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Update

Allied-Signal and Travelers settle pollution cover dispute

MORRISTOWN, N.J.—In what is believed to be the largest settlement of its kind, Allied-Signal Corp. has settled a massive pollution coverage dispute with Travelers Indemnity Co.

Exact terms were not disclosed.

However, Travelers is believed to have written substantially more than $50 million in primary general liability coverage for the Morristown, N.J.-based firm from the 1950s to the present.

"This is the first case of this magni-

Continued on next page

Cooperative oversight

Groups suggest a federal role in regulation

By DOUGLAS McLEOD

WASHINGTON—The federal government may need to take some role in supplementing state regulation of insurer solvency, officials of several insurance industry trade groups say.

While generally supporting state regulation, trade group officials told the House Oversight & Investigations Subcommittee last week that federal involvement may be needed to "enhance" state solvency regulation.

"The limitations of 50 separate entities attempting to regulate a business that often operates in a national or international arena may necessitate some federal involvement to bolster the 'will' needed to take action against troubled companies," said Robert E. Vagley, president of the American Insurance Assn.

Mr. Vagley was one of several trade group officials to testify before the House panel in its first hearing since the February release of its report on the causes of several insurer insolvencies.

That report—highlighting the failures of Mission Insurance Co., Transit Casualty Co., Integrity Insurance Co. and Anglo-American Insurance Co. of Louisiana—heavily criticized state solvency regulation and cited several lapses in states' efforts to police insurer finances (*BI*, Feb. 26).

The subcommittee, chaired by Rep. John D. Dingell, D-Mich., held several hearings into the causes of these failures over 18 months before releasing the report.

Mr. Vagley cited several problems with state oversight, the most serious of which he described as regulators' lack of "will" to take action against troubled companies.

Facing political pressures or fearing blame for the insolvency, regulators may delay action to attempt a "fruitless rescue" and thus make the problem worse, Mr. Vagley observed.

Other regulatory shortcomings, he noted, include:

- Inadequate resources devoted to solvency regulation.
- Failure to focus attention on those insurers that need it most.
- Inconsistent state financial standards, asset valuation rules and reporting requirements.
- A rising burden of state guaranty fund assessments and inconsistent guaranty fund coverage rules.

Mr. Vagley also attacked mandatory rate rollback laws as damaging to insurer solvency.

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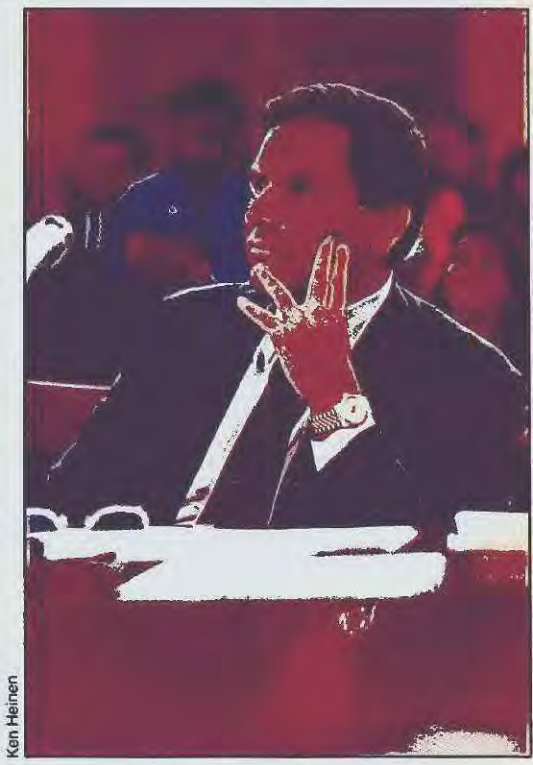

Ken Heinen

Robert Vagley of the American Insurance Assn. testifies before the House panel

34th Rendez-Vous de Septembre

Calm before the storm?

Most reinsurers say competition remains immune from catastrophes

By STACY SHAPIRO and KATHRYN J. McINTYRE

MONTE CARLO, Monaco—Despite ailing retrocessional and catastrophe reinsurance markets, where rates are increasing and capacity is shrinking for year-end renewals, there still is no sign that competition will abate in the overall property/casualty insurance or reinsurance market for at least another year.

The $17 billion in insured losses from natural and man-made disasters will create havoc during year-end renewals in the retrocessional markets in Europe, particularly in London. Prices for retrocessional coverage will as much as triple compared with last year, while lack of capacity will leave gaps in various layers.

With weather seemingly becoming more severe, major players like Swiss Reinsurance Co. will review catastrophe reinsurance at year-end to determine whether to reunderwrite the coverages. While rate increases are inevitable for this class of business, changes in terms and conditions also could drastically reduce available coverage.

However, most brokers and underwriters at the 34th Rendez-Vous de Septembre in Monte Carlo earlier this month predicted that tightening catastrophe and retrocessional reinsurance markets, in the short-term, generally will not affect property/casualty insurance and reinsurance programs.

The earliest prediction for an increase in rates in the insurance and general re-

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Kathryn McIntyre

The Cafe de Paris was a popular venue at the 34th annual Rendez-Vous.

FASB rules to hike firms' retiree care costs: Study

By CHRISTINE WOOLSEY

Retiree health care liabilities will devour a much higher percentage of most employers' pretax profits and equity if proposed FASB accounting standards are adopted, says a soon-to-be-released survey.

If the Financial Accounting Standards Board adopts the new rule, those liabilities would rise nearly sixfold to 6.25% of payroll and would represent 7.5% of pretax profits and 2% of equity—four times the current figures.

Employers can "expect retiree medical expenses under FASB to be four to eight times greater than on a current pay-as-you-go basis," said Gary Laugharn, a group benefits consultant at Hewitt Associates in Lincolnshire, Ill., which conducted the survey.

The impact, he adds, "would be lower for firms with a relatively high ratio of retirees to actives."

Many employers are changing their medical plans for both future and current retirees to try to reduce the financial strain of retiree health care obligations, the poll also found.

"Survey of Retiree Medical Benefits 1990," which also discusses the design, cost and funding of retiree medical benefits, will be released in early October.

Hewitt surveyed 463 large and medium-sized companies, 363 of which offer a medical plan to at least some retirees.

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Courts guide insurer conduct in claims investigations
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GM contract boosts benefits for UAW workers, retirees
Page 3

Aon withdraws cash offer after second Corroon rebuff
Page 2

Update

Massive pollution case settled

Continued from previous page
tude that has been settled," said Allied-Signal attorney Robert Johnson of Anderson, Kill, Olick & Oshinsky in New York.

The manufacturer is still litigating with more than 170 liability insurers over coverage for the cost of cleaning up 400 hazardous waste sites.

A year ago, a New Jersey state court judge hearing this dispute ordered Travelers to reveal in a sworn statement any statements or positions it took concerning coverage for pollution claims that are inconsistent with its position in the Allied-Signal case (*BI*, Sept. 25). As part of the settlement, Travelers was dismissed from this dispute.

Allied-Signal also has agreed to drop its appeal in the 4th U.S. Circuit Court of Appeals for coverage for the cost of cleaning up two Maryland waste sites. A federal judge last year ruled that the Travelers policies did not cover those cleanups (*BI*, June 26, 1989).

H.S. Weavers assets sold

LONDON—H.S. Weavers (Underwriting) Agencies Ltd.'s assets were sold last week to a sister company, Southwark Run-Off Services Ltd., a Walbrook Insurance Co. Ltd. unit.

Terms of the deal were not disclosed.

Weavers and Walbrook are both owned by London United Investments P.L.C., which has been run by a court-appointed administrator since Walbrook stopped underwriting in March. Although Walbrook is technically solvent, four other LUI units that participated as insurers or reinsurers on the Weavers line slip are being wound up under the scheme of arrangement (*BI*, Sept. 3).

Furniture, cars and other tangible assets were sold, said Roger Borley, who is a Southwark director and the managing director of Weavers. Weavers directors accepted an offer from the Walbrook board, he said.

Southwark now will offer runoff services to the Weavers' stamp companies, including the four insolvent LUI units, and "the cast of thousands" that had participated on the line slip, said Mr. Borley.

"Weavers is still solvent and is still around, but the board of Weavers took the view that the best way to manage (the stamp companies') runoff is to sell (Weavers') assets.

"Weavers will still survive," he added, providing underwriting guidance to the runoff companies.

LUI administrators did not return calls. In July, they put Weavers' book value at 1.1 million pounds ($2.1 million), though they were unsure what price it could actually fetch.

RICO limit bill faces House vote

WASHINGTON—The House Judiciary Committee last week sent to the full House a bill that would make it more difficult to bring civil suits under the federal Racketeer Influenced and Corrupt Organizations act.

However, the committee struck a controversial portion of the bill passed by the Crime Subcommittee in June that would have allowed the new standards to apply to pending cases (*BI*, July 2).

The National Assn. of Insurance Commissioners had sharply criticized that provision because it could affect pending insurance fraud actions.

Insurance regulators still oppose the bill, H.R. 5511.

The bill would tighten the "pattern of racketeering" standards for determining whether a suit can be prosecuted under RICO. Federal judges would act as "gatekeepers," deciding which cases meet the more stringent standards.

"At a time when state insurance regulators are working diligently to bolster their arsenals in the battle against insurer insolvency and white-collar crime in the industry, the (House) Judiciary Committee has chosen to limit one of our more potent weapons," said NAIC Vp and North Carolina Insurance Commissioner James Long.

The bill could "severely hamper" regulators' ability to pursue RICO suits, Mr. Long said.

"We need all the strength we can muster," he said.

"You simply cannot ask those of us who are charged with. . .protecting the public from insurer insolvency to redouble our efforts and, at the same time, place legal hurdles like this bill in our path," he said.

Taylor pleads guilty to bribery

CHEYENNE, Wyo.—Former Wyoming Insurance Commissioner Gordon Taylor has pleaded guilty to one count of a criminal complaint charging him with taking bribes from insurance company officials in exchange for favorable regulatory treatment.

Mr. Taylor pleaded guilty to one count of interstate travel to carry on the bribery scheme.

Roy E. Thigpen III, owner of defunct Commercial General Insurance Co. of Casper, Wyo., also pleaded guilty to a similar charge.

The complaint alleges Mr. Taylor took bribes from Mr. Thigpen; Robert Davis, an official with Lloyd's U.S. of Dallas; and James R. Wining, a former officer with the parent of now-insolvent Laramie Insurance Co. of Laramie, Wyo. (*BI*, April 16).

Mr. Davis, who was also charged in the complaint, has not entered a guilty plea and is scheduled to go to trial Oct. 9, said Assistant U.S. Attorney Vincent J. Horn.

Mr. Wining was not charged.

Mr. Taylor and Mr. Thigpen, expected to be sentenced next month, face jail terms of 15 to 21 months and 21 to 27 months, respectively.

Under plea agreements with the two men, the U.S. Attorney's office will recommend the minimum sentence for Mr. Taylor and will not oppose Mr. Thigpen's request for the minimum, Mr. Horn said.

The two men also could could be fined up to $250,000 each. Prosecutors will recommend against any fines, Mr. Horn said.

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Rebuffed by Corroon, Aon drops cash offer

By LINDA J. COLLINS

NEW YORK—Aon Corp. Friday withdrew its $840 million cash bid for Corroon & Black Corp. after the New York-based broker rejected the bid on Tuesday and on Thursday refused a second request by Aon for a meeting to discuss the proposal.

The C&B board voted unanimously Tuesday to reject Aon's offer in favor of its previously planned merger with London-based Willis Faber P.L.C. and on Thursday C&B's chairman asked Aon to withdraw its offer.

In a letter sent Friday withdrawing the proposal, Aon Chairman Patrick G. Ryan reiterated his position that Aon's offer was "superior—strategically, financially and otherwise."

He added, "Should circumstances change and your board alter its position, please give us a call."

Aon had offered on Sept. 12 to purchase all outstanding shares of C&B for $40 per share, a bid Aon considered "superior" to the Willis Corroon merger (*BI*, Sept. 17).

That merger would involve an exchange of 7.8 Willis Faber ordinary shares for each C&B common share.

While Aon's acquisition bid would have provided C&B shareholders with a guaranteed payout, the value of the Willis Faber merger to C&B shareholders hinges on the performance of Willis Faber's stock, which has fallen in value since the proposal was first announced (*BI*, June 18; June 11).

Willis Faber's stock, which was trading at 289 pence on May 31 closed at 214 pence on Thursday down 26%.

Corroon & Black's shares have also fallen, down 8.5% to $30.88 last Thursday from $33.75 on May 31.

"The Willis-Corroon merger offers Corroon & Black shareholders a stake in one of the world's four largest insurance brokerage concerns. . .(which) will have the international presence required to be an effective competitor in today's globalized industrial and financial markets," Richard M

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Kuwait Air war risk loss

London underwriters to pay $228 million

By STACY SHAPIRO

LONDON—Aviation hull war risk underwriters agreed last week to pay their share of a $300 million loss for 15 Kuwait Airways Corp. aircraft confiscated by Iraq after its Aug. 2 invasion of Kuwait.

The claim will only be paid to those proving they are legitimate airline representatives, said war risk underwriter Stephen Merrett, chairman of Merrett Holdings P.L.C. "The Iraqis may have a different view of who owns the airline."

Willis Faber & Dumas Ltd., the airline's broker, Sept. 13 filed an official claim for the confiscated aircraft with London war risk reinsurers that underwrote 76.0125% of the airline hull war risk coverage, said Mr. Merrett, who led the reinsurance. The underwriters reinsured five Kuwaiti insurers, including Kuwait Insurance Co., Gulf Insurance Co., Warba Insurance Co. and Al-Ahleia Insurance Co.

Mr. Merrett and the other reinsurers met Sept. 14 to discuss the claim. Four days later they agreed to settle the war risks claim up to the policy's limit of $300 million for aircraft losses on the ground. Their share of the loss totaled $228 million.

The aircraft were actually valued as high as $690 million.

The claim was agreed "subject to satisfaction on entitlement, legitimacy of payment and appropriate safeguards," said Mr. Merrett's statement.

In an interview, Mr. Merrett added that the reinsurers are expecting to pay the money directly to the airline rather than to the Kuwaiti insurers "once the airline satisfies us that we can do that." Putting the money in escrow "as an intermediate stage," was "rejected as unwieldy," he said.

The remainder of the reinsurance is placed overseas.

Underwriters had said that there

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Eastern agrees to funding of plans overseen by PBGC

By ADRIENNE C. LOCKE

WASHINGTON—The Pension Benefit Guaranty Corp. will terminate and administer seven Eastern Air Lines Inc. pension plans underfunded by $700 million but will require the airline and its parent to fully fund the plans under a tentative structured settlement.

Last week's agreement guarantees full, uninterrupted pension benefits—including those not guaranteed by the PBGC—for the 39,500 employees and 11,500 retirees covered by the plans, the agency said.

The settlement, which is subject to approval by the court presiding over Eastern's bankruptcy, was reached one day after Eastern was scheduled to make a $80.5 million payment to its pension plans.

Eastern's parent, Continental Airlines Inc., made the $80.5 million payment to fund the pension plans last week.

Eastern filed for reorganization under Chapter 11 of the Federal Bankruptcy Act in March 1989 in New York. As of June 30, Eastern was insolvent by $1.6 billion, according to the PBGC.

"The agreement is truly precedent-setting" because it allows the agency to recoup 100% of the amount necessary to fully fund the plans, said Diane E. Burkley, deputy executive director and chief negotiator for the PBGC.

"We would like to be able to accomplish this with other cases, but it is something that we generally have been unable to do with other plans and, in particular, with plans that were so underfunded," she said.

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- A government proposal to widen coverage under New Zealand's no-fault accident compensation scheme is opposed by employers. **PAGE 13**
- Lloyd's of London is prepared to assume a major role as a global insurance marketplace, says the chairman of Lloyd's at the annual meeting of the National Assn. of Professional Surplus Lines Offices Ltd. **PAGE 22**
- Without reforms, state workers comp systems will continue to face grave problems, speakers warn at the International Assn. of Industrial Accident Boards & Commissions convention. **PAGE 26**
- Basic health care and retirement benefits will be the leading issues of the '90s, a benefit researcher predicts before a gathering of the International Society of Certified Employee Benefit Specialists. **PAGE 31**

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Court sets investigation standards

Judge blasts Monsanto insurers

By STACY ADLER

WILMINGTON, Del.—Courts hearing insurance coverage disputes are setting standards that insurers must follow when investigating whether coverage may have been voided by a policyholder's conduct.

For instance, a Delaware state court judge earlier this month chastised insurers that are contesting coverage for pollution claims of Monsanto Corp. for failing to have their investigators properly identify themselves when interviewing former Monsanto employees.

The judge's actions against the insurers could influence the outcome of the chemical company's coverage dispute.

"There have been a series of recent rulings in which courts have started to set standards on contacting current or former employees" during claims investigations, said David F. Snively, assistant litigation counsel for Monsanto.

"As a general proposition, it is very constructive for courts to establish proper investigatory standards," added policyholder attorney Jerold Oshinsky of Anderson, Kill, Olick & Oshinsky in Washington, D.C.

"Policyholders and insurers alike benefit from clear court directives," he said.

The practice of conducting in-depth factual investigations of a policyholder's practices has gained momentum ever since similar tactics were used in coverage litigation involving Shell Oil Co.

In the Shell case, liability insurers cited evidence that Shell employees had removed dead ducks from Shell's property to prove that the oil company knew it was polluting the environment (*BI.* Dec. 26, 1988). By showing that the policyholder knew it was polluting the environment, the insurers were able to avoid paying billions of dollars in pollution cleanup costs.

The legacy of the Shell litigation has been the "dead duck" defense, in which insurers attempt to prove that policyholders knowingly polluted the environment. The most common method of gathering this proof is by interviewing former employees.

However, in the most recent case, Delaware Superior Court Judge Vincent J. Poppiti said that interviews with a policyholder's current or former employees must be done with "honesty and integrity."

Specifically, Judge Poppiti held that it was wrong for insurer investigators to fail to identify themselves as working for an insurance company that is litigating with the employee's former employer.

"I embrace the proposition that in civil litigation in this jurisdiction one who is in search of the truth must tell the truth," said Judge Poppiti said in his ruling.

Judge Poppiti said that affidavits of several former Monsanto

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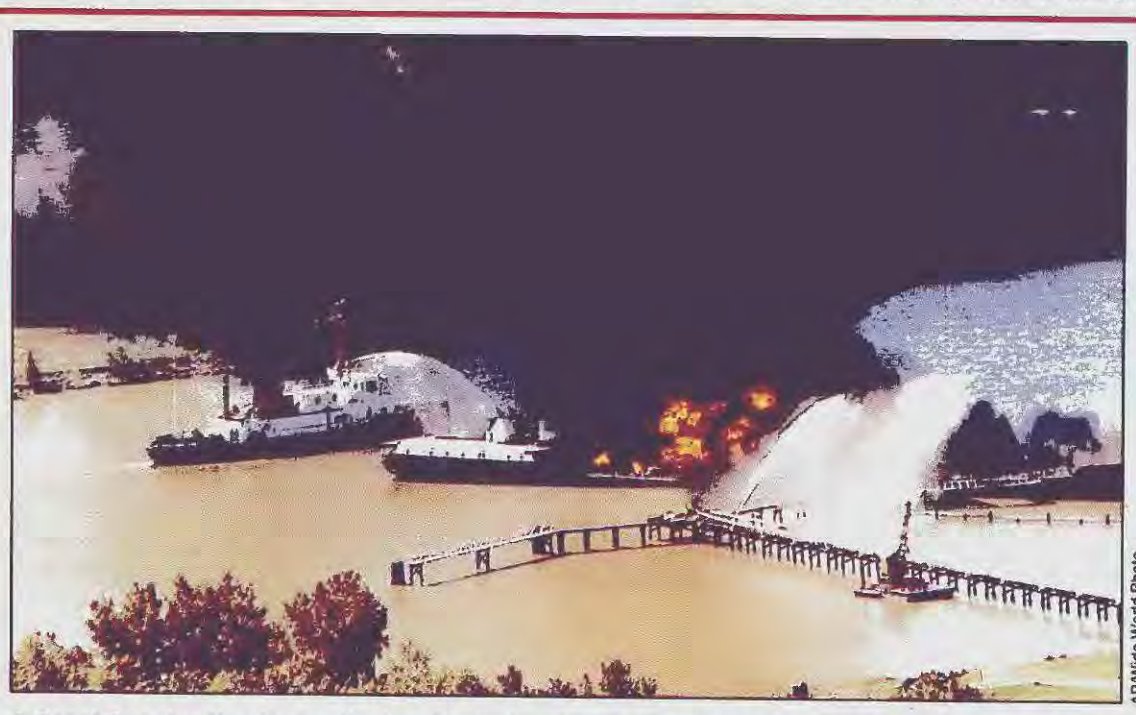

AP/Wide World Photo

A Coast Guard cutter douses the burning tanker Jupiter last week, after it exploded and caught fire.

Oil loss insured, cause uncertain

BAY CITY, Mich.—Two oil companies are insured for the undetermined amount of losses they suffered when an oil carrier exploded and burned while offloading gasoline at Bay City, Mich., last week.

The accident occurred while the 381-foot Jupiter, owned by Ohio-based Cleveland Tanker Inc., a subsidiary of Ashland Oil Co., was delivering unleaded gasoline belonging to Denver-based Total Petroleum Inc. at Total Petroleum's dock on the Saginaw River.

Most of the oil carrier's mooring lines suddenly broke free and the Jupiter pulled away from the dock, rupturing the service connection through which the gasoline passed. A spark from an unknown source ignited some of the 21,000 barrels—or 882,000 gallons—of gasoline still in the carrier and caused an explosion that killed one of 18 crewmen and injured 11, most slightly.

The fire burned from Sunday morning until Monday afternoon, but reignited a few hours later and burned until it was smothered in foam Tuesday afternoon.

The accident also seriously damaged Total Petroleum's dock, but did not damage the 34,000 barrels of gasoline that had already passed into its onshore storage tanks, a company spokesman said.

There appears to be little or no environmental damage.

A spokesman for Ashland Oil said Cleveland Tanker maintains "full" coverage for pollution and liability claims, including those anticipated from crewmen—who can seek compensation under fed-

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Direct scrutiny of reinsurers on the horizon, experts warn

By JOANNE WOJCIK

KANSAS CITY, Mo.—The end of relying on indirect regulation of reinsurance is near, industry experts predict.

An increase in ceding company insolvencies and reinsurer refusals to honor many reinsurance contracts is forcing regulators to stand up and take notice, several experts said at the Midwestern Zone Meeting of the National Assn. of Insurance Commissioners, which was held Sept. 9-12 in Kansas City, Mo.

NAIC

Growing use of alternative risk financing mechanisms that give policyholders direct access to the reinsurance market as well as the increasing globalization of insurance also will likely trigger greater regulation of reinsurers, one industry expert observed.

And states are likely to step up regulatory efforts in response to the growing use of financial reinsurance, according to another.

"All regulation is reactive. It takes a series of negative events or a catastrophe for corrective action to be taken," said George K. Bernstein, a reinsurance attorney in New York.

"The growing interplay between the solvency of ceding insurers and the reinsurance they carry promises increased regulatory reaction," Mr. Bernstein warned at an NAIC seminar co-sponsored by the Society of Financial Examiners Education Foundation and the Reinsurance Assn. of America.

"We may be seeing the beginning of the end of indirect regulation of reinsurance," he said.

Regulators have been concerned with reinsurer security for many decades. But it "emerged as a major issue in the 1980s because of slow-pay and no-pay reinsurers," asserted N. David Thompson, president of North American Reinsur-

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Contract boosts benefits for workers, retirees

GM, union reach accord

By MICHAEL SCHACHNER

DETROIT—Pension benefits for unionized General Motors Corp. employees and current retirees would be boosted under a tentative three-year labor contract the United Auto Workers reached with the auto maker last week.

In addition, unionized workers stand to gain improvements in benefits for substance abuse and mental health treatment, short-term and long-term disability, orthodontics, dental and life insurance.

GM also would implement a pilot long-term care program under the agreement.

Meanwhile, unionized workers would continue to receive fully-paid, first-dollar hospitalization benefits.

The agreement was overwhelmingly approved last Tuesday by the UAW executive committee and more than 400 local UAW officials, but the rank and file still must vote on the agreement.

The contract affects approximately 280,000 active employees, 60,000 employees on short-term duty or on temporary layoffs and about 175,000 retirees.

The current UAW contract with GM expires Sunday.

A UAW spokesman said the union will seek similar three-year contracts from Ford Motor Co. and Chrysler Corp.

"Our expectation is to pattern negotiations with Ford and Chrysler based on the contract we have with GM," he said.

By the third year of the agreement, the basic pension benefit of UAW members who retire during the next three years would be increased by $4.45 each month for every year of credited service to $30.70 from $26.25.

For example, a 62-year-old worker with 30 years of service would receive $921 monthly, or $11,052 annually, in pension benefits under the new contract, up from $787.50, or $9,450 annually under the current contract.

The monthly basic pension benefit would increase by $2.10 to $28.35 in the first year of the contract and by $3.25 to $29.50 in the second year.

Retirees with fewer than 30 years of service and younger than 62—who would not be eligible for Social Security benefits—would receive higher interim supplemental benefits on top of the improved basic pension benefits.

For example, interim supple-

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New Mexico legislation raises comp benefits, seeks to control costs

By CHRISTINE WOOLSEY

SANTA FE, N.M.— Employers, labor groups and insurers generally agree that New Mexico's new workers compensation reform legislation is a good first step in an effort to improve benefits and control system costs.

The legislation would increase some benefits for injured workers, but it also would attempt to control system costs.

For example, a measure designed to discourage litigation calls for the creation of a state-funded program to help employers and injured workers through the workers comp system.

Another state-funded program would investigate workers comp fraud.

In addition, a provision calls for the state to provide funds to establish a mutual company to write affordable coverage for small and medium-sized employers. However, the state would be reimbursed by the mutual over the first 10 years of its operation.

Critics, though, question whether the provision is constitutional under state law, and they doubt how effective the mutual would be.

The legislation is a combination of workers comp reform proposals developed by the Business Workers' Compensation Coalition, a statewide group of about 100 business owners and managers, and system reform proposals drafted by a legislative task force created by Democratic legislators.

The reform package is expected to cost employers and the state approximately $24 million, legislators say.

In an effort to discourage Gov. Garrey Carruthers from line item vetoing significant reforms because of concerns over their funding mechanisms, legislators split the legislation into two bills—one outlining reforms and the other providing for state funding of several reform measures.

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A&A creates 3-person Office of Chairman

William M. Wilson and **Michael K. White** last week were elected deputy chairmen in a new three-person Office of the Chairman at Alexander & Alexander Services Inc. of New York.

T.H. Irvin remains chairman and chief executive officer.

Messrs.. White and Wilson had been executive vps and both are members of the board of directors.

Also at A&A: **Thomas D. Gunnin** named managing vp in the Costa Mesa, Calif., office; and **James A. Mancuso** appointed division director of select market services for A&A of New York Inc.; **Kevin J. Smith** named vp and controller in the corporate finance and administration office in Owings Mills, Md.

Other agent/broker news:

Patrick Fitzpatrick appointed vp with James Econn & Co., a Los Angeles brokerage.

At Adams & Porter, a Rollins Burdick Hunter Co. subsidiary in Houston, **Gary Cooper** appointed vp in a new surety division.

Jeanne Nicholson and **Mary A. Fish** promoted to vps at William Gallagher Associates in Boston.

John P. Powers joined Meeker Sharkey & DiLeo, a brokerage unit of Meeker Sharkey & DiLeo Financial Group Inc. in Cranford, N.J., as vp-business development. He had been vp at Jardine Insurance Brokers of New York Inc.

R. Bradley Johnson is resigning as executive director of the Public Risk Management Assn. to become a vp with Sedgwick James Inc. in the brokerage's public entity division in Columbia, S.C.

Comings & goings: industry

Insurers

Glenn S. Thomas elected senior vp and director of commercial property-liability insurance for Transamerica Insurance Co. of Woodland Hills, Calif. Mr. Thomas, formerly vp and director of commercial property underwriting, replaces **Dante Vincenti**, who left the company.

In addition, Transamerica announced these changes: **James C. Vogt** named senior vp of commercial claims; **Thomas E. Aichele** appointed vp; and **Roger L. Torneden** joined the company as senior vp and director of specialty insurance marketing.

Richard D. DeSimone named senior vp-marine at Atlantic Mutual Insurance Co. of New York.

Gary Pingel appointed director of underwriting for Pioneer State Mutual Insurance Co. of Flint, Mich.

Anne C. Campbell appointed vp of the standard commercial accounts department at the New Hampshire Insurance Co., an American International Group Inc. unit in Manchester. Also, **Daniel P. McMahon** appointed vp-technical support and risk management services.

Richard H. deMoll named executive vp in the business credit services division of Dun & Bradstreet Corp. He will responsible for American Credit Indemnity Co., a Baltimore-based Dun & Bradstreet unit.

Eileen S. Lynch named deputy representative for Abeille General Insurance Co. of New York, a U.S. branch whose ultimate parent is Groupe Victoire of Paris.

Michael McGarragan named vp-claims and risk management with Physicians Insurance Co. of Wisconsin, a physician-owned medical malpractice insurer in Madison. He had been risk manager for Catholic Health Corp. of Omaha, Neb.

Carl V. Casterlin, manager of the Richmond, Va., office of Selective Insurance Co. of America, was named resident vp of the Branchville, N.J., insurer and an affiliated company, Selective Way Insurance Co.

The Home Insurance Co., an AmBase Corp. subsidiary in New York, announced these changes: **Thomas A. Daffron** promoted to vp-property claims from assistant vp; **Roger F. Ablett, David R. Whiting** and **Stephen J. Vaccaro** promoted to vps of the specialty lines division from assistant vp; and **Gerald A. Verrilli**, general manager of the Milwaukee branch office, was promoted to vp.

Excess/Surplus Lines

William D. Brecht named president of Hull & Co. (California) Inc., a subsidiary of the Fort Lauderdale, Fla.-based surplus lines brokerage.

Richard A. Hofmann joined Midwest Employers Casualty Co., a St. Louis company specializing in excess workers compensation insurance for self-insured employers, as vp-actuarial services and government relations.

Victor O. Schinnerer & Co. Inc. of Chevy Chase, Md., announced two appointments to executive vp: **Marshall A. Ames** and **Merrill B. Walker Jr.** Mr. Walker will continue as chief financial officer. Mr. Ames had been senior vp and head of the construction industry insurance division. Also, **Douglas C. Dolan Jr.** appointed president of Potomac Insurance Managers Inc., an underwriting manager and administration unit of Schinnerer in Chevy Chase.

Harvey Goldenberg promoted to senior vp-regional director in San Francisco for Alexander Howden North America Inc.

John H. Burke Jr. named president of Burnett & Co. of New Orleans, a wholesale subsidiary of Thomas R. Miller & Son (Holdings) Ltd. of London specializing in oil, gas and marine insurance. **Felix W. Burnett Jr.**, the founding president of Burnett 30 years ago, is now chairman.

Crum & Forster Managers Corp. and affiliate International Surplus Lines Insurance Co. announced the election of four new vps in Chicago: **Colin L. Gray**, **David L. Hall**, **Robert S. Kant** and **Terrance O'DeKirk**. Also, **Lynn Rishe** was elected vp of ISLIC.

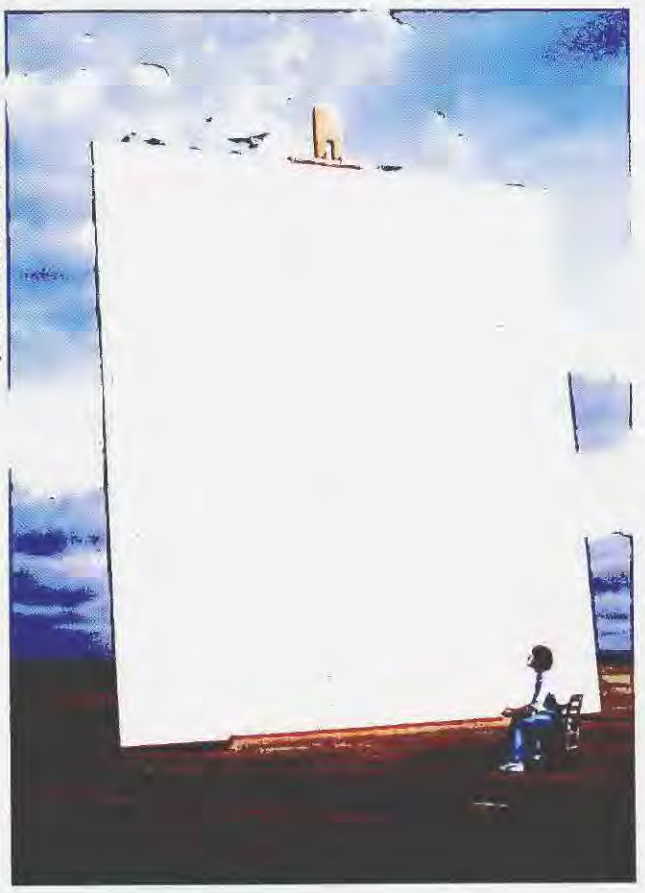
Thomas P. Bowie promoted to vp at General Star Management Co. of Stamford, Conn.

Reinsurance

James A. Giordano named senior vp for treaty underwriting with Chartwell Reinsurance Co., a Stamford, Conn., unit of NWNL Companies Inc.

General Reinsurance Corp. of Stamford, Conn., announced these changes: **Charles F. Sutton** promoted to vp in Atlanta; **Carl M. Webster** promoted to vp in Stamford; and **Arthur Nielsen** joined the treaty division in Stamford as vp.

Michael C. McFadden promoted to vp at Genesis Underwriting Management Co. in Stamford, Conn. ■



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Coverage dispute

Continued from page 3

employees who were contacted by insurer investigators revealed that the investigators "affirmatively misled" the former employees.

For example, some of the former employees stated, under oath, that the investigators either did not disclose that they represented insurance companies or reveal that Monsanto was suing the insurers.

There were even more incredible stories, according to court papers:

- Two former Monsanto employees were under the impression that the investigators represented Monsanto.
- One former employee was told by an insurer investigator that the investigator "worked for a firm in New Orleans which had been commissioned by the chemical industry to look into which companies were polluting."
- Another employee was told that the investigator was "interested in Monsanto's efforts to correct environmental problems."
- Two former employees were told by investigators that the investigators were "compiling a book" about the Monsanto plant.
- One former employee was told by an investigator that the investigator "worked for the government, and was checking on pollution."

"I will not countenance this type of conduct," said Judge Poppiti. "At least in this litigation in Delaware, the parties and their agents will be guided by truth and honesty, and not by lies and deception.

"In the courts of Delaware, the hallmark of justice under law in civil litigation cannot be expedience marred by deception, but must rather be truth. To accept or require anything less would, in my view, debase the system of justice and belittle all who serve it," he concluded.

As a result, Judge Poppiti ruled that the insurers must furnish Monsanto with a list of all their investigators, the former employees they contacted and all of the statements the former employees gave.

He also said that any evidence obtained as a result of investigations where the investigators failed to properly identify themselves would not be admissible at trial.

For the future, Judge Poppiti gave the insurers a script that must be used by their investigators when contacting former employees. The script requires the investigators to identify the insurer for which they work and to report that Monsanto is litigating with the insurer. In addition, the investigator must describe the litigation and inquire as to whether the former employee is represented by counsel.

"Any interview conducted in violation of this order will result in sanctions issued against counsel," added the judge.

"This ruling sends a message to insurers that informal discovery ought to be conducted with fairness and honesty," said Monsanto attorney Charles S. Crompton Jr. of Potter, Anderson & Corroon in Wilmington, Del.

"It tells policyholders they are entitled to have their claims handled fairly, honestly and without deception," added Mr. Crompton.

"This gives policyholders a measure of protection against abusive practices," agreed Mr. Snively, who is in-house counsel for Monsanto.

'The hallmark of justice under law in civil litigation cannot be expedience marred by deception, but must rather be truth. To accept or require anything less would, in my view, debase the system of justice and belittle all who serve it,' says Judge Poppiti.

Because the evidence gained by the insurers' investigations could have been critical to their defense, Judge Poppiti's ruling could influence the outcome of Monsanto's dispute, said Mr. Crompton.

Monsanto is suing 36 property and liability insurers for the cost of cleaning up 80 hazardous waste sites nationwide. There are billions of dollars at stake in the litigation.

Among the dozens of insurers involved in the litigation are: Travelers Indemnity Co., Aetna Casualty & Surety Co., Allstate Insurance Co., The Home Insurance Co. and several units of American International Group Inc.

A list of attorneys representing the insurers reads like a "Who's Who in Insurance Coverage Defense." These attorneys last week filed several motions with the court seeking to have the order modified or revoked.

For example, Travelers, the lead insurer in the litigation, claims that its investigators were not guilty of any alleged wrongdoing and that the order should be modified so that it does not name Travelers. As it is currently drafted, Judge Poppiti's order names only Travelers.

Monsanto, on the other hand, says that since all of the insurers entered into a joint defense agreement whereby they share the costs of the defense and investigations, they should be held jointly responsible for any wrongdoing. Monsanto wants the order modified so that it encompasses all of the insurers, not just Travelers.

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Monsanto Co. vs. Aetna Casualty & Surety Co., et al., Superior Court of the State of Delaware in and for New Castle County; No. 88C-JA-118.

N.C. comp hike faces challenge

RALEIGH, N.C.—A proposed workers compensation rate hike of nearly 30% for 1991 will likely prompt North Carolina Insurance Commissioner Jim Long to call for insurers to defend the request at a public hearing, according to an insurance department official.

The North Carolina Rate Bureau, which sets rates for all of the state's workers compensation insurers, filed for an overall statewide increase of 29.3%. But, that figure, says Senior Deputy Insurance Commissioner Roger Langley, "appears much too high."

Jerry Hamrick, workers compensation manager at the bureau, defends the proposal, saying insurers' loss experience in 1990 calls for at least a 20% increase.

In addition, the state's Industrial Commission, which issues a physician fee schedule every two years, raised fees across the board in July for all medical procedures under workers compensation. Also, weekly indemnity benefits are expected to increase 3% to 4% in 1991, Mr. Hamrick said.

The requested increase comes on the heels of an 9% increase approved last year. In 1988, no increase was requested, and in 1987, the industry's request was scaled back from 16.8% to 4.2%.

"This is quite a jump from those levels to this year's filing," said Mr. Langley. "Commissioner Long will be taking a hard look at it."

Mr. Long has until Nov. 1 to order a hearing. A final ruling on the filing must be entered by Jan. 1.

—By Michael Schachner

At issue

What is the most critical element of your property loss control program?

George Griffith
Risk & Insurance Analyst
Zellers Inc.,
Montreal

We are a retail organization with 250 locations across Canada. As a corporate risk manager, I cannot visit and inspect every location. I place my emphasis on educating our field managers and sensitizing them to the importance of loss control. Fire and theft are the most common risks so sprinkler systems and motion detectors must be regularly inspected.

Robert S. Coker
Risk Management Coordinator
City of Coral Springs,
Coral Springs, Fla.

The most critical elements of our program are engineering and inspection. Here in South Florida, our buildings must be constructed to withstand 120-mph winds. Also, we must be sure alarms, sprinklers and fire suppression equipment are working properly. Annual fire inspections and daily inspections of electrical equipment are important.

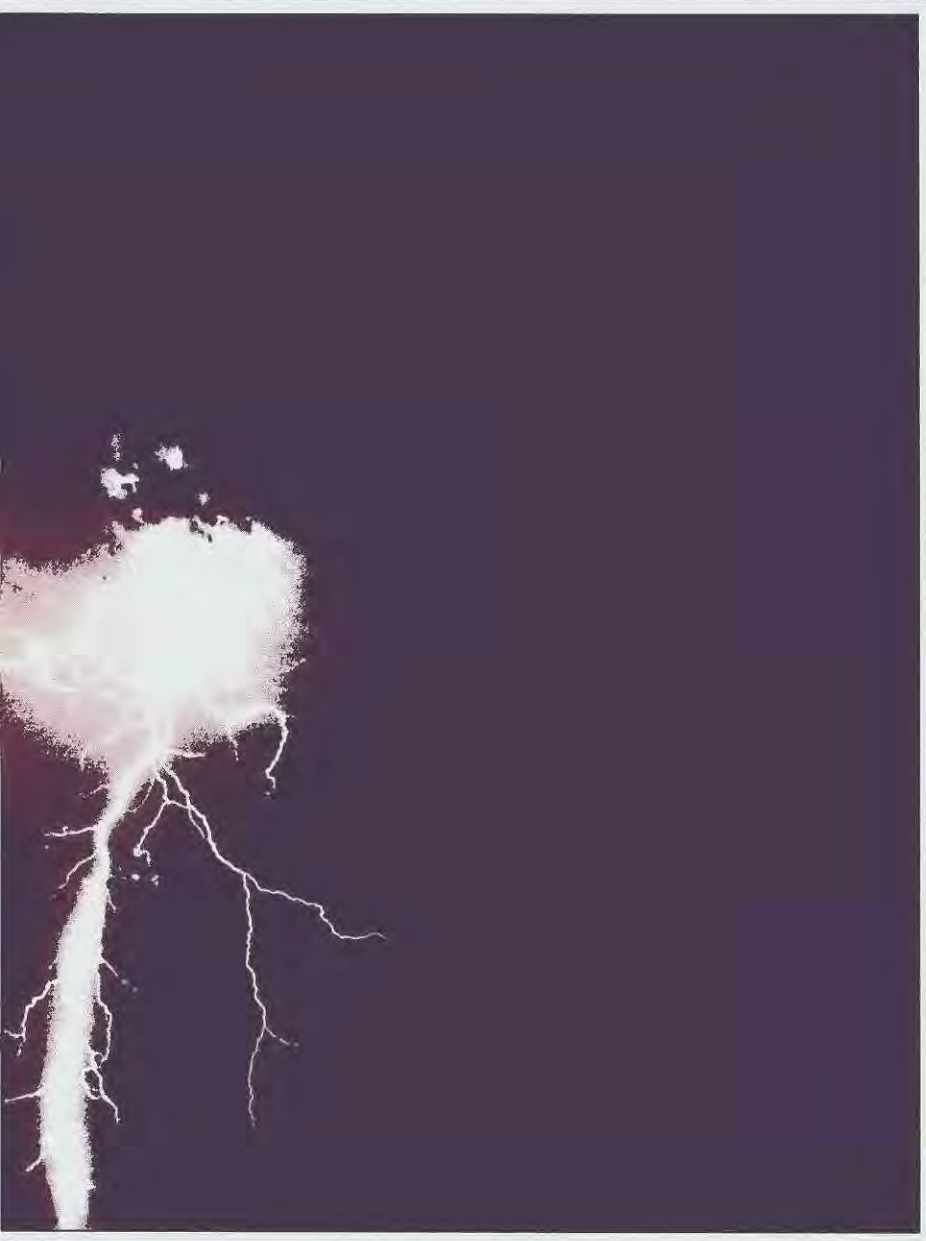
Judith M. Tornese
Vp-Risk Management
Transamerica Corp.,
San Francisco

Our major risk is earthquake damage. Our buildings are periodically surveyed by an outside earthquake consultant who checks the structures and verifies that equipment is properly anchored and computer facilities are adequately protected. Also, a business recovery plan is important to be sure operations continue with as little disruption as possible.

Sandra K. Jackson
Risk Manager
AP Parts Manufacturing Co.,
Toledo, Ohio

Engineering coupled with ongoing support from top management is crucial to our property loss control program. And, promoting interest in loss control throughout the workforce is important.

Compiled by Christine Woolsey



MERCANTILE & GENERAL
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Eastern pension

Continued from page 2

PBGC Executive Director James B. Lockhart believes that terminating the plans was necessary to protect not only Eastern retirees but also the agency from one of the largest potential losses it has ever faced.

