Deutsche Bank.

A major growth factor for the insurance company in 1990 was private pension plans. Only six insurers are active in this area in Germany, the company reports.

Gerling also sees an "increasing importance" of business in eastern Germany, according to Herwig Gueckelhorn, a Gerling executive.

—By Don Lewis Kirk

LONDON

Continued from page 13

shore energy, shipowners' liability and hull war risk policies, according to its annual report.

Syndicate 662 was also one of the leading syndicates on coverage for the four companies that owned the Piper Alpha North Sea oil platform, which exploded in 1988 causing a $1.44 billion loss, according to the syndicate's annual report.

Shortly after the explosion, syndicate 662 estimated that its gross loss would be $11.25 million, plus $1.5 million for the cost of reinstating its excess-of-loss reinsurance. However, when it closed its 1988 account, the syndicate noted that the Piper Alpha explosion resulted in a net loss to the syndicate of $1.94 million.

Mr. Rome's syndicate was also affected by the end of the Iran/Iraq War in August 1988, according to the report. Although the syndicate had incurred losses during the war, it was unable to recover premium from increased war risk rates once the war had ended.

"Rates were increased, but losses increased faster and the sudden end to hostilities in August 1988, followed by a premature reduction of premiums, left us in a position where we could not recoup our losses," said Mr. Rome. "With hindsight I should have withdrawn from the (Persian Gulf war risk) market in 1986 or 1987 and I am sorry that I did not take that decision."

The Piper Alpha accident, war losses and other losses caused the syndicate to post an overall loss of 929,000 pounds ($1.6 million) for its 1988 account, the last year to close under Lloyd's three-year accounting system.

The syndicate also produced an overall loss of 414,000 pounds ($719,532) in 1985, though it did produce profits of 12,000 pounds ($20,856) in 1987 and 652,000 pounds ($1.1 million) in 1986.

Mr. Rome says that syndicate 662's loss in 1989, like many other syndicates', will exceed its 1988 loss.

However, Mr. Rome is not giving up. "I am in a fighting mood and determined to play a leading role in the profitable and professional market which will form the basis of Lloyd's in the future," he told members. "I am very sorry that the 1988 account resulted in a loss but my colleagues and I are in a very determined mood and fully intend to repay the confidence you have shown in us." ■

Catastrophes

Continued from page 13

rent record level of $14 billion."

Of man-made disasters covered in the study, 55 were traffic-related; 43 involved waterborne traffic; 35 were major fires; 28 were aviation disasters; eight were mine disasters; six involved the collapse of buildings or bridges; and the remaining 16 were from other miscellaneous events.

The largest man-made loss occurred Aug. 2, 1990, when Iraq confiscated 15 Kuwait Airways aircraft. The planes were insured for $300 million (*BI*, Sept. 3, 1990).

The second-largest man-made loss was an explosion at a Phillips Petroleum Co. petrochemical plant in Pasadena, Texas, with damage of $220 million (*BI*, April 23, 1990).

While man-made losses in 1990 accounted for two-thirds of the total insured catastrophic events, they caused about 8,192—or 11.8%—of deaths related to catastrophes.

Man-made catastrophes include:

- 35 major fires that were responsible for about 8.5% of the total insured damage, or $1.4 billion. In 1989, 41 major fires caused $3.2 billion in insured damage.
- 28 aviation disasters, which accounted for 5.9%, or $949 million, of total losses. In 1989, 34 aviation disasters caused $1.04 billion in insured damages.

There were 732 deaths due to airplane crashes in 1990, almost half the 1989 total of 1,474.

Many of the deaths in 1990 occurred in the Oct. 2 airline crash in Guangzhou, China, when a jetliner collided with a parked aircraft upon landing. The accident caused 127 deaths and $76.5 million in insured damages. (*BI*, Oct. 8, 1990).

- 43 shipping disasters, which accounted for $453 million in insured damages. While there were only 33 shipping disasters in 1989, total insured damages that year hit $561. The number of ship-related deaths in 1990 also dropped to 1,562 from 1,821 in 1989.
- 16 miscellaneous events, which accounted for $133 million in insured damages.

These events included, among others, measles, cholera, malaria and rabies epidemics in Guatemala, India, Indonesia, Nigeria, the Philippines and Zambia; polluted mineral water in France; a food poisoning at an engagement party in India; a broken leg that caused the death of the racehorse Alydar in the United States; and panic in a pedestrian tunnel in Mecca, Saudi Arabia. Events in this category accounted for 2,585 deaths.

●

For a copy of the report, "Natural catastrophes and major losses 1990," contact Swiss Reinsurance Co., 50/60 Mythenquai, P.O. Box CH-8022, Zurich, Switzerland.

Employee privacy

Continued from page 3

provide details.

Approval by the Democrat-dominated subcommittee seems likely due to Rep. Williams' support and a campaign that has netted 130 co-sponsors, observers say.

A companion bill, S. 516, was introduced in the Senate by Sen. Paul Simon, D-Ill. The Senate bill was referred to the Labor and Human Relations Subcommittee on Employment and Productivity, which has scheduled a hearing on Tuesday.

The proposed "Privacy for Consumers and Workers Act" is designed "to prevent potential abuses of electronic monitoring in the workplace."

"The primary proponent of the legislation is the Communication Workers of America," said Larry Sabbath, vp with Rowland/Sellery Inc., a consulting firm in Washington, D.C. He represents Security Companies Organized for Legislative Action, a Washington, D.C.-based coalition of five security industries.

"The apparent purpose of the bill is to prohibit the monitoring of telephone operators" by telephone companies "and limit the use of calls-handled data for setting work standards," he said.

The bill defines "electronic monitoring" as "the collection, storage, analysis and reporting of information concerning an employee's activities by means of a computer, electronic observation and supervision, remote telephone surveillance, telephone call accounting or other form of visual, auditory or computer-based surveillance conducted by any transfer of signs, signals, writing, images, sounds, data or intelligence of any nature transmitted in whole or in part by a wire, radio, electromagnetic, photoelectronic or photo-optical system."

The bill requires that each employer engaged in electronic monitoring:

- Provide every current and prospective employee with prior written notice explaining the form and frequency of monitoring, how the data will be used and interpreted, existing production standards and the work performance expectations of employees who are being monitored.
- Provide the monitored employee —and the telephone customer when the monitored employee is a telephone operator—with "a signal light, beeping tone, verbal notification or other form of visual or aural notice, at periodic intervals," indicating that the electronic monitoring is taking place.
- Collect from current or former employees only personal data that is "relevant to the employee's work performance."
- Not use the data as the sole basis for job evaluation or determining whether production quotas are met.
- Limit disclosure of the data to the employee, company officials who have a "legitimate" need to be aware of the data and court-appointed recipients.

The bill's provisions would not apply to law enforcement agencies carrying out criminal investigations.

Employers that violate the act would face civil fines of up to $10,000.

In addition, employees may sue for "appropriate equitable relief," including employment, reinstatement, promotion and payment of lost wages and benefits.

The AFL-CIO and American Civil Liberties Union voiced their support for the measure at two hearings this summer.

However, employers and security firms believe the legislation is too far-reaching.

"We believe that the bill is drafted with such broad and vague language that it would seriously impair a business' ability to safeguard its patrons and employees and to protect personal and business assets located in and about the business premises," says a statement by SCOLA President Vincent L. Ruffolo, who also is president of A&R Security Services Inc. in Blue Island, Ill.

The legislation "would also make it difficult to document off-premises fraud, theft and sabotage," he said.

The Risk & Insurance Management Society Inc. in New York also "is looking into the bill and its ramifications for risk managers," said Paul Brown, director of governmental affairs.

In addition, insurer groups also are monitoring the bill's progress.

The Schaumburg, Ill.-based Alliance of American Insurers is aware of the bill and has told congressional staff members about its "real concerns" that it could inadvertently restrict an employer's ability to investigate fraudulent workers compensation claims, said Tom O'Day, an associate vp in Washington, D.C.

The Alliance is helping to draft an amendment that will allow video surveillance of workers comp claimants, and Mr. O'Day said he expects the House subcommittee expected to adopt that or a similar measure.

In addition, the American Insurance Assn. "is monitoring" the bill, a spokeswoman said.

Opponents of the proposal launched a telephone and letter-writing campaign over the summer to generate more support.

"We are deluging them and telling them if the bill passes as written, it will be devastating to the corporate security function of every corporation," said Jim Royer, director of corporate security for diversified manufacturer FMC Corp. in Chicago.

Mr. Royer claims that if the bill is enacted, an employer would have to tell a workers comp claimant when he or she is being videotaped, which would "defeat the purpose."

"The deterrent effect against fraudulent workers compensation claims would be removed," agreed SCOLA's Mr. Sabbath.

"Don't handcuff investigators," said Bill Kizorek, president of In-Photo Surveillance in Naperville, Ill. He also recommends that the bill be amended to exempt surveillance conducted in connection with claim investigations.

Employers hire investigators to surreptitiously videotape workers comp claimants to obtain a candid look at a claimant's actual daily routine, which is then compared to the worker's alleged limitations as a result of his or her disability, Mr. Kizorek explains.

If the worker's videotaped actions differ dramatically from those that could be reasonably expected following the alleged disability described in the workers comp claim, his or benefits may be eliminated or reduced when the videotape is shown at an administrative or court hearing, Mr. Kizorek said.

Without these candid videotapes, the evidence pits the claimant's word against the investigator's, he added.

FMC uses videotape surveillance to determine "the validity" of some employees' workers comp claims, Mr. Royer said. He became a strong supporter of video surveillance after an investigation of 25 questionable claimants, which cost about $25,000, saved FMC about $1.5 million in workers comp-related costs.

Critics say the legislation also conceivably could prohibit several important corporate security practices, including the use of:

- Card access systems that permit only authorized individuals to enter a plant during authorized times and record unauthorized attempts.
- Access systems for computer rooms and cashiers' offices that permit only authorized access.
- Both interior and exterior closed-circuit television monitoring. Companies use exterior cameras to detect unauthorized and illegal activities and inside cameras to protect assets and ensure safe operating procedures.
- Individual passwords on computer systems that generate records about access patterns.
- Telephone records that department heads check for unauthorized or excessive calls. ■

Offshore insurers

Continued from page 3

drafts has been turned over to the FBI, though FBI officials in Dallas and Lexington would not say whether they are investigating.

In addition, the U.S. Comptroller of the Currency is preparing a letter warning banks and bank regulators that Eastech and a related entity, Islamic Panamerican Bank, may be operating from the Dallas address without federal or state authorization, a U.S. Treasury department official said.

Mr. Campbell did not return several phone calls for comment.

The Kentucky department's complaint is not the first time that companies allegedly operated by Mr. Campbell have attracted state and federal government scrutiny.

A U.S. Senate subcommittee investigating insurance fraud identified several of the offshore insurers as among a group of companies managed by Atlanta-based consultant Alan Teale and his wife, Charlotte Rentz (*BI*, July 29; July 1).

Apex Placement Insurance Co. Ltd. of Anguilla, another of Mr. Campbell's companies, was hit with a conservation order in May after California regulators found that one of its main assets was a yen note issued by a Japanese company believed to be bankrupt.

The FBI also was notified earlier this year that a policyholders' trust account that Northern Commercial claimed to have at a Johnstown, Pa., bank did not actually exist (*BI*, May 6).

Mr. Campbell was licensed as an agent in Kentucky more than a decade ago, but his licence was revoked in 1979 after he issued cover notes for truck physical damage insurance without authorization from the insurer, said Stephen B. Cox, assistant general counsel for the Kentucky department.

The Kentucky department filed its complaint Sept. 13 in Franklin County Circuit Court. In addition to Mr. Campbell, the suit names:

- American Financial Co. of Lexington, which the suit says has acted as a holding company for the 15 offshore insurers named in the complaint. Mr. Campbell is chief executive officer of the company, which is unrelated to American Financial Corp. of Cincinnati.
- First American International Trading Co., described in the complaint as a successor company to American Financial Co.
- Apex Placement, which was struck from the Turks & Caicos register of companies earlier this year and has purportedly moved to Anguilla.
- Northern Commercial, formerly known as American Transportation Insurance Co. (*BI*, July 25, 1988).
- Brasoz International Insurance Co. Ltd. of Anguilla.
- Caribbean Excess Insurance Co. Ltd., Caribbean Protective Excess Insurance Co. Ltd. and Caribbean Title Insurance Co. Ltd., all of the Turks & Caicos.
- Cie. Internationale Financiere de Reassurance of Belgium.
- Wilmington Marine & General Insurance Co. and Wilmington National Insurance Co. of the Turks & Caicos. Wilmington Marine & General was struck from the Turks & Caicos register earlier this year, the complaint says.
- Overseas Deposit Insurance Co. of the Turks & Caicos.
- Southern Commercial & General Insurance Co.
- Wilmington Cie. Belge de Reassurance Maritime et Generale S.A.
- Guardian Insurance & Guaranty Co.
- Royal International Assurance Co.
- Majestic International Insurance Co.

The domiciles of several companies could not be determined.

The department's suit charges that all of the insurers are "sham corporations having little or no capital" that were "formed by Campbell to act as his alter ego."

Since 1989, Mr. Campbell has used the companies to conduct unauthorized insurance business and has engaged in "unfair, false, misleading or deceptive practices," the suit alleges.

Northern Commercial, for example, violated state laws by writing coverage for policyholders in Kentucky, Alabama, Texas and Kansas and caused the issuance of dishonored sight drafts in payment of claims, the suit charges.

The suit seeks an injunction barring Mr. Campbell and the companies from doing business without proper authority and restraining them from disposing of or transferring any records, money or other assets connected with the insurance operations.

Kentucky regulators also are seeking an order requiring Mr. Campbell, the offshore insurers or their producing agents to pay any outstanding claims on business already written.

The lawsuit does not provide details of the allegedly worthless sight drafts used to pay Northern Commercial losses.

However, *Business Insurance* has obtained copies of two Eastech drafts issued to settle claims against two of Northern Commercial's Los Angeles policyholders, one a defunct topless bar and the other a seafood market.

Lawyers for both claimants say they presented the drafts to their banks, which forwarded them to Eastech's Dallas address. Both came back marked "addressee unknown," and the lawyers say they have been unable to locate Eastech or contact David Elliott, a Lexington businessman who signed the drafts on Eastech's behalf.

U.S. Claims Service Inc.—an Orange Park, Fla., claims administrator that mailed the drafts for Northern Commercial—referred complaints to a Northern Commercial office in Anguilla, which proved another dead end, said both Dave M. Barela, the Diamond Bar, Calif., lawyer for the topless bar claimant, and Cesar Escobar, the Los Angeles lawyer for the seafood market claimant.

Details of Eastech's operations and the origin of the drafts are murky.

The bank is not incorporated in the United States, but it is licensed in the People's Republic of China, according to Michael Russo, an Eastech vp in Tacoma, Wash.

An Eastech "executive summary" obtained by *Business Insurance* includes undated balance sheet information—purportedly audited by an accounting firm in Pretoria, South Africa—showing total bank assets of $90.5 billion.

The total purportedly includes $50 million in deposits with the Bank of China, $1.4 billion in other bank deposits, $14.7 billion of negotiable securities, $50.7 billion of "other securities" and $23.5 billion of unspecified "resource inventories."

Mr. Elliott, the businessman who signed the sight drafts, said in an interview that he was granted a power of attorney to sell certificates of deposit and other Eastech services by the bank's Geneva, Switzerland-based chairman, Shirley Rhodes, whom he described as a longtime acquaintance.

Mr. Elliott said he then approached Mr. Campbell, another longtime acquaintance, for his suggestions on sources of business for the bank, and Mr. Campbell said he could use it to issue sight drafts for Northern Commercial.

Mr. Campbell was supposed to sign an agreement under which he would have provided funds to back up the Eastech sight drafts, but the agreement was never executed, Mr. Elliott said.

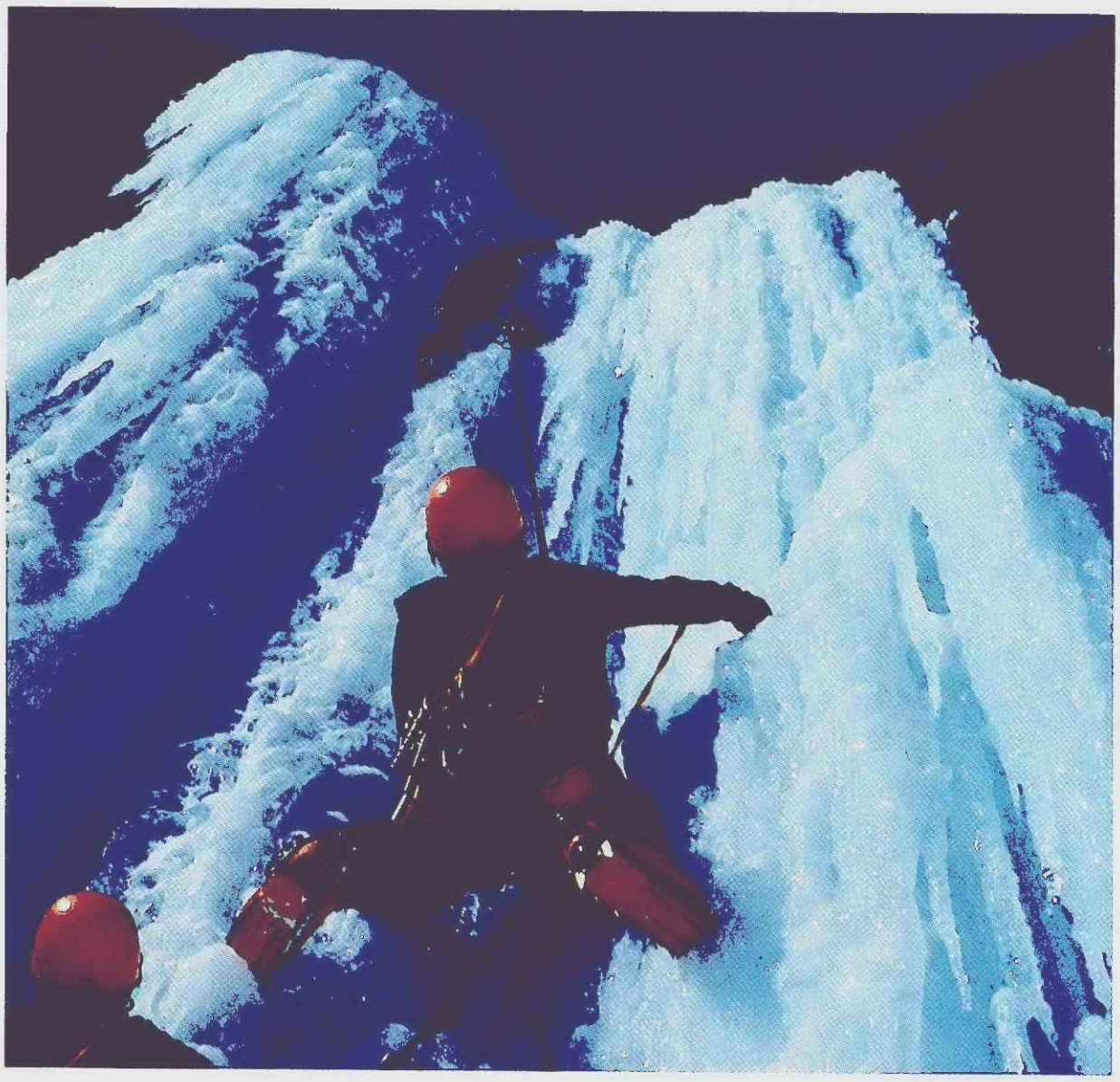
Meanwhile, though, Mr. Elliott

Continued on page 20

Who takes the fall?

They say accidents will happen. And they will. It's just that some reinsurers can protect you better. Like CIGNA RE for example.

Years of experience enable us to analyze situations more accurately. And with greater insight. Around here, unique, challenging risks are routine. Which not only gives us a better idea of what you'll need, but also allows us to respond quickly and competitively.



So it's not surprising that in a recent survey, brokers singled out our people for their knowledge and thoroughness.

Just as important, our financial stability and capacity enable us to take on higher limits.

We'll be there for your short-term needs, such as Known Concentration. As well as the long run. Some personal accident risks have even been on our books for over thirty years. And we do more than just manage risk, we share it with you.

No wonder we are one of the largest and most respected personal accident reinsurers in the United States and the world.

For additional information, fax Donna Peterson at 215-523-4153. Or call her at 215-523-4622.

After all, when you take a risk, you ought to have a partner who knows the ropes.

Connecticut General Life Insurance Company is the primary legal entity through which CIGNA RE underwrites reinsurance products.

We get paid for results.® CIGNA

Offshore insurers

Continued from page 18

said he issued 238 sight drafts in payment of about $2.8 million in Northern Commercial claims. He added that he signed the drafts in Mr. Campbell's office using forms Mr. Campbell provided.

"That was the first time I had ever seen a sight draft," Mr. Elliott said. "I feel like I was taken advantage of," he added.

In addition to a Lexington post office box address for Mr. Elliott, the drafts included the Dallas office address supposedly belonging to Eastech.

The Dallas offices are occupied by a company called Burch Management, which Mr. Elliott says acted as a contact office for Eastech and an affiliated bank, Islamic Panamerican.

Laura Barton, a Burch Management official, said the company manages Dallas nightclubs and is not a contact office for Eastech. She said she has received and returned numerous Eastech sight drafts submitted by banks around the country.

However, Ms. Barton also said that Burch Management has a commodities trading division called Interfin that is using Islamic Panamerican to finance a gold transaction.

"We may receive some faxes here (for Islamic Panamerican), but that's about it," Ms. Barton said. "There's no daily banking going on here."

Mr. Russo, the Eastech vp, said Eastech has a "correspondent relationship" with Islamic Panamerican—which he said is based in Argentina—and that Burch Management acted as a representative office for Islamic Panamerican.

Mr. Russo also denied that Eastech issued sight drafts used by Northern Commercial. He said the people who issued them "were just using our name, apparently." ■

401(k) plans

Continued from page 3

cate those values elsewhere. It's the second thing prospective employees ask about," right after the company's medical plan, he said.

While more employers than ever are offering 401(k) plans, employers point out that meeting some of the many regulations governing the plans can be very difficult.

Sixty percent of the respondents said that meeting regulations requiring employers to identify and recharacterize employee contributions to 401(k) plans that exceed the maximum allowed is "difficult" or "very difficult." Furthermore, 54% said the process of refunding these excess contributions was difficult or very difficult.

Also, 56.7% of employers said that running non-discrimination tests on their 401(k) plans proved to be difficult or very difficult.

Other rules, though, presented few problems. For example, only 9.8% said that complying with limits on employee deferrals to a plan in a given year is difficult or very difficult.

Small employers have the real problems meeting the administrative and legal requirements, Mr. Rumack suggested. "With a small staff, they're not focusing a lot of attention on the tests, because they have other things requiring their attention. As a result, the requirements become harder and harder. '

Employers that can afford the time and trained staff to oversee these regulations find that the requirements become easier to meet. "It's never easy. The survey has confirmed that these are difficult rules but, nevertheless, if you pay attention, you can master them," Mr. Rumack said.

The largest percentage of employers—44.7%—allow employees to defer a maximum of 11% to 15% of their salary to 401(k) plans on a pretax basis. Some 31.2% of employers limit pretax contributions to 6% to 10% of salary, while 22.3% limit pretax contributions of 16% to 20% of salary. The remainder imposed some other limit.

However, 45% of employers that allow aftertax contributions limit those contributions to a maximum of 6% to 10% of salary, compared with 28.3% of responding employers that imposed a deferral cap of 11% to 15% of salary and 23.8% that limited aftertax contributions to 16% to 20% of salary. The remainder placed some other limit on aftertax contributions.

And, the percentage of employers that allow aftertax contributions has shrunk dramatically. Only 44% of surveyed employees allow aftertax contributions, the same percentage as in 1989 but a sharp drop from 76% in 1984.

Many employers have stopped accepting aftertax contributions because they found that higher-paid employees were most likely to make these contributions, Mr. Rumack explained. Limiting these contributions helps many employers to pass non-discrimination tests, he said.

More than 82% of the surveyed employers match employees' pretax 401(k) deferrals. The most common match, reported by 29.7% of the respondents, was between 26 cents and 50 cents per dollar deferred by the employees. Some 12.2% of employers say they provide matching contributions of 76 cents to $1, 6.3% provide a match of 25 cents or less, 3.8% provide a match of between 51 cents and 75 cents, and 1.3% contribute more than a dollar for every dollar deferred by the employee.

Twenty-nine percent of the respondents reported that they match pretax contributions on some other basis.

More than four-fifths of the respondents set a minimum service requirement for eligibility to participate in the company's 401(k) plan.

One full year of service was required by 53.1% of the respondents, while six months of service was required by 12.1%, and three months of service was required by 6.5%. Only 0.2% of responding employers reported a nine-month service requirement. Almost 10% of the employers imposed some other requirement, while 18.5% imposed no minimum service requirement.

Minimum age requirements were somewhat less popular, the survey found, with 59.6% imposing no requirement. Some 30.3% of the employers require that 401(k) plan participants be 21 years of age; 8.6% require that participants be 18 years of age; and 1.4% set some other age requirement.

Among other survey findings:

- Most employers—77.8%—that match employee deferrals do so with cash. However, nearly a fifth of the respondents, 19.3%, use company stock for matching contributions and 2.9% use a combination of cash and company stock.
- Almost three-quarters of employers, 73.3%, offer three to five investment choices. Some 16.8% of responding employers offer two choices, and 5.6% offer more than five choices. Only 4.3% offer only one investment choice.
- The most investment option most often offered by employers was the managed stock fund, offered by 67.4% of the respondents. Other investment options offered by employers included guaranteed investment contracts or bank investment contracts, offered by 62.3%; money market funds, offered by 40.7%; balanced funds, offered by 32.5%; managed bond funds, offered by 30%; and company stock, offered by 29.9%.

●

Copies of "401(k) Plan Practices 1984-1991" are available for $50. Contact Carolee Martin, manager of marketing, Buck Consultants Inc., 500 Plaza Drive, Secaucus, N.J. 07096; 201-902-2555.

Employers differ on the success of managed care

By LORI BLOCK

CHICAGO—Does managed care really control employers' health care costs?

The Managed Health Care Congress
MIDWEST

Assessing whether managed care works depends on how, and on what scale, it is evaluated, according to two benefit managers who spoke at the Midwest Managed Health Care Congress, held Sept. 5-7 in Chicago.

Raymond B. Werntz, vp of human resources-compensation and benefits at Whitman Corp. in Rolling Meadows, Ill., says that when examined on a broad basis, managed care definitely is not working.

But Susan M. Colburn, associate director-benefit planning for Southwestern Bell Corp. of St. Louis, says managed care is solving many of her company's health care problems.

Mr. Werntz asked the audience, primarily made up of benefit managers of companies with fewer than 2,000 employees: "Why do (employers) get involved with managed care arrangements?"

Presumably, he answered, employers establish managed care plans to:

- Lower the medical cost inflation rate. "I don't think anyone, anymore talks about lowering their absolute costs," just the inflation rate, Mr. Werntz said.
- Control "inappropriate behavior" on the part of either the patient or the provider by cutting excess services.
- Provide better care by "sending employees to better providers."

Because there are few tools that can help employers sort through "good" and "bad" health care providers, Mr. Werntz said he is unsure this is actually taking place. However, he is convinced managed care directs employees to cheaper providers.

- Restore, maintain and—theoretically—improve employees' health.

When examined in light of these five goals, Mr. Werntz is convinced that the answer to "the $64 question" regarding the effectiveness of managed care is a resounding, "No, it's not working!"

It is true, he conceded, that medical costs associated with health maintenance organizations, preferred provider organizations and other managed care techniques are lower than those associated with traditional indemnity plans. But he doesn't believe this constitutes success; true success would be cutting costs, not merely cutting the increase in costs.

As for eliminating inappropriate behavior, "sure, we've weeded out" some unnecessary tests and procedures, but "have we really controlled inappropriate behavior? I don't know," he said.

Similarly, Mr. Werntz remains unconvinced that employees covered by managed care plans are being directed to better providers because it's difficult to separate the good providers from the bad.

In the final analysis, he asked: "Are we really accomplishing a better quality of life?" through managed care. "I don't think so," he concluded.

While Mr. Werntz takes exception with the idea that managed care represents better care, he concedes he doesn't have a solution that would be decidedly better.

Everybody is utilizing managed care "because they think it's the only way to get at the inappropriate stuff," he said.

Part of the problem with managed care is it ignores some fundamental American cultural and behavioral tendencies, he theorized. It requires that "people give up something they want" in order to provide greater health care access at a lower price.

Furthermore, managed care seems to value cost control over good health, while it fails to address the root of the cost problem, he insisted.

What really needs to be addressed is Americans' level of expectations. "American people place wants ahead of needs (and) managed care doesn't try to help people differentiate be-

Continued on page 24

In 1913, when football history was made, Allendale

Notre Dame at Army. Few thought the Irish had a fighting chance. But that was before Notre Dame unleashed its secret weapon—the forward pass. In the game's last half, quarterback Gus Dorais and star receiver Knute Rockne dazzled the crowd. Thirteen times Dorais put the ball in the air for ten completions. And when Notre Dame engineered its historic 35-13 triumph over Army, Allendale's engineers had been leading a winning team for eight decades.

In a changing world where events like this shape history, this is our way of reminding you of one progressive, stable company that's been in business since 1835.

had been tackling loss control problems for 78 years.

Today at Allendale, we continue to shape the history of loss control with engineering, training, research and testing, responsiveness and fairness in the way we do business.

Throughout the years we've been more than an ordinary insurance company. Commitment to our insureds goes well beyond the property coverages we provide. After a century and a half, that part of our philosophy is not about to change. Allendale Insurance, P.O. Box 7500, Johnston, Rhode Island 02919.

