

business insurance

A.C.E. offers to buy back up to \$200 million in stock
 HAMILTON, Bermuda—A.C.E. Holdings Ltd., the Cayman-based holding company for A.C.E. Insurance Co. Ltd., is offering to buy back up to \$200 million of its stock from its 242 policyholder/shareholders.
 A.C.E. Chairman John Cox said that under the buyback plan approved last month, A.C.E. is offering to purchase between 250,000
Continued on next page

Reporting weekly for corporate risk, employee benefit and financial executives / \$1.75 a copy; \$68 a year © Entire contents copyright 1987 by Grain Communications Inc. All rights reserved

Brokers' first-half results (In thousands of dollars)

Broker	Gross revenues	% change	Net income	% change
Marsh & McLennan	\$1,099,100	22.4%	\$171,800	32.5%
Alexander & Alexander	564,200	8.7	42,300	1.4
Frank B. Hall	202,185	0.8	5,553	-60.0
Corroon & Black	185,018	11.3	18,709	-8.2
Arthur J. Gallagher	60,905	9.5	6,167	-11.0
Hilb, Rogal & Hamilton	18,368	21.2	1,806	92.1
Poe & Associates	16,150	-0.6	1,863	-21.8

Brokers trim costs as market softens

By LINDA J. COLLINS

The rapid change in the commercial insurance market is forcing some insurance brokers to beef up their cost control measures.

Insurer price competition is eating into many brokers' revenue growth, prompting them to carefully assess expenses in all areas of operation, brokers and analysts explain.

Alexander & Alexander Services Inc., Frank B. Hall & Co. Inc., Corroon & Black Corp. and Poe & Associates Inc. all have implemented cost control measures this year to pare operating expenses. Other brokers, while not establishing formal expense control policies, say they are examining expenses closely.

"All the brokers are very much surprised by the rapid turn in rates," noted John E. Keefe, a financial analyst at Drexel Burnham Lambert Inc. in New York. "They are talking about hiring freezes, salary caps and cutbacks on travel and entertainment, non-producer bonuses and educational compensation."

"Every broker has been surprised at the suddenness and magnitude of the changes."
Continued on page 41

Congress takes aim at benefit, risk issues

By JERRY GEISEL and DEBORAH SHALOWITZ

WASHINGTON—Congress is ready to take action on a variety of employee benefit and risk management issues when it reconvenes next month, including some that may save businesses money and some that will cost them more.

Approaching the midpoint of what already has been an action-filled session, the Senate—following in the footsteps of the House—is poised to consider and pass legislation that would expand Medicare and give the elderly more protection from catastrophic health care expenses.

Final enactment of that legislation—considered a virtual certainty—could help take financial pressure off many employer-provided supplemental retiree health care plans that pick up costs not covered by Medicare.

In addition, an effort is expected to be made in the Senate Finance Committee—as it drafts a budget reconciliation bill—to tack on a provision that would allow states to set up employer-subsidized health care pools to provide coverage for high-risk uninsured individuals.

That proposal, similar to one that died last year in a House-Senate conference committee, already has been approved by the House Ways and Means Committee as part of that panel's budget reconciliation measure. Business groups are worried that the proposal stands a better-than-ever chance of being enacted.

In another health care issue, Senate Labor and Human Resources Committee Chairman Edward Kennedy, D-Mass., will hold another hearing on legisla-

tion, S. 1265, that would require all employers to offer health insurance.

At the same time, Kennedy staffers will be meeting with business groups next month to resolve complaints that employers have about the bill.

On the pension side, the Senate Labor and Human Resources and Finance Committees both will begin drafting legislation—also part of a budget reconciliation bill—to increase premiums employers with pension plans must pay the Pension Benefit Guaranty Corp. and to require employers to speed up contributions to pension plans.

In the House, the Ways and Means Committee and the Education and Labor Committee already have completed action on their pension/PBGC proposals.

While business groups have recognized the need for higher PBGC premiums and tougher funding rules, they worry that Congress will go too far and will include provisions—such as restricting an employer's ability to recover excess assets—that have little or nothing to do with the legislation's intent: shoring up the PBGC and making the agency less vulnerable to big pension claims.

"There is a growing consensus in the business community that perhaps we would be better off with nothing" compared with current proposals, said Mark Ugoretz, executive director of the Washington-based ERISA Industry Committee—also known as ERIC.

Congress is also expected to take action on a variety of risk management issues.

The Senate—following in the wake of House action last month—is ready to vote on legislation that would expand the liability of the nuclear power industry for a
Continued on page 39

Health insurance rates keep climbing

By KARI BERMAN

NEW YORK—Group health insurance rate increases will continue unabated through the remainder of 1987, even though the official health care inflation rate is moderating slightly.

Rates for traditional indemnity health care plans could increase up to a staggering 40% in isolated cases, while many group health insurers are increasing their rates 10% to 20%, or about what insurers predicted at the end of last year (BI, Dec. 22, 1986).

Rate increases charged by health maintenance organizations will be more moderate, ranging between 6% and 9%, while rate hikes for indemnity plans with preferred provider organization options are expected to hover somewhere between the price increases for traditional indemnity plans and HMOs.

"Utilization and inflation are the keys to the rate increases," explains Tom Billet, vp and senior consultant at the Princeton, N.J., office of Johnson & Higgins.

"People are checking into hospitals and staying longer, increasing the amount of services provided and raising the utilization

costs," Mr. Billet says.

While the "base cost" of providing medical services is rising modestly, "it is the increased utilization that has brought our rates up 15% to 16%," points out Randell C. Horn, vp and director of group risk management at Mutual of Omaha and United of Omaha in Omaha, Neb.

"Just the cost of delivering medical care has gone up," adds Neil Waldron, assistant vp for group marketing at Metropolitan Life Insurance Co. in New York.

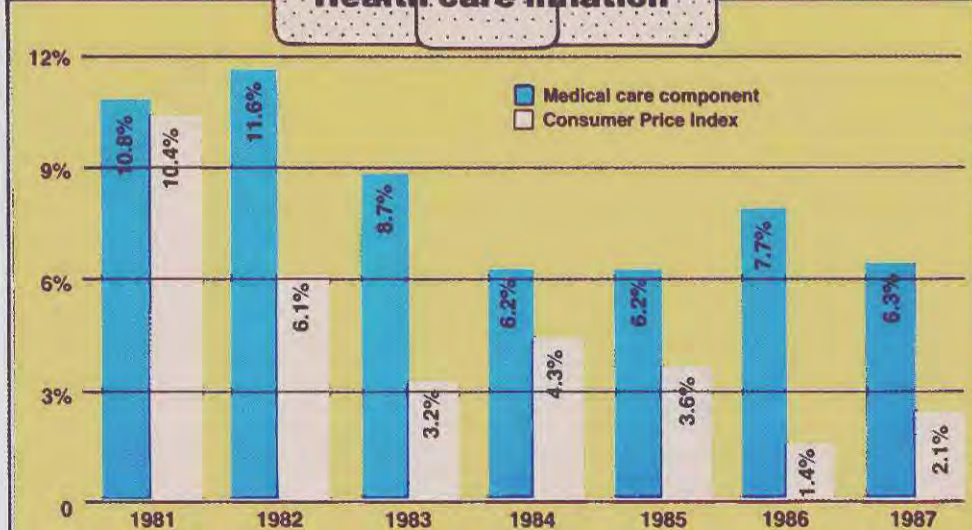
However, health care inflation as officially measured by the Bureau of Labor Statistics is down slightly from last year's levels.

The medical care component of the Consumer Price Index has risen at an average annualized rate of 6.3% in the first six months of 1987, compared with a 7.7% increase in all of 1986 (see chart).

However, health care costs continue to rise much faster than the general inflation rate. The overall Consumer Price Index rose at an average annualized rate of only 2.1% in the first six months of this year, compared with a 1.4% jump in all of 1986.

Continued on page 34

Health care inflation*



*As measured by the Consumer Price Index's medical care component; 1987-first six months annualized. Source: U.S. Bureau of Labor Statistics

Chart: Amy Palmer

Court rules against Manville in case against government
 Page 3

Massachusetts considers employer tax for health pool
 Page 3

Two new court rulings conflict on insurer liability for pollution
 Page 2

update

A.C.E. offers to buy back stock

Continued from previous page

and 1 million shares—representing 5.4% to 21.8% of A.C.E.'s equity—at a price of between \$100 and \$200 per share.

"Because we've had the good fortune not to have had any claims, we are in the position of having more capital than we need at the moment," said Mr. Cox, explaining that A.C.E.'s bylaws allow the company to buy back shares provided it maintains capital of at least \$625 million.

"We were at about \$775 million in May and we'll still be above the \$625 million floor even if we use the full \$200 million," he said.

The price and number of shares A.C.E. will buy back will be determined at a Dutch auction.

Unaudited financial statements accompanying the offer show that A.C.E. produced net underwriting profit of \$122.7 million in the eight months ending May 31 on a premium volume of \$183 million. Net income totaled \$161.6 million, including \$41 million in investment income.

Delay may affect pension funds

WASHINGTON—The Internal Revenue Service, following two appellate court decisions, temporarily has stopped issuing acknowledgments certifying IRS criteria have been met when over-funded defined benefit pension plans apply for termination in eight states.

An IRS determination letter recognizes that a pension plan meets all the requirements for federal qualification and can receive certain tax advantages when it is set up.

A determination letter upon termination—which acknowledges that the plan is qualified upon termination—is not required by law. However, many plan trustees require the letter before they will allow the assets to be distributed.

In one case, the 4th U.S. Circuit Court of Appeals in Richmond ruled in *B.E. Tilley, et al. vs. The Mead Corp.*, that the company must use excess assets of a terminated pension plan to pay employees the value of early retirement supplements.