As of December 1989, Eastern's seven pension plans had approximately $1.5 billion of assets and nearly $2.2 billion of liabilities, leaving approximately $700 million of unfunded liabilities, according to the PBGC, which currently is responsible for about $1 billion in total unfunded liabilities.

"In this case, with Eastern in bankruptcy and economic uncertainty facing the airline industry, we saw an unreasonable risk of loss. . .if we did not terminate the pension plans" now and reach the pension plan funding agreement, he said.

The PBGC has been working for nine months to hammer out this agreement with Eastern, Continental and Eastern's Unsecured Creditors Committee, according to Ms. Burkley. "It took some hard negotiation to reach this agreement."

Ms. Burkley added that the settlement underscores the joint and several liability provision under the Employee Retirement Income Security Act of 1974.

Indeed, if Continental would be unable to fulfill its commitment under the agreement, its parent—Continental Airlines Holdings Inc., formerly Texas Air Corp.—would have to assume responsibility for funding the plans.

Continental also said it is happy with the agreement.

"We are pleased that this matter has been resolved and in such a way that it will not hinder Continental's plans for future growth and. . .profitability," said Hollis L. Harris, president and chief executive officer of Continental Airlines Holdings.

Ms. Burkley said she expects the federal bankruptcy court in New York overseeing Eastern's bankruptcy to approve the plan by mid-October and that the PBGC would then terminate the plans. Any benefit accruals not already frozen will stop when the plans are terminated, the PBGC noted.

Under the settlement, Continental, which has assumed responsibility for the lion's share of the unfunded liabilities, agrees to make monthly payments to the PBGC of between $4 million and $5 million beginning in May 1991.

However, Continental must make additional payments of up to $50 million annually in profitable years beginning in 1994.

If the plans are not fully funded after 12 years from the date the agreement is approved, Continental would have to make a lump sum payment to cover any remaining liabilities. Monthly payments of $5 million for 12 years would total $720 million.

Continental must post $500 million of yet-to-be-determined collateral with the PBGC, and the agency has the authority to foreclose on if Continental misses any payment.

In addition, Eastern has agreed to pay $30 million to the PBGC: $8 million in October and the remainder on Jan. 15, 1991.

Eastern also has agreed to grant the PBGC a general unsecured creditor's claim for $565 million in the airline's bankruptcy.

However, the agency expects to get only between $50 million and $140 million back on that claim, Ms. Burkley said.

The PBGC will establish a separate trust fund to hold the pension plan assets of the terminated plans and to receive the payments made by Eastern and Continental.

Meanwhile, the PBGC gave Pan American World Airways permission to defer a $53 million payment to its pension plans. The airline is scheduled to make a $30 million payment on or before Nov. 1 and a $23 million payment by Feb. 28, 1991. ■

Opinions

Don't rule out federal role

THE IDEA OF the federal government taking a role in insurance solvency regulation is one that is worth study, and we hope everyone concerned—legislators, state regulators, insurers and and policyholders—will approach the possibility with an open mind.

It is still far from clear how such a complementary federal/state system would work. The American Insurance Assn. and other trade groups floated several alternatives in congressional testimony earlier this month, including the establishment of minimum federal standards that insurance departments or insurers would have to meet or the formation of a federally supervised self-regulatory body (see story, page 1).

Since the primary goal of all parties should be improving solvency regulation, we would be disappointed to see this debate degenerate into a turf war between supporters of state and federal regulation.

No one can argue that state solvency regulation has been wildly successful: The disastrous failures of Mission Insurance Co., Transit Casualty Co. and other insurers in recent years provide eloquent testimony to the shortcomings.

The National Assn. of Insurance Commissioners conceded as much by developing its own solvency policing agenda last year (*BI*, June 19, 1989).

The NAIC deserves—and has received—high praise for this push to clean its own house. It remains to be seen, though, whether these steps will prove effective.

A key element of the NAIC's solvency policing agenda, for example, involves NAIC accreditation of insurance departments in states that have adopted model laws and regulations. Presumably, though, some states will fail to meet accreditation standards and these states may attract exactly the types of insurers most in need of regulatory oversight.

In addition, it is unclear whether the solvency policing agenda will resolve several of the problems that AIA President Robert E. Vagley and others cited in their congressional testimony: duplicative and contradictory state reporting requirements, chronically underfunded and understaffed state insurance departments, and regulators' failure to focus resources on the insurers most in need of attention.

Mr. Vagley rightly expressed concern about whether any state regulatory system can keep up with an increasingly complex and fast-moving industry operating on an international scale.

But the question remains: Could the feds do any better?

As critics of federal regulation are fond of pointing out, the federal government did nothing to prevent the $500 billion savings and loan debacle. Quite the contrary: It helped create the monster through deregulation.

"LET'S ALL BEGIN BY USING THE SAME MUSIC...."

Complementary federal/state insurance regulation would mean creating a new layer of oversight, and confusion could arise over who has regulatory responsibility if regulators' turf is not clearly defined.

There are successful examples of federally supervised self-regulatory schemes. Mr. Vagley, for instance, cited the role played in the securities industry by the National Assn. of Securities Dealers. But he added that it is uncertain whether such a scheme would work when applied to more complex insurance solvency issues.

The fact is that no regulatory system will end insurance company insolvencies.

While investigating the failures of Mission, Transit and Anglo-American Insurance Co. of Louisiana, the House Oversight and Investigations Subcommittee focused much of its attention on the role of fraud. But Harry A. Koch Jr., a National Assn. of Casualty & Surety Agents official, correctly observed that banishing all the insurance crooks would still leave the industry facing the age-old causes of insolvency: unwise rate competition, underreserving, bad reinsurance and plain old-fashioned mismanagement.

The goal is to limit the damage.

If a federal role in solvency regulation would help fulfill this goal, it's certainly worth a look.

Letters

Congresswoman clarifies role in COBRA bill

To the editor: I read with great interest the article, "Proposal Would Expand COBRA," regarding the extension of COBRA continuation coverage for up to 15 years (*BI*, July 30). There is a point, however, that I wish to clarify.

While I was somewhat involved in the drafting of this legislation, after much thought I concluded that the administrative burdens and subsequent changes in health policy placed on certain small businesses outweigh the benefit of this piecemeal approach to the extension of health care coverage. As a consequence, I decided not to endorse the COBRA legislation.

While I certainly believe that we must find ways to extend health care coverage to the 37 million Americans who do not currently have it and I will continue to seek reasonable methods of achieving this goal, I want you and your readers to know that I do not support this proposal.

Barbara B. Kennelly, D-Conn.
U.S. House of Representatives
Washington

■ *Editor's note: Rep. Kennelly, however, is a co-sponsor of the Women's Health Equity Act, H.R. 5397, which includes the COBRA expansion provisions (*BI, *Aug. 20).*

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.

Manufacturers must improve ergonomics

To the editor: I read with interest the articles on cumulative workplace trauma and ergonomics in the Sept. 10 issue. It is unfortunate that no federal agency has authority to specifically address the potential for cumulative injury inherent in so many product designs.

Because so few product manufacturers are equipped to, or even attempt to, conduct ergonomic analyses of designs, it is left to the employer (often, as your articles note, only after a substantial number of injuries have occurred) to try to retrofit the design to accommodate the human users.

It is particularly unfortunate that employers, which cannot be expected to have the same access to ergonomics expertise as the manufacturers, are the ones that are bearing the great burden of poor product design.

Certainly, if manufacturers do not soon attend to this area, they will begin to feel the impact of meritorious product liability lawsuits.

Michael Garth Moore
Attorney
Columbus, Ohio

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SUBSTANCE ABUSE IN THE WORKPLACE— THE WHITE COLLAR VIEW.

One in an ongoing series of conversations between Argonaut Insurance Company, our clients and their brokers, dealing with issues important to their business. The intent is to keep the lines of communication open. We invite your participation.

THE PARTICIPANTS: **MICHAEL DUNLOP,** *VP Risk Management for Countrywide Mortgage Bank, one of the nation's largest.* **ELISE KAPLAN,** *Personnel Manager for Countrywide.* **DON SCHAEFER,** *with Frank B. Hall Corporation, Countrywide's broker.* **STEVE LA SHIER,** *Senior VP Safety Management, Argonaut Insurance Company* **LARRY EVANS,** *Manager of Safety Management, Argonaut Insurance Company.*

MODERATOR Countrywide is a New York Stock Exchange Company. Just how big is it?

MD: We're the largest originators of loans in the United States, with about 100 branches in 28 states for retail operations and 12 wholesale branches located around major cities. We're primarily a mortgage banking operation with roughly 1100 employees, about 1000 of those white collar. So we're a sizeable operation with people located in various states.

MODERATOR What's prompted your company to address the problem of substance abuse? Is it an awareness of a problem in the corporate world as a whole, or do you have evidence of abuse within your own company?

MD: Generally, we just know there's a problem in the country as a whole. It's talked about a lot, it has to touch us in some way. We're a very dynamic company. When we recognize problems we get into them as fast as we can.

SL: What's the average age of your employees? And the ratio of men to women?

EK: We have a lot of women, including most of our branch managers. And I'd guess that the majority of our employees are in their 30s.

SL: From a statistical standpoint, the early 30s is a prime group for substance abuse, including alcohol. Let me ask you an interesting question. How would you describe the average alcoholic?

EK: I think you'd stereotype a male, at the end of his career. A burned out executive.

SL: Do you realize that close to 40% of the alcoholics in this country are women? And that 57% of all women now work? One of the keys to managing substance abuse in the workplace is teaching your managers to recognize it. And the first thing they have to learn is we're not just talking about the stereotypical guy.

MODERATOR Is there a real stress-related issue to alcoholism?

SL: When you talk to alcoholics, you'll find trying to deal with stress is how a lot of them got started. "I need a drink to relax." "I have to have that martini when I get home." But we're not talking just about the alcoholic or drug addict here. We're talking the abuser. There is a difference between a user, an abuser and an addict, and a company has to learn to separate the three. The abusers are the reasons you lose money. Not addicts, abusers.

MODERATOR Is there more to substance abuse than alcohol, cocaine and marijuana?

SL: There are more than 10 million prescription drug abusers in this country, a lot of them white collar executives. And the number one abused drug is valium. You can get a prescription from almost any doctor. Often that's how it starts, and it's all legal.

MODERATOR Does Countrywide have a stated drug policy?

EK: We have a policy of not using on the premises. We don't have a drug screening or testing program.

MODERATOR Are you setting one up?

MD: Yes. We've looked into programs two or three times in the last few years. And working with our corporate counsel, it's been very difficult to identify what kind of a program Countrywide can have.

MODERATOR Is that part of the problem? There isn't much out there in the way of successful models.

MD: On the health industry side, there's a lot of ideas about how to do it, but when you look at how many companies have done it, and at how many companies have gotten sued as a result, there isn't a lot of experience out there for people to hang their hats on.

MODERATOR Is that a big threat, potential litigation?

MD: In California it is.

LE: Do you see that as the major stumbling block for your company?

EK: That's certainly part of it, but I really think the bigger issue is that you can't see the problem.

DS: I think it's important to understand that Countrywide's a fairly young company. It's a very health conscious company. They have a corporate gym and a health director, which is not a common thing in this business. But it was an awareness of stress and the claims problem regarding stress that really caused Countrywide to become aware of the issue of substance abuse.

MODERATOR How was it manifesting itself? Claims, days off, employee theft?

DS: Stress was manifesting itself in terms of increased workers' compensation claims costs and the difficulty in buying workers' compensation insurance. Once they found out about it, they took a proactive approach to dealing with it. That led to looking at an employee assistance program which led them into an awareness of substance abuse and the attitude that, "Hey, substance abuse is a problem throughout society, what's to make us think it's not a problem here." Although they have not specifically identified, even now, a substance abuse problem.

MODERATOR As a broker, have you found claims costs to be the trigger? Do companies start to look for a problem before the claims start to pile up and the premiums accelerate?

DS: I expect that it's an unusual company that would take a proactive approach to a societal problem before it financially impacts the organization. The fact that our workers' comp claims costs have gone up is really why Argonaut's loss control people came in and started talking about the connection between accelerating costs and productivity. Once Countrywide started looking at the loss of productivity that accompanied the increased costs, they got excited about doing something about it.

MODERATOR So in other words, with many corporations too often it's the "If it ain't broke don't fix it" approach?

DS: I think they're just not aware of it. They have a company to run and mortgage banking is a very complex business with low margins in a complex society and you're running fast just to stay ahead.

MD: We looked at our 23 largest stress claims over the past five years and found out that 17 of them started as medical leave of absences. We felt there was something in there, something that happens, or doesn't happen, during that medical leave that turns it into a stress claim. It's also a matter of communications. We have to communicate to our employees that we're concerned about them. That they're out ill for some reason and we want to help them get back in a healthy state, however we can.

MODERATOR How do you communicate with your employees?

MD: We have a regular newsletter called the "Pipeline" that all employees receive. We have topical articles in there about what our senior management thinks is important to the company and within those articles they address subjects like substance abuse.

MODERATOR How do companies find the substance abusers?

SL: Well, the first thing you need to do is to approach substance abuse in the workplace from a safety and health issue. No one in this company is a police officer, no one is a district attorney. You want to approach the whole idea with the attitude of making it a more safe and healthful place to work. These people are not criminals. They need help.

Recent statistics show the substance abuser is sick three times as often as your average employee. That is a key indicator. You can look down through your list and say, "Okay, the average person takes two days here, three days there, maybe four days a year." You've got somebody over here with 12 or 15 days. That's a very good indicator that there may be some other problem.

LE: Loss runs are another area many companies look at to identify potential substance abusers. They look for individuals that have repetitive injuries. More than a few injuries a year, something is going on in a person's life that is causing them to be injured. That's something that's worth an in-depth look.

SL: You're asking your supervisors to manage a group of people. You've got a performer who's been with you for a couple of years and all of a sudden they're ill more often, they're late for work, their productivity drops, their judgment is impacted. Suddenly you have a mysterious disappearance. A company theft. These are the types of things a supervisor looks for.

MODERATOR What else?

SL: Obviously if a person walks in who can't keep their balance, if their speech is slurred, their pupils dilated, there's something wrong. Now you have to be careful. That person could very well be a diabetic who didn't have their insulin. You don't teach your people to be experts. You teach them to look for a reasonable suspicion that there is something out of the ordinary.

MODERATOR What do you do then? You have a supervisor who's not an expert but who has a reasonable suspicion something is wrong. You have legal counsel skittish about potential legal problems there. How do you address the problem without getting yourself into some serious trouble?

Substance abusers are absent 2 1/2 times more often. Sick 3 times as often. And 65% less productive.

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Continued next week

We'd like to hear what you have to say about substance abuse in the workplace, and about our discussions on topics that concern your business. Send your comments to Mike Crall, President, Argonaut Insurance Company, 250 Middlefield Road, Menlo Park, CA 94025.

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INTERNATIONAL

Manville cover dispute cleared for U.S. court

By LOUISE KERTESZ

OTTAWA—The Canadian Supreme Court is sending Manville Corp. and an insurer of a former Manville unit to U.S. court to settle their decade-long insurance coverage dispute.

The court dismissed the request of the unit's insurer to annul its asbestos-related liability insurance policies.

The Canadian Supreme Court's Sept. 13 decision affirms a lower court's ruling that Toronto-based Canadian Indemnity Co. cannot rescind two three-year occurrence-based comprehensive general liability insurance policies it wrote in 1970 and 1973 for Canadian Johns-Manville Co. Ltd. that cover personal injury and third-party property damage claims (*BI*, Nov. 7, 1988).

The policies provided $1 million of per occurrence coverage each year, but Canadian Johns-Manville canceled the final year of the second policy.

The policies also provided product liability coverage with an aggregate limit of $1.3 million annually, according to Manville attorney Paul Sugarman of Heller, Ehrman, White & McAuliffe in San Francisco.

Canadian Indemnity has denied coverage for asbestos-related bodily injury claims against the Manville subsidiary, claiming that Canadian Johns-Manville did not disclose the health risks associated with asbestos.

However, in its ruling, the Canadian Supreme Court found that Canadian Indemnity was at fault for writing the coverage without making an effort to obtain sufficient information about asbestos risks. Blaming the policyholder "for the gaps in knowledge of the risk. . .would certainly amount to bad faith," the court ruled.

The decision enables a 1980 suit Manville filed seeking coverage under the policies and $100 million in punitive damages from the insurer to proceed in California Superior Court in San Francisco, Mr. Sugarman explained.

That litigation had been stayed pending the Canadian court's decision.

Canadian Indemnity is one of 28 insurers that Denver-based Manville sued in the early 1980s seeking coverage for more than 1,000 asbestos product liability claims. Manville has received $870 million in settlements from the other 27 insurers.

These insurance proceeds have been used along with funds from Manville to establish the Manville Personal Injury Settlement Trust, which pays asbestos bodily injury victims.

Manville sold Canadian Johns-Manville—which mined, manufactured and sold asbestos products—as part of its reorganization following bankruptcy in 1982. The subsidiary's insurance assets were placed in trusts.

In a suit filed in Quebec Superior Court in 1979, Canadian Indemnity sought to have the policies annulled, claiming the company had withheld information regarding the health risks associated with asbestos.

The trial judge found in Canadian Johns-Manville's favor in 1985, ruling that information about asbestos risks was widely disseminated and readily available to Canadian Indemnity.

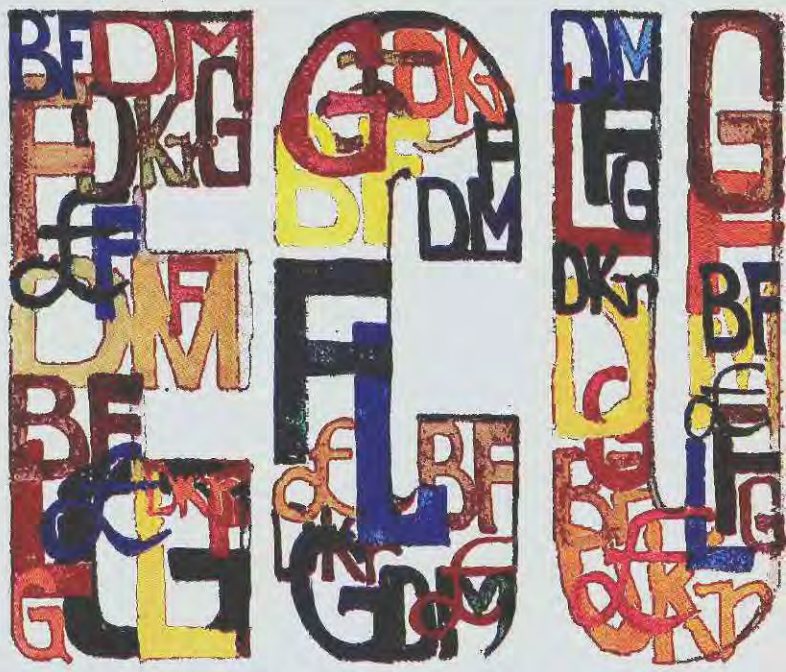
The insurer appealed the decision, but the Canadian Court of Appeal agreed with the trial judge in 1988.

One judge on the appellate court wrote: "All of this published material on the health risks of exposure to asbestos fibers made those risks sufficiently public and notorious so that an insurance underwriter ought to have known of their existence and their seriousness."

The Canadian Supreme Court, noting that the insurer's underwriting standards were lax, affirmed the appellate decision.

"The risk was assessed by an underwriting trainee without experience; none of the plaintiff's underwriters in Montreal where the risk was written or in Winnipeg, where the company's chief underwriter accepted it, had any knowledge about asbestos as such nor about any of the risks involved in the handling of this product; and no research as simple as looking up an encyclopedia was done

Continued on page 16



French insurer offers policies expressed in common currency

PARIS—France's largest insurer, Union des Assurances de Paris S.A., is increasingly offering policyholders the option to purchase policies expressed in European Currency Units as a hedge against exchange rate fluctuations.

UAP predicts that the practice will become more common. European insurers, it said, will see the advantages and stability offered by the ECU, a unit of value based on a basket of European currencies.

The ECU was created in 1979 by eight E.C. nations to stabilize their exchange rates. Currently equal to $1.33, the ECU is based on the currencies of Belgium, Denmark, France, Ireland, Italy, Luxembourg, The Netherlands and West Germany.

UAP says it issued ECU-based contracts to major French companies like Saint Gobain, a Paris-based building materials concern, and Alcatel Cit, a telecommunications company based in Velizy. The insurance contracts express the coverage amounts, the deductibles, and the premiums in terms of ECUs, though premiums are still paid in an equivalent amount of national currency.

According to the insurer, Alcatel specifically requested such a contract after it was hurt by exchange fluctuations in several European nations. The Alcatel Group is trying to introduce the ECU into most of its business dealings as part of an overall corporate strategy, and financial reports are now kept and published in ECUs. ECUs also are used for all budgeting purposes at the company.

The European Commission is keen to encourage the extensive use of ECUs in all financial transactions, particularly as a precursor to the creation of a single European currency. The commission recently suggested that a single currency could be put in place as early as mid-1993.

In the immediate future, the commission will push for all legal obstacles to be removed for the private use of the ECU, so it can be used freely in day-to-day business activities and in all business contracts and so its role can be developed in the issuing of public bonds and in public borrowing operations.

—By Denise Clavelaux

Terrorists attack refinery

Spanish plant damage to exceed $4 million

By MARIA KIELMAS

TARRAGONA, Spain—Property damage losses from a terrorist attack on an oil refinery in Tarragona, Spain, earlier this month will total about 400 million pesetas ($4.1 million), estimates its owner, state-owned oil company Repsol S.A.

A Repsol spokesman said business interruption losses have not been calculated. The refinery was shut down for two days and there were no casualties, he added.

A bomb that had been placed on a rack of 25 pipelines carrying petroleum products from the Repsol refinery to tankers loading facilities on the coast exploded on Sept. 9. The blast wrecked three pipelines that carried kerosene, butane and propane.

Police suspect the Catalonian separatist group, Terra Lliure, is responsible for the attack. It was similar to a 1987 bombing at the same installation, which resulted in physical damage and business interruption losses totaling more than 4 billion pesetas ($40.9 million at current exchange rates).

After the most recent explosion, the refinery's safety system automatically shut down operations, which consequently halted operations at the entire Tarragona petrochemical complex. About 30 Spanish and foreign petrochemical companies have operations there.

The Repsol refinery was activated for a short time on the day of the blast so that petroleum products in the damaged pipelines would burn off. Normal operations at the refinery and surrounding complex resumed on Sept. 11.

By comparison, the 1987 attack shut down the entire complex for 22 days.

The Repsol spokesman said that the oil company's insurance program is underwritten by state insurer Musini Sociedad Mutual de Seguros y Reaseguros in Madrid, although much of the policy is reinsured with underwriters in the world market.

He could not provide further details and Musini would not comment.

Coverage against terrorist acts is provided by the government agency Consorcio de Compensacion de Seguros, the spokesman said.

However, any compensation from the government terrorism coverage would only amount to a percentage of the loss on the basis of actual cash value, not replacement value. ■

BI/HOLLY SEGUINE

No-fault benefit hike proposed

Employers protest New Zealand plan

By KATE McILWAINE

WELLINGTON, New Zealand—Employers are up in arms over a recent government proposal that would impose additional financial burdens on them in order to increase benefits under New Zealand's no-fault accident compensation scheme.

New Zealand employers believe they are already paying a larger-than-equitable share of the cost of the sweeping no-fault system and oppose any proposals to increase benefits.

The unpopularity of the measure also may be contributing to the waning popularity of the ruling Labor Party, which faces national elections on Oct. 27. Prime Minister Geoffrey Palmer resigned earlier this month when opinion polls indicated the Labor Party would be routed by the opposition National Party in the voting.

The accident compensation system, administered by the Accident Compensation Corp., is one of the most comprehensive no-fault systems in the world because it covers individuals for the cost of both work-related and non-work-related injuries.

Under New Zealand law, claimants have no legal right to sue a third party for damages resulting from an accidental injury.

The system is financed with funds collected through an annual levy on employers and the self-employed as well as on owners of motor vehicles.

The government reimburses the system for claims filed by the unemployed and visitors to the country.

The ACC scheme, set up in 1974, replaced "a system of workers compensation and court-based remedies which were widely con-

Continued on page 16

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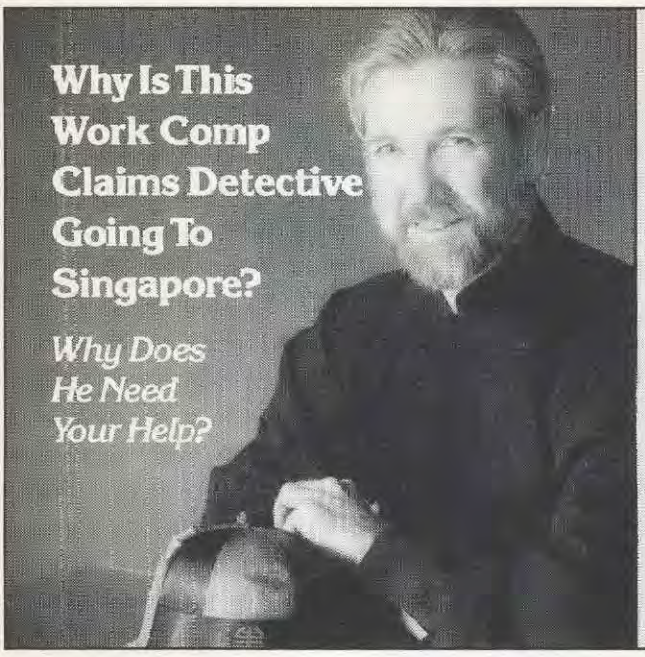

At the end of October, Bill Kizorek, InPhoto Surveillance, will be speaking at the RIMAS/ RIMS Conference. The topic will be claims investigations. Bill is researching the topic by asking claims handlers for input on their most effective cost control techniques. For the brief questionnaire call **800-822-8220 Ext. 62.** For information on attending the conference call Barbara Parker at RIMS **212-286-9292.**

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INTERNATIONAL

Manville

Continued from page 13
by any of them," the Canadian Supreme Court said.

"In short, the proof leaves little doubt that plaintiff accepted the risk almost blindly as far as its possible product liability exposure was concerned, none of the underwriters concerned having stated that they had completely read the (Johns-Manville) 1969 annual report," the Canadian Supreme Court said in its ruling.

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The Canadian Indemnity Co. vs. Canadian Johns-Manville Co. Ltd., Canadian Supreme Court, No. 21265

New Zealand accident law

Continued from page 13
demned as a lottery and in which less than 1% of injured workers ever won real compensation for their losses," said Michael Cullen, the Labor government's associate minister for labor.

However, according to the most recent figures available, employers are responsible for 56.9% of the ACC's funding even though only 36% of the covered injuries occurred in the workplace. The levy on employers for the 1989-1990 fiscal year is $2.45 New Zealand ($1.53 at current exchange rates) for every $100 New Zealand ($62.65) of earnings.

New Zealand employer groups have called for a compensation system under which they pay only for work-related accidents.

However, the Labor Government has proposed widening the coverage offered under the scheme.

Mr. Cullen has proposed extending the scheme to include compensation for illness as well as accidental injury as of April 1, 1992.

In addition, the waiting period for benefits would be increased to seven weeks from one week currently, under Mr. Cullen's proposed scheme.

However, if the injured or ill person is employed, the employer would have to pay 75% of the employee's wages for two weeks, after which the ACC would compensate the injured worker.

In addition, under the proposal, during the first four weeks of ACC wage replacement, an injured or ill worker's employer would have to pay the difference between the benefit and the worker's previous wage.

Making 'employers liable. . .will be an incentive to increase workplace safety,' Mr. Cullen says.

Currently, if an injured person is employed, the employer must pay 80% of his or her wages during the one-week waiting period for benefits.

"Making individual employers liable in this way will be an incentive to increase workplace safety," Mr. Cullen contends.

"It will no longer pay for an employer to skimp on safety measures on the understanding that the ACC or other, more careful, employers will pick up the tab," according to Mr. Cullen.

Peter Duncan, chief legal advisor to the ACC, noted that all the details of the proposal "won't be clear until the legislation is actually introduced."

He said there is a chance the Labor government could introduce the measure before the Oct. 27 election, although it is unlikely to be passed before then.

In addition, the ACC would be renamed the Rehabilitation & Incapacity Corp. if the proposal is implemented.

The opposition party, the National Party, has not indicated whether it would support the proposed changes if elected, according to Mr. Duncan.

However, he said it is unlikely there would be major changes to the ACC's operations if the National Party is elected.

The ACC has faced legal challenges from employers in the past.

In 1988, the New Zealand Meat Industry Assn. challenged the ACC's power to increase levies. A New Zealand High Court decision favoring the industry group was later overturned by the New Zealand Court of Appeal, and that decision was confirmed by the Privy Council in London. ■

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Photo by Elliott Erwitt

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Info

• **"Where in the World is the Coverage?"** explores international exposures associated with businesses and lists extraterritorial coverages available in standard U.S. insurance policies. Using coverage territories as defined in domestic property/casualty insurance contracts, the 32-page report examines each territory to determine if any extraterritorial coverage is provided. The study points out some of the more common problems which may occur if only domestic policies are used to protect international exposures. In the property category, for example, it examines import/export activities, overseas travel, overseas investments, and automobile use. The casualty area looks at product liability, general liability and employer liability. Copies of the study are $10 each, prepaid. Contact the Academy of Producer Insurance Studies, P.O. Box 27027, Austin, Texas, 78755-1027; 800-526-2777.

• The **"Employee Benefits Resource Guide"** is an updated bibliography compiled by the Information Services department of the International Foundation of Employee Benefit Plans. The 29-page guide contains descriptions of employee benefits books, journals, services and databases. Also included are directories of the Department of Labor, Internal Revenue Service, Pension Benefit Guaranty Corp. and the field offices of the Pension and Welfare Benefits Administration. The guide costs $25, including shipping and handling. Prepaid orders for publication ISBN 0-89154-401-1 may be sent to the Publications Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

• W.H. Alger—an agency with over 70 years of specialized insurance experience in the cosmetics industry—has produced a brochure describing **product liability insurance for manufacturers and distributors of skin and hair care products**. The free brochure describes the types of policies available and the advantages of dealing through a specialized agent. Single and multiple copies are available by contacting W.H. Alger Inc., 1500 Waukegan Road, Glenview, Ill. 60025; 708-729-1466 or 800-752-8669.

• **"Workers Compensation Audit,"** a checklist designed to help benefits managers better understand their workers compensation program, is available from Webber Consulting Group Inc. The checklist gives the user a step-by-step, category-by-category method of evaluating their workers compensation function. It includes questions users should ask while examining their workers' comp program as well as questions that should be answered by their insurer or third party administrator. The checklist can also be used in developing performance standards and levels of service for workers comp insurers. Free copies are available from the Webber Consulting Group Inc., 630 Colonial Park Drive, Suite 200, Roswell, Ga. 30075; 800-476-1209.

• Reprints of a report, **"Questions and Answers on Employee Benefit Issues,"** published by the Employee Benefit Research Institute, are now available. The 32-page Issue Brief—a monthly periodical from the EBRI Education and Research Fund devoted to evaluations of a single employee benefit issue—addresses 15 topics, including health insurance costs, flexible benefits, parental leave and the impending retiree health accounting rules. In a question-and-answer format, the report responds to questions such as: How much do employers spend on employee benefits? How common are flexible benefit plans, and what types of benefits are typically included? How prevalent are parental leave benefits, and what are other family-supportive employee benefits? The report also addresses how employers are responding to proposed accounting rules for retiree health benefit liabilities, and the implications for future retiree health benefits. Copies of EBRI Issue Brief No. 102 are available for $19.95 each prepaid from EBRI, P.O. Box 4866, Hampden Station, Baltimore, Md. 21211; 301-338-6946.

• Simon & Schuster's Bureau of Business Practice has published a **"Safety Pays Calendar"** for 1991. The 24-page, 12-inch-by-17-inch color calendar has large blank blocks for each day and provides plenty of room for recording information. The top half has a different humorous safety poster each month, incorporating corresponding safety tips. Calendars are $2.95 each for fewer than 10. Discounts are available for larger orders. Contact Susan Baker, Bureau of Business Practice, 24 Rope Ferry Road, Waterford, Conn. 06386; 800-243-0876, extension 520.

• Reprints of a Standard & Poor's Insurance Rating Services report on the **Nordic insurance market** are now available. According to the 82-page report, the Nordic insurers' relatively mature markets have allowed them to develop a variety of tactics—such as cross-shareholdings, joint ventures and corporate restructurings—to enhance or protect their market positions. The report analyzes nine leading Nordic insurers that have S&P claims-paying ability ratings. S&P also assesses the financial security of 18 other companies in the market. Free copies are available from Standard & Poor's Insurance Rating Services, 25 Broadway, New York, N.Y. 10004; 212-208-1690.

• The American Institute for Property and Liability Underwriters has published the third edition of "Computers in Insurance," a textbook developed for use in the management course leading to the Chartered Property Casualty Underwriter designation. The book, written by Alan J. Turner and James Gatza, provides a concise overview of **insurance automation** and explores the industry's progress in achieving such goals as agency/company interface. The 167-page book costs $10 plus shipping and handling. Contact the Order Department, American Institute for Property & Liability Underwriters, 420 Eagleview Blvd., Exton, Pa. 19341-1115; 215-644-2100.

• The Brokers and Reinsurance Markets Assn., a trade group for reinsurance brokers and underwriters, is issuing its "Contract Wording Reference Book." The volume is a compilation of common **reinsurance treaty clauses**. The book, which will be published in loose-leaf form next month, can be easily updated. The book is available free to intermediaries, cedants and reinsurers and may be ordered from Dow-Jones Irwin, 1818 Ridge Road, Homewood, Ill. 40430; 800-634-3966.

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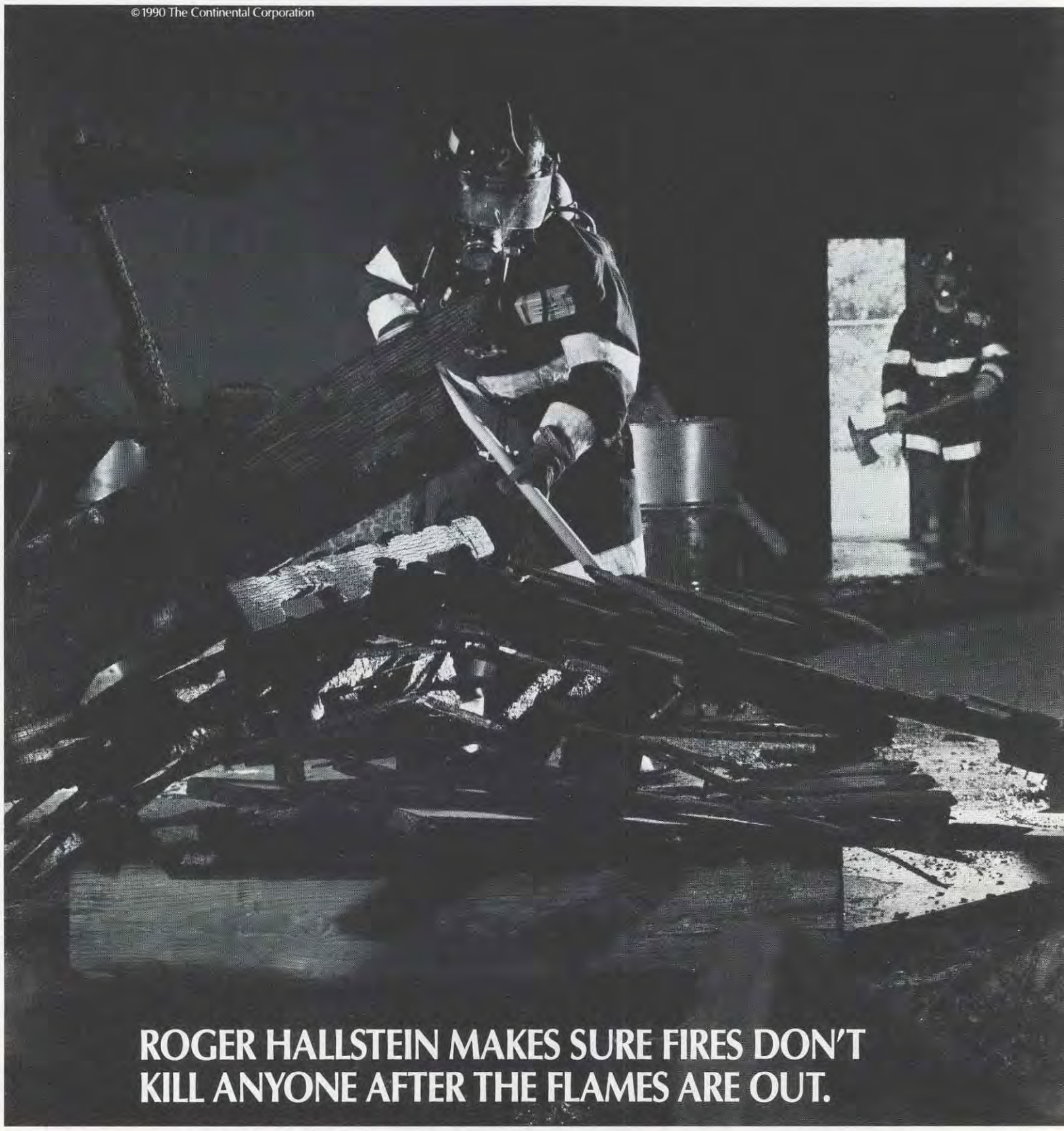


FASB rule

Continued from page 1

Approximately 51% of the respondents were manufacturing companies. Others included banks, other financial service firms, communications companies, retailers and utilities.

The proposed FASB rule would take effect in January 1993. Employers would be required to recognize as an expense against corporate earnings retiree health care liabilities from the date an employee is hired until the employee is eligible for post-employment health care coverage.

Currently, most employers recognize retiree health case expenses on a pay-as-you-go basis.

In addition, retiree health care liabilities must appear on corporate balance sheets (*BI*, Feb. 20, 1989; Oct. 17, 1988).

FASB delayed the compliance date from 1992 after employers balked at the little time they would have had to compile the appropriate financial information under the previous proposed standard (*BI*, July 2).

In the Hewitt survey, 49% of the respondents that offer retiree health care coverage said they had estimated their liabilities under the proposed FASB rule. Respondents based their answers on liabilities for all retirees, not just those associated with their largest plan for salaried employees.

Mr. Laugharn said only the largest employers typically have estimated future retiree medical expenses under the proposed rule. "We think other companies will confront the issue once the effective date gets closer," he said.

Respondents reported higher retiree health liabilities as percentages of payroll, pretax profits and equity. For example, the average cost of future retirees' health care benefits under the FASB proposal would equal 6.25% of payroll, a nearly sixfold increase from the current 1.1%.

Mr. Laugharn noted that expenses would be greater for employers with many retirees or especially rich retiree medical plans.

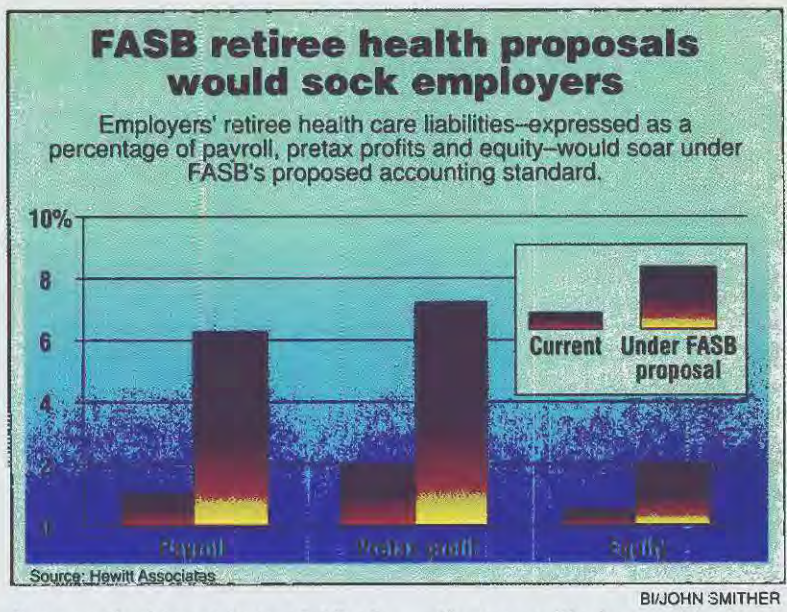
Eighty percent of respondents reported that retiree health care liabilities under the proposal would represent 3% or more of payroll. Only 28% said their current total annual retiree medical plan costs equal 3% or more of total payroll.

The FASB proposal also would have a significant impact on pretax profits, according to the survey.

Employer liabilities for retiree medical benefits would average of 7.5% of pretax profits if the proposal is approved, up nearly fourfold from the current 2%.

"That jump will often be a huge slice compared to current operating margins," Mr. Laugharn said, noting that Hewitt has seen even larger percentage increases among clients.

"Because of the tax impact, these firms are looking at losing 5.5% of their profits—that is going to come right off the bottom line," he said.



BI/JOHN SMITHER

No one really knows how analysts will figure future retiree liabilities into corporate financial profiles, Mr. Laugharn said.

"The irony is that all along the financial community has been saying" that it has taken into account retiree health care liabilities as would be required by the FASB proposal when evaluating a company's financial status. "But this says very directly that reported earnings will drop 5%," he said.

And he pointed out, "if stock prices relate directly to earnings, a decrease in earnings may decrease the stock value" of companies offering retiree health care benefits.

In addition, some companies' equity could drop up to 15% over the next 10 years as a direct result of accruing liabilities for future retirees' health care benefits as an expense against corporate earnings.

Employers' retiree health care liabilities would represent 2% of a company's equity on average under the FASB proposal, a fourfold increase from an average of 0.5% currently, the survey found.

The "additional expense amounts to about 1.5% of equity every year," Mr. Laugharn explained. "We're not trying to seem alarmist on this, but the point is FASB does have an impact on the numbers," he said.

Hewitt found that health care costs for each retiree would jump dramatically if the proposal is adopted.

The median annual plan cost per employee under the age of 65 would more than quadruple to $9,464 from $2,246, according the the survey. For each retiree older than 65, median annual health care costs would increase more than ninefold to $9,464 from $1,033.

Mr. Laugharn pointed out that "younger firms"—or those with a high ratio of active workers to retirees—would be hit harder than "older firms." But the dollar amounts may not differ significantly over time, he said.

"The point is, this is an issue for everyone, not just for industries characterized by a high number of current retirees," he said.

"Employers have been living on credit cards in the past to fund retiree medical (costs), but now they'll have to start" saving money to fund those programs, he said.

One strategy is to raise the amount employees and/or retirees must contribute toward retiree health care costs.

The Hewitt survey found that employers are not only implementing plan changes and cost shifts for future retirees, but also that more than half have changed benefits in the last two years for workers who are already retired.

Design changes reported by respondents pertain only to their largest retiree plans for salaried employees, Mr. Laugharn noted.

About 70% of the respondents with retiree medical plans implemented design changes in 1988 and

Continued on next page

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FASB rule

Continued from previous page

1989 that affected active employees or future hires.

In that same time period, more than half—55%—changed the plans for current retirees, according to the survey.

"Usually you think (employers) can't touch current retirees," Mr. Laugharn observed. However, he pointed out that the changes made were not "drastic" and typically were implemented to keep up with medical cost inflation.

In retiree medical plans for both current and future retirees, employers most often have:

- Increased retiree contributions for dependent coverage.
- Increased deductibles or coinsurance requirements.
- Increased retiree contributions for individual coverage.
- Added utilization management programs.

Employers also have reduced or limited coverage for such benefits as dental and outpatient psychiatric care; have offered retirees a choice of coverage options; and have introduced health maintenance or preferred provider organizations.