Allendale Insurance/Factory Mutual System
Over 150 years of progress and stability.

Managed care

Continued from page 21

tween wants and needs," Mr. Werntz explained. Instead, managed care makes that distinction without teaching the individuals that this distinction needs to be made if costs are to be controlled and health care made available to a greater number of people, he said.

Mr. Werntz also expressed concern that, because managed care tends to shift costs from savvy to less-savvy employers and, eventually, to those without employer-provided health care plans, the "indigent" members of society continue to lack adequate care.

In light of these concerns, Whitman Corp. has developed a health-management system designed to provide adequate care while it teaches employees what is and isn't necessary treatment. The program includes a customized utilization review plan that provides for greater employee involvement in decision making and health education programs.

The idea, Mr. Werntz said, "is to not only have employees take care of themselves, but to better understand what's going on."

The key to this approach, Mr. Werntz said, is that the employees are no longer "objects of managed care"; instead, they are co-managers of their care.

The company's goal is to establish an effective physician-patient relationship, he said. For example, during utilization reviews, employees—rather than the company's employee benefit manager—discuss their case with the health care provider, he said.

Further down the road, Mr. Werntz sees the possibility that certain health problems of employees will be treated similarly to substance abuse problems. For example, employees with weight problems will be given incentives to successfully participate in a weight loss program, he said.

While Mr. Werntz is convinced that managed care—as it is being practiced today—is not a solution to America's health-care woes, Southwestern Bell's Ms. Colburn insisted that managed care can heal some of an individual corporation's health care benefit problems.

From 1979 to 1985, Southwestern Bell's health care costs increased 217%, reaching $161 million in 1985, excluding dental and vision benefits. In all, health care benefits represented 59% of the company's total benefit costs.

While it was clear Southwestern Bell needed to control these costs, the company quickly realized no "off-the-shelf" product was capable of meeting the company's requirements, Ms. Colburn said, noting that the company's options were limited by its labor agreements.

Faced with this reality Ms. Colburn said the company developed CustomCare, a program administered by The Prudential Insurance Co. of America in Newark, N.J.

The plan, which includes risk-sharing provisions if claims growth exceeds a certain amount, is designed to:

- Reduce health care cost trends.
- Involve employees in health care purchasing decisions.
- Control post-retirement benefit costs.
- Promote wellness.
- Protect employees from catastrophic risk.

Furthermore, Ms. Colburn said the plan had to be easy to use and understand so that employees would "buy into it."

The answer was a specialized point-of-service plan, dubbed CustomCare. Under CustomCare, employees are enrolled in HMO-like networks but can opt to receive service from non-network providers at reduced benefit levels. Employees who live outside the network area receive benefits comparable to those received from network providers.

As the plan administrator, Prudential contracts with selected doctors, hospitals and other health care providers. This group, divided into a number of local provider networks, must meet certain performance standards so that participants receive high-quality managed care. Claims and all documents related to precertification, second surgical opinions and utilization reviews are handled by the attending network physician.

Under the risk-sharing provisions, Southwestern Bell and Prudential establish a target for claims growth in the upcoming year. At year end, if the actual claims expenditures were lower than what was anticipated, Southwestern Bell and Prudential share the savings. Conversely, if the actual claims exceed the target, the two share the excess expense.

By whatever management tool

Continued on next page

Continued from previous page
Southwestern Bell uses to evaluate the program—financial reports, utilization reports, employee surveys and third party analyses—CustomCare has been a success, Ms. Colburn said.

First, it has reduced the company's medical trend costs far below the national average. For instance, in 1989, the national medical trend was 22%. Yet Southwestern Bell experienced a mere 7% inflation rate, Ms. Colburn reported.

"The good news for Southwestern Bell is that CustomCare did reduce our trend from what it would have been" without the program, she explained. The bad news, however, is that the costs associated with those employees served by the outside network plan continue to rise uncontrollably.

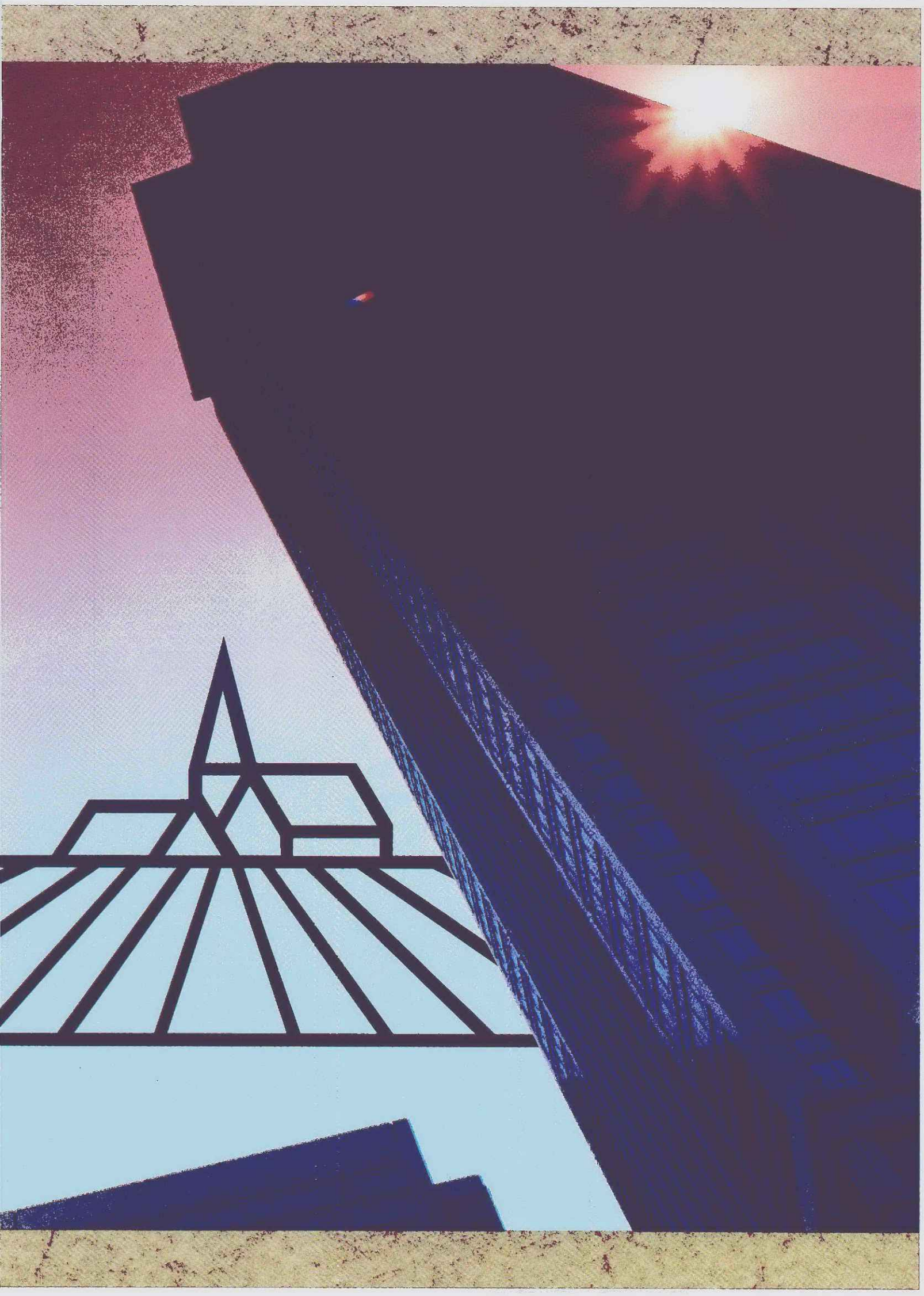
Part of the reason for the resounding financial success is that 84% of the claims being paid within the network portion of the program are going to network doctors. This fact alone, Ms. Colburn said, proves that employees have truly bought into the program.

That analysis has been supported by three employee surveys. The most recent, conducted last year, showed that 84% of the employees "think highly" of the medical care they receive from network doctors; 83% have a high degree of confidence in the network doctor's medical ability; and 92% would be willing to recommend the network doctor to a friend.

Similarly, evaluations by third parties, including Johnson & Johnson Health Management Inc. of Santa Monica, Calif., reflect the program's success. In its evaluation, the consultant verified "CustomCare's success in controlling (Southwestern Bell's) health care costs."

However, Southwestern Bell is not ready to rest on its laurels. Instead, the company seeks to address the runaway costs incurred by employees who do not use CustomCare network providers. "We're considering everything and throwing out nothing" in exploring cost containment options, Ms. Colburn said.

While CustomCare has helped Southwestern Bell contain its health care costs—and provides employees with a degree of choice—Ms. Colburn is not touting the program as the "be-all and end-all" solution to the nation's health-care problems. ■



1,000 discuss managed care

CHICAGO—More than 1,000 managed health care professionals attended the Midwest Managed Health Care Congress, held Sept. 5-7 in Chicago. The congress, an offshoot of the National Managed Health Care Congress, was co-sponsored by the Midwest Business Group on Health and Business Week magazine.

The conference program featured 80 speakers who addressed a variety of health care, employee benefits, management and labor issues.

This was the first of three regional congresses designed to explore how national issues and important developments in both business and government affect each region's managed care programs and participants. The goal of the meeting is to analyze the challenges, problems and solutions found within those regions.

The next regional congress will be held in New York City Nov. 14-16. Among the keynote speakers are Donald J. Sacco, vp-human resources, quality planning for White Plains, N.Y.-based NYNEX Corp.; Rashi Fein, professor of the economics of medicine in the Department of Social Medicine at Harvard Medical School in Cambridge, Mass.; Dr. Alan L. Hillman, assistant professor of medicine and health and director-center for health policy at the Leonard Davis Institute of Health Economics at the University of Pennsylvania in Philadelphia; and Stuart M. Butler, director-domestic and economic policy studies for The Heritage Foundation in Washington, D.C.

The third regional congress is slated for Jan. 16-18, 1992, in Los Angeles.

In addition, the fourth annual National Managed Health Care Congress will be held March 29-April 1, 1992, in Washington, D.C.

For more information on the regional and national Managed Health Care Congresses, contact Karen Von der Haar, Director-Public Relations, NMHCC, Bay Colony Corporate Center, 1000 Winter St., Suite 4000, Waltham, Mass. 02154; 617-487-6709. ■

Patients need information

By JERRY GEISEL

The Managed Health Care Congress **MIDWEST**

CHICAGO—Physicians should give patients more information so they can make more informed decisions on the risks and rewards of surgery, a physician advises.

"We are beginning to democratize the doctor-patient relationship," said Dr. John E. Wennberg, professor of epidemiology at Dartmouth Medical College in Hanover, N.H.

Patients historically have been given little information by their physicians to help the patient evaluate the pros and cons of surgery, said Dr. Wennberg at a session during the Midwest Managed Health Care Congress, held Sept. 5-7 in Chicago.

Information was not always shared with patients because of a historical belief in the medical community that only physicians had the clinical backgrounds to make decisions involving surgery, he said.

"Leave it up to the doctor because the doctor knows best," Dr. Wennberg said, describing the traditional belief.

In addition, physicians could not always share information on the pros and cons of surgery because outcome research—ascertaining what happened to a patient's health after surgery and whether surgery was successful—was not always available, Dr. Wennberg said.

For example, new research involving men who develop prostate disease shows how patients, if given information about surgery, can decide for themselves whether they should undergo the procedure, he said.

Research dating back to the 1970s found that the rates of prostate surgery varied significantly from one community to the next. For example, in one Maine county, 55% of older men with prostrate trouble had surgery, compared with only 15% in another Maine county only a short distance away, Dr. Wennberg said.

This variation, he explained, was caused by a distinct split in the medical community on the necessity of prostate surgery.

One school of thought held that early surgery was necessary to stop the spread of the disease. "Operate early while the patient is healthy," was the credo of that school of thought, Dr. Wennberg said.

The other camp in the medical community believed that prostate disease developed very slowly and that surgery often was needed only to alleviate certain symptoms—such as difficulties in urination—rather than to save a patient's life.

"Which theory was closer to the truth?" Dr. Wennberg asked.

Medical research involving about 500 Maine men supported the second medical theory. "It was clear that the life of men was not extended by surgery," Dr. Wennberg said.

But the Maine research also found that a high percentage of men reported that surgery alleviated their symptoms. Other men, though, reported post-surgical prostate problems, including incontinence.

Analyzing the results of the research, Dr. Wennberg concluded that general guidelines for prostate surgery were not possible.

Surgery depends on whether the patient wants it, he said. "You come to the conclusion: patients must get involved," Dr. Wennberg said.

With that premise, Dr. Wennberg and other medical researchers formed the Foundation for Informed Medical Decision Making, a private non-profit foundation that developed a new interactive video to help patients get involved in the surgery decision-making process.

In that video, which has been used by several health maintenance organizations and the U.S. Veterans Administration, men in their 60s and 70s who are candidates for prostate surgery discuss their decisions to undergo or not undergo prostate surgery.

In a study of 700 men who watched the video, most patients said it was a useful aid in helping them to decide whether to have surgery. In fact, most men who saw the video later decided not to have surgery, Dr. Wennberg said.

For example, in one study, only 20% of men who reported various symptoms decided on prostate surgery after watching the video.

"Patients do seem more risk-averse than physicians. The fact that only 20% of men chose surgery is very encouraging," he said.

Dr. Wennberg said the foundation is developing similar videos about treatments for other surgical procedures.

"More than any other country, we are trying to" help patients make informed decisions, Dr. Wennberg said.

Patients need to be told that while surgery has rewards, it also has risks. "Patients have to know that they have choices and that surgery is not like getting your hair cut," he said. ■

For Some People, The Extraordinary Is Ordinary.

For Kieron Farrelly the extraordinary is standard procedure. No matter what the individual problems or special needs of his customers, he consistently forges solutions that keep them out front in their markets. His keen insight, expertise in the field and plain hard work produce results that count.

And that's why Tod Duncanson, chairman emeritus, is proud to present this year's Duncanson Award for Excellence to Kieron Farrelly and our Chicago Office.

Extraordinary results, every day. That's what keeps Duncanson & Holt, by any measure, first in the field.

dh

Duncanson & Holt Group

By any measure, first in the field

Atlanta, Chicago, Dallas, Hartford, London,
New York, Philadelphia, Portland (Me),
San Francisco, Seattle, Toronto

If managed care fails, is it 'O Canada' for U.S.?

By JERRY GEISEL

The Managed Health Care Congress **MIDWEST**

CHICAGO—Managed care may be the last hope to bring health care costs under control and avert the establishment of a national health insurance system, a physician says.

If managed care does not work, "it may be 'O Canada' for us," he said, referring to the Canadian national health insurance program.

The crisis in health care costs is "real, not imaginary," said Dr. William Fifer, clinical professor of medicine and public health at the University of Minnesota in Minneapolis.

By the year 2000, annual health care expenditures could hit $2 trillion compared with current expenditures of about $700 billion, he said during the Midwest Managed Health Care Congress in Chicago earlier this month.

With corporate health care costs rising each year by double-digit amounts, employers are starting to say, "What does an executive do when faced with these increases? Can we find something" to stanch these tremendous increases? Dr. Fifer asked.

He advised employers and other purchasers of health care to become more prudent buyers of services and eliminate wasteful and unnecessary procedures.

For example, Dr. Fifer cited a Blue Cross/Blue Shield Assn. study that illustrated how one managed care technique—precertification of certain medical and surgical procedures—cut down on unnecessary services.

In that study, BC/BS nurse and physician reviewers, using a special computer software program developed by Value Health Sciences Inc. of Santa Monica, Calif., found that patients' physicians had proposed inappropriate treatment in more than 11% of 9,125 reviewed cases involving 21 surgical and diagnostic procedures (*BI*, March 18).

At one test site, the BC/BS precertification program saved $265,280 in medical costs by identifying procedures that were inappropriate, compared with an outlay of more than $100,000 in software licensing fees, computer hardware, staff training and salary expenses.

Dr. Fifer acknowledged that the medical provider community has not been wildly enthusiastic about precertification programs.

"Doctors hate these lists" of medical and surgical procedures that must be reviewed if the patient is to receive full coverage, he said. "A board-certified surgeon needs permission from a high school graduate"—a reviewer, Dr. Fifer said.

Another way that employers and insurers can better manage health care costs is to try to reach agreements with physicians so that flat fees are set for each patient treated by a physician, a technique health maintenance organizations often use.

"Capitation is the way to go," Dr. Fifer said, referring to such arrangements.

Without such agreements, physicians may increase the volume of services they provide to make up for discounts on services, he suggested.

Dr. Fifer also advised employers to become more active in the drive to publicize the prices charged by hospitals for certain procedures.

In a handful of geographic areas, employers have access to information that allows them to compare prices charged by different hospitals.

For example, in the Pittsburgh area, where state law mandates that hospital charges be made available to the public, some hospitals have charged more than double for a procedure that involves replacement of heart valves compared with other local providers, he said.

"Buyers want cost data, hospital by hospital, procedure by procedure," Dr. Fifer said. Employers should demand reform from legislators so such information is available, he said.

In other cases, employers may try to work out arrangements with hospitals and clinics in which providers will provide specified services at fixed prices, he suggested.

Through such arrangements, the health care provider takes the risk if its costs are higher than its agreed-upon charges.

Doctors have not been wildly enthusiastic about precertification, concedes Dr. Fifer. 'Doctors hate these lists. . .a board-certified surgeon needs permission from a high school graduate,' he says, referring to reviewers.

Dr. Fifer noted that one reason that hospital costs are so high is that facilities often compete on the services they provide rather than on price.

For example, he pointed out that all major hospitals in Lake County, Ind., had facilities to perform open-heart surgery. "Are all these facilities needed? Of course not," he said.

In another example of wasteful competition, Dr. Fifer described a well-publicized case in which a hospital in Kalamazoo, Mich., decided to offer helicopter ambulance service after another hospital in the area started such a service.

"We compete on services, not price," he said.

Dr. Fifer noted that hospital costs also are driven up by paperwork demands imposed by the federal government and private payers.

For example, Canadian hospitals often have just a few employees in their billing departments, compared with dozens or even hundreds of billing department staffers in U.S. hospitals, Dr. Fifer said.

While not endorsing the Canadian program, the relative administrative efficiency of the Canadian health care system "is food for thought," he said.

Under the Canadian program, virtually all residents have comprehensive coverage, while the provincial governments appropriate funds for hospital budgets. Physician fees are set following negotiations between provincial medical officials and physician organizations. ■

Communication advice clashes with reality

By LORI BLOCK

The Managed Health Care Congress MIDWEST

CHICAGO—Companies should follow five key communication principles if they want to ensure that employees understand managed health care and use their health care benefits wisely, a consultant says.

However, adhering to these principles is no easy task, given the real-world constraints often placed on benefit managers.

Mary Page, a communications consultant with Buck Consultants Inc. in Chicago, advises employers on effectively communicating benefit programs. But, even if employers understand her advice, they may be unable to follow it, as was illustrated by the experience of Alejandra Garza, manager-health care plans for Chicago-based Hartmarx Corp.

Ms. Page and Ms. Garza addressed some of the challenges benefit managers face when communicating the introduction of managed care plans or changes to those plans in a joint presentation at the Midwest Managed Health Care Congress held in Chicago Sept. 5-7.

"When we need to communicate managed care, most of us are torn," Ms. Page said. "There is the ideal way, and then there's the way we may have to communicate."

In either case, employers should try to follow five key principles when considering and communicating changes to managed health care benefits, she said. They are:

- Know your employees.

Getting to know the company's employees is important, Ms. Page said, because it will determine not only how the benefit manager will communicate benefit issues, but it may also determine the actual shape of those benefits.

For example, a new benefit package will be explained differently to professional employees and to blue-collar workers, she said.

And, in the case of a diverse workforce, "you can gear your communications to the majority and develop a few specific versions for different groups," Ms. Page suggested.

Furthermore, by getting to know employees, benefit managers can predict what their response to the plan changes may be.

"Find out what the employees are thinking," Ms. Page said. For example, do they think the company is cheap or generous? Do they think existing benefits are good, bad or just adequate?

Surveys are an excellent tool to get to know employees, but don't forget to tap into the company grapevine, Ms. Page added. "Listen to your employees closely."

- Involve your employees early.

By getting employees involved at an early stage before managed care is introduced, they are more likely to buy into the new plan, Ms. Page said.

Employee involvement can be handled in a variety of ways. For instance, a labor-management committee can be established to "hammer out a solution to managed care." However, Ms. Page stressed that while this committee should include representatives of all types of employees, it cannot be used in lieu of direct communication with each employee.

Cost concerns and benefit options also should be communicated companywide, she said. Here, too, surveys and focus groups can be used to solicit employee input.

"They'll appreciate the fact that they've been asked," she said, adding that for this activity to be truly effective, employees must also receive the results of these studies.

- Prepare your employees.

"Employees prefer to adopt change slowly," so it's imperative that they be notified of any plan changes long before those changes go into effect, Ms. Page said.

When explaining the reasons behind a change in health care benefits, don't rely on government statistics that show, for example, the impact of health care costs on the nation's gross national product, she said.

"You've got to put it in terms they can grasp," she said. A better way to illustrate this would be to compare the rise in health care costs with what a similar rise in inflation would do to the price of bread or their take-home pay, she said.

Similarly, it's best if you "communicate information in small doses over time," she added.

- Treat your employees like customers.

In the United States, employees are either treated like children or handled indifferently by their employers, Ms. Page asserted. "But this doesn't work anymore. You need to treat employees like customers," she insisted.

To employee benefit managers, this means that they must adopt marketing techniques to sell managed care to employees, she said. Making this task a little more challenging is the fact that the benefit manager's audience is accustomed to receiving messages from such eye-catching media as People magazine and MTV, Ms. Page pointed out.

However, marketing managed care to employees must be done judiciously, she stressed, noting that if the materials explaining managed care are too glitzy, employees may wonder if the company really needs to contain its health care costs.

Along those same lines, Ms. Page warned against trying to sell employees on something that doesn't exist. "You wouldn't lie to your customers," she said. "Don't sugarcoat managed care as an improvement. Be honest."

Of course, treating employees like customers also requires lots of face-to-face communications, Ms. Page said. Hence, benefit managers should host meetings during company time to explain the upcoming changes. Company managers should be told of the importance of these meetings so that they encourage—not discourage—employees to attend, she said.

These meetings can also be supported by a telephone "hot line" designed to address any employee questions that arise, she suggested.

- Continue communicating.

Employers should measure the success of both the changes made to health care benefits and the communication program that supported those changes, Ms. Page said.

One way to judge the success of the communication effort, she said, is to evaluate how the health care program is being used. If employees are availing themselves of the benefits incorrectly, the communication effort probably failed, she said.

But, even if the initial communication program was a success, it shouldn't end with the program's implementation, Ms. Page said. In-

Continued on next page

Communication

Continued from previous page

stead, companies should establish an ongoing campaign to communicate the results of managed care, she said.

"By keeping (employees) abreast of developments, it will make it easier the next time any changes have to be made," she said.

That last statement should provide a modicum of encouragement to Hartmarx's Ms. Garza, who recently coordinated a managed care communication effort that on several points strayed from the ideal.

As she explained in response to each of Ms. Page's principles, Hartmarx had just two months to prepare its employees for a new preferred provider network that was added as an option to its existing indemnity plan.

Further complicating matters was the recession, which limited the funds the apparel manufacturer and retailer could use to publicize the change, she said.

Ms. Garza outlined how her company responded to the five principles identified by Ms. Page:

- Know your employees.

Prior to implementing the managed care plan, Hartmarx conducted a limited analysis of claims under the old health care plan, which did have an impact on the new plan's design, Ms. Garza said. That analysis revealed that 55% of the health care plan's participants were women, although they only accounted for 45% of the charges. As a result, mammography was added to the list of services provided under the new managed care plan.

However, beyond that, "getting to know" Hartmarx employees was confined to meeting with managers to discuss the plan and hosting a few focus groups, Ms. Garza said.

- Involve your employees early.

Hartmarx was constrained from involving employees by the Taft-Hartley Act, which requires that benefit changes for union workers be negotiated through the union, she said. "Hence, employee involvement was limited."

Employees were presented with the bare facts concerning the "alarming" increases in health care costs the company was experiencing, Ms. Garza said. Employees were notified, through a mailing, that Hartmarx's average annual health care cost per employee was $3,094 in 1990, up 23% over 1989 levels.

However, there was no time to solicit employee input—either through surveys or focus groups—when the plan was in the development stages, she said. As a result, "We had little information regarding the perception of our employees concerning health care costs," Ms. Garza said.

- Prepare your employees.

Due to the time constraints, Hartmarx relied on three mailings to communicate the details of—and the reasons for—the new managed health care plan to its employees.

The first discussed general health care cost issues; the second discussed benefits, comparing what was offered under the old plan and what would be covered under the new plan; and the third, the most comprehensive, featured a question-and-answer sheet describing how the new plan worked.

"Since these facts were communicated within a two-month time frame, many employees were left confused and angry," she admitted. And, to make matters worse, the only face-to-face discussions that could be held were between benefit managers and administrators, she added.

- Treat your employees like customers.

In this area, time and money constraints had a dramatic, adverse impact, Ms. Garza said. She described Hartmarx's actual campaign as "low-key" and conceded that "we didn't do any of" what Ms. Page recommended. However, she did quip that the plainness of the materials was certainly in keeping with the spirit of cost containment associated with the new plan. "Face-to-face communications were limited once again," Ms. Garza said. "This did not encourage an effective two-way communication process."

Furthermore, with the absence of a hot line, Ms. Garza's telephone and electronic mail system became the company's de facto hot line. Although not set up for this purpose, this informal line has received numerous employee comments regarding the new plan, she said. Many have been negative, while a few have been positive, she noted.

- Continue communicating.

Using an ongoing survey about the climate of the workplace, Hartmarx plans to begin monitoring the effectiveness of its communications effort and the acceptance level of the plan, Ms. Garza said. In addition, the company plans to run regular articles in the company's semiannual magazine on the managed care program. Hartmarx is also considering producing newsletters designed to discuss managed care issues. ■

FAST TURNAROUND, NO RUNAROUND.

What makes it possible for NAC Re to turn around most facultative submissions in 24 hours?

Our commitment to your timetable. At NAC Re, superior service is our top priority. We understand you need a quick, thoughtful response and we provide it.

Expertise helps too. It's what gives us the ability to evaluate risks and underwrite consistently. This ability, teamed with our capacity of $35 million ($15 million PML) for property and $5 million for casualty, helps us deliver a response that's quick and predictable.

When you need a fast, intelligent quote, call us. We'll give you the turnaround — without the runaround.

We'll be there when you need us.

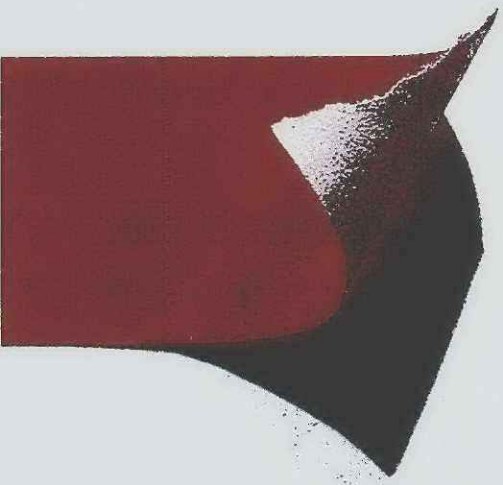
NAC Reinsurance Corporation

GREENWICH
(203) 622-5200
FAX: (203) 622-1494

HARTFORD
(203) 293-6200
FAX: (203) 247-3734

CHICAGO
(312) 876-7200
FAX: (312) 876-1399

SAN FRANCISCO
(415) 616-8200
FAX: (415) 616-8275



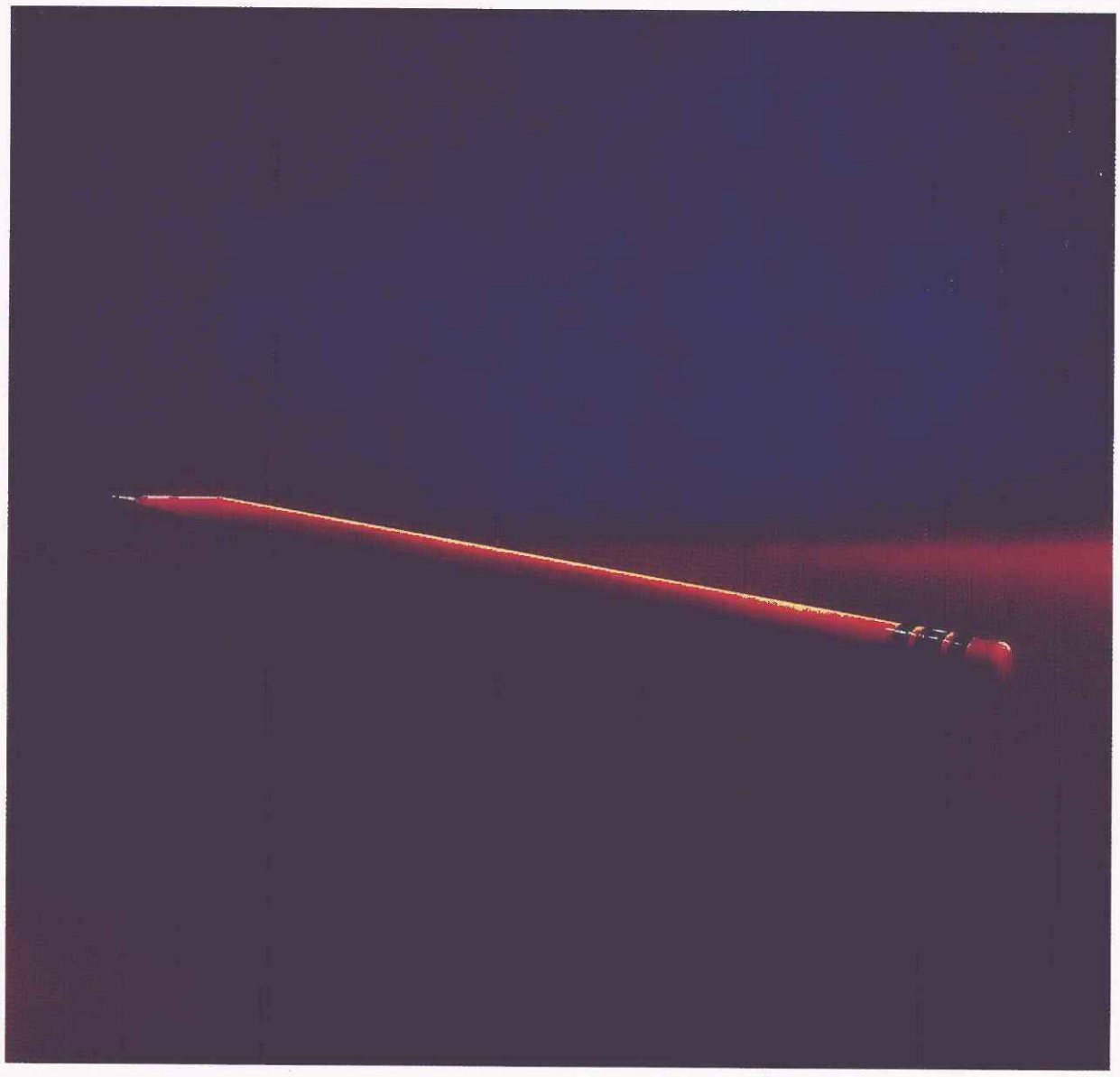
Cutting through the red tape means having your claims processed quickly, accurately and consistently on a single national claims processing system. It means maintaining membership files and claims history on a central system. It means having one-source access to employee utilization data. It means having that data customized and presented to suit your needs. It means working flexibly with all aspects of national provider networks. It **means a new integrated claims processing system** for Blue Cross and Blue Shield National PPO and Point of Service Networks. If you're a large employer with locations in two or more states, or a benefits consultant, you can find out what else our Centralized Claims Processing System means to you by calling John Kibler at 1-800-426-2583.