In the other case, *George G. Blessitt and Willie Neal Jr. vs. Dixie Engine Co.*, the 11th Circuit Court of Appeals in Atlanta ruled the company must use excess assets of a terminated pension plan to pay employees the value of unaccrued benefits (*BI*, Aug. 10).

The IRS suspension affects the 4th Circuit—Florida, Georgia and Alabama—and the 11th Circuit—North Carolina, South Carolina, Virginia, West Virginia and Maryland.

Skandia buys Hanna Insurance

HAMILTON, Bermuda—Skandia America Group in New York intends to buy Hanna Insurance Management Ltd. in Bermuda in September.

An agreement in principle was announced Friday, with the sale subject to regulatory approvals.

Hanna Insurance Management, a subsidiary of Pittsburgh-based M.A. Hanna Co., is the fifth-largest captive manager in Bermuda, based on premiums under management last year. It managed 84 captives generating premiums of \$300 million in 1986. Skandia's Bermuda-based subsidiary Hudson Underwriting Ltd. managed 11 captives generating premiums of \$32 million in 1986. Combined, the operations in 1986 were slightly larger than those of fourth-ranked Marsh & McLennan (Bermuda) Ltd.

"This move conforms with Skandia's objective to increase our involvement in alternative risk transfer mechanisms and develop new sources of fee income," said Skandia America President and Chief Executive Officer James F. Dowd in a prepared statement. Skandia America, a subsidiary of Skandia International Holding A.B. in Stockholm, Sweden, is the seventh-largest reinsurance company in the United States, based on policyholder surplus of \$269.3 million at year-end 1986.

Hanna, which formed the management company in 1978 as an offshoot of its own captive company ownership, is in the process of restructuring its business.

Liquidation costs \$6.7 million

HAMILTON, Bermuda—Fees and operating costs connected with the liquidation of Mentor Insurance Co. Ltd. consumed \$6.7 million of the company's remaining cash as of June 30, a report by Mentor's liquidators says.

Legal and actuarial services accounted for \$2.1 million, operating costs totaled almost \$2.6 million and fees paid to liquidators Charles Kempe and Michael Arnold topped \$2 million.

In addition, Mentor's estimated deficit for unsecured creditors was increased by almost \$40 million to \$505.6 million. The deficit was increased after attorneys advised that claims arising after Mentor was ordered liquidated June 21, 1985, may be submitted to the liquidators. Messrs. Kempe and Arnold earlier ruled claims arising after that date would not be considered.

Mentor earned investment income of \$11.5 million during the 12 months ending June 30, and recoveries from debtors totaled \$5 million, bringing Mentor's assets to about \$180 million.

Ambassador review sought

MONTPELIER, Vt.—The Vermont Supreme Court is considering whether to review a lower court ruling that prohibits using assets of the insolvent Ambassador Insurance Co. to pay some of the fees Ambassador executives incurred during their unsuccessful three-year fight to avoid liquidation (*BI*, Sept. 1, 1986).

The high court's review was requested after Vermont Superior Court Judge John Meaker rejected using Ambassador's assets, which are now being liquidated, to pay \$707,797 in fees for legal and expert advisers: Carter, Ledyard & Milburn, \$452,545; Ernst &

Continued on page 42

Two more federal judges split on pollution coverage

By STEPHEN TARNOFF

Federal courts continue to issue conflicting opinions on whether general liability insurers must provide coverage for pollution claims.

In *Pepper's Steel & Alloys Inc. vs. United States Fidelity & Guaranty Co.*, a U.S. District Court judge in Miami last week ruled that two insurers owed Pepper's Steel a defense for claims arising out of contamination caused by the discharge of polychlorinated biphenyls or PCBs.

However, in *American Motorists Insurance Co. vs. General Host Corp.*, a U.S. District Court judge in Wichita, Kan., ruled last month that General Host's coverage for suits arising out of salt brine pollution was barred by the pollution exclusion clause in general liability insurance policies.

Officials for the losing sides in both cases say they are not certain if they will appeal to the appropriate U.S. Circuit Court of Appeals. If appealed, it would be one of the first federal appellate court rulings on the applicability of the pollution exclusion.

The decisions are among the latest in the nationwide battle between policyholders and their insurers over who will pay billions of dollars in pollution damages, cleanup costs and defense costs.

The Pepper's Steel case involved a now-inactive metal recovery business whose operations in Medley, Fla., included recovering metals from transformers purchased from Florida Power & Light Co. The trans-

formers frequently contained oil that, unknown to Pepper's, contained potentially hazardous concentrations of PCBs.

Although the company cleaned up the PCBs when first discovered in 1977, the Florida Department of Environmental Regulation and the U.S. Environmental Protection Agency discovered additional PCB contamination in 1983 and sued Pepper's and others as potentially responsible parties. The EPA filed an additional action in 1985 to recover initial response costs incurred by the government.

Pepper's insurers refused to defend it and Pepper's President Norton Bloom in the litigation, and Pepper's subsequently filed declaratory judgment actions against the insurers.

The insurers were USF&G in Baltimore; Transportation Insurance Co. and Continental Casualty Co., both units of Chicago-based CNA Financial Corp.; and The Home Insurance Co. in New York.

USF&G wrote primary general liability coverage for Pepper's between 1966 and 1977, and CNA wrote primary coverage between 1977 and the end of 1981. CNA and The Home wrote excess coverage.

The major issue in the case was whether, under Florida law, the primary insurers had a duty to defend in the underlying litigation or whether coverage was precluded by the pollution exclusion clause and another clause barring coverage for damage to property owned or controlled by the insured. The court said it was

Continued on page 42

Informational literature to be listed

Business Insurance will publish its annual Info issue on Sept. 14.

The publication date of this special issue was previously announced as Sept. 28.

The issue will contain listings of educational and informational literature concerning programs, products and services related to risk management and employee benefits.

Companies that want to offer literature should complete a special fact sheet that describes each item to be listed and send it with a copy of the item. The literature must be available to readers at no charge and must be less than 1 year old.

To request information on how to offer items in the special Info issue, call Directory Editor Marilou Jones at 312-649-5279.

Business Insurance must receive a completed fact sheet and sample copy of all items to be listed no later than Aug. 24.

Germany considers product liability cap

By DENISE CLAVELOUX

BRUSSELS, Belgium—West Germany may become the first member of the European Community to cap damages in product liability lawsuits if the government approves draft legislation implementing the EC product liability directive.

The draft bill, issued in June by the West German Ministry of Justice, currently is being examined by several interested associations, including the West German liability, accident and motor insurers' association, HUK Verband, and the consumer association, Arbeitsgemeinschaft der Verbraucherverband, or A.G.V.

They will submit their detailed comments on the proposed bill to the Ministry of Justice by Sept. 1. The law is expected to be adopted next spring, in time for the directive's July 1988 deadline, according to a Ministry of Justice official.

The bill would make West German manufacturers strictly liable for product liability lawsuits, but with a ceiling of 160 million deutsche marks (\$84.5 million) for accumulated losses resulting from the same product and/or fault.

Also under the bill, manufacturers could use the state-of-the-art defense when faced with a product liability suit. The West German bill also excludes the manufacturers of primary agricultural products and livestock from strict liability rules.

Only two other EC member nations have drafted legislation implementing the EC directive, but neither caps product liability awards.

Under the EC directive, all 12 EC nations must enact legislation to implement the EC product liability directive by next July.

Continued on page 6

inside

✓ The escalating Iran/Iraq war may lead cargo war risk underwriters to hike their rates in the Gulf of Oman, as did hull war risk underwriters last week. **PAGE 4**

✓ This week's editorial examines a potpourri of issues mulled over in the hot summer days. **PAGE 8**

✓ Six universities consider capitalizing a Vermont-based captive to underwrite directors and officers liability insurance and excess liability insurance. **PAGE 12**

✓ The Assn. of Trial Lawyers of America is organizing an Illinois risk retention group to provide professional liability insurance to its members. **PAGE 13**

✓ Barnett Banks Inc.'s manager of employee benefits explained how she tamed COBRA administration and communication problems at the *Business Insurance* Employee Benefits Communication Conference. **PAGE 16**

✓ David H. Atkins and Robert M. Holmes of Coopers & Lybrand in Toronto explain in the Perspective section the role of an insurance company liquidator. **PAGE 25**

✓ Risk management information system users need to apply some pest controls, according to risk management consultant David A. Tweedy in his monthly RMIS Commentary. **PAGE 27**

✓ Employers and insurers are rewarding employees for finding errors in medical bills. **PAGE 34**

✓ Leonard M. Wilson, a managing director at L.F. Rothschild, Unterberg, Towbin in New York, after analyzing brokers' second-quarter results, finds that all is not well with pricing commercial insurance. **PAGE 43**

departments

Around the states	36
Classifieds	38
Comings & goings: industry	36
Insurance services guide	42
Legal briefs	27
Letters	8
Opinions	8
Perspectives	25
Risk Retention Roundup	13
RMIS commentary	27
Spotlight report	3
Ticker	43
Washington	35

Vol.21, No.33—*Business Insurance* (ISSN 0007-6864) is published weekly at 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 313-446-1611. Copyright 1987 by Crain Communications Inc.

Manville's case against government fails

By STEPHEN TARNOFF

WASHINGTON—In the first attempt in U.S. Claims Court to recover billions of dollars from the federal government for compensation paid to former shipyard workers with asbestos-related diseases, the asbestos producer has lost.

Johns-Manville Corp. cannot recover damages in Claims Court from the federal government because it failed to prove that the government breached its World War II contracts with the company, according to a recent decision by U.S. Claims Court Judge Christine Cook Nettesheim.

The decision is very important to Denver-based Manville Corp. and other asbestos producers because as many as one-half of the more than 50,000 cases pending against the producers are believed to involve former

Navy shipyard workers. Although the judge wrote that other cases brought by asbestos producers would be bound by the decision, last week attorneys for other asbestos producers said they hope the decision's impact will be limited because their cases are different.