Most respondents also reported they intend to introduce cost shifts and other changes in their retiree medical plan in the next two years. Among those respondents, 63% said they plan at least one change that will apply to current retirees.

Most of the changes mirror those implemented over the last two years, Mr. Laugharn pointed out.

Many respondents also expect to implement cost shifts and other changes over the next five years.

For example, 62% said they would "definitely consider" increasing retiree contributions and 24% said they would contemplate contributing a fixed annual dollar amount for retiree health care benefits.

In addition, 39% said they would consider basing contributions to retiree health care plans on an employee's length of service; 32% said they would consider basing benefit levels on length of service; and 28% said they would "definitely consider" tightening retiree health care plan eligibility requirements.

Mr. Laugharn noted that these strategies already have been applied to pension plans and "employers are now waking up to the idea" that they can effectively control retiree health care expenses.

"We were encouraged that there was more of an understanding" by employers that these types of techniques make sense in the retiree benefit arena, he said. "It's promising because it shows people are listening and they know it is an issue."

Employers said they definitely would not consider some changes.

For example, 63% of the respondents said they would definitely not consider eliminating retiree health care benefits altogether.

In addition, 53% said they would not consider increasing retirement benefits while requiring retirees to pay the full cost of health care coverage.

And 24% said they would not limit their contributions to retiree health care coverage to a fixed annual amount.

"There seems to be a strong sense that employers need to participate in providing retiree benefits," Mr. Laugharn noted.

The survey also found that:

- 82% of manufacturers offer retiree health care plans, compared with 74% of non-manufacturers.
- Larger employers are more likely to offer retiree medical plans. For example, 62% of the respondents with fewer than 1,000 employees offer a retiree health care plan, while 90% of employers with 15,000 or more workers provide retiree medical benefits.
- 69% of the respondents offer health care benefits to all of their retirees.
- The eligibility requirements for retiree health care benefits imposed by 60% of the respondents with retiree medical plans are pension eligibility requirements. Among those respondents, 70% said employees must be 55 or older to qualify for retiree medical benefits.
- Employers usually offer retirees the same level of benefits they provide to their active employees.
- Nearly half—49%—of the respondents providing health care benefits to retirees age 65 and older use a Medicare "carve-out" method, under which they reduce benefits by the amount Medicare would pay.
- Less than one in 10 companies currently offer long-term care coverage to their retirees.
- Respondents use a wide variety of methods to determine retiree and employer contributions to the cost of retiree medical care coverage, but most respondents require retirees to make some contribution.

The average monthly retiree contributions for individual coverage is $36 for retirees 65 and younger and $25 on average for retirees eligible for Medicare, the survey noted. Retiree contributions for dependent coverage for these two groups average $55 and $31, respectively.

Approximately 10% of the respondents require retirees to pay the full cost of their retiree health care coverage, the survey found.

- Few respondents said they currently plan to prefund retiree health care liabilities or plan to prefund these obligations in the next two years.

Only 11% of respondents currently prefund their retiree health care liabilities under their largest plan for salaried employees, the survey noted. And 79% said they do not plan to begin prefunding in the next two years.

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Copies of "Survey of Retiree Medical Benefits 1990" will be available for $50 from Cathy Schmidt at Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60069; 708-295-5000.

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Lloyd's going global, Lawrence says

Market makes bigger push internationally

By MICHAEL BRADFORD

DALLAS—Lloyd's of London is prepared to assume a major role as a global insurance marketplace, says Lloyd's Chairman Murray Lawrence.

Technological advances and changes in the European marketplace have set the stage for Lloyd's growth as an international insurer, Mr. Lawrence said at the annual National Assn. of Professional Surplus Lines Offices Ltd. convention in Dallas.

"There is no doubt that since World War II, insurance has become increasingly global," Mr. Lawrence remarked. As it has served multinational companies, the industry has "itself become multinational," he added.

Some 70 countries are represented among Lloyd's membership, according to Mr. Lawrence. And of the 838 insurers operating in Britain, 167 are based overseas, he noted.

"With the advent of the single European market, which for insurance purposes became a reality on July 1, the tendency toward globalization has increased with acquisitions now almost a daily occurrence."

Unable to grow through acquisitions, Lloyd's has been "gearing itself for European business" by completing licensing requirements in most of Europe, he said. European business outside the United Kingdom accounts for less than 9% of the exchange's premium income.

Still, he said, progress will be slow outside the United Kingdom because Europeans may resist the changes accompanying the dropping of commercial barriers.

Europe, with a population of 320 million, "and an average per-capita expenditure on non-life insurance of under 50% of that of the United States, offers great potential," Mr. Lawrence said. But changing attitudes can be difficult regardless of what "freedoms the law may now allow," he added.

As an example, Mr. Lawrence noted that the United States introduced a common currency just after the Civil War. Europe still has no common currency.

"It has taken until now for the European Community to begin seriously to address this problem. Not so at Lloyd's, which I am glad to say, issued its first policy in European currency units, known as ECUs, back in 1987" (see story, page 13).

On the technological side, Mr. Lawrence pointed out that Lloyd's is beginning to use an electronic network that ties together the London insurance market.

He said that since 1987 Lloyd's "has been a major participant in LIMNET, the London Insurance Market Network, which connects underwriters, brokers and most London companies to a common system aimed at improving our service and making London a more efficient and cost-effective market in which to do business" (*BI*, Sept. 3).

Plans are being made to electronically link Lloyd's brokers to their producers in other countries, according to Mr. Lawrence.

Technology also has helped overhaul Lloyd's insurance and reinsurance claims-paying process.

"Lloyd's reputation for the prompt settlement of large and prestigious claims is second to none," Mr. Lawrence said, but payment of "run-of-the-mill losses. . .has, on occasion, not been everything it should be."

As a result of concerns with claims payments, a "unified system" will begin operating in 1991, he explained. "To this end, punched cards, which are about as obsolete as the quill pen, magnetic tape and the inevitable reams of paper are to be replaced by a single route of electronic communication for syndicates, brokers and the relevant claims offices, thereby speeding up and rationalizing the whole settlement process."

Lloyd's also is attempting to mold itself into a more cost-effective and accessible market for intermediaries and policyholders, according to Mr. Lawrence.

The marketplace often is thought of by corporations as one that only handles large and difficult-to-place risks and by the public as an insurer of the unusual, Mr. Lawrence said. "Unfortunately, this has tended to obscure the interest of Lloyd's underwriters in the small- to medium-sized industrial, commercial and personal lines business."

Therefore, he noted, Lloyd's is analyzing "the insurance products people buy" to increase the amount of small- to medium-sized risks and personal lines business its syndicates insure.

"Already we have become active in such areas as public entities, fast food, winter sports programs and even such things as adoption cover in the state of California," Mr. Lawrence pointed out, "which I think shows our readiness to respond to whatever demands are made upon us."

To reach more prospective customers, Lloyd's also is expanding its advertising.

"For the first time, space has been taken in a number of selected publications both at home and abroad to promote what is arguably one of the world's best-known brand names," Mr. Lawrence said of the marketplace. "More activity on this front can be expected in the years to come."

Even as Lloyd's tries to increase its visibility, it also is trying to "counter the adverse publicity which some loss-making syndicates have been attracting," Mr. Lawrence said.

Syndicates that experience heavy losses are held accountable for those losses, he stressed.

"The council, while sympathizing wholeheartedly with the names concerned and assisting them in numerous ways, has no alternative but to require that all underwriting obligations legitimately incurred be fully met. That, in essence, is what the principle of unlimited liability, to which all members of Lloyd's subscribe, really means."

Despite heavy losses by some syndicates, Lloyd's ability to accept risk has not diminished, Mr. Lawrence remarked.

Membership has fallen in each of the last two years. But Mr. Lawrence adds that about 9,000 members have increased their participation in syndicates. "Even more encouraging" are estimates that show fewer members will leave the marketplace in 1991 and more intend to raise available limits, Mr. Lawrence said. ■

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Insurer executive seeks safer products

By MICHAEL BRADFORD

DALLAS—The insurance industry should use its clout as a consumer to demand the development of safe products that would lower legal costs and insurance prices, an insurer executive maintains.

"I contend that the insurance industry is the largest consumer of all," said Gerald Stephens, president and chief executive officer of R.L.I. Corp., a specialty insurer in Peoria, Ill.

"We buy medical services, we buy repair services on behalf of our customers. We must get better at demanding quality, service, dependability and fair prices," Mr. Stephens said.

Moreover, insurers must demand "products that are safe," he said during a panel discussion at the 16th annual convention of the National Assn. of Professional Surplus Lines Offices Ltd. in Dallas earlier this month.

Safer products would reduce the cost of the tort system and insurance, Mr. Stephens said.

For example, automobiles built to withstand crashes would prevent human suffering and its accompanying costs, he said.

"Sure, we have accomplished some improvements, such as seat belts and air bags, through lobbying efforts," he acknowledged.

However, he asserted: "We need to do more."

If a race-car driver can walk away from a 180-mph accident, "why can't we survive a 35-mile-an-hour crash?" Mr. Stephens asked.

He urged individuals in the insurance industry to "join consumer groups who are demanding lower premiums and lead a crusade against unsafe automobiles and other products."

There is plenty of room for safety improvements, agreed Marvin Cetron, president of Forecasting International, a business forecasting firm in Arlington, Va.

Automobile companies, for instance, should include many more safety-related displays on dashboards, similar to the displays found in aircraft cockpits, Mr. Cetron argued.

Such changes are "not that difficult" to incorporate, Mr. Cetron said.

"The people that have the clout are the ones who pay the bills. And that's you," Mr. Cetron said. "He who hath the gold, maketh the rules."

If members of the insurance industry "don't stand up and yell on the basis of ethics, of what's right, no one is going to," Mr. Cetron said.

But if the insurance industry helps stabilize legal and insurance costs, "I see a bright future for those of us who really care about our customers and want to serve those in need," Mr. Stephens said.

"If we continue the media hassle that sounds like greedy lawyers fighting greedy insurance companies," customers may eventually demand a system like one in in New Zealand, he said. "And our future under that scenario is disastrous."

New Zealand has abolished its tort system. "If you're injured in that country, a state-run accident pool pays your medical expenses and loss of wages. No pain, no suffering, no punitive damages," said Mr. Stephens.

If such a system were instituted in the United States, "what would happen to the 400,000 or so employees of the insurance industry no longer needed because casualty insurance no longer exists?" Mr. Stephens mused.

'Why can't we survive a 35-mile-an-hour crash?" Mr. Stephens asks.

"What will happen to all those defense and plaintiffs' attorneys?" he added.

Insurers say a strong lawyers' lobby would derail any similar proposal here. But lawyers, Mr. Stephens noted, say the powerful insurance lobby would quash the idea.

But if auto insurance premiums continue to rise, the public could reach a breaking point and demand a system like New Zealand's, he said.

"It seems to me our industry and the bar have a common interest in preserving the court system or something close to it," Mr. Stephens noted.

"It's got to be a system much more efficient than the one we have now, but a system where the insurance industry is still a player and the lawyers can earn a living."

Mr. Stephens suggested that insurance companies "cooperate with the bar in the search for a fair, efficient system—a system that will provide insurance benefits where they are needed most and for a price that consumers can afford."

Kurt Bingeman, president of wholesale brokerage Russell Bond & Co. in Buffalo, N.Y., moderated the session. ■

NAPSLO takes global view

DALLAS—The National Assn. of Professional Surplus Lines Offices Ltd. took a look at the big picture at its annual conference in Dallas.

This year's conference, titled "Horizon 2000—Global Opportunities," featured seminars on insurance in the worldwide market and a speech by Lloyd's of London Chairman Murray Lawrence that touched on that market's growing international role.

Nearly 2,000 NAPSLO members and guests gathered at the Loews Anatole Hotel just outside downtown Dallas for the September 12-16 meeting.

When the sessions ended, shuttle buses carried convention-goers to the lively West End district where bars and restaurants provided evening diversions.

Next year's conference is scheduled for October 1991 in Los Angeles.

Information on NAPSLO and the 1991 meeting is available from the organization at 816-455-3210.

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E/S status can be 'regulatory ruse': Attorney

By MICHAEL BRADFORD

DALLAS—The surplus lines insurance industry is both a commercial necessity and a regulatory ruse, says a National Assn. of Insurance Commissioners official.

"I think we all know it's both," said David Simmons, general counsel for the Kansas City, Mo.-based NAIC.

"A number" of companies "intentionally avoid regulation in whatever way possible and for numerous motivations," Mr. Simmons said during a panel discussion earlier this month at the annual National Assn. of Professional Surplus Lines Offices Ltd. convention in Dallas.

The panel debated whether insurers and brokers are using the surplus lines industry to avoid state rate and policy form rules that admitted insurers must follow.

"Most of you represent very honest and ethical firms. You're not attempting to intentionally avoid regulation," he told NAPSLO members, adding that those acting ethically must not stick their heads in the sand.

"We all know fraud is abounding out there in the marketplace," Mr. Simmons remarked, "and it's simply not helpful for you to separate yourself from that and say, 'We're not a part of it.' Most of you aren't a part of it and never will be. But many of you know about it and know of colleagues who are engaged in it."

Insurers, like some that are based offshore, lack the proper capital to cover their obligations to policyholders. Yet those companies, he points out, operate with the support of U.S. brokers.

"The surplus lines industry is not perfect," said Joseph Walsh, president of American Empire Surplus Lines Insurance Co. in Cincinnati. "And we are very much concerned about our representatives who do not behave as they should.

"In this room," he added, "there can be only two guilty parties: surplus lines brokers who commit perjury in the execution of surplus lines affidavits and surplus lines company management who allow their companies to be used in a fashion they recognize violates the spirit of the surplus lines law."

William McCartney, Nebraska's director of insurance and chairman of the NAIC surplus lines committee, said concerns about abuses in the non-admitted market began mounting about a year ago.

Regulators saw signs that some admitted companies were shifting business to surplus lines affiliates as a way to circumvent regulatory requirements for rate filings and forms, he said.

"So we looked at that for about six months, and earlier this year we decided to just put it on hold for now," Mr. McCartney said.

"We won't do anything with it, but we'll let the admitted carriers who have surplus lines affiliates know that we have some concern about that. We're hopeful that a word to the wise will be sufficient and there won't be any major problems," he said.

Mr. Walsh pointed out that remedies for the unethical behavior could be stringent.

Subjecting surplus lines insurers to the same rate and form regulation as admitted companies, he pointed out, will have the same effect as would repealing the surplus lines laws or "eliminating the surplus lines industry."

Mr. Simmons of the NAIC said, "I think today, more than ever, there is a responsibility on the regulators and on you to get behind responsible legislation that will correct some of these abuses and get some of these bad players out of the marketplace."

Mr. Walsh contends that surplus lines insurers need freedom from rate and policy form rules to fulfil their roles in the marketplace.

Social changes, like an increased interest in cleaning up the environment, are altering the mix of "traditional and non-traditional" business, Mr. Walsh explained.

Who is better-equipped to respond to these new needs than insurers that specialize in risks with little or no historical data and no established rates? he asked.

Surplus lines—the "product development arm of the industry"—has proven its mettle in such difficult areas as asbestos abatement risks and environmental coverages, Mr. Walsh said. "Risk-taking in these uncharted waters is best accomplished by the surplus lines industry."

And at least until more is known about such difficult and unpredictable risks, freedom from rate and form regulations is important to surplus lines insurers, he remarked.

On another front, Mr. McCartney said there is evidence that some surplus lines insurers are beginning to write business that does not belong in the non-admitted market.

Mr. McCartney said that within the last year he has learned that insurers in "some jurisdictions" are entering markets "no regulator ever thought a surplus lines company would get into."

For example, accident and health business is being written on a surplus lines basis in "one or two states," he said.

While he pledged "great support for the surplus lines market," Mr. McCartney said it is "completely offensive" for a surplus lines company to write health insurance coverages.

"That is not what surplus lines was designed to do," he commented.

He added that such market practices concerns regulator "and especially concern me."

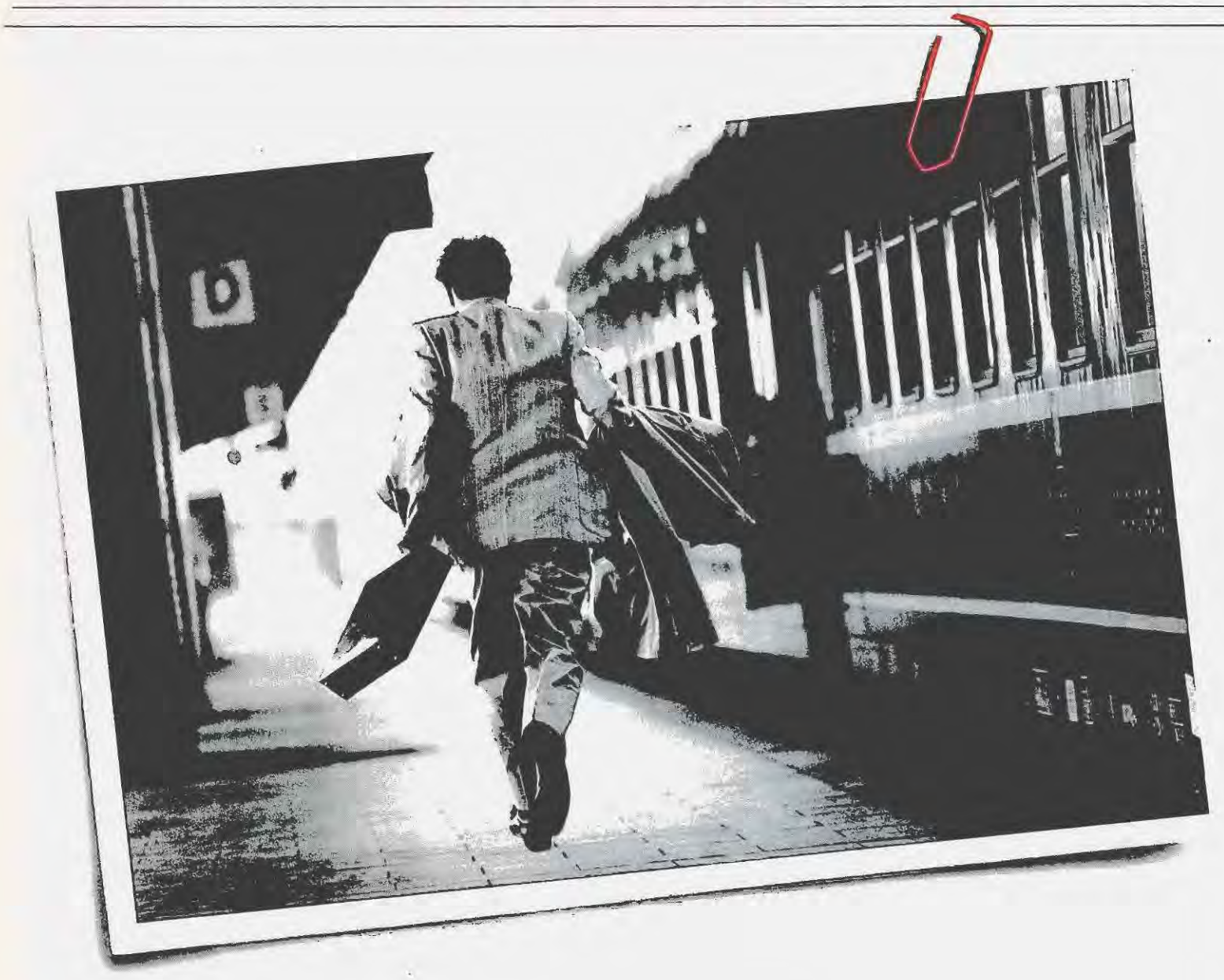
Mr. Walsh said he thinks the surplus lines industry will continue to play a crucial role in the insurance marketplace.

Changes are proceeding that make surplus lines "a far more attractive option than was ever envisioned by its inventors," he said.

For example, he said, the financial strength of surplus lines insurers has made "a hollow threat of the suggestion that a policyholder is exposed by the absence of a guaranty fund. Indeed, in many cases a surplus lines insurer is far stronger financially than its licensed competitor."

The surplus lines market "has and will again play a critical role as the industry goes through its necessary correction" to a hard market cycle, Mr. Walsh said. "We will maintain our importance so long as the market is truly competitive."

Ralph Palmieri, president of First State Insurance Co. in Boston, moderated the session. ■



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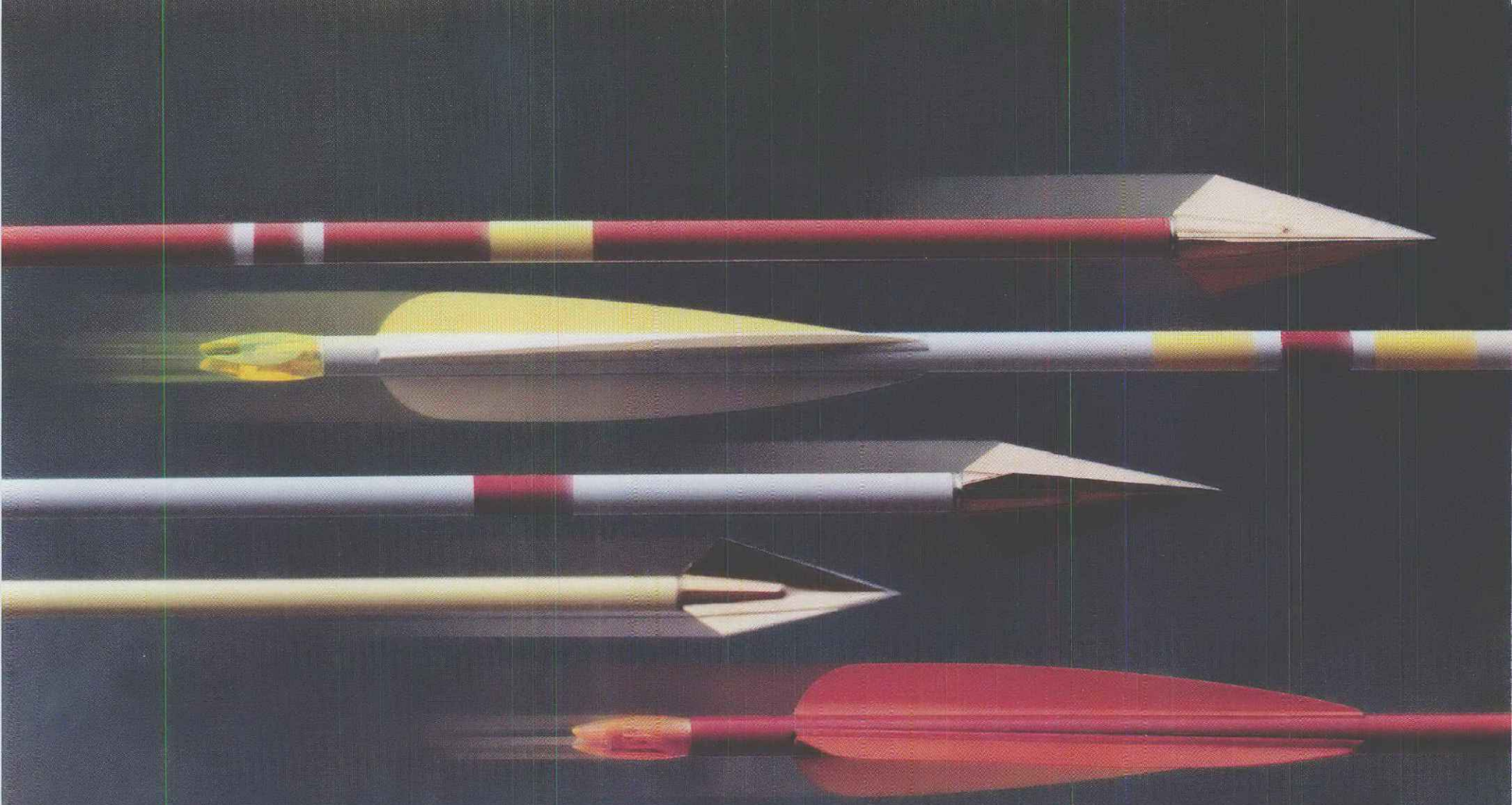

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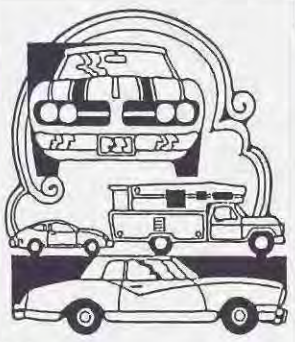

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State comp systems need reform: Experts

Coalitions working in some states

By MEG FLETCHER

NEW YORK—Unless many state workers compensation systems are reformed, grave problems will continue to plague employers, workers, insurers and state work comp administrators say.

However, in a few states, representatives of those groups are optimistic that they have found workable solutions by negotiating to improve the entire system rather than focusing only on their specific interests.

"The system is in great disarray," said Richard L. Thomas, senior vp of American Home Assurance Co., a unit of American International Group Inc.

"By most measures, the workers compensation system is in the worst shape since its inception," he said at the 76th annual convention of the International Assn. of Industrial Accident Boards and Commissions in New York Sept. 9-12.

Related topics also were discussed at the mid-year meeting of the National Council of Self-Insurers, which ran concurrently with the convention.

Employers, insurers, workers and state administrators face challenges on several fronts, workers comp experts noted.

For example, medical costs now account for nearly 40% of all workers comp claim costs. And work comp medical costs tend to rise faster than general medical costs, according to workers comp experts.

In addition, increasing litigation in many states delays delivery of benefits to injured workers and raises costs by involving lawyers in what was designed to be a no-fault process.

When seriously injured workers routinely can obtain larger benefits through litigation, scheduled benefits become merely "a floor" for recoveries, Mr. Thomas said.

Each party to the workers comp system—employers, insurers, workers and administrators—faces its own problems, experts note.

Many insured employers, for example, see rates rise continually as insurers pass off residual market burdens.

One reason for higher residual market costs is fraudulent or unethical employee leasing schemes in many jurisdictions, according to Allyn C. Tatum, a commissioner with the Arkansas Workers Compensation Commission.

Such operations are designed to allow employers with poor workplace safety records to avoid tens of millions of dollars of premiums annually. Regulators and workers compensation insurers are cracking down on these devices (*BI*, June 25).

Some problems are limited to employers in certain states.

New York employers are often brought into litigation that injured workers file against third parties, said Hugh O'Boyle, an attorney with Foley, Smit, O'Boyle & Weisman in New York. For example, if an employee sues a manufacturer of defective equipment, that manufacturer often then sues the employer to try to make it contribute to a settlement or a judgment against the manufacturer.

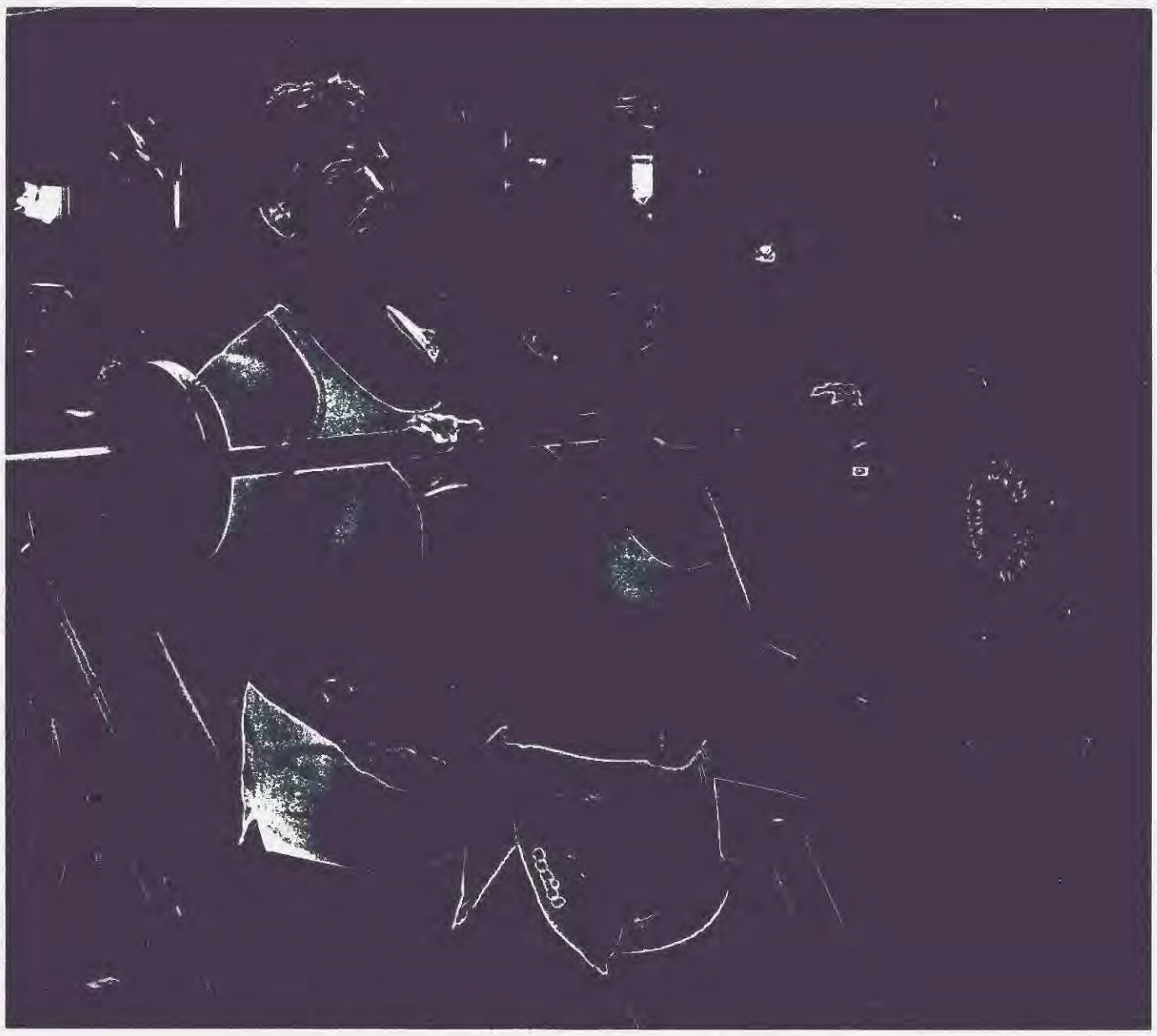
The business community is "disenchanted" with New York's workers comp reform law, which did nothing to remedy this situation, Mr. O'Boyle said. Employers say the law significantly increased workers comp benefits but did little to cut costs (*BI*, July 16).

And an employer lawsuit challenges the legal procedures Pennsylvania uses to decide workers comp cases, claiming they violate a company's right to due process.

BethEnergy Mines Inc., a Bethlehem Steel Corp. unit in Bethlehem, Pa., is arguing in both state and federal courts that state law provides that a workers comp referee need not explain his or her findings on a claim, an attorney said.

BethEnergy also contends that an appellate reviewer must affirm a referee's decision if, upon review, it finds any evidence supporting that decision, regardless of whether it also finds evidence that could support a different decision, Stephen I. Richman of Ceisler Richman Smith in Washington, Pa., said at the National Council of Self-Insurers meeting.

Continued on page 28



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Comp problems

Continued from page 26

Another player in the workers comp system—the insurance industry—primarily is concerned about what it calls inadequate rates in some states and soaring residual market deficiencies nationwide, said American Home's Mr. Thomas.

Insurers also are concerned about state commissions growing more liberal in accepting certain workers comp claims, like those related to stress, after rates were set based on a historically conservative approach, Mr. Thomas said.

Given the long-tail nature of workers compensation claims and the way rates are set, insurers have no good way to go back and collect more money to cover unanticipated claims, said Joseph Edwards, superintendent of the Maine Bureau of Insurance.

Workers, meanwhile, are plagued by inadequate or inequitably distributed benefits in many states.

Injured workers too often "have no voice or no advocate" in the workers comp system, said Hazel N. Dukes, president of the National Assn. for the Advancement of Colored People in New York.

"Workers must become a part of the debate and the action on a compensation system which critically affects their health and well being and that of their families," she said.

The national AFL-CIO is particularly concerned about employers that discriminate against workers and job applicants who have filed workers compensation claims, said Thomas R. Donahue, secretary/treasurer of the Washington, D.C.-based union.

In about half the states, laws do not protect workers from retaliatory discharges, he said.

There also has been an increase in the number of companies that help employers screen out applicants who have previously filed claims, Mr. Donahue noted.

To curb this "pathetic and scurrilous" practice, state agencies should not release workers comp claims information to anyone not involved in the claims process, he said.

Workers also are concerned about the competency of state workers compensation board members, said Edward J. Cleary, president of the New York AFL-CIO. He favors a civil service examination to help ensure that board members are qualified.

The fourth component of the work comp system—state administrators—faces a backlog of cases in several states and often lack adequate resources.

State workers comp officials too often use only written testimony to rule on back injuries and other serious cases because they say they lack the resources to hold a hearing, said Hervey P. Levin, a Dallas attorney and immediate past chairman of the American Bar Assn. unit's Workers Compensation and Employers Liability Committee.

Yet, in state civil courts, juries could spend weeks deciding liability in minor automobile accidents with much lower potential payouts, he pointed out.

Data requests present another problem. Demands for work comp information are proliferating with little or no uniformity in the way requests are made, said Mr. Thomas of American Home.

However, joint efforts by the IAIABC and the National Assn. of Insurance Commissioners to develop standard data collection elements and procedures are a step in the right direction, he said in an interview.

Those groups, though, cannot require respective members to adopt the recommendations, he noted.

"I'm encouraged, but it is not done yet," Mr. Thomas said.

Employers and labor sometimes must consider broad-based solutions to fundamental problems within state systems, experts said.

Reform was possible in California because labor, employers and insurers together were able to hammer out proposals and had the support of a governor who was not seeking re-election, pointed out Alan Tebb, general manager of the California Workers' Compensation Institute (*BI*, Oct. 2, 1989).

Reformers, though, need to remember the "Byzantine" nature of worker comp politics and realize there are many groups—including attorneys, rehabilitation therapists and forensic physicians—who will oppose changes that will reduce their income, Mr. Tebb added.

"Labor and management are the key players in the system," said Richard Schafstall, an attorney with Cincinnati Gas & Electric Co. and Union Light, Heat & Power Co. in Cincinnati.

For example, a key to the 1989 reform of Ohio workers comp system was establishing an oversight board that puts real authority about operational policy and implementation strategies into the hands of employers and labor, Mr. Schafstall said (*BI*, Aug. 21, 1989).

Injured workers too often 'have no voice or no advocate' in the work comp system, says Ms. Dukes.

On the 12-member board are four voting labor and four voting employer representatives, and four non-voting legislative representatives.

"It all operates on the basis of consensus," said John Hodges, president of the Ohio AFL-CIO.

The new board has come under fire for setting the salary of the new executive director of the state Bureau of Workers Compensation at $230,000. That is considerably more than had been paid in the past, Mr. Hodges acknowledged.

However, he said the board felt that the salary was appropriate because it sought a highly competent person to implement the new law in Ohio, where employers either purchase workers comp insurance through the state's monopolistic state fund or self-insure.

In addition, the new workers comp law limited the authority of the five-member Industrial Commission to adjudicating claims. The commission formerly had shared responsibility for administering Ohio's workers comp system with the state's Bureau of Workers Compensation.

The AFL-CIO prefers monopolistic workers comp state funds—like Ohio's—because it believes they are the most cost-effective system, Mr. Donahue said.

Other states can be encouraged by the positive changes in Ohio and California, speakers at the IAIABC convention said.

"The winds of change" appear to be with us again, said Donald Elisburg, executive director of the Occupational Health Foundation in Washington, D.C.

To improve the workers comp system, all sides must seek fair and equitable changes that will restore the no-fault concept and reduce costs, American Homes' Mr. Thomas said.

Efforts to initiate broad-based discussions about work comp reforms were launched earlier this year by the National Council on Compensation Insurance and are continuing through a national workers comp advocacy group organized by Gary Countryman, president of Liberty Mutual Insurance Co. (*BI*, Feb. 26).

Other industry and trade groups are working on similar efforts. ■

Novel challenges to exclusive remedy seen

By MEG FLETCHER

NEW YORK—Employers should expect more and increasingly creative legal challenges to the doctrine that limits employees' compensation for work-related injuries or illnesses to state-approved workers compensation benefits, says a workers compensation expert.

"Attacks on the exclusive remedy doctrine can be expected to continue at an increasing rate, particularly if the size of American civil justice awards and the scope of damages in tort cases continues to expand," said Donald T. DeCarlo, senior vp and general counsel of Commercial Insurance Resources Inc., a New York holding company that provides financial and management services to Primerica Corp.'s property/casualty insurance units.

"What's new is the extent of the attacks and the creative theories used," Mr. DeCarlo said at the 76th annual convention of the International Assn. of Industrial Accident Boards & Commissions, held Sept. 9-12 in New York.

Mr. DeCarlo said the three most significant categories of cases attacking the exclusive remedy doctrine involve:

- Intentional injury or misconduct by the employer.

An intentional act "is one that is not accidental or severs the employment relationship, which provides the basis for a successful tort suit," said Mr. DeCarlo, a former official with both the National Council on Compensation Insurance and the American Insurance Assn.

However, employee suits seeking exceptions to the exclusive remedy doctrine also have been based on an employer intentionally: failing to inform employees about the harmful nature of a product; inflicting emotional distress on workers; defaming workers; and failing to correct safety violations. In addition, suits have been based on injury inflicted by another employee.

'Attacks on the exclusive remedy doctrine can be expected to continue,' warns Mr. DeCarlo.

- Alleged bad faith on the part of self-insured employers or workers compensation insurers for claims handling delays and denials.

"The more rapidly developing issue of employer and carrier liability is whether the self-insured employer or the carrier can be held civilly liable for bad faith for improper processing and investigation of a claim," Mr. DeCarlo noted.

Courts in more than a dozen states have found improper claims handling can give rise to a separate intentional tort and the self-insured employer or workers comp insurer may be held liable for intentional infliction of emotional distress or similar torts, he said.

Those states include Alaska, Arizona, Indiana, Maine, Michigan, Montana and Texas.

- Tort claims filed by an injured worker against third parties. Such a third party—like the manufacturers of a machine involved in a worker's injuries—then sues the employer for its role in the worker's injury.

About a dozen states, including New York, allow such claims, which are known as "third-party-over" claims.

"It appears that in New York, and probably other jurisdictions as well, 'third-party-over' employers' liability costs are escalating," Mr. DeCarlo said.

The New York State Fund, which writes more than one-third of the workers' compensation business in the state, paid out more than $100 million in employers liability cases in 1989, up from $9.2 million in 1983.

The bulk of these cases were third-party-over cases, Mr. DeCarlo said.

In other related claims developments, at least 31 states now consider mental-mental stress—in which a non-physical cause causes a mental ailment—as compensable even if the employee has not suffered a serious physical injury, Mr. DeCarlo reported.

He anticipates that more such "mental-mental" cases will be filed, especially since some recent scientific research found that persons—like some secretaries—who have jobs which hold little authority but are highly stressful are more susceptible to heart attacks.

For example, in a case decided earlier this year in New York, a hospital employee was awarded workers compensation benefits for mental-mental stress because she was unable to cope with her employer's introduction of a new computerized billing system.

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E.J. Noble Hospital vs. New York Workers Compensation Board, Case No. 6870 9272.

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Ignorance proves costly in work comp suits

NEW YORK—Most employers can improve their recoveries against third parties in workers compensation cases, an attorney says.

In such cases, self-insured employers or workers comp insurers may be able to recover at least some workers comp benefit costs if a third party is found liable.

For example, if defective safety equipment is to blame for a worker' injury, recoveries may be possible from the manufacturer.

Typically, an employee has the first right to sue a third party. But, depending on state law, an employer also can sue a third party if the employee chooses not to sue or if statutory limitations for filing such suits are approaching.

"Most companies say they have third-party recovery programs, but a lot of them are not really effective," said Jeffrey M. Kilmer of Allen Kilmer Schrader Yazbeck & Chenoweth in Portland, Ore.

Many workers comp claims handlers lack the background to understand the process, he said at a National Council of Self-Insurers meeting in New York.

In addition, several other factors combine to direct the claims handler's focus away from possible recoveries from third parties.

State laws, designed to deliver benefits to injured employees quickly, often require claims to be processed relatively quickly, Mr. Kilmer noted.

Those laws also can make it difficult for claims handlers to conduct the investigation needed for a good third-party recovery effort, Mr. Kilmer said.

In addition, regulators have been lax in requiring insurers to pare down losses as much as possible, Mr. Kilmer said. Those losses are important because insurers use them to justify rate requests.

Employers should educate and stimulate claims handlers to seek out third-party recoveries, he said.

Only ongoing efforts can ensure that work comp claims handlers don't fall back into old patterns that produce few recoveries, says Jeffrey M. Kilmer. 'The greater the aggressiveness of the claims handler, the more money recovered.'

But a one-time reminder will not suffice, he warned. Employers must follow up with claims handlers to ensure they do not fall back into old patterns that produce few recoveries.

"The greater the aggressiveness of the claims handler, the more money recovered," he said.

A good third-party recovery program should begin with prompt investigation of the accident scene.

The next step is assessing the recovery potential of a claim. In most cases, that can be determined quickly so an employer will know up front whether such a claim should be pressed or settled.

"There is a huge potential for settling relatively skinny claims," Mr. Kilmer said.

A good program also should include computer tracking of filing deadlines.

When the injured employee's attorney has the responsibility to press a good claim against a third party, the employer may find it beneficial to help out with advice and even pay expert witness expenses, he said.

An employer that has a lien against any recovery an employee may make from a third party should be prepared for pressure from judges to reduce that lien amount to speed up the settlement process, Mr. Kilmer said. A good negotiation strategy can help deal with this pressure, he added.

—By Meg Fletcher

Allen elected IAIABC chief

NEW YORK—The newly elected president of the International Assn. of Industrial Accident Boards & Commissions is Reginald J. Allen, chairman and general manager of the Workers' Compensation Board of Nova Scotia.

Mr. Allen was chosen to head the association of workers compensation administrators during the IAIABC's 76th annual convention, held Sept. 9-12 in New York.

Other officers elected to one-year terms are: Allyn C. Tatum of Arkansas, president-elect; Evelyn Scott Ferris of Oregon, vp; and C. John Ehrling Jr. of Pennsylvania, secretary.

Elected as executive committee members were: Steven W. Cavanaugh of Louisiana; Gerald Stuyvesant of New Mexico; Ann Clayton of Minnesota; Robert Anderson of Kansas; and Michael Clingman of Oklahoma.

More than 800 delegates attended the meeting, which centered on the theme: "Workers' Compensation. . .Is It Still Working for the Injured Worker —A Re-examination of the System."

The meeting featured more labor representatives than any previous IAIABC gathering, said Thomas Gleason of New York, the association's immediate past president. The labor representatives emphasized that the workers compensation system was designed to serve injured and ill workers.

During the convention, the association adopted resolutions from two committees as recommendations to members.

The Medical Committee's resolution urged jurisdictions to encourage cooperation between professional provider societies and workers compensation administrators to establish programs to educate providers about their legal obligations.

In addition, the association's Statistics Committee encouraged jurisdictions to adopt uniform statistical reporting methods.

The next IAIABC annual convention will be Oct. 6-9 in Halifax, Nova Scotia.

For information, contact Robert Collyer, Executive Director, International Assn. of Industrial Accident Boards & Commissions, 1575 Aviation Center Parkway, Daytona Beach, Fla. 32114; 904-252-2915.

—By Meg Fletcher

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Non-essential plans: 'Cheap highs'?

Basic medical benefits called key for aging population

By MICHAEL SCHACHNER

BOSTON—Employers must stop focusing on non-essential benefits and work to ensure that the basic medical benefits the aging workforce needs are protected, two researchers contend.

"I think that as the '90s progress, some of the popular benefits of today—day care, referral services and long-term care—will be viewed as cheap highs," said Dallas Salisbury, president of the Employee Benefits Research Institute in Washington, D.C.