Blue Cross. Blue Shield.

The pencil costs 14¢. The eraser, millions.

Mistakes make products late, more expensive and inferior. Leaving customers dissatisfied, reputations damaged. Since there are no quick fixes, only costly ones, what's a business to do?

At the CIGNA Property and Casualty Companies, we have a very basic goal: Get it right the first time.



Granted, nobody's perfect. But it's surprising how many mistakes can be prevented.

By working to find the best solution, rather than the most expedient one.

Whether we're providing protection for small and medium-size businesses, or meeting the risk management needs of the largest corporations, the benefits are the same: Answers that are fast and accurate. Service that is responsive. Value that is real. And customers who are satisfied. Anything less would be a big mistake.

For information write the CIGNA Property and Casualty Companies, Department RB, 1600 Arch Street, Philadelphia, PA 19103.

After all, anyone can pay for lots of pencils. But who can afford all the erasers?

We get paid for results.℠ CIGNA

Arbitration American-style

European retrocessionaires can 'win' disputes

By Jack Edward Koepke

THE TERM "WINNING" IS A BIT STRONG for describing the outcome of arbitrations; nevertheless, there are attitudes and actions that can lead to successful arbitrations.

An essential spirit of arbitration prevails in spite of the adversarial system in the United States. In general, arbitration is still about people, and—for good or bad—the spirit of arbitration may at times be influenced by the personal attitudes of the attorneys and the arbitration panel. This is especially so in the United States where one quite rightly speaks of "party arbitrators." The umpire, too—much like a judge—may have predictable leanings and opinions.

The question may thus be asked whether a foreign party, like a European retrocessionaire, must be on its best behavior to avoid adverse treatment in the United States. A foreign company may indeed be at a disadvantage before a U.S. panel in much the same way that a New York company may be at a disadvantage before a Texas court.

One cannot often combat these personal and political attitudes directly, except perhaps to show reasonableness and courtesy to avoid making a sensitive situation worse through lack of instinct.

Any party can make its situation worse through misplaced reliance on privilege, excessive use of formal objections, pursuit of frivolous motions and insufficient preparation.

Nevertheless, even with the best of panels and the most reasonable of parties, arbitration in the United States remains an inexact science. The result, for all its flaws, is probably more than just the result that would generally have been obtained under litigation.

The decision to arbitrate

The decision to arbitrate unfortunately is often more emotional than rational and seldom taken in a straightforward manner. The parties to a reinsurance contract usually stew about a problem for years; meanwhile, underwriting results go sour. The level of cooperation deteriorates on both sides, and finally—often without the benefit of an audit or even of the facts, and before any serious attempt at negotiation—one party serves an arbitration demand.

Arbitration demands are served for collateral reasons like gaining a bargaining edge, achieving commutation or settlement, fulfilling a statutory requirement or avoiding a technical penalty.

Sometimes arbitration is seen as a wild card, a way of gaining time or simply as a leveraging device.

The first strategic consideration, therefore, is to make an informed decision to arbitrate.

When considering the fundamental decision to arbitrate or not to arbitrate, I recommend avoidance where reasonable discussion is still tenable because the arbitration process is costly and uncertain.

And, in situations where other parties similarly situated are in arbitration, it is wise to await the results of these other arbitrations, avoiding costs and uncertainty, and perhaps achieving commutation on the backs of other arbitrating parties, so to speak. This may be the case in large quota-share treaties or in pool business.

Obviously, the arbitration of any issue that may have a potentially major impact in related areas, like the arbitration of one's own retrocessional program, should be avoided. Also avoid arbitration of issues that are fact-intensive, due to the time and costs involved.

In addition, the arbitration of issues involving fraud or recision should be undertaken with caution because arbitration panels are traditionally reluctant to grant recovery unless the stench of wrongdoing is overpowering. Litigation would be the preferred route when alleging fraud or demanding contract recision.

Ultimately, one ends up arbitrating those cases which appear, after careful audit and research, to be strong on the facts.

Conscientious research, including appropriate inspections and audits, is the best foundation and surest strategy for successful arbitration.

To the maximum extent feasible, the complaining party should exhaust all rights under contract, especially the right to thoroughly inspect the books and records of its business partner before undertaking arbitration. And, I recommend that the plaintiff have audited its partner more than once before arbitrating.

A major mistake of European retrocessionaires and reinsurers is the failure to audit U.S. reinsurance contracts out of a feeling of misplaced pride, honor or trust.

Moreover, the failure to audit during the life of the contract is a commonly raised defense in arbitration proceedings. Often, the failure to audit, rightly or wrongly, takes on the color of contributory fault in the eyes of the panel.

Useful settlement or commutation discussions take place after a proper case has been built on facts ascertained by audit or research. Only after these discussions have failed is the step toward arbitration strategically correct.

It is important to remember that an arbitration award never commutes the contract under which the arbitration arises. Arbitration merely regulates a specific case of controversy. The right to audit survives the arbitration so that the parties may continue their audits even after the arbitration is over.

Regardless of the outcome of the arbitration, the parties are still "stuck with each other" and must look for ways to commute or continue their relationship, depending on the goal. Worse still, litigation may still follow arbitration, doubling the costs to both parties.

Selecting the parties involved

Among Europeans it is commonplace to observe that the U.S. system of justice is neither a system, nor capable of dealing justice.

Assuming this observation to be correct; parties contemplating arbitration in the United States may indeed conclude it would be appropriate to "fight fire with fire." Thus it may seem a good idea to employ a rough and thorough attorney, a "cowboy" or street-fighter type; however, caution is advised.

"Cowboy counsel" are often motivated to transform the arbitration process into a major cash flow exercise where, due to counsel's own antics, reasonable settlement just never seems possible.

Today's arbitrations are often complex, generally requiring appointment of counsel to manage the arbitration process. I recommend appointment of conservative, professional reinsurance counsel with a reputation for turning arbitrations into settlements.

If the decision to arbitrate is unavoidably taken, one should select an arbitrator who is known and trusted. A knowledgeable arbitrator is important because the field of reinsurance has many areas of special knowledge. While a well-known, knowledgeable and experienced arbitrator is desirable, this alone is not sufficient.

In the United States, one will want a trusted advocate, or party arbitrator, who has backbone and the courage of his or her convictions. In the United Kingdom, the arbitrator is always regarded as a neutral person, not as a party arbitrator, and my discussion is not intended to address the traditional English situation.

After the arbitrator is selected, the next step is to select an umpire.

It is commonly observed that most arbitrations are won or lost on the vote of the umpire. It is virtually impossible to win an arbitration with the wrong umpire; that is, one whose mind has already been made up in favor of the other side.

When selecting an umpire, it is therefore not uncommon to see the parties engaged in extensive, elaborate maneuvers in search of the third person.

While it is strategically vital to obtain the best umpire possible, the parties should not assume a take-it-or-leave-it attitude on umpire selection. Lack of readiness to compromise in the selection process may lead to drawing by lot or, in the worst of all scenarios, a judge-appointed umpire.

After an umpire is selected, an effort should be made as soon as possible to hold a preliminary conference of the parties. The preliminary conference is for the purpose of laying out basic procedure on diverse issues and it may present items of strategic importance:

- Disclosure of any potential conflicts by each arbitrator, recorded in the minutes of the meeting.
- Preliminary indication by the parties that they do not object to any member of the panel, and agreement not to attempt to have any member of the panel disqualified.
- Agreement by the parties to hold the panel harmless and provide to each member of the panel a formal hold-harmless and indemnification agreement.
- Stipulation among panel members of the manner in which communications between panel and parties are to be conducted.

For example, each party may communicate with its own arbitrator on a one-sided basis up until the close of the evidentiary hearings. Once the evidentiary hearings are closed, the parties usually may not communicate with their appointed arbitrators about the substance of the arbitration.

- The parties may not directly communicate solely with the umpire about the subject matter of the arbitration.
- Definition of scope of audit and discovery, if any, and delineation of a detailed plan for compliance.
- Agreement as to establishment of escrow accounts, if any.
- Discussion of confidentiality agreements, if any.
- Detailed commitment of all parties as to scheduling for all future discovery, exchange of pre-hearing and post-hearing briefs, dates of any meetings of the parties, and the schedule for all future panel meetings and hearings.
- Preservation of the record through court report or other official minutes, written and agreed upon by the parties.

Given the technical and adversarial nature of some arbitrations, preservation of the exact record—even of preliminary conferences—by a court reporter may be considered a strategic measure in some cases.

The above list of preliminary items clearly reveals the need for a policy regarding discovery. There is one strategic distinction: an audit is not discovery. Audit rights are not fishing expeditions but contractually protected rights.

Typically, an audit consists of an inspection of books and records, whereas discovery constitutes the use of interrogatories, depositions and other production requests outside the bounds of contractual audit requirements. Normally, audit precedes discovery. Modern discovery is a U.S. invention—the product of litigation—whereas the audit is an older, internationally recognized contractual right, pre-existing and independent of both litigation and arbitration. While a good arbitration panel should exercise sharp control over discovery—which in numerous recent arbitrations has gone somewhat out of control—audit rights should not be unduly curtailed.

Strategic considerations

Confidentiality agreements, while having really nothing special to do with arbitration, may be strategically important in the domain of auditing and discovering information.

The party against whom audit and/or discovery is directed will generally insist upon a tightly drawn

Continued on next page

Reinsurance arbitrations

Continued from previous page

confidentiality agreement prior to the inception of any hostile audit. Panels will likely support and require such confidentiality agreements where the parties state a timely request.

Escrow of outstanding balances is also a strategic consideration in U.S. arbitrations. In most situations, the complaining party has not yet fully availed itself of its audit rights under the contract. For example, sometimes a cedant has found something wrong and simply ceased making payment. Must the cedant pay to see the books, or may he see in order to pay? Most reinsurance contracts are entirely silent on this point. Thus, it is difficult to lay down rules, but I would observe that U.S. panels used to regularly deny escrow except in unusual situations.

Increasingly, however, arbitration may be viewed in the United States as a means of attempting to avoid or diminish payment. Escrow, as a general approach preceding audit or discovery, is therefore gaining popularity in the United States and will be seriously contemplated by arbitration panels where a party has failed to bring balances current.

Escrow generally takes the form of posted letters of credit in the amount of all or some of the outstanding items in dispute. Generally, escrow is not required for incurred but not reported losses.

For the party with a reasonable complaint, partial escrow is often the intelligent approach. The willingness to accept some limited form of escrow often appears to the panel as a showing of good faith, as a means of burden-sharing and as a way of avoiding an embarrassing debacle.

Another issue of strategic importance is the pre-hearing brief. While much can be said about the spirit of arbitration and the quality of the panel, arbitrations are won or lost on the facts. From the arbitrator's point of view, the true foundation for success ends with the pre-hearing briefs, which contain a description of the facts and theories of the case and of the anticipated evidentiary presentations.

On the basis of the pre-hearing briefs, the outcome of most arbitrations can be predicted because the pre-hearing briefs review the state of the audit and/or discovery to date and summarize the proof which will be offered at the hearing.

The presentation of the pre-hearing briefs, therefore, creates an opportune moment for both sides to take account of their own relative strengths and weaknesses and to again review the merits of settlement.

After the arbitration panel has read the pre-hearing briefs, the panel will be in a position to identify those issues the panel will wish to hear more about. Those are the issues that the parties should concentrate on. The parties should take these suggestions seriously.

Missed opportunities

Arbitration is an equitable undertaking within the insurance/reinsurance industry. The parties should realize that to some degree they will be judged not merely on the factual evidence. Every issue in dispute presents many-faceted logical perspectives as well as opportunities for a showing of diplomacy, competency and fair dealing.

The scope of discovery may become problematic, with one party frequently requesting documents related to every issue and the other party refusing unless and until documents have been clearly identified.

Obstructionistic, ritualistic fights and senseless petty skirmishes generally precede the inevitable compromise. The winning or losing of preliminary skirmishes sometimes gives a clue on the relative strengths of the parties, so if you can't win an argument, don't start it.

The time factor is also a typical area of abuse, each party often vigorously demanding and taking as much time as possible to present its case. The tendency toward overkill here can be damaging for a number of reasons:

- First, the panel generally knows what it wants to hear.
- Second, time is an area in which the parties can, with a degree of flourish, create the impression of confidence and skill in presentation.
- Third, the tendency of any party to constantly add new issues leads ultimately to a perception by the panel that the party doesn't have a case.

Conflicts exist to be resolved. Most arbitration panels believe in the spirit of arbitration, and will respond favorably to a show of reasonableness and good faith.

It is generally a mistake to take an overly technical, defensive or even obstructionistic approach when dealing with people. Arbitration proves the rule.

The best strategy for winning an arbitration in the first instance is to audit, investigate and research wherever practicable and reasonable. Then, arbitrate the likely winners and settle the obvious losers as quickly as possible. When conducting the arbitration process itself, the parties should follow normal instincts of good business practice applicable to an equitable proceeding. ■

Jack Edward Koepke is a director of Gerling-Konzern Globale Ruckversicherungs-A.G. in Cologne, Germany.

Estimating impact of property loss

By The Insurance Institute of America

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

This month's exercise, drawn from a May 1987 national examination, considers a procedure for estimating the likelihood of a major property damage loss, the factors affecting the financial consequences of such a loss and some ways of preventing or reducing the loss.

Q: An earth-moving company that specializes in major excavations for commercial buildings and highway projects occasionally incurs damage to its bulldozers, backhoes and other mobile equipment. Significant damage to any particular item of equipment is likely to slow or stop the construction project on which that equipment was used, thus adding a net income loss for the construction company to the direct property losses to its mobile equipment.

Price adjustment factors for equipment losses

Year	Annual equipment damage	Equipment price index
1987	$120,000	118
1988	180,000	125
1989	90,000	130

Source: Insurance Institute of America

GRAPHIC BY JOHN HALL

A.R.M. exercises

To measure this company's equipment damage losses in constant 1989 dollars, the dollar amounts of machinery losses for the last three years, shown in the middle column below, need to be adjusted for equipment price changes. The appropriate values for this equipment price index for the past three years are shown below.

- Showing your calculations, express this company's equipment damage losses for 1987, 1988 and 1989 in constant 1989 dollars (see table, below left).
- The mobile equipment can be valued for various purposes by a number of valuation standards, including actual cash value, accounting (book) value, replacement cost and functional replacement cost. Which of these four valuation standards would be the most appropriate for this company to use in placing a financial value on the damage to its equipment? Justify your answer.
- Describe three distinctly different actions this company can take, either before or after a major item of mobile equipment has been damaged, to reduce the severity of the company's net income loss from this damage.

A: • To express all loss costs in 1989 dollars, all losses must be multiplied by a price adjustment factor. For each year, this factor equals the 1989 price index divided by the price index for the year in which the losses occur. Thus, in thousands of dollars rounded to the nearest hundred dollars, the appropriate calculations are as indicated in the table below.

- Each of the four evaluation standards may be appropriate under specific circumstances. If the equipment is to be replaced, the two most appropriate evaluation standards are replacement cost and functional replacement cost.

If the old equipment is not technologically obsolete, then the replacement cost—the market price of comparable new equipment without any deductions for depreciation—is the best measure of the company's actual loss.

However, if the lost equipment were technologically outdated and would not be replaced by a similar model, then functional replacement cost—the value of new equipment of more modern design that would perform the same function as the old and damaged equipment—would be the best measure of value.

In either of these two circumstances, replacement cost or functional replacement cost would best measure the expenditures the company would need to make to return to its pre-loss condition.

- To preserve its net income—its normal revenues minus its normal expenses—despite damage to its equipment, the earth-moving company can take a number of actions. One would be to purchase or arrange to borrow substitute equipment, so that normal operations could continue without interruption.

Secondly, after the original equipment was damaged, the company could act promptly to arrange for replacement equipment.

The third option would be for the company to reduce its dependence on any particular item of equipment by undertaking more projects that would not require use of the particular item of damaged equipment. ■

Calculating adjusted losses

Dollars in thousands

Year	Actual losses		1989 price adjustment factor		1989 adjusted losses
1987	$120	x	130/118	=	$132.2
1988	180	x	130/125	=	187.2
1989	90	x	130/130	=	90.0

Source: Insurance Institute of America

GRAPHIC BY JOHN HALL

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

Keep Environmental Risks From Spilling Over Your Books.

Environmental risk has become the hottest issue in the industry.

Unfortunately, there are no easy answers when environmental claims arise. Each case has to be handled on an individual basis. There is no consistency in court decisions.

But there are ways to deal with these hazards, and reduce their impact.

North American Re has expanded our Environmental Claims Unit to help clients with these difficult risks.

Through careful analysis of policy coverage and loss events, we help clients reduce current liabilities and avoid or diminish future risks.

North American Re.

We help keep environmental losses from creating a mess in the executive office.

NORTH AMERICAN

RE

Choosing A Reinsurer Shouldn't Be A Risk

NORTH AMERICAN REINSURANCE CORPORATION 237 PARK AVENUE, NEW YORK, NY 10017 (212) 907-8000
ATLANTA BOSTON CHICAGO DALLAS LOS ANGELES NEW YORK PHILADELPHIA SAN FRANCISCO

Rostenkowski sees 'radical' health reform

By JERRY GEISEL

The Managed Health Care Congress
MIDWEST

CHICAGO—It may take a decade, but a "radical restructuring" of the nation's health care delivery system is inevitable, says the chairman of the House Ways and Means Committee.

Once that restructuring is complete, all Americans will have health insurance, said Rep. Daniel Rostenkowski, D-Ill.

It took nearly a decade of heated debate before Congress enacted the federal Medicare program in 1965, he recalled. "I think we will see a repeat of that" on health care access reform, he said.

While universal health care coverage will mean an increase in federal spending, "it is a price worth paying. There is a growing consensus this is necessary," Rep. Rostenkowski said earlier this month in Chicago at the Midwest Managed Health Care Congress.

Rep. Rostenkowski acknowledged that a sweeping reform bill, H.R. 3205, he introduced in August has no chance of passage during the current congressional session.

"We are not looking for a quick and easy victory. Legislation is like protracted trench warfare," he said. "Much as I would like to be lionized as the Norman Schwarzkopf of health care, I know that will not happen," Rep. Rostenkowski said.

His bill would give the federal government new authority to hold down health care costs. National spending limits would be established by an 11-member commission. The secretary of health and human services then would set specific payment rates for health care services that would result in expenditures equal to the national limits.

By the year 2000, Rep. Rostenkowski's proposal aims to hold the annual rise in health care costs to no more than the rise in the gross national product.

Current double-digit annual cost increases are "not good news," he said. "I don't think you can name another business that has double-digit growth."

Cost control, though, is only half of the Illinois Democrat's agenda. Under a "pay or play" provision in his bill, employers would have to offer a health plan or pay a new tax set at 9% of employees' wages, up to the Medicare wage base. Employees could be required to pay up to 20% of the tax, which would be used to help fund a new public plan for the uninsured.

If the 9% tax proves inadequate to pay for universal coverage for the uninsured, the measure calls for a surtax, initially set at 6% and gradually rising to 9%, on corporate and individual taxpayers.

In addition, the bill would boost the Medicare tax and wage base. The current 1.45% Medicare tax—paid by both employers and employees—is imposed on the first $125,000 of wages. Under the Rostenkowski bill, the tax rate gradually would rise to 1.65%, while the amount of wages subject to the tax would be lifted to $200,000.

Aside from being hit with tens of billions of dollars in new taxes, employers would face administrative burdens.

Under the measure, employers with health plans would have to inform the federal government each time an employee dropped coverage—like when a person changes companies—and each time an employee joined their health plan.

This could mean that a national company with high employee turnover would have to send out thousands of notices a year.

The measure, though, would shift a substantial amount of retiree health care costs from employers to the federal government. It would gradually lower the eligibility age for a retiree to receive Medicare benefits to 60 from 65 (*BI*, Aug. 19).

Rep. Rostenkowski described his measure—which will be discussed during three days of Ways and Means Committee hearings next month—as a good starting point for a debate that he expects to last years.

"We are not ready to act soon," he cautioned, adding that too often legislators act quickly on bills, then "repent slowly."

But Rep. Rostenkowski said he hopes his proposal will trigger the Bush administration to produce its own health care reform legislative package.

'Legislation is like protracted trench warfare,' says Rep. Dan Rostenkowski.

"Foreign policy may be more fun. But real leadership begins at home," Rep. Rostenkowski said.

"The president has to respond to the growing chorus" for health care reform and come out with his own proposal, he added.

Various interest groups will target the specifics of his proposal, the Ways and Means Committee chairman acknowledged.

Labor groups and congressional liberals, for instance, consider the basic benefit package inadequate and will press for improved benefits, he said. And they would be joined in their call for better benefits by physician groups and other health care providers.

Indeed, Rep. Rostenkowski fears that his bill could be stalled by an informal alliance of liberals who want expanded benefits and conservatives opposed to significant changes in the health care delivery system.

Rep. Rostenkowski noted that his proposal would require adjustments by both providers and users of health care services.

For example, while physicians would have their fees limited for specific services, they would be assured of payment either from employers or from the federal government.

Similarly, because patients would have health insurance, hospitals no longer would face the problem of picking up bills of the uninsured.

Hospitals would not have to perform a "wallet biopsy" to see if patients had health insurance before admitting them, Rep. Rostenkowski said.

At the same time, as hospitals are forced to operate more efficiently and possibly consolidate, patients might have to travel further to receive health care services, he said.

While a major overhaul of the health care delivery system will re-

Continued on next page

Continued from previous page

quire adjustments by both users and providers, fundamental change is something that the voters want, he said.

"My sense is that the voters are getting restless," he said. "This is a chance for my profession to redeem itself. I honestly and truly believe it is time for a change in policy."

Turning to a related subject, Rep. Rostenkowski warned those who advocate managed care not to oversell the potential of managed care.

In fact, he surmised, the evolution of managed care appears to resemble that of health maintenance organizations, at least in their early years.

"In the beginning, it (managed care) will be oversold like HMOs. You should be wary of overselling," Rep. Rostenkowski said.

Because managed care is not clearly defined, the Ways and Means committee chairman conceded that it is difficult for him to tell whether the concept is actually a step forward or backward for the nation's health care delivery system.

But he hopes that managed care is more than a "disembodied voice" saying to every fourth or fifth patient, " 'you can't get that service.' "

Still, while managed care may be good for some particular employers and their employees, it could lead to broader problems for the nation, he said.

For example, employers and insurers that win price concessions from hospitals and physicians actually make it more difficult for those facilities to care for the poor and uninsured.

"Your victories will merely make more serious the problem the political system is currently facing," he said.

"By itself, managed care is not the answer to the massive problems we face," Rep. Rostenkowski added. ■

How to find health care value

By LORI BLOCK

The Managed Health Care Congress **MIDWEST**

CHICAGO—Although few benefit managers may be familiar with them, "Nash's Rules" reflect two fundamental principles they may want to follow to get the most out from their health care plans.

Devised by Dr. David Nash, director of health policy and clinical outcomes for Thomas Jefferson University Hospital in Philadelphia, these two rules are simple. Yet they seem to be rarely, if ever, applied to purchasing health care benefits, Dr. Nash said.

Nash's Rule No. 1: "You pay, you say."

Speaking to executives from large corporations, Dr. Nash stressed that corporations "control the purse strings, particularly in your collective clout."

Nash's Rule No. 2: "You get what you pay for."

Benefit managers may be surprised to hear this from a physician, but Dr. Nash also holds a master's degree in business administration and thus serves as a liaison between the hospital's physicians and administrators.

At the Midwest Managed Health Care Congress, held Sept. 5-7 in Chicago, Dr. Nash discussed what benefit managers and other executives "ought to be asking" when making health care decisions.

Employers tend to evaluate providers in a network in a rather cursory fashion, said Dr. Nash. They typically require physicians to have board certification and hospitals to have residency and fellowship training, conduct ongoing research programs and be affiliated with a medical school.

"Quite frankly," Dr. Nash said, "there simply isn't any evidence that shows these four criteria produce better health outcomes. . .at a better price."

Instead, he recommended that corporations strive to judge hospitals and other providers in greater depth. After initial inquiries about fellowship programs or board certifications—what he calls "level one" criteria—he recommends moving on to questions designed to elicit "sexier" answers.

These level-two questions might be designed, for example, to determine the number of complications brought about by medical treatment that a particular hospital experiences. And employers could ask how many surgical procedures require unexpected returns to the operating room.

At level three, purchasers utilize the services of outside consultants who evaluate providers on established standards.

Level four, the most advanced level, would include a direct comparison of provider physicians or hospitals against established practice profiles and would link financial and clinical data sets.

Although these more advanced forms of provider evaluations may seem impossible to many benefit managers, Dr. Nash insisted that hospitals can answer such questions. For instance, he said, hospitals can examine how doctors handled a certain type of treatment and determine which one had the best recovery rates, the highest costs or the longest hospital stays.

As businesses become more aggressive purchasers of services, hospitals eventually will acquiesce to providing such information, he said. "Imagine the kind of fun you would have if you asked your local doctor to provide this kind of information," Dr. Nash quipped. But, "the more questions you ask, the more interesting the discussion will get."

Looking ahead, Dr. Nash predicted a number of changes in the health care system.

First, the call for written clinical guidelines eventually will reach a peak. But doctors will follow these guidelines "when and only when reimbursement is tied to those guidelines," he cautioned.

Dr. Nash also foresees more doctors like himself, dual-degree professionals capable of bridging the schism that has developed between health care practitioners and administrators. Employee benefits managers will have to negotiate with this new type of "physician-manager," he said.

And he hopes for a "less acrimonious" dialogue between health care providers and the business community. The two groups, he said, ought to be able to "speak the same language and try to achieve the same goal": to provide "the best quality care at the best price."

It is with that goal in mind that the Midwest Business Group on Health continues work on its Value Managed Purchasing program, said its president, James D. Mortimer, who also spoke at the session.

Begun four years ago, the program focuses on "quality assessment, quality assurance and quality improvement," he said. One fundamental part is gathering as much data as possible so purchasers can make educated decisions.

Mr. Mortimer advocated that employers and providers share goals and management tools to improve health care.

Also speaking at the managed care session was Bob Hungate, government affairs-health care manager for Hewlett-Packard Co. in Washington, D.C. ■

Bank gets handle on health outlays with data systems

By LORI BLOCK

The Managed Health Care Congress MIDWEST

CHICAGO—Management information systems—which companies have used for years in a myriad of functions—are increasingly being used to manage health care costs.

The idea behind a health care MIS is simple: By compiling and manipulating extensive amounts of data, companies can gain a better understanding of where their health care dollars are going, said Dr. Wayne N. Burton, vp-corporate medical director for Chicago-based First Chicago Corp.

Five years ago First Chicago, the nation's 12th-largest bank, began developing what he calls a "health data management computer system" to try to control health care costs and improve the care received by its 15,000 employees.

"Periodically, we can put in a managed care program and flatten out the slope (of cost increases)," Dr. Burton said. But that fix is only temporary, he said.

What First Chicago wanted was a more permanent fix—and the company believes it has found one.

Dr. Burton shared First Chicago's solution during the Midwest Managed Health Care Congress, held Sept. 5-7 in Chicago.

First Chicago's solution revolves around its version of a health care-based MIS: the Occupational Medical Nursing Information System.

"The goal of these systems is to change the slope of the (medical cost) curve by better understanding where our costs are," said Dr. Burton. Then, armed with this knowledge, companies can use cost containment strategies like preventive care, prenatal care and employee wellness programs with a high level of assurance that the programs are properly targeted and, thus, will be effective, he explained.