For example, because Manville was the leader in the industry and was more aware of the dangers of asbestos, Judge Nettesheim's rejection of Manville's claim that the government had superior knowledge should not apply to smaller, less knowledgeable producers, attorneys say.

The decision came after a six-week trial that concluded in June.

It was the first trial involving an asbestos producer's claims against the government arising out of contracts entered into during World War II.

Robert Batson, senior litigation counsel for Manville, said in a prepared statement that the company was "extremely disappointed" with the decision, but that it had not yet decided whether to appeal to the U.S. Court of Appeals for the Federal Circuit.

Manville has filed two other similar lawsuits against the government in U.S. Claims Court to recover payments made to asbestos victims who worked in shipyards during time periods other than World War II.

Other asbestos producers with pending contract claims in U.S. Claims Court include: Keene Corp., a subsidiary of Bairnco Corp. of New York; Eagle-Picher Industries Inc. of Cincinnati; GAF Corp. of Wayne, N.J.; UNR Industries Inc. of Chicago; Fibreboard Corp., a subsidiary of Portland, Ore.-based Louisiana-Pacific Corp.; and H.K. Porter Co. of Pittsburgh.

In addition, tort claims against the government filed by Manville and other producers under the Federal Tort Claims Act are pending in various federal courts.

A government attorney called Judge Nettesheim's decision "very significant."

"This decision represents the latest loss—and certainly the most substantial loss to date—by the asbestos manufacturers," said Robert Willmore, deputy assistant attorney general with the U.S. Justice Department. "Manville had all the opportunity to make its case and couldn't."

Manville's case against the government involved 15 test claimants who worked at four shipyards during World War II.

The locations are the Boston and Philadelphia Navy Yards—both government-owned and operated—and the privately owned

Continued on page 37

Massachusetts health pool plan would tax firms

By DEBORAH SHALOWITZ

BOSTON—Massachusetts employers could be assessed up to 5% in additional payroll taxes to help finance a state health insurance pool under a provision of an omnibus health care bill that also mandates employer-sponsored health care coverage.

The new payroll tax is expected to generate about \$540 million for the new health insurance pool, while an additional \$140 million would come from assessments on cigarettes, health maintenance organizations and health insurers.

Under the bill, employers that do not provide medical benefits to their employees would be assessed a 5% payroll tax, while employers that do provide medical benefits would pay a 0.5% payroll tax. The payroll taxes would be assessed on all employers in the state, including self-insured employers.

Facing an uphill battle is the mandated coverage provision of the bill, which requires all employers with more than 15 workers to offer health insurance as of Oct. 1, 1990. The mandate likely will be challenged under the Employee Retirement Income Security Act of 1974, and might not even survive scrutiny as the bill passes through the Legislature, according to a legislative aide.

But the state's attorneys have assured legislators that levying a payroll tax does not violate ERISA, which pre-empts states from regulating employee benefits.

The bill, H.B. 5968, sponsored by Senate Ways and Means Committee Chairwoman Patricia McGovern, D-Essex/Middlesex, already has passed a joint committee on health care in the Legislature.

It goes next to the House Ways and Means Committee and then to the House floor, after which it will be considered by the Senate Ways and Means Committee and the full Senate.

The proposed health insurance pool would replace Massachusetts' uncompensated care pool over a period of three years. Under the uncompensated care pool, enacted in 1985, all payers of hospital bills are assessed a surcharge equal to 13.5% of their bill to fund the hospital's charity care and bad credit. The surcharge generates about \$300 million annually.

Continued on page 6



Chevron Corp. expects property damage from a spectacular fire at its Philadelphia tank farm to be less than its property insurance deductible. The fire, which started when lightning struck a gasoline storage tank, caused about \$200,000 in damage, far less than Chevron's \$2 million deductible, said Edward Kettel, head of San Francisco-based Chevron's insurance department. Chevron's property insurance is written by numerous U.S. and foreign insurers. The fire, which took 31 hours to control, was limited to the tank hit by lightning. The tank, which had a 100,000-barrel capacity, contained only 25,000 barrels. No one was injured. (Photo: AP/Wide World)

Iowa challenges 2 more insurers

By MEG FLETCHER

DES MOINES, Iowa—The Iowa Insurance Division is challenging the right of two more unauthorized insurers to sell or plan to sell insurance to purchasing group members in Iowa under the aegis of the federal Risk Retention Act of 1986.

American Interstate Insurance Co. of Hapeville, Ga., and Diamond State Insurance Co. of Philadelphia, Pa., bring to 23 the number of insurers Commissioner William D. Hager summoned to an administrative hearing Sept. 8 to determine whether they have violated the state's Unauthorized Insurers Act.

If they are found to have violated the law, the insurers could be subject to a \$50,000 penalty and a 2% premium tax (BI, July 27; Aug. 3).

However, several insurers already have negotiated or are in

the process of negotiating settlements with the Insurance Division, according to Deputy Commissioner Tony Schrader.

Iowa insurance regulators view the settlements as "a victory and vindication" of its view that purchasing group members in Iowa—even if the groups are established in another state—must buy insurance from Iowa-authorized companies, Mr. Schrader said.

However, many insurers and insurance buyers interpret the federal act to mean that only the state in which a purchasing group is established—not all states in which group members operate—can require the group to purchase insurance from an admitted insurer or an eligible surplus lines insurer.

Iowa regulators expect that their regulatory action will lead to the first court test of the Risk Retention Act to clarify where

Continued on page 37

Peru delays nationalization of insurers

By MARIA KIELMAS

LIMA, Peru—President Alan Garcia is heeding a court order—for the time being—that calls on the government to suspend its proposed nationalization of Peru's insurance and banking industry.

However, Peruvian observers expect the nation's Congress to approve President Garcia's nationalization proposal.

In an Independence Day speech on July 28, President Garcia called on Congress to nationalize all insurance companies, banks and credit institutions, which he called "the greatest obstacle precluding the democratization of our production."

The next day, the president authorized the government to intervene in the operations of 17 insurers, 10 banks and six other financial institutions, pending debate and approval of the nationalization proposal by Congress.

However, on July 31, a court order suspended the government's intervention until the court rules on its legality.

There are 20 insurers currently operating in Peru. Two already are state-owned: Popular y Porvenir Compania de Seguros, which is the largest Peruvian insurer with 50% of the

market, and Compania Peruana de Credito a la Exportacion (Segrex).

However, unaffected by the order was the Peruvian subsidiary of Brazilian insurer Sud America Compania de Seguros, Compania de Seguros America. The government excluded the Brazilian company in order to maintain good relations with Brazil, which supports Peru's foreign debt policy, sources say.

Insurance brokers—not mentioned in President Garcia's proposal—currently are not subject to any nationalization legislation.

One broker, who asked not to be named, commented, "As long as they (the government) don't step on your corns, you don't shout."

However, others say brokers will be driven out of business by state control of insurers, noting that state-owned Popular y Porvenir does not use brokers.

Testimony on the nationalization proposal from interested parties—including insurers, bankers, trade unions and other workers' representatives—currently is being heard by the Economics, Banking and Finance committees of the lower house

Continued on page 33



Hull war risk rates hiked in Gulf of Oman

By STACY SHAPIRO

LONDON—Cargo war risk underwriters may increase their minimum rates in the Gulf of Oman following last week's damage to a Texaco-owned tanker that struck a mine off the coast of the United Arab Emirates.

Last week Lloyd's of London hull war risk underwriters hiked their rates to 0.125% from 0.025% of a hull's value for a 14-day voyage in the Gulf of Oman. For example, the minimum hull premium

on a vessel insured for \$20 million will increase to \$25,000 from \$5,000.

This is the first time hull war risk underwriters have charged separate rates for ships traveling in the Omani Gulf to the United Arab Emirates ports of Fujairah and Khor Fakkan.

Lloyd's minimum hull and cargo rates for ships traveling in non-hostile regions are unchanged, each at 0.025%.

Hull and cargo war risk rates traditionally fluctuate in the Per-

sian Gulf, depending on the amount of hostility in a specific region.

The increased use of mines by Iran to thwart oil shipments as the Iran-Iraq war escalates is causing the Cargo War Risk Rating Committee to consider increasing the minimum cargo rates for ships traveling from the Saudi Arabian coast to the Oman coast. Just last August, the rates were reduced to 0.1% from 0.125%.

Missiles, a danger in the past, have not caused any total cargo

loss because missiles only hit above the waterline and do not affect oil cargo holds.

However, "Here, with mines now, tankers can lose much of their cargo," said one source who did not wish to be named.

The Texaco Caribbean is believed to have lost 4% to 5% of the value of its cargo after being struck by a mine last week, he said. The London market, which provided some of the coverage for the cargo, has been notified of a claim but no figures have been revealed

to underwriters as yet, sources say.

Cargo war risk underwriters only two weeks ago increased minimum rates for 14-day voyages to Kuwait to 0.375% from 0.2% of the insured value following the U.S. Navy's decision to safeguard Kuwaiti tankers flying under American flags. Hull rates are 0.5% for ships sailing to Kuwait.

So far, underwriters have paid \$300 million to \$500 million in claims from tankers and cargo ships that were damaged or seized in the Persian Gulf during the 7-year Iran/Iraq war, said a Lloyd's spokesman.

According to a spokesman at the Institute of London Underwriters, the joint cargo War Risk Rating Committee made up of Lloyd's and ILU underwriters, suggests that:

- There be no minimum rate for "the worst part of the gulf" between the Iranian port of Bushire west to the coast of Iraq and upwards, including Kharg Island, a main Iranian oil terminal.

"That's bomb alley," the ILU spokesman said. "Anyone stupid enough to go there can pay through the nose."

Cargo underwriters in the past have quoted rates as high as 10% for ships traveling in that region, but current rates are lower, varying between 5% and 7% for trips to and from Kharg Island.