"We need to ask if employers are spending too much time worrying about unimportant benefits, non-discrimination tests and tax exemptions when, instead, we should be getting tax preference for the benefits that are essential and offered to everyone," Mr. Salisbury said.

"Health care and retirement benefits will be the leading issues of the 1990s," Mr. Salisbury predicted at the ninth annual employee benefits symposium sponsored by the International Society of Certified Employee Benefits Specialists, held in Boston Sept. 10-12.

In a recent survey of employees nationwide, when EBRI "asked people what would be the one benefit they would want above all others, 67% said medical coverage and 17% said retirement income," he reported.

But, he predicted that employer-provided retiree medical care benefits will shrink this decade.

In addition, he believes that Medicare beneficiaries will be required to pick up a larger portion of their medical costs. Medicare beneficiaries currently pay 25% of their medical care but will have to pick up about 40% by the year 2000, Mr. Salisbury commented.

The 1990s also could be marked as a decade in which even more small employers move away from providing benefits to workers, he warned.

"And, I anticipate that small employers will never offer retiree medical benefits," he said.

In addition, he commented: "Most Baby Boomers we talk to say they want to retire by the age of 52, but only 5% have begun saving. Something has to give in this equation."

Steve Taylor, senior education specialist with Age Wave Inc. in Emeryville, Calif., a marketing/consulting firm, concurred that because of demographic factors, the U.S. population will never be as youth-oriented as it is now.

During the 1990s the number of adults between the ages of 18 and 35 will shrink 14.3% to 60 million from 70 million, while the population between the ages of 35 and 54 will increase 27.6% to 81 million from 63.5 million, according to Mr. Taylor.

"We will definitely be moving to an older population, especially with all the bionic and genetic breakthroughs we have witnessed. Scientists say that the human body could withstand 120 years, and there's the likelihood of unknown breakthroughs," Mr. Taylor commented.

"We are currently redefining the second half of life. This is no longer your father's aging process," he said.

However, the 1990s will mark the "Baby Bust," Mr. Taylor said.

"We'll see what's known as career compaction—or too few jobs with too many chasers. Productivity will become even more imperative than it is today, and the need for educating and retraining older employees to perform different jobs will rise," Mr. Taylor predicted.

Employers that will best be able to handle the demands of an aging population are those that approach the challenge in the same way that National Hockey League star Wayne Gretzky approaches his sport, Mr. Taylor said.

"A reporter recently asked Gretzky why he thought he was the best hockey player ever to play the game, and Gretzky told him that it was because most players skate to where the puck is, while he skates to where the puck will be," Mr. Taylor related.

"That's what I suggest for you. Skate to where the puck will be," he said.

However, the work and family benefits that Mr. Salisbury termed "cheap highs" will continue to be considered vital, legitimate benefits for a workforce that will age and consist of a growing number of women as the 21st century approaches, said Stephen C. Caulfield, a principal with William M. Mercer Inc. in Boston.

"Dependent care is by no means a second-tier benefit," Mr. Caulfield said.

"This benefit—along with incentives for later retirement, health promotion, flexible benefits and long-term care—is here to stay. Stress in the workplace, substance abuse and sedentary lifestyles are all up right now, and the changing workplace needs to address these problems," he commented.

Mr. Caulfield also predicted that health care costs will remain a dominant management problem throughout the next decade.

"There is no national solution on the horizon as far as I can tell," he lamented.

Mr. Caulfield said employers also can expect by 1995 taxes on employee benefits and blossoming employee incentives to participate in employer-sponsored savings plans.

Moderators for the sessions at which Messrs. Salisbury, Taylor and Caulfield spoke were, respectively: Sally S. Welborn, president of ISCEBS and vp-corporate benefits of Union Bank in San Francisco; Roy Gonella, a principal with employee benefits consultant William M. Mercer Inc. in Los Angeles; and Thomas K. Langston, corporate director of employee benefits and services for SSM Health Care System of St. Louis, which owns and manages hospitals in five states. ■

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Older workforce will alter some benefit practices

By MICHAEL SCHACHNER

BOSTON—Come the turn of the century, employers will have to hire and retain more older employees because workers in late adulthood will comprise the majority of the skilled labor force, according to the pension plan manager at a large pharmaceutical company.

Peter J. McCauley, manager-corporate pension and savings plans with Kalamazoo, Mich.-based Upjohn Co., addressed workplace trends during a session at the ninth annual benefits symposium presented by the International Society of Certified Employee Benefit Specialists, Sept. 10-12 in Boston.

The 21st century and its older workforce will also necessitate an end to job discrimination based on age, added Walter F. Jacobson, second vp with Minneapolis-based Northwestern National Life Insurance Co.

"The ageism that exists today in the workplace will have to be eliminated in 10 years," he said.

"It will take a major effort on the part of employers, but they will start to realize that older employees will make up the largest pool of labor. Employers will also have to dispel myths that older workers are less committed, take more sick days and are less productive. That just isn't true," he said.

Employers will also find themselves in the difficult position of having to train more younger, entry-level employees, said Upjohn's Mr. McCauley.

"Forty percent of entry-level jobs will require specialized skills by 1995," Mr. McCauley said. "However, 25% of young people in the U.S. don't graduate from high school and 25% of high school graduates are functionally illiterate, which doesn't make the task an easy one."

The upcoming century will also see individuals assuming more responsibility for their personal welfare, NWNL's Mr. Jacobson suggested. He pointed out that this will require employers to provide more information and tools to help workers achieve their goals.

Employees "will need more information, tools to help them plan, vehicles that aid their lifestyle and assistance to pursue wellness," said Mr. Jacobson.

As the face of the workforce changes, employers will likely reduce the overall level of employee benefits, instead structuring benefits to reward the most productive and those remaining with the company the longest, according to Mr. McCauley.

"I think the need for pay-for-performance will increase throughout the 1990s," he said. "There will be limited resources available for total compensation and employers will make a major effort to hold down benefit growth."

Employers will also cut back on the amount of retirement income they provide as the year 2000 approaches, Mr. McCauley predicted.

"In order to control costs and FASB (Financial Accounting Standards Board) liabilities, employers will encourage employees to retire later. They'll also shift a lot of the cost responsibilities to employees by linking total compensation to performance," said Mr. McCauley.

An increasingly older population —13% of the census population will be older than 65 by the beginning of the 21st century—will prompt employers to replace existing defined benefit retiree medical programs with defined contribution-type programs, Mr. McCauley said, adding that contributions to retiree medical plans will be related to age and service.

However, many employers may simply eliminate retiree medical plans, he said.

Not only will the workforce include more older people in the year 2000, but the number of working women with young children will also increase, said Mr. McCauley.

Currently, about 57% of women with children under the age of 6 hold jobs outside their home. That level should increase to about 64% by the end of the decade, he said.

Therefore, benefits for working parents will become even more popular than they are today, Mr. McCauley said. "Stress hurts the bottom line. Until this is addressed, problems like absenteeism, high turnover and low productivity will continue to plague employers."

While benefits like sick child care, employee assistance programs, resource and referral networks and long-term care insurance are starting to become more widespread, these so-called "benefits of the 1990s" will not be offered by most employers until the next century, said Mr. McCauley.

Roy Gonella, a principal in the Los Angeles office of William M. Mercer Inc., moderated the discussion. ■

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Communicate to support benefit changes

By MICHAEL SCHACHNER

BOSTON—A communications program is paramount in obtaining employee support when redesigning benefits programs, according to an employee benefits communications consultant.

Several factors have prompted employers across the country to revise their employee benefit plans, noted Marjorie Gross, president of consultant Marjorie Gross & Co. Inc. in New York.

A main factor is rising health care costs, Ms. Gross said at a session during the ninth annual symposium sponsored by the International Society of Certified Employee Benefits Specialists. The meeting was held Sept. 10-12 in Boston.

In addition, there are demographic changes in the workforce, and benefit managers are trying to help employees balance their work and family responsibilities.

"There are many more women working, and most households are two-paycheck households. Benefit programs and issues are changing, and it's important to educate employees," Ms. Gross said.

Communications programs are the key to generating maximum employee support, but they don't just happen, she said.

"The key ingredients for success include planning, defining the audience and research," Ms. Gross said. "But at all times, try to keep things short and simple."

Ms. Gross stressed the importance of researching employee attitudes about benefits changes. "Do your homework."

To obtain such information, benefits managers can:

- Conduct surveys.

"You can do random surveys, broad cross-sections or survey everyone at the company, even if all the responses aren't processed," she said.

- Conduct focus groups.

"These are good for measuring attitudes. Don't underestimate the value of focus groups. Responses you get in a group setting are often different from survey responses," because some responses will be different in a group than in a written survey, Ms. Gross noted.

- Set up pilot programs whenever possible.

"Even though these are usually more of a luxury due to the expense, it can be vital if you're implementing flexible benefits or overhauling a plan," she said.

Successfully communicating a restructured benefits program consists of four stages, she said:

- Establishing a budget.

"You need to know how much money is at your disposal" for the program, she said. "For example, while $100,000 may sound like a lot, that's pretty normal."

- Outlining program objectives.

"Once you have money, it must be spent wisely. You can't go hit and miss. You must be focused. Determine whether you're trying to modify behavior or increase participation or deliver bad news."

- Scheduling.

"Playing beat-the-clock is all too common. You don't have to wait until the last minute."

- Assigning responsibilities.

"There's the writing up of materials, graphic design and production. While this can be done in-house, it may require outside assistance. Also, try to define a clear role for the consultant."

Next, Ms. Gross said, those in charge of the project should identify special interest groups and their unique needs.

"A generic presentation isn't always appropriate. For instance, retirees aren't at the worksite and may not be able to view videos. Managers, too, need special information because they become the program's cheerleaders. Managers don't have to become experts, but it's good to make them early supporters of the plan. Administrators also need up-to-date materials," Ms. Gross said.

Logistics of the communications program also must be considered, she said. "Very few workforces are concentrated on one site. You need to decide who'll handle meetings at which locations," she pointed out.

When designing the communications program, be creative, Ms. Gross advises.

"Communications can be looked at as a form of advertising," she said. "The best campaigns are the most creative ones. They're the ones that capture people's attention."

Communications programs also should grab the audience's attention. "You're always competing for attention, so make it brief and creative, Ms. Gross said. "Once you have communicated your message, make sure to reinforce it. That's what turns messages into positive ideas."

But the message has to be earnest, she said.

"Don't try to pull the wool over your employees' eyes," Ms. Gross urged. "So often when companies are cutting back on benefits they disguise it by telling their employees how much they're going to love the new situation. . .If costs are running out of control, tell your employees what has to be done to stop the bleeding."

Videos are excellent for enhancing awareness but not as effective as literature for education and enrollment, Ms. Gross said.

Newsletters are probably the easiest and most cost-effective way to reach employees, she added.

David A. Harvey, senior vp in St. Louis with ALTA Health Strategies Inc., moderated the session. ■

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Benefits unlikely prey in 'revenue' hunt

By MICHAEL SCHACHNER

BOSTON—Neither a tax on employer-paid health care benefits nor several other benefits-related revenue proposals will likely be passed by Congress this year, say two experts.

"Some say that the only way we'll ever see the taxing of health benefits is if it's to fund a universal health care system. And even if that were to happen, the revenues would only cover the federal government's costs," not those of the states, said Phyllis C. Borzi, employee benefits counsel to the House Subcommittee on Labor-Management Relations.

Tax-exempt employee benefits—with a value totaling $47 billion in 1989—are probably safe from taxation for now, agreed James A. Klein, director of the Assn. of Private Pension & Welfare Plans, a business-supported benefits lobbying group in Washington, D.C.

"But it seems that pension benefits are at a far greater risk for taxation than health care benefits. Health care benefits won't be taxed this year, but. . .there's not the political opposition toward taxing pension benefits," he said.

Ms. Borzi and Mr. Klein assessed the legislative and regulatory outlook during separate sessions at the annual Employee Benefits Symposium, presented earlier this month in Boston by the International Society of Certified Employee Benefits Specialists.

"For cash purposes, Congress would like to go after benefits because that's where the money is. They're staring at a $110 billion shortfall to meet the provisions" of the Gramm-Rudman deficit-reduction law, Ms. Borzi said.

The Congressional Budget Office estimates that $50 billion in federal income and payroll tax could be raised over the next five years by taxing employees on employer-paid health care premiums exceeding $100 a month for individuals and $250 for families (*BI*, Aug. 27).

"At the least, Congress needs to come up with $64 billion in additional revenues or else members of the budget committee are going to find themselves sequestered at Andrews Air Force Base until they hash something out. Right now, they're talking about coming up with about $50 billion by cutting almost 40% of the nation's public services," she said, referring to talks held at the air force base outside Washington on how to reduce the budget deficit that continued into last week.

Taxing employer-provided health care benefits is one of three major revenue boosters now being considered, according to Ms. Borzi. The other two are:

'It seems pension benefits are at a far greater risk. . .than health care benefits,' says James A. Klein.

- Taxing short-term profits.

"Taxing short-term profits raises money and can easily be wrapped into policy," Ms. Borzi said. "But it's bad policy in my opinion, and it won't likely be adopted because Congress is instead tinkering with taxing securities transfers."

Such a levy would likely be 7% to 10% of short-term gains, a level that could, according to Ms. Borzi, further destabilize the economy.

- An excise tax on securities transfers, also known as STET, for Securities Transfer Excise Tax.

"This would be the most likely change considering it would be the easiest to market," said Ms. Borzi. "It could be a very low tax, even as low as one tenth of 1%, and it would still raise about $10 billion."

Mr. Klein agreed that billions could be raised with STET, but said such a tax "would wreck the securities market and drive investment abroad."

All three proposals will likely remain on the table at year-end, Ms. Borzi said. "Personally, I don't think you'll see any of these changes. But we could see some smaller things" to raise revenues.

Employers, she said, could soon be permitted to pay for retiree medical benefits with assets from overfunded pension plans.

Under legislation introduced last year by Rep. Rod Chandler, R-Wash., and Rep. Ronnie Flippo, D-Ala., employers would be allowed to transfer—on a one time basis—from a defined benefit plan assets exceeding 125% of plan liabilities without terminating the plan.

"But employers must be aware that this type of move provides a short-term revenue gain only. It can work once, but it's not permanent," she warned.

Meanwhile, no action has been taken on a bill proposed earlier this year by Sen. Nancy Kassebaum, R-Kan., that would have imposed an 18-month moratorium on pension asset reversions. Employers that terminated pension plans would have had to return surplus assets to participants or place them in a trust for 18 months (*BI*, April 23).

Observers said the bill, which was not passed, was designed to give legislators more time to decide whether employers could keep surplus assets after terminating overfunded defined benefit plans.

Ms. Borzi said that Congress would also like to simplify employee benefits regulations because current rules are too complicated.

Current regulations lead to violations, she said, because employers don't understand, and therefore cannot follow, the rules. Government agencies also do not understand the regulations well enough to enforce them.

Peter J. McCauley, manager-corporate pension and savings plans with Upjohn Co. of Kalamazoo, Mich., and Sally S. Welborn, president of the ISCEBS and vp-corporate benefits with San Francisco-based Union Bank, moderated the sessions. ■

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Benefits meeting draws 350 people

BOSTON—The 9th annual employee benefits symposium sponsored by the International Society of Certified Employee Benefits Specialists drew about 350 attendees and speakers to Boston Sept. 10-12.

Next year's 10th annual meeting is scheduled for Oct. 20-23 at the Harbour Castle Westin in Toronto. For information on that meeting, contact the International Society of Certified Benefits Specialists, P.O. Box 209, Brookfield, Wis. 53008; 414-786-8771. ■

U.S. 'heritage' thwarts plan like Canada's

By MICHAEL SCHACHNER

BOSTON—The United States will not adopt a national health care system on the Canadian model any time soon because of different national ideology, predicts the director of a leading U.S. hospital.

And, while a Canadian lawmaker says denial of health care to the poor in the United States is the best reason for the United States to adopt a national health care plan, the head of a conservative think tank contends socialized medicine might create more problems than it would resolve.

"The bottom line is that the two countries are very different. The heritages are such that doing anything the same is unlikely," said Richard H. Egdahl of Boston University Medical Center.

Canadians "show great respect for royalty and authority. Americans don't, which can be best exemplified by our overwhelming rejection of any new taxes, even taxes for necessary services," Dr. Egdahl said at a symposium sponsored by the International Society of Certified Employee Benefits Specialists earlier this month in Boston.

Dr. Egdahl said he believes the Canadian national health care system delivers quality care and that there is an adequate number of providers in the country.

But a similar system in the United States would require billions of dollars in new tax revenues, a prospect that few Americans would embrace, he said.

In addition, the Canadian government pays only 29% of the cost of government-provided health care, while the provinces pay 71%, he pointed out. Imposing a similar burden on U.S. states would be virtually impossible, Dr. Egdahl contends.

Health insurers' lobbying muscle also makes a national health care system unlikely here, he said, noting that creating such a system would destroy much of the U.S. health insurance industry.

However, a supporter of the Canadian national health care system said the denial of emergency services to the poor is sufficient reason for the United States to nationalize health care coverage.

Hospitals denied emergency care to about 330,000 Americans last year because they could not afford to pay, according to David Barrett, a member of the Canadian Parliament.

"There is a large percentage of the U.S. population that is out of the mainstream. They're part of the underclass," he said.

"Without access to basic services, people fight back. When people are rejected, violence is the answer," he warned.

"And, jail provides the best socialized medicine in the United States," he noted.

The president of a conservative think tank conceded faults with the U.S. health care system but contended the solutions lie in expanding free markets.

Indeed, several common arguments for universal health care are "myths," asserted John C. Goodman, president of the National Center for Policy Analysis in Dallas. Those arguments are:

- Nationalized health care controls costs.

"Canada spends 9% of its GNP on health care compared with 11% in the United States. But what that doesn't take into consideration is that the United States has the highest rate of teen-age pregnancies, we do the bulk of the medical research for the world and we have an older average population than Canada," Mr. Goodman said.

- Despite paying more for health care, U.S. citizens do not get more care.

"U.S. hospitals are the best in the world for treating birth defects, and the U.S. treats critical illnesses better than any other country," Mr. Goodman said.

"We have the most advanced technology in the world, too. We perform eight times as many (magnetic resonance imaging scans) and three times as many open-heart surgeries as Canada," he said.

"Other countries delay the purchase of modern equipment to see how they work here first," he noted.

Canada "isn't fascinated with the exotic," Mr. Barrett countered. "We are worried more about people being devastated by catastrophic cases."

- A national health care system guarantees access to care.

However, "very often, universal health care is used as a vehicle for denial of care," Mr. Goodman asserted.

"There are huge waiting lines for surgeries in Canada. For example, heart bypass surgery entails a six-month wait in British Columbia, and other lesser procedures take up to a year," Mr. Goodman said.

- Universal care ensures equal access to care for all citizens.

The poor and elderly in countries with national health care systems lose out to wealthier, more well-connected citizens, according to Mr. Goodman.

Indeed, in Canada, the elderly receive the worst care of all citizens, Mr. Goodman charged.

However, Mr. Barrett argued that Canada neither discriminates against the poor and elderly nor awards privileges to the upper class.

"We are a free, democratic society. Canadians are not dummies who sit back and let government run over them," he said.

If the elected members of Canadian hospital boards perform poorly, they are voted out of office, Mr. Barrett said. "We are sophisticated people. Politicians that oppress get kicked out."

- Nationalized health care would be a more efficient health care delivery system than the current U.S. health care system.

Nothing could be further from the truth, Mr. Goodman asserted. "Health care isn't really efficient anywhere, and it's least efficient when government runs it."

- Limited health care resources are appropriated to where they can do the most good.

However, Mr. Goodman contends that citizens in countries with national health care systems overutilize the system, resulting in inefficiency.

"In Great Britain, for example, they have 21 million ambulance rides annually. That's almost one for every two people. It's crazy. You even have old people calling on an ambulance to take them to the pharmacy to fill their prescriptions," he said.

The session was moderated by Jack VanDerhei, an associate professor at the School of Business and Management at Temple University in Philadelphia. ■

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A few unanswered questions

Widely praised Allied-Signal plan still needs critical analysis

By David Aquilina

THE ALLIED-SIGNAL health benefits plan, called "Health Care Connection," and the company's relationship with CIGNA Corp. are receiving a great deal of national attention in the managed care field. The HCC network is organized around CIGNA health maintenance organizations and eligible employees face strong cost sharing incentives to use participating providers. Many observers hail Allied-Signal's HCC plan as the most innovative and successful arrangement in managed care today and a bellwether for effective managed care in the 1990s.

CIGNA and Allied Signal have made public some summary data on the results of the HCC plan. The reported results for the first 18 months of HCC appear very promising but many important questions remain unanswered. Since the history of corporate health care cost management is like a roller coaster—high expectations for the latest "answer" followed by disillusionment as the cost problem persists—it is important to temper enthusiasm about HCC's very positive initial results with a critical look at some of the major unresolved questions. Moreover, these questions are relevant not only to Allied-Signal's plan but to all companies engaged in such significant managed care initiatives.

HCC began in March 1988. According to Allied-Signal, the plan now covers some 51,000 employees (including 2,900 unionized workers under 18 collective bargaining agreements) and about 76,500 dependents. About 28,000 employees,

It appears that HCC certainly achieved impressive results. . .But since it is still relatively new and involves many major changes in health benefits, important questions are as yet unanswered.

including approximately 12,000 organized employees, are not eligible for HCC. The reported results, however, are based upon an enrollment of 43,000 non-union employees plus roughly 70,000 dependents.

About 75% of those eligible for HCC reportedly use network providers 95% to 100% of the time. CIGNA has said that 83% of the costs incurred by those eligible for HCC are in-network. Physician visits average 4.4 per eligible employee per year for those covered under the plan vs. 2.0 for Allied-Signal employees who are not covered in the plan and remain in non-managed indemnity plans.

The reported hospital use rates are substantially lower for HCC participants.

For example, for all services, HCC-eligible workers seeking care both in and out of the network had 271 inpatient days per 1,000, while the non-HCC employees incurred 562 days per 1,000.

For maternity services, HCC eligibles had 23 inpatient days per 1,000, compared with 27 days per 1,000 among non-HCC employees. And, for mental health services, HCC eligibles had 42 inpatient days per 1,000, while the non-HCC employees logged 175 inpatient days per 1,000.

Likewise, the average length of stay is lower among HCC-eligible workers than non-HCC employees. For all services the average length of stay is 4.8 days for HCC eligibles, compared with 7.3 days for non-HCC employees.

Total per-capita costs for employees not eligible for HCC have not been reported. Total per-capita costs for HCC eligibles are said to be $2,450 vs. a "projected" cost (if HCC had not been implemented)

Speaking out

of $3,200.

It appears that HCC certainly achieved impressive results in reducing utilization and containing Allied's corporate health costs over the first 18 months of the program. But, since the program is still relatively new and involves many major changes in the company's health benefits, important questions are as yet unanswered:

- Possible effects of coverage changes. For example, under HCC, combined in- and out-of-network coverage for mental health/alcohol/chemical dependency treatment is limited to 30 outpatient visits and 30 inpatient days per eligible employee per year (with lifetime maximums of 90 visits and 90 days) with dollar maximums of $15,000 per year and $50,000 lifetime. Prior to HCC, Allied-Signal employees were covered under a variety of plans.

If the new benefits reflect substantially reduced coverage from the previous plans, the benefit design change may have had a strong utilization-reducing and cost-containing effect. (It should be noted that lower mental health utilization accounts for 45% of the reported difference in HCC vs. non-HCC rates of inpatient days per 1,000.) Assessing the direct impact of such important benefit modifications therefore, is important for a more thorough and complete evaluation of HCC.

- Unknown effects of phased implementation. Since CIGNA did not have HMOs in all Allied-Signal locations in March 1988, HCC enrollment was phased in as CIGNA established new networks. If the company had lower prior use and cost patterns in locations with existing HMOs, reported results may be influenced by the fact that lower use and cost locations could have been part of HCC for a longer period of time. Of course, the opposite might also be true if areas with existing CIGNA plans were characterized by above-average historical utilization and cost rates.

The actual effects of the phase-in, based on possible geographic variations in Allied-Signal's prior use and cost rates, are unclear. This issue merits analysis.

- Out-of-network use and costs. Under HCC, 25% of those covered use network providers less than 95% of the time. About 17% of total HCC costs result from out-of-network use.

Little information is available on the range and types of services HCC eligibles seek from non-network providers.

Allied-Signal is still examining out-of-network data in detail. Relevant questions include: Of those 25% who use the network less than 25% of the time, what portions of their use and costs are actually out of network? And, for what specific types of services?

- Impact of switching providers. Large numbers of Allied-Signal employees enrolled in HCC had to switch primary care providers and this varies enormously by location. The impact on the continuity of care is unknown and raises several questions, including: Did the necessity of selecting new primary care providers create time lags in employees seeking care? If so, what was the cost impact?

- Possible "favorable" selection. At the time initial results were reported, HCC did not yet cover unionized workers. Since medical use and cost rates, on average, are higher for union vs. non-union workers, initial HCC results may reflect lower prior use and cost patterns for the employees enrolled in the plan.

Other possible selection effects include potential differences in the age-sex distribution and in the average number of dependents between employees offered and not offered HCC.

The potential impact of a wide range of possible selection effects requires detailed analysis.

- The cost comparison. Most importantly, according to Allied-Signal, the per capita cost under HCC of $2,450 compares to a "projected" cost of $3,200. HCC cost savings are based on a calculation of actual costs vs. these "expected" costs.

The method for calculating the expected costs was to take the prior indemnity plan cost per HCC participant (adjusted for age, sex, geographic location and prior HMO enrollment) and trend the figure by the rate of per capita cost increase experienced by employees and dependents remaining in the company's non-managed

Since the history of corporate health care cost management is like a roller coaster, it is important to temper enthusiasm with a critical look at some unresolved questions.

indemnity plan. This appears to be a fairly reasonable approach but, as Allied-Signal has acknowledged, it is not flawless.

If, on average, those not eligible for HCC had substantially higher prior use and cost experience, the selection effect could certainly have influenced the rate of increase in costs for the remaining indemnity plan experience. If HCC enrollees had lower average per capita costs prior to HCC, their enrollment in the new plan (and consequent removal from the indemnity plan experience) could have automatically increased per capita costs for the remaining indemnity plan.

Thus, selection effects may have biased the rate of per capita cost increase in the company's non-managed indemnity plan upward, thereby inflating the HCC projected cost.

Ideally, it would be better to examine more detailed data, specifically including the actual pre-HCC use and per capita costs of HCC eligibles vs. non-eligibles and previous years' rates of change in their respective prior rates. The key unanswered questions: Before the introduction of HCC, what was the prior utilization and cost experience of HCC eligibles vs. non-eligibles? Before the introduction of HCC, what was the annual rate of increase in per capita costs for HCC eligibles vs. non-eligibles? After the introduction of HCC, what was the rate of increase in per capita costs for HCC eligibles vs. non-eligibles (i.e., did HCC lower the actual rate of increase in per capita costs for HCC enrollees?)?

Allied-Signal in partnership with CIGNA has embarked on a bold course that may be a genuine innovation in managed care. The implementation of HCC, in itself, is an impressive achievement. The reported results seem quite positive and promising and have been widely publicized and uncritically acclaimed—but not critically examined. Many important questions are yet to be answered.

Allied-Signal, recognizing the keen interest in HCC and acknowledging that the plan is still relatively new, intends to release more information as more data becomes available and is analyzed internally. Exploring the issues outlined here would help answer important questions and better enable purchasers, payers and providers to assess HCC, which may indeed be a promising direction for managed care in the 1990s. ■

David Aquilina is a Minneapolis-based consultant specializing in health data and managed care.

Employers face new liability

As firms' role grows in health care area, so do potential risks

By Charles Morgan and Alan L. Sherman

HEALTH CARE PLANS are becoming an increasingly costly and complex burden confronting employers of all sizes. In an effort to control health care costs, many firms are resorting to innovative methods of plan administration. With the advent of cost containment programs, however, the potential risk of liability has expanded to include all those in the health care delivery system. This may include even the unwary employer seeking to control its escalating health care costs.

Thus, the potential liability that may arise when the care provided does not meet the employee's needs must be defined. As will be seen, there are certain situations in which the employer, as well as the health care provider, may be faulted for the quality and consequences of the treatment rendered.

The cost of group health insurance now exceeds $3,000 per year for each covered employee and his or her family. To put this into perspective, this benefit costs a medium-sized employer with 1,000 covered lives about $3 million a year, a figure that probably exceeds many firms' annual net profit.

Historically, the cost of health care was simply passed on from the health insurers to employees through annual premium increases. The double-digit inflation of the 1970s and early '80s finally sparked the demand on the part of employers for remedial action. The business community perceived that health care costs were running out of control and it wanted something done.

In order to control health care costs and meet the needs of the marketplace, utilization review and other case management firms evolved that held out the promise of relief to the beleaguered employer. Such "managed care" programs were initially well received and generally successful in their cost containment initiatives. The positive results achieved were due to pre-admission certification, concurrent and retrospective review and various medical case management programs.

Inevitably, however, such measures created problems of their own. A key consideration in this UR process is the determination of "medical necessity." Those procedures that do not meet this threshold requirement are generally disallowed by the payer. Thus, there is an inherent conflict between the professional delivery of medical care and the "gatekeeper" function of the UR firm. While such determinations as "length of stay" are derived from empirical data, the duration of a particular illness may deviate substantially from the norm. Herein lies the potential for legal liability.

The free hand historically accorded the medical profession has been significantly curtailed in the drive for cost containment. In the pursuit of this goal, the process may not contain adequate safeguards to restrict the overzealous "gatekeeper." In effect, the physician's professional judgment may be compromised, resulting in potential harm to a patient denied treatment.

Who will be held accountable? In the past, the physician and other health care professionals have assumed exclusive responsibility for substandard care. Now, however, to the extent that the employer is involved, it too may be culpable.

An employer may thus be charged with an affirmative duty of securing quality health care for its workforce, whereas in a typical indemnity plan, the employer merely funded the program. Now, however, it is acting effectively to restrict the employee's access to medical treatment.

Such "access" is essentially limited in at least two ways. First, in a preferred provider network, the patient is directed to a restricted panel of providers and he is thus denied his previously unfettered freedom of choice. Second, the patient's prescribed treatment is no longer determined exclusively by his personal physician. The design of the plan and the utilization review firm now play a significant role in the quantity of care provided.

Whereas an employer has no obligation to provide quality health care to its workforce, a plan that contains stringent cost containment measures may serve to create exposures where none existed previously. Thus, a prudent employer must be aware of the inherent risk that it unwittingly may be assuming.

In an effort to minimize such exposures while deriving the benefits of meaningful cost containment, such an employer should perform a medical liability audit.

A medical liability audit consists of identifying potential problems in one's health care cost containment program. Once identified, the problems are rendered more manageable by eliminating factors in the plan that are too restrictive. This thereby minimizes the potential liability exposure.

The possible conflict between controlling costs and providing first-rate medical care can create a liability exposure for the party administering the program. A comprehensive medical liability audit can identify such pitfalls and serve to reduce this exposure to a minimum. ■

Charles Morgan is professional liability manager for Reliance National Risk Specialists in New York. Alan L. Sherman is a health care consultant in Bala Cynwyd, Pa., and an adjunct faculty member at Pennsylvania State University Graduate School of Management.

Determining liability premiums

By The Insurance Institute of America

A.R.M. excercises

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

This month's exercise, drawn from a recent ARM 54 national examination, deals with a very basic model for anticipating changes in insurance markets and for planning responses to such changes. For clarity, the answer explains, rather than merely shows, the appropriate calculations.

Q: Because of the wide swings in Acme Manufacturing Co.'s liability insurance premiums over the past few years, Acme's liability costs will be high, moderate or low in the company's coming fiscal year.

The risk management professional has recognized that the level of the company's liability insurance premiums will depend upon two general factors: first, whether Acme's loss experience during the current fiscal year is good, average or poor; and, second, whether insurance markets are generally hard or soft. The table indicates, for each combination of Acme's current loss experience and insurance market conditions, whether Acme can expect its liability insurance costs to be high, moderate or low.

- Assume for the example shown in the table that there is a 20% chance that Acme's loss experience for the current year will be good and a 70% chance that it will be average. Also assume that there is a 60% chance that next year's insurance market will be soft. Given these estimates, calculate the probability that Acme's liability insurance premiums for the coming fiscal year will be:
  - ✔ High.
  - ✔ Moderate.
  - ✔ Low.

  Show your calculations.
- If Acme's liability insurance premiums are high in the coming year, what recommendation should Acme's risk management professional then make with regard to both of the following:
  - ✔ Changing Acme's retention levels.
  - ✔ Emphasizing liability risk control measures.

A: • Acme's insurance premiums will be high, moderate or low depending on the joint outcome of two events: the condition of the reinsurance market and Acme's loss experience. The 60% probability that the market will be soft implies a 40% probability that it will be hard, since the sum of the probabilities of these two mutually exclusive market conditions must be 100%. Similarly, given that there are only three possible conditions for Acme's loss experience and that their probabilities also must equal 100%, the probability of Acme having poor experience is 10%.

✔ The table indicates that Acme's premiums will be high if two events occur jointly: first, the market must be hard and, second, Acme's loss experience must be either average or poor. Thus, the probability of both a hard market and average Acme loss experience is the product of the separate probabilities of each of these events, or 40% times 70%, which equals 28%. Similarly, for the probability of both a hard market and poor loss experience for Acme is 40% times 10% or 4%. Since average loss experience and poor loss experience for Acme are mutually exclusive events, meaning that they both cannot occur simultaneously, the probability of either occurring in conjunction with a hard market is the sum of their separate probabilities, or 28% plus 4%, or 32%. Thus, there is a 32% probability that Acme's insurance premiums will be high next year, given the assumptions of this model.

✔ Similarly, Acme's insurance costs will be moderate if either the market is hard and Acme's experience is good, or the market is soft and Acme's experience is poor. The joint probability of a hard market and good experience is 40% times 20%, or 8%. The joint probability of a soft market

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Liability insurance costs

Acme's liability insurance premiums depend on its loss experience and the condition of the insurance market.

Loss experience	Condition of insurance market: Hard	Soft
Good	Moderate	Low
Average	High	Low
Poor	High	Moderate

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Liability premiums

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and poor experience is 60% times 10%, or 6%. The probability of one or the other of these combinations occurring is, therefore, 8% plus 6%, or 14%.

✔ Acme's premiums will be low if the market is soft and its loss experience is either good or average. The joint probability of a soft market and good experience is 60% times 20%, or 12%. The probability of a soft market and average loss experience is 60% times 70%, or 42%. Therefore, the probability of low premiums is 12% plus 42%, or 54%.

• Acme may be able to lower its liability insurance costs by raising its retentions, provided its insurer gives reasonable credits for greater retentions. Going completely without any type of otherwise appropriate liability insurance is not normally a prudent way to raise retentions. In contrast, adequate limits of coverage with carefully chosen retentions of limited, more predictable losses remains a sound strategy for making good use of insurance premium dollars.

• Placing greater emphasis on liability risk control is likely to reduce Acme's overall cost of risk from liability exposures, provided that the overall retentions in Acme's insurance premiums and retained losses are greater in the long run than its additional costs for enhanced risk control.

Weighing the present costs of enhanced controls against further benefits of reduced liability losses and insurance premiums requires careful analysis of projected cash inflows and outflows on a present value basis. ■

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.

How to beat insurers in the claims game

"Claims Paid: A Consumer's Guide Through the Insurance Claims Maze"
By Frank R. Dumas
Published by Stratton Press, P.O. Box 22391, San Francisco, Calif. 94122
$15.95

By Kevin M. Quinley

IN POLITICS, high-ranking presidential aides will occasionally leave office and then write a hot-selling book giving the inside scoop on the inner workings of the White House. Critics call these "kiss-and-tell" books.

The risk management equivalent of the kiss-and-tell opus involves former insurance company employees who author guidebooks on how to beat insurers at their own game. In the case of Frank Dumas, claims is the game.

Most risk managers may think they know their way through the insurance claims maze. And, although this book might be targeted to the individual insurance consumer, Mr. Dumas can teach corporate buyers some new tricks on how to maximize recoveries in "Claims Paid: A Consumer's Guide Through the Insurance Claims Maze."

Mr. Dumas is a California-based insurance consultant who has worked at the claims game for 40 years and who definitely knows his subject. His perspective comes from sitting on the other side of the desk, opposite the policyholder. As a result, he knows the tricks of the trade, the right buzzwords to get an insurer's attention—"bad faith" is often a good start—and the levers to press to get results.

Mr. Dumas walks the reader through each step of the claims process, from phoning in a notice of the loss right up to the point of settlement. This is a helpful overview for those risk managers who seek a better understanding of how claims departments function. He dissects their anatomy and also tells readers where to apply pressure to get immediate attention when a claim bogs down. For example, he suggests working one's way up the chain of command, starting with the field adjuster right up to the home office vp of claims.

Should the risk manager hire a public adjuster to wage war against the insurer? Mr. Dumas doesn't give a definite yes or no, but he does suggest treading cautiously in this situation. For starters, public adjusters take a portion of the recovery, in some cases up to 25%. On the other hand, Mr. Dumas notes that many public adjusters "understand obscure policy provisions that many company adjusters are unaware of, provisions that can add many dollars to the insured's claim."

For the risk manager who has exhausted all informal pleas to an insurance company's claims department, hiring an attorney may be the next step. Mr. Dumas lists four key areas where hiring an attorney may be advisable: persistent mistreatment, an examination under oath, appraisals and claim denial. He covers how to choose an attorney, how to negotiate a contingency fee arrangement and how small claims courts work for those who will not hire a lawyer.

Mr. Dumas' book also tells how to avoid blind alleys. For example, he cautions against complaining to state insurance departments. State complaint bureaucracies are slow to respond, he notes. And, in Mr. Dumas' view, these agencies are protective of the industries they regulate. Don't expect much relief by complaining to the insurance commission about a recalcitrant adjuster, he says.

Unlike many authors of so-called kiss-and-tell books, Mr. Dumas has no ax to grind with his former employer. Nor does he advocate policyholders milking claims, bilking insurers or falsifying losses. Instead, he aims to put policyholders on a more equal playing field with insurers in the claims game.

Risk managers need not endure delays, capricious decisions and indifference when presenting claims to insurers. When they have losses, they need help—fast. Mr. Dumas' book strips away the mystery surrounding the insurance claim settlement process and helps risk managers get the insurance recovery to which they are entitled.

For the price of this book, the risk manager can become a recovery specialist and maximize the benefits many companies pay dearly for in the form of insurance premiums. ■

Kevin M. Quinley is vp-risk services for Hamilton Resources Corp. and MEDMARC Insurance Co., both of Fairfax, Va.

Court throws out cumulative trauma awards

Do injuries resulting from repetitive trauma, continuing mental or physical stress or other cumulative events amount to an "injury by accident" within the meaning of the state workers compensation act? Not according to the Supreme Court of Virginia.

The court consolidated three workers compensation appeals, each differing substantially in facts, because it considered the issue noted above common to all as involving significant precedential value. In two of the cases, awards of benefits were made to employees who had suffered myocardial infarctions after performing a work effort. In the third case, an award was made to a worker for a cervical condition that became acute after performing physical labor. The employers all appealed the awards.

The state Supreme Court stated that it had always required proof of an accident, identifiable incident or sudden precipitating event to support a workers compensation claim. In each of the cases here, the court said the injury made its appearance suddenly, at a particular time and upon a particular occasion. But, the court said that was not enough. In order to prove injury by accident, a claimant must prove that the cause of the injury was an identifiable incident or sudden precipitating event and that it resulted from an obvious sudden mechanical or structural change in the body. The court concluded that the claimants here failed to sustain that burden of proof. *Morris vs. Morris*, Supreme Court of Virginia, Nov. 10, 1989 (*BI*/04/Oct.-$10).

Intoxication exclusion

The U.S. Court of Appeals for the 1st Circuit held that Massachusetts' public policy permitted an insurer to exclude catastrophic hospital expenses coverage for a policyholder's injuries resulting from intoxication.

Kenneth Sutherland Jr. was a certificate holder in a group catastrophic hospital plan issued by NN Investors life Insurance Co. Inc. The policy excluded claims arising from any loss resulting from intoxication. His minor daughter was an insured person hospitalized within the policy's general terms as a result of a car accident. It was concluded that she was driving and was intoxicated. The insurer denied coverage. Mr. Sutherland sued. The trial court ruled for the insurer.

On appeal, Mr. Sutherland argued, in part, that the policy exclusion for intoxication was contrary to public policy. The court noted that no cases, anywhere, suggested that it is against public policy to exclude coverage for injuries due to intoxication. "Under the banner of public policy, plaintiff (Sutherland) is saying defendant (insurer) cannot choose not to indemnify the insured for an illegal act," the court said in denying coverage. *Sutherland vs. NN Investors Life Insurance Co. Inc.*, U.S. Court of Appeals for the 1st Circuit, March 1, 1990 (*BI*/05/Oct.-$10).

Defining amount of policy

The Supreme Court of South Dakota ruled that a state law providing that the policy amount of property totally destroyed by a fire would be taken conclusively to be the true value of the property did not apply to an insurance binder.

Wayne Gueke owned a club. In September 1986 an insurance binder was issued providing "all risks" coverage to Mr. Gueke as owner. The binder named Sentinel General Agency as the company. On Nov. 4, 1986, a formal insurance policy was issued by Capitol Indemnity Corp. On Dec. 14, 1986, the club was destroyed by fire. The policy insured the real estate for $175,000 and the personal property for $25,000. A proof of claim was filed demanding a $200,000 recovery. Capitol asserted that it was responsible under state law only for the actual cash value of the property destroyed, here about $71,000. This suit was brought seeking clarification. The trial court ruled for the insurer.

The appellate court said that the term "binder" was clearly not intended to be included within the meaning of the term "policy" as it was used in the state law. *Capitol Indemnity Corp. vs. Bank of Hoven*, Supreme Court of South Dakota, March 7, 1990 (*BI*/01/Oct.-$10). ■

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

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- *Banking and Insurance*
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Reinsurance

Continued from page 3
ance Corp. of New York.

"This problem has been made more acute by insolvencies of ceding and assuming companies and by the ever-growing tail of casualty reinsurance," he explained.

While most casualty insurance claims are known relatively quickly, casualty reinsurance claims often take years to develop, said Mr. Thompson.

"For general liability insurance, primary insurers know 35% of the ultimate claims after one year, whereas reinsurers know only 3.5% of the ultimate claims after one year," he said.

Reinsurers also "have the same problems in recovering reinsurance as do primary insurers, but it's accentuated even more so because the tail is longer," said Bard E. Bunaes, chairman and chief executive officer of Constitution Reinsurance Corp. of New York.

For example, the reinsurer that underwrote a risk in 1970 "may not be around in 1994," said Mr. Bunaes, who also moderated the seminar.

Until recently, reinsurers have viewed ceding insurer insolvency "as an inherent risk of doing reinsurance business," said Mr. Bernstein, the reinsurance attorney.

No more. With the frequency and size of insurer solvencies on the rise, many reinsurers will no longer risk being unable to recoup previous losses by raising premiums in later years, he said.

Instead, they try to recoup "at the expense of the insolvent insurer's estate by reneging on reinsurance contracts," Mr. Bernstein asserted. "They are raising issues of fraud, negligence and late notice by insolvent insurers in an attempt to disclaim liability."

Mr. Bernstein predicts that most such attempts will fail, but only after litigation and substantial receiver expenditures reduce recoveries to the insolvent ceding company's policyholders and claimants.

He also foresees a regulatory backlash from reinsurers refusing to honor contracts and trying to shift much of the burden onto policyholders and claimants. That prospect "should surprise no one aware of insurance history and the fact that all regulation is reactive," said Mr. Bernstein.