Dr. Burton calculated that if First Chicago reduced its health care costs by less than 1%, the management information system would pay for itself. That's why the bank holding company's chief financial officer told Dr. Burton that the decision to institute the system was "a no-brainer; go for it," Dr. Burton explained.

First Chicago's health data management computer system utilizes several existing data bases. It pools information on benefit claims, employee health risks, employee demographics, workers compensation claims, disability costs and absenteeism, occupational exposure, lab testing and employee assistance programs.

In the future, Dr. Burton said, companies should also be able to include detailed medical records—obtained through health care providers and/or insurers—in their system. Other information, like worker productivity records, could

Continued on page 42

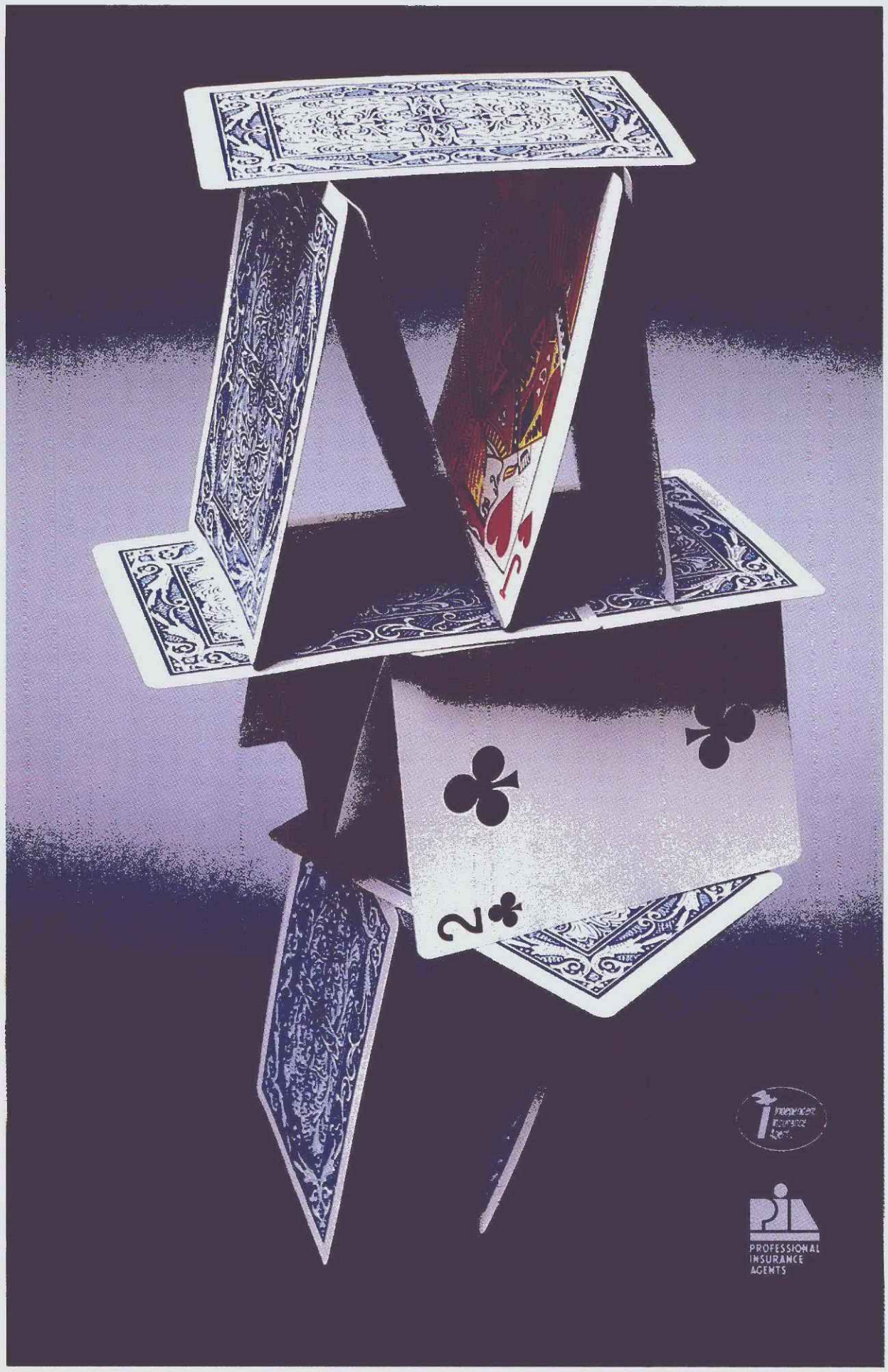
DON'T SNEEZE.

Not on the ordinary commercial property program, anyway. Between the gaps and overlaps in coverage and service, it just might not stand up.

On the contrary, ITT Hartford's commercial property programs are built to last.

Our foundation is loss control. More than 400 on-staff engineers and specialists make it their business to help stop accidents before they start.

Next, we provide a broad framework of products for everything from the Main Street enterprise to the multi-national corporation. This includes domestic *and* international locations, property in transit, excess and surplus lines insurance and layered programs.



A full range of options and enhancements fill the niches.

And when a claim is filed, we do more than just process it, we monitor and manage it.

We top it all off with a wide variety of payment plans designed with the customer's cash flow needs in mind.

The result is the right coverages backed by the right services at the right price.

Nothing more. Nothing less.

Splitting coverages and services among different carriers and third parties can be a shaky proposition at best.

To put it all under one roof, contact your local ITT Hartford Regional Office Property Underwriting Department.

You won't find a better deal.

ITT HARTFORD

Managed care requires employer study

By LORI BLOCK

The Managed Health Care Congress **MIDWEST**

CHICAGO—Before entering the "brave new world" of managed care, benefit managers, particularly those at smaller organizations, have some homework to do, a consultant advises.

"Managed care means you are much more in the loop" and are taking a more active role in delivering health care to employees, said Robert J. Williams, an actuary with The Wyatt Co. in Washington, D.C.

Under a managed care system, employee benefit managers "have to understand it all," he said during a session at the Midwest Managed Health Care Congress, held Sept. 5-7 in Chicago.

"You need to micromanage it if you are going to manage it," Mr. Williams said of managed care. This means employee benefit managers must understand how the various components of the health care delivery system work. They must understand how insurers, hospitals and primary care physicians operate, as well as understand the conflicts that can and do arise among them, he explained.

While many people define managed care as a health care plan that includes such features as utilization reviews or a preferred provider network, Mr. Williams takes a much broader view.

Managed care exists when the benefit manager takes the initiative and begins "mucking things up," he quipped. In other words, it is "an intervention utilized by an employer to control the amount and cost of medical care provided to employees in order to enhance efficiency and quality," he said.

Mr. Williams stressed the use of the word "intervention," noting that other people might choose a different word. Physicians, for instance, might call this an interference, while others might say it is an intrusion into employees' lives, he said.

Regardless of what it is called, corporations increasingly are turning to managed care to curb soaring health care costs and, perhaps, provide higher quality care, Mr. Williams said.

While he debated whether managed care actually accomplishes what it was designed to do (see story, page 21), Mr. Williams did acknowledge that, for many companies, it is the most viable cost-control option currently available.

But, he added, adopting a managed care philosophy forces some fundamental changes upon the employee benefit manager.

To help those about to embark on a program of managed care, he recommended that they ask themselves the following questions:

- How much overall cost—total and per employee—can I bear?
- How much choice should be offered? Should there be multiple plans? Multiple providers?
- Should there be a uniform benefit plan for all employees, nationwide?
- What role should quality play?
- What role should health promotion and education play?

"By forcing yourself to ask these questions, it forces you to then ask, 'what do I have to do,' " Mr. Williams said.

He suggested that once benefit managers have developed the company's philosophy and objectives regarding managed care, they should screen potential vendors, using those firms' proposals to help formulate the plan's design. Next, benefit managers should develop a request for proposal, evaluate vendors and negotiate the deal.

When negotiating, Mr. Williams advised benefit managers not to accept "a purely self-funded situation." Instead, force the vendors to share some of the risk. "Hold their feet to the fire," he said.

The idea of truly negotiating a health care plan may put some benefit managers in an unfamiliar position but, then again, this is a brave new world, Mr. Williams said. "You are in a world where you are going to be intervening. You want to make sure this intervention is well thought out." ■

Data systems

Continued from page 40
also be added.

The key is verifying that the data is accurate and of good quality, Dr. Burton said. To that end, First Chicago worked with two computer consultants to divide the work of acquiring and analyzing insurance claims data: Health Decisions Inc. of Minneapolis and Stephens Systems Services Inc. of New York.

From this combination of data bases, First Chicago now can:

- Identify and project disease and injury trends.
- Identify health-related costs.
- Project cost trends.
- Construct models of cost management options and evaluate them.
- Evaluate the quality of health services.
- Facilitate, monitor and evaluate employee compliance with recommended treatment.

In addition, Dr. Burton says he hopes that the system will eventually be able to track whether an employee is being prescribed the proper course of treatment.

These analyses enable First Chicago to break down its medical costs almost like an insurer examines its costs, Dr. Burton said, adding that "the importance of looking at this data is to design intervention strategies." For instance, First Chicago is using the system to track the effectiveness of the in-house prenatal education program established four years ago in cooperation with the March of Dimes.

According to Dr. Burton, a recent report generated through the data system showed that the average cost for deliveries among participants of the prenatal education program was $7,346, compared with $10,289 for those who did not participate.

As a result of these savings, First Chicago now waives the $250 deductible in its health care plan for the newborn during its first year of life if the mother participates in the prenatal program.

Although Dr. Burton maintained that First Chicago's health data management system is the nation's most comprehensive, he added that the company is not alone in developing health care data systems. Companies like Southern California Edison Co. of Rosemead, Calif.; and Pacific Bell, a San Francisco-based subsidiary of Pacific Telesis Group, are also tracking health care data through automation systems (*BI*, April 30, 1990).

Dr. Burton also stressed that the information revealed by such systems is rarely startling and usually confirms long-held beliefs regarding employee health, absenteeism and claim costs. Still, he said, compiling such data is important for companies trying to design plans that truly meet employee needs, while lowering costs and boosting worker productivity.

"There is no magic pill," he said, but "there is data available that can help you manage your costs." ■

Superfund stalemate: Only lawyers clean up?

By JOANNE WOJCIK

SAN DIEGO—There is no end in sight to the battle raging between policyholders and insurers over coverage for the cleanup of pollution sites, attorneys for both sides say.

On the one hand, policyholders accuse insurers of reneging on their promise to pay for environmental losses; on the other, insurers say they are fighting for survival (see story, page 1).

Insurers have been trying to nullify policies by claiming that policyholders are wrongdoers, alleged policyholder attorney Eugene R. Anderson of Anderson, Kill, Olick & Oshinsky in New York.

But because the cost of cleaning up all of the environmental damage discovered so far "is significantly higher than the capital base of all insurance companies in the world," insurers are fighting for their survival, said Barry L. Bunshoft, managing partner in the San Francisco insurance defense firm of Hancock, Rothert & Bunshoft.

However, James L. Kimble, senior counsel for the Washington, D.C.-based American Insurance Assn., observed that despite all the litigation over who will pay for the cleanup of hazardous waste, "the only real cleaning up is being done by attorneys."

All three attorneys made their remarks during a session on environmental pollution insurance issues during the American Risk & Insurance Assn.'s annual meeting last month in San Diego.

Because of the stalemate between policyholders and insurers, "it will take more than 10 years to bring this idiocy to an end," predicted Mr. Anderson.

Indeed, "I don't think I will be practicing law by the time there are significant changes," he quipped.

In courtrooms across the country, insurers have accused policyholders of "committing the twin evils of fouling the land in which we live and swindling the insurance companies that never intended to provide that coverage," Mr. Anderson asserted.

Insurers have argued that "liability insurance should not cover tortfeasors"—or companies that commit torts—because "they don't deserve it. If you allow tortfeasors to collect insurance, you are encouraging torts," he explained.

But if courts universally accept this reasoning, they may also deny coverage for drivers who cause auto accidents, Mr. Anderson said.

Companies buy insurance just in case they do misstep, he argued.

Policyholders thought they were buying "safe hands" and the "rock of Gibraltar," but instead of sending the "Kemper cavalry" to their rescue, "the courts have told them (policyholders) they ought to be incarcerated instead of insured," Mr. Anderson said, borrowing from several insurers' marketing slogans and symbols.

Mr. Bunshoft countered that, in order to ensure their own financial survival, insurers must resist providing blanket pollution cleanup coverage to policyholders.

"It's a fight about survival" that is pitting the world's largest oil and chemical companies against international insurers, he said.

"We're not talking about actuarially predicted accident losses," he continued. "We're talking about ongoing corporate practices that caused pollution. That has nothing to do with liability insurance."

Insurers are perfectly willing, under comprehensive general liability insurance policies, to cover sudden accidents that cause pollution, according to Mr. Bunshoft.

"But when you're talking about disposing of hazardous wastes into a pond that's nothing but a depression in the sand where it's going to seep into the ground, and it doesn't stop until the EPA says, 'That's enough! Clean that up!'—that's not sudden and accidental," he asserted.

"It's a moral concept in many respects, and moral and contractual concepts intersect," Mr. Bunshoft said.

The answer to the debate over who should pay may be found by revamping the federal law that provides for the cleanup of hazardous wastes, according to Mr. Kimble of the AIA.

'It will take more than 10 years to bring this idiocy to an end,' predicts Eugene Anderson.

He said the argument between Messrs. Anderson and Bunshoft was a perfect example of how the federal Comprehensive Environmental Response, Compensation and Liability Act, also known as the Superfund Act—which was intended to force polluters to clean up pollution—"is not working."

"In some cases, innocent polluters are being forced to pay, leading to delays in cleanup," he said.

The law also has created three layers of litigation, according to Mr. Kimble. They are:

- First, that the federal government must go to court to enforce the law.
- Second, that the so-called "responsible parties" often try to pass the buck by filing suits to name other potentially responsible parties.
- And finally, that the parties determined to be ultimately responsible go to court to force their insurers to cover their cleanup costs.

As a result of this tangled web of litigation, it takes an average of eight years from the time a polluted site comes to the attention of the U.S. Environmental Protection Agency until cleanup begins, Mr. Kimble said.

"This is not an efficient cleanup scheme," he said.

Mr. Kimble suggested that the most efficient way to minimize litigation and speed up the cleanup process is to "put cleanup on a public works level."

Spreading the cost among all the U.S. taxpayers is the only equitable solution, Mr. Kimble said, because "arguably, we are all polluters."

And apportioning the cost without finding fault "would tremendously reduce the friction costs we are all greatly concerned about," he said.

"Litigation would be minimized and the money would go to cleanup, not to pay attorneys," he added.

The session was moderated by Robert Witt, professor of insurance and risk management at the University of Texas at Austin. ■

Harsh rules could damage property/casualty insurers

By JOANNE WOJCIK

SAN DIEGO—The insurance industry is in better financial shape than the savings and loan industry, a state regulator and an property/casualty industry official contend.

In addition, the property/casualty insurance industry is stronger than the life insurance industry, the regulator says

However, oppressive regulatory tactics like rate suppression and forcing insurers to underwrite unprofitable lines of business could drive some property/casualty insurers to the brink of insolvency, they warn.

While financial analysts have drawn parallels between the savings & loan industry crisis and the recent financial problems of two large life insurers—Executive Life Insurance Co. of Los Angeles and Mutual Benefit Life Insurance Co. of Warren, N.J.—it is unlikely that large property/casualty insurers will follow suit, said Arizona Insurance Director Susan Gallinger.

Ms. Gallinger made her comments during a panel discussion on insurer solvency at the 1991 annual meeting of the American Risk & Insurance Assn. held Aug. 18-21 in San Diego.

"Clearly there are similarities in terms of the asset portfolios" of the insurance industry in general and S&Ls, with both holding large amounts of non-performing real estate assets and junk bonds, she said.

For example, as much as 4% of life insurers' investment portfolios is composed of junk bonds and 19% is made up of mortgage investments, according to Ms. Gallinger

However, junk bonds comprise less than 1% of property/casualty insurers' investment portfolios, she said.

To further illustrate the strength of the property/casualty insurance industry, Ms. Gallinger said it would take 37 years—until the year 2028—for the weakest 20% of insurers to fail if they continue to lose money at the rate they were losing it between 1987 and 1989. She based her estimate on an industry solvency study conducted on behalf of the Insurance Information Institute by industry analyst Orin Kramer (*BI*, Jan. 14).

But S&Ls that continue to lose money at the rate they had been during the late 1980s could go out of business by 1994, she said.

"The property/casualty insurance industry has not been earning excessive profits, but it's not on the verge of insolvency," agreed Debra Ballen, vp-policy development and research for the American Insurance Assn. in Washington, D.C.

While the property/casualty insurance industry suffered underwriting losses of $21 billion in 1990, those losses were offset by $33 billion in investment income, she pointed out.

Overall, the property/casualty industry reported $11.1 billion in aftertax net income and generated an 8.4% return on net worth in 1990, according to Ms. Ballen.

While such profitability may not seem "excessive," she said that insurers are now at the bottom of the underwriting cycle, a time during which they slash rates to remain competitive in the marketplace.

But these thin profits could be threatened by oppressive regulatory tactics, both Ms. Ballen and Ms. Gallinger warned.

"Regulators preventing insurers from leaving a state when they are losing money in a particular line should be added to the list of possible triggers of insolvency," Ms. Ballen asserted.

And suppressing rate increases in some lines, like personal auto insurance, also threatens insurer solvency, according to Ms. Gallinger, pointing to California's controversial Proposition 103.

"Rate suppression and cross-line subsidies don't work," she said. "Instead, insurers should be permitted to develop minimum coverage plans to increase affordability" for policyholders, she said.

'Rate suppression and cross-line subsidies don't work,' says Ms. Gallinger.

Rather than forcing solvent insurers to reduce rates in some lines of business, regulators should focus on the overall financial health of the insurance industry in their states, she said. "Regulators should target companies that have high-risk profiles," she added.

Another threat to the solvency of the property/casualty insurance industry is the kind of fear that led to a "run on the bank" by Mutual Benefit Life policyholders, according to Ms. Ballen (*BI*, July 22).

"A crisis in confidence can cause a run on a company that could cause an otherwise solvent company to fail," she said.

One way to improve public confidence in the insurance industry is to improve the regulatory system that monitors insurer solvency, according to Ms. Ballen.

While she praised efforts to improve the regulatory process, like those by the National Assn. of Insurance Commissioners and U.S. Rep. John Dingell, D-Mich., she was not quick to embrace their proposals.

For example, Ms. Ballen said Rep. Dingell's proposal to provide a single, national system to regulate insurer solvency may not be flexible enough. Under the proposal, an independent Federal Insurance Solvency Corp. would be formed to develop and enforce minimum solvency standards and issue certificates of approval to insurers that meet those standards (*BI*, Aug. 12; Aug. 5).

The FISC also would be authorized to accredit state insurance departments. Any insurer domiciled in a state whose insurance department is not accredited by the FISC would not be allowed to do business outside its state of domicile.

While "the proposal would provide oversight at the regulatory level and the company level in terms of issuance and renewal of certificates of authority," the "annual renewal procedure could be burdensome," she said.

Also speaking during the panel discussion was California Sen. Patrick Johnston, D-Stockton.

The moderator was Patricia Strong Cheshier, a professor of insurance and risk management at California State University in Sacramento. ■

Taking the long view

ARIA chief decries 'rate suppression' as political quick-fix

By JOANNE WOJCIK

SAN DIEGO—Although ordering insurers to cut rates may enhance political careers in the short run, over the long term it will damage markets and threaten overall industry solvency, an insurance academician warns.

However, public pressure to force insurers to lower rates below sensible levels is unlikely to let up, a state legislator says.

"Rate suppression yields short-run political benefits at a cost of long-run damage to insurance markets and economic welfare," asserted Scott Harrington, president of the American Risk & Insurance Assn. in his inaugural address last month at ARIA's annual meeting in San Diego.

"There are some winners but many losers," said Mr. Harrington, who is a finance and insurance professor in the College of Business Administration at the University of South Carolina in Columbia.

Among the winners are the politicians whose careers are enhanced by controlling rates, but who move on to other issues before the damage from their actions becomes obvious, he said.

Other winners include special interest groups "whose power or income grows with greater bureaucratic control over prices and supply" of insurance, according to Mr. Harrington.

Other beneficiaries are consumers, "who get the lion's share of any rate cuts, and, last but not least, all groups that benefit from higher claim costs," he said.

However, all of those groups could ultimately lose if the solvency of the industry as a whole is threatened, Mr. Harrington said.

"Premiums must be sufficient to cover the discounted value of incurred losses and other costs," especially when establishing reserves for long-tail liability business, he said.

"However, little attention has been devoted to the long-term relationship between losses paid each year for all occurrences to date and the discounted value of new losses incurred," he added.

As a result, rate suppression could force insurers to adopt a pay-as-you-go reserving practice, which could lead to financial troubles if large losses occur, Mr. Harrington warned.

"From the perspective of economic efficiency, pay-as-you-go plans and, for that matter, rate suppression in general are likely to produce significant losses," he asserted.

Rollback laws trade short-run political gains for long-term damage, says Scott Harrington.

For example, they could lead insurers to engage in such high-risk activities as investing in high-yield securities to increase capital, Mr. Harrington said.

Furthermore, "incentives for efficient monitoring of claims will be diminished if such policies give rise to arrangements in which claims costs are shared among insurers," he said.

In addition, suppressing rates in some lines will force insurers to make up for the losses by increasing rates in other lines, according to Mr. Harrington.

"Rate suppression also detracts attention from the causes of high discounted claim costs, such as large numbers of lawsuits for minor auto injuries and pervasive litigation in workers compensation," he added.

Suppressing rates without attacking their source will not solve the problem, Mr. Harrington asserted.

The public must be educated "concerning the true causes of high premiums and thus be mobilized to support" legislation to reduce and control claims costs, he said.

Unfortunately, it may be too late to turn back the tide of politically induced rate suppression, he warned.

"The scenario of rapid growth in claims costs, followed by significant rate suppression, still higher claims costs and ever-increasing government control or displacement of private insurance markets is well under way in some states," Mr. Harrington said, referring specifically to California's controversial Proposition 103.

Proposition 103, narrowly approved by California voters in November 1988, mandated that most property/casualty insurance "charges" in effect between November 1988 and November 1989 be rolled back to 20% below November 1987 levels. In addition, the law subjected future rate increases to prior approval.

Indeed, "politicians worry about price—insurance rates—and not about insolvency," conceded California Sen. Patrick Johnson, D-Stockton, during a separate session at the ARIA meeting addressing insurer solvency issues.

"We talk about issues our constituents care about," said Sen. Johnson. "Our constituents are concerned about insurance cost. The rest is for the insurance commissioner to worry about."

Sen. Johnson was elected last November to fill the seat vacated by John Garamendi, who at the same time was elected California insurance commissioner and who is a strong advocate of rate suppression. ■

Harrington takes over as ARIA's president

SAN DIEGO—Scott E. Harrington, an insurance and risk management professor at the University of South Carolina in Columbia, was installed as president of the American Risk & Insurance Assn. during the 1991 annual meeting held here Aug. 18-21.

Mr. Harrington assumes the post vacated by Sandra G. Gustavson, a professor of insurance and risk management at the University of Georgia in Athens.

Other ARIA members named to board seats for 1991-92 were: Jerry L. Jorgensen, an insurance professor at the University of Utah in Salt Lake City, who was named president-elect; Patricia Cheshire, an insurance and risk management professor at California State University in Sacramento, executive director; and Harold D. Skipper Jr., an insurance professor at Georgia State University in Atlanta, vp.

Also during the meeting, two professors received awards for innovation in instruction:

- Stephen P. D'Arcy, an insurance professor at the University of Illinois at Champaign-Urbana, received an award for his paper, "Introducing Students to Insurance."
- Arnold F. Shapiro, a professor of risk management at Pennsylvania State University in University Park, received an award for his multimedia computer-based "Colloquium for Risk and Insurance Instruction."

Also at the meeting, Travis Pritchett announced he would retire at the end of the year as editor of the Journal of Risk & Insurance, which is published by ARIA.

Approximately 200 people attended the annual meeting of ARIA, an academic group devoted to furthering the science of risk management and insurance through education, research, literature and communications.

Plenary session focused on topics like pollution coverage and insurer solvency. Members presented research papers on numerous insurance and finance-related topics.

Next year's ARIA meeting will be held Aug. 16-19 in Washington, D.C.

For more information, contact David R. Klock, 1990-91 Executive Director, American Risk & Insurance Assn. Inc., Finance Department, College of Business Administration, University of Central Florida, Orlando, Fla. 32816-0991; 407-823-5567 or 407-823-5766.

Rendez-Vous

Continued from previous page
and, eventually, to consolidate, he predicted.

The one area where rates have increased dramatically and capacity has contracted is the catastrophe reinsurance and retrocession market.

Indeed, rates are so high that at least two U.S. companies are entering the market with large capacity: Berkshire Hathaway insurance units and a unit of American International Group Inc. (see story, page 50).

The catastrophe losses that have hit the insurance and reinsurance markets between 1988 and 1990 cost $32 billion, forcing many underwriters out of the catastrophe reinsurance market and pushing rates up by as much as 300%.

"There is a great shortage of capacity in catastrophe areas, especially coverages for storm catastrophes," said Mr. Heyer of Swiss Re.

The European storms in 1987 and 1990 forced up catastrophe rates, but capacity was greatly reduced as reinsurers pulled out of the market.

And the remaining catastrophe reinsurers are unwilling to provide any more capacity, Mr. Heyer said.

"I could take a lot of business by offering catastrophe coverage, but I do not want to expose the company's capital to this market because we are sure that the climate is changing and the losses could get much worse," he said.

Swiss Re currently has a team of 15 people researching changing weather patterns, he said.

"We can't prove anything yet, but when we are able to prove it, it will be too late because the losses would have happened," he said.

"For reinsurers, it will be a very difficult to find catastrophe covers," said Mr. Cachin of SAFR. "We don't know yet if we'll be able to place out entire cover," he said, noting that SAFR was able to find all the coverage it needed for 1991.

The shortfall in catastrophe coverage already has hit European and U.S. reinsurers.

SCOR is buying only two-thirds of the catastrophe protection it would like to have.

And American Re did not complete its catastrophe coverage for 1991, with the shortfalls varying by layer.

"The rates are ridiculous," said Mr. Jobe.

"We funded for the shortage" in the higher layers, he said. "I think there will be more and more of that," he added.

But, critics of funded catastrophe programs point out that if the catastrophe occurs before the funds have built up sufficient investment income, the ceding company will not be covered for its losses.

Rates on line of 25% to 40% for catastrophe coverages—that is, premiums expressed as a percentage of the policy limits—were being routinely mentioned as the going rate by underwriters and brokers at the Rendez-Vous.

Some say rates will not increase any more. "If catastrophe coverage became any more expensive, it would be uneconomical to buy it," said Mr. Payne.

However, some ceding companies could see their catastrophe reinsurance premiums go up 15% to 25%, suggested Mr. Nyssen of Le Rocher Re. And, he expects capacity will become tighter.

"On higher layers, the price could go up," agreed Mr. Fillebeen of SAFR.

Catastrophe coverage may have to radically change if enough capacity is to be provided at a reasonable price, Mr. Heyer said.

Alternative risk financing techniques may be used to provide coverage, he said. "We may be able to offer a financial solution where we pay the claim but the cedant then has to pay us back over a period of time," he suggested.

This would differ from the typical funded cover under which the ceding company receives only its own premiums and investment income back at the time of a loss.

Alternatively, reinsurers could work more closely with large insurers and pool information on catastrophes so they have much better underwriting information to base their coverages on, Mr. Heyer said.

The latest large loss to hit the reinsurance market, Hurricane Bob, has had little effect, reinsurers say.

Although the loss could be as much as $800 million, it was not large enough to affect rates, they say.

"A loss of that size is enough to wipe out a profit but its not enough to increase rates given the current state of the market in the U.S.," said Mr. Dodd of British & European.

However, it should serve as a warning to reinsurers that an even bigger loss is bound to arise in the future, Mr. Holmes said.

"It's another warning that one day a hurricane of that force is going to come onshore at the wrong place and at the wrong time, and we should bear that in mind when we are writing our business," he said.

Political events also have had little immediate effect on insurers and reinsurers in the past year.

The Persian Gulf War produced profits for marine war risk underwriters and losses for aviation war risk underwriters, and had some effect on policy wordings, reinsurers say.

For example, aviation liability war risk underwriters now include a first landing clause in policies, which grants policyholders war risk coverage until their aircraft land after a nuclear detonation. Previously, coverage would have been terminated immediately on the detonation of a nuclear weapon regardless of whether an aircraft was on the ground or in the air (*BI*, Aug. 5).

"There were some areas in some countries where there was a reduction in premiums because there was a reduction in industrial production due to the war, but the main impact was in the war risk market," Generali's Mr. Pagnanelli said.

Political risk insurers were little affected by the war, said Louis Habib-Deloncle, chairman of the P.A.R.I.S. Pool.

"We had no commitments in Kuwait because people considered it a safe country, and in Iraq the losses were not substantial," he said.

The losses occurred over two years. In the first year P.A.R.I.S. suffered a 50% loss ratio in Iraq and in the second year about 85%, he said. However, Iraqi risks comprised less than 2% of the pool's liabilities, he said.

And many of the losses should be recovered when normal trade is resumed with Iraq because Iraqi companies will have to pay off past debts before other companies will trade with them again, he said.

However, the Gulf War did show a need for political risk insurers and governments to work more closely together, Mr. Habib-Deloncle said.