- There be a minimum rate of 0.375% for sailings to Sirri Island, Northwest of Dubai, which is another oil terminal where Iran shuttles oil down from Kharg Island. Sirri has been damaged in the past by Iraqi aircraft.

- There be a minimum rate of 0.125% for sailings to and from ports just north of the Strait of Hormuz.

- There be a minimum rate of 0.25% for the rest of the Iranian coastline.

Hull war risk underwriters do not have a committee to suggest minimum war risk rates in the Persian Gulf. However, Lloyd's List, the maritime newspaper owned by Lloyd's of London Press, suggests that minimum hull war risk rates are: 0.25% of the hull value for vessels in the Persian Gulf, except for those visiting Iran, Iraq or Kuwait; 0.5% for vessels visiting Kuwait, Sirri Island or Lavan; 1% for vessels visiting Bandar Abbas; and 0.25% for vessels visiting ports in the Strait of Hormuz. There are no agreed rates for any other ports in the Persian Gulf.

There may not be as much demand for hull war risk coverage to Kharg Island because Iran offers a shuttle service—which is not insured—for its oil down to Sirri Island.

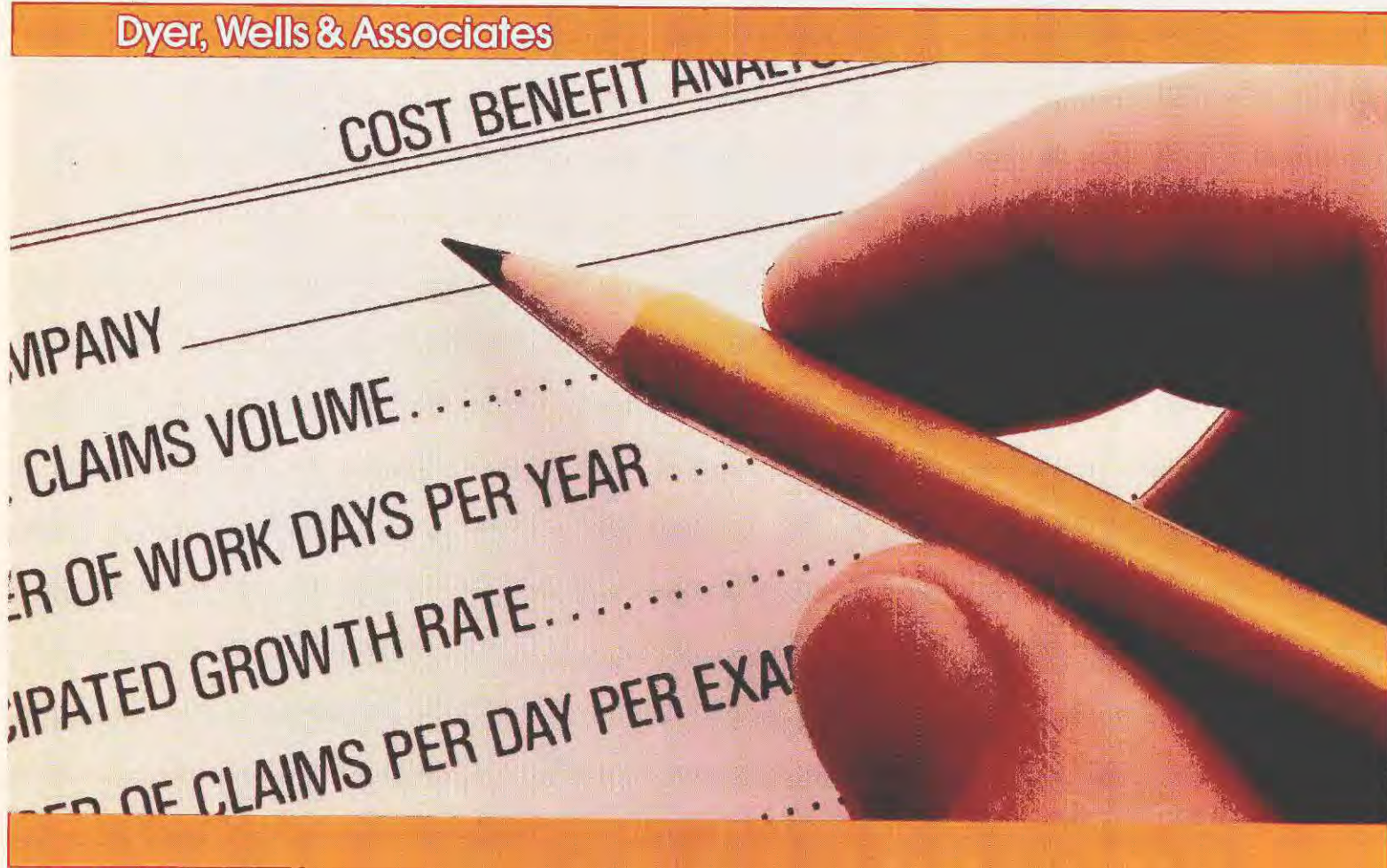
Meanwhile, Lloyd's two largest marine syndicates have decided not to offer new war risk coverage.

Stephen Merrett, chairman of Merrett Holdings P.L.C. and underwriter for Lloyd's largest marine syndicate, 418, decided last year to stop writing new war risk coverage on a facultative basis. The decision came "largely because of the Gulf war," he said.

Mr. Merrett, a leading war risk underwriter, confirmed that he is still honoring war risk coverage that was placed with him before this decision, which sources say is a "substantial chunk" of war risks.

Also, Michael Maughan, marine underwriter for syndicate 206, the second-largest marine syndicate, which is managed by R.W. Sturge (Marine) Ltd., has been gradually withdrawing from the hull war risk market over the last year.

"Due to the dangerous state of the (Iran/Iraq) war now, we have to a great extent withdrawn from that area because, although the premiums are high, the risks are higher," said Mr. Maughan. ■



You Could Save Thousands Of Dollars By Taking This Simple Test.

We're so sure FASTRAK™ can save you money on health claims administration, we're offering to prove it.

Just send for our free cost benefit analysis which will show you how much money you can save with a FASTRAK online claims administration system from Dyer, Wells & Associates.

Save Money Two Ways.

FASTRAK completely automates the adjudication and processing of health claims. So you'll be handling claims faster and with greater accuracy. In fact, your administrative savings alone could pay for FASTRAK within the first year of use.

And you'll save money

another way too: by accurately interpreting data, identifying problem areas and improving cost-control strategies. With FASTRAK, all the information you need to implement the latest cost-containment provisions is right at your fingertips.

Just Your Size.

Whatever your company's size, one of our three FASTRAK systems (mainframe, minicomputer, personal computer) is the perfect fit. Plus, we offer processing services. Which-

ever you choose, you'll find FASTRAK has the capability to grow with your company to meet your changing needs.

Send For Your Free Cost Benefit Analysis.

Enough talk. Call or write today for your free cost benefit analysis. No risk. No obligation. Just the chance to prove that we're not all talk. And the chance for you to save a lot of money.

Yes, I'd like to know how much money FASTRAK can save me in claims administration. I have checked the system(s) I'm interested in.

IBM Mainframe Wang VS Minicomputer IBM PC and compatibles Processing Services

Name _____

Title _____

Company _____

Address _____

City _____ State _____

Zip _____ Phone (____) _____

Dyer, Wells & Associates

The Right Solutions. For 10 Years Running.

BI-81787 2251 Lake Park Drive, Smyrna, GA 30080 (404) 432-5888

Thanks to modern medicine, he'll now be able to outlive his savings.



Advancements in medicine are helping Americans live longer than ever. But not everyone is financially prepared for a longer life.

Particularly retirees who end up needing expensive long-term care. Currently, that's 6 million people. That number should be 14 million by the year 2020.

Personal savings are seldom enough to pay the costs of retirement health care. And Medicare and Medicaid are only a partial solution. Companies with retirement health care benefits also face the problem of unfunded future liabilities.

Additional solutions must be found to address this retirement health care cost issue that will eventually affect every person, company and institution in our country. Ideas that go beyond traditional products.

At NWNL Group, we're developing an employee benefit program called LifeScope® that would provide for a person's retirement and working years. What makes the LifeScope Program unique is its comprehensive approach to providing benefits. It is more than life insurance and a nursing home policy.

By managing the delivery of health care and planning for future needs, the LifeScope Program can find alternatives that make health care more affordable, while allowing individuals to live independently. The program's benefits would be voluntary, flexible and portable.

Many elements of the LifeScope Program have already been put into place through current NWNL Group benefit programs. Using our resources as the nation's 10th largest

group insurance company, we will soon be adding more elements.

To find out more about NWNL Group and the LifeScope Program, contact Ginny Patrick, NWNL Group, Box 20, Minneapolis, MN 55440 or call (612) 372-5784. Because now is the time to begin solving the problems of providing health care in the future.

NWNL GROUP
*The right benefits for today.
The right ideas for the future.™*

Sources for statistics: Employee Benefit Research Institute, 1985; National Underwriter, 1986.

A division of Northwestern National Life Insurance Company, Minneapolis, MN (not admitted in the State of New York). The North Atlantic Life Insurance Company of America, Jericho, NY (a member of the NWNL Companies).

EC directive

Continued from page 2

Although strict liability must be implemented, each nation has three options it can enact to make legislation more or less restrictive to manufacturers. They are to limit damages, to include the state-of-the-art defense and to include primary agricultural products or not under strict liability.

France has drafted a bill that places no cap on damages for product faults and would not allow producers to use the state-of-the-art defense, according to a spokesman for the Ministry of Finance.

And, the legislation holds manufacturers of primary agricultural products liable.

The French bill, which is now being considered by working groups, is not expected to be adopted until after July 1988.