Reinsurers try to recoup losses 'at the expense of the insolvent insurer's estate by reneging,' Mr. Bernstein says, noting 'they are raising issues of fraud, negligence and late notice by insolvent insurers in an attempt to disclaim liability.'

Until 1939, he pointed out, "no state required the standard insolvency clause" in reinsurance contracts. The clause requires reinsurers to pay an insolvent ceding company's claims to the company's liquidator without diminution, even if the insolvent insurer failed to pay all or part of its obligations to the reinsurer.

"But when Fidelity Deposit Co. successfully resisted such payment, relying on reinsurance contract language limiting payments to indemnification for 'actual loss,' the New York Legislature dictated that reinsurer credit would not be granted" unless reinsurance was paid in full, Mr. Bernstein explained.

"In 1950, the NAIC adopted this provision, and today 47 jurisdictions enforce it statutorily," he said. "In practice, the provision is enforced in all jurisdictions."

However, regulators still are reacting to reinsurers' refusal to honor their obligations, he said.

For example, the California Insurance Department as liquidator of Mission Insurance Co. is attempting to collect payment immediately from Underwriters Reinsurance Co. for $71 million of incurred-but-not-reported losses, Mr. Bernstein pointed out.

After the California Court of Appeals refused to review a lower court ruling that allowed the liquidator to demand the IBNR loss payments, Underwriters Re said it would challenge the liquidator's demand at trial (*BI*, Aug. 13).

"Had the Insurance Department not been faced with reinsurers' non-payment of their traditional liabilities, it is unlikely that it would be attempting to broaden the scope of such liabilities," Mr. Bernstein said.

Similarly, the NAIC may not have amended the Insurers Rehabilitation and Liquidation Model Act to restrict offsets had commissioners not perceived "a systematic over-reaching by reinsurers in their dealings with insolvent insurers," Mr. Bernstein observed.

Regulators also will scrutinize reinsurer efforts to revoke supposedly irrevocable letters of credit on grounds of alleged fraud by insolvent ceding insurers, Mr. Bernstein predicted.

Reinsurer resistance to honoring obligations, Mr. Bernstein says, likely will prompt increased regulatory action including:

- Establishing a time period after which reinsurance contracts become statutorily inviolable, regardless of fraud or other wrongdoing by the ceding insurer.
- Disqualifying reinsurers from offsetting ceding insurers' obligations based on a pattern of disputing coverage.
- Directly regulating reinsurance transactions, including policy provisions and rates.

And "while regulatory reaction to reinsurance abuses in insolvency situations can be expected, these reactions will only be the tip of the iceberg if the frequency and size of insolvencies are not restrained," Mr. Bernstein predicted.

Regulators are also concerned with the increasing use of captives and other non-traditional risk financing mechanisms that give policyholders immediate access to the reinsurance market, said Thomas S. Case, executive vp of Employers Reinsurance Corp. of Overland Park, Kan.

"Many reinsurers are not prepared to offer the necessary services that primary companies previously provided, such as engineering, auditing and claims handling. If these added responsibilities are ignored rather than recognized and assumed or procured, the overall impact on the reinsurer's results can be substantial," he said.

"This presents an added responsibility (for regulators) to assess the reinsurer's ability to recognize the obligations it has assumed that go beyond merely providing reinsurance capacity," Mr. Case said.

The increasing globalization of the reinsurance market also is likely to heighten regulatory concern, he predicted.

"Traditionally, there have been two major locations where reinsurance has been transacted: Europe —primarily in the United Kingdom —and in the United States," Mr. Case explained.

Today, however, reinsurers in Scandinavia, the Pacific Rim and Australia are becoming more active, he said.

This move toward a global insurance market presents regulators

Continued on next page

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Reinsurance Underwriting Managers

The Lockwood Companies

Continued from previous page
with "the added challenge of interpreting terms of contracts and viability of organizations located geographically afar," Mr. Case explained.

Regulators also will need to consider the potential impact of domestic reinsurers' foreign exposures, he said.

In addition, financial reinsurance, often used to facilitate insurer mergers and acquisitions, also is likely to trigger some regulatory interest, according to Robert A. Spass, president and chief executive officer of International Insurance Advisors Inc. in New York.

Financial reinsurance is a transaction in which anticipated investment income is an acknowledged component of underwriting and in which the reinsurer's ultimate liability is capped (*BI*, May, 14; April 30).

"Given concern over solvency, regulators may be more comfortable if a company acquiring an insurance company purchases (financial) reinsurance as part of the overall transaction," especially if the acquisition target has reserve problems, Mr. Spass said.

For example, in some mergers and acquisitions, reinsurance could be used to protect the insurer's historical loss reserves as well as its projected losses, Mr. Spass explained.

Mr. Spass said that regulators will likely consider such financial reinsurance issues as:

- The credit quality of the reinsurer.
- The adequacy of the reinsurance protection based on the acquired company's historical loss reserves and current market conditions.
- The adequacy of transfer of risk. ■

NAIC gathers in Kansas City

KANSAS CITY, Mo.—More than 1,000 insurance industry representatives attended the 1990 Fall Midwestern Zone Meeting of the National Assn. of Insurance Commissioners, held Sept. 9-12 at the Westin Crown Center in Kansas City, Mo.

The event was co-hosted by Kansas Insurance Commissioner Fletcher Bell and Missouri Insurance Director Lewis E. Melahn.

Those in attendance included 42 insurance commissioners; 18 consumer and academic representatives; five federal government officials; 296 state insurance department staff members; 637 insurance industry representatives; and 15 other state government officials, including three legislators.

The next regularly scheduled NAIC meeting is the group's winter national meeting to be held Dec. 2-6 in Louisville, Ky.

For more information, contact Miriam Heim, Meetings Manager, NAIC, 120 W. 12th St., Suite 1100, Kansas City, Mo. 64105; 816-221-2075.

Foundation focuses on examiners

The Society of Financial Examiners Education Foundation was established in the early 1980s to promote education and training of financial examiners in banking and insurance.

Initially funded by $500,000 donated by insurers and industry groups, the foundation now uses the interest on that fund to finance educational projects, according to Vincent Vaccarello, the foundation's chairman and founder.

NAIC

Mr. Vaccarello is an assistant special deputy to the Pennsylvania Insurance Department and is currently working on the rehabilitation of Mutual Fire Marine & Inland Insurance Co. of Philadelphia.

More than a dozen videotaped programs on topics from life and casualty reinsurance to equity funding and junk bonds have been distributed to insurance departments nationwide through the foundation, Mr. Vaccarello explained.

The programs are intended to "promote more in-depth study of areas key to the financial stability of a company," he explained.

Regulatory agencies are also supplied with TV monitors, videocassette recorders and extensive libraries of study materials like textbooks for accreditation and certification exams.

While the group's founders are all members of the Society of Financial Examiners, the two are separate, sister organizations, according to Paul L. Sweeney, project manager and president and chief operating officer of John Hancock Management Co. in Boston.

In addition to Messrs. Vaccarello and Sweeney, other foundation trustees are:

- John B. Kline, secretary/treasurer and co-founder, who is deputy commissioner of banking and finance for the Georgia Insurance Department.
- Christy P. Armstrong, funds coordinator and co-founder, who is an executive consultant with Coopers & Lybrand in San Francisco.
- Roy D. Bess Jr., NAIC liaison and co-founder of the foundation, who is vp of Provident Life & Accident Co. in Nashville, Tenn.
- Richard A. Gregg, trustee and co-founder, who is former chief examiner for the Ohio Insurance Department and now owns Regulatory Insurance Consultants Inc. in Columbus, Ohio.
- E.J. Voorhis, trustee and co-founder, and who is now retired. He is a former Texas insurance commissioner.
- Morton L. Mann, trustee, who is vp and chief of operations at Trinity Square Services Inc., a New York company that provides runoff services to insurers.

For more information on the foundation, contact Vincent Vaccarello at the Mellon Independence Center, 701 Market St., Second Floor, Philadelphia, Pa. 19106; 215-592-800.

—By Joanne Wojcik

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NAIC may issue model law on small group health plans

By JOANNE WOJCIK

KANSAS CITY, Mo.—State regulators for the first time are acting to inhibit rating practices that limit availability of health insurance for small employer groups.

At its December meeting, the National Assn. of Insurance Commissioners is expected to adopt a draft model law on small group health insurance rating practices.

The model law aims to eliminate "abusive rating practices" by insurers that underwrite plans for groups of 25 or fewer employees. It was approved to be made available for public comment by the Accident & Health Committee at the NAIC's Midwestern Zone Meeting held Sept. 9-12 in Kansas City, Mo.

Some provisions of the new act may have appeared in other legislation, but this is the first time the commissioners have specifically addressed small group rating practices, said Earl R. Pomeroy, NAIC president and North Dakota insurance commissioner.

"The intent is to prohibit certain activities occurring in the small group market today that are contrary to the legitimate interests of the public," according to Mr. Pomeroy.

Among the targeted practices are "tier" and "durational" rating.

In tier rating, the claims experience of a group is used to determine its premium at renewal. The NAIC opposes tier rating because, in some cases, rate increases based on claims experience have been excessive.

Durational rating occurs when insurers competing for business by offering low rates in early years build in rate increases if the group continues with the insurer.

In addition to limiting rate variations within certain classes of business and capping annual premium hikes, the model act also requires insurers to disclose rating practices to purchasers and establishes rules for continuity of coverage.

The model act was initially presented in testimony to the House Subcommittee on Antitrust, Impact of Deregulation and Privatization in August, explained Greg Claxton, an NAIC staffer for the accident and health panel.

Minor changes were made at a meeting of the Group Health Rate Review Working Group held during the zone meeting.

The model act's most sweeping provision is to limit current rating practices.

The intent is to ban practices 'contrary to the legitimate public interests,' says Earl Pomeroy.

Premiums for small group health plans would be subject to the following provisions:

- Rates may not vary more than 25% from the midpoint of any class of business.
- The midpoint rate of any class of business cannot be more than 25% higher than the lowest-rated class of business.
- Annual increases cannot exceed the medical inflation rate plus 15%.

"The overall rate bands are designed to assure that rates will not vary excessively within a class of business or within the insurer's entire book of small group business," David Lyons, acting commissioner in Iowa, testified before the House panel in August.

And the model act would require small group health insurers to include the following information in contract and promotional materials:

- Any factors, including claims experience, health status or duration of coverage, that could affect rates.
- The class of business into which the group is or would be placed.
- Conditions that affect renewability.

"Disclosure of these factors should enable small businesses to make more informed purchases of group coverage and to better understand how their rates may change at renewal," Mr. Lyons testified.

A small group insurer also will be required to maintain at its principal place of business a complete and detailed description of rating and renewal underwriting practices, including proof that its rating methods are based on sound actuarial principles.

And health insurers will have to file an actuarial opinion certifying compliance with the model act with state regulators each March.

The model law allows underwriters only these reasons for

Continued on next page

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Continued from previous page
refusing to renew small group health coverage:

- Non-payment of premiums.
- Fraud or misrepresentation by an employer or an insured individual.
- Non-compliance with plan provisions.
- The number of individuals covered under the plan is less than the plan's minimum enrollment requirements.
- The small employer is no longer active in the business in which it had been on the plan's effective date.

Small group insurers could, however, opt to stop renewing all plans on a certain class of business.

Those insurers choosing to do so will be barred from establishing a new class of business for five years.

The NAIC tackled a host of other issues at its recent zone meeting, including:

TPA model act revised

Revisions to the 1977 Third Party Administrator Statute that address licensing of multistate operations were adopted by the NAIC's Life and Health Committee.

"We did some wholesale rewriting," said Greg Claxton, the NAIC staffer for the committee. "Before, the TPA model act didn't specifically address the issue of multistate operators."

Among the changes were:

- If a TPA is licensed in one state with standards at least as stringent as the model law's, no further licensing would be required.
- If a TPA takes on a national account with one employee in a state other than its principal place of business, it will not be required to be licensed in that state unless 5% of the employer's workforce or 100 employees—whichever is smaller—resides in that state.
- The insurer, and not the TPA, will hold title to records.

This last provision is intended to eliminate problems that arise when a TPA severs business ties with a particular insurer, explained Bob Johnson, director of the Division of Insurance Services at the Florida Insurance Department.

Previously, this issue was only addressed in contracts between TPAs and insurers, according to Mr. Claxton.

Solvency regulation

The Examination Oversight Committee heard a report from the Potentially Troubled Companies Working Group during a closed-door executive session.

In addition, the Standards Committee plans to complete audit procedures for determining whether insurers meet minimum regulatory solvency standards before an NAIC meeting in December, according to Mr. Pomeroy.

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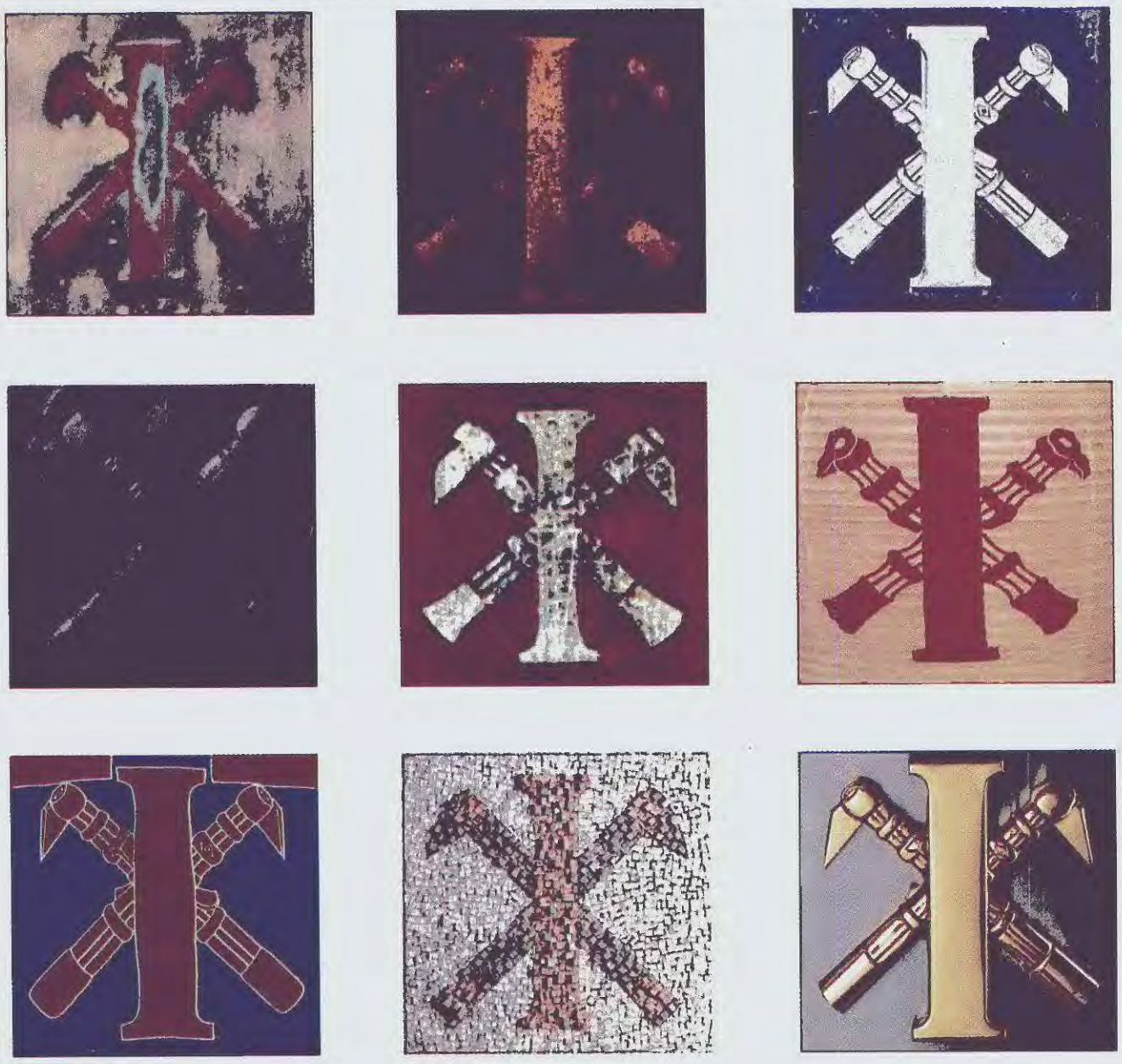

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Residual, voluntary service similar: NCCI

By JOANNE WOJCIK

KANSAS CITY, Mo.—Claims-handling services provided to residual market workers compensation risks are comparable to those provided to the voluntary market, the National Council on Compensation Insurance reports.

But tremendous residual market growth in the mid- and late 1980s has stretched many insurers to the limit, forcing them to hire and train new staff to handle mounting claims, the NCCI says.

These were the findings of an ongoing audit of residual market claims-handling practices presented to a task force at the National Assn. of Insurance Commissioners' Midwestern Zone Meeting Sept. 9-12 in Kansas City, Mo.

"NCCI's claim audit staff has, with very few exceptions, found that servicing carriers are making every effort to provide pool risks with the same level of service rendered to their voluntary business," said Robert B. Dorsey, assistant vp of the NCCI in Boca Raton, Fla.

Indeed, work comp claims adjusters at Continental Corp. in Cranbury, N.J., don't distinguish between residual and voluntary market claims, Vincent Kivlen, vp-corporate claims, told the NAIC's Workers Compensation Task Force. "Regardless of where a claim may arise from, there are a number of issues regarding medical care and cost that are the same."

Continental applies to comp claims a managed care approach similar to that used to treat health care claims, he explained. "Obviously we're concerned about costs, but the end result is to get the most appropriate care."

Residual market claims handled by Continental surged 29% in the first six months of 1990 and now make up 27.7% of the new work comp claims it handles, he said.

In response to a 137% surge in residual market claims since 1986, Travelers Insurance Co. has added more than 500 employees to its workers comp claims-handling staff, Michael R. Costigan, director of workers compensation claims, told the task force.

Hartford, Conn.-based Travelers will invest $25 million in hiring and training workers compensation claims staff by year-end, he added.

The explosion in residual market claims "has completely stretched resources and quality," says Mr. Costigan. "We are very committed to being part of the solution and not the problem."

Like Continental, Travelers does not differentiate between residual and voluntary market workers compensation claims, he said.

Generally, it is difficult for the claims-handling staff of many insurers to know whether a claim is from the residual or voluntary market, the NCCI's Mr. Dorsey pointed out.

"Documentation found in the claim files of many carriers makes it difficult for carrier claim staff to easily determine whether or not the risk is from the residual market," he explained.

Most manuals, for example, have only one set of claim procedures. "Where residual market procedures are found in the carrier manual, it is generally because the (assigned risk) pool performance standards establish the need to provide. . .a higher level of service," he said.

And, in the few instances in which insurers have special units, it is usually because they have a large volume of assigned risk business, Mr. Dorsey explained.

Despite the NCCI findings, the erroneous perception exists that claims-handling service provided to residual market risks is inferior to that in the voluntary market, Mr. Dorsey says.

For example, an employer new to the residual market may find that the insurer to which it is assigned has different claims-handling procedures than that of its previous workers comp insurer.

And high claims volume in the residual market means most workers comp claims are handled by telephone rather than in person.

"Finally, whether we like it or not, there are some characteristics about many residual market risks that make claims handling more challenging and sometimes make the claims more costly," Mr. Dorsey asserted. Among those features are delayed reporting of incidents and lack of cooperation with employers.

"Our audits reveal that many residual market risks fail to report incidents to the carriers within a reasonable time frame," he said.

Part of the reason may be that many employers using the residual market are small and do not have personnel specifically handling work comp claims reporting, explained Continental's Mr. Kivlen after the presentation.

'Carriers are making every effort to provide pool risks' with equal service, Mr. Dorsey says.

Small employers also are not easily persuaded to rehabilitate injured workers.

"The employer may be unwilling to devote the necessary time to carry out ongoing contact with the employee, making sure the employee knows that there will be work available when he or she is able to return," Mr. Dorsey explained.

Or, light-duty jobs may be unavailable and, even worse, employers may no longer need the work an injured employee previously did, he added.

Since the average premium paid by employers in the residual workers compensation market is small —just $4,435 in 1989—the size of these employers must be small, Mr. Kivlen pointed out.

"To have an injured person come back on light duty would sorely tax those employers," he observed.

The NCCI report is part of its Servicing Carrier Claim Audit Program, which was launched in 1988 to study how well workers comp insurers meet the terms of their contracts with assigned risk pools. The audits are conducted on-site every three to four years.

An expansion of the program is planned for 1991 to provide for more frequent audits, including annual audits when needed, according to Mr. Dorsey.

The NCCI administers residual market plans in 33 states. It also administers 17 active and inactive pools, the largest of which is the National Workers Compensation Reinsurance Pool that reinsures all residual market coverage in 31 jurisdictions. In addition, NCCI administers statutory pools in Maine and New Mexico. ■

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Small firms lag on computer use in benefits

By DEBORAH SHALOWITZ

Technology is helping human resources departments substantially improve their productivity, according to a new survey.

However, small companies still lag behind larger ones in computerizing areas like employee benefit plan administration, according to a report by KPMG Peat Marwick, a large accounting and consulting firm.

"There is a wide variation between companies of all sizes in terms of to what extent they're using technology in the human resources area," said Charles F. Miller, a KPMG regional partner in Dallas who directed the survey.

Of the 287 senior-level human resources executives who responded, 30% worked for companies employing fewer than 500 workers; 43% were from companies with 500 to 5,000 workers; and 27% were from companies employing more than 5,000.

Companies that have integrated their payroll, personnel and benefit systems reported getting human resources information to the chief executive officer 10 times faster than those that had not integrated the three functions, KPMG found.

Forty-seven percent of medium-sized companies have integrated payroll, personnel and benefit systems, compared to 40% of large companies and 29% of small companies, according to the survey.

Only 20% of large companies and 22% of medium-sized companies have completely separate systems for payroll, personnel and benefits information, the study found. But twice as many—41%—small companies said the functions were completely separate.

Only a few executives—9% of those from large firms; 8% of those from medium-sized firms and 3% of small-company executives—said only personnel and benefits systems were integrated.

One way to convince top managers that human resources are critical is to get them involved in planning, says Charles F. Miller of KPMG Peat Marwick. 'Once you get them to spend some time, they generally see the importance.'

And even fewer—5% for large and 2% for small and medium-sized firms—said payroll and benefits systems were integrated.

Survey respondents said requests from senior and line managers take up 44% of their time and 30% is spent on inquiries from other employees.

Another 15% is taken up by requests from the budget and finance department; 6% by requests from retirees; and the other 5% by requests from various others.

Among those responding, 36% said they invested in technology to gain faster access to human resources information and 22% cited improved service to senior managers.

Other reasons they invested in technology were: reducing operating costs, cited by 16%; improving service to employees, 14%; improving service to line management, 11%; and improving service to retirees, 1%.

Mr. Miller noted that budget constraints often leave human resources departments last in line for funding for technology.

"Top human resources officials need to persuade their boss or the CEO that (human resources) is a critical area," he continued.

One way to do that is to "get the CEO involved in human resources planning," he suggested. "Once you get them to spend some time, they generally see the importance."

Employee compensation and benefits make up 60% or more of a typical company's operating budget, according to Mr. Miller.

Even so, small companies still lag far behind their larger counterparts in computerizing human resources departments, according to the survey.

Ninety percent of large companies surveyed have computerized most payroll and reporting tasks for personnel, compensation and health plans, according to the survey. Only 30% to 40% of the small companies said they have computerized these same areas.

In the health benefit administration area, small firms also lag behind their larger counterparts, the survey found.

However, the reported figures can be misleading, the survey warns, because many companies use third-party administrators and consultants to perform key benefit administration functions and these organizations generally are computerized.

In the health benefit administration area, 33% of small companies have computerized reporting capabilities. For medium-sized and large companies, that figure is 66% and 88%, respectively.

And, 13% of small companies reported computerizing benefit statements, compared to 39% of medium-sized companies and 61% of large companies.

Similarly, 13% of small companies, 32% of medium-sized companies and 63% of large companies have computerized health claim processing, the survey found.

A fifth of small employers reported computerizing records on plan eligibility, compared with 59% of medium-sized employers and 88% of large employers.

Administration of the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 was computerized in 18% of small firms, 47% of medium-sized firms and 68% of large firms.

Among all sizes of companies, the most frequently computerized health benefit administration function was a payroll deduction for an employee's contribution toward a health insurance premium. It was cited by 46% of small, 79% of medium-sized, and 88% of large companies.

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Single copies of "Human Resource Information Technology in the 1990's" are available from Pam Germano, KPMG Peat Marwick, 1601 Elm St., Suite 1400, Dallas, Texas, 75201; telephone 214-754-2000. Single copies are $95; two to four copies are $70 each; five to nine copies are $50 each; and 10 or more copies are $40 each.

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State regulation

Continued from page 1

"The regulatory system cannot adhere to the principles of solvency—adequate pricing, adequate reserve levels and reliable reinsurance—while requiring that premiums be set below costs," Mr. Vagley maintained. "That priority should not be diluted by politically expedient, but otherwise unsupportable, rate levels."

In some states, "unwarranted rate rollbacks" are combined with "lock-in" provisions that limit the insurer's ability to withdraw from a market, he noted.

"This combination not only prevents an insurer from earning a reasonable rate of return but also prevents the company from voluntarily leaving an unprofitable market," he observed. "Such restrictions could have lasting, adverse effects on insurer solvency."

Mr. Vagley recommended eliminating these "impediments to the free flow of capital." Instead, he suggested designating certain states that meet federal regulatory standards as "ports of entry" for insurers, with no limits on their freedom to exit the market.

Ken Heinen

George Shaffer, left, of the IIAA, and Harry A. Koch Jr., of NACSA, testify before the House Oversight & Investigations Subcommittee.

Another possibility, he added, would be to establish federal certification for insurers and reinsurers doing business in the United States, again allowing de-licensing of companies for any lines in any state.

Mr. Vagley also advocated:

- Removing commercial and excess coverages from state guaranty fund protection. This would force sophisticated corporate buyers to pay more attention to insurer solvency and discourage them from buying coverage they know to be underpriced, he said.
- Focusing regulatory resources on solvency regulation and concentrating on troubled insurers rather than those clearly able to meet their obligations.
- Correcting "conflicting" regulations. For example, though 17 states now require insurer financial statements to be audited by independent accountants, no two states have adopted exactly the same rules, Mr. Vagley said.

Such regulations 'serve no useful purpose in the overall regulation for solvency and result in expensive and unnecessary efforts on the part of insurance companies," he said.

While Mr. Vagley applauded recent efforts by the National Assn. of Insurance Commissioner to improve solvency regulation—particularly development of financial regulatory standards—he added that AIA has been examining ways the federal government could play a role.

One proposal AIA is considering calls for new federal minimum standards. These could either be regulatory standards applied to state insurance departments or financial standards applied to insurers, Mr. Vagley explained.

Such standards could be implemented in several ways, including through a federal regulatory agency or through certification of states meeting "port of entry" standards, he said.

Another possibility is establishing a self-regulatory body similar to that played by the stock exchanges and the National Assn. of Securities Dealers in the securities industry, he said.

A variation on that concept, he added, would be to enhance the authority of the NAIC through federal legislation.

The AIA is still in the preliminary stages of assessing these options for federal involvement, Mr. Vagley said.

Despite recent marked improvements, the quality of state regulation has lagged behind the rising complexity and speed of the insurance industry, said Richard Yingling, president of the National Assn. of Professional Insurance Agents.

Mr. Yingling stressed that the national PIA believes that state regulators, if they are adequately funded and subject to appropriate oversight, could regulate effectively.

However, a PIA and Consumer Insurance Interest Group study of 47 insurance departments between 1987 and 1989 produced some disturbing data on the departments' operations, he suggested.

It found, for example, that on average less than 6% of annual premium taxes collected by states are plowed back into funding for insurance departments. Insurance department funding represents less than 0.1% of the average state budget, he reported.

As a result, each insurance department has an average of $250 to investigate each complaint it receives and $4,000 to conduct each insurance company examination, Mr. Yingling said.

PIA has recommended that insurance departments receive 10% of state premium taxes, while the Risk & Insurance Management Society Inc. has advocated 25%.

Other areas covered by the PIA/CIIG study include:

- Consumer complaint resolution. Insurance departments receive an average of 23,000 consumer complaints per year, Mr. Yingling said. However, only one-third of the departments surveyed had written procedures for handling complaints and one-third still logged complaints manually rather than electronically.

Most departments had no formal system for sharing complaint information with other regulators, the study found.

- Market conduct oversight. While about two-thirds of the departments surveyed conduct market conduct exams of insurers, "a large minority" have no formal systems for triggering such exams, the study found.
- Financial monitoring. About one-half of the departments conduct financial exams of domiciled insurers at least once every three years, the study found.

Continued on next page

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Each department should have the staff needed to examine all domiciled companies at least this often, Mr. Yingling testified.

Regulators should also be alert to changes like rapidly shrinking premium volume, that could indicate claim payment delays or other poor service unrelated to financial difficulties, he said.

• Insurance department staffing. Salaries for consumer affairs staff, actuaries, attorneys and commissioners themselves are well below national scales, Mr. Yingling said.

Noting that non-competitive salaries can lead to a decline in the quality and longevity of government workers, he recommended that departments audit their salaries at least biennially to see if they are competitive with other agencies and private employers.

A separate study commissioned by PIA and CIIG looked at the employment history and tenure of insurance commissioners and the positions assumed by those leaving office from 1984 to 1989.

The study found that 51% of the commissioners had been state employees before taking office, and 37% had worked in the insurance industry, Mr. Yingling said.

On average, those surveyed spent 3.3 years in office. Though two former commissioners had served over 16 years each, 20% of those surveyed had held their jobs for less than two years and 64% for less than four years, he noted.

The study also found that after leaving office, 49% of the commissioners went to work for insurance companies or provided legal, accounting or consulting services to the insurance industry.

"This career path has raised questions in the minds of some insurance industry critics about the adequacy and impartiality of the decisions they made as commissioners," Mr. Yingling observed. "It also may jeopardize public confidence in insurance commissioners and departments."

He favors barring commissioners from lobbying on behalf of insurers for a year after leaving office.

Officials of the Independent Insurance Agents of America and the National Assn. of Casualty & Surety Agents, meanwhile, echoed Mr. Vagley's proposal for a federal role in supplementing state regulation.

"It is possible that the federal government could be involved in the creation of uniform reporting requirements that would assist insurance agents and their customers without displacing the primary role of" states, testified George Shaffer, chairman of the IIAA's government affairs committee.

"We believe in state regulation. But we also believe that a federally sponsored system could complement state efforts," agreed Harry A. Koch Jr., vice chairman of NACSA's legislative committee.

Noting that the subcommittee's hearings focused a great deal of attention on allegedly fraudulent practices that contributed to the demise of the insurers it studied, Mr. Koch added that insurer collapses don't always involve fraud.

Pointing out that Iowa National Insurance Co. collapsed in 1985 because of overly rapid growth, underreserving and poor management, Mr. Koch cautioned, "We can't forestall the risk of insurer insolvencies just by chasing a few crooks out of the business.

"Instead, we must be alert to the management practices of all companies in order to ensure that a series of mistakes or unhappy circumstances don't lead to the same financial disaster."

Gregory A. Allgeier, president of the American Assn. of Managing General Agents, defended the role of MGAs in the industry against the subcommittee's conclusion that MGAs caused major problems for several of the insurers it studied.

Mr. Allgeier asserted that a few bad MGAs have tarnished the reputations of many responsible agents. He called for new laws making insurance fraud a federal crime and granting state regulators immunity from libel suits that might otherwise deter them from passing on information about "problem individuals."

Not all industry trade groups appeared ready to accept a federal role in insurance regulation, however.

In a written statement to the subcommittee, the Alliance of American Insurers applauded steps taken by the NAIC to improve solvency regulation and notes that "individual state efforts, currently under way or proposed, will enhance the existing system.

"Clearly, regulation for solvency can be improved, but state insurance departments do a much better job than popular reports sometimes seem to suggest," the Alliance said. ■

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Two risk financing groups formed in Colorado

By JOANNE WOJCIK

DENVER—Two new alternative risk financing facilities have been established in Colorado.

One, a new risk retention group, has been licensed to underwrite major structural defects coverage for homebuilders that belong to the Residential Warranty Corp.

The other is an excess-of-loss self-insurance pool that will provide liability coverage to two of the state's largest school districts.

The new risk retention group, Western Pacific Mutual Insurance Co., was licensed July 23 as an industrial insured captive in Colorado, according to Michael Murphy, president of Risk Consultants Inc. of Denver.

The risk retention group's initial capital of $750,000 came from the surplus generated from the association's existing commercially insured home warranty program. The group, which eventually will be registered in all 50 states, will replace the insured program, Mr. Murphy explained.

Its initial 1,500 member policyholders are expected to generate first-year premium and surplus contributions of $1.8 million, said Sherrie Farrell, a consultant at Risk Consultants involved in the project.

Within five years, the program is expected to insure 200,000 structures and have total annual premiums and surplus contributions of $15.5 million, she added.

Lloyd's of London syndicates fully reinsure the risk retention group.

Residential Warranty Corp. will serve as warranty administrator, handling homeowner complaints and processing claims.

However, during the nine years it was commercially insured, the program generated no claims, according to Mr. Murphy.

Under the program, homebuilders pay an enrollment fee to Residential Warranty Corp., which in turn makes a premium and surplus contribution to Western Pacific, Ms. Farrell explained.

The premium contribution for the average home—valued at $116,000—would amount to $58, while the surplus contribution would be $15, she said.

The school districts are trying to gain greater control over their coverage, Mr. Murphy says.

The homebuilder then issues a 10-year warranty to the buyer. Such a warranty, needed to qualify for Federal Housing Administration or Veterans Administration financing, covers major structural defects up to the value of the home over 10 years.

Ground movement such as mudslides and earthquakes are not covered.

For more information, contact the Residential Warranty Corp., 185 Second St., Suite 202, Highspire, Pa. 17034; 1-800-247-1812.

Meanwhile, two large Colorado school districts have formed an excess-of-loss self-insurance pool to fund their liability exposures.

Administrators at the Aurora Public School District and Colorado Springs District 11 are trying to gain greater control over their coverage, which had been underwritten by an American International Group Inc. unit, according to Mr. Murphy of Risk Consultants, which manages the pool.

Another advantage of forming the pool is that the districts have "direct access to the reinsurance market. It's illegal for a reinsurer to quote on a direct, excess-of-loss basis," Mr. Murphy said.

The school districts had considered participating in the 90-member Colorado School District Self-Insurance Pool. After reviewing coverage and premium options, they decided forming their own pool would be more cost-effective, Mr. Murphy said.

The Excess-of-Loss Self-Insurance Pool, or ELSIP, will provide each district with liability limits of $1 million per occurrence/$2 million annual aggregate above a $250,000 per-occurrence self-insured retention.

The pool was licensed by Colorado July 1. It will underwrite the districts' liability risks, including auto and hazardous conditions, Ms. Farrell said.

General Reinsurance Corp. of Stamford, Conn., fully reinsures the pool.

Claims will be handled by the Denver office of Alexsis, a unit of Alexander & Alexander Services Inc. ■

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insurance business is the end of 1991. Some do not see rates rising for two to three more years.

"I feel we will just limp along," said Edward B. Jobe, president and chief executive officer of American Re-Insurance Co. in Princeton, N.J.

"While there are moves to talk up rates in the cat area, in the United States there are no signs of hardening at the moment," said Anders Grabo, senior vp and chief underwriting officer of Skandia America Group in New York. "Our impression is we are in for a prolonged period of competition. And Europe is in even worse shape than the United States in terms of overcapacity and confusion," he added.

"We see a flat scenario on the primary side while reinsurers are under pressure," Mr. Grabo said, noting that reinsurance rates are stable but terms are being broadened.

"We may have hit bottom," said Jacques Blondeau, vice chairman of Societe Commerciale de Reassurances in Paris.

Only a few factors could alter this scenario for the world insurance and reinsurance market before 1991.

Another natural catastrophe could harden the minds of underwriters, causing a psychological turn in the market. Or the lowering of interest rates or a stock market crash—perhaps caused by the current Middle East crisis—could immediately raise rates.

But few consider a market turn imminent.

Many at the Rendez-Vous said they had no clear idea what it would take to harden the market.

"If a hurricane, an earthquake and petrochemical explosion won't do it, what will?" asked LeRoy J. Simon, an executive consultant in Coopers & Lybrand's Casualty Actuarial and Risk Management Consulting group, referring to last fall's record string of catastrophes.

"I can't see anything at the moment which is going to push up the pricing of major commercial industrial risks," said John Lock, general manager of Mercantile & General Reinsurance Co. P.L.C. in London. "We don't get the feeling that there is much impetus for that to happen."

"I think the market's going to have another two bad years" before lower-layer reinsurance and direct insurance rates increase, added Theo Dielmann, executive vp of Hannover Reinsurance A.G.-Eisen & Stahl Reinsurance A.G. of Hannover, West Germany. "I don't see any silver linings there."

This is more of a global trend than in the past, when rates might have hardened in the United States but not in Europe, according to Mr. Dielmann. "That makes it more difficult for reinsurers to balance their books of business because that one global trend is going to hit you wherever you are.

"This (global trend) has manifested itself more than a year ago. The States are in the doldrums. Europe is in the doldrums (as are) all major producing areas other than Japan, where you get precious little business," said Mr. Dielmann.

Pierre Croizat, president of Sorema North America Insurance Co. in New York, predicts that "competition will be very strong in Europe in the next few years." While he expects "the United States will be very competitive as well, in the next few years profitability in the United States will be better than in Europe."

"In Europe, there is not the pressure to produce quarterly returns," said Mr. Jobe of American Re, adding, "It does interest me how strong the balance sheets are in Europe while in the United States they are understated."

A "serious wind" in the United States during year-end renewals could harden the minds of underwriters, particularly in London, to increase rates, said Ron Iles, chairman of Alexander Howden Reinsurance Brokers Ltd. in London.

However, "although everyone has been talking about the disasters of the last year, nothing has happened on the direct rates," said Mr. Iles. "I don't know what it will take to turn the insurance rates. It's a paradox."

Reduced interest rates or a stock market crash could harden the direct market, said Mr. Iles. "Maybe it will take something in the financial sector this time to change the market.'

Mr. Jobe suggested that the primary marketplace could turn if in-

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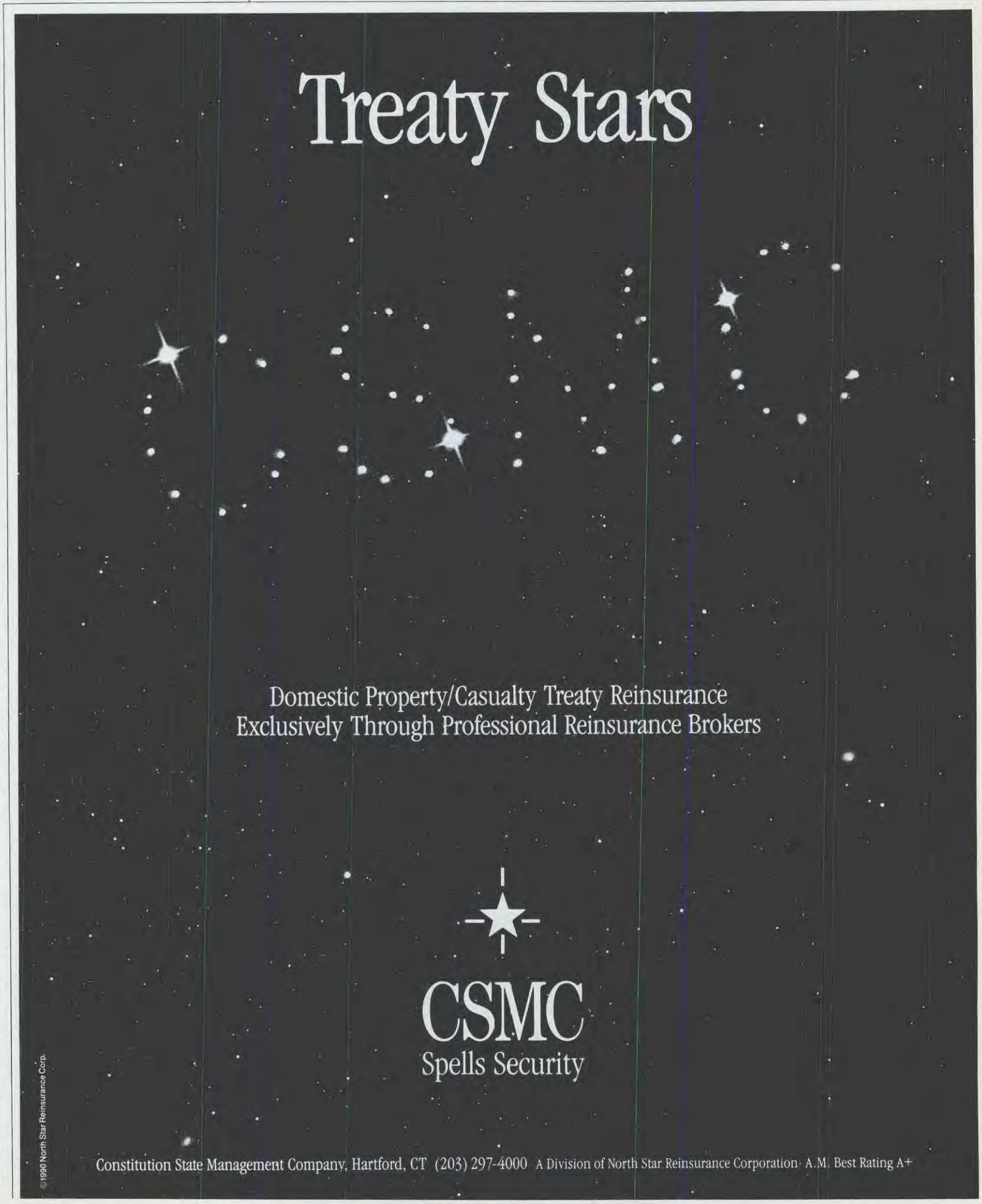

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Rendez-Vous

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surers are forced to sell assets to pay claims. "That may happen fairly soon, but there is far too much capital and the results are not that bad" now, he added.

Sylvain Boueil, senior vp and chief underwriting officer of SCOR in Paris, was more definite on what would cause a world market turn: "bottom line reasons."

To force a change, many agree, insurers will have to lose money—or at least not satisfy investors with their return on equity.

"Surplus has to go down in the market" for prices to rise, said Mr. Grabo of Skandia America.

This year's Rendez-Vous, held Sept. 9-14, drew 1,954 people from 78 countries and colonies to Prince Rainier's elegant city of Monte Carlo, which covers most of the small principality of Monaco on the Mediterranean.

Official attendance wasn't much smaller than last year's 1,979, yet there seemed to be fewer people in Monte Carlo than in previous years (see story, page 62).

Some participants speculated that people from London were staying home to protect their jobs during this year's grueling retrocessional renewal season. Others noted that personal reasons—the Rendez-Vous was a week later than usual, conflicting with the start of fall terms at many private schools in Europe—may have kept couples at home.

Still others thought that the numbers may have been the same, but the faces had changed so fewer people were recognized.

Nevertheless, finding hotel rooms and reserving restaurant tables was easier this year. And it was notably easier to find tables in the lobbies of the Loews Hotel and the Hotel de Paris, where many people hold half-hour to one-hour meetings.

Only the Cafe de Paris seemed to be continuously packed, mainly because it is outdoors and the weather was glorious throughout the week.

Conversation this year revolved mainly around the Middle East crisis, Eastern Europe and the state of the world markets following the worst series of natural and man-made disasters ever recorded (see stories, pages 61 and 63).

Only a year ago, Rendez-Vous participants speculated that only a hurricane that hit U.S. shores could change the soft market scenario for year-end 1989 renewals (*BI*, Sept. 18).