"It was probably the first United Nations risk. You had the whole international community bringing sanctions against Iraq, and in such cases we are subject to the decisions of the governments. We as political risk insurers should have a closer contact with the governments," he asserted.

The war also created confusion over war risk exclusions, said Mr. Heyer of Swiss Re.

Policyholders queried whether military actions ordered by Saddam Hussein would be excluded under

Continued on next page

35th Rendez-Vous de Septembre

Continued from previous page
war risk exclusion clauses if they took place outside of Iraq or Kuwait, he said.

"American companies were coming to us and saying, 'Is this terrorism and covered under the policies or is it excluded because it is war?' We said it was excluded," Mr. Heyer said.

Outdated wordings caused the confusion, but no changes have yet been made, he said. "People are too concerned about sorting out their normal underwriting problems at the moment."

Radical changes are needed throughout the reinsurance industry, Mr. Payne said.

"People accept that radical change will have to take place and the issue now is what will have to happen," he said.

Ceding companies and reinsurers will have to enter much more stable and long-term relationships if the industry is to recover, Mr. Payne said.

"Cedants must accept that reinsurers are useless unless they are stable and they can only achieve that stability if they have long term relationships with the companies they are supporting," he said.

And cedants should discard the view that if reinsurers are profitable, insurers are giving up profits for no reason when they buy reinsurance, Mr. Payne said. "The key is to achieve profitable direct underwriting and not rely on manipulating the reinsurance industry to make your profits."

Changes must also include a more technical approach to underwriting, said Mr. Pagnanelli of Generali.

"We must forget the idea that we can cover our technical losses with profits on financial markets. This is bound to lead to trouble because financial markets are so unpredictable," he said.

Buyers of reinsurance should also become more professional and avoid buying cheap reinsurance from companies that offer poor security, said Mr. Holmes of Zurich.

"There is no such thing as cheap reinsurance just like there is no such thing as a cheap pair of shoes. You might find a pair of shoes which you don't have to pay much for, but if you take them for a walk in the rain, they let the water in," he said.

While many professional reinsurers decried the current market conditions, no one compared the current market with the dismally underpriced and overcompetitive marketplace of the early and mid-1980s.

"It's not like '82, '83 or '84," said Mr. Jobe of American Re. "There is more prudent use of reinsurance. Buyers are more circumspect about reinsurers and reinsurers are more circumspect.

"The competition is responsible," he said.

And, as Mr. Rhulen contrasted this year's Rendez-Vous with those of the early to mid-1980s when brokers were offering underwriters all kinds of reinsurance packages of questionable profitability: "You don't see people hawking a lot of garbage." ■

35e Rendez-Vous de Septembre

Specialist areas show healthy growth

By KATHRYN J. McINTYRE

MONTE CARLO, Monaco—While few are happy with current market conditions, some reinsurers and insurers cite successes in specialist areas.

Reinsuring alternative risk funding mechanisms, financial and finite risk reinsurance and niche programs are areas of growth for several companies.

The financial guarantee reinsurance market also continues to produce profits.

Edward Jobe, president of American Re-Insurance Co. in Princeton, N.J., reports that "last year was American Re's best in history, and the first six months have been pretty good—about the same as last year." American Re reported $134 million in net income in 1990, based on generally accepted accounting principles.

American Re, Mr. Jobe explained, is focusing on non-traditional products. This includes finite risk reinsurance, serving the alternative risk market and providing funding mechanisms for companies with particular liabilities, like pollution.

In 1990, 62% of American Re's earnings were generated by this type of business, which it was not involved in five years ago.

For example, American Re works with businesses that expect to pay for pollution losses in the future and the contractors that will perform the cleanup work. American Re can provide a business with a funding mechanism for its pollution liabilities while assisting the contractor in meeting the minimum financial requirements of the Environmental Protection Agency.

"This will be a growing area," Mr. Jobe predicted.

The recently introduced specialized products also are purchased by American Re's direct treaty clients, which generally place their entire reinsurance account with American Re. American Re writes about $450 million to $500 million in premium for these 77 clients.

With such a limited client base—a broker may have 2,000 treaty clients—"we can be very close to these people," says Mr. Jobe.

Remaining selective, the company has targeted only another 30 treaty clients.

American Re, with 1,200 employees, reorganized Sept. 1 from a product line structure—treaty, facultative, bonds, alternative risk, finite risk—to a client structure. "We want to deliver products based on what the client needs, rather than what a department sells," Mr. Jobe explained.

Skandia America Corp. in New York is carving out specialties in casualty excess business, decreasing its property reinsurance underwriting "because of the cost of protecting those exposures," said Steve Bensinger, president and chief operating officer.

However, Skandia America does not write "the difficult lines," like professional liability and directors and officers liability, he noted.

Skandia America also is committed to serving the alternative risk market, especially risk retention groups, association programs and individual municipalities and municipal pools.

Only two years ago, the company did not reinsure risk funding mechanisms. Its premiums in this area this year will be at least $30 million, he pointed out.

But, Mr. Bensinger sees "a lot of competition—more everyday" among reinsurers seeking to serve the alternative market.

The most competition for captive business is coming from underwriters in London, according to Jonathan Crawley, president of Sphere Drake Underwriting Management (Bermuda) Ltd., which underwrites only reinsurance for alternative funding mechanisms on behalf of London-based Sphere Drake Insurance P.L.C.

Sphere Drake (Bermuda) nonetheless wrote $25 million in premiums for the year ended Aug. 31, he noted. Nearly 90% of that business was placed by Bermuda-based intermediaries, brokers or captive managers. "The business comes to us because we are there," he observed.

In financial reinsurance, another Skandia America product, "the competition is becoming fiercer," Mr. Bensinger observed. Skandia rejects 90% of the business it is offered, he said, predicting that other companies "will get burned" by claims developing more quickly than anticipated, as well as by fluctuating interest rates.

Financial reinsurers soon have another Bermuda competitor. Next year, SCOR S.A. in Paris and others will invest $100 million in capital in a new company.

"We're selecting our partners," said Jerome Karter, president of SCOR Reinsurance Co. in New York, whose U.S. underwriting staff's expertise will be useful to the Bermuda company.

The company will underwrite policies with substantial transfer of risk, emphasized Jacques Blondeau, president of operations for SCOR in Paris.

"It is designed for the U.S. market," explained Francois Negrier, president of reinsurance for SCOR in Paris.

Daniel G. Marren, the former Centre Reinsurance Holdings Ltd. chief financial officer who advised SCOR to enter the finite risk reinsurance business, will be president of the new company.

Executives of SCOR in Paris also report widespread support in Europe from major primary insurers for HELP, a facility it is organizing to write a high excess liability policy for European companies with U.S. exposures (*BI*, Nov. 26, 1990).

Scheduled to be completed in November, the policy will first be effective Jan. 1. Its limits will be 50 million European Currency Units ($60.8 million) excess of 50 million ECUs.

SCOR also is pleased with the growing interest in the United States in its inherent defect insurance, offered through SCOR Reinsurance in New York. Developers buy the policy—an adaptation of the coverage developers in France are required to buy—to cover property construction defect losses.

The company has written only a few of these policies in the United

Continued on next page

35e Rendez-Vous de Septembre

Rendez-Vous gets down to business

MONTE CARLO, Monaco—The Rendez-Vous de Septembre is increasingly about serious business, says a 19-year veteran of the annual reinsurance market gathering, who says he has attended his last as an active participant.

LeRoy J. Simon, who is retiring Dec. 1 at age 67 after 42 years in the insurance and reinsurance industry, says he sees an increased "business attitude" toward the Rendez-Vous.

"A far higher percentage of people are here strictly for serious business reasons," according to Mr. Simon.

"It used to be a lot of people were here who wanted to be someplace glamorous, or it was a reward for something accomplished during the year," he said. "Some people came to sponsor a party" or attend those of others, he added.

"There's less of that now" on all counts, he said.

Conceding that Monte Carlo "is a nice place and the weather is pleasant," he observed that "after 10-hour days followed by a business dinner, there is no opportunity to just plain enjoy it."

Mr. Simon, for example, had 30 appointments during the week in Monte Carlo as an executive consultant with Coopers & Lybrand. He joined the firm four years ago after retiring from a 17-year career with Prudential Reinsurance Co. in Newark, N.J., where he rose to senior vp.

One of the last projects Mr. Simon will complete at Coopers & Lybrand is a study to be used by the liquidators of Transit Casualty Co. in commutation negotiations.

Reflecting on the industry, he predicted that "19 years from now, people attending the Rendez-Vous for the first time will find that the problems are very similar to the ones we have now. But, the solutions won't be the same because the circumstances leading to the problems will be different."

The problems, Mr. Simon says, are the interplay of capacity, profitability, interest rates and economic conditions that lead to the cyclical nature of the business.

Mr. Simon recalled that the "down-cycle of the 1980s was a terrible, painful lesson that I hope no one will ever forget. The reinsurance fraternity nearly led to its own destruction by throwing underwriting out the window."

Acknowledging that "certainly prices are eroding again," he said, "I hope this time around it won't be a repeat of the 1980s."

Mr. Simon is optimistic that the industry will not repeat the errors of the 1980s, especially because interest rates are not as high as they were then, which encouraged companies to write business more for investment income than for underwriting profit.

But to keep underwriters fully aware of how interest income affects profitability of their business, Mr. Simon advocates that underwriters be fully informed at all times—not just when interest rates are high—of the investment income earned on the business they underwrite.

"A lack of knowledge of how it works in good times leads you to erroneous conclusions in bad times" regarding how much investment income can be earned, he asserts.

As he looked forward with relief to his last business appointment at the end of the Rendez-Vous, Mr. Simon allowed, "Maybe there will come a time when I will miss the Rendez-Vous."

—By Kathryn J. McIntyre

Specialist areas

Continued from previous page

States, each covering a large development generating millions of dollars in premium.

To obtain the coverage, developers must conduct an engineering study that costs $25,000 to $50,000, whether or not the coverage is issued, noted Mr. Karter.

He predicts that states will require developers to buy this coverage to protect homeowners.

Growth continues for reinsurers that focus on one specialized product.

New York-based Capital Re Corp., the strictly financial guarantee reinsurer, will report premiums in excess of $60 million and net income of $21 million to $22 million, said Michael Satz, president. It will be the company's best year since it was founded in 1988, he said, with the company's assets approaching $300 million from an initial $100 million.

Capital Re's investors—including United States Fidelity & Guaranty Co., Baltimore Gas & Electric Co., Minnesota Power & Light Co. and Siemens A.G.—have committed to inject another $25 million into the company to bring its statutory capital to about $150 million.

"Our goal in five years is be at $1 billion in assets, without being overly aggressive," Mr. Satz said.

Capital Re, Mr. Satz noted, has developed "a significant network of international relationships, with a least a half-dozen major European insurers and reinsurers" to which it has ceded business. It hopes also to obtain access to European financial guarantee business, while exercising its highly analytical approach to underwriting.

Among executives of primary companies attending the Rendez-Vous, Peter Rhulen was upbeat about the program business underwritten by Markel/Rhulen Underwriters and Frontier Insurance Group Inc., both of Monticello, N.Y.

Mr. Rhulen attended the Rendez-Vous representing both Markel/Rhulen, a managing general agency unit of the Markel Corp. where he is vice chairman, and Frontier Insurance, an insurance company of which he is vp and a director.

Markel/Rhulen and Frontier jointly underwrite many specialist insurance programs, including those for children's activities, sporting activities and agricultural interests.

"We're specialists—niche players," said Mr. Rhulen. "The more exotic it is, the more we like it," he said, speaking for both organizations.

True to his word, he noted that the company is developing a liability program for the operators and landowners of bungee jumping sites in the United States.

Frontier last year reported net income of $10.8 million on total revenues of nearly $86 million. ■

35e Rendez-Vous de Septembre

What a short, strange trip it's been for EIL market

By GAVIN SOUTER

MONTE CARLO, Monaco—Environmental impairment liability insurance has been marked by radical changes in its short history.

Seeing a potentially huge market for pollution coverage, underwriters jumped eagerly into the market in the early 1980s. Just as quickly, though, many saw the huge looming liabilities and jumped back out.

Constantly changing laws and more specialized coverages have only made the field more complicated, several experts said earlier this month at a Rendez-Vous de Septembre panel that alternated between the historical and the analytical.

"Both the new product development and the increase in underwriting companies addressing environmental liabilities are representative of significant changes in the relatively short history" of these products, said John Amore, president of Commerce & Industry Insurance Co., an American International Group Inc. unit in New York.

At their roots, the policies are closely linked to general liability contracts. When those contracts changed from an accident to an occurrence definition of loss, pollution was excluded unless it was sudden and accidental, Mr. Amore said.

But by the end of the 1970s, he said, several innovative underwriters were offering environmental impairment liability policies that covered some gradual pollution incidents.

By 1983, more than 15 companies offered such coverage and premium volume was in the range of $60 million to $80 million, Mr. Amore said.

That growth was short-lived. "If 1983 was the first high-water year for the embryonic environmental insurance industry, then 1984 was the year that a resorting began to take place," he said.

By 1986, only two underwriters—one of which being AIG—offered the coverage, with neither offering more than $10 million in capacity.

Among the reasons Mr. Amore gives for this reduction are poor underwriting results and U.S. courts' interpretation of policy language against insurers. Insurers also realized that it would take more technical and engineering expertise to underwrite the policies and that premium volume would fall short of their original expectations, he said.

Soon some U.S. courts were ruling that gradual pollution was not excluded from general liability contracts. "During 1985 and 1986," he said, "most casualty underwriters providing coverage in the U.S. began utilizing an absolute pollution exclusion in their general liability contracts" to counter these rulings.

Speciality underwriters responded by extending their coverage to both sudden and gradual pollution. And by 1990, Mr. Amore said, speciality pollution insurance premium volume totaled $200 million.

Products now on the market include: pollution legal liability; asbestos abatement liability; contractors pollution liability; underground storage tank liability; professional liability; pollution coverage directed at industry classes; and real estate transactions.

Environmental insurance will expand further in the 1990s largely due to the growing awareness of the potential damages and liabilities caused by pollution, he added.

"This has already begun changing the mix of policyholders. While heavy industry and the hazardous waste industry are still the typical purchasers, we consistently see more lighter industry and service industry interest (in the coverage)," Mr. Amore said.

Several factors, he added, will contribute to further growth.

Industrial companies will come under increasing pressure to protect their assets with pollution coverage, Mr. Amore said. And financial institutions, which use property to secure loans, more often demand borrowers get pollution insurance.

Also, he said, more construction contracts—whether for new projects, renovations or remediations—are "requiring bidders to include pollution insurance along with other insurance requirements."

Despite the expansion of pollution insurance in the past five years, Mr. Amore predicted growth in coverage for areas for which coverage now is not available, like indoor air pollution, radon, electromagnetic radiation and acid rain.

Other growth will come from outside North America, he said. 'We have only begun to see the emergence of (speciality pollution insurance) outside the U.S. and Canada."

One major impediment to future expansion, he said, is delays in cleaning up past pollution that have been caused by the Comprehensive Environmental Response, Compensation and Liability Act, or Superfund.

By the end of the century, the number of Superfund sites is expected to grow to 2,000 from its current 1,200. Each site costs an average of $25 million to clean up, but only 5% of the sites on the list have been completely cleaned, Mr. Amore said.

"Superfund's liability system is a major cause of this delay," he asserted. "Protracted litigation. . .has wasted billions of dollars while allowing hazardous waste sites to languish."

Mr. Amore instead favors creating an environmental trust fund to finance the cleanups. It would be funded through a tax on property/casualty insurance premiums.

Such a fund has been proposed by AIG Chairman Maurice R. Greenberg (*BI*, March 6, 1989).

Insurance companies are often considered the natural entities to pay for cleaning up pollution, but some ideas regarding their role in such an effort are misguided, contended Walter Diehl, chairman of Swiss Reinsurance Co. of Zurich, who also spoke at the Rendez-Vous.

"Some rather curious ideas abound as to the role international reinsurance might play in solving these problems," said Mr. Diehl.

Although insurers and reinsurers do have a role to play in cleaning up past pollution, neither should be financially overstrained, he said.

"Technical progress has brought industrialized countries prosperity and high living standards and the fruits are being consumed by our generation. For quite some time due attention has not always been given to risk and safety," he said.

Now, the world has the responsibility of cleaning up this past pollution, Mr. Diehl said. "We are being called upon to pay the price for the prosperity we have hitherto enjoyed 'on credit.' "

And traditional insurance jargon has often proven "too imprecise" in disputes over paying to clean up pollution. In courts, contract wordings have been "twisted" to require insurers cover risks they never intended to, Mr. Diehl contended.

Now, he said, insurers must look at environmental risks in a new light, considering the following:

- These risks, more than almost any other, call for a joint effort by insurance, science, government, business and society.
- If insurance is remain credible and insurers are to remain financially strong, they need a clear, firm policy toward environmental risks.
- No environmental impairment liability coverage should be written without an expert risk assessment.
- Inadequate data leaves traditional insurance techniques unable to handle environmental risks.
- Stepped-up competition in the liberalized European Community market will make it far more difficult for insurers to cover losses on environmental policies with profits from other lines.
- The widest possible scale of statistical data should be collected and evaluated.
- Environmental coverages should be clearly defined regarding amounts insured and periods of coverage.
- If insurers act together, policyholders would be more aware of the special nature of the risk.
- The insurance industry should encourage cooperation among the small group of experts assessing en-

Continued on next page

35th Rendez-Vous de Septembre

Continued from previous page
vironmental risks.

Another speaker at the Rendez-Vous discussion, Joachim Schmidt-Salzer, focused on a new German environmental liability law and its likely impact throughout Europe.

Passed on Jan. 1, "this act will fundamentally influence the impact of environmental liability on society," said Mr. Schmidt-Salzer, a member of the board of management at German insurer HDI.

The act imposes liability on the owners or operators of specific installations—whether or not they were negligent—when those installations cause bodily injury or property damage via the soil, air or water.

Although limited to bodily and property damage and to certain installations, the act could be expanded to embrace environmental liability in general, said Mr. Schmidt-Salzer.

"The lesson to be drawn from the evolution of product liability law and of medical malpractice law," he warned, "is that spectacular new liability law contributes beyond its limited scope of applicability."

Ultimately, the act will make German society in general more claims-conscious, he predicted.

And it will encourage courts to take a more plaintiff-oriented view of environmental disputes, though not to the extent U.S. courts do, Mr. Schmidt-Salzer added.

The new law it is being studied by the Council of Europe and the E.C. Commission, Mr. Schmidt-Salzer said.

"What is today new law in Germany may emerge as the law of tomorrow in the other European member states," he said.

Currently, two E.C. draft directives cover ground similar to the German law. One, covering waste discharge, was issued in June, and the other, on general environmental liability, came out in January.

Future directives could use the German law as a model. Or the directives could merely be indirectly affected by discussions provoked by the law, he said.

Despite this new law, a great deal of uncertainty remains over the extent to which liability insurance will cover environmental damage, noted Ulrich Steger, the final speaker at the Rendez-Vous session.

Insurers complained that the law made damages from operations that complied with regulations uninsurable, said Mr. Steger, a professor at the European Business School in Oestrich-Winstel, Germany.

"On the one hand it was presumed that the necessary element of fortuity was lacking because such damage resulted from permitted emissions and was therefore viewed as being a certainty," pointed out Mr. Steger, who is also a member of the board of management at Volkswagen A.G.

"On the other hand, it was pointed out that the costs for businesses and insurers could not be calculated as even adherence to all duties of care could not exclude liability," Mr. Steger said. Those liabilities, though, can be contained by risk management, he said.

Replacing technology that damages the environment with newer equipment that does not is one way to limit risks. To determine which technologies pollute the environment, companies could exhaustively test industrial processes or could proceed on a trial-and-error basis, he said.

"Clearly, environmental liability can have an effect above all in the areas in which society tolerates development of technology by trial and error, for in the area of anticipation the development of technology is dominated by strong regulation," Mr. Steger said.

When companies test technologies by trial and error, they will need to consider whether the reduced potential environmental liability of using established safe technologies provides greater savings than using unknown new technologies, he said.

Companies can also reduce their pollution risk by adding safety features to existing installations, Mr. Steger said. As an example, he cites using reservoirs to stop harmful substances from leaking into the ground.

Such measures also help reduce the risk of the "legally approved" processes, Mr. Steger said. ■

Outlook cautious on newly free nations

MONTE CARLO, Monaco—Insurers and reinsurers do not expect a windfall anytime soon from the emerging countries of Eastern Europe and the Soviet Union.

But, several reinsurers are interested in establishing contacts now for growth in the years to come, especially in Eastern Europe, they said in interviews here at the Rendez-Vous de Septembre earlier this month.

"In Eastern Europe, there is not a lot of money available. The economies are flat," observed Claude E. Nyssen, chief executive officer of Le Rocher Reinsurance Ltd., a London-based subsidiary of Prudential Reinsurance Co. of Newark, N.J.

"Even if Western investors inject a lot of money, there won't be an enormous amount of business overnight to create an insurance interest," he explained. "The real opportunities will be there in five years."

As a result, Le Rocher is "maintaining contacts and bringing services to the local insurers," said Mr. Nyssen, who is most optimistic for the future of Poland, Czechoslovakia and Hungary.

Le Rocher, for example, recently held general management courses over three days for about 25 managers of Warta Insurance & Reinsurance Co. Ltd. in Poland. "It gave us a chance to be known by many managers," Mr. Nyssen observed.

Le Rocher also held reinsurance rating courses for about 20 Warta employees.

"That's the type of investment we are prepared to do," instead of joint ventures in these countries, Mr. Nyssen said.

Executives of Societe Anonyme Francaise de Reassurances in Paris say they will increase their travel to Eastern European countries to obtain positions in reinsurance programs. But, "we don't expect short-term results," said General Manager Herve Cachin.

Business from all of Eastern Europe should be treated cautiously, suggested Tony Dodd, treaty underwriting manager at British & European Reinsurance Co. Ltd. in London.

"We just don't have enough information about the industries in Eastern Europe, and we have virtually no knowledge of what the loss experience (of the industries) is," he said.

The new insurance markets of Eastern Europe are bound to provide opportunities for Western insurers, said Benito Pagnanelli, joint general manager of Assicurazioni Generali S.p.A.

But Generali will enter Eastern Europe only to increase business, not just to re-establish old ties with markets that predate World War II.

"Everybody expected Generali to go back to Eastern Europe because we have connections from before the war in many of the countries, but we will only go back for business reasons," Mr. Pagnanelli said.

Generali also is particularly interested in Hungary, Czechoslovakia and Poland, he said.

The Eastern European countries have better opportunities for economic growth than the states breaking away from the Soviet Union, because Eastern European countries have been under Communist rule for about half as long as the Soviet Union, Mr. Nyssen said.

The new countries that have emerged from the Baltic republics of the Soviet Union do have opportunities, he said, noting that Scandinavian insurers already are poised to be the Baltic states' first line of contact.

SAFR will "wait" to deal with the countries emerging from the Soviet Union, Mr. Cachin said.

It is too early to judge how much business will come from the Soviet Union, said James Payne, chairman of E.W. Payne Cos. Ltd., the reinsurance brokerage unit of Sedgwick Group P.L.C.

"We will have to wait and see what is the outcome of the political changes in the country before we will be able to assess what new business will emerge and who will be transacting it from the Soviet Union," he said.

"But Sedgwick as a group is very interested in Eastern Europe, including the Soviet Union," he added.

American Re-Insurance Co., though, is "active in the Baltics," said American Re President Edward B. Jobe. "And, we have four people going to Moscow this week to talk to government officials," he said during the Rendez-Vous.

"We see real opportunities."

—By Kathryn McIntyre and Gavin Souter

35e Rendez-Vous de Septembre

Lloyd's troubles worry ceding companies

By GAVIN SOUTER

MONTE CARLO, Monaco—Concerns about the stability and security of Lloyd's of London syndicates may cause reinsurance buyers to move their business to continental European reinsurers, some reinsurers say.

Representatives of Lloyd's and the London market, however, deny that the security of Lloyd's policies has been weakened, despite the losses the market has suffered. They say they have successfully allayed any concerns regarding the future of the market.

Lloyd's—its troubles and its future—was a major topic of conversation and speculation at the Rendez-Vous de Septembre earlier this month in Monte Carlo.

No one suggested that Lloyd's will not pay losses.

However, many suggested that some syndicates may go out of business, disrupting the continuity of reinsurance programs. And, others questioned if all syndicates will be able to pay losses on a timely basis due to cash flow and litigation problems.

Several reinsurers said that their discussions revealed that Lloyd's may lose premiums because of the well-publicized turmoil in the market created by a near $1 billion loss for the 1988 year.

"In my meetings this week I have had confirmation that people are expressing their worries about Lloyd's," said James Holmes, senior vp of assumed reinsurance at Zurich Insurance Co. in Zurich.

As a result, reinsurance buyers are showing more interest in large continental reinsurers, which they perceive to be more stable than Lloyd's syndicates, he said.

"Things like stability, continuity and security are becoming very important instead of just buzzwords," Mr. Holmes said.

Ceding companies from the United States are the most concerned, he said.

"They are not querying whether Lloyd's will pay, but they are looking for stability and continuity. And they are seeing that on the Continent there are strong companies that can offer this, but that Lloyd's is going through problems," Mr. Holmes said.

"The security of Lloyd's is under scrutiny," confirmed Steven J. Bensinger, president and chief operating officer of Skandia America Reinsurance Corp. in New York.

He noted that Skandia reviews the security of individual syndicates at Lloyd's before ceding business, unlike many others that accept Lloyd's syndicates as being secure because they are part of Lloyd's.

Previously, Mr. Bensinger said, "Lloyd's was considered invulnerable to adverse developments."

The cash calls on syndicate members needed to pay claims could result in an explosion of litigation at Lloyd's, Mr. Bensinger said. "This will create opportunities" for other reinsurers, he predicted.

Newark, N.J.—based Prudential Reinsurance Co. President James Dwane also expects that "Lloyd's share of the global market will decrease."

"I don't think we'll see the demise of Lloyd's, but it has a lot of rebuilding to do," Mr. Dwane observed.

If Lloyd's decides to scrap its system of unlimited liability for names to limited liability, "it would be a catastrophe for them," suggested Prudential Re Senior Vp Dewey Clark. "But if they maintain unlimited liability and quality of names, Lloyd's security will improve."

Mr. Dwane emphasized that he expects all claims against Lloyd's syndicates to be paid because Lloyd's is such an important contributor to the British economy.

"Knowledgeable reinsurers don't have any anxiety about Lloyd's," Mr. Clark said.

Nonetheless, "the situation at Lloyd's is very worrying," said Herve Cachin, general manager of Societe Anonyme Francaise de Reassurances in Paris. "The losses for 1989 and 1990 will be bigger," he predicted.

He also disagreed with those in London who predict Lloyd's will show a profit on its 1991 business.

"The main problems at Lloyd's are past commitments on casualty business from the United States, and this could last a very long time," he said.

While also not questioning Lloyd's ability to pay losses, Mr. Cachin expressed concern about the willingness of some syndicates to pay and the possibility of litigation delaying payments.

The problems facing Lloyd's have both a positive and a negative effect on continental reinsurers, according to Balth Heyer, senior vp at Swiss Reinsurance Co. in Zurich.

The problems reveal weaknesses at Lloyd's and the strengths of professional reinsurers, but the sight of Lloyd's in trouble is detrimental to the image of the reinsurance industry, he said.

"Lloyd's has always been a competitor of ours, which was not very technical. When it was faced with a problem, it reacted by cutting or increasing premiums rather than reconstructing treaties or policies," he said.

The difficulties at Lloyd's are highlighting this for cedants, who are questioning the security of some syndicates and are now turning to professional reinsurers as being stronger and more stable, Mr. Heyer said.

"But on the other, the whole image of reinsurance is being affected in a way that is bad for the industry," he said.

The problems at Lloyd's also affect the London company market, said David Trace, managing director of CNA Reinsurance of London Ltd.

"We as a company market are great supporters of Lloyd's and problems for Lloyd's are not good for the company market," he said.

Despite the bad publicity, Lloyd's is still performing its duties to policyholders, Mr. Trace said.

"The truth of the matter is that valid claims get paid if you have a policy at Lloyd's," he said.

Insurers and reinsurers were asking about the problems of the market at the Rendez-Vous, acknowledged Quentin Paillard, Lloyd's general representative in Paris.

"It's true that for the first time, due to the adverse publicity, I have had inquiries about the stability of Lloyd's and sometimes about the solvency of Lloyd's," he said.

And, although Lloyd's policies are "second to none," cedants do not always understand this because of the complicated structure of Lloyd's, Mr. Paillard said.

However, most insurers and reinsurers realize that Lloyd's will become successful again when rates improve, he maintained.

"We know that the number of names may decrease and that capacity may shrink for the next two years, but this may be good for the market because the number of names increased too rapidly in the past," Mr. Paillard said.

Lloyd's also is more carefully reserving for future pollution losses than many companies, and this will help it compete in the future, he said.

"We are very confident about the future because for the past 10 years we have worked on the problem of regulation. Now we can concentrate on business," he said.

However, regulations may still have to be changed if Lloyd's is to grow in Europe, Mr. Paillard said.

"We have always been reinsurers in Europe, and maybe we should allow European brokers to become Lloyd's brokers because the reinsurance broker really should be able to talk to the underwriter," he said.

In addition, Lloyd's syndicates could become co-insurers with European companies, he said.

"For example, if I were UAP, I would prefer to co-insure with Lloyd's than with AGF because AGF is a direct competitor to UAP," Mr. Paillard said, referring to two leading French insurance groups.

There already have been some changes in how European business arrives at Lloyd's.

For example, beginning in 1991, French yachts have been insured on a direct basis at Lloyd's, Mr. Paillard said.