Also, Britain's Consumer Protection Act, which was passed in May and is the only national law to implement the EC directive, does not impose a limit on damages.

The British law, however, does include the state-of-the-art defense and excludes primary agricultural products as the West German bill does (BI, May 18).

Generally, the West German insurance industry is satisfied with the draft legislation.

"The German insurance industry is on the whole very happy with the new draft law on product liability," said Joachim Richter, legal adviser to HUK Verband.

However, insurers question the West German government's observation that product liability insurance premiums would have to be increased by 10% to 20% after the legislation is passed.

"Any increases must be really be worked out sector by sector in the light of experience," said Mr. Richter.

Insurers also fear that putting a financial ceiling on manufacturers' liability will encourage many manufacturers to unnecessarily increase their policy limits to 160 million deutsche marks.

"With competition in the German (insurance) industry at this time, this could lead to insurers not getting sufficient premiums to cover the (limit) increases," said Dr. Richter.

Consumer associations, on the other hand, are concerned about implementation of the state-of-the-art defense in West Germany. "This is probably the worst part of the proposal from the consumers' point of view," said Gabriele Erkenz, legal adviser to A.G.V.

"It means that producers will be able to escape liability by saying that they did not know of the risk at the time they started selling their product. It gives consumers no protection," she said.

The state-of-the-art defense, which conflicts with West Germany's current strict liability legislation on pharmaceutical companies that does not give pharmaceutical manufacturers a state-of-the-art defense, is expected to supercede the current legislation, she said.

The Brussels-based European Consumers' Assn. BEUC—which is monitoring the implementation of the EC directive in the 12 EC countries—also is critical of West Germany's legislation.

"It is a step backward," said BEUC Director Tony Venables.

"So far, the only country which has proposed really progressive legislation from the consumers' points of view is France. The others are all giving way to industry."

BEUC, in fact, is so concerned about Britain's consumer protection law that it is seeking legal advice on whether the United Kingdom can be taken to the European Court of Justice in Luxembourg for failure to properly implement EC legislation. ■

Iowa challenge

Continued from page 3

purchasing groups are located for the purposes of regulation.

Meanwhile, the Insurance Division is set to dismiss The Doctors' Co. of Santa Monica, Calif., and Kraft Insurance Co. of London from administrative action because they are eligible surplus lines insurers in the state.

The Doctors' Co. became an eligible surplus lines insurer after receiving the notice. A purchasing group filing error resulted in Kraft receiving a notice even though it is an eligible surplus lines insurer in Iowa, Mr. Schrader said.

In addition, the Insurance Division has negotiated verbal agreements calling for dismissal of action against four other insurers:

- The division will dismiss action against the TriStar Insurance Co. of Phoenix, Ariz., if it becomes an eligible surplus lines insurer.

- The division also will dismiss Capital Insurance Co. Ltd. of Barbados and Transatlantic Insurance Co. Ltd. of Britain if they notify the department in writing that they will not write insurance for the purchasing group.

- Victoria Insurance Co. of Atlanta will be dismissed from administrative action if the eight purchasing groups now affiliated with the insurer notify the Insurance Division that Victoria has withdrawn its involvement. The division is now investigating a ninth purchasing group that names Victoria as its insurer, although Victoria has no knowledge of it, Mr. Schrader said.

The Insurance Division is not expected to take administrative action against insurers awaiting dismissal of their cases unless the division believes the insurers will not fulfill their agreements, Mr. Schrader said.

The division appears to be close to an agreement with two other insurers.

- The division has a few details to work out with Markel American Insurance Co. in Richmond, Va., which expects to write through Richmond-based Essex Insurance Co., which is an eligible surplus lines insurer.

- Also, the division is negotiating with Stone Mountain Insurance Co. of Marietta, Ga.

Regardless of any action the Insurance Division takes, it considers contracts of insurance between insurers and purchasing groups to be valid and enforceable, a letter to insurers and purchasing groups says.

That letter was sent shortly after the original notices of hearing were mailed to the targeted insurers in late July.

While Iowa insurance regulators acknowledge the enforceability of the insurance contracts, they have "a real concern beyond the academic" about some insurers involved because they are new, unknown companies or located offshore where regulatory standards differ from those in the United States, according to Mr. Schrader.

In addition, purchasing groups are subject to only limited regulation and buyers are not protected by guaranty funds if the insurer is not licensed, he added.

Mr. Schrader explained that action is being taken against the insurers to protect Iowa's insurance consumers.

The Risk Retention Act was designed for sophisticated buyers with similar risks to band together in groups to find insurance, he said, not for insurers to seek out unsophisticated buyers to form groups, which is happening to some extent in Iowa.

Insurers have organized many of the more than 90 purchasing groups that have notified Iowa regulators that they intend to do business in the state, he said. ■

Does your employee belong in a psychiatric hospital?

Maybe so. Fortunately, serious mental illness is highly treatable. But what sort of treatment setting is most appropriate? If your group insurance plan offers mental health care benefits, you can't afford to be confused about what types of therapeutic services, hospitals and facilities are available. In fact, understanding who needs a private psychiatric hospital and who doesn't can help you manage your inpatient psychiatric benefits more efficiently.

Not all hospitals treating mental illness are alike—and you need to know the difference.

The diverse and individual needs of the mentally ill require an equally diverse range of health care facilities, from state institutions to general hospital settings to specialty psychiatric hospitals. The services and therapies offered by different types of hospitals also vary in scope and intensity.

The National Association of Private Psychiatric Hospitals (NAPPH) has assembled a comprehensive booklet which clearly defines the differences among mental health inpatient providers. We've also included useful information about the types of patients we treat and the costs involved, plus the latest facts on hospital trends and the utilization of inpatient services, all broken out in easy-to-understand, reproduceable language and charts.

The booklet is free—but the information is invaluable.

**The National Association of
Private Psychiatric Hospitals**

Using Inpatient
Psychiatric
Benefits Wisely

A Guide to Differences
in Psychiatric Hospitalization Settings
The National Association of Private Psychiatric Hospitals

New!

Please send
me a free
copy of
"Using
Inpatient

Psychiatric Benefits Wisely"
with all the latest statistics on
mental health inpatient care.

Name _____

Title _____

Company _____

Address _____

City _____ State/Zip _____

The National Association of
Private Psychiatric Hospitals
1319 F Street, N.W.
Washington, D.C. 20004
(202) 393-6700

BI 8/17

A \$25 MILLION UMBRELLA IS EASIER TO RAISE THAN YOU MIGHT THINK.

SOME VERY GOOD NEWS ABOUT OUR EXCESS UMBRELLA COVERAGE

American Home Assurance Company, a member of American International Group, Inc., has long had a commitment to serving the needs of the excess liability marketplace. When those needs change, so do we.

AN EXCLUSIVE OFFER

That's why we're offering a unique new package of casualty insurance: \$25 million lead umbrella coverage. Available on either a claims-made or occurrence basis, we provide special consideration for

insureds coming off the first year of claims-made coverage and seeking an occurrence policy.

IT'S A STURDY UMBRELLA

Our A + rating from Best & Co. assures you of our stability. For more information, please ask your agent or broker to call the American Home representative in the nearest AIG office.

Don't wait for a rainy day.

**AIG AMERICAN INTERNATIONAL GROUP
OF INSURANCE COMPANIES**

Our Policies Are Your Best Insurance.

opinions

Collecting our thoughts

ISSUES WE'VE BEEN mulling in the hot summer days:

• Congressmen clearly don't understand the private pension system.

If they did, they would not even discuss charging employers that terminate defined benefit pension plans the hefty sum of \$200 per plan participant. While the Pension Benefit Guaranty Corp., which would be the beneficiary of this special charge, certainly needs the money, this is no way to encourage employers to set up new pension plans. Furthermore, this tax, and the proposal to require employers to give participants a share of excess assets when terminating plans, do not encourage better funding of pension plans. Why can't Congress focus on the real problem—shoring up the PBGC—and see the clear logic of allowing the PBGC to set premiums based on a pension plan's financial condition?

• Health insurance pools for the uninsured are more likely than most employers realize.

The problem of people without health insurance will not go away. Forming health insurance pools funded by employers is gaining popularity as a solution. Never mind that it is unfair to make employers offering health care plans pay twice—once for their own employees and again for individuals who don't have coverage.

• Some tort reforms deserve to be overturned.

The Kansas Supreme Court threw out the state's law allowing evidence of a plaintiff's payments from collateral sources in medical malpractice cases. The court said it violated the state's equal protection guarantees by potentially discriminating against a class of tort claimants: those filing

medical malpractice claims. Further, the court said the law gave preferential treatment to health care providers, because a doctor guilty of malpractice would benefit from the law, while another professional would not.

Evidence of a plaintiff's payments from collateral sources should be permitted in all personal injury and wrongful death suits.

• For an industry that decries the litigation explosion, insurers and reinsurers appear to file more than their share of lawsuits.

Hardly a week goes by that we don't report on an insurer suing a policyholder to deny coverage—or, to be fair, a policyholder suing an insurer for coverage. Then there's the rash of litigation between ceding companies and their reinsurers and between reinsurers and their retrocessionaires, often involving managing general agents, over whether or not retrocessionaires and reinsurers must pay losses under contracts allegedly entered into without authorization or involving fraud.

The insurance business should set an example and settle more disputes through arbitration and other forms of alternative dispute resolution.

• Maybe the trial lawyers will learn it isn't easy to make money underwriting insurance.

We were more than a bit bemused to see the trial lawyers form their own risk retention group to underwrite lawyer's professional liability insurance. Here's a group that gets much of the blame for the liability insurance crisis—as an instigator of the litigation explosion—in desperate need of insurance. And while they expect to be able to offer a stable market to their members, we expect they will soon develop more empathy for the problems inherent in pricing liability insurance.

letters

Industry must realize value of public image

To the editor: The last time I wrote an article to you was in 1978. You published it as a Perspective: "Punitive Damages Controversy—Broker's View" (*BI*, March 20, 1978). I hope you will find that the following also deserves a place in *Business Insurance*. Your recent editorials have reflected the same sense of frustration and disappointment that I often feel about the insurance industry.