But, following the meeting last year, several natural and man-made events have struck—Hurricane Hugo; the California earthquake; the Newcastle, Australia earthquake; and the $1.3 billion Phillips Petroleum Co. plant fire in Pasadena, Texas. These events were topped by storms in January and February that did an estimated $8 billion in insured damage in Europe.

Altogether, some $17 billion of catastrophe losses have been accumulated by underwriters worldwide since last year's Rendez-Vous. And many companies, particularly European cedants, reporting that storm losses depressed first-half profits.

Patrick Peugeot, chairman of SCOR, pointed out that if the European storm losses are estimated on the low side of $6 billion, then about $4 billion will be paid by reinsurers with $2 billion paid under retentions by primary insurers.

He estimates that London's share of the $4 billion reinsurance loss is about $3 billion, with only $1 billion to be paid by continental European underwriters.

SCOR's gross losses from the windstorms total about $200 million, said Mr. Peugeot, with its net loss capped at $60 million.

Primary insurers' $2 billion in windstorm losses "is not supported by premium," Mr. Peugeot observed.

As a result of the market conditions, worsening results and uncertainty for the future, "the general mood is a bit down, to say the least," summed up Victor Blake, chairman and chief executive of CNA Reinsurance of London Ltd.

"People are very serious, very concerned, very sober about the whole scene. Business is in for a difficult period without question," he said.

"But interestingly, while people will say that 'in the short-term. . . ' people will also use expressions like 'the next 10 years could be the most exciting, most dramatic.' So it's a mixture of concern for results in the short-term and getting rates back up, which we haven't seen happen yet, and also the knowledge that the whole business is undergoing massive change," Mr. Blake said.

At the cafes and cocktail parties 'the general mood is a bit down, to say the least,' says Victor Blake of CNA Reinsurance. 'People are very serious, very concerned, very sober about the whole scene.'

James E. Dwane, president o Prudential Reinsurance Co. ir Newark, N.J., concluded at the enc of the Rendez-Vous that "mos companies are having poor to me diocre years, bigger is better (fo companies in the marketplace) anc we are in for a lot more of the same."

One area where there is a contraction is the retrocessional market, said Mr. Dielmann. "Rates have been going up substantially there and there's a substantial contraction of capacity. It's difficult, even with substantially increased rates, to complete protections.

"That should hopefully filter through to the front end, but I haven't seen it so far. It might come in January, but I'm somewhat pessimistic," he said.

The retrocessional market is "tough as hell" this year end renewal season, summed up Mr. Iles.

"People are pulling out the market; rates are tripling," he said, adding that the recent disasters "are crucifying the LMX (London market excess-of-loss) market. Already mid-year (retrocessional) buyers had to pay more and retain more."

Hannover Re renewed its property/casualty retrocessional program on June 1 and paid double what it did the year before for less coverage, confirmed Mr. Dielmann.

The company is retaining 25% more of its risk following June 1 renewals than it did in 1989 because "we were not able to complete some layers," particularly in the London market, he said.

However, Hannover Re does not expect to pass on the increased cost and the higher retentions to ceding companies, said Mr. Dielmann.

During midyear renewals for retrocessions, "buyers had to pay more and retain more," added Mr. Iles. "There were a lot of renewals and they all went up," he added, explaining that prices sometimes tripled and most retrocessional buyers retained 25% to 100% more risk than they had in the past.

"Most had to co-reinsure, and instead of co-reinsuring 5% or 10%, reinsurers insisted on more like 20% to 25% co-reinsurance," he said.

Year-end retrocessional renewals will continue this trend, particularly in London, where most retrocessions worldwide are now placed.

"People are saying that it's difficult now because they can't find retrocessional capacity and it's more expensive when they do," said Tony Taylor, managing director of English & American Insurance Group P.L.C. in London.

"But we think that's good news. We view reduction in retro capacity as a good thing because increased pricing in the retro market should filter through to the direct (insurance) buyer. And there are signs in virtually every class of business that it's getting more difficult to place retrocessional covers. It ain't getting any easier," he said.

Prices are also rising for catastrophe reinsurance programs, as much as doubling for U.K. composite insurers.

For example, one major U.S. ceding company that will renew its program Dec. 1 does not expect

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much change in its proportional reinsurance program. It also does not expect the lower layers of its non-proportional excess-of-loss property reinsurance program to change much in capacity or price since it is profitable.

"However, when it comes to catastrophe covers, there has to be on the part of reinsurers a global approach on rating," says the U.S. insurer.

For catastrophe reinsurance layers above $100 million, the U.S. insurer "is looking at the possibility of a shortfall on the upper layers, which we are not worried about." At about 10% on each layer, the shortfall is "manageable."

The insurer says it may use alternative funding like financial reinsurance to protect the gaps.

Catastrophe reinsurance prices will rise 30% to 50%, predicts John Engestrom, chief operating officer of reinsurance operations for Skandia International Insurance Corp. in Stockholm.

"This is a major area where repricing is in the cards," said Mr. Engestrom. "But we're only getting to the right technical level. And there will be more co-reinsurance and a Swiss-cheese affect (on layers)."

There is talk, too, that in London there may not be any coverage for the first catastrophic loss in the excess-of-loss on excess-of-loss retro market, added Philip Heitlinger, director of English & American Underwriting Agency Ltd. and general manager in charge of the non-marine department in London.

"XL on XL will be very tight," said Mr. Heitlinger. "Some people may not get their covers placed."

In addition, Swiss Reinsurance Co. (U.K.) Ltd. will be reassessing all catastrophe reinsurance programs this year following the series of disasters since the October 1987 windstorm in England, known as 87J.

Swiss Re U.K. will review retentions, propose that co-reinsurance requirements be reintroduced as they existed in the 1950s and '60s and look at aggregate exposures, said Brian Prevost, general manager of Swiss Re U.K. and chairman of the Reinsurance Offices Assn.

"Without all that, you can't begin to decide what sort of premium should be charged," he said.

"I think we have probably reached a watershed in the European catastrophe market and the whole (area) needs to be reassessed," he said. "We have to get back to some basic principles. It's obvious that it isn't just a question of increasing the price (if no one knows) what the risk is. If you don't know that, then how can you start to fix the price?

"You can't have 87J, Hurricane Gilbert, Hurricane Hugo, and then 90A through D (the European windstorms earlier this year) and say that nothing's changed in life," said Mr. Prevost.

"We've honestly tried to broach the question with clients" about rethinking the underwriting of catastrophe reinsurance, added Bob R. Robinson, director of Swiss Re U.K.

Swiss Re U.K. is asking clients to think about "what precisely their exposures are compared to what they thought they were."

Swiss Re U.K. will use its capacity more selectively for catastrophe reinsurance programs during year-end renewals, added Mr. Robinson.

"A catch phrase is 'being wise after the event,' " added Mr. Prevost. "But what is the event? You've actually got to be wise before the event now and reappraise the whole of the catastrophe risk. We can't just be in the business of just surviving because with losses of this size people won't survive if

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Rendez-Vous

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this is repeated and there is nothing to prove yet that it won't be repeated. We're not in the business of survival, (but in business of) profit-making."

Scientists are now trying to determine whether the apparent change in weather patterns is historical or due to global warming triggered by pollution. However, "we can't wait for 20 or 30 years to see whether what's happening today is going to be a repetitive thing," said Mr. Prevost. "We have to assume it is. . .So it isn't just a question of renewing at a payback rate. We have to reappraise the whole risk.

"Everybody must share in the consequence of catastrophes rather than unload the whole thing at a highly competitive price," said Mr. Prevost.

With catastrophe reinsurance rates rising rapidly, new underwriters could be expected to enter the market. But, as Bermuda-based Belevedere Insurance Co. Ltd. President Colin D. O'Connor says, "It's still too cheap, and the retrocessional coverage is too expensive," to enter the market.

Mr. Grabo of Skandia America noted, "We are wary of cat exposures in the property area and that limits our growth appetite."

Rendez-Vous participants have varying ideas on when, and if, tightening retrocessional and catastrophe reinsurance markets will trigger changes in the direct property/casualty insurance market. Opinions also vary on when insurance and reinsurance rates might increase.

"If the retrocessional market goes, there will be pressure" on reinsurers to increase rates and retain coverage, said Mr. Taylor of English & American. "And those not affected will still use it as an excuse to increase rates."

Mr. Dwane of Prudential Re agreed that the LMX market is in the "worst condition," but suggested that rising rates and shrinking capacity there will not alter overall market conditions.

'Reinsurers didn't start the rate cutting this time. So they can't stop it,' says LeRoy J. Simon.

"There has to be more than one force" to change the market, he said. "It will be difficult for reinsurers to buy retro protection, but that won't filter through the distribution process."

Mr. Simon of Coopers & Lybrand agrees that the restrictions in the retrocessional market "will not affect the primary market because it is too small a piece of primary companies' overall costs."

He added: "Reinsurers didn't start (the rate cutting) this time, so they can't end it."

Instead, he predicts pressures to increase loss reserves will affect prices in "a couple years." These pressures include: scrutiny by Congress, pressure from accountants and the spreading requirement by regulators that insurers actuarially certify loss reserves.

Mr. Grabo of Skandia America adds that the effect of higher U.S. taxation of property/casualty insurers may hit home this year. "That's a big factor that has not been fully realized," he said.

"I think we've reached bottom," said Benito Pagnanelli, director of the aviation, space, fire and miscellaneous, and reinsurance cessions departments for Assicurazioni Generali S.p.A. of Trieste, Italy.

"But I think we have to wait one year before this reaches the insurance market. There are marketing considerations to be considered and nobody wants to be the first (to increase prices). If we could have a common approach, then yes. Otherwise, I see little change in competition."

"If anything happens to create a hemorrhaging of cash" from insurers and reinsures, then the market will change, Mr. Simon said. This could happen if, to pay claims, insurers have to liquidate bonds that are now under market value due to higher interest rates, he noted.

"A lot of companies do not have asbestos claims fully reserved," Mr. Simon noted. "That could be a serious problem."

But it would take six months after a large settlement of asbestos claims, as is being proposed by several U.S. federal judges, before reinsurer results would be affected, he said.

Mr. Croizat of Sorema, which is writing about $40 million in premiums against capital and surplus of $110 million while waiting for market conditions to change, doesn't expect to see a turn in the market until 1992. ■

Here's why Rendez-Vous was so late

MONTE CARLO, Monaco—"Why is this meeting so late this year?" registrants asked each other all week at the 34th Rendez-Vous de Septembre.

Recently accustomed to gathering the first week of September in Monte Carlo for the largest international gathering of the world's reinsurers, the registrants were confused and wondered why this year's meeting was scheduled for Sept. 10-15.

The reason for the date change: The hotels in Monte Carlo did not want early registrants for a meeting officially beginning Monday, Sept. 3, to begin arriving on Friday, Aug. 31, the end of the tourist season in Monte Carlo.

Many registrants begin arriving on the Friday preceding the Rendez-Vous to recover from jet lag and to enjoy Monte Carlo and the surrounding south of France before meetings begin in earnest on Monday and wind up on Thursday or midday Friday.

Some residents of the United States with families preferred coming to Monte Carlo the second week of September rather than the first week. Children were already back in school and spouses could more easily join them, they said.

In addition, everyone agreed the weather this year was the best since the early 1980s: warm days made more pleasant by cool breezes and clear, sunny skies. But no one was sure if the fine weather was due to the dates or luck.

Jacques V. Papon, general secretary of the organizing committee for the Rendez-Vous, notes that the Rendez-Vous is postponed a week about every five years. In 1985, the meeting was held Sept. 9-12.

Mr. Papon has good news, though, for those who prefer the first week in September for the meeting.

The meeting dates begin moving forward next year: Sept. 9-14, 1991; Sept. 7-12, 1992; Sept. 6-11, 1993 and Sept. 5-10, 1995.

But come 1996, it's possible the Rendez-Vous will again be postponed a week to begin Sept. 11. ■

34th Rendez-Vous de Septembre

Reinsurers differ on when market will turn

By KATHRYN J. MCINTYRE and STACY SHAPIRO

MONTE CARLO, Monaco—There's little agreement among reinsurance underwriters as to how much longer highly competitive pricing will reign in the marketplace.

Registrants at the 34th Rendez-Vous de Septembre, asked to peg the 1990 marketplace with its comparable year in the underwriting cycle of the early 1980s, answered anywhere from a pessimistic 1981 to an optimistic 1985.

Through the early 1980s, reinsurers attending the Rendez-Vous complained how bad business was, but they showed few signs of changing their underwriting ways.

It was at the 1984 Rendez-Vous de Septembre that reinsurance underwriters warned they would no longer support cheap primary insurance prices with cheap reinsurance. Year-end 1984 reinsurance renewals were difficult, with increased rates and reduced capacity.

Throughout 1985, the insurance and reinsurance markets tightened their underwriting, culminating in what many called a bloodbath at year-end 1985 reinsurance renewals, with reinsurers pulling out of lines entirely. That led to unprecedented rate hikes and coverage cancellations by primary insurers.

"It's 1981," declared LeRoy J. Simon, an executive consultant with Coopers & Lybrand's Casualty Actuarial and Risk Management Consulting group and former senior vp of Prudential Reinsurance Co. "The worst has yet to come," he warned.

"My favorite question is: 'Are you or anyone you know putting limits on your business?' And the answer is 'No,' " he said.

However, he found one encouraging sign: "Attendance is down. That means underwriters are starting to realize that they have a serious problem or the start of a serious problem. They can't control losses so they try to control expenses." And, Mr. Simon noted, "if we don't have unusually high interest rates, that may shorten the cycle."

Jacques Blondeau, vice chairman of Societe Commerciale de Reassurance in Paris, suggested 1990 is about the same as 1982.

But James E. Dwane, president of Prudential Reinsurance Co. in Newark, N.J., offered that "this is 1983 or 1984," depending on the line of business, with the catastrophe reinsurance and retrocession market more resembling 1984.

Benito Pagnanelli, director of the aviation, space, fire and miscellaneous, and reinsurance cessions departments at Assicurazioni Generali S.p.A. in Trieste, Italy, hopes that this year's renewal season is like 1984.

This year may be like 1985, said John Engestrom, chief operating officer of reinsurance operations for Skandia International Insurance Corp. in Stockholm, Sweden. But, tightening in 1985 was more severe, particularly in the United States, he noted.

What is happening in the retrocessional and catastrophic reinsurance market "may affect direct insurance rates at the end of 1991 for 1992 renewals," he said.

But Francois Negrier, vice chairman of SCOR in Paris, emphatically said: "This is not 1984," offering that the market conditions may be more like 1982 or even 1981.

Edward B. Jobe, president of American Re-Insurance Co. in Princeton, N.J., agreed that 1990 market sentiment in no way resembles 1984.

"In 1984, I could just smell what was going to happen; everyone was so concerned about operating losses," Mr. Jobe said. There were no such signals this year.

Ron Iles, chairman of Alexander Howden Reinsurance Brokers Ltd., said he thinks that this renewal season is more like 1965 when Hurricane Betsy hit the market. Its horrendous impact on the London market in particular was not felt until two years later when insurance rates started to go up.

Patrick Peugeot, chairman of SCOR, pointed out that the soft market of the 1980s did not include the string of catastrophes that have battered insurers recently. "There is no previous story of this kind."

As the soft insurance and reinsurance market continues longer than insurers would like, the issue of how severe the turnaround will be when it happens grows larger.

'We have to manage the insurance and reinsurance pricing cycle. If we do that, the cedant will have stable products and we will build relationships that will outlast the cycles,' says Edward B. Jobe of American Re-Insurance Co.

Mr. Jobe said he does not expect dramatic change in prices in the future. "The peaks and valleys will be more narrow. Buyers want less volatility."

And, primary insurance companies now have systems to monitor price compared with exposure, he said. "We see sophisticated systems" that did not exist in the early and mid-1980s, Mr. Jobe added.

While there is "always going to be a cycle" in the pricing of insurance and reinsurance, "we have to manage the cycle. If we do that, the cedant will have stable products and we will build relationships that will outlast the cycles," Mr. Jobe said.

In underwriting reinsurance for alternative funding mechanisms, American Re has found that those relationships "outlast underwriting cycles. And that's taking some volatility out of books of business," he said.

Pru Re's Mr. Dwane commented, "We've been saying there will be a gradual adjustment, but we didn't think this competitive environment would last as long. This industry goes from competitive to highly competitive." ■

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34th Rendez-Vous de Septembre

Transit receivers meet with reinsurers

By STACY SHAPIRO

MONTE CARLO, Monaco—Transit Casualty Co.'s receivers expect to begin seeking commutations with reinsurers and retrocessionaires within the next 12 to 18 months.

Transit's receivers already have collected $170 million from reinsurers—without litigation—for paid documented losses, noted Paul E. Dassenko, director of insurance operations for the Transit receivership.

By May 1991, Transit expects to have collected $205 million, or an additional $35 million, from reinsurers to cover paid losses, according to J. Burleigh Arnold, special deputy receiver for Transit.

"We believe that only about $230 million remains to be billed to reinsurers for what the state guaranty funds have paid out," Mr. Dassenko said.

However, reinsurers will still be billed by Transit for paid losses that exceed the state guaranty fund limits and for losses that are excluded by the state guaranty funds, like losses on reinsurance programs underwritten by Transit, Mr. Dassenko said.

"We believe the remaining paid losses should be paid (by reinsurers) within the next 12 to 18 months," he said.

Once reinsurers are billed for all paid losses, Transit will begin commuting outstanding losses and incurred-but-not-reported losses with reinsurers "who are financially solid," Mr. Dassenko said. Commutations will allow Transit and the reinsurers to develop fair settlements for outstanding losses and IBNR claims without litigation.

While the size of Transit's insolvency still is not known, the total —including outstanding unpaid losses and IBNR losses—could climb to as high as $4 billion, Mr. Arnold said. "But we just don't know."

The Transit receivership could conclude within the next seven to 10 years, even though "we will never know during our lifetime what the gross liabilities of Transit Casualty are," Mr. Dassenko estimated.

"Because of the manner in which inward-bound casualty reinsurance functions, it will take that long for (losses) to trickle in," he explained. "But that doesn't mean the estate won't be settled before then.

Mr. Dassenko

"We're very hopeful to settle this estate expeditiously, and we (plan) to commute with our reinsurers once we have a fair settlement on paid losses. And, we're very hopeful to be able to do some sort of a present value settlement with claimants in the property/casualty liability business," he said.

"There's got to be an end to all this. Even though the losses are going to play out over 40 years or longer, there has to be an end to this receivership. And, we want to be around just as long as we are maximizing the return to creditors. We hope that's not longer than seven years, but it might be 10 years" from now.

This latest update of Transit Casualty's liquidation took place during an hour-long meeting with Transit's foreign reinsurers at the 34th Rendez-Vous de Septembre in Monte Carlo earlier this month. More than 30 people attended the Sept. 10 meeting at the Loews Hotel.

Mr. Dassenko said in an interview that it was the first time the Transit receivers have held an open meeting with any of Transit's reinsurers on either side of the Atlantic.

And, the Monte Carlo meeting proved worthwhile, because representatives from two reinsurers that the Transit receivers have never heard from—even though they have been sent bills—attended the meeting, he said.

The Transit receivers may consider holding similar open forums in the United States, though the receivers already have good working relationships with Transit's U.S. reinsurers, Mr. Dassenko said.

Mr. Dassenko told reinsurers: The Monte Carlo meeting "is an opportunity for you to ask us some questions and for us to exchange some kinds of information that we're used to doing with domestically based reinsurers."

To bring the foreign reinsurers up to speed on the status of the Transit liquidation, Mr. Dassenko outlined the history of the receivership.

When Mr. Arnold was appointed Transit's receiver in May 1987, "there were almost no records on the premises of the Transit Casualty Co. in Los Angeles—no records to support reinsurance collections," Mr. Dassenko said.

In addition, there were "no reinsurance professionals on the staff of Transit Casualty," he said.

"Most of Transit's management which Mr. Arnold might have wanted to keep to run the business off were already gone with the exception of two or three employees on the middle management level. There were really no systems for managing claims and no reinsurance (computer) systems," he said.

All these tasks had been assigned to the managing general agents that underwrote business, issued policies and handled claims on Transit's behalf, he said.

As a result, "these records had to be brought in, and the systems had to be built, and the staff had to be assembled," Mr. Dassenko said.

Many people ask why the receivers have taken so long to get up to speed, he noted. "It's really a rather quick and easy answer. Records had to be brought in from 300 sources involving some 17 million documents. We had to build four major computer systems: one to manage our records and documents; one to manage our claims; one to bill reinsurers; and one to manage state guaranty fund information," he said.

Mr. Dassenko added that state guaranty funds are among Transit's largest creditors.

"In addition to that, 10 key reinsurance managers had to be hired, and 150 temporary and salaried employees had to be put on staff to facilitate the winding down of this business," he explained.

Then the newly formed group had to assess the "size of the hole" —or the amount by which Transit was insolvent—which took 18 months with the help of consul-

Continued on next page

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34th Rendez-Vous de Septembre

Continued from previous page

tants Arthur Young & Co., now Ernst & Young, Mr. Dassenko said.

"Frankly, the first indications gave no inkling to the people who were looking at it that the receivership was as large as it probably is," he said.

The Transit receivership finally issued its first bills to reinsurers in July 1989.

"I think our bills have shocked a few reinsurers," Mr. Dassenko said.

The reinsurers were shocked for several reasons, but mainly because they had not heard from the receivers for some time, he speculated. "We're trying to rectify that, quite frankly, by getting out and talking to you."

For the most part, reinsurers have been responsive and have honored their obligations as they have seen the bills and documented losses, he said.

And, the Transit receivership is proud that there has been no lawsuit filed to date regarding reinsurance payments, though Transit receivers are currently in arbitration with European reinsurers that participated on Transit's reinsurance program through Lloyd's of London broker Carter Wilkes & Fane (Holding) Ltd., Mr. Arnold said.

The arbitration, brought by Transit after nine months of collection activity, is mainly over interest payments and letters of credit held by Transit in the reinsurers' names since the reinsurers have "paid in full" their billed losses, Mr. Dassenko said.

"We hope this kind of arbitration is the last of its kind," though "that's probably a little overly optimistic," Mr. Dassenko said.

"We recognize our duty is to prove our losses, but we also recognize that Transit was not operated in an exemplary manner. If Transit had been operated in an exemplary manner, we wouldn't all be here today," he added.

However, "there are some areas where we are quite certain about our operation and our losses are documented, and in those areas we will expect cooperation from the reinsurers," he continued.

"We don't like to deal in a confrontational manner that raises conflicts between the receiver and its reinsurers. We like to build bridges of communication, and we like to think we give you the opportunity to do that," he said.

But during a tense question-and-answer session at the Monte Carlo meeting, it became clear that the Transit receivers are not communicating well with all of Transit's reinsurers.

In particular, reinsurers that depend on intermediaries for information complained that they were not getting any information from the Transit receivership, even when they have asked for it.

"We would have been spared a lot if normal accounting was still being done as it was done before 1986/1987, because I know that we haven't been receiving any accounts for the last three or four years," a French reinsurer said.

"So, how could we contest what we are supposed to be paying when we are not receiving any accounts at all? This is the major point of everything. I think the problem lies within your company," the reinsurer said.

Mr. Dassenko again explained that it took four years to get the receivership up and running. "The reason you didn't get accounts from us for the last four years is because we didn't have the ability to generate a credible reinsurance bill," he said.

However, the Transit receivership is now issuing this information, and if reinsurers are not getting it, then the reinsurance broker/intermediary may not be passing it on, he said.

Mr. Dassenko took that reinsurer's card—as well as cards from other reinsurers who had the same complaint—and said he would try to find out where the problem is. He also said he would try to send information to reinsurers directly from now on.

Another reinsurer wondered if the receivers could commute claims with reinsurers earlier than 12 to 18 months from now.

"We will do it as soon as we can," Mr. Dassenko replied. But, "I think 12 to 18 months is a responsible time period. But if it turns out we have a very complete picture of the losses before then, we would certainly entertain discussions. But I don't want to raise expectations."

Mr. Arnold added that deciding when commutations will commence is not entirely up to the receivers, because the receivership must report to Circuit Court Judge Byron Kinder in Cole County, Mo., who is supervising the Transit liquidation. The receivers must have all documented records and the ability to prove that the commutations are fair and accurate to all creditors or "the judge will not approve" the commutations, he said.

Another reinsurer strongly criticized the Transit receivers for not replying to his company's correspondence. "We feel that the ball is in your camp since we don't get any replies," he said.

The same reinsurer also said he believed that Transit owes his company money rather than the other way around. He said the receivership owes his company money because it holds letters of credit from the reinsurer that had a higher value than the claims assessed against the reinsurer's contracts. Transit should therefore release untapped letters of credit, he said.

In addition, "we say you owe us money under our own catastrophe covers and we get no response," said the executive for the reinsurer, which purchased reinsurance from Transit. "So, we're a little desperate about the situation. I don't think we reinsurers are to blame."

Mr. Dassenko, aware of the questioner's particular case and the intermediary involved, explained that the intermediary only just found out that it was involved in placing reinsurance for Transit. The U.S. intermediary has now hired and assigned staff to investigate Transit records that the company holds and is only now trying to unravel the business it did with Transit.

As for releasing letters of credit —a point that other reinsurers raised—Mr. Arnold said the court will not allow him to release assets of Transit until Transit has a picture of its total ultimate losses. Because it faces pollution and other long-tail claims, the Transit receivership still has no idea of the company's ultimate liabilities and assets, Mr. Arnold said.

"So please be patient," he told the reinsurers. "We don't want you to pay a penny more than you owe us. You don't want to pay us a penny more than you owe us. But we want every penny that you do owe us."

Walter Lampkin, a partner with Buechner, McCarthy, Leonard, Kaemmerer, Owen & Laderman in St. Louis, general counsel for the Transit receivership, added that there is no provision in the statutes covering the Transit liquidation for offsetting what Transit owes reinsurers from what the reinsurers owe Transit.

Litigation now pending in federal and state courts in Missouri should be resolved soon and should clarify the issue, Mr. Lampkin said. ■

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34e Rendez-Vous de Septembre

AGF acquires ICI's ongoing operations

By STACY SHAPIRO

MONTE CARLO, Monaco—When the name Insurance Corp. of Ireland P.L.C. appears on policies these days, it is the insurer's ongoing Irish operations now owned by Assurances Generales de France and not the discontinued operations of the group.

The old ICI was sold in 1985 to the Irish government for about $1 by Allied Irish Bank P.L.C. after it became virtually insolvent from losses from U.S. liability insurance underwritten from its London office.

On Aug. 1, ICI changed its name to Icarom P.L.C. Still under Irish administration, Icarom continues to run off the old ICI's discontinued operations.

"We are anticipating a number of years to complete" the runoff, said Brendan Murphy, general manager of Icarom and former general manager of ICI's discontinued operations. Mr. Murphy reports to Administrator William M. McCann.

Although most of the reinsurance owed ICI has now been recovered for the runoff, there is still some reinsurance to collect, Mr. Murphy said.

To date, Icarom "has paid all valid claims" he said, although he didn't say how much the company has paid.

Under the sale agreement with AGF, which was announced earlier this year, the name "Insurance Corp. of Ireland" remains with the ongoing operations of the company in Ireland.

Insurance Corp. of Ireland has continued to write personal and commercial property/casualty insurance in Ireland since the company was sold to the Irish government.

"It's business as usual on both sides of the company, but this legally recognizes the position" of both the ongoing and runoff operations, said Mr. Murphy at the 34th Rendez-Vous de Septembre earlier this month.

Technically, the ICI now owned by AGF is a new company set up to acquire the ongoing Irish business of the old ICI. However, the new ICI's chief executive is also the old company's chief executive: Andrew J.G. Banks.

AGF's Irish company also employs the same 450 people who have worked on the insurer's continuing operations since it was put into Irish government administration.

The old company's London operations, however, have been eliminated, Mr. Banks said. On July 31, the London operations of ICI stopped underwriting and several of the underwriting staff—including ICI's underwriter in London, Colin Yellop—moved to Sirius Insurance Co. Ltd.

One underwriting manager remains in London to handle Icarom's runoff, he said.

Mr. McCann, the old ICI's administrator, decided to sell the ongoing operations earlier this year "because the time was right to capitalize on the interest that had been shown in the operations," Mr. Banks said. "It was agreed that now was the time to look for a purchaser."

Warburg Investment Management Ltd. was hired to look for a buyer for the ongoing operations and those who had expressed an interest in the company over the past three or four years were told that offers would be considered, he said.

In the autumn of last year, sealed bids were accepted and considered. Once the administrators agreed that AGF had the best offer, the offer had to be approved by the Irish High Court, which agreed to the sale on July 31 this year, Mr. Banks said.

"ICI is now a part of a European group which is ranked in the top half-dozen by premium volume in Europe and now has access to all of AGF's resources," Mr. Banks said.

"ICI suffered very little from any loss of confidence after it was put under administration in 1985. However, for commercial and multinational clients, the company is now more attractive than before.

"It's the culmination of what the staff's been looking for for the past five years—to sell to strong purchasers," Mr. Banks said.

ICI continues to be the largest liability insurer in Ireland, as well as one of the country's major underwriters of marine, auto and credit insurance. Its current gross premiums total about 80 million Irish punts ($138.8 million) annually, Mr. Banks said.

Meanwhile, although the Irish insurance market has "gotten off lightly" from the European windstorm losses earlier this year, Mr. Banks says that Ireland is still suffering from high personal injury awards that have not been reduced even though juries have been eliminated in personal injury cases.

"We are hurting more on the personal injury situation," Mr. Banks said. "The juries are gone, but those who thought judges would award lower damages have been disappointed."

Irish judges, like judges in other parts of the world, are increasing the level of damages awarded to personal injury plaintiffs, he said. And "there is an increasing frequency of awards," he noted.

ICI will report higher personal injury claim payments later this year, he said, but it will be less than the 14% increase last year.

Mr. Banks would like to see increased highway safety in Ireland, including the installation of third brake lights on new cars as is required in the United States. The Irish Insurance Federation has submitted to the Irish government "a combined initiative for accident prevention, safety administration and law enforcement to reduce the severity of road accidents," Mr. Banks said. ■

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Reinsurers debate retention trends

MONTE CARLO, Monaco—Unlike the soft insurance market of the early 1980s that was supported by cheap reinsurance, the current marketplace is punctuated by large retentions by primary insurance companies.

And reinsurers attending the 34th Rendez-Vous de Septembre were divided over whether insurers' retentions have topped out.

"U.S. retentions are at their maximum and there seems to be some slight movement to proportional cover," said Jerome Karter, president and chief executive officer of SCOR Reinsurance Co. in New York.

In the last several years, ceding companies have been moving more toward excess-of-loss reinsurance, which reduces reinsurers' premium volume while generally increasing their risks of high-layer losses.

However, Edward B. Jobe, president and chief executive officer of American Re-Insurance Co. in Princeton, N.J., says primary companies continue to increase their retentions. As a result, American Re's premium volume in 1990 will be down about 10% from $908 million in 1989.

Faced with "fairly firm reinsurance prices and declining primary prices, insurers decide reinsurance is too expensive," he explained.

For example, he said, one insurance company client of American Re increased its retention on umbrella liability insurance to $5 million from $1 million, while another hiked its retention on umbrella business to $500,000 from $100,000.

"Also, primary companies' appetites for exposure is increasing," he said, commenting that proportional reinsurance continues to be renewed on an excess-of-loss basis.

At least two clients with proportional reinsurance programs recently changed to excess-of-loss, Mr. Jobe said.

"This is not a complaint," Mr. Jobe hastened to add. "It shows that the traditional reinsurance pool is declining while capacity continues to increase."

Mr. Jobe sees the same trends in Europe, where the "new conglomerates will buy less reinsurance than they did as individual companies. And, the new conglomerates have an interest in assuming reinsurance."

Anders Grabo, senior vp and chief underwriting officer of Skandia America Group in New York, observed that about 15% of premiums written in Europe is reinsurance, "but that probably will come down," as primary companies retain more of their business.

There may be another reason that primary insurers are not decreasing their retentions as one would expect amid reinsurer competition: They don't want to part with the cash for reinsurance because they can't afford the hit to their cash flow, according to one reinsurance expert who preferred not to be quoted on a comment so critical of primary insurers.

—By Kathryn J. McIntyre

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34th Rendez-Vous de Septembre

Insurers may feel fallout from Gulf crisis

By STACY SHAPIRO

MONTE CARLO, Monaco—The crisis in the Persian Gulf, which already is hurting insurance business in the Middle East, could wallop the insurance industry worldwide.

Several brokers and underwriters at the 34th Rendez-Vous de Septembre said they are feeling the pinch already from the Iraqi invasion of Kuwait because business is at a standstill in the Middle East.

Not only is there no new investment in Iraq or Iraq-occupied Kuwait because of the United Nations embargo, but investment in other Middle Eastern countries like Saudi Arabia also has tailed off because of the threat of war in the region, participants said. As a result, there are very few new premiums or brokerage commissions coming from the area.

Furthermore, speculation circulated at the Rendez-Vous that the Gulf crisis could result in stock market crashes worldwide. Falling stock prices would reduce the net worth of many major world insurers and could therefore lead to an increase in insurance prices more quickly than within the one to three years that many are anticipating (see story, page 1).

Political risk insurance underwriters, meanwhile, are waiting to see how much the crisis will cost them, if anything, on coverages already issued.

However, marine and aviation war risk underwriters are benefiting already from the crisis because of the additional war risk premiums that they are receiving.

One London aviation insurance broker, for example, said that aviation war risk underwriters currently are taking in as much as $9 million a week in additional war risk premium for flights to the Middle East.

During the week in Monte Carlo "half of each of our meetings would be talk about the Gulf," said Henri Chaloub, chairman of Paris-based MEPA Group. "There has been a lot of talk about the war risk future. Some people are happy because they are (insuring) the war risk and are happy about the rates. But other people are nervous and anxious."

For MEPA, which receives 55% of its $200 million in premium volume from its Middle Eastern business, the situation is worrisome, according to Mr. Chaloub. MEPA is the exclusive underwriting agent in the Middle East for France's largest insurer, Union des Assurances de Paris.

"Insurance is not a need there (in the Middle East) at the moment," said Mr. Chaloub. Although the situation has improved recently, in the first month of the Gulf crisis there was a 60% loss of production by MEPA's agencies in the Middle East and a 75% loss of premium collections, said Mr. Chaloub. "Now it's picking up again," he said earlier this month.

Mr. Chaloub, who left Lebanon with his family in 1975 to escape that war-torn country, predicts that one day everyone will "kiss and make up," although it will be a long and protracted "conflict of personalities" between President Bush and Iraqi President Saddam Hussein.

And to show his confidence in the future, Mr. Chaloub and UAP have agreed to maintain MEPA's three offices in Saudi Arabia and its two offices in the United Arab Emirates. "We will remain open and we will get in some more support," said Mr. Chaloub. "I will double my personnel there because when everyone is afraid and they leave, you must show fidelity and courage to the people who trusted you. It's my way of indicating security."

MEPA will also continue its growth in Europe and North America to become less dependent on Middle Eastern business, according to Mr. Chaloub.

Ron Iles, chairman of London-based brokerage group Alexander Howden Reinsurance Brokers Ltd., also noted that the Gulf crisis has caused business to slow down in the Middle East.

"The whole area is suffering from lack of investment," said Mr. Iles.

Howden Reinsurance was involved in Iraqi business until the country invaded Kuwait and the U.N. embargo was imposed. "Now we have to do what the (U.K.) government says," says Mr. Iles, although the embargo is vague on business other than hull and cargo shipments. "If there is a fire in Iraq, then it seems at the moment that any claim payment must go into an escrow account."

Assessing the global impact of the Gulf crisis, executives predict it "could trigger a stock market crash," said Theo Dielmann, executive vp of Hannover Reinsurance A.G.-Eisen & Stahl Reinsurance A.G. of Hannover, West Germany.

"It's interesting because a stock market crash is what turned the (insurance) market back in 1973 or 1974," he noted.

The Gulf crisis "could also drive up the oil price even further, which could do untold damage. If the Saudi oil fields are no longer producing because of military action, then that could trigger a major (economic) crisis worldwide," added Mr. Dielmann. "Then all business will be involved. It would be difficult to tell you right now what the impact would be (just on insurance). But I think there will be a major impact."

For example, there may be war risk or political risk losses to pay, he said. "But even if there are no losses, I think you will have a stock market crash or slump which would definitely have an impact," he said.

What will be just as significant during year-end renewals as the massive underwriting losses plaguing the world markets is "what happens on the political scene worldwide and on the stock markets and the economic situation," added John Lock, general manager of London-based Mercantile & General Reinsurance Co. P.L.C. "I'm not an economist, but the general feeling is that the world stock markets will end the year lower than when they started it, although how much I'm not going to speculate. That will hurt the solvency position of quite a lot of companies—not so much North American ones because they don't invest so much in equities—but certainly it will have an impact on some of the European markets."

The worsening solvency position from a falling stock market, coupled with rising claims that eat into investment income because companies are paying out more than they are collecting in premiums, "could mean price rises," said Mr. Lock.

Patrick Peugeot, chairman of Societe Commerciale de Reassurances in Paris, observed, however, that "the world is trained to deal with a stock market crash," referring to the minimal economic reverberations of the 1987 stock market crash.

Jacques P. Blondeau, vice chairman of SCOR, suggested, "The main concern is if there is a recession in the United States and if it spills over to Europe" as a result of the Gulf crisis.

However, on the bright side, an oil crisis triggered by the Middle East tensions would increase exploration for oil and gas elsewhere, he said, and that would generate new premiums for insurers.

David Avasthi, president and chief executive officer of UIC Ltd., a managing general agent underwriting political risk insurance, noted that losses from the Gulf crisis also could hit accidental death and dismemberment insurers, life insurers, and underwriters of kidnap and ransom insurance.

And, while most speculation focused on the potential loss to underwriters from Iraq's seizure of Kuwait's fleet of airplanes (*BI*, Sept. 3), Mr. Avasthi questioned the potential loss to underwriters from the suspension of lease payments by Iraq on planes it leases.

"The waiting periods are short—six months—or there may be no waiting period" under non-repossession insurance purchased by those leasing planes to Iraq, he said.

While UIC underwrites the coverage, it did not write any non-repossession insurance on planes leased to Iraq. "Lloyd's is the biggest player," he said.

UIC, based in Miami, underwrites political risk insurance on behalf of La Reunion Francaise and the P.A.R.I.S. Pool in France. It wrote about $10 million in premiums last year for its product lines, which include expropriation and nationalization insurance, export and import insurance, service contact deterioration and repudiation insurance, and on-demand guaranty insurance.

UIC offers more than $50 million in capacity for investment coverages and up to $7.5 million for contract-related coverage.

The P.A.R.I.S. Pool is still underwriting political risk insurance for ventures involving Saudi Arabia and the United Arab Emirates, but would "prefer to avoid Jordan," noted pool President Louis Habib-DeLoncle.

The pool has a "subsequent" exposure in Iraq and Kuwait, he said, where the pool stopped underwriting on Aug. 3, the day after Iraq's invasion of Kuwait.

"But we do not see anything to say we will suffer a heavy loss. It is too early to know," he said, referring to the 18-month waiting periods that must be met before the pool's political risk coverage is triggered by a loss.

The pool insured payments for priority goods imported by Iraq, like medical goods, he noted.

Overall, he estimated that private political risk insurers' exposure to losses involving Iraq and Kuwait total less than the $1.4 billion loss of the Piper Alpha oil platform in 1988.

Nonetheless, Mr. Habib-DeLoncle expressed frustration with the terms of the United Nations trade ban with Iraq, which preclude his policyholders from engaging in any activity with Iraq to reduce their exposure to losses under past transactions.

"We are very concerned with what will be the basic trends in international trade after the conflict," he said. "The decision by the U.N. to impose the trade embargo is entirely new."

In the future, nations imposing trade bans should be as concerned about the potential harm to political risk insurers by the ban as they are with the potential harm to banks, he said.

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Associate Publisher and Editor Kathryn J. McIntyre contributed to this report.

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34th Rendez-Vous de Septembre

Rendez-Vous attendance drops for first time

By STACY SHAPIRO and KATHRYN J. McINTYRE

MONTE CARLO, Monaco—Every year since the hard market in 1986, participants have speculated that there were fewer people at the Rendez-Vous de Septembre than there were the previous year.

This year, for the first time, that perception proved correct. Official attendance for 1990 was 1,954, down from 1,979 last year, according to figures released after the meeting.

It certainly was easier to book a hotel room in the principality compared with previous years when it was almost impossible to find a room several months before the meeting.

Participants also had an easier time finding tables in hotel lobbies for their short meetings. With the delightful weather, though, finding a table at the outdoor Cafe de Paris near the Old Casino remained a struggle.

Views varied on why attendance was down this year.

"I have been coming 17 years and it has grown every year (in numbers) except this year when it hasn't," summed up Nicholas Davenport, director of Lloyd's brokerage Willis Faber & Dumas Ltd.

"All we are seeing is a clearing of the decks."

Fewer people in Monte Carlo is a sign that companies are becoming more efficient and need fewer people to handle the business, according to Mr. Davenport. Mergers and acquisitions in Europe over the past few years have also thinned the ranks.

Seventeen years ago, Willis Faber sent two people; this year it sent 14. "But that's bound to fall away" as the reinsurance market grows more efficient, Mr. Davenport said.

Also, fewer younger people appear to have attended the Rendez-Vous this year, which may indicate that companies were cutting expenses, he said.

"Our presence here is reactive. If our clients are here, then we're here. But I don't want to talk the market down. If we do, then fewer people will come down. And I love it here," said Mr. Davenport.

Attendance appeared to have fallen off since 1989, "but I think that's always the case when the market is in a soft cycle so I'm not surprised," said Victor Blake, chairman and chief executive officer of CNA Reinsurance of London Ltd.

"People are looking at expenses and being very conscious of the difficulty (in paying) claims and they don't want to be seen to be frivolous in any way, shape or form. So people probably asked themselves twice whether they really need to go (to Monte Carlo) and they conclude that they do and therefore they go," he said. "But others say 'Do I really need to go?' And they conclude that they don't, so they don't go."

Some people stayed in Monte Carlo for only a few days rather than the whole week, whether to control expenses or because they had more pressing business at home. That may explain why the meeting seemed more sparsely attended than official figures would indicate.

John Lock, general manager of Mercantile & General Reinsurance Co. P.L.C., for example, shortened his stay this year, though the company sent the same number of people to the Rendez-Vous both years.

Mr. Lock comes to Monte Carlo every year to "be interviewed by a few journalists," he quipped. "I don't really have a very busy program. I see a few people, do a bit of entertaining."

Kathryn McIntyre

Nearly 2,000 people enjoyed the sights of Monte Carlo at the meeting.

Judging from registration lists, it appears that the same European companies attended, Mr. Lock observed, and there are a lot more Americans than there used to be.

Lower attendance, he said, wouldn't be surprising, considering the impact of mergers, hard times and brokerages watching expenses.

"Who wants to spend $10,000 to come here when things are bad?" asked David Avasthi, president of UIC Ltd., a political risk underwriter in Miami.

For Rendez-Vous veterans, the lower numbers may have been exacerbated by the perception that fewer familiar faces were to be found this year. Some participants had retired or moved from their positions, replaced by individuals who had never been to the Rendez-Vous.

"There are an amazing number of people who I don't recognize," said Henri Chaloub, chairman of MEPA Group of Paris. "I think that there are a number of small fish and new faces. It's not the traditional people that you have met but the new people who are here. I have gone to four cocktail parties here (and) I only knew about 25% of the people. It is the first time that the number of people I know is so low."

As usual, the usefulness of the Rendez-Vous was a popular topic of conversation among participants.

Some suggested the importance of the Rendez-Vous is waning because the meeting takes place too early in the year. A late October meeting in Baden-Baden, West Germany, offers much better indications of what will happen at year-end renewals, participants say. And, business is conducted at that meeting, rather than just talked about as it is in Monte Carlo.