The main concern that some cedants have about Lloyd's is the long-term future of some syndicates, said Dennis Purkiss, underwriter at Merrett Underwriting Agency Management Ltd. at Lloyd's.

"There are still people who do not understand the way Lloyd's operates, and they try to look at the security of Lloyd's in the same way as they might look at the security of a company. They don't consider how the names are distributed in the market and the makeup of syndicates they are on," Mr. Purkiss said.

People have become more curious about Lloyd's largely because of the increased press interest in Lloyd's, suggested James Payne, chairman of E.W. Payne Ltd., a unit of Sedgwick Group P.L.C.

"People don't fear that Lloyd's will disappear. They are intrigued to see how it will handle its problems, but there is no question of it going out of business," Mr. Payne said.

The current strategic review of Lloyd's being conducted by a special task force will result in a stronger market, Mr. Payne predicted.

"What will happen is Lloyd's will get smaller for a period of time, but not by nearly as much as some people predict. And the awareness of the capital base of Lloyd's and how it works will be enhanced," he said.

Members already are becoming aware that they should be better informed about Lloyd's, and this is good for the market, Mr. Payne said.

The level of concern over the stability of Lloyd's syndicates also was obvious in the interest shown by attendees of the Rendez-Vous in the new Lloyd's Syndicate Reports scheduled to be published soon by Insurance Solvency International, a unit of Standard & Poor's Insurance Rating Services (*BI*, Sept. 2).

ISI officials explained their new product, as well as S&P's rating services, to those who visited its display in a salon of the Loew's hotel.

ISI Managing Director John Gardner reported "extreme interest" in the new Lloyd's syndicate reports, which will detail each syndicate's financial reports and how they stand up under certain financial performance tests.

The interest in the product suggests some clients of Lloyd's are concerned, at least about the continuity of their programs placed at Lloyd's, he said.

"There is an increasing perception that you have to look at the syndicate" when buying reinsurance at Lloyd's, Mr. Gardner said.

Rather than concern for payment of claims, clients at Lloyd's want to feel secure that their programs will be renewed for years to come by the same syndicates and not cut off by cash flow problems at a syndicate, he explained.

Cash flow problems already are occurring at Lloyd's, according to Mr. Gardner's research.

However, "I still have great confidence in Lloyd's ability to overcome this," he stressed.

While ISI is offering fact sheets on key financial data for individual syndicates at Lloyd's, it is not yet ready to establish individual ratings for them, Mr. Gardner pointed out.

"Every syndicate is different and requires considerable understanding," Mr. Gardner observed. Ratings could be issued only after meetings with the underwriters of the syndicates, he said.

•

Business Insurance Associate Publisher/Editor Kathryn J. McIntyre contributed to this report.

35th Rendez-Vous de Septembre

Retrocessional market gets new capacity

By KATHRYN J. McINTYRE and GAVIN SOUTER

MONTE CARLO, Monaco—New capacity is entering the desperate property catastrophe reinsurance and retrocessional marketplace.

The insurance units of Omaha, Neb.-based Berkshire Hathaway Inc. are prepared to underwrite on a net basis up to $300 million aggregate in property catastrophe reinsurance and retrocession coverages in 1992, says Ajit Jain, president of the company's professional liability and specialty risks division.

New York-based American International Group Inc. is set to inject $100 million of capacity into the ailing retrocessional and London excess-of-loss market, also on a net basis, said underwriters and brokers at the Rendez-Vous de Septembre, held earlier this month in Monte Carlo. AIG will commit $75 million to the non-marine LMX market and $25 million to the marine LMX market.

In addition, New York-based reinsurance broker Willcox Inc., a unit of Johnson & Higgins, believes it can deliver U.S. capacity to underwrite catastrophe reinsurance for European insurers—provided it is priced at the market leaders' rates.

This new capacity is entering a worldwide marketplace suffering from an acute shortage of catastrophe and retrocessional coverage. The shortage stems from the series of huge catastrophe losses suffered by the insurance and reinsurance markets between 1987 and 1990 that drove reinsurers from writing catastrophe reinsurance and retrocessional business.

The new capacity is not expected to satisfy demand, though it could draw others back into the market. A few underwriters even fear new capacity in the LMX market, since cheap retrocessional coverage has been the downfall of the reinsurance industry because it allows underwriters to charge uneconomical rates.

Berkshire Hathaway's insurance units, principally National Indemnity Co., have already sold in excess of $100 million in catastrophe limits for calendar year 1992, Mr. Jain said.

"We are willing to do close to $300 million of risk covers—not financial products"—for calendar year 1992, he said, dispelling the reputation that Berkshire Hathaway only offers financial or funding products. The products Berkshire Hathaway is offering include market loss warranty covers, subsequent event covers and traditional catastrophe coverages, both for primary insurers and reinsurers needing retrocessional protection.

In general, a primary company is an attractive risk for Berkshire Hathaway even if the contract does not include a market loss warranty, which limits coverage to an indemnifiable loss by the cedant when the marketwide loss has exceeded a predetermined amount.

However, the inclusion of a market loss warranty can make retrocessional and London market excess coverages very attractive to underwrite, Mr. Jain said.

Overall, most of the policies written for 1992 contain the market loss warranty, he noted. "The 1991 book was more balanced," he said.

For some clients, Berkshire Hathaway has written up to $40 million in limits on a program. The rate on line can vary from 6% to 40%, although most are in the 30% range.

Berkshire Hathaway insurance units, with $7 billion in capital and surplus, can afford to write cover-

Continued on next page

LUC to open by year-end 1992: Blake

MONTE CARLO, Monaco—The opening of the London Underwriting Centre will not be delayed as long as first feared after a fire gutted the building early last month.

The building, designed to house 80 non-marine insurance and reinsurance companies, was due to open in March 1992. But, after the fire it was thought that it would not be ready before spring 1993.

However, the opening date will now be no later than year-end 1992, LUC Chairman Victor Blake announced in a speech at a London market reception during the Rendez-Vous de September in Monte Carlo.

"We can say now that it will be the end of 1992 before it is actively open. We are having negotiations with developers and insurers to provide a fast-track solution, so the end of 1992 can be underpinned as a date," said Mr. Blake, who also is chairman of CNA Reinsurance of London Ltd.

The Aug. 7 fire that gutted the LUC building caused severe damage, but the event was not a disaster, Mr. Blake said.

" 'Why isn't it a disaster?' some may ask. Because no one was killed, and we had not forgotten to buy insurance," he said.

Damage to the internal furnishings of the building is estimated at 26 million pounds ($45.2 million). The lead property insurer was Royal Insurance P.L.C. (*BI*, Sept. 2; Aug. 12).

The rebuilding process has already started, Mr. Blake said.

"Loose debris has been removed and the building made safe. Stripping-out is set to commence immediately. Once this stage is complete, we will begin to develop firmer estimates of the likely delay," he said.

The ultimate completion of the building is not in doubt, Mr. Blake stressed.

"I can categorically state that there will be a London Underwriting Centre," he said.

Also, none of the 72 companies that have signed up for space when the LUC is completed has "even hinted of pulling out" since the fire, he said.

"Delayed we may be, defeated we are not. We intend to demonstrate the resilience and resolve of the London market, and we will not fail," Mr. Blake added. ■

Retrocessions

Continued from previous page
age on a net basis.

National Indemnity alone had capital and surplus at June 30 in excess of $4.3 billion. And, as a net line underwriter, it is not hampered by limits on the amount of catastrophe business imposed on other would-be catastrophe underwriters by their reinsurers—or by lack of reinsurance.

Straight from a week in London, Mr. Jain was attending his first Rendez-Vous, accompanied by Thomas Bolt, senior vp in the reinsurance division of Berkshire Hathaway. Mr. Bolt attended the Rendez-Vous for the first time last year.

"We have met with existing clients and brokers and potential clients," Mr. Jain said. "Our focus has been to cover the continent."

Mr. Jain has found that ceding companies are more concerned about security and capacity than they are about the price of the coverage. In addition, they want to "lock in capacity" and they are willing to pay a higher price to do so, he said.

Berkshire Hathaway entered the catastrophe market in 1989, writing back-up catastrophe covers following Hurricane Hugo and the San Francisco earthquake—making the coverages exposed to the next catastrophe.

Berkshire Hathaway offered renewal quotes for 1990, but few wanted to buy, so its losses on the 1990 European storm losses were far lower than they could have been.

In 1990, Berkshire Hathaway did write market loss warranty covers, which respond when the ceding company had an indemnifiable loss and the entire industry's loss exceeds a predetermined amount.

For calendar 1991, Berkshire Hathaway underwrote in excess of $200 million in aggregate catastrophe limits.

In addition, Berkshire Hathaway has written contracts that will become effective July 1, 1992, for those cedants that want to lock in price and capacity now for catastrophe coverages.

Some clients also have paid to reserve specific coverage at an agreed-upon price to be purchased later.

"It is a volatile market," Mr. Jain said of the catastrophe and retrocession market. "By injecting capacity, we will help to dampen the volatility and prevent prices from going much higher."

While Berkshire Hathaway is offering catastrophe coverage on a risk basis, Mr. Jain said he is "surprised by the number of people interested in financial products."

"I'm also amazed at the number of people willing to sell the products," he added.

However, Mr. Bolt noted that there is a "large continuum of products from a three-year commitment to offer traditional coverage to those with more limited amounts of risk transfer."

Berkshire Hathaway also is "looking into the marine and aviation business," said Mr. Jain. If it entered these businesses, it would be offering capacity in addition to its allocated capacity for property catastrophe business.

AIG is currently establishing a retrocessional line of coverage totaling $100 million net aggregate, sources agree. And the line is split $75 million in the non-marine market and $25 million in the marine market, sources say.

The coverage will be written though a subsidiary, Transatlantic Reinsurance Co. in London.

Capacity for retrocessional covers from other U.S. insurers will be difficult to find, says Robert O'Leary, president of Willcox. "There is some market for retrocessional business if there is an opportunity for other collateral business, but placing stand-alone retrocessional business will be difficult," he said.

But, "there is a serious market in the U.S. for direct catastrophe reinsurance coverage for European ceding companies," Mr. O'Leary said. "The amount is in question, but it would be substantial if it is priced on original leaders' terms."

Willcox Vp Thomas Wafer estimated that 20 U.S. markets would write catastrophe coverage for indigenous primary business on a net line basis, if properly priced.

While ceding companies outside the United States were not interested in U.S. catastrophe capacity three years ago, they are now, he noted.

"New opportunities are created by the big problems here," observed Thomas Hancock, executive vp of Willcox. "We are the one U.S. broker traveling worldwide producing direct business for the U.S. market."

Capacity for catastrophe reinsurance shrank and the non-marine LMX market virtually collapsed after the European storms in early 1990.

After $10 billion in losses, underwriters ceased writing LMX business and some ceased trading altogether due to disastrous results.

The problems arose in the LMX market because of the notorious LMX spiral, underwriters say. The spiral effect itself was caused by the same underwriters covering the same risk at different levels.

AIG's entrance will not have a great effect in itself, said Tony Dodd, treaty underwriting manager at British & European Reinsurance Co. Ltd. of London.

"$100 million is just a drop in the ocean of the LMX market. A large drop, but still just a drop," he said.

However, if AIG is successful on its LMX account, it may encourage other underwriters to return to the market, Mr. Dodd said.

But even then, the revival may be only temporary, Mr. Dodd said.

"Rates have increased dramatically, but they needed to. If other underwriters came back into the market and prices went down again, then it may become unprofitable again and their insurers will pull out again," he said.

This year British & European has been able to buy only one-third of the coverage it bought in previous years—at the same premium it paid for the more extensive coverage, Mr. Dodd said.

The lack of retrocessional coverage has been good for the reinsurance market, said Benito Pagnanelli, joint general manager at Assicurazioni Generali S.p.A. in Trieste, Italy.

"It would be a good thing if retrocessional coverages were made illegal," Mr. Pagnanelli said.

If reinsurers had to write a net account, they would take more care in assessing the risks they were underwriting, and this would lead to more technical and more professional underwriting, he asserted.

"It would lead to more sensible underwriting generally if the retrocessional market was not there," Mr. Pagnanelli said.

Dennis Purkiss, underwriter at Merrett Underwriting Agency Management Ltd. at Lloyd's of London, is skeptical about a resurgence of the LMX market.

"I don't see much future for LMX syndicates," he said.

Merrett syndicates pulled out of non-marine LMX spiral business in November 1989, and Merrett is not going to re-enter that market, Mr. Purkiss said. Merrett will write first-layer LMX retrocessional business, but not retrocessional coverage for retrocessional risks.

"The standard principle of reinsurance went out of the window in the LMX market, and although it will blossom again, it won't operate in the same way," he said. He does not expect underwriters to write retrocessional coverage for retrocessional risks.

Reinsurers should not provide capacity that is reliant on retrocessional coverage, said James Holmes, senior vp of assumed reinsurance at Zurich Insurance Co. in Zurich, Switzerland.

"A reinsurer cannot provide stability if his capacity is based on the retrocessional market," he said.

Even when retrocessional coverage is inexpensive, reinsurers should not rely on it to conduct their business because the coverage may disappear in a year, he said.

"There are professional ways of buying retrocessional coverage and that is what we need to see in the future," Mr. Homes said.

Inexpensive LMX coverage has caused problems for reinsurers in the past, but if a more professional attitude is taken by buyers and sellers of LMX business, the market will be revived, said James Payne, chairman of E.W. Payne Cos. Ltd., the reinsurance brokerage unit of Sedgwick Group P.L.C. in London.

"There is nothing wrong with LMX business in itself. It is just that in the past it has been used like an arbitrating business," he said.

There is a great deal of good reinsurance in London, and there is no reason why this should not be covered in the LMX market, Mr. Payne said.

However, the business should be conducted on the basis of long-term relationships between the Lloyd's syndicates and their LMX underwriters, Mr. Payne said.

"We will never eliminate competition, but that doesn't mean that competition has to be uncontrolled, and that doesn't mean that there have to be cartels, either. There just has to be a set of principles and a set of objectives," he said.

There were signs at the Rendez-Vous that the LMX market is changing with capacity returning and underwriting techniques changing, said Jonathan Marland, a director at Lloyd Thompson Group P.L.C., who was attending the meeting to inform underwriters about the broker's new non-marine unit.

"Non-marine LMX capacity is not going to return in the way it did before. However, there will be a market for risk excess business," he said.

Previously, different classes of business had been collected into one risk, but in the future, different classes of business will be placed individually in the LMX market, Mr. Marland said.

As a result of the changing market and high rates, more underwriters may be attracted back into the LMX market, he said.

"At the moment, it's a fair punt that with rates at 40%, you are going to make a profit," Mr. Marland said.

Consequently, in 10 years' time "people may look back on the early 1990s as the golden days of reinsurance," he said.

The Lloyd Thompson non-marine division is built around Richard Lay, who was formerly managing director of C.E. Heath P.L.C.'s LMX division, and Sue Christiansen, who formerly was a director of Bradstock Blunt & Crawley Ltd. ■

Advertiser Index

Issue of September 23

Business Insurance

35th Rendez-Vous de Septembre

Prudential Corp. decides to keep M&G

By GAVIN SOUTER

MONTE CARLO, Monaco—Prudential Corp. P.L.C.'s reinsurance subsidiary Mercantile & General Reinsurance Co. P.L.C. is not for sale.

The announcement comes after 18 months of speculation in the insurance and reinsurance industry over whether M&G, the largest British reinsurer, would be sold and who would buy it.

London-based Prudential's announcement was released midweek during the Rendez-Vous de Septembre, where underwriters and brokers had been speculating about potential buyers.

The news about M&G was just one of the many market updates being discussed at the Rendez-Vous.

The decision to keep M&G was made after "an intensive review of the business had been undertaken," said Mick Newmarch, chief executive of Prudential.

"We have concluded that given the strength of the long-term operation, the significant inherent value of the life fund and the opportunities we have to improve the result of the general reinsurance business, M&G is capable of delivering higher returns than have been obtained in the past," Mr. Newmarch said while reporting Prudential's interim results.

By retaining M&G, Prudential will be able to offer better returns to its shareholders, he added.

Speculation that M&G was for sale began when Mr. Newmarch became Prudential's chief executive in April 1990 and began a review of all of the poor-performing parts of the company, including its real estate business—which was sold in May—and M&G.

The reinsurer has a strong life reinsurance business, but it has suffered badly on its general reinsurance side, largely due to the huge loss from the 1988 explosion of the Piper Alpha North Sea drilling platform, said M&G General Manager John Lock.

"The announcement must come as a huge disappointment to some people," quipped Mr. Lock, referring to the pleasure some members of the reinsurance market took in discussing a potential buyer for M&G.

Prudential will retain M&G, because the general insurance and reinsurance markets are improving, Mr. Lock said.

"Prices are rising in general reinsurance, particularly in the non-proportional areas, and we don't think that they will weaken. Also, there is less capacity in the market, so M&G should be able to improve its results," Mr. Lock said.

The general insurance market in Britain also is hardening as companies suffering from poor results are increasing their rates, he said.

Prudential posted half-year profits of 170 million pounds ($275.6 million at applicable exchange rates) up from 120.9 million pounds ($227.3 million) in the first half of 1990. Life insurance accounted for most of that improvement. Its general insurance business produced a loss of 54.2 million pounds ($87.9 million), compared with a loss of 71.3 million pounds ($134 million) for the first six months of 1990.

Mr. Lock declined to say whether any discussions with potential buyers had taken place since Mr. Newmarch joined Prudential.

But if M&G was to have been sold, it may have taken some time to find a buyer, he said. "The market for potential buyers is not very large, simply because of our size," he explained.

Based on 1990 net reinsurance premiums of $1.4 billion, M&G ranks ninth in the *Business Insurance* ranking of the world's largest reinsurers (*BI*, Sept. 2).

While M&G is not for sale, consolidation in the reinsurance marketplace continues.

The previously announced merger of two French reinsurers—Societe Anonyme Francaise de Reassurances and AGF Re—will be completed Sept. 30, said Herve Cachin, general manager of SAFR. After the merger, SAFR will be the second-largest reinsurer in France with 1992 gross premiums of approximately 3.5 billion French Francs ($614 million at current exchange rates).

SCOR S.A. is the largest reinsurer in France, with consolidated 1990 gross reinsurance premiums written of 11.2 billion French francs ($2.2 billion at year-end exchange rates).

"It is difficult to grow in the present market," observed Mr. Cachin, referring to the low commercial rates in most countries.

AGF Re will add 500 million French francs ($87.5 million) in capital and surplus to SAFR, and another 200 million French francs ($35 million) in unrealized capital gains. This will bring SAFR's total stockholders' funds, including unrealized capital gains, to 3 billion French francs ($526 million).

AGF Re also will add 70 people to the staff of SAFR, bringing the total to 260 employees, almost all based in Paris. SAFR has a small branch in Seoul, South Korea.

"This merger will allow us to provide our clients with improved service via a reinforcement of our technical department and development of our international network," commented Jean-Pierre Fillebeen, senior vp of SAFR.

About 30% of SAFR's business emanates from France, with the bulk of its business from Western Europe. It also underwrites a North American property account and some Japanese business.

Assurances Generales de France, the parent of AGF Re and already a shareholder in SAFR, will hold approximately 42% after the merger.

Meanwhile, at least one U.S.-based reinsurance company is increasing its capital commitment to its European business and is consolidating its European operations.

Prudential Reinsurance Co. of Newark, N.J., earlier this month increased the capital of its U.K. subsidiary Le Rocher Reinsurance Ltd. by 8 million pounds ($13.9 million) to 20 million pounds ($34.8 million).

Prudential also is merging Le Rocher Re (formerly Le Rocher U.K. Ltd.) in London with its Le Rocher Compagnie de Reassurance

Continued on next page

No M&G sale

Continued from previous page

S.A. of Brussels effective Jan. 1, 1992. Le Rocher Re will be registered in London, serving London brokers from London and serving its European clients from a branch office in Brussels.

After the merger of the Le Rocher companies—thus named so as not to create any confusion with the unrelated U.K.-based Prudential Corp.—Le Rocher Re will have capital of about 30 million pounds ($52.1 million).

"So many companies now are contracting their operations. We are showing commitment to the market and to the European Economic Community by adding fresh capital," said Claude E. Nyssen, chief executive officer of Le Rocher Re and vp-Europe for Prudential Re.

Le Rocher will write net premiums in 1992 of about 53 million pounds ($92.1 million), which is about double from 1988 when Mr. Nyssen joined the company from Allstate Reinsurance Co. Ltd. in London.

The capital contribution to Le Rocher Re was announced the week before the Rendez-Vous.

One very large deal that the parties had hoped to announce at the Rendez-Vous was not made public in Monte Carlo because lawyers were still completing the papers: the acquisition of Bermuda-based Pinnacle Reinsurance Co. Ltd. by Centre Reinsurance Holdings Ltd., also based in Bermuda (see story, page 13).

Uncharacteristic for a Rendez-Vous, where gossip is the major trading commodity, news of the acquisition did not leak.

The Centre Re acquisition of Pinnacle marks the first consolidation in the so-called financial reinsurance marketplace. Pinnacle is best known as an underwriter of time-and-distance policies for Lloyd's of London syndicates, while Centre Re is a finite risk reinsurer and the largest specializing in this business (*BI*, April 29).

Meanwhile, acquisitions of London reinsurers are unlikely to increase, said Tony Dodd, treaty underwriting manager of British & European Reinsurance Co. Ltd. in London.

"If I had a lot of capital, I wouldn't buy an existing reinsurance company in the London market, because a lot of the businesses are so bad. I would employ the underwriters instead, because then you don't have to worry about run-off problems," he said.

Internal growth can also be preferable to growth by acquisitions, said David Trace, managing director of CNA Reinsurance of London Ltd.

"We want to develop in Europe, and we have an office in Amsterdam, but we tend not to buy companies; we develop our own company," he said.

Consequently, CNA may open offices in other European cities in the future as long as it can find the right person with a knowledge of the local markets, according to Mr. Trace.

In the primary insurance marketplace, it's expected that the rapid pace of mergers and acquisitions will continue in Europe as companies prepare for the removal of European insurance market barriers 1992.

"People are positioning themselves for 1992, so the merger and acquisition activity will not slacken," said James Holmes, senior vp of assumed reinsurance at Zurich Insurance Co. in Zurich, Switzerland.

Prospective buyers are studying the market, and several companies with poor results are available, he said.

"The logical conclusion is that the longer the time the rates are depressed and people jostle for the position, more money will be lost and more companies will become available," he said.

Assicurazioni Generali S.p.A in Trieste, Italy, particularly is looking for opportunities in Central and South America, said Joint General Manager Benito Pagnanelli.

"We have historic connections with these areas, and with the liberalization of the markets, opportunities are developing," he said.

Generali operations in some Latin American countries may grow internally, but the company also would like to set up operations in Venezuela and Panama, Mr. Pagnanelli said.

In Europe, Generali is seeking to set up an operation in Brussels to improve its service to multinational clients, he said.

Also, to this end, the company created Generali Group International Services this year. This division seeks to provide service to multinational clients through the worldwide network of Generali offices and the offices of affiliated companies, Mr. Pagnanelli said.

"We have to provide multinational clients with the same kind of service worldwide as we provide them with in Italy," he said.

The international services division also will supply engineering and loss control services to international clients, Mr. Pagnanelli said. ■

LTV ruling

Continued from page 1

The agency argues that its priority standing is spelled out in the Employee Retirement Income Security Act of 1974 but not in the Bankruptcy Code.

Without such changes, ailing companies with large underfunded pension liabilities may seek bankruptcy court protection to pass on those obligations to the PBGC, the agency and pension experts say.

And that burden would force the agency to seek significantly higher premiums for all employers with defined benefit plans, they say.

Others, however, caution that many other factors will discourage troubled companies with underfunded pension liabilities from flooding bankruptcy courts.

Judge Duffy's decision stems from the PBGC's 1987 termination of three pension plans that LTV said it could no longer afford. But LTV, as part of a collective bargaining agreement with the United Steel Workers union, later established new follow-on plans to provide union members certain non-PBGC guaranteed benefits that were lost when the old plans were terminated.

The pension agency then moved to restore the plans, charging LTV was abusing the pension insurance program.

After years of legal wrangling, the U.S. Supreme Court last year ruled that the plans could be restored (*BI*, June 25, 1990)

But only a few weeks before the high court decision, a U.S. Bankruptcy Court judge ruled that the PBGC, which continues to administer the disputed plans, should not be given priority over LTV's unsecured creditors (*BI*, June 4, 1990).

The PBGC appealed to the federal court, which upheld the bankruptcy court ruling.

"For priority status, the claimant must show that the claim arose post-petition," Judge Duffy wrote. "In this case, PBGC argues that its statutory obligations under the plans at bar were triggered by post-petition termination, thus according its obligations post-petition priority status. I disagree. PBGC's claims are pre-petition contingent claims because the labor giving rise to the pension obligations was performed pre-petition."

LTV would not comment directly on Judge Duffy's decision.

But, the PBGC and some pension experts say the ruling may encourage ailing companies to file for bankruptcy to dump their pension liabilities on the PBGC.

The ruling "is really a backdoor way for companies to shed their pension liabilities and terminate their plans because they aren't paying on-going contributions," said James B. Lockhart III, the agency's executive director.

"I would be the first one to say the PBGC is crying wolf here, but I'm not so sure they are," said Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans, a corporate lobbying group in Washington, D.C.

He believes that the same type of companies that now are using bankruptcy proceedings "aggressively and creatively" will "see this ruling as another way to take advantage of the bankruptcy law."

While no company "wants to go into into bankruptcy, the decision certainly makes it easier, and it will be factored in by bankruptcy and pension attorneys," said Mark Ugoretz, president of the ERISA Industry Committee, a Washington, D.C.-based lobbying group for large companies.

"Bankruptcy can take years, so basically, according to this decision, companies can have a free pension plan," said Kathleen Utgoff, a former PBGC executive director who is now an economist with the law firm of Groom & Nordberg in Washington, D.C.

If Judge Duffy's ruling stands, the PBGC—already straining under a $2 billion deficit—would likely have to seek a sharp hike in premiums to meet its long-term obligations, pension experts said.

And, it "will encourage companies to shed billions of dollars of pension responsibility, forcing the PBGC, employers that pay PBGC premiums and potentially taxpayers to bail them out," Mr. Lockhart said.

The PBGC estimates that financially troubled companies—many of which are in bankruptcy—have about $8 billion in unfunded pension liabilities.

"The amount of money involved" in the LTV case alone "is very large," Mr. Lockhart said. If the PBGC is not given priority status among LTV creditors and receives only "10 cents or 20 cents per dollar on $3.1 billion, you can see the tremendous losses," he said.

Mr. Ugoretz says the ruling could spell disaster for "a lot of employers that provide defined benefit

Continued on next page

LTV ruling

Continued from previous page

plans." The ruling "could translate into a premium increase of somewhere around $35 to $40 total per participant," he said.

"The result would be a substantial cutback in benefits or a cutback in defined benefit plans," he predicted.

Employers' annual PBGC premiums increased during the 1980s from a flat $2.60 per participant to a variable rate of $16 to $50, depending on how well the plan is funded. Last year, the rate was again raised to between $19 and $72 (*BI*, Oct. 15, 1990).

But some benefits experts and bankruptcy lawyers say it is unlikely that companies with large underfunded pension liabilities will flood the bankruptcy courts.

"The notion that there will be some type of rush to the door given this decision is probably more a political concern of the PBGC than a reality," said Baruch Fellner, a former a former PBGC associate general counsel who is now a partner with Gibson, Dunn & Crutcher in Washington, D.C.

Christopher J. Redmond, a bankruptcy specialist with the Wichita, Kan., law firm of Redmond, Redmond & Nazar, noted employers must consider several other factors before entering bankruptcy.

For example, employers would have to consider what effect bankruptcy proceedings would have on other promises made to employees, including retiree medical benefits and collective bargaining issues, he said. Issues that the employer does not want to disturb could be radically changed during Chapter 11 proceeding, he noted.

'It's a high-risk, high-stakes approach,' Mr. Salisbury of EBRI says.

In addition, a company can be tied up in bankruptcy proceedings for much longer than it originally expects, he warned.

"You may end up losing your key management because they don't want to stay and fight it out or they may feel the bankruptcy will" tarnish their images, Mr. Redmond said.

And, "the PBGC would bring up the same issue (of priority) in each case, so the battles would be long and protracted," he said.

"I wouldn't advise most clients—even those with substantial pension liabilities—to make a decision to file for Chapter 11 based on Judge Duffy's decision alone," said Michael H. Reed, a partner with Pepper, Hamilton & Scheetz in Philadelphia, which represents the state of Pennsylvania, a creditor in the LTV bankruptcy case.

"As a means of gaming the system, it's a high-risk, high-stakes approach," said Dallas Salisbury, president of the Employee Benefit Research Institute, a benefits think tank in Washington, D.C.

Some observers say publicity from the decision may help the PBGC persuade Congress to give it priority status in bankruptcies.

"The PBGC is attempting to create a crescendo of concern in order to create a momentum in Congress to solidify its priority in bankruptcies," said Mr. Fellner, the former PBGC associate general counsel.

The agency has been lobbying for changes in the bankruptcy code for months. "We have a legislative package we've been fine-tuning for months, and it's close to being ready to introduce," Mr. Lockhart said. "We may have to go with a temporary fix. But we think there's a good chance of getting our legislation considered in Congress next year," he said.

"There is some sympathy on Capitol Hill for the PBGC's position on this issue," said Frank McArdle, a consultant with Hewitt Associates in Washington, D.C.

Indeed, Rep. Rod Chandler, R-Wash., last week called for legislation giving the agency priority status in bankruptcy proceedings. In a letter to Rep. Dan Rostenkowski, D-Ill., chairman of the House Ways and Means Committee, Rep. Chandler said: "Let's move quickly on this one. We need to develop legislation and hold a hearing as soon as possible in order to avoid another S&L-like bailout."