The Insurance Information Institute recently embarked upon a \$10 million campaign to improve the image of the insurance industry in the minds of the American public.

Part of the campaign is a series of television commercials that stresses the industry's support for and sponsorship of organizations such as the Institute for Highway Safety and Underwriters' Laboratories. You probably didn't know, the ads say, that insurance companies spend a lot of money on studies that attempt to prevent losses from happening in the first place.

They're good, upbeat, positive spots that treat what we do with respect and dignity—a nice change of pace from the gimmickry of trying to communicate with cartoon characters, wild animals and businessmen who like to wear fire hats.

The other important part of III's campaign is a public speaking effort that ut-

ilizes industry leaders to speak to community groups about "insurance problems." The name of the speech they have prepared for delivery throughout the country is "Insurance, Consumers and the Lawsuit Crisis." In other words, if you think these are insurance problems we're having, you really don't understand the problem because what we have here are lawyer problems and what we need is tort reform.

Three observations: First, when we attempt to reduce the problems of the insurance industry to a simple case of excessive litigiousness—whose solution, naturally, is tort reform—we're cheating. We're cheating a full discussion of the "insurance problems" but, more importantly, we're cheating the American public. And they know better. If we propose to deal with this complex set of problems, let's be honest, let's give a balanced discussion. What about cash-flow underwriting, underreserving, reinsurance shell games and the cyclical nature of this industry? We are better off to admit our mistakes than to attempt to divert everyone's attention by focusing on tort reform. True, our litigious society is not a red-herring issue, it's a real problem, but it suffers as an issue when the other problems are not discussed as frankly and thoroughly. "Always tell the truth," said Mark Twain. "This will please some people and astonish the rest."

Second, tort reform is not the only available remedy for our litigiousness. Alternative dispute resolution techniques (mediation and arbitration, for example) and greater emphasis on loss prevention and control are just as important. There are many positive ways to get insurance costs under control and it serves the industry well to let the public know about them.

My third observation is about the III's budget. To some people, \$10 million may seem like a lot of money. But as any advertiser knows, that won't buy a lot of

prime-time television for those "bet you didn't know we were such great guys" ads that III has produced. To put this in perspective, consider that the entire insurance industry spends over \$200 million a year on ads that feature cartoon characters, stags, cavalries, geological formations, train stations, etc., to deliver its (usually condescending) messages, while Proctor & Gamble spends about \$35 million just to introduce a new mouthwash. That's \$10 million to change people's perceptions about an industry that ranks somewhere in the minds of most Americans with used car salesmen and television evangelists? For a \$150 billion industry, \$10 million is a spit in the ocean.

I can only hope that one day the insurance industry will really try to deal with its public image problem. By being honest about itself, and by making a real effort to create an informed public. Perhaps the repeal of the McCarran-Ferguson Act will finally force upon us the necessity of doing this.

James Whitaker
Carmel-By-The-Sea, Calif.

Accolades welcomed by A&A employee

To the editor: Congratulations! Finally my employer, Alexander & Alexander Inc., has received the positive press it deserves. Your July 27 issue actually did it twice and I am personally delighted.

We assisted in reforming the London marketplace, which was very costly to us not only in dollars but also in negative publicity.

I am extremely proud of being an employee of Alexander & Alexander Inc., which, as Leonard Wilson stated, "is one of a few world-class brokers."

Catherine T. Hartlieb
Alexander & Alexander Inc.
Chicago

business insurance®

Reporting weekly for corporate risk,
employee benefit and financial executives

Publisher: Alfred Malecki (New York)

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

Managing Editor: James M. Burcke (Chicago)

Assistant Managing Editor: Dave Lenckus (Chicago)

Assistant Managing Editor/Graphics: Holly E. Seguire (Chicago)

CHICAGO: Stacy Adler (Assistant Copy Editor)
Karen Brown (Assistant to the Editor)
Linda J. Collins (Agent/Broker Editor)
Donna DiBlase (Associate Editor)
Meg Fletcher, A.R.M. (Associate Editor)
Karen Huelsman (Copy Editor)
Marilou Jones (Directory Editor)
Laura Mazzuca (Agent/Broker Topics Associate Editor)
Amy Palmer (Graphic Artist)
Roger Schillerstrom (Editorial Cartoonist)
Stephen Tarnoff (Associate Editor)
Paul Winston (Assistant Copy Editor)
Joanne Wojcik (Copy Editor)

DALLAS: Michael Bradford (Associate Editor)

LONDON: Stacy Shapiro (International Editor)
Carolyn Aldred (Associate Editor)

LOS ANGELES: Robert A. Finlayson (Bureau Chief)
Steve Taravella (Associate Editor)

NEW YORK: Douglas McLeod (Bureau Chief)
Judy Greenwald (Associate Editor)

WASHINGTON: Jerry Geisel (Washington Editor)
Deborah Shalowitz (Associate Editor)

Corporate: H.L. Stevenson (Corporate Editor)

Advertising Director: Donald A. Walsh (New York)

Midwest Sales Manager: Robert L. Niesse (Chicago)

CHICAGO: Deborah D. Neale (District Manager)
Margaret Hikido (District Manager/
Classified Sales)
Elmer Kerstowski (Production Manager)

LOS ANGELES: Michael J. Sharpe (District Manager)

NEW YORK: Charles A. Horvath (District Manager)
Jack Forrest (District Manager)
Martin J. Ross (District Manager)
Courtney Bauer (District Manager)

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

Corporate Marketing Manager: Alice Sieloff (Detroit)

EDITORIAL: Chicago: 312-649-5398

Dallas: 214-363-1066

London: 01-404-4228

Los Angeles: 213-651-3710

New York: 212-210-0100

Washington: 202-662-7200

ADVERTISING: New York: 212-210-0133

Chicago: 312-649-5276

Los Angeles: 213-651-3710

COMMUNICATIONS: New York: 212-210-0132

CIRCULATION: Detroit: 313-446-1611

Published by Crain Communications Inc., Chicago

G.D. CRAIN JR.

Founder (1885-1973)

MRS. G.D. CRAIN

Chairman

KEITH E. CRAIN

Vice chairman

S.R. BERNSTEIN

Chairman-executive committee

RANCE CRAIN

President

MARY KAY CRAIN

Treasurer

MERRILEE P. CRAIN

Secretary

WILLIAM A. MORROW

Senior Vp-operations

Published weekly at 740 Rush St., Chicago, Ill. 60611, Telex 6871241, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017, Telex 640207 CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231; Suite 814, National Press Building, Washington, D.C. 20045; 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 20-22 Bedford Row, London WC1R 4EB, England. \$1.75 a copy. \$68 a year in U.S. Canada and all other foreign add \$16 for surface mail. Europe and Middle East only add \$47 for air delivery. First-class mail to U.S. and Canada only, add \$48. Bermuda only, \$105 per year expedited delivery. WILLIAM STRONG, vp-circulation. BARBARA KISCH, circulation manager. JOHN HUFFMAN, fulfillment director. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, *Business Insurance*, 965 E. Jefferson Ave., Detroit, Mich., 48207, or phone 313-446-1611. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611, 312-649-5303. For reprints or reprint permission contact: Reprint Department, *Business Insurance*, 220 E. 42nd St., New York, N.Y. 10017, 212-210-0229.

BPA

Member of Business
Publications Audit of Circulation

ABP

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

Stay Ahead.



Burst into the new era of benefits management with LifeAdvantage™, the innovative group universal life program offered by the Mutual of Omaha Group Operation.

Employer-friendly LifeAdvantage, underwritten by United of Omaha Life Insurance Company, puts you out front in the dramatically changing environment of employee benefit programs. Group universal life coverage is one of the fastest-growing employee benefits in today's economy — and LifeAdvantage leads the way.

It's easy to administer, with no additional premium cost to you. LifeAdvantage "portability" helps you avoid costly conversion charges, since retirees can convert LifeAdvantage to a paid-up life insurance policy or start receiving benefits.

LifeAdvantage can be added to existing benefit programs, and up to certain limits can be issued with no physical exams or health questions. It's tailored for the times, offering employees current life insurance protection, tax-deferred interest and attractive loan and withdrawal features.

Partners in cost-efficiencies.

LifeAdvantage is backed by the Managed-Cost ProfessionalsSM of Mutual of Omaha's Group Operation, one of America's largest and most responsive group insurers. Our precise disciplines in benefit planning and administration give benefit managers enhanced programs in a cost-controlled environment.

Is group universal life right for *your* company?

On your business card, ask for our new special report on group universal life. Send to: Terry Van Noy, Vice President, Mutual of Omaha Companies, Mutual of Omaha Plaza, Omaha, NE 68175.

Mutual
of Omaha 
Companies
Group Operation
The Managed-Cost
ProfessionalsSM

This is the long, confusing a benefits manager of Maxicare's national h

Addresses

Name
Address
Phone ()

Name
Address
Phone ()
*Maxicare
(213) 568-9000
ext. 4600*

Name
Address
Phone ()

Name
Address
Phone ()

Name
Address
Phone ()

Name
Address
Phone ()

Name
Address
Phone ()

M
N

g list of phone numbers needs to stay on top health maintenance plan.

If you're administrating an HMO program for a company with multiple locations, it's normal to spend a certain percentage of your time on the phone.

However, 90% is not normal.

So you should seriously consider the Maxicare Health Plan.

With Maxicare, there's only one phone number you'll ever need to call: (213) 568-9000, Ext. 4600.

At the other end, you'll have your own national accounts manager—the only contact person you'll ever have to deal with—who'll design a single unified health benefits package for all your locations throughout 26 states.