"It's the 12th time I have been to Monte Carlo and it seems to be the same number of people," said Benito Pagnanelli, director of the aviation, space, fire and miscellaneous, and reinsurance cessions departments for Assicurazioni Generali S.p.A. of Trieste, Italy.

"But, I don't know if Monte Carlo has the same meaning as the past," said Mr. Pagnanelli.

Insurers and reinsurers used to come to discuss business without the brokers. "Now we come here to feel out the market. Monte Carlo represents the preview of what's going on for year-end renewals. But in Baden-Baden you get a better view of the market (and) it's more important practically," he said.

Mr. Pagnanelli believes that the Rendez-Vous should be eliminated altogether.

"Monte Carlo is more of a social event while Baden-Baden is an occasion for talking and doing business," Mr. Pagnanelli said.

"This is probably my last Rendez-Vous," said Joseph J. Prochaska, chairman and chief executive officer of Chicago-based underwriting manager Shand, Morahan & Co. Inc. "In 1978-79, we got signed lines and decisions. That doesn't happen anymore."

Mr. Prochaska says that, rather than the Baden-Baden meeting, the annual November meeting of the National Assn. of Independent Insurers is the most important "because it's closer to year-end."

'Who wants to spend $10,000 to come here when things are bad?' asks David Avasthi of UIC Ltd.

The NAII will meet Nov. 11-15 in Los Angeles.

Shand, Morahan will be represented at next year's Rendez-Vous by Executive Vp Richard A. Adler, Mr. Prochaska said.

Others said there still are good reasons to come to the meeting.

"There's two reasons," said Mr. Blake. "One is to scurry around with 15-minute appointments and that's a valid thing to do. But in my case, I don't do that. But I do see people and renew acquaintances. It saves me a trip around Europe in order to accomplish the same thing."

If the meeting adds something to the "equation" of doing business "then it's valuable," said Mr. Blake. "This is a people business, so any time you get a chance to talk to people in the business, it's very valuable."

This aspect of getting to know individuals in the marketplace is sometimes undervalued, noted Mr. Blake. "So the mere idea that we shouldn't sum each other up, look each other in the eye, take measure and decide whether we like the person and decide whether we should do business with them is a nonsense."

And why not Monte Carlo? he asked. "Is Scunthorpe (in England) better? If you actually leave aside the restaurants (in the Cote d'Azur), which are obviously ripoffs, on every other comparative measure it's not that expensive."

Hotel rates in Monte Carlo are the same or cheaper than in London. The air fares are comparable, he said. "To meet your customer in a pleasant environment makes all the sense in the world."

Only U.S. citizens, faced with a weak dollar that bought only five French francs, were complaining about costs, including the $60 required to fill up the tank of a four-door Volvo.

"I think (the Rendez-Vous) will go on because there is nothing to stop it from going on. Nobody has to take a decision for it to go on," said M&G's Mr. Lock. "There really isn't anybody to make a decision to stop it from going on unless all the hotels in Monte Carlo went bankrupt, which seems unlikely. It's got an in-built momentum, continuity."

It's not a question of whether the Rendez-Vous has lost its importance as much as "whether it ever had any importance," he continued.

"If you went back 35 years ago, in the early days, it was very much a smallish sort of gathering. Then it became a much more commercial meeting. Now, looking at the list of participants it feels as if it's almost been taken over by consultants and lawyers and bankers."

Mr. Chaloub says his 12 people will be back to Monte Carlo next year, although they may change their setup. Instead of meeting people in hotel lobbies and the Cafe de Paris, and wasting 10 minutes because people are late or they are not recognizable, Mr. Chaloub will encourage meetings at a hotel suite and at the Sea Club.

Many agree that the Rendez-Vous de Septembre is a lasting institution.

"It will go on forever," said up James Payne, chairman of London-based reinsurance brokerage E.W. Payne Cos. Ltd., a unit of Sedgwick Group P.L.C.

Edward B. Jobe, president of American Re-Insurance Co. Ltd. in Princeton, N.J., predicts that "10 years from now, if its just a meeting for reinsurance, it will be a lot smaller in attendance. How many reinsurers will there be 10 years from now? The small reinsures are having trouble attracting good business because security lists are getting shorter and shorter."

Nonetheless, Mr. Jobe finds the Rendez-Vous "a great place to renew relationships with CEOs. We have a suite at the Hermitage where we bring people for meetings."

American Re is not now writing renewals, but is asking clients "What can we do better? What are your needs?" Mr. Jobe said. American Re also was meeting with its partners in a new financial reinsurance company (see related story), retrocessionaires and markets of its Am-Re Brokers Inc. unit.

Where else in the world can you bring so many people together?"

"Monte Carlo won't disappear," says Claude E. Nyssen, vp-Europe for Prudential Reinsurance Co. in Brussels, Belgium, who attends both the Rendez-Vous and the Baden-Baden meeting.

"People on the one hand will always need a forum to exchange ideas and to socialize, which has always been the intention of Monte Carlo, in a more friendly atmosphere," he said. "Besides, nonprofessionally, people simply love Monte Carlo."

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34th Rendez-Vous de Septembre

Reinsurers view Eastern Europe with caution

By STACY SHAPIRO

MONTE CARLO, Monaco—If you'd told anybody attending the Rendez-Vous de Septembre a year ago that the Berlin Wall would be coming down, "no one would have believed you," summed up Claude Nyssen, a vp with Prudential Reinsurance Co. in Brussels, Belgium.

Those attending the Rendez-Vous last year were commenting on the flood of East Germans across the just-opened Hungarian border to West Germany.

Only 12 months later, reinsurers gathered in Monte Carlo speculated on the pending October merger of the two Germanys and the investment opportunities in a non-Communist Eastern Europe.

Nearly all agreed that the Western insurance world must wait patiently for returns on investments in Eastern Europe. Now may be the time to forge good relations; it's not the time to make money quickly, they said.

"Look at the economic problems that the Eastern Europeans have to face," Mr. Nyssen pointed out. "I don't see any sudden expansion there. However, we are constantly visiting markets in this (region) and nurturing our contacts there and keeping an eye on it.

"I was in Warsaw last week and someone said that it is more difficult to compete than to nationalize."

"I am diametrically opposed to the enthusiasm that we had a few months ago" over Eastern Europe and the merging of the two Germanys, added Theo Dielmann, executive vp of Hannover Reinsurance A.G.-Eisen und Stahl Reinsurance A.G. of Hannover, West Germany.

"I think (progress) will be very, very slow," he said.

"Generally, before things get better they will get worse, which is never good for business. It will be a high-risk area, which is never a good situation for making a fast buck. It will be a very tedious, slow, time-consuming process (of change). And, of course, insurance is geared very much to the standard of living and the standard of living has to improve before a lot of money can be made on insurance," he said.

"It may take at least 10 years before we see some potential results, some decent profit potentials," said Mr. Dielmann. "But if there is a time (to invest), it should be now for those who are able to spend the money. Now is the time to make your connections because I think that will be money well spent."

German unification, for example, offers "great potential" for West German insurers. However, East Germany still has to build its economic infrastructure and improve its loss experience "which hasn't been too good," Mr. Dielmann said. And reinsurance opportunities so far are somewhat limited, he added.

It is also hoped that unification would ease some competition among West German insurers as the nation's insurance companies become more interested in investing in East Germany, Mr. Dielmann said.

Most insurance business in Eastern Europe "is still written by the old regimes," commented Ron Iles, chairman of Alexander Howden Reinsurance Brokers Ltd. in London.

"Although there are new insurers in Hungary and Poland, they won't write a lot of business for a few years yet. But it's an exciting market," he said.

Mr. Iles pointed out that the Eastern European countries need Western help with technology and training, which would be the first step on the road to good, long-term relationships with these countries.

Among those companies already with Eastern European investments is one of Europe's largest insurance groups.

Assicurazioni Generali S.p.A. in Trieste, Italy, which is right next to the Yugoslavian border, already is operating in Hungary through a joint venture established two years ago with state insurer Allami Bizosito.

Generali owns 40% of the venture, Allami Bizosito Generali, and manages the company, said Benito Pagnanelli, director of the aviation, space, fire and miscellaneous, and reinsurance cessions departments at the Italian insurer.

Generali also has an agreement to start an operation in Czechoslovakia as soon as foreign investors are allowed in, Mr. Pagnanelli noted.

> 'It may take at least 10 years before we see some potential results, some decent profit potentials,' says Mr. Dielmann. 'But if there is a time (to invest), it should be now for those who are able to spend the money.'

And, Generali is considering entering the Soviet Union, Bulgaria and Romania, where Generali had maintained offices before the start of World War II, Mr. Pagnanelli said.

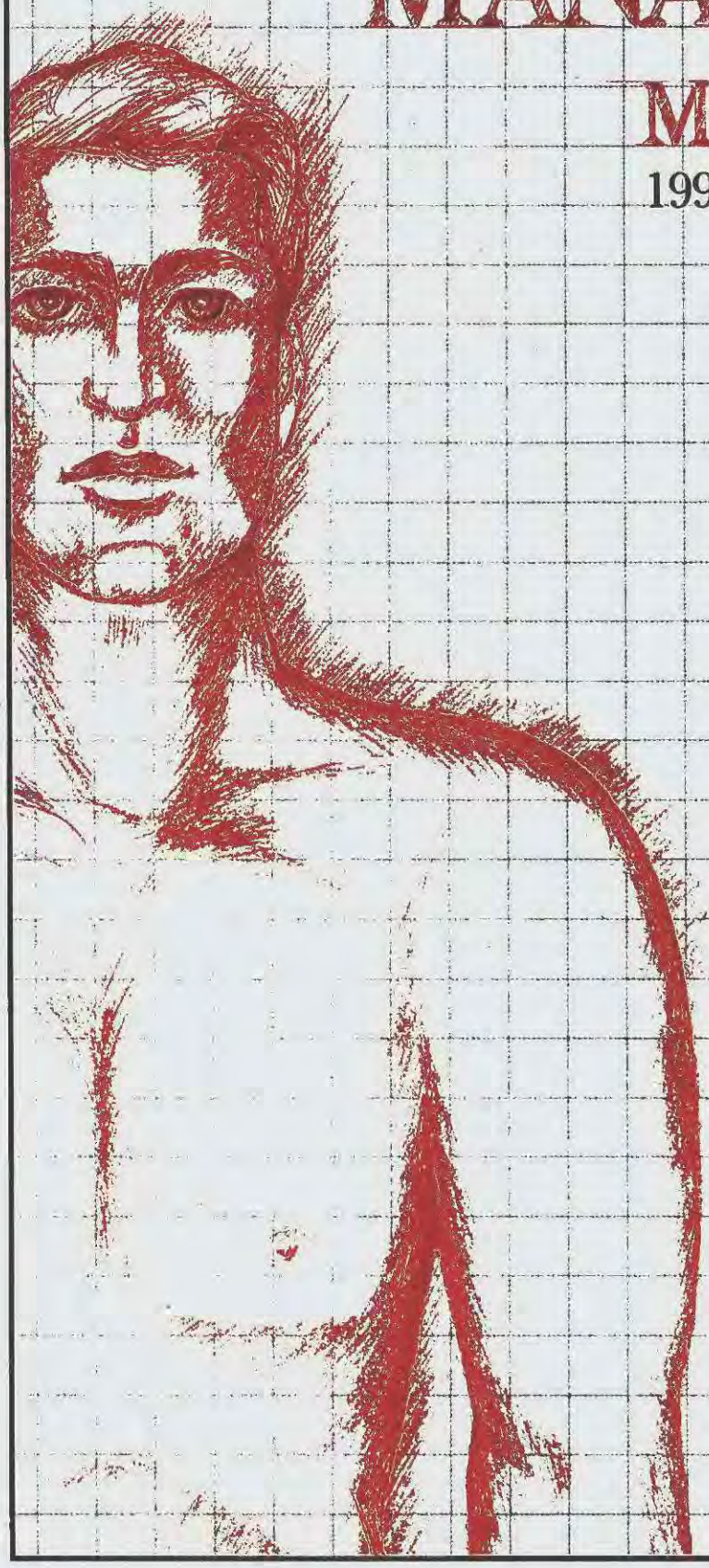
The insurer does not intend to rush into any countries, and knows that it will take as long as 10 years for investments to bear fruit, Mr. Pagnanelli said. "Investments won't produce results for some time."

Political change in Eastern Europe could present more immediate opportunities for political risk insurers, says President Louis Habib-DeLoncle, president of the P.A.R.I.S. pool.

Mr. Habib-DeLoncle sees the need for a new product to respond to the privatization of government-owned entities.

If a government-owned entity does not meet its financial obligations to a business partner, it is clearly a political risk loss, he explained. But when a government entity doesn't pay its obligations and becomes a private company, the loss probably is not covered by conventional political risk insurance, he said.

"We are going to put together special capacity for that," according to Mr. Habib-DeLoncle. ■



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34th Rendez-Vous de Septembre

News of Aon bid and other deals is freely traded at Rendez-Vous

By STACY SHAPIRO

MONTE CARLO, Monaco—By the time the Sept. 13 morning newspapers got to their hotel rooms, many registrants at the 34th Rendez-Vous de Septembre already knew that Aon Corp. had made a bid the previous evening to snap up Corroon & Black Corp. despite its planned merger with Willis Faber P.L.C.

News travels fast by word of mouth as participants socialize all day and all evening, gathering market information in the relaxed atmosphere of lunches, receptions, dinners and nightcaps.

Willis Faber Chairman Roger Elliott had flown from London on Sept. 12 to host a dinner for about 150, the largest of the many dinners Willis Faber holds all week. At about 7 p.m., his shower was interrupted by a call from his secretary with the news: Aon had made a counteroffer for Corroon & Black (*BI*, Sept. 17).

On his way to the restaurant and over dinner, Mr. Elliott said, he told a few friends about the bid. One of those was Patrick Lucas, chairman of Paris brokerage Gras Savoye S.A., which is a part of the UNISON international network of brokers from which Willis has been estranged since announcing its planned merger with Corroon & Black.

Although Mr. Elliott only told a few people, by 2 a.m. the news was racing through the back bar of the Loews Hotel casino where many Londoners and Bermudians traditionally gather for nightcaps before going to sleep or dancing at the Living Room discotheque. Several people rushed out of the bar to call their companies to verify the news.

Rendez-Vous participants, in addition to private meetings with business associates, gather market news and discuss business all week at luncheons, receptions, dinners and late-night dances hosted by brokers, underwriters, accountants and lawyers.

In other words, pleasure is business at the Rendez-Vous.

Kathryn McIntyre

Hosts of the Bermuda reception sporting their Bermuda shorts are, left to right: James Parkinson of Stockholm Re (Bermuda) Ltd.; John Marett of Pinnacle Reinsurance Co. Ltd.; Joe Gibbons of the Bank of Butterfield; Jim Kemp of Tate & Lyle Reinsurance Ltd.; Michael Jenkins of HJF International Ltd.; Ian Hawker of Independence Insurance Co.; Jonathan Crawley of Sphere Drake Underwriting Management (Bermuda) Ltd. (back); Robin Spencer-Arscott (front), Nigel Clark and John Williams, all of Anchor Underwriting Managers Ltd.; Nick Wheeler of Victory Reinsurance Management (Bermuda) Ltd.; Colin Murdoch-Muirhead of the Bank of Bermuda; Colin O'Connor of Belvedere Insurance Co. Ltd.; John Swain of the Bank of Bermuda; Alain Wattiez of Stockholm Management Ltd.; and David Thirkill, formerly of Forum Reinsurance Co. Ltd.

This year, glorious weather—sunny skies, cool breezes and no rain—allowed all the functions to proceed without a hitch.

Two evening receptions on Sunday, Sept. 9, were once again the unofficial start of the Rendez-Vous.

One was hosted by Kroll & Tract, a New York law firm, at the Hotel Hermitage; the other was hosted by the directors of London-based brokerage PWS Holdings P.L.C. in the Loews Hotel lobby outside the Grand Salon.

At lunchtime Monday, reinsurance broker William F. Delaney Jr. hosted his traditional reception in the Churchill Room of the Hotel de Paris overlooking the harbor.

Mr. Delaney, an elder statesman of the Rendez-Vous, surprised guests by announcing that he intends to soon sell his New York-based Delaney Offices Inc. to "a major broker."

While Mr. Delaney says he would be happy to remain on his own "forever," he said his clients are suggesting that he arrange for another broker to take over their accounts someday. An announcement is expected this fall.

On Monday evening, Sept. 10, several London market associations hosted a cocktail reception to announce the move of the non-marine insurance company market into the London Underwriting Centre, currently under construction (*BI*, Sept. 3).

The Policy Signing & Accounting Centre Ltd. and the Reinsurance Offices Assn. held the reception in the Loews Hotel lobby outside the Grand Salon also to announce their Jan. 1 merger into the London Insurance & Reinsurance Market Assn. While hundreds milled about, cocktails in hand, a videotape showed the LUC building and some LIRMA representatives.

Ian Dean, chairman of Sphere Drake Insurance Group P.L.C., kept popping up on the videotape. Mr. Dean made an appearance at the party, but was only at the Rendez-Vous for that evening's events.

Also on Monday evening, the Principality of Monaco held its biennial dinner-dance at the Old Beach Club, among the city's most scenic areas. Long tables hugged the side of a glassy-calm Olympic-sized pool tucked between the mountains of the Cote d'Azur and the Mediterranean.

Several participants however, said they prefer the traditional Monday night cocktail party the principality holds every other year behind the Old Casino. It offers more of a chance to mingle, they say.

On Tuesday, Groupe MEPA once again presented brunch at the Sea Club. This has become known as a place to meet the heads of the French underwriting and brokerage fraternity, as well as members of other markets, and to taste every type of hors d'oeuvre, entree and dessert imaginable.

MEPA Chairman Henri Chaloub situates officials of his company all week in Sea Club cabanas and hosts individual lunches aside from the large brunch. More business was done at those lunches than at all the other meetings his dozen employees had, he said.

Several other cocktail parties rounded out Tuesday evening, including two hosted by accounting firms. Ernst & Young International held a champagne reception at the Atrium of the Old Casino, while Coopers & Lybrand Deloitte hosted a lavish reception at the Terasse of the restaurant Belle Epoque above the Cafe de Paris.

Coopers & Lybrand Deloitte lived up to its advertising pitch—that it's "not plain vanilla"—with strawberry sundaes.

The reception was just part of Coopers' week-long marketing drive. Eschewing official name badges in favor of tags shaped like ice cream cones, members of the firm met with most of the journalists at the Rendez-Vous and held other meetings at its hotel suite.

Also on Tuesday evening, Paris-based Societe Commerciale de Reassurance held a reception on the California Terrace overlooking the harbor, which was crammed with yachts.

Just a few hours later, Copenhagen Reinsurance Co. Ltd. of Denmark took over the terrace for its annual late-night party where guests danced under the stars.

During the week, many brokers, accountants and underwriters invite clients and friends to dinner parties.

For 15 years, the Spanish market has hosted such a dinner on Tuesday evenings. The unofficial host is Jose Luis San Roman of broker Morice Tozer Ltd. in Madrid, a subsidiary of Alexander & Alexander Services Inc.

On Wednesday, SCOR hosted a lunchtime reception on the terrace above the Cafe de Paris overlooking the old casino.

Also on Wednesday, members of the Bermuda insurance and reinsurance market hosted their annual reception at the Monte Carlo Sporting Club. Although a five-minute cab ride away from the center of action at the Cafe de Paris, the party was packed with members of the U.S. and London insurance markets, from which many now working in the Bermuda market hail.

The most frequent topic of conversation at the Bermuda party was the establishment of Sphere Drake Underwriting Management (Bermuda) Ltd., with hearty congratulations extended to its president Jonathan Crawley, formerly president of Aneco Reinsurance Underwriting Ltd. (*BI*, Sept. 17).

Excitement over a major investment in Bermuda by a London company was tempered somewhat by concern over Aneco's demise and the uncertain business plans of Forum Reinsurance Co. Ltd. following the resignation of David A. Thirkill as president.

Nonetheless, a festive atmosphere prevailed. Members of the Bermuda market, all sporting their trademark shorts, cheerfully posed for a group photograph.

On Wednesday evening, Lloyd's reinsurance brokerage Kininmonth Lambert, a subsidiary of Lowndes Lambert Ltd., held its annual reception on the yacht M.Y. Moonmaiden in Monte Carlo Harbor.

Last year strong incoming seas whipped up waters in the harbor, leaving many people afraid to go aboard for fear of being seasick. This time around, as the yacht sat calmly, hundreds drank champagne and discussed the market in the cabin and on the top deck.

On Thursday, a dinner at the Monte Carlo Sporting Club closed the 34th Rendez-Vous de Septembre.

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Associate Publisher and Editor Kathryn J. McIntyre contributed to this report.

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34th Rendez-Vous de Septembre

Citicorp exits financial reinsurance venture

By KATHRYN J. McINTYRE

MONTE CARLO, Monaco—Citicorp Insurance Group has pulled out of a proposed joint venture with Skandia International Insurance Co. to write financial reinsurance.

The project, dubbed Gemini, is not going forward because Citicorp decided against it, confirmed Anders Grabo, senior vp and chief underwriting officer of Skandia America Group, during an interview at the 34th Rendez-Vous de Septembre.

Only a few people at the Rendez-Vous had heard of the demise of the project, which was expected to present a major competitor to Centre Re Holdings Ltd. in Bermuda, the largest underwriter of financial reinsurance.

Loosely defined, financial reinsurance involves acknowledging anticipated investment income as an underwriting component and capping the reinsurers' ultimate liability (*BI*, April 30).

Citicorp, which had approached Skandia with the project, ultimately decided not to invest approximately $25 million in Gemini, which was expected to be capitalized at $100 million.

Skandia, which already underwrites financial reinsurance programs from offices worldwide, is not seeking another partner, pointed out James F. Dowd, president and chief executive officer of Skandia America Group in New York.

The advantage for Skandia of a joint venture with Citicorp would have been the bank's distribution network, noted Mr. Dowd in an interview following the Rendez-Vous.

The demise of Gemini is good news for a new financial reinsurance company to begin writing soon in Bermuda: Inter-Ocean Holdings Ltd.

With 11 investors from four continents whose combined assets exceed $150 billion, Inter-Ocean is capitalized at $25 million, which is expandable to $100 million.

The new financial reinsurer has not written any business yet, but items have been submitted by foreign investors, said Edward B. Jobe, president and chief executive officer of American Re-Insurance Co. in Princeton, N.J., an investor in Inter-Ocean.

Inter-Ocean, which will be an open market, will hold a board meeting next month during which the details of the company will be finalized.

Announcements of investors and business plans will follow, according to Mr. Jobe.

While obviously not unhappy at the news that Gemini will not be entering the financial reinsurance market at the same time as Inter-Ocean, Mr. Jobe said Inter-Ocean is not concerned that Centre Re is the largest underwriter of financial reinsurance, reporting $268 million in reinsurance volume in 1989.

"There's room for both of us," said Mr. Jobe, noting that "there are a lot of needs."

Indeed, Centre Re's top executives—President Steven M. Gluckstern and Executive Vp Michael D. Palm—did not attend the Rendez-Vous this year due to the press of business.

Maralyn Fichte, managing director of Centre Reinsurance (Representative) Ltd. in London, Centre Re's contact office, did attend the meeting.

"Europeans are fascinated with our product," Ms. Fichte said. In particular, Centre Re's products can assist companies in handling their discontinued business, she noted.

But with one potential new competitor out of the picture, another reinsurer is considering entering the business and is especially interested in the European market.

Societe Commerciale de Reassurances, the 10th-largest reinsurer in the world with $1 billion in net reinsurance premiums written in 1989, earlier this month engaged Daniel G. Marren, former vp and chief financial officer of Centre Re, as a consultant on an exclusive basis.

Mr. Marren is helping SCOR determine if it should enter the financial reinsurance business on a worldwide basis.

SCOR is questioning, among other issues, whether it can write financial reinsurance from its base in Paris, or whether it needs a special subsidiary elsewhere, explained Jacques P. Blondeau, vice chairman.

Replacing Mr. Marren at Centre Re is Ted Pritchard, formerly with GTE REinsurance Co. Ltd. in Bermuda.

While more reinsurers are becoming interested in underwriting financial reinsurance, companies that specialize in time-and-distance policies—which guarantee ceding companies specific payments at specific times in the future based on the initial premium paid and investment returns expected by the reinsurer—for Lloyd's of London syndicates may find less demand for that type of financial reinsurance product based on this year's poor underwriting results.

"Unfortunately, they are spending all their money on claims," quipped John Marett, a director of Pinnacle Reinsurance Co. Ltd. in Bermuda, referring to the spate of storm losses in Europe earlier this year.

Pinnacle specializes in time-and-distance policies, as well as other financial reinsurance products that entail assuming the risk of when claims will be paid.

Meanwhile, Mr. Jobe noted that American Re subsidiary Am-Re Brokers Inc. "has been a major producer to Centre Re."

Am-Re Brokers, with a staff of about 80, is starting to make money, Mr. Jobe added.

Am-Re Brokers will generate commissions of $10 million to $15 million this year, he said, stressing that American Re generally has underwritten a portion of the risk before the business is offered to the market.

"About 95% of the time, American Re has a retained line on the brokered business," Mr. Jobe pointed out.

And, risks offered the market by Am-Re Brokers are accompanied by all the work done by American Re before it underwrote a portion of the risk: underwriting audits, claims audits, actuarial reviews, price-to-exposure monitoring and management reviews.

Only when American Re doesn't write a particular line does Am-Re Brokers offer it to the reinsurance marketplace without American Re's participation, Mr. Jobe explained. ■

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IN THE MATTER OF LIQUIDATION OF YORKTOWN INDEMNITY COMPANY) NO. 88 CH 9367

NOTICE

PLEASE TAKE NOTICE, that on FEBRUARY 7, 1989 an Order of Liquidation With a Finding of Insolvency was entered against Yorktown Indemnity Company ("Yorktown") by the Honorable Sophia H. Hall, Judge of the Circuit Court of Cook County, Illinois. Zack Stamp, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of Yorktown.

TAKE FURTHER NOTICE, that pursuant to the Order of said Court, all rights and liabilities of Yorktown and of its creditors, policyholders and all other persons interested in its assets are fixed as of February 7, 1989, unless otherwise provided by such other Order of the Court.

TAKE FURTHER NOTICE, that the form of and required content of all Proofs of Claim are described in Illinois Revised Statutes, 1987, Chapter 73, Paragraph 821. Proofs of Claim, together with supporting documents, if any, are to be filed with, and may be secured from, the Special Deputy Liquidator, Yorktown Indemnity Company, In Liquidation, 446 East Ontario Street, Suite 700, Chicago, Illinois 60611. Filing shall occur upon the receipt of Proof of Claim by the Liquidator. The Liquidator reserves the right to require such additional information with respect to any claims as he may deem necessary. The Liquidator Further reserves all rights to any an and all defenses of Yorktown concerning such claim. All Proofs of Claim must be duly sworn to before an Officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR AT HIS ABOVE-MENTIONED OFFICE IS DECEMBER 31, 1990 AT 4:30 P.M., CHICAGO TIME. NO PERSON HAVING OR CLAIMING TO HAVE ANY CLAIMS, CONTINGENT OR OTHERWISE, AGAINST YORKTOWN INDEMNITY COMPANY SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE FILED WITH THE LIQUIDATOR ON OR BEFORE DECEMBER 31, 1990 AT 4:30 P.M. C.S.T.; AND IF ANY SUCH CLAIMS ARE CONTINGENT CLAIMS, THEY MUST BE LIQUIDATED PURSUANT TO SECTION 209 OF THE ILLINOIS INSURANCE CODE (ILL. REV. STAT., 1987, CH. 73, PARA.821) ON OR BEFORE DECEMBER 31, 1991 AT 4:30 P.M. C.S.T.

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CEO's Presidents, and Owners . 2,670
Vice-Presidents, General Managers and Other Administrative Personnel 4,438

Financial:
Chief Financial Officers and Vice-presidents of Finance 3,149
Secretaries, Treasurers, contollers and other Financial Personnel 4,505

Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 10,830
Sub-total 25,592

Associations 511
Government, Unions and Educational Institutions 1,289
Commercial Consumers
Sub-total 27,392

Insurance Agents and Brokers . . 9,815
Insurance Companies 7,891
Accountants, Actuaries, Attorneys & Consultants 3,377
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,218
Others Allied to the Field 1,693
TOTAL 51,386

* Source Business/Occupational breakdown of qualified circulation, May 28, 1990 issue, as submitted to BPA for June 1990 BPA Publisher's Statement.

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34th Rendez-Vous de Septembre

Brokers must beef up services: Panel

Intermediaries told to 'sharpen skills'

By KATHRYN J. McINTYRE

MONTE CARLO, Monaco—Reinsurance brokers must improve their service to ensure they will play a strong role in the future, a panel of reinsurance experts agrees.

"Those halcyon days of high revenues derived from nothing but a simple placing function in a 'low tech' or 'no tech' business have gone," James Payne, chairman of E.W. Payne Ltd. of London, said at the 34th Rendez-Vous de Septembre.

"The days when a few experienced people could start a reinsurance intermediary firm with just enough financial backing for the first few years' expenses are past," warned Richard H. Blum, chairman and president of Guy Carpenter & Co. Inc. of New York, the reinsurance brokerage unit of Marsh & McLennan Cos. Inc.

Reinsurance brokers, says Societe Commerciale de Reassurances Chairman Patrick Peugeot, "will need to sharpen their skills as product innovators as well as cost managers" to "continue to thrive in a competitive environment."

Edgar Muller-Gotthard, chairman of Victoria Ruckversicherung A.G. in Dusseldorf, West Germany, added that reinsurance brokers will have to "come up with much more upfront knowledge of primary markets and individual insurers' books of business; much more professionalism in manpower, tools and skills for assessing adequate reinsurance needs; more meticulous conveyance of 'transparent' language from the insurer to the reinsurer and vice versa; and avoid delays in the transfer of funds."

'Brokers must not forget that placing a risk is one task, but managing claims is another. . . .No reinsurer should write any business from ceding companies and brokers that would not be able to manage the claims,' Mr. Peugeot says.

These remarks came during the only formal general meeting at the Rendez-Vous earlier this month in Monte Carlo.

Unlike other years when speakers' papers were included in registration packages, registrants had to wait until after the discussion to collect the papers.

This tactic—and the stature of the speakers—only marginally improved attendance this year. For years, only a few hundred people have attended the formal panel discussion.

Panel chairman Hans Dalborg, president and chief executive officer of Skandia International Insurance Co. in Stockholm, Sweden, set the stage for the panelists' comments on the future of reinsurance brokers by identifying three trends:

- The internationalization of the insurance business. Multinational insurers and reinsurers are being formed, but he questioned whether they have developed global strategies.
- Deregulation, including the blurring of lines between banking and insurance and the creation of a common market in Europe.
- Explosive developments in electronic communications.

With these developments in mind, Mr. Dalborg posed the provocative question: "Is there a need for reinsurance brokers and, if yes, in what role and scope?"

Each executive on the panel agreed there will continue to be a need for brokers, and each offered suggestions on how they could best fulfill the role.

Mr. Payne admonished reinsurance brokers that they "must do better" in eight traditional service areas:

- Development of a wide network of contacts, relationships and associations.
- Speedy and decisive response to client needs.
- Presentation of alternative thoughts and attitudes on reinsurance options.
- Knowledge of markets, prices and conditions.
- Knowledge of the client and client needs to assist in the program design.
- Collection and distribution of premiums.
- Collection and distribution of claims.
- Advice on the security and performance of markets to reduce the risk of non-performance.

"None of these things is new," Mr. Payne pointed out. However, the reinsurance broker "must expect to deliver standards of excellence in every one of these areas to a level that has not historically been contemplated if he is to maintain indispensability in the future."

While saying that he intended "no offense," Mr. Payne continued that "many brokers are not far beyond the Stone Age when it comes to the matter of integrated reinsurance planning."

For example, instead of merely selling a new top layer to a ceding company with a flood exposure, the broker today must first help accurately determine exposures, he said.

"To do so, they will need to provide an amalgam of actuarial science, statistical acumen and consultancy skills allied with traditional broker judgment and entrepreneurial flair," Mr. Payne said.

Reinsurance brokers that do not "move in this general direction" have one other alternative to survive in the future, Mr. Payne suggested: Operating as smaller, niche brokers in a small geographic area like London.

Mr. Blum of Guy Carpenter also emphasized that much more capital and expertise must be invested by reinsurance brokers today to "understand the goals and competitive strategies of their clients, who use reinsurance as a tool to manage risk, to augment their capital structure and to optimize the profitability of their companies."

Intermediaries, Mr. Blum pointed out, must not only place reinsurance but be consultants and advisers.

In addition, intermediaries have to develop products, tools and capabilities in response to the client's desire to use reinsurance as a substitute for capital, he explained.

"Third, the intermediary must retain his role as the advocate for the client," Mr. Blum emphasized. This requires that the broker act with "integrity and intelligence" in representing the client in the marketplace while "fairly and equitably" representing the views of the reinsurance market to the client.

To accomplish these goals, they will need capital to invest in data processing technology as well people with higher skills who can master the traditional and new financial challenges in reinsurance, he advised.

"Reinsurance intermediaries with vision, efficient management and sufficient capital will be able to succeed in the global marketplace," Mr. Blum wrote in his paper.

From his perspective as a reinsurer, Mr. Peugeot of Paris-based SCOR said brokers can assist reinsurers generally in deciding what lines of business to write through their knowledge of the marketplace and specifically in determining on a preliminary basis the needs of a particular ceding company.

Brokers also can assist reinsurers in reducing administrative expenses through their "technical and administrative competence" in such areas as wordings, accounting, taxation and jurisprudence, Mr. Peugeot advised.

But brokers also can present reinsurers with "major drawbacks," Mr. Peugeot warned: This happens if the broker impedes the free flow of information from the ceding company to the reinsurer, preventing a thorough understanding of the risk; and if the broker acts as a "passive observer" instead of a problem-solver in the handling of claims.

"Brokers must not forget that placing a risk is one task, but managing claims is another. Commissions are paid for both, and no reinsurer should write any business from ceding companies and brokers that would not be able to manage the claims in the long term," Mr. Peugeot commented.

In advising reinsurance brokers to "add value to the service they provide," Mr. Peugeot suggested that brokers:

- Offer more efficient service in the distribution of reinsurance.
- Move money—both premiums and claims—more quickly.
- Develop a worldwide network of contacts capable of acting efficiently and rapidly.
- Grow in size in order to offer the facilities needed by the "sophisticated giants" being formed by mergers and acquisitions.
- Extend the range of services they offer, including electronic networking, actuarial services, auditing and new product development.

Finally, Mr. Peugeot advised reinsurance brokers against allowing "security and service to take a back seat to price" when selecting markets. When they do, "the insurer suffers from inadequate service, and the reinsurer from inadequate information and an insufficient premium, which in turn reduces the brokerage earned by the broker."

Mr. Muller-Gotthard of Victoria Ruckversicherung warned brokers that if the cost of reinsurance to the primary company is to include brokerage, "then this function must be worth its money."

To be worth the money, a broker must keep "much closer to the primary insurance scene than in the past," Mr. Muller-Gotthard wrote in his paper.

Primary insurers will require brokers to focus on finding an "adequate and reliable supply of coverage, mainly for highly exposed classes and not necessarily the easy-going, bread-and-butter type of exercise," Mr. Muller-Gotthard suggested.

Reinsurance transactions in the future will involve "tailor-made risk transfers in special and target types of risk; catastrophe protections; and exposures assumed in developing international activities by mergers, establishments abroad or practicing freedom of services internationally," he explained.

The broker's role, Mr. Muller-Gotthard said, is "wherever and whenever the broker is capable of matching his client's demand for reinsurance with a corresponding supply which is not otherwise—i.e. directly—offered at equal or better terms to the insurer." ■

Insurance services guide

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34th Rendez-Vous de Septembre

Fewer mergers announced at meeting

By KATHRYN J. McINTYRE and STACY SHAPIRO

MONTE CARLO, Monaco—The Rendez-Vous de Septembre is a target date for companies to complete new mergers or acquisitions in order to announce them to the marketplace.

While the flurry of mergers and acquisitions that overpowered news at the Rendez-Vous de Septembre last year died down during this year's gathering in Monte Carlo—not one formal press conference was held—some informal announcements were made.

For example, Ernst & Young, the joint administrators of British & Commonwealth Holdings P.L.C., issued a press release announcing that B&C subsidiaries Abaco Investments P.L.C. and B&C Insurance Management Holdings P.L.C. had agreed to a management buy-out of their non-U.K. brokerage subsidiaries at an undisclosed price.

The U.K. brokerage operations of Abaco and B&C Insurance Management will be sold to Lloyd's brokerage group C.E. Heath P.L.C.

And, pending the completion of the contract, the names of B&C's Lloyd's of London brokerages involved in the transaction will be changed:

- B&C Non-Marine Brokers Ltd. will become Morgan, Read & Coleman Ltd.
- B&C Marine Brokers Ltd. will become Morgan, Campbell & Wright Ltd.
- B&C Aviation Insurance & Reinsurance Brokers Ltd. will become Morgan, Read & Sharman Ltd.

In addition, Shand, Morahan & Co. Inc. also arrived at the Rendez-Vous with news: Markel Corp. will become its owner.

Markel plans to purchase the interest Fairfax Financial Holdings Ltd. currently holds in F-M Acquisition Corp.—Shand, Morahan's parent company—for $45 million in cash and substantially all of Markel's ownership of Fairfax and other securities.

Markel currently owns 42.5% of F-M, which owns all of the outstanding stock of Shand and its insurance subsidiaries: Evanston Insurance Co., Insurance Co. of Evanston and National Specialty Insurance Co.

Following the transaction, Markel would own 90% of F-M. In addition, the other 10% of the company—half of which is held by Shand management—will be sold to Markel for stock, said Shand President Joseph Prochaska.

"There will be no changes in our operations," Mr. Prochaska said, "but we also expect the opportunity to do different things."

Shand, with 260 employees, is underwriting about $100 million to $125 million in premiums this year. It specializes in professional liability lines including architects' errors and omissions insurance and medical malpractice coverage. Shand also writes product liability insurance and professional liability insurance for insurance agents and brokers, lawyers and insurance companies.

Also sporting new ownership as well as a new name is the former National Underwriters (Reinsurance) Ltd. of Bermuda.

The property/marine reinsurance company is now ultimately 100% owned by Lansforsakringsbolagens AB of Sweden. LAFB continues its 39% ownership in the company, while its subsidiary, Stockholm Reinsurance Co. Ltd., purchased the outstanding 61%.

Under its new ownership, the company is called Stockholm Re (Bermuda) Ltd.

In addition, Stockholm Re (Bermuda) has purchased 80% of the stock of Bermuda-based broker HJF International Ltd., which will retain its name. HJF's management retains a 20% interest in the firm.

'There will be no changes in our operations,' says Shand, Morahan's Mr. Prochaska.

And, Stockholm Re (Bermuda)'s captive management company has assumed the name Stockholm Management Ltd.

Meanwhile, Anglo American Insurance Co. Ltd. in London distributed its first "Anglo Bulletin" in the lobbies of the hotels hosting the Rendez-Vous, its first marketing effort since Anglo American was sold to John Head & Partners by Calfed Inc. earlier this year.

Anglo American, which is not affiliated with the insolvent Anglo-American Insurance Co. in Louisiana, has been quiet about the growth of its operations since its former London underwriting agent, H.S. Weavers (Underwriting) Agencies Ltd., stopped underwriting March 26.

Anglo American and Weavers' sister company, Walbrook Insurance Co. Ltd., were the only two insurers on the Weavers line slip when Weavers stopped underwriting. Although Walbrook is solvent, it has ceased underwriting because of concerns about reinsurance recoveries (*BI*, April 2).

Anglo American remains a healthy, solvent insurer employing more than 40 people in new offices at Guild House on Fenchurch Street near Lloyd's in London.

In the newsletter, Anglo American Chairman John C. Cumming notes that when he became chairman on March 19, "I had no idea of the upheaval the ensuing 90 days would bring—a series of events outside our company's control that will still have repercussions for some time to come on a number of other companies in the London market."

Mr. Cumming said his key task as incoming chairman was "effectively to build a new company out of the old, following acquisition of all the company's issued share capital from Calfed Inc. by Magister Agency Investments Ltd., our U.K. company. One week into the job and with the beginning of an 18-month development plan under way, the crisis broke."

With Weavers not underwriting, "we were faced with the need to set up a completely independent operation," wrote Mr. Cumming.

During the "frenetic" 90 days following this development, Anglo American grew from a staff of one with a tiny office in Guild House to "a fully fledged insurance company occupying two floors of the building."

By the end of June, the initial restructuring of Anglo American had taken place. However, the company since then has only focused on renewals of the business formerly written by Weavers, wrote Mr. Cumming.

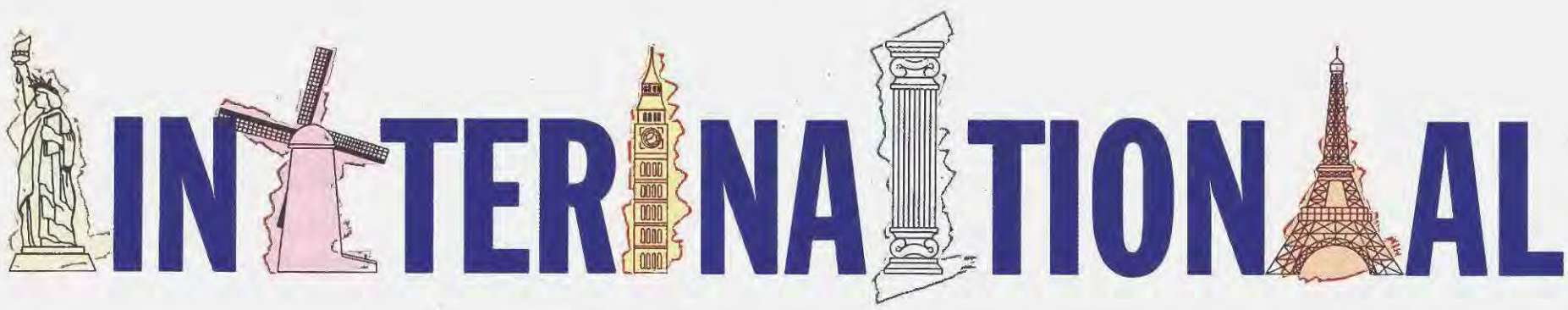
"We are rapidly approaching the time when we will be able to consider new business," he said. "During Phase 2 we will progressively bring support services in-house and undertake limited new business, while by the end of the third phase we will have all computer-based systems in place and the company will be ready for the move to the London Underwriting Centre."

With its book of North American casualty business written on a claims-made basis by Weavers, Anglo has reserves standing at more than 200 million pounds ($377 million), wrote Mr. Cumming.

As a result, "Anglo American has emerged from the (Weavers) affair in a strong, healthy position with the capacity and staff to underwrite specialist risks. We are very fortunate that we have had dialogue with the Department of Trade and Industry and other statutory authorities since March and we are grateful for the assistance they have given us."

The glossy Anglo American newsletter also introduced "who's

Continued on next page



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Business Insurance
a publication of Crain Communications Inc

Continued from previous page
who" at Anglo American. Many of the insurers' new employees came from Weavers.

Other reinsurers discussed their acquisitions and new business ventures in the last year.

Paris-based Societe Commerciale de Reassurances, for example, purchased Continental Reinsurance Corp.'s subsidiary in West Germany and sold 20% of it to the public.

"We wanted a better foot in Germany and Europe," explained SCOR Chairman Patrick Peugeot, noting that SCOR's European reinsurance companies are in France, Germany, Italy and Spain.

In addition, SCOR four months ago purchased 20% of a financially troubled reinsurance company in Venezuela and is managing the company on behalf of other investors, including local banks and local insurers. SCOR also is reinsuring the company.