However, because bankruptcy law is "fraught with complexities," it may be difficult for the PBGC to persuade Congress to change it, Mr. McArdle said. ●

LTV Corp. et al vs. Pension Benefit Guaranty Corp., U.S. District Court for the Southern District of New York; No. 89 Civ. 6012.

LTV Corp. and LTV Steel Co. Inc. vs. Elizabeth Dole, Secretary of the United States Department of Labor, U.S. District Court for the Southern District of New York; No. 90 Civ. 6048.

MEWA hearing

Continued from page 1

State regulators say they are overwhelmed just trying to locate MEWAs, let alone regulate them.

There is "no radar to let me know that a MEWA is operating. Generally, by the time we find out, it is too late" to help participants, said Georgia Insurance Commissioner Tim Ryles.

Even when state regulators have been able to locate MEWAs, regulators often have had to engage in court battles with the MEWAs, which argue that federal law preempts states from regulating them, according to the GAO.

In fact, state regulators told the GAO that fraudulent MEWAs deliberately claim federal pre-emption as a stalling technique to give them more time to collect additional premiums from employers.

According to the GAO study, states have tried to correct compliance problems suspected with an estimated 663 MEWAs.

While the problems of fraudulent and mismanaged MEWAs are growing, a legislative remedy does not appear imminent. Bush administration officials who testified last week could not say when they would propose legislation to crack down on MEWA fraud.

'Over 70% of the states said they were unable to proactively apply such established standards as funding and reporting and disclosure standards because they were unable to identify MEWAs until they received complaints,' Mr. McDonald says.

The testimony presented at last week's congressional hearing underscores how legislation passed by Congress in late 1982 to halt MEWA problems has not worked.

Indeed, the scope of today's MEWA problems appears to equal, if not exceed, the MEWA failures of the late 1970s and early 1980s that led to congressional intervention. In fact, the roots of today's MEWA problems outlined by hearing witnesses—soaring health insurance costs, regulatory ambiguities, unsophisticated small employers and fast-buck operators—are similar to problems that led to the wave of MEWA fraud in the 1970s and 1980s.

Problems with MEWAs—also known as multiple employer trusts or METs—developed after Congress enacted the Employee Retirement Income Security Act in 1974.

Large employers at the time feared a patchwork quilt of state laws regulating employee benefit plans. At their urging, Congress included pre-emption provisions in ERISA that barred states from regulating benefit plans.

In the wake of ERISA, entrepreneurs, often insurance agents or third-party claims administrators, brought together unrelated employers, especially small firms, and formed self-funded MEWAs to provide health care coverage for the firms' employees.

MEWA organizers claimed that the MEWAs were "employee benefit plans" and thus were exempt under ERISA from regulation by state insurance officials. The state regulators, however, contended that the MEWAs were no more than unauthorized insurers.

While the MEWAs resisted state efforts to regulate them or shut them down, the Labor Department failed to set any kind of standards, like funding and reserve levels, to govern MEWAs.

In this regulatory vacuum, fast-buck operators thrived in the late 1970s and early '80s. To lure small employers, MEWA organizers often set premiums substantially below premiums charged by commercial insurers or Blue Cross/Blue Shield plans. The organizers then paid themselves or their agents high commissions and administrative fees, instead of putting sufficient reserves aside or purchasing adequate stop-loss coverage.

The MEWAs could continue operating as long as premiums from new employers continued to offset the claims of employers already in the program. However, when new premiums began to slow, the MEWAs collapsed because of inadequate reserves.

When that happened, the MEWA administrators quickly disappeared, though they often popped up in another state and set up other MEWAs.

As MEWA problems intensified in the early 1980s, especially in California, Texas and Illinois, Congress at last intervened.

A bill approved by Congress in late 1982 attempted to eliminate the uncertainties that dogged MEWA regulation by clarifying the roles of state and federal officials. Under the measure, states generally are free to apply any insurance law and standards to self-funded MEWAs.

However, collectively bargained plans and plans maintained by rural electrical cooperatives were excluded from the definition of a MEWA and thus are exempt from state regulation. Earlier this year, Congress also passed legislation excluding health plans maintained by rural telephone cooperatives from state regulation.

But the 1982 legislation has far from eliminated the regulatory uncertainties surrounding MEWAs, says the GAO's Mr. McDonald.

For example, 80% of the states surveyed by the GAO said that MEWAs still claim ERISA pre-emption from state regulation. And, 13 states reported they were forced to resolve the issue through court action.

While states reported that they won almost all of those cases, those legal battles were costly in both time and resources.

Officials in one unidentified state said that fraudulent MEWAs sometimes claim pre-emption specifically to stall for time to collect more premiums, Mr. McDonald said in his written testimony.

State officials also told the GAO that MEWA operators are using a variety of schemes, like marketing "associate union memberships," to exploit the exemption from state regulation that ERISA gives to collectively bargained benefit plans.

"Pre-emption concerns are not static," Mr. McDonald said.

But the heart of the MEWA problem is that MEWAs can begin operating before state regulators find out about them, Mr. McDonald and other witnesses testified.

"Over 70% of the states said they were unable to proactively apply such established standards as funding and reporting and disclosure standards because they were unable to identify MEWAs until they received complaints. To the extent that states are able to react only after problems have occurred, their options for protecting participants and curtailing losses are lessened," Mr. McDonald said.

"Identification is the real problem," said Assistant Secretary of Labor George Ball.

"There should be a system of compulsory registration," recommended Rep. Gerry Studds, D-Mass.

Several trade groups representing third-party claims administrators, which often help operate MEWAs, say fraudulent and mismanaged MEWAs can be stopped from even getting off the ground by establishing federal standards that MEWAs would have to meet to be exempt from state regulation. Those standards should be enforced by the Labor Department, they said.

For example, both the Self-Insurance Institute of America of Santa Ana, Calif., and the Society of Professional Benefit Administrators in Chevy Chase, Md., say they support the approach taken in legislation introduced by Rep. Tom Petri, R-Wis.

That bill, H.R. 2773, would require MEWAs to obtain federal "certificates of compliance" from the Labor Department that the MEWA meets the funding, reserve and stop-loss insurance requirements laid out in the bill. States could immediately shut down MEWAs lacking these certificates.

MEWAs need a single set of federal rules rather than 50 different state rules, said SIIA Executive Vp James Kinder.

"MEWAs should be under control of the Labor Department from day one," said Robert C. Gerald, president of Group Services Administrators Inc., a Jersey City, N.J.-based TPA.

Mr. Ball agreed that new legislation is needed to curb MEWA problems. But, he said the administration is not ready yet to endorse specific proposals.

"We are considering a whole range of options," Mr. Ball said. ■

Ex-Louisiana commissioner seeks post

By MICHAEL BRADFORD

BATON ROUGE, La.—Former Louisiana Insurance Commissioner Sherman A. Bernard wants his old job back.

Mr. Bernard is one of seven contenders who will square off in an Oct. 19 primary election in their bid for the commissioner's post.

If a candidate receives a majority of the votes, he or she will be the commissioner. If no candidate receives a majority of votes, the two top finishers, regardless of party affiliation, will face each other in the Nov. 16 general election.

The field is battling for the spot now held by Acting Commissioner Darrell Cobb, who is not running for the office.

Mr. Cobb, a deputy commissioner, is completing the term of former Insurance Commissioner Doug Green, who is serving a 25-year prison term on bribery, money laundering, mail fraud and conspiracy charges stemming from his regulatory treatment of the now-insolvent Champion Insurance Co. (*BI*, July 1).

Mr. Bernard, who held office for 16 years before being unseated by Mr. Green in 1987, said he is trying to regain his old job because "so many people are urging me to go back and straighten the insurance department out. It's adrift. It's in shambles."

Mr. Bernard said that if elected, one of his priorities will be to tackle problems with automobile insurance.

"Everybody in Louisiana is screaming about auto insurance," Mr. Bernard said. He said he would develop a no-fault auto insurance system if elected.

Since leaving office four years ago, has concentrated on "having fun," he said. "If I win, I'll serve another four years and that's it. If I lose, I'll never run again. This is my last hurrah."

In 1988, Mr. Bernard blamed a bad back and leg on his failure to pass Louisiana's property/casualty agent licensing exam. Pain in his back and leg made it impossible for him to sit through the entire exam, he said.

The former commissioner scored a 44 on the first half of the test, 26 points short of the 70 points needed to pass (*BI*, July 25, 1988).

"I never wanted to be an agent," Mr. Bernard said last week. "I just did that for the fun of it."

Having served as insurance commissioner for 16 years, name recognition will figure into Mr. Bernard's campaign. However, he will face another contender who also has a well-known name in the state.

Jim Brown, former secretary of state and a candidate for governor in 1987, has entered the race.

Mr. Brown, a Baton Rouge attorney, also hosts a cable television talk show in Baton Rouge.

Another well-known candidate for the office is Peggy Wilson, an outspoken member of the New Orleans City Council, who has pledged to "clean up" the Insurance Department.

Ms. Wilson also plans to work for insurance reforms, including a system whereby private firms—rather than the state—would audit insurers. She also advocates the creation of an insurance fraud task force.

The other candidates are:

- Neal J. Burke, president of the Lafayette Parish Council, who pledges to shore up consumer protection practices at the department.

Mr. Burke, who has experience in the life and health insurance business, stressed his administrative qualities as an advantage in the race.

- Eddie Fletcher, an independent agent in Baton Rouge. Mr. Fletcher says that as commissioner he would improve insurer audit procedures to eliminate weak companies from the Louisiana market.

He also pledges he will work for reforms to ensure faster claims payments and improvements in the department's complaint section.

- Gene Guffey, a Baton Rouge insurance agent. Mr. Guffey will concentrate on insurer solvency if elected, he says. He claims an advantage as the only candidate with a background in property/casualty insurance.
- Flo Robinson, a New Orleans real estate broker and independent insurance agent. Ms. Robinson pledges that she will work toward improving insurer solvency and ending corruption in the Insurance Department. ■

Cleanup coverage

Continued from page 1

Co. vs. Northeastern Pharmaceutical & Chemical Co., is to be given deference, it was wrongly decided and therefore should not be followed (*BI*, Sept. 16).

"It is very significant that an important court so strongly criticized NEPACCO," said John Gross of Anderson, Kill, Olick & Oshinsky in New York, who represented Independent Petrochemical Corp. in this case. He predicted the ruling would be influential nationwide as policyholders seek coverage for cleaning up hazardous waste.

"It is very unusual for a federal court of appeals not to follow an interpretation of state law by another federal appeals court whose jurisdiction encompasses that state," agreed policyholder attorney William Greaney of Covington & Burling in Washington, D.C. "It must be an egregious case, and that is what the D.C. Circuit found."

The court "says in a very loud voice that the NEPACCO decision is intellectually indefensible," he said.

Because the appeals court is "one of the most influential of the federal appeals courts," the decision is of tremendous importance to policyholders, he said.

"The D.C. Circuit is well respected and the decision will be influential," agreed Robert Shulman of the Washington, D.C., office of Anderson, Kill, Olick & Oshinsky, who also represented IPC.

The District of Columbia Circuit's opinion also is important because the 8th Circuit's NEPACCO decision has been a key precedent for insurers trying to deny coverage for cleanup costs, attorneys say.

The District of Columbia Circuit's decision "pulls the rug right out from under the insurers," said policyholder attorney Donald Kiel of Pitney, Hardin, Kipp & Szuch in Morristown, N.J.

Insurers, for their part, are playing down the ruling's importance.

"The 8th Circuit is a better predictor of Missouri law" than the District of Columbia Circuit is, said insurer attorney Thomas Brunner of Wiley, Rein & Fielding in Washington, D.C.

Furthermore, "NEPACCO is still good law everywhere except the D.C. Circuit," he said.

And, each state supreme court still will have to issue a definitive ruling on this issue, Mr. Brunner said.

"It ain't over till it's over," said attorney James P. Schaller, who represented several American International Group Inc. units in the dispute. Those units had underwritten primary and excess coverage.

He said Supreme Court review is possible because the District of Columbia Circuit's decision not to follow the 8th Circuit is "so unusual."

Insurer attorney James Rocap of Miller, Cassidy, Larroca & Lewin in Washington, D.C., said he doubts that the District of Columbia Circuit's ruling will greatly influence cases nationwide.

"The D.C. Circuit is not any more well-respected than the 8th Circuit," said Mr. Rocap, who represented Aetna Casualty & Surety Co. in the case.

In its decision, the District of Columbia Circuit said it could not follow the 8th Circuit's decision.

"We will not follow another circuit's decision if that court 'ignored clear signals emanating from the state courts,' " wrote Judge A. Raymond Randolph, quoting from an earlier opinion by the District of Columbia Circuit.

"While the instances when this has occurred will be 'rare,' we believe the 8th Circuit's decision in NEPACCO falls within the. . .exception," the court said.

Specifically, the court found the 8th Circuit was wrong when it gave the term "damages" in the CGL policy a legal, technical definition that excluded cleanup costs, rather than a common, everyday definition.

The policy states that an insurer must "pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages."

Policyholders favor a common, everyday definition of "damages" that would encompass money spent to clean up pollution.

Insurers argue that the term should be construed to exclude coverage for cleanup costs. They argue that cleanups costs are a type of equitable relief and that "damages" only encompasses legal relief: monetary amounts awarded by a court of law.

The 8th Circuit in 1988 in the NEPACCO case agreed with insurers, ruling that under Missouri law: "The term 'damages' in the CGL policies refers to legal damages and does not cover cleanup costs."

But the District of Columbia Circuit refused to follow this ruling, finding that the court used a definition of damages that was not in accord with the common understanding of the word.

"As the NEPACCO majority itself acknowledged, the lay insured would not distinguish between legal and equitable relief when construing 'damages,' " the District of Columbia Circuit said.

"The Missouri layperson would expect 'damages' to encompass all financial liabilities one is obligated to pay as a result of another's loss," the court said. "Liability for environmental cleanup costs quite naturally fits this common and ordinary understanding of damages."

Furthermore, the District of Columbia Circuit said that with the exception of the NEPACCO case, every court that has applied such a common and everyday meaning has found that cleanup costs are covered by the CGL policy.

To date, three federal appellate courts have found that environmental cleanup costs are "damages" under the CGL policy: the 3rd Circuit (*BI*, May 6, 1991), the 2nd Circuit (*BI*, Oct. 23, 1989) and now the District of Columbia Circuit.

And on Sept. 18, the Iowa Supreme Court became the sixth state supreme court to rule this way (see related story).

The five earlier rulings that pollution cleanup costs were "damages" under the CGL policy came in: California, Massachusetts, Minnesota, North Carolina and Washington (*BI*, Nov. 26, 1990; June 25, 1990; June 11, 1990; Feb. 19, 1990 and Jan. 15, 1990).

Only the supreme courts of Maine and New Hampshire have ruled that the costs are not "damages" (*BI*, April 16, 1990).

And, the only federal appellate courts ruling in favor of insurers on this issue are the 8th Circuit in the NEPACCO case and the 4th Circuit (*BI*, July 27, 1987).

Ironically, the District of Columbia Circuit and the 8th Circuit cases involve the same pollution in Times Beach, Mo., a city that the federal government bought for $33.7 million in 1983 because of its high dioxin levels.

The 8th Circuit litigation involved NEPACCO and its insurers while the D.C. Circuit ruling involved IPC and its insurers.

From 1970 to 1972, NEPACCO produced hexachlorophene at a plant in Verona, Mo. Among the waste generated was dioxin, which in sufficient concentrations has been linked with cancer.

In 1971, Independent Petrochemical agreed to assist NEPACCO in disposing of waste containing dioxin. IPC hired Russell M. Bliss, an independent contractor, to do the job.

Mr. Bliss transported more than 20,000 gallons of the hazardous waste to a facility in Frontenac, Mo., where he mixed it with waste oil. Later the deadly mixture was sprayed to suppress dust at sites in eastern Missouri.

In 1974, NEPACCO's assets were liquidated and the proceeds distributed to shareholders, and in 1976 it forfeited its charter.

After finding a high level of dioxin at one of the Missouri sites in 1980, the U.S. Environmental Protection Agency cleaned the site and then sued NEPACCO, IPC, Mr. Bliss and Syntex Corp., the owners of the property leased to NEPACCO and on which the dioxin was produced.

A federal district court in Missouri in 1987 found that IPC was jointly and severally liable for the cleanup costs under the Comprehensive Environmental Response, Compensation & Liability Act, better known as the Superfund act.

IPC's potential joint liability is estimated to be at least $96 million, according to court papers.

IPC is now insolvent. The company filed for bankruptcy in 1984. Under its plan of liquidation, IPC must continue to defend the CERCLA claims against it and pursue coverage under its liability policies.

Between 1971, the year IPC began assisting NEPACCO in disposing of its waste, and 1983, the year this litigation began, IPC and parents Charter Oil Co. and Charter Co. bought 67 CGL policies from 23 insurance companies.

IPC paid more than $10 million for the policies. Between 1971 and 1983 coverage totaled approximately $1.1 billion for each occurrence of bodily injury and property damage, if the limits are stacked.

In 1984, the U.S. District Court for the District of Columbia ruled that IPC's five primary insurers must pay IPC's defense costs (*BI*, March 24, 1986). Those insurers are Aetna, Continental Insurance Co., Insurance Co. of North America, The Travelers Indemnity Co. and Hartford Accident & Indemnity Co.

The district court dismissed a sixth primary insurer, Pacific Indemnity Co., from the litigation, ruling it did not insure IPC or its parents.

The District of Columbia Circuit upheld this ruling.

Then in 1988, the district court ruled that cleanup costs were not "damages," relying on the 8th Circuit decision in the NEPACCO cases.

This ruling was overturned by the recent circuit court decision.

•

Independent Petrochemical Corp., et al. *vs. Aetna Casualty & Surety Co.*, et al. *U.S. Court of Appeals for the District of Columbia; No. 89-5367; No. 89-5366.*

Iowa ruling a policyholder victory

By STACY ADLER

DES MOINES, Iowa—The Iowa Supreme Court last week became the sixth state supreme court in the nation to rule that pollution cleanup costs are insurable "damages" under the comprehensive general liability policy.

In a unanimous ruling, the nine-member court said: "We agree with the majority of courts which hold that the ordinary meaning of 'damages' is broad enough to include government mandated response or cleanup costs under CERCLA and similar state environmental protection statutes.

"We rejected the (insurers') suggestion that we give 'damages' a technical, legalistic meaning," the court said in its Sept. 18 ruling.

"Rather, we give 'damages' its ordinary meaning. . .under this meaning, we think a reasonable person purchasing a CGL policy like the one here would expect government mandated response costs under CERCLA to be covered."

Five state supreme courts have ruled in favor of policyholders on this critical issue, while the high courts of two states have ruled in favor of insurers (see story, page 1).

The Iowa decision stems from a dispute between A.Y. McDonald Industries Inc. and its 14 liability insurers from 1972-1986. Those insurers include: Insurance Co. of North America, The American Insurance Co., Hartford Accident & Indemnity Co. and Aetna Casualty & Surety Co.

From 1949 to 1983, A.Y. McDonald operated a brass foundry in Dubuque, Iowa. Residue from the manufacturing process containing lead contaminated groundwater at the site.

In 1987, A.Y. McDonald agreed to clean the site. The company entered into a consent decree with the U.S. Environmental Protection Agency and the Iowa Department of Transportation in keeping with its liability under the Comprehensive Environmental Response, Compensation & Liability Act, better known as the Superfund act.

A.Y. McDonald then turned to its primary and excess liability insurers for indemnification for these cleanup costs. The insurers denied coverage.

A.Y. McDonald sued its insurers in federal district court in Iowa, which certified certain coverage questions to the Iowa Supreme Court.

The case will now be returned to the federal district court for further factual findings.

•

A.Y. McDonald Industries Inc. vs. Insurance Co. of North America et. al., Supreme Court of Iowa; No. 70/89-1722.

Broker dispute

Continued from page 2

next legal step."

However, Mr. Gallagher said that it is unclear whether Judge Hamilton's decision can be appealed before the issue of damages is determined.

In his decision, Judge Hamilton referred to a confidential settlement between A&A and Hall reached in May 1990 that settled five other cases filed by A&A against Hall concerning the defection of A&A employees. Among other provisions, that agreement established a procedure to resolve future disputes between the parties to avoid litigation.

The agreement also provided that neither broker would recruit or solicit the other's employees for two years, and any employees hired by the other firm would sign an affadavit that they had not been solicited.

According to the decision, however, three of the defendants nevertheless did solicit other A&A employees to defect to Hall and persuaded them to falsely sign affadavits that claimed they had not been solicited.

"The affadavits were nothing more than a sham and ruse behind which the conspirators believed they had found a shield for their planned raid upon A&A's office staff and the business clients of A&A," said Judge Hamilton in his decision.

In addition, the decision states the defendants began to copy and remove confidential information from A&A "to further Hall's competitive business interests" before their resignations from A&A.

Judge Hamilton also said in his decision that a temporary restraining order he had issued in November had been violated. The temporary injunction prohibited the defendants from soliciting business from any client with which they had dealt during the two years before they left A&A.

"It is readily apparent from the evidence at the hearing on the permanent injunction that the defendants have been violating the terms of this order by shifting the solicitation of this business to other (Hall) employees, who had not had the contact with the client," the ruling said.

Judge Hamilton said he believes these acts were "deliberate attempts to evade the court's injunction and will not be tolerated in the future."

"The court finds the credibility of defendants to be most unreliable in the fact of so many contradictory and wholly unbelievable characterizations of events by the defendants throughout these hearings that are too numerous to relate in this opinion," he said.

Meanwhile, Hall and A&A are awaiting a date for oral arguments on two cases, which have been consolidated, that are now before the federal appellate court in St. Louis.

One case, according to Mr. Gallagher, involves an appeal by A&A of a federal judge's decision that denied A&A's request for a preliminary injunction to prohibit two former employees of A&A's Kansas City, Mo., office who joined Hall from soliciting A&A clients (*BI*, May 20).

The second case involves an appeal by Hall of an April decision by U.S. District Court Judge Lyle Strom in Omaha. Judge Strom held that there was nothing in the confidential agreement between Hall and A&A to prevent A&A from enforcing its noncompete agreements against former employees, said Mr. Gallagher.

In a separate case, a former A&A employee who now works for Hall brought suit in federal court in Providence seeking a ruling that his noncompete covenant with A&A was not enforceable.

Last week, Magistrate H.A. Gopian, who has been delegated to handle preliminary motions in the case, granted a motion to stay the case and requested that A&A file a motion for a summary judgment that reflected Judge Hamilton's decision in Omaha, said Arthur J. Schwab of the Pittsburgh law firm Buchanan Ingersoll, who represents A&A. ■

Scaled-back family leave legislation unveiled

WASHINGTON—Senate supporters of family leave legislation are proposing a new, scaled-back measure in a renewed effort to gain sufficient congressional support to override a likely presidential veto.

Like a bill passed by both houses of Congress last year but vetoed by President Bush, the amended proposal unveiled last week by Sens. Christopher Bond, R-Mo., Christopher Dodd, D-Conn., and Wendell Ford, D-Ky., would require employers with at least 50 employees to offer 12 weeks of unpaid job-protected family leave (*BI*, July 9, 1990).

During the leave, health insurance benefits would have to be continued as if the employee were still on the job. Also like the earlier bill, the amended S.5 would not apply to "key employees," defined as highest-paid 10%.

But, the new proposal tightens eligibility requirements for part-time workers. Eligibility would be limited to those who work at least 1,250 hours annually, compared with 1,000 hours under the 1990 proposal. And penalties for non-compliance are halved in the new version to twice the amount of economic damage suffered by an employee.

Several business groups, including the National Federation of Independent Business and the Concerned Alliance of Responsible Employers, condemn the amended legislation as an unwarranted mandate.

—By Mark A. Hofmann

Executive Life

Continued from page 2

Sarfaty said.

"But we don't think there will be additional cash calls," he said.

Unlike the Altus proposal, the NOLHGA offer would not liquidate Executive Life's extensive junk bond portfolio, according to Mr. Sarfaty.

Rather, "over time the entire portfolio will be restructured," he said. "We think we can manage this portfolio in a way that will provide significant benefits to policyholders."

However, NOLHGA does not plan to purchase Executive Life's real estate holdings, valued at $680 million, he said.

Other provisions of the NOLHGA plan include:

- More than 95% of Executive Life policyholders covered by guaranty associations—including pension plans that purchased guaranteed investment contracts from Executive Life—would be guaranteed 100% of death benefits and annuity payments.
- Policyholders not covered by state guaranty funds or those whose policy values exceed the funds' payout limits would receive at least 4% higher guaranteed contract values than under the Altus proposal.

Under the Altus proposal, individual annuity contract holders and pension plans that purchased Executive Life GICs would receive 81 cents on the dollar, according to Insurance Department estimates.

- Individual policyholders would be permitted to make cash withdrawals of up to 10% of their contract values per year without additional surrender charges.
- Higher interest crediting rates would be paid and policyholder surrender fees would be cut in half, compared with the Altus plan.
- Initially, the pension GICs would be subject to the same withdrawal provisions that were part of their original contracts with Executive Life. However, the contracts would eventually be renegotiated.

Under the Altus plan, pension plans that purchased Executive Life GICs would be barred from cashing out for five years. And, during that moratorium, the GICs would be paid interest calculated using a formula tied to five-year U.S. Treasury bond rates, less 100 basis points. The minimum rate would be 4%.

- Once all policyholders have been made whole, remaining funds would be available to provide payments to holders of municipal GICs, which were excluded from both the Altus buyout proposal and the NOLHGA agreement with the Insurance Department.

NOLHGA will file its proposal—which was not released in detail—in Los Angeles Superior Court by the Oct. 11 deadline the Insurance Department set for bids on the financially impaired life insurer, Mr. Sarfaty said.

Insurance Commissioner John Garamendi, who orchestrated the bid by Altus, said the NOLHGA offer demonstrates that the bidding process he set up is working.

Mr. Garamendi anticipates that at least three other offers for Executive Life will be submitted to the court by the deadline. He declined to identify the other prospective purchasers. ■

NAIC proposal

Continued from page 2

eral legislation, several regulators still question the approach and await a final version of the gatekeeper law, noted James W. Schacht, chief deputy director of the Illinois Insurance Department. He also heads the NAIC Executive Committee's Special Committee on Alien Insurers.

Many states now require NAIIO approval before non-U.S. insurers can write surplus lines business in their states. But the NAIC resolution approved in April would require such approval before those companies could write business in any state.

In addition, the proposal calls for the NAIIO to regulate non-U.S. underwriters that provide reinsurance to U.S. insurers.

Under the proposal, non-U.S. reinsurers that assume business from U.S. insurers would be required to be on the NAIIO's approved list before the ceding companies could take credit for the reinsurance.

Currently, a U.S. ceding company can take credit for reinsurance ceded to non-approved, non-U.S. reinsurers—including offshore captives owned by U.S. parents that reinsure parent company risks—if the reinsurer posts adequate security with the ceding company.

To obtain NAIIO approval under the proposal, a non-U.S. direct insurer would be required to have $15 million in capital and surplus, while a non-U.S. reinsurer would be required to have $20 million in capital and surplus.

In addition, a non-U.S. insurer generally would have to maintain a U.S. trust fund containing $2.5 million or an amount equal to its U.S. obligations, whichever is greater. A non-U.S. reinsurer generally would have to maintain a U.S. trust fund containing $5 million or 25% of its U.S. reinsurance obligations, whichever is greater.

Also, both insurers and reinsurers would have to be in business for at least three years to win approval.

Because most captives couldn't meet those requirements, the proposal would "severely curtail" the captive insurance market, Mr. Brown of RIMS complained at a NAIC committee drafting session last week.

Captives are "a different breed of animal" and should not be lumped together with all non-U.S reinsurers, he said.

Mr. Brown had proposed in a July letter to Mr. Schacht that the proposal exclude any non-U.S. insurer or reinsurer "which assumes all or a portion of those risks arising out of direct insurance" of its parent or affiliates.

"RIMS does not believe that policyholder-controlled captive insurance companies should be the focus of such severe scrutiny and regulation," especially since they "have never been indicted as the cause of an insurance company insolvency," he wrote.

Mr. Brown also emphasized that corporate consumers should be able to enjoy the affordable capacity that captives can offer.

However, Mr. Schacht said at the drafting session last week that he could find no satisfactory way to exclude offshore captives from the proposal and still adhere to the regulatory goal of protecting U.S. companies and consumers.

David B. Simmons, the NAIC's general counsel, said regulators tried to satisfy risk managers by modifying the definition of "U.S. reinsurer obligations" for purposes of financing the required U.S. trust fund. These obligations would not include "any obligation for which security is provided for the full amount recoverable under such contracts."

That change, Mr. Brown said, is both inadequate and confusing.

At the end of the committee discussion, Mr. Schacht agreed to reconsider the treatment of offshore captives in an effort to address RIMS' concerns.

In a separate interview, however, James Long, the NAIC president, said that regulators are "very much" concerned with the solvency of captives.

"I'm concerned about the solvency of every entity out there," said Mr. Long, who is North Carolina's insurance commissioner.

Michael Mullen, executive director of the National Assn. of Insurance Brokers in Washington, D.C., said the NAIB shares RIMS' concerns about new efforts to regulate captives and intends to ask regulators to reconsider the gatekeeper proposal.

Captives also are threatened by revisions to the proposed NAIC fronting model law, which was also discussed at last week's NAIC meeting.

"Major" changes in the fronting proposal have been made since an Aug. 13 drafting session with members of an insurance industry advisory committee, according to Vincent Laurenzano, chief of the New York Insurance Department's Property Companies Bureau and chairman of the NAIC working group drafting the model law.