During enrollment periods, this same accounts manager will see that local representatives handle all the details for you.

And at the end of every month you'll receive one of the most welcome benefits of all. A single bill. In a single envelope.

We already have more than 700 national accounts in the Maxicare family. If you'd like to be one of them, or if you'd just like more information, call the number we told you about earlier.

Or if, for understandable reasons, you'd rather not use the phone, write Maxicare National Marketing, 5200 West Century Blvd., Los Angeles, CA 90045.

Maxicare 

Six universities consider Vermont captive

By ROBERT A. FINLAYSON

EVANSTON, Ill.—A group of six large universities is considering capitalizing a captive insurance company to write excess general liability and directors and officers liability insurance.

Tentatively named HELM—Higher Education Liability Mutual Inc.—the group, headed up by Northwestern University in Evanston, Ill., has been exploring the idea of pooling their risks in a captive for more than a year and plans

to make a final decision later this summer.

About six major universities are involved, said Lee A. Ellis, senior vp of business and finance at Northwestern. He declined to identify the schools involved, but *Business Insurance* has learned that the group includes The University of Michigan in Ann Arbor; Yale University in New Haven, Conn.; Columbia University in New York; Duke University in Durham, N.C.; Stanford University in Palo Alto, Calif.; and Massachu-

setts Institute of Technology in Cambridge.

So far, the group has decided to incorporate the captive in the next few months as a mutual insurance company domiciled in Vermont so that a vehicle would be readily available if enough of the potential participants agreed to capitalize the venture, according to William F. Ryan, the University of Michigan's director of risk management.

The group has retained a consultant, who Mr. Ellis would not name, and both the feasibility and

actuarial studies are complete.

Potential sponsors would not say how much capital they are seeking.

Mr. Ellis says the schools want to set up the captive to insulate themselves from the ups and downs of the commercial market. "We're trying to get off the roller coaster. We know the swings are getting wilder and wilder and that they are inevitable, and we simply don't want to play in that ball park anymore."

The group decided to form as a mutual to hold down the capitali-

zation costs, Mr. Ellis said. The facility will write only excess insurance, probably \$25 million excess of \$10 million. Organizers don't plan to buy reinsurance, although that might be considered in the future if market conditions change.

If the group decides to proceed, Mr. Ellis says the captive could be activated by November. But the softening insurance market is making it difficult, Mr. Ellis notes. "The market's easing is noticeable and it is having an influence."

According to Mary Brieghner, director of risk management at Columbia University, Columbia has participated in the discussions with Northwestern, but has not yet decided if it will join the captive.

Columbia became interested in forming a captive because the commercial insurance market was not fully meeting its needs, Ms. Brieghner says.

However, she says the insurance market recently has improved, although additional adjustments are still needed.

Kathy M. Van Nest, insurance manager for Duke University, says the university is considering several alternatives to commercial insurance, including the captive.

"We are looking at possible alternatives, but we have not made any commitments to any of these groups," she says.

Although no timetable has been established for joining a captive, Ms. Van Nest says the university would like to have an alternative facility in place before the next hard market cycle.

Rapidly rising insurance prices and coverage restrictions that occurred during the hard market "got the attention of the right people in the university system," Ms. Van Nest says. "We will continue to look at alternatives and hopefully will have them in place when the next cycle comes around so we can take appropriate action."

The university's board of trustees ultimately would decide whether to join the captive, Ms. Van Nest notes, because it would involve a capital expenditure.

In contrast, Michigan is "ready to sign on the dotted line," says Mr. Ryan. "I think it's a fine idea. We are very favorably disposed toward the concept."

The university is more comfortable with the captive concept than other schools because it already has its own captive, Mr. Ryan says.

The captive, Veritas Insurance Co., is domiciled in Vermont and writes the university's primary general liability, D&O and medical malpractice coverage.

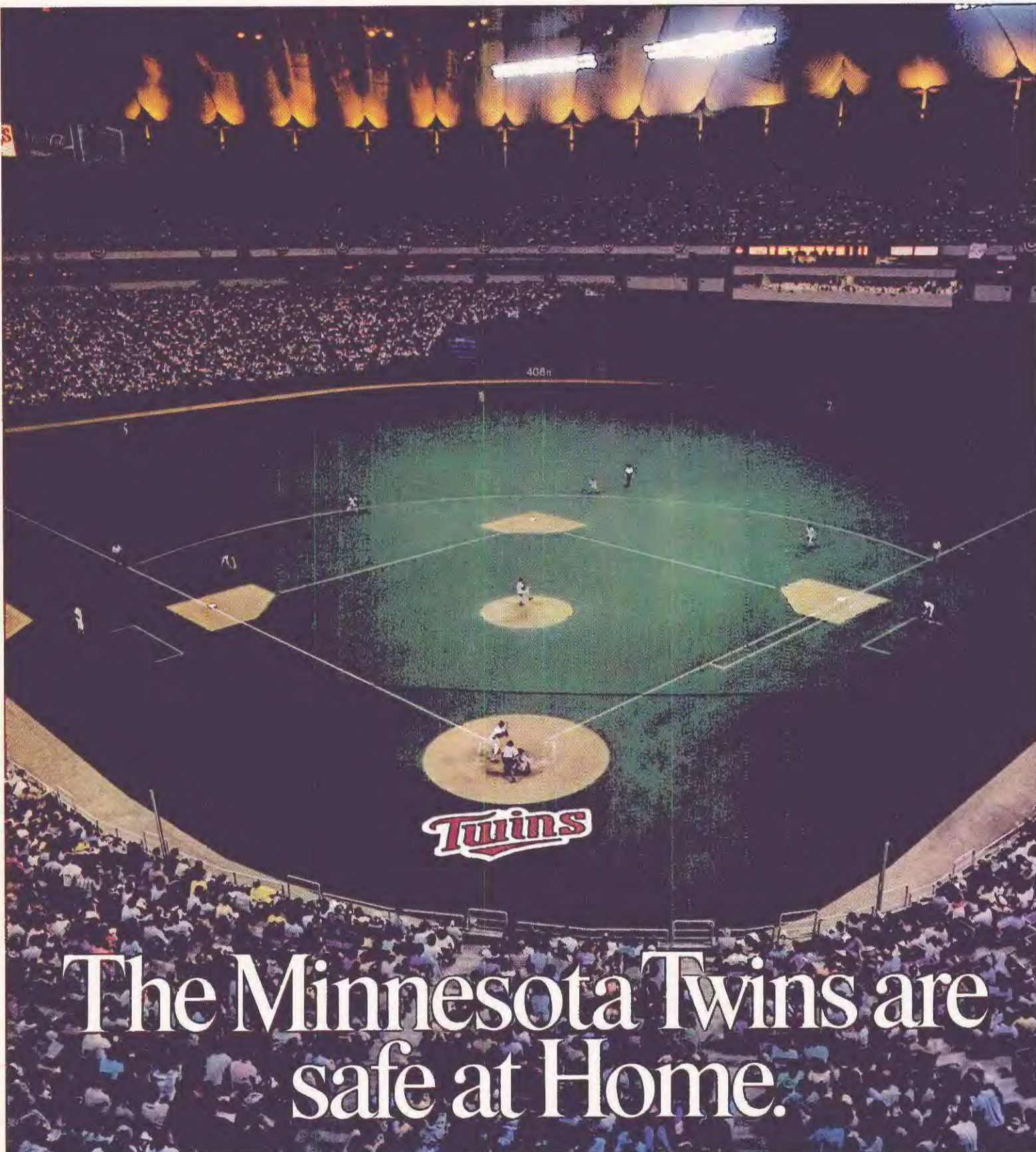
"Forming a captive is a radical step to take, especially for a public institution," he says, adding that Michigan's captive was a natural growth out of the university's 30-year-old self-insurance program.

Like the other university risk managers, Mr. Ryan says he sees some easing of prices in the commercial insurance market. However, he says coverage restrictions continue, and he does not expect these restrictions to ease much in the near future.

"If you go out to buy coverage, you end up with a piece of paper that's not worth papering the walls with," he says.

More sophisticated risk managers and financial officers will not be dissuaded from considering a captive because of current softening of the commercial insurance market because they know that another market swing is inevitable, according to Mr. Ryan.

And, he hopes that more colleges and universities will form captives so that eventually they can all "pool" their excess liability risks. HELM is a good first step toward that goal, he adds. ■



The Minnesota Twins are safe at Home.

A good ballplayer has his own special way of fielding the thousand and one problems that come up every season. So does a Home underwriter.

He brings his expertise to putting together a policy as creative as the coverage we write for the Twins. And gives the continuing personalized service Home Insurance clients have come to expect.

But in a ballplayer or a Home underwriter, individual expertise isn't enough. Each has to be an effective part of a team, as well.

Our underwriters work with a Loss Prevention Engineer to

advise the Twins on ways to minimize risk. Plus a Professional Claims Handler to take care of special claims rapidly and smoothly.

It's the kind of imaginative treatment Home has been giving clients since we started business in 1853—just eight years after the first official rules of baseball were drawn up.

If your company or corporation would benefit from this kind of major-league treatment, have your broker or agent contact the nearest Home field office. Or write Marshall Manley, Chairman, The Home Insurance Company, 59 Maiden Lane, New York, N.Y. 10038.

Home Insurance
There's no place like it.

THE HMO-USA NETWORK SERVES THESE U.S. CITIES AND MANY OTHERS:

ARIZONA

Phoenix
Tucson

CALIFORNIA

Bakersfield
Fresno
Los Angeles
Sacramento
San Diego
San Francisco Bay Area
San Jose

COLORADO

Boulder
Colorado Springs
Denver
Pueblo

CONNECTICUT

Branford
Bridgeport
Hamden
Hartford
New Haven
Stamford

DELAWARE

Northern Delaware
Wilmington

DISTRICT OF COLUMBIA

Washington, D.C.