SCOR also operates in the Far East through companies in Hong Kong and Singapore.

In the meantime, SCOR plans to export to other countries an unusual coverage that is mandatory in France: decennial liability insurance.

Under French law, developers must purchase the coverage to guarantee their workmanship against defects for 10 years.

SCOR believes the coverage can be marketed elsewhere, to a voluntary market, under the name of inherent defect insurance.

SCOR U.S., a New York-based affiliate of SCOR Paris, will offer the coverage as a reinsurer of Lexington Insurance Co., a unit of American International Group Inc. The coverage will be offered in the United States, the United Kingdom, Canada and Spain.

"It's a new product, introduced by a reinsurer," said SCOR Reinsurance Co. President Jerome Karter. However, brokers will market the coverage, he said, and Lexington is not an exclusive market for the coverage.

"So far, we've written just a few," Mr. Karter admitted, but he expects the market to develop, noting that the coverage can satisfy statutory bonding requirements.

The coverage also should be more economical than covering the risk under third-party liability insurance, SCOR executives say.

The cost, as a percent of the total value of a development, will vary depending on the characteristics of the development. And, the client will be billed for the engineering assessment, whether or not the coverage is ultimately underwritten.

SCOR plans to export an unusual coverage that is mandatory in France: decennial liability insurance.

In another development, the capacity of the P.A.R.I.S. Pool, a Paris-based political risk underwriter, was increased July 1 to 12 million ECUs ($16 million). The new capacity came from increased underwriting commitments by some members of the pool and the entry of a new member: Namur Credit of Belgium, said P.A.R.I.S. President Louis Habib-DeLoncle.

The pool, whose lead participant is La Reunion Francaise of France with a 30% participation, wrote 10 million ECUs ($13.3 million) in premiums in 1989, a 54% increase from 1988.

Mr. DeLoncle could not predict underwriting volume in 1990, given developments in Eastern Europe as well as elsewhere in the world. Recognition of the need for political risk insurance is increasing, he said, as is the justification for rate increases, which he added are "not really substantial."

Meanwhile, some as-yet-unheard-of reinsurance companies also made their way to the Rendez-Vous to tout their names.

In particular, Brussels-based Royal Standard Re S.A. passed out leaflets giving a pencil-sketch of the company and of its executive directors, Michael Walker and Gordon Cameron-Dick.

Royal Standard Re was formed in December 1988 with capital of $450,000, which has since been increased to $2.5 million, said Mr. Walker.

Royal Standard Re is now selling 51% of its shares to a U.S. public corporation, whose name the executives would not yet reveal, to increase its capital to $15 million, said Mr. Walker.

The sale is expected to be completed next month, so the reinsurer does not want to reveal the purchaser's name "in case it doesn't go through and we get egg on our face," said Mr. Walker.

So far, 85% of Royal Standard Re's business is U.S.-based, even though the company is headquartered in Brussels, according to Mr. Cameron-Dick.

To date, the company has three people employed in its Brussels office. "We want to keep it small," he said. ■

Explosion

Continued from page 3
eral law rather than through the state workers compensation system. The coverage is purchased from U.K. Mutual Steam Ship Assurance Assn. (Bermuda), a protection and indemnity club managed in London.

Ashland Oil also had hull insurance for the 14-year-old double-hulled Jupiter from Oil Insurance Ltd., a Bermuda captive. The spokesman would not elaborate.

A spokeswoman for Total Petroleum said the cargo of gasoline is insured for up to $10 million by Fireman's Fund Insurance Cos.

Total Petroleum's other property, including the dock, is insured for up to $250 million by Industrial Risk Insurers in Hartford, Conn.

U.S. Coast Guard officials and other local authorities were holding hearings last week to determine the cause of the accident.

An issue under consideration is Ashland Oil's allegation that the Buffalo, a 634-foot bulk carrier, caused the accident when it cruised past the Jupiter shortly before the explosion, confirmed a spokeswoman for the American Steamship Co. in Buffalo, N.Y., the Buffalo's owner.

Ashland maintains that American Steamship should be liable for damages, charging that the Buffalo created an unusually large wake that rocked the Jupiter and caused it to break free from the dock.

However, American Steamship, which is a subsidiary of GATX Corp. in Chicago, denies that allegation, saying that the Buffalo was not going excessively fast. The Jupiter may have been improperly moored, she said.

Details of American Steamship's coverage were unavailable.

—By Meg Fletcher

Kuwait

Continued from page 2
was also a preliminary notification of a $150 million claim for confiscated spare aircraft parts owned by the airline. Mr. Merrett said no claims have yet been made under the policy's "spare section," but said he expects such a claim, although the size is unknown.

The war risk underwriters, he said, will only pay for a loss of spare parts if the parts were actually in the aircraft when they were confiscated. Parts left in a hangar, for example, would be considered cargo and not covered.

Mr. Merrett said he believes three other Western planes, including a British Airways 747, are on the ground in Kuwait. So far, no hull war risk claims have been filed, presumably because the airlines believe Iraq will release these aircraft "in time," he added. ■

Datebook

OCTOBER

OCT. 1-2. OSHA and Cumulative Trauma Disorders in the Workplace conference in Washington, D.C., co-sponsored by Dickerson Occupational Health Services Inc. and Columbia University Occupational Medicine Program; $695. DOHS, 575 Eighth Ave., 14th Floor, New York, N.Y. 10018; 212-560-1234.

OCT. 1-2. Cost Control of Environmental Remediation Projects conference in Atlanta, sponsored by Executive Enterprises Inc.; $1,045. **Also Nov. 14-15** in Houston. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

OCT. 1-2. Illinois Environmental Regulation Conference in Chicago, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

OCT. 1-2. Groundwater Contamination: Managing Liability and Remediation conference in Philadelphia, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

OCT. 1-2. Hazardous Waste Business '90: West conference in Los Angeles, sponsored by Hazardous Materials Intelligence Report; $695. HMIR, P.O. Box 535, Harvard Square Station, Cambridge, Mass. 02238; 800-666-4430.

OCT. 1-2. Environmental Issues seminar in Boston, sponsored by the Casualty Actuarial Society; $300 for CAS members; $400 for non-members. Kathy Spicer, Casualty Actuarial Society, 1 Penn Plaza, New York, N.Y. 10119; 516-352-8453.

OCT. 1-2. The Three Cs of Employee Benefits: Consultation, Communications and Commissions symposium in San Francisco, sponsored by the American Society of Chartered Life Underwriters & Chartered Financial Consultants; $399 for society members; $499 for non-members. American Society of CLU & ChFC, 270 Bryn Mawr Ave., Bryn Mawr, Pa. 19010; 215-526-2500 or 800-392-6900.

OCT. 1-3. Fundamentals of Risk Financing course in Honolulu, sponsored by the Risk & Insurance Management Society Inc.; $540 for RIMS members; $640 for non-members. Risk & Insurance Management Society, Education Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 2. Flex 2000 Conference in Boston, sponsored by the Employers' Council on Flexible Compensation; $185 for ECFC members; $195 for non-members. **Also Oct. 16** in Seattle, **Oct. 17** in Los Angeles, **Oct. 23** in Houston, and **Oct. 30** in Pittsburgh. ECFC Conference Center, Dept. 5063, Washington, D.C. 20061-5063; 202-659-4300.

OCT. 2-3. Employee Benefits Course in Philadelphia, sponsored by Personnel Research Associates; $495. Connie Quinn, PRA, 49 Oakridge Road, Verona, N.J. 07044; 201-239-6154; 201-239-6154.

OCT. 3-5. Techniques of Loss Control course in Scottsdale, Ariz., sponsored by the Risk & Insurance Management Society Inc., $540 for RIMS members; $640 for non-members. RIMS, Education Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 4. Insurance Procurement & Negotiations seminar in Chicago, sponsored by the American Management Assn.; $525 for AMA members; $575 for non-members. **Also Oct. 15** in San Francisco; **Nov. 1** in New York City. American Management Assn., P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

OCT. 4-5. Fifth Annual Non-Qualified, Deferred and Executive Compensation Conference in Chicago, sponsored by the Employers' Council on Flexible Compensation; $185 for ECFC members; $195 for non-members. ECFC Conference Center, Dept. 5063, Washington D.C. 20061-5063; 202-659-4300.

OCT. 4-9. Guaranteed Replacement Cost Policies seminar in White Plains, N.Y., sponsored by the Inland Marine Underwriters Assn.; $65. John Paulson, Utica Mutual Insurance Co., P.O. Box 530, Utica, N.Y. 13503; 315-735-3321.

OCT. 5. Establishing an Effective Claims Management Program seminar in Chicago, sponsored by the American Management Assn.; $525 for AMA members; $575 for non-members. **Also Oct. 16** in San Francisco; **Nov. 2** in New York City. American Management Assn., P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

OCT. 7-10. Cleaning up Environmental Liability seminar in Washington, D.C., sponsored by The Society of Chartered Property & Casualty Underwriters; $400 for Society of CPCU members; $245 for spouses and guests. The Society of CPCU, Kahler Hall, 720 Providence Road, CB No. 9, Malvern, Pa. 19355-0709; 215-251-2750.

OCT. 7-10. Controlling the Costs of Workers Compensation Insurance seminar in Washington, D.C., sponsored by The Society of Chartered Property & Casualty Underwriters; $400 for Society of CPCU members; $245 for non-members. The Society of CPCU, Kahler Hall, 720 Providence Road, CB No. 9, Malvern, Pa. 19355-0709; 215-251-2750.

OCT. 8-12. Advanced Reinsurance Practice course in London, England, sponsored by Insurance & Reinsurance Research Group Ltd.; 825 pounds ($1,603) plus 15% VAT. Joy Bambrough, IRRG Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD; 071-236 2175.

OCT. 9. Labor/Management Workshop in Columbus, Ohio, sponsored by the Health Research Institute; $595. **Also Nov. 13-14** in Meadowlands, N.J.; and **Dec. 11-12** in Chicago. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 10-11. Natural Resource Damages Claims and Litigation Conference in Washington, D.C., sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 212-645-7880.

OCT. 10-11. Reinsurance for Underwriters Seminar in Rosemont, Ill., sponsored by the National Assn. of Mutual Insurance Cos.; $349 for NAMIC members; $379 for non-members. NAMIC Education Dept., P.O. Box 68700, Indianapolis, Ind. 46268-0700; 317-875-5250.

OCT. 10-11. Advanced Risk Management Analysis course in Denver, sponsored by the Risk & Insurance Management Society Inc.; $545 for RIMS members; $645 for non-members. RIMS, Education Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

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The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Business Insurance reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.

GM to appeal $5.6 million award in California

LOS ANGELES—General Motors Corp. says it will move for a new trial after a jury awarded $5.6 million to a woman who claims that faulty brakes on a Chevrolet pickup truck caused the 1984 accident in which she was seriously injured.

A Los Angeles Superior Court jury in Van Nuys ordered the Detroit-based auto giant to pay 85% of the $5.6 million award—$4.8 million. Murray's Truck Service of Chatsworth, Calif., which serviced the truck before the collision, was ordered to pay the remainder.

Lois Gass of Encino suffered a broken neck, a ruptured spinal disc and an eye injury when the car she was riding in was rear-ended by the 1977 pickup. Her husband was awarded $350,000 for loss of consortium.

Under product liability coverage from Royal Insurance Co., the automaker's self-insured retention is greater than the award, said GM attorney Eugene R. Grace, of Grace, Skocypek, Cosgrove & Schrim in Los Angeles.

Two other defendants were absolved of blame: the truck's owner and Gene Berg GMC of Van Nuys, which sold the truck.

Mr. Grace argued that the truck was not serviced according to GM specifications. He also charges that "the court erred in giving instructions on law to the jury."

A. Tod Hindin, a Beverly Hills lawyer representing Ms. Gass, argued that the truck's design was flawed because it had a single hydraulic brake system. When brake fluid escaped from a hole that had developed in the brake line, the vehicle was left without brakes, Mr. Hindin said.

In 1983 the federal government began requiring dual brake systems on trucks.

—By Louise Kertesz

UAW pact

Continued from page 3

mental pension benefits for a 55-year-old retiree under the agreement would total $11.00 a month of every year of credited service during the first year of the contract. The monthly benefit would increase to $12 in the second year and to $12.90 in the third year.

The benefit under the expiring contract is $9.40 a month for every year of credited service.

A 60-year-old retiree would receive $23.75 a month for every year of service under the first year of the contract, $25.85 during the second year, and $27.85 in the final year of the agreement.

The benefit under the expiring contract is $20.30 a month for every year of credited service.

For employees who retire before turning 62 and who have 30 or more years of service, monthly pension benefits will be $1,600 the first year, $1,700 the second year and $1,800 the final year of the contract, the spokesman said.

Under the expiring contract, the monthly benefit was $1,500.

However, when those retirees reach age 62 and become eligible for Social Security benefits, their pension benefits would be reduced to the basic benefit rate.

UAW members cannot retire and receive pension benefits before age 55 at GM.

Pension benefits for current retirees also would be improved under the tentative contract.

The monthly pension benefit of those who retired between Oct. 1, 1979, and Sept. 1, 1990, would be increased by $37.50, or $1.25 per month per year of service.

Those current retirees also would get two $630 lump sum payments over the next three years.

For current employees who are UAW members, GM has added a managed care component to its self-insured substance abuse and mental health care program.

The change is designed to improve quality and access to appropriate facilities, said the UAW spokesman.

GM will establish local central diagnostic and referral agencies to act as gatekeepers and serve as access points for UAW members seeking inpatient treatment for substance abuse and mental health problems, he said.

The CDRs will be affiliated with a network of mental health care providers.

GM also would improve substance abuse and mental health care benefits.

Under the agreement, the 140-visit maximum on lifetime outpatient visits for substance abuse treatment would be eliminated. UAW members would be able to receive full coverage for up to 35 visits per year.

The cost of substance abuse treatment received outside of the network would not be covered.

GM also would pay for 45 days of inpatient substance abuse care, up from 40 days. These benefits renew after the UAW member has been discharged for 60 days.

UAW members seeking inpatient mental health services from physicians outside of the network would be reimbursed at 50% of the network level.

Mental health care from non-network psychologists and social workers would not be covered.

For outpatient mental health treatment, the first 20 visits would be covered in full, with the next 15 visits covered at 75%.

Under the expiring contract, the first five visits are covered in full, the next five are covered at 90% and all subsequent visits are covered at 75%. However, there is a $1,200 annual per-person maximum on benefits.

Short-term disability benefits under the tentative agreement would increase 14.7% to $390 from $340 for assembly line workers and 13.8% to $455 from $400 for tool and die workers.

Monthly long-term disability benefits for an assembler with 10 or more years of service would increase 14.9% to $1,545 from $1,345, while the benefit for assemblers with fewer than 10 years at GM would increase 14.7% to $1,405 per month from $1,225.

Tool and die workers with 10 or more years of service would receive $1,815 per month of long-term disability benefits, up 14.9% from $1,580, while those with fewer than 10 years of service would receive $1,650 per month, up 15% from $1,435.

The agreement also calls for GM to increase certain orthodontics and dental benefits.

Beginning Jan. 1, 1991, the lifetime maximum orthodontics benefit would be increased 15.6% to $1,300 from $1,125, and one additional teeth cleaning procedure will be covered at no cost to the employee if the employee has a history of periodontal disease.

The life insurance benefit for an assembly line worker would increase 15.4% to $37,500.

The life insurance benefit would increase 15.8% to $44,000 for a tool and die worker, up from $38,000.

The contract also calls for GM to implement a company-paid long-term care pilot program by Jan. 1, 1991, at a location to be determined. The pilot program would run three years.

The plan would cover all active employees at the site, and their families; employees at the site who retire during the contract and their families; and current retirees who worked at the location and who retired after Oct. 1, 1979, and their dependents.

The plan is to cover services that assist persons in such basic activities of daily life as bathing, dressing, eating and housekeeping, according to the contract.

Meanwhile, UAW members at GM will continue to receive fully-paid, first-dollar hospitalization coverage, which GM self-insures.

GM's hospitalization plan is administered by various Blue Cross and Blue Shield organizations nationwide.

Unionized workers who opt out of managed care arrangements are required to pay a portion of the cost of care.

UAW members who participate in health maintenance organizations or preferred provider organizations pay only a small copayment on prescription drugs, the spokesman said. ■

Aon's failed bid

Continued from page 2

Miller, C&B chairman and chief executive officer, said in a statement issued Sept. 18, immediately following a special board meeting held to discuss Aon's proposal.

"This merger has become the centerpiece of our long-standing plans to internationalize our operations, and our board has determined that its consummation will serve the best interests of our shareholders, customers and employees," Mr. Miller stated.

Willis Faber last week said in an announcement that it "looks forward to the completion of the merger" with Corroon & Black.

C&B's flat rejection of Aon's offer surprised analysts.

"It's truly outrageous conduct to have simply walked away from the deal without giving it due consideration," said financial analyst Michael A. Smith, vp of Lehman Brothers in New York, a division of Shearson Lehman Hutton Inc.

The "board has a fiduciary duty to look for the best deal for its shareholders," Mr. Smith said.

"I can't imagine why these guys wouldn't at least sit down with (Aon) and discuss their evaluation of the offer. I was surprised and disappointed," said Walter Fitzgerald, an analyst with Baird, Patrick & Co. Inc. in New York.

Mr. Smith said the board's chances of gaining shareholder approval for the Willis-Corroon merger are better than they were before the Aon offer.

Aon's proposal triggered heavy trading of C&B shares and about 4 million, or roughly 20% of its outstanding shares, changed hands. Many of those sellers were institutional investors.

The merger vote will be put to shareholders of record as of Aug. 24, so "new shareholders won't be eligible to vote and former shareholders don't care any more," Mr. Smith said.

Thus, while only about 30% of C&B stock is held by its managers and employees, their voting strength has been substantially bolstered by trading last week.

When Aon made its offer, Mr. Ryan had said he was "not interested in pursuing any transaction" that was opposed by C&B's board of directors.

Mr. Ryan stated Wednesday that when he made that assurance to C&B, he "had assumed that we would be given a full hearing" by C&B's board of directors.

In the absence of this hearing, "Aon's proposal remains on the table and is not being withdrawn," Mr. Ryan stressed.

"I am convinced that if we have an opportunity to talk with the Corroon board, which we continue to seek, we can address any concerns that members of the board might have. It is our hope that we can ultimately elicit the support of a fully informed Corroon board for our proposal," he added on Wednesday.

But, Mr. Ryan also stressed that if C&B's board again "denies us a hearing or, after a hearing, persists in its position that the Willis Faber transaction—currently valued at around $30 per share—will serve the best interests of Corroon's stockholders, then we will withdraw our proposal."

Late last Thursday, Corroon's Mr. Miller said in a letter to Mr. Ryan that "the position of our board is clear and unequivocal; it does not consider the proposal made by Aon to be in the best interests of the Corroon & Black shareholders and therefore it opposes that proposal.

"The board has unanimously rejected Aon's demands for a meeting to discuss its proposal and for an opportunity to conduct a due diligence examination of Corroon & Black. . . .In light of the above, we expect that you will honor your commitment and withdraw your proposal," Mr. Miller concluded.

On Friday, Mr. Ryan complied.

It's speculated that in rejecting Aon's offer, the C&B board is relying on a Delaware Supreme Court decision last year that upheld the right of Time Inc. to reject an all-cash hostile takeover bid from Paramount Communications Inc. in favor of a planned merger with Warner Communications Inc.

The high court said directors could reject the bid if they believed they were acting in shareholders' best interests. C&B, like Time Inc., is domiciled in Delaware.

Robert P. Cuthbert, C&B first vp and chief financial officer, said that the special shareholders meeting scheduled for Sept. 28 to vote on the merger may have to be postponed.

"The proxy has to be amended with a supplement of the current information that has happened and filed with the Securities and Exchange Commission," he said. Because of this, C&B's ability to hold the meeting on Sept. 28 depends "on how fast we can get the information to them and how fast they can respond."

As of Friday, Willis Faber still planned to hold its shareholder meeting Sept. 28. ■

Update

Subway socked by huge award

NEW YORK—The New York Transit Authority says it will appeal an "excessive and ludicrous" $9.3 million damage award to a man whose left arm was cut off last year when he fell onto a New York subway track and was hit by a train.

Both sides acknowledge that the injured man, Francisco Merino, was drunk when he fell onto the tracks.

The award is one of the largest ever in New York for the loss of a limb, says Jury Verdict Research Inc. of Solon, Ohio.

A self-insured public liability fund would cover the award, transit authority officials say.

A transit authority spokesman said Mr. Merino's lawyers argued at trial that the transit authority was liable because employees at the subway station did not follow agency procedures.

Agency rules say that "passengers appearing unable to care for themselves by reason of intoxication. . .and liable to injury must be placed in the charge of a transit employee or official."

Jurors "indicated to us that had it not been for the clearly written rule they would not have found" for Mr. Merino, the transit authority spokesman said.

Mr. Merino's attorney was unavailable for comment.

The award will likely be reduced on appeal, predicted Victor Schwartz, a defense attorney at Crowell & Moring in Washington, D.C., a specialist in tort cases.

"You can't reward people who cause their own problems because they're drunk or on drugs. This type of verdict encourages recklessness," Mr. Schwartz said.

Paper to appeal libel award

CLEVELAND—The Cleveland Plain Dealer plans to appeal a $13.5 million jury award—including $9 million in punitive damages—to two auto race promoters who claim they were libeled in news stories from 1984 through 1986.

The paper, owned by S.I. Newhouse's Advance Publications Inc., said there were "fundamental legal errors" in the Sept. 14 verdict by a Cuyahoga County Common Pleas Court jury.

Plaintiffs' attorney Bob Seibel of Jacobson, Maynard, Tuschman & Kalur in Cleveland said he believes that punitive damages in this case would not be insurable.

After an eight-week trial, the jury found in favor of two former promoters of the Budweiser Cleveland Grand Prix car race. News articles had alleged that Charles K. Newcomb and James H. Foster—principals in C.K. Newcomb & Associates in Cleveland—violated an agreement with the city by paying themselves nearly $1 million of salaries, commissions and fees out of race proceeds, Mr. Seibel said.

The promoters presented evidence that the information was incorrect and that the paper published it either knowingly or with reckless disregard for the truth, Mr. Seibel said.

The promoters sold the race in 1985 to Roger Penske, a businessman and former race driver. At that time, the Plain Dealer became a co-sponsor.

Cal/OSHA blasts contractor

SAN FRANCISCO—The California workplace safety agency is recommending that criminal charges of unsafe working conditions be filed against the contractor involved in last November's fatal crane accident in downtown San Francisco.

Four construction workers and a bus driver were killed in the accident (*BI*, Dec. 4, 1989).

Cal/OSHA already has assessed $80,000 in civil penalties against The Erection Co. of Seattle for failing to provide qualified supervision and maintain an adequate accident prevention program.

However, Erection is appealing the fine, according to attorney William Staples in Walnut Creek.

A Cal/OSHA spokesman declined to identify the specific criminal charges it is recommending. Jerry Coleman, assistant district attorney, said he would not comment until after he reads the file on the case that Cal/OSHA has sent him.

Generally,, violations of California workplace safety laws that cause an employee's death are misdemeanors punishable by up to six months of imprisonment of company officials. However, in egregious cases, prosecutors can press manslaughter charges against company officials under the general penal code.

Briefly noted

The Manville Personal Injury Trust last week asked U.S. District Judge Jack B. Weinstein of Brooklyn to confirm its contention that the trust has limited financial resources for the purpose of creating a mandatory nationwide class-action lawsuit. . . .A Los Angeles Superior Court judge has approved a $20 million settlement between some disgruntled shareholders of **MGM/UA Communications Co.** and four directors and officers liability insurers over the sale of company assets to MGM/UA's largest shareholder. The agreement, which leaves majority shareholder Kirk Kerkorian and his Tracinda Corp. holding company as sole defendants in the shareholders' class-action suit, has sparked a bad-faith suit by MGM/UA against the insurers (*BI*, Sept. 17). . . .The **New York Insurance Department** and the state Department of Finance and Taxation have filed a brief opposing insurers' appeal of a state court's dismissal of their claims that the state improperly appropriated $124 million from the New York property/casualty insurance guaranty fund. Oral arguments in the appeal are scheduled for Oct. 16 (*BI*, Aug. 27). . . .Wind and hail caused an estimated **$10 million of insured property damage** to the Portales, N.M., area on Sept. 10, according to the Property Claim Services division of the American Insurance Services Group. . . .**Texas Insurance Commissioner A. W. "Woody" Pogue**, citing health problems, is resigning Nov. 1 to return to the Texas State Board of Insurance. He will resume his previous duties as associate commissioner for regulated lines and licensing. Mr. Pogue replaced Doyce R. Lee as commissioner in November 1988.

New Mexico

Continued from page 3

Gov. Carruthers has until Oct. 7 to sign both bills, which would take effect 90 days afterward. Gov. Carruthers is expected to sign the reform bill, but he has concerns over the appropriation bill, according to those involved in the legislation.

The reforms are "a significant step in the right direction in terms of controlling the costs of the workers compensation system in New Mexico," said Bill Garcia, president of the Assn. of Commerce and Industry in Albuquerque. Mr. Garcia was the coordinator for the Business Workers Compensation Coalition.

"Our overall impressions are favorable," said Jerry Walker, state director of the Aztec, N.M.-based National Federation of Independent Business of New Mexico, which represents about 300 small businesses in the state.

"It was give and take, but we supported the reforms for the most part," said Neil Gonzalez, president of the New Mexico AFL-CIO in Albuquerque.

Attorney groups, though, had little to say about the legislation. "We really don't have any position" on the bill, said Peter Mallery, executive director with the New Mexico Trial Lawyers Assn. in Albuquerque.

However, Rod Dunne, an Albuquerque attorney specializing in workers comp cases and who represented the NMTLA during task force meetings, said: "My purpose of being there was clearly for damage control. We knew we'd take some steps backward."

Provisions of the legislation that would increase benefits call for:

- Providing maximum benefits to workers with total permanent disabilities for their lifetime, up from 700 weeks.
- Providing benefits for workers with permanent partial disabilities who are 80% or more disabled for 700 weeks, up from 500 weeks. Workers who are less than 80% disabled remain eligible for 500 weeks of benefits.
- Requiring all construction contractors to provide workers comp coverage to their employees. Previously, contractors employing two or fewer workers were exempt from providing coverage.

Provisions of the reform legislation designed to control system costs call for:

- Requiring employees to pay half the cost of their attorneys' fees. Previously, employers picked up 75% of the cost.

However, when an injured employee rejects an employer's offer and a court makes an award that is smaller than the employer's offer, the employee must pay the employer's legal costs and all his own.

If the award is larger than the employer's original offer, the employer pays the employee's entire legal costs.

- Setting $12,500 caps on employers' and employees' attorney's fees. Previously, only employees' attorney fees were capped at $12,500.
- Establishing an ombudsman's program to direct parties through the system without resorting to litigation.

Other cost control measures under the legislation call for:

- Establishing a state fraud and safety division to provide inspections and investigate abuses by claimants, employers, adjusters or doctors.
- Establishing a fee schedule that sets the maximum amounts health care providers can charge for certain services.
- Determining permanent partial and permanent total disabilities more objectively by more clearly defining impairment.

And, permanent partial disability benefits will be based on a mathematical formula that includes the American Medical Assn.'s impairment ratings as well as the employee's age, education and physical capacity.

However, Mr. Dunne of the NMTLA said he expects to see "a lot of litigation that will involve questions about what all this new language means."

Other observers also expect an increase in litigation over the language of the legislation.

"I have some serious fear that it won't control costs or reduce litigation," said Roger Buelow, manager of the claims department of Mountain States Mutual Casualty Co. in Albuquerque, which wrote approximately 16% of the workers comp coverage in New Mexico in 1989, according to A.M. Best Co.

A controversial reform would order the debt-ridden assigned risk pool to become self-sufficient by imposing premium surcharges on employers with bad safety records.

The pool of about 8,000 mostly small employers had a $63.7 million deficit in 1989, according to John Lacy, director of government, consumer and industry affairs in the Denver office of the National Council on Compensation Insurance.

In the first quarter of this year the pool is already registering a $17 million deficit, he said. As a result, the NCCI is asking State Insurance Superintendent Fabian Chavez to approve a staggering 39.3% rate increase for employers in the pool.

However, some observers hope the recently passed reforms would encourage Mr. Chavez to deny the increase. Some critics, though, say the reforms do not eliminate the need for rate increases because the bill increases some benefits.

"The additional increase in benefits, which in my view will increase utilization, will offset any cost controls," said Sen. Victor Marshall, R—Albuquerque.

The legislation also calls for the creation of a $10 million mutual insurer to sell affordable workers comp insurance to small and mid-size employers. The fund, called Employers Mutual Co., would provide workers comp coverage at competitive rates and would not function as an insurer of "last resort," explained Sen. Martin Chavez, D—Albuquerque, co-chairman of the legislative task force.

In addition, the mutual company would provide legislators with reliable workers comp experience data, said Sen. Chavez, adding that such information often is unavailable from insurers in the state or the NCCI.

Initial funding for the mutual company would be provided through a $10 million "loan" from the state's permanent severance tax fund. The $10 million is to be paid back by profits of the mutual over its first 10 years.

Employers say the mutual company is a necessary source of competition.

"We weren't able to come up with any incentives we felt comfortable with to make sure general insurers provide affordable coverage to small businesses," said Ty Juana G. Hise, corporate secretary of CEMCO Inc., a small manufacturer in Albuquerque.

Ms. Hise, who served on the task force, said she considers CEMCO's workers comp rates "excessive." CEMCO pays about $30,000 per year in workers compensation premiums for its approximately 20 employees, she said.

However, critics of the new mutual company question how effective it would be and say it is not clear that the financing method approved is constitutional.

New Mexico's constitution prohibits the state from chartering an insurance company, pointed out Rep. Linn Tytler, R—Albuquerque. And, the state constitution contains an anti-donation clause that prohibits the state from contributing to a private enterprise, she noted.

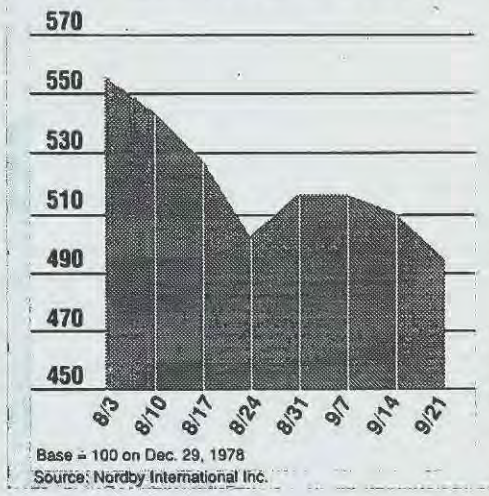
Other critics predict the fund would not operate any more efficiently than commercial insurers in the state.

"I feel we still don't need it and they are just setting up another bureaucracy," said Peter DiGangi Jr., general manager for United States Fidelity & Guarantee Co. in Albuquerque. Employers Mutual Co. would "be facing the same problems we are," he said.

Other provisions of the bill would:

- Require an annual safety inspection of all employers in the state that pay annual workers compensation premiums of $5,000 or more.
- Allow employees to choose their own physician after 60 days of care by a physician appointed by the employer. Previously, employees had to seek all care from an employer-appointed physician. ■

BI Insurance Index



Insurance industry stocks continued to plunge last week as the *Business Insurance* Index fell 16.85 points to 497.67 on Sept. 21, from 514.52 on Sept. 14. Advancing issues were led by American Indemnity/Fin'l, up 9.0%; Lawrence Insurance Group, up 7.1%; and SCOR U.S. Corp., up 2.8%. Declining issues followed AmBase Corp., down 28.6%; American General, down 19.5%; and Corroon & Black Corp., down 19.0%. The most active issue during the week was American General, 5.4 million shares traded. The *BI* Index lost 3.27% for the week; The Standard & Poor's 500 dropped 1.7%; the Dow Jones 30 Industrials fell 2.0%; and the New York Stock Exchange Composite dropped 1.8%.

British Issues

Sept. 20 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	427	19.6	28.7	6.7	452—	427
Genl Accident	443	13.3	33.4	7.5	455—	443
Gdn Royal Exch	175	15.2	15.3	8.2	184—	175
Royal	363	19.4	34.0	9.4	393—	363
Sun Alliance	278	10.0	16.7	6.0	280—	276
Brokers						
Bradstock	203	14.2	10.0	4.9	204—	203
CE Heath	379	11.1	34.5	9.1	405—	379
Hogg Group	135	9.0	9.7	7.2	139—	135
Lloyd Thompson	282	17.5	9.7	3.4	283—	282
PWS Holdings	71	11.0	3.3	4.6	71—	71
Sedgwick Grp	170	12.8	16.0	9.4	186—	170
Steel Brrl Jones	235	14.1	14.7	6.2	235—	233
Willis Faber	214	15.6	16.0	7.5	214—	201

Source: Philip Olsen, Insurance Industry Specialist London

BI Industry Stock Report

SEPTEMBER 17, 1990 THROUGH SEPTEMBER 21, 1990

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	19.75	0.00	-37.30	34.00	19.50	223	1.00	5.06	18	9.18	2.15
Corroon & Black	NYS	29.25	-19.04	-23.53	41.00	28.50	2406	1.36	4.65	14	12.73	2.30
Gallagher Arthur J. & Co.	NYS	21.25	2.41	-14.14	26.50	20.25	15	0.60	2.82	17	5.33	3.99
Frank B. Hall	NYS	3.00	0.00	0.00	4.25	2.50	36	0.00	0.00	-2	-2.80	-1.07
Hilb, Rogal & Hamilton	OTC	12.88	0.98	-30.87	20.63	12.25	59	0.28	2.17	17	4.60	2.80
Marsh & McLennan	NYS	64.00	-5.37	-17.95	89.75	64.25	826	2.60	4.06	15	10.56	6.06
Poe & Associates	OTC	10.25	-8.89	-22.64	13.00	8.25	2	0.40	3.90	13	1.93	5.31
BROKERS	AVERAGE		-4.3	-20.9					3.2	13		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	33.50	0.00	-19.52	46.50	31.75	95	0.44	1.31	7	25.06	1.34
Berkshire Hathaway Inc.	NYS	6025.00	-3.21	-30.14	8900.00	5675.00	0	0.00	0.00	-20	2869.00	2.10
ITT (Hartford Group)	NYS	48.63	-4.43	-18.79	63.75	49.13	1618	1.60	3.29	6	56.33	0.86
Sears (Allstate)	NYS	26.63	-4.91	-31.29	44.25	26.63	3135	2.00	7.51	8	37.75	0.71
CONGLOMERATES	AVERAGE		-3.1	-24.9					3.0	0		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	40.13	-3.62	-30.82	62.50	41.00	1501	2.76	6.88	7	58.11	0.69
Ambase Corp.	NYS	1.25	-28.57	-90.10	16.13	1.25	610	0.00	0.00	0	29.08	0.04
American General	NYS	32.13	-19.45	-1.91	50.63	28.13	5375	3.20	9.96	7	34.68	0.93
American Heritage	NYS	20.00	-0.65	-29.82	24.63	19.88	7	1.00	5.00	10	22.60	0.88
American Indemnity/Fin'l	OTC	4.50	8.96	-43.75	10.50	3.38	0	0.08	1.78	-1	17.38	0.26
American International	NYS	63.00	-1.95	-25.36	89.63	62.63	1802	0.44	0.70	9	41.92	1.50
Aon Corp.	NYS	31.38	-3.85	-25.96	43.25	31.38	271	1.52	4.84	9	19.62	1.60
Argonaut Group	OTC	70.00	1.45	1.63	78.00	63.25	23	1.60	2.29	8	36.83	1.90
AVEMCO Corp.	NYS	22.25	-4.83	-8.72	30.13	20.38	16	0.44	1.98	16	9.52	2.34
Baldwin & Lyons Inc.	OTC	20.50	-0.63	-4.65	24.00	19.25	6	0.28	1.37	7	20.80	0.99
Belvedere Corp.	ASE	3.13	-7.54	-43.18	5.63	3.13	2	0.04	1.28	-4	8.03	0.39
Chandler Insurance	OTC	5.63	-6.25	-52.13	13.25	5.50	116	0.00	0.00	3	9.53	0.59
Chubb Corp.	NYS	39.63	-3.35	-58.67	51.38	38.63	1542	1.32	3.33	8	55.49	0.71
CIGNA Corp.	NYS	40.63	0.93	-32.57	66.75	39.88	1169	3.04	7.48	11	66.64	0.61
CNA Financial Corp.	NYS	57.13	-4.39	-42.88	108.75	56.63	174	0.00	0.00	9	54.87	1.04
Continental Corp.	NYS	20.75	0.00	-33.86	36.38	20.50	717	2.60	12.53	15	41.36	0.50
Durham Corp.	OTC	26.00	1.96	-15.45	34.75	25.00	11	0.92	3.54	12	26.32	0.99
Fund American Corp.	NYS	44.63	-4.55	26.60	51.88	29.50	895	0.68	1.52	99	32.74	1.36
Fremont General Corp.	OTC	14.50	-3.33	-27.95	22.50	12.88	151	0.80	5.52	4	19.09	0.76
Frontier Insurance Group	NYS	20.50	-8.89	10.81	33.00	14.13	21	0.00	0.00	9	7.29	2.81
General RE Corp.	NYS	72.75	1.04	-19.17	96.25	69.00	596	1.52	2.09	11	29.04	2.51
Hanover Insurance Co.	OTC	22.75	-1.09	-25.41	33.00	22.75	325	0.44	1.93	7	32.03	0.71
Harleysville Group	OTC	17.50	-4.11	-36.36	27.38	16.75	53	0.60	3.43	6	18.94	0.92
Hartford Steam Boiler	NYS	46.38	-2.12	-14.52	62.13	43.50	88	1.80	3.88	12	18.94	2.45
Kansas City Life Ins.	OTC	36.25	0.69	1.05	36.50	34.50	10	1.12	3.09	10	39.22	0.92
Kemper Corp.	NYS	26.88	-3.60	-43.12	51.88	27.38	254	0.92	3.42	41	29.97	0.90
Lawrence Insurance Group	ASE	7.50	7.14	5.26	9.13	6.50	2	0.36	4.80	13	4.40	1.70
Liberty Corp.	NYS	42.25	-9.63	-0.59	50.25	35.00	16	0.92	2.18	10	31.82	1.33
Lincoln National	NYS	42.25	-2.87	-30.74	62.88	42.00	148	2.60	6.15	7	49.19	0.86
NAC Re Corp.	OTC	26.75	0.94	-26.21	41.00	26.25	65	0.20	0.75	12	22.81	1.17
Navigators Group	OTC	30.25	-3.97	10.00	33.75	25.25	3	0.00	0.00	11	15.22	1.99
Nobel Insurance LTD.	OTC	3.06	2.10	53.15	3.75	1.50	113	0.00	0.00	-8	7.76	0.39
NWNL Companies	OTC	16.63	-6.34	-57.91	44.13	15.63	909	1.32	7.94	3	37.50	0.44
Ohio Casualty Corp.	OTC	35.88	-0.35	-24.87	52.50	34.25	402	2.32	6.47	11	33.30	1.08
Old Republic Int'l	NYS	22.75	-7.63	-11.22	24.00	23.00	42	0.76	3.34	5	30.70	0.74
Orion Capital Corp.	NYS	16.75	-4.99	-27.96	28.50	16.88	23	0.92	5.49	5	19.72	0.85
Phoenix RE Corp.	OTC	7.50	-9.09	-42.31	15.50	7.50	264	0.20	2.67	-8	12.99	0.58
Protective Life Corp.	OTC	12.50	0.97	-12.28	15.38	10.25	13	0.76	6.08	7	14.54	0.86
Provident Life	OTC	18.00	1.41	-30.43	30.13	17.00	569	0.80	4.44	5	23.24	0.77
Re Capital Corp.	ASE	12.88	1.94	-11.21	15.25	11.25	4	0.00	0.00	10	14.43	0.89
RLI Insurance Corp.	NYS	10.25	0.00	15.49	14.75	6.88	18	0.44	4.29	5	12.42	0.83
St. Paul Companies	OTC	52.50	0.48	-12.50	63.50	51.25	965	2.40	4.57	6	43.47	1.21
SAFECO Corp.	OTC	28.75	0.88	-27.67	42.38	28.25	590	1.36	4.73	7	24.87	1.16
SCOR U.S. Corp.	NYS	9.25	2.78	-35.09	14.50	8.50	12	0.20	2.16	13	10.61	0.87
Seibels Bruce Group	OTC	5.75	-11.54	-47.13	11.75	5.75	51	0.80	13.91	-1	-13.75	0.42
Selective Ins. Group	OTC	14.75	0.00	-22.88	20.25	14.50	80	1.04	7.05	5	15.72	0.94
Statesman Group Inc.	OTC	1.38	-11.86	-50.00	3.31	1.25	208	0.04	2.91	2	4.19	0.33
Tokio Marine & Fire	OTC	38.38	-0.66	-49.09	78.13	36.00	4	0.26	0.68	-	70.93	0.54
Torchmark Corp.	NYS	43.88	-0.58	-23.36	58.75	42.38	412	1.40	3.19	10	13.23	3.32
Transamerica	NYS	29.38	0.43	-34.17	48.00	28.75	381	1.92	6.54	7	34.63	0.85
Travelers Corp.	NYS	23.00	1.10	-37.63	42.38	22.25	1121	2.40	10.43	6	44.85	-
Trenwick Group Inc.	OTC	17.63	-6.00	-27.69	26.88	17.25	54	0.48	2.72	8	16.91	1.04
United Fire & Casualty	OTC	32.00	-6.57	-3.03	35.00	30.50	1	1.20	3.75	8	22.56	1.42
USF&G Corp.	NYS	20.13	-10.56	-32.07	31.63	20.00	2186	2.92	14.51	14	22.87	0.88
UNUM Corp.	NYS	46.13	-6.82	-3.40	57.13	39.38	785	0.80	1.73	10	31.20	1.48
USLIFE Corp.	NYS	30.13	-3.23	-33.43	47.75	29.13	230	1.48	4.91	7	54.34	0.55
Washington National	NYS	17.75	-1.39	-37.17	28.75	17.88	11	1.08	6.08	20	32.90	0.54
USLICO Corp.	NYS	20.75	0.00	-12.63	24.50	19.50	51	1.00	4.82	8	27.73	0.75
Zenith National Ins.	NYS	13.75	1.85	-26.67	19.50	13.38	13	0.88	6.40	8	13.81	1.00
INSURERS/REINSURERS	AVERAGE		-3.2	-24.1					4.3	9.7		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	12.50	-10.71	-41.18	26.38	11.50	495	0.00	0.00	11	3.54	3.53
HMO America Inc.	OTC	4.88	-4.97	-37.10	9.75	4.38	103	0.00	0.00	6	1.12	4.35
Pacificare Health Sys.	OTC	14.75	-4.84	-43.27	30.38	12.00	612	0.00	0.00	11	6.35	2.32
Safeguard Health Enter.	OTC	5.38	-14.00	-36.76	12.50	5.13	34	0.00	0.00	9	2.99	1.80
Sierra Health Services	ASE	6.63	-1.85	-25.35	9.63	5.50	7	0.00	0.00	-18	0.62	10.69
United Healthcare Corp.	OTC	18.00	-2.07	46.94	20.13	7.84	921	0.12	0.67	19	0.34	52.94
United Medical Corp.	ASE	7.13	-6.62	18.75	11.38	5.88	8	0.20	2.81	10	5.70	1.25
U.S. Healthcare	OTC	20.00	-0.65	40.35	22.25	9.63	0	0.36	1.80	22	3.07	6.51
HMOs	AVERAGE		-5.7	-9.7					0.7	9		
ALL COMPANIES	AVERAGE		-3.4	-21.8					3.6	9		

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