Mr. Laurenzano presented only a brief oral summary of the changes. He promised a written version of the revised proposal would be available shortly.

Mr. Laurenzano said he would accept comments on the proposal through Oct. 15 and plans to meet with the advisory committee Oct. 31 in Washington, D.C.

Observers generally were confused by the sketchy information about the changes to the proposal provided last week.

"I'm very disappointed," RIMS' Mr. Brown said.

But, he noted that, for now, the gatekeeper proposal "is at least as serious—and probably more serious"—of a threat to captives than the fronting bill, because the gatekeeper proposal would affect nearly all risk management programs that include an offshore captive, not just fronted programs.

The fronting proposal, though, is more likely to be adopted by the NAIC, he said.

Many observers point out that state regulators still are not sure that a nationwide gatekeeper system is the correct approach to regulate offshore insurers and reinsurers. ■

Allstate quits N.J. property/casualty market

TRENTON, N.J.—New Jersey Insurance Commissioner Samuel F. Fortunato has promised a "deliberate and responsible" review of Allstate Insurance Co.'s request to withdraw from the New Jersey property/casualty market due to huge automobile insurance losses.

The insurer said its decision was based on losses of more than $448 million on its private passenger automobile business in New Jersey between 1973 and 1990. Its overall property/casualty insurance losses in New Jersey during that period totaled about $259.4 million.

Allstate is New Jersey's largest personal auto insurer, with 15.9% of the market, according to A.M. Best Co. It is the state's third-largest property/casualty insurer.

If Allstate's withdrawal is approved, it would no longer be an authorized reinsurer in New Jersey since its reinsurance business is run by Allstate Insurance Co., not a separate reinsurance unit.

State regulations require an insurer withdrawing from an unprofitable property/casualty line to surrender all property/casualty licenses.

Mr. Fortunato said state law allows him "to impose reasonable conditions on any company seeking to withdraw." These conditions can include requiring the company to remain in the state for up to five years, to remain financially stable and to continue to meet its obligations under the state Fair Access to Insurance Requirements plan.

"Allstate is not going anywhere soon," he said.

Personal auto losses also led Allstate to withdraw from the Massachusetts property/casualty market in 1988 (*BI*, Nov. 21, 1988).

—*By Mark A. Hofmann*

Update

Bill limits bank insurance sales

Continued from page 2

The bill also would prohibit banks from soliciting loan customers for insurance products until there is a written loan commitment.

However, the bill would permit federally insured banks in "qualified distressed communities" to sell insurance locally.

Insurers and agent associations are pleased with the latest version, which maintains and refines provisions in House and Senate bills that are most favorable to the insurance industry, said Robert A. Rusbuldt, director of federal affairs for the Independent Insurance Agents of America. He expects a House vote on the bill by November.

Oakeley names set to go to trial

LONDON—Members of loss-riddled Lloyd's of London syndicates formerly managed by Oakeley Vaughan Underwriting Ltd. are entitled to have their grievances heard during a full High Court trial early next year, an appeals court has ruled.

The decision means that three former chairmen and the current chairman of Lloyd's may have to testify before the court, which will decide whether Lloyd's owed a duty of care to the members.

The decision sets aside a June decision by Justice Gatehouse. He ordered a preliminary hearing—rather than a trial—to determine whether Lloyd's owed a duty of care to the members and, if so, whether Lloyd's was immune from member suits under the 1982 Lloyd's Act.

If Justice Gatehouse's decision had been upheld, the case could have been dismissed if Lloyd's was successful in the preliminary hearing.

"Now we will be able to cross-examine the past chairmen: Sir Peter Green, Sir Peter Miller, and Murray Lawrence at the trial," said members' lawyer Michael Freeman, a senior partner of Michael Freeman & Co. in London. Current Chairman David Coleridge also may be called. Members claim that his comments at the Lloyd's annual general meeting are an admission that Lloyd's owes a duty of care to members.

The appeal court's decision is "a disappointment," a Lloyd's spokesman said. "The same points of law will be argued, but instead of having a swift resolution, it is now going to be a long resolution," he said.

Yugoslavian rate cap lifted

LONDON—London's marine cargo war risk underwriters agreed last week to lift the suggested war risk rate on cargo sailing to and from Yugoslavia following the seizure of two cargo vessels caught in the country's civil strife.

The vessels are owned by Jugoceanija, a Yugoslavian-owned concern.

The leaders of the Lloyd's of London and Institute of London Underwriters Joint War Risks Rating Committee agreed last week to place war risk rates for cargo sailing by ship to and from war-torn Yugoslavia on a "held cover" basis. This means that marine war risk underwriters can charge whatever they want, rather than accept the guideline to write the coverage at 0.0275% of the value of the cargo.

The joint cargo war risk rating committee earlier this year placed all cargo traveling by air to Yugoslavia on a held cover basis (*BI*, July 15).

MOAC sells reinsurance unit

BOSTON—The Marine Office of America Corp. is selling its reinsurance subsidiary for an undisclosed sum.

MOAC, a Cranbury, N.J. subsidiary of New York-based Continental Corp., reached agreement in principle last week to sell MOAC Reinsurance Management Co. to Underwriters Reinsurance Co. of Woodland Hills, Calif., confirmed MOAC President Thomas J. Prendergast at the International Union of Marine Insurance conference in Boston.

MOAC Re, which this year will generate about $40 million in premium volume, will be a good fit with Underwriters Re, which is expected to generate about $80 million in premium volume in 1991, said MOAC Re President James Stevens.

The sale is the final move by MOAC to cut back on operations to concentrate on its core business, which is direct U.S. marine insurance underwriting, Mr. Prendergast said. MOAC already has pulled out of the American Hull Insurance Syndicate and shut down its European operations (*BI*, Sept. 9; Aug. 26).

Briefly noted

The Occupational Safety and Health Administration has proposed fines of more than $2.8 million against **Union Carbide Chemicals & Plastics Co. Inc.** following investigation of an explosion and fire that killed one worker and injured 32 others at a Seadrift, Texas, plant in March. OSHA cited Union Carbide for 112 alleged willful violations of safety standards, including locked exit doors and three instances of alleged serious violations. . . .The federal Pension Benefit Guaranty Corp. last week filed claims in U.S. Bankruptcy Court in New York for $914 million that it says **Pan American World Airways** owes to three underfunded pension plans. The PBGC earlier said it intends to terminate two of the plans. The agency also filed separate claims of $2.6 million that it says Pan Am owes in pension termination insurance premiums. . . .The Texas Insurance Department has issued an emergency cease-and-desist order against **International Bahamian Insurance Co. (S.V.) Ltd.** of St. Vincent, which regulators charge has been fraudulently soliciting medical malpractice business in the state. IBI is one of several companies and individuals whose operations were enjoined and assets frozen by a Maryland federal judge earlier this month (*BI*, Sept. 16). . . .A Pennsylvania workers compensation insurer trade group is asking the state insurance commissioner to approve a **51.8% workers compensation rate increase** for 1992. Such a hike would raise premiums for Pennsylvania employers about $1.5 billion, the Insurance Department says. Democratic Gov. Robert P. Casey opposes the request. . . .**Robert Clements** has been named vice chairman of Marsh & McLennan Cos. Inc. He will continue as chairman of Marsh & McLennan Inc., the company's insurance brokerage unit. . . .A California legislative conference committee established to hammer out **automobile insurance reforms** plans to meet for the first time during the Legislature's fall recess time to discuss "all options." Among those proposals is a no-fault plan unveiled this month by Insurance Commissioner John Garamendi (*BI*, Sept. 9).

Brokers hold growth promise

By LEONARD M. WILSON

Special to Business Insurance

SHAREHOLDER VALUE is a concept that defines what investing is really all about. In equity markets, creation of shareholder value is the only meaningful badge of success.

Investment analysis not infrequently loses sight of this reality in the minutiae of industry trends and company developments. Reflecting on the issue of shareholder value, we set forth tc assess how well insurance brokerage stocks have performed in the 1980s.

One source of shareholder value is superior management. Within every industry, there are managements that outstrip their competitors through well-grounded strategies and forceful execution. High returns and faster earnings growth are benchmarks of management success.

Industry conditions also importantly influence the creation of shareholder values. In the 1980s, a stagnating industry like steel was a poor investment compared with the pharmaceutical industry. Even the best managed steel company could not match the shareholder returns of an indifferently managed drug company.

In a rapidly growing industry, it is relatively easy for management to look good. Thus, deficient growth in shareholder values cannot be gratuitously ascribed to management shortcomings.

We have consistently viewed insurance brokerage as a growth industry afflicted with bouts of cyclicality due to competition in commercial insurance. In contrast, the underwriting side of the industry struck us as mainly cyclical, with growth prospects distinctly inferior to the brokerage side of the business.

Insurance brokerage has all the attributes of an industry that ought to generate superior growth in shareholder values. Brokers typically grow faster than commercial premiums. Barriers to entry tend to keep competition among brokers orderly. Clients are by and large loyal. Capital requirements are modest, and free cash flow is almost taken as a given. Rates of return on shareholders' capital typically have been generous.

The recent underperformance of brokerage stocks led us to examine more critically comparative growth in shareholder values. We decided as a consequence to compare gains in shareholder values for the insurance brokers, selected underwriters and the Standard & Poor's 500 index. We chose two time periods for our comparisons, 10 years beginning in 1981 and five years beginning in 1986. The longer period encompasses a decade of price competition in commercial lines, excepting 1985 and 1986. The shorter period coincides with the current cycle of soft pricing. For this analysis, we used three of the highest-quality underwriters: Chubb Corp., General Reinsurance Corp. and American International Group Inc.

Averaging performance for the stocks of both brokers and underwriters, we found that the stocks of the underwriters outperformed the stock prices of the brokers in both time periods. Only Marsh & McLennan Cos. Inc. came close to equaling the rise in shareholder values of the underwriters. The others fell short.

Again, on average, the underwriters surpassed the S&P 500 over the 10-year period and roughly matched the index over the five-year period. The brokers, on average, underperformed the index in both periods. Only M&M was able to outstrip the percentage rise in the S&P index.

It could be argued that we stacked the deck against the brokers by selecting the strongest underwriters, but if insurance brokerage really is an exceptional business (which is, incidentally, our belief), then we should have a high hurdle for our comparisons.

As we indicated earlier, rising shareholder returns emanate from the quality of management and industry conditions. In addition, pre-existing competitive positions also can be a factor. Take M&M. The industry leader and the best performer among the brokers was well-situated in reinsurance brokerage at the beginning of the decade. For the first five years of the 1980s, this segment grew rapidly. Other brokers were much weaker absolutely and relatively in reinsurance brokerage.

On the whole, we rate insurance brokerage management quite highly. Nonetheless, mistakes in the early 1980s did impair shareholder value for some of the brokers. But as we reflect on the performance of brokerage shares, we conclude that structural changes within the industry have played the more important role in restraining the advance in shareholder values.

We view as structural the chronic soft markets of the 1980s. The brokers have experienced anemic revenue growth as a result. In the meantime, their costs have continued to increase, driven by the underlying inflation of the 1980s. And service to existing clients and a fast-growing roster of new clients cannot be stinted.

The three underwriters in our survey, on the other hand, were able to pursue well-defined strategies within the property/casualty insurance industry that provided increased market share in generally profitable lines. They were able to insulate operating results from much of the effects of persistent soft pricing and show consistent earnings growth.

The level of commission rates is another structural change we believe the brokers have faced. The public brokers, in our view, have undergone an indeterminate amount of erosion in commission rates as a percentage of premiums over the past decade. It is impossible to gauge this effect from publicly reported data, but a commission squeeze, even of modest proportions, has burdened the ability of brokers to deliver increased shareholder values.

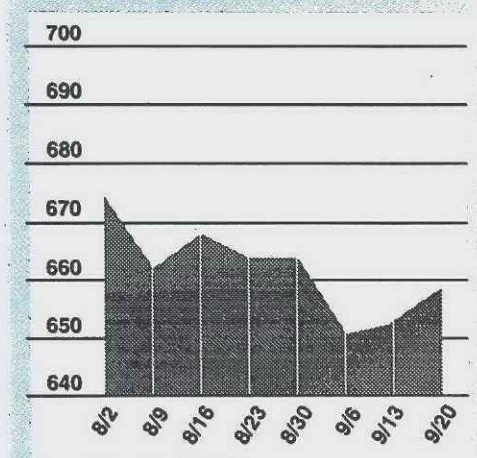
Is the past prologue? That is an ever-present question in the investment process. We continue to regard the insurance brokerage industry as intrinsically a very attractive business.

We think that managements are currently adapting well to the environment. As for industry conditions, the worst of this cycle's rate reductions in commercial insurance are likely behind the industry, notwithstanding any doubts concerning the timing of a turn in pricing. It is doubtful, too, that commission rates will decline further.

If these judgments are accurate, then insurance brokerage stocks ought to offer appreciably better prospects for growth in shareholder values for the 1990s. ■

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks jumped ahead last week as the *Business Insurance* stock index rose 4.7 points to 657.1 on Sept. 20 from 652.4 on Sept. 13. Advancing issues for the week were led by NWNL Cos., up 16.1%; Orion Capital Corp.; up 14.2%; and SCOR U.S. Corp., up 9.4%. Declining insurance issues for the week followed Chandler Insurance Co., down 9.4%; Frank B. Hall & Co. Inc., down 9.7%; and Sierra Health Services, down 7.3%. The most active insurance issue for the period was U.S. Healthcare, with 4.7 million shares traded. The *BI* index rose 0.7% last week, while the the Standard & Poor's 500, the Dow Jones 30 Industrials and the New York Stock Exchange Composite all increased 1.1%.

British Issues

Sept. 19 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	509	N/M	30.7	6.0	518	509
Genl Accident	540	N/M	35.7	6.6	551	540
Gdn Royal Exch	185	N/M	15.9	8.6	192	185
Royal	365	N/M	34.7	9.5	375	365
Sun Alliance	349	N/M	18.7	5.3	350	346
Brokers						
Bradstock	166	18.9	6.0	3.6	168	166
CE Heath	506	17.7	34.5	6.8	506	497
Hogg Group	215	12.8	10.7	5.0	215	214
Lloyd Thompson	412	27.3	10.0	2.4	412	411
Lowndes Lmbrt	316	15.7	15.3	4.8	316	315
PWS Holdings	73	9.0	4.7	6.4	74	73
Sedgwick Grp	264	25.1	16.0	6.1	266	264
Steel Brrl Jones	339	17.8	16.3	4.8	339	330
Willis Corroon	305	16.1	17.6	5.8	313	305

Source: Philip Olsen, Insurance Industry Analyst London

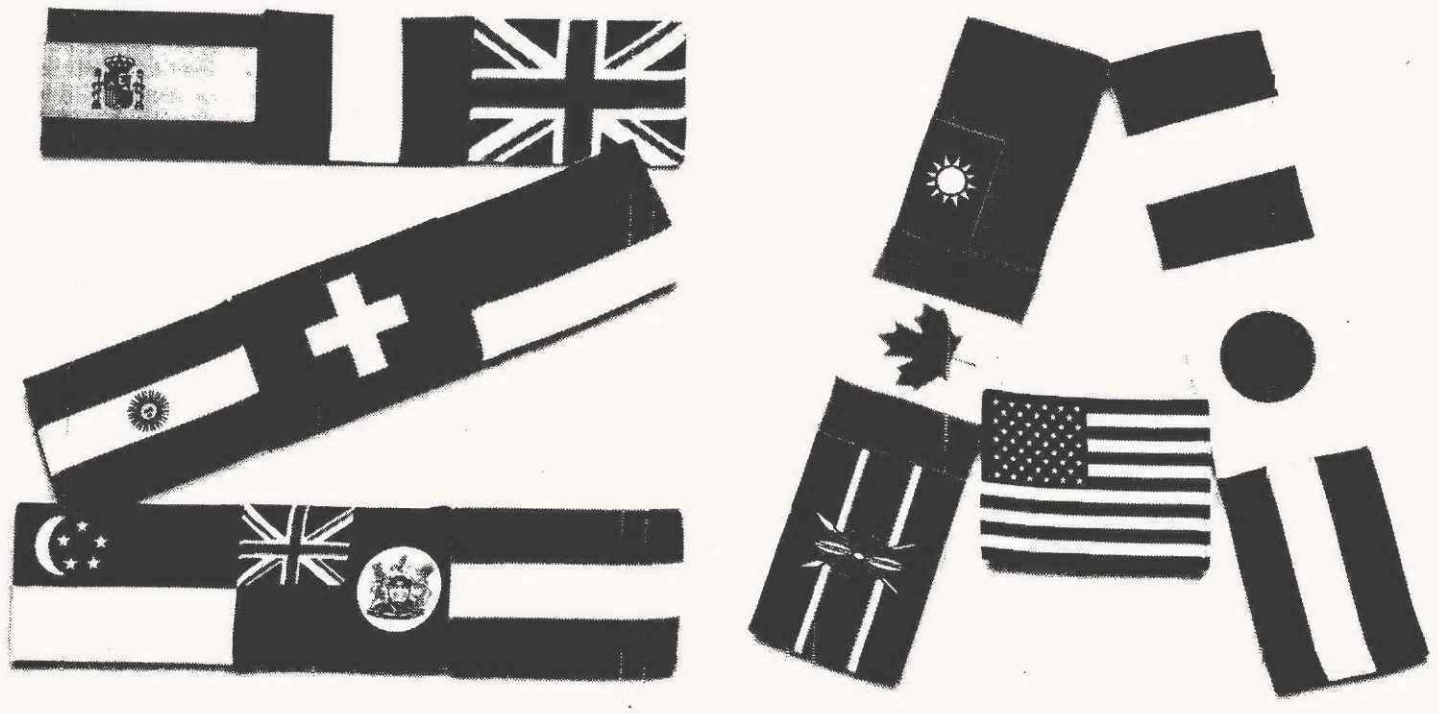
BI Industry Stock Report

SEPTEMBER 16, 1991 THROUGH SEPTEMBER 20, 1991

BROKERS		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander	NYS	20.75	1.84	-10.27	27.63	16.13	413	1.00	4.82	17	9.77	2.12
Gallagher Arthur J. & Co.	NYS	19.50	-1.89	-16.13	28.38	19.00	80	0.64	3.28	16	5.88	3.32
Frank B. Hall	NYS	3.50	-9.68	-3.45	4.38	2.00	41	0.00	0.00	-7	-5.24	-0.67
Hilb, Rogal & Hamilton	OTC	14.00	-5.88	-5.08	17.50	11.25	236	0.36	2.57	22	3.56	3.93
Marsh & McLennan	NYS	77.38	4.21	-0.80	87.25	59.75	771	2.60	3.36	19	14.77	5.24
Poe & Associates	OTC	11.75	0.00	83.59	12.50	6.25	11	0.32	2.72	14	2.29	5.13
BROKERS	AVERAGE		-1.6	6.8					2.4	11		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	24.25	-2.02	-35.33	32.25	19.00	399	0.32	1.32	14	23.89	1.02
Berkshire Hathaway Inc.	NYS	8550.00	1.18	28.09	8550.00	171.88	1	0.00	0.00	-31	4612.00	1.85
ITT (Hartford Group)	NYS	56.88	0.22	18.49	63.00	40.25	1154	1.72	3.02	9	64.01	0.89
Sears (Allstate)	NYS	39.25	-1.88	54.68	43.50	22.00	2638	2.00	5.10	13	37.38	1.05
CONGLOMERATES	AVERAGE		-0.6	16.5					2.4	1		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	33.88	5.04	-13.14	49.13	29.00	2988	2.76	8.15	7	64.23	0.53
American General	NYS	39.88	1.59	29.67	41.13	23.50	1198	2.00	5.02	9	37.14	1.07
American Heritage	NYS	28.88	-1.70	37.50	32.25	19.63	1	1.08	3.74	12	19.25	1.50
American Indemnity/Fin'l	OTC	6.75	-6.90	107.69	7.75	2.75	14	0.08	1.19	4	12.93	0.52
American International	NYS	82.75	-3.64	7.64	102.00	57.00	1757	0.48	0.58	12	45.34	1.83
Aon Corp.	NYS	37.00	4.23	6.47	41.75	26.75	338	1.60	4.32	10	18.50	2.00
Argonaut Group	OTC	25.25	1.00	18.36	33.38	17.75	37	0.68	2.69	8	48.26	0.52
AVEMCO Corp	NYS	23.00	2.22	36.63	23.25	14.13	18	0.40	1.74	17	9.55	2.41
Baldwin & Lyons Inc.	OTC	23.00	-2.13	22.67	25.25	17.00	2	0.28	1.22	7	24.29	0.95
Belvedere Corp	ASE	3.25	-3.70	30.00	3.38	1.75	103	0.04	1.23	22	7.65	0.42
Chandler Insurance	OTC	2.50	-16.67	-63.64	7.25	2.50	165	0.00	0.00	-2	5.95	0.42
Chubb Corp.	NYS	63.50	-0.20	17.05	75.25	34.63	901	1.48	2.33	10	35.19	1.80
CIGNA Corp.	NYS	45.50	2.25	11.31	56.75	33.25	729	3.04	6.68	11	73.15	0.62
CNA Financial Corp.	NYS	87.25	4.49	27.14	92.50	49.50	137	0.00	0.00	12	70.23	1.24
Continental Corp.	NYS	25.00	-0.99	0.50	30.63	15.75	526	2.60	10.40	9	37.83	0.66
Durham Corp.	OTC	31.50	-1.18	12.50	34.25	23.00	9	1.00	3.17	18	28.04	1.12
Fund American Corp.	NYS	64.25	0.59	23.86	65.25	41.63	113	0.68	1.06	19	36.11	1.78
Fremont General Corp.	OTC	25.13	3.61	73.28	25.25	10.13	195	0.88	3.50	7	19.13	1.31
Frontier Insurance Group	NYS	24.88	0.00	30.92	25.88	15.22	11	0.00	0.00	10	11.20	2.22
General RE Corp.	NYS	87.88	-0.28	-5.51	102.50	69.88	849	1.68	1.91	13	37.50	2.34
Hanover Insurance Co.	OTC	29.88	-0.42	12.74	30.75	21.00	47	0.44	1.47	11	37.44	0.80
Harleysville Group	OTC	27.75	0.00	21.31	32.00	13.50	77	0.64	2.31	8	22.99	1.21
Hartford Steam Boiler	NYS	53.75	3.37	10.26	63.75	43.63	133	1.80	3.35	14	17.05	3.15
Kansas City Life Ins.	OTC	35.00	0.00	13.36	36.50	30.00	11	1.20	3.43	9	39.22	0.89
Kemper Corp.	NYS	31.75	8.09	33.68	39.25	17.13	282	0.92	2.90	8	34.20	0.93
Lawrence Insurance Group	ASE	9.13	-1.35	30.36	9.50	6.38	3	0.48	5.26	14	4.71	1.94
Liberty Corp.	NYS	42.00	0.90	2.13	48.00	39.00	19	0.92	2.19	13	23.86	1.76
Lincoln National	NYS	49.50	5.32	15.12	55.25	30.75	289	2.72	5.49	10	45.16	1.10
Markel Corp.	OTC	18.50	0.00	57.45	19.25	10.25	104	0.00	0.00	9	3.22	5.75
Mutual Risk Mgmt. Ltd.	NYS	25.75	-0.96	-	26.75	17.00	69	0.00	0.00	26	-	-
NAC Re Corp.	OTC	24.50	-1.01	-25.76	28.34	17.00	212	0.16	0.65	13	18.90	1.30
Navigators Group	OTC	33.50	-0.74	53.44	35.00	16.50	5	0.00	0.00	20	13.52	2.48
Nobel Insurance LTD.	OTC	3.50	0.00	16.67	4.38	2.50	4	0.00	0.00	5	7.76	0.45
NWNL Companies	NYS	29.75	16.10	76.30	32.88	11.75	1065	1.40	4.71	7	42.73	0.70
Ohio Casualty Corp.	OTC	45.25	-0.55	10.37	50.25	26.75	83	2.48	5.48	9	36.38	1.24
Old Republic Int'l	NYS	30.50	-0.81	33.33	31.88	17.38	117	0.72	2.36	7	33.09	0.92
Orion Capital Corp.	NYS	31.25	14.16	78.57	31.25	13.00	164	0.92	2.94	9	20.42	1.53
Phoenix RE Corp.	OTC	9.75	2.63	25.81	10.25	5.00	152	0.20	2.05	11	13.30	0.73
Protective Life Corp.	OTC	22.00	1.15	47.90	22.50	11.50	152	0.84	3.82	9	16.29	1.35
Provident Life	OTC	20.25	3.85	15.71	24.50	12.00	115	1.00	4.94	6	25.88	0.78
Re Capital Corp.	ASE	14.25	-5.00	10.68	18.63	11.75	18	0.20	1.40	10	15.05	0.95
Reliance Group Holdings	NYS	5.00	5.26	8.11	7.50	4.25	45	0.32	6.40	-8	1.32	3.79
RLI Insurance Corp.	NYS	15.00	2.56	3.45	16.38	9.63	22	0.48	3.20	8	14.41	1.04
St. Paul Companies	OTC	64.50	0.39	2.79	74.25	47.00	593	2.60	4.03	7	52.00	1.24
SAFECO Corp.	OTC	39.13	0.64	19.01	44.75	25.13	471	1.48	3.78	10	31.50	1.24
SCOR U.S. Corp.	NYS	14.50	9.43	17.17	15.25	8.38	82	0.24	1.66	9	11.19	1.30
Seibels Bruce Group	OTC	7.25	-3.33	70.59	8.88	4.25	191	0.36	4.97	145	7.35	0.99
Selective Ins. Group	OTC	17.75	5.97	33.96	18.00	12.50	38	1.04	5.86	10	18.91	0.94
Statesman Group Inc.	OTC	5.00	5.26	219.90	5.88	1.25	351	0.00	0.00	-250	2.48	2.02
Tokio Marine & Fire	OTC	50.63	2.79	7.14	56.50	34.50	9	0.00	0.00	-	70.93	0.71
Torchmark Corp.	NYS	50.25	0.50	2.81	58.50	38.00	362	1.60	3.18	12	16.70	3.01
Transamerica	NYS	37.50	3.09	14.94	38.38	23.25	655	1.96	5.23	14	36.56	1.03
Transatlantic Holdings	NYS	33.88	0.00	23.74	39.38	18.88	60	0.20	0.59	12	18.38	1.84
Travelers Corp.	NYS	19.88	3.92	19.55	26.38	11.50	715	1.60	8.05	-10	41.44	0.48
Trenwick Group Inc.	OTC	26.50	-2.30	14.59	30.00	16.25	69	0.60	2.26	10	21.71	1.22
United Fire & Casualty	OTC	46.75	8.72	33.10	58.00	28.75	8	1.32	2.82	12	35.39	1.32
USF&G Corp.	NYS	7.00	-1.75	-6.67	20.38	6.13	1721	0.20	2.86	-1	11.96	0.59
UNUM Corp.	NYS	61.13	1.45	31.10	70.25	32.13	524	1.04	1.70	11	37.25	1.64
USLIFE Corp.	NYS	40.50	0.31	44.64	42.75	23.25	150	1.64	4.05	9	60.34	0.67
Unitrin	OTC	38.00	0.00	23.58	41.50	24.50	466	1.00	2.63	14	30.70	1.24
Washington National	NYS	14.75	-1.67	35.63	18.00	9.38	31	1.08	7.32	-5	26.86	0.55
USLICO Corp.	NYS	18.50	-1.33	16.54	21.00	14.75	23	1.00	5.41	10	29.44	0.63
Zenith National Ins.	NYS	15.75	-3.82	15.60	18.50	9.88	15	1.00	6.35	-83	13.14	1.20
INSURERS/REINSURERS	AVERAGE		1.2	28.1					3.4	6.6		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	18.00	-0.69	18.03	29.75	8.88	1306	0.00	0.00	13	5.44	3.31
HMO America Inc.	OTC	12.25	-4.85	88.46	17.13	4.25	632	0.00	0.00	14	0.61	20.08
Pacificare Health Sys.	OTC	28.25	0.00	73.85	42.50	12.50	1125	0.00	0.00	14	6.55	4.31
Safeguard Health Enter.	OTC	7.00	7.69	47.37	7.25	4.00	169	0.00	0.00	24	3.53	1.98
Sierra Health Services	ASE	14.38	-7.26	4.55	29.50	5.88	208	0.00	0.00	7	1.78	8.08
United Healthcare Corp.	OTC	50.00	-1.48	115.05	55.25	13.13	2740	0.06	0.12	28	3.76	13.30
United Medical Corp.	ASE	7.13	-5.00	-10.94	10.88	6.63	7	0.00	0.00	10	8.79	0.81
U.S. Healthcare	OTC	27.00	-2.70	-8.09	38.00	10.00	7593	0.32	1.19	16	3.38	7.99
HMOs	AVERAGE		-1.8	41.0					0.2	16		
ALL COMPANIES	AVERAGE		0.5	26.2					2.9	8		

System design: Nordby International Inc.

Who Has A World of International Experience?



Zurich-American. We cover the globe in order to cover your business.

In fact, as part of the worldwide Zurich Insurance Group, one of the largest insurance organizations, we can offer you 600 offices doing business in over 100 different countries.

And insurance is our only concern. So you are assured of in-depth understanding, commitment and professionalism, both for foreign exposures of American companies and American subsidiaries of foreign corporations.

So if you're looking for truly expert international service, just look to Z-A. Zurich-American.

ZURICH-AMERICAN INSURANCE GROUP

American Creativity. Swiss Dependability.

Zurich Insurance Company • American Guarantee and Liability Insurance Company • Executive Offices, Schaumburg, IL 60196

A MEMBER OF THE WORLDWIDE ZURICH INSURANCE GROUP