INDIANA

Bloomington
Evansville
Fort Wayne
Gary
Hammond
Indianapolis
South Bend

IOWA

Ames
Cedar Rapids
Des Moines
Dubuque
Iowa City

KANSAS

Lawrence
Manhattan
Salina
Topeka
Wichita

KENTUCKY

Bowling Green
Covington
Frankfort
Lexington
Louisville

LOUISIANA

Baton Rouge
Lafayette
New Orleans

Minneapolis
St. Cloud
St. Paul

MISSOURI

Kansas City
St. Louis

MONTANA

Helena

NEBRASKA

Grand Island
Lincoln
Omaha

NEW JERSEY

Atlantic City
Camden
Jersey City
Morristown
New Brunswick
Newark
Patterson
Union City

NEW MEXICO

Albuquerque
Santa Fe

NEW YORK

Albany
Buffalo
Jamestown

OREGON

Portland

PENNSYLVANIA

Allentown
Camp Hill
Harrisburg
Lehigh Valley
Philadelphia
Pittsburgh

RHODE ISLAND

Providence

SOUTH CAROLINA

Charleston
Columbia
Florence
Greenville
Spartanburg

TENNESSEE

Chattanooga
Jackson
Knoxville
Memphis
Murfreesboro
Nashville
Oak Ridge

UTAH

Ogden
Provo
Salt Lake City

NOBODY COVERS THE USA LIKE HMO-USA.

FLORIDA

Ft. Lauderdale
Gainesville
Jacksonville
Miami
Orlando
Palm Beach
Pensacola
Sarasota
Tallahassee
Tampa

GEORGIA

Atlanta

HAWAII

Islands of Hawaii
Kauai
Maui
Oahu

ILLINOIS

Champaign
Chicago
Danville
Decatur
De Kalb
Peoria
Rockford
Springfield

MAINE

Bath-Brunswick
Portland

MARYLAND

Annapolis
Baltimore
Columbia

MASSACHUSETTS

Greater Boston
Essex County
Lowell
Pittsfield
Springfield
Worcester

MICHIGAN

Battle Creek
Benton Harbor
Detroit
Flint
Grand Rapids
Kalamazoo
Lansing
Saginaw
St. Joseph
Traverse City

MINNESOTA

Duluth

New York City
Niagara Falls
Rochester
Utica

NORTH CAROLINA

Ashville
Charlotte
Durham
Greensboro
Raleigh
Winston-Salem

NORTH DAKOTA

Bismarck
Fargo

OHIO

Akron
Canton
Cincinnati
Cleveland
Columbus
Dayton
Toledo
Warren
Youngstown

OKLAHOMA

Oklahoma City
Tulsa

VIRGINIA

Alexandria
Arlington
Newport News
Norfolk
Petersburg
Richmond
Virginia Beach

WASHINGTON

Olympia
Puget Sound
Seattle
Spokane
Tacoma
Vancouver
Walla Walla

WISCONSIN

Appleton
Burlington
Janesville
Kenosha
Milwaukee
Racine
Sheboygan
West Bend

WYOMING

Cheyenne

EBC conference

Bank tames COBRA administration

By DONNA DIBLASE

NEW YORK—Barnett Banks Inc.'s manager of employee benefits faced what she described as a "venomous" task.

As the loser of a coin toss in the Jacksonville, Fla.-based company's benefits department, Catherine Corse was nominated to develop a communication, notification and administration system to bring the bank holding company into compliance with the health coverage continuation provisions of the Consolidated Omnibus Budget Reconciliation Act.

Ms. Corse told benefit experts attending the *Business Insurance Employee Benefits Communication Conference* earlier this month "a little about how COBRA first slithered into my life."

Barnett Banks, with \$22 billion in assets, has 498 locations in 198 cities in Florida and Georgia. The company, with 17,000 employees, is highly decentralized, with each location maintaining its own human resource department, while the corporate headquarters handles

policy and program development, Ms. Corse explained.

When Ms. Corse first received the COBRA assignment, "I procrastinated. I was sure it would go away."

"But, eventually, I had to face facts. There was no budget to hire a COBRA clerk—there was no one except me," she lamented.

With the design and implementation of a flexible benefits plan in the works, Ms. Corse said she had enough paperwork to keep her busy.

"I figured out that it would take me about six days a month just to do the notification letters. And there would be quite a few because we have turnover. We hire the young and they are restless," she added.

But, along with notification, "you also have to worry about administration of premium billing and when an employee has a qualifying event, such as termination of employment, or notifying dependents of their continuation of coverage rights when an employee dies or divorces a spouse," Ms. Corse explained.

Some qualifying events, like termination of employment or a reduction in hours that would result in termination of health coverage, require the employer to offer employees and dependents the right to continue coverage for up to 18 months following notification.

Other events, such as the death of an employee or divorce, require employers to offer employees' dependents the right to continue coverage for up to 36 months.

Ms. Corse said she eventually realized that the risk of non-compliance was one the company's top officers were unwilling to take and that action was necessary.

Employers not complying with the provisions run the risk of losing their tax deductions for health care benefit expenditures. "For Barnett, that's an \$8 million risk if even one subsidiary doesn't comply with COBRA," Ms. Corse said.

The company evaluated the possibility of purchasing a personal computer-based COBRA administration program. However, even a computerized system still would have required Ms. Corse to collect and input all of the necessary employee termination information. And, "I'm allergic to PCs," she said.

So, she next turned to the company's own computer programming department "and told them we

wanted a program that could send letters and enrollment forms," while automatically keeping track of all 18-month qualifying events.

The end result is a computer system that generates continuation of coverage notices, enrollment forms and continued premium bills to all employees experiencing 18-month qualifying events. The notices, generated each pay period, are sent to employees' home addresses.

Because the company automatically mails all employees' paychecks to their home addresses, it already has an accurate listing of employees' addresses, she explained.

The notices are a three-in-one communications piece that informs terminated employees of their rights to continue coverage, the effective

dates of the continued coverage and the price of continuing the health and dental benefits they had when their employment was terminated.

The communications piece also includes an enrollment form, which the recipient must mail to the company's third-party claims administrator: Provident Life & Accident Insurance Co.

Provident also handles continuation of coverage elections for employees choosing health maintenance organizations and dental coverage, which is provided by Prudential Insurance Co. of America.

"We pay Provident an administrative fee to notify all of the HMOs and Prudential. They collect the payments and notify the HMOs of when to stop coverage," she said.

"The system is completely user-friendly, because there are no users. The notices are generated automatically with paychecks" and mailed first-class, Ms. Corse said.

Barnett's corporate benefits department receives updated reports each pay period of which employees were terminated and received coverage continuation notices.

"We send out about 125 to 150 COBRA notices each pay period and expect about 3,000 to 3,500 a year. Between the Jan. 1 effective date and June 30, we've had 75 employees who elected continued health coverage. Of those, 45 elections were for single coverage and 30 were for family coverage," she said.

"Since January, we have collected \$36,000 in premium, paid \$21,000 in

claims and \$2,700 in administrative fees," Ms. Corse said. While Barnett hasn't lost money on COBRA benefits, "all it will take is one big health claim, like one premature baby."

Along with the automated administration system for employees with 18-month qualifying events, Barnett created a procedural handbook to help subsidiaries handle COBRA notification and administration for 36-month qualifying events, like a death or divorce, she said.

"Ninety-five percent of the administration for continued coverage is automated. The other 5% is handled by our subsidiaries, which notify employees when they experience a 36-month qualifying event," she said. ■



Ms. Corse



WHEN A REINSURER PLAYS FOLLOW THE LEADER,

Interactive effort key to flex success

By DONNA DiBLASE

NEW YORK—Communicating a new flexible benefits plan to a group of skeptical, savvy employees who are already covered by a rich benefits plan is never easy.

But, a fun and highly interactive training program for employee meeting leaders was one of the keys to San Francisco-based Pacific Gas & Electric Co.'s success in introducing its "Flex" benefits program, said Sally Gottlieb, the utility's Flex project coordinator in the corporate compensation and benefits department.

The communications effort, a 1986 *Business Insurance* Employee Benefits Communication Award winner, was the subject of a communications case study at *BI's* Employee Benefits Communication

'We had the group split into four separate groups and had them come up with the meanest, nastiest, dirtiest questions about Flex' to stump the 'flexperts' panel, explains Jeffrey Horn of Towers, Perrin, Forster & Crosby.

Conference Aug. 2-3 in New York.

With the help of benefit consultant Towers, Perrin, Forster & Crosby, PG&E developed a communications program including a video, an interactive personal computer diskette, enrollment books and newsletters for its 8,000 salaried management employees.

To determine its communications objectives, the company considered the demographics of the group.

For example, about 83% were male; about 65% were between the ages of 25 and 45; 68% had at least a bachelor's degree; and 73% earned between \$30,000 and \$54,000.

The company's objectives in designing the communications program included:

- To create an understandable and attractive program that would inform and educate employees.

- To get employees to react positively to the benefit changes.

- To create a program that was unique and special to the workforce and the plan.

- To manage the grapevine, because at PG&E, "the grapevine works overtime," Ms. Gottlieb said.

- To have fun in the communications process.

The key messages of the communications program were to be that the Flex plan would better meet employees' needs; that Flex was result of employee input; and that Flex is a substantial part of employees' total compensation at PG&E.

The communications program was divided into three phases: announcement, education and reinforcement.

First, an article in the company newsletter announced that a benefits survey would be conducted.

Then, employees completed a mail-in survey of their attitudes about their benefits.

The company then announced in the newsletter that a flexible benefits plan was being studied. Next, employees received an article informing them that "Flex was coming."

As the communications process got under way, employees received a series of Flex bulletins, informing them of the different benefits options under the plan and how they worked.

Next came the education phase of the program.

The company knew that one-on-one communication with employees in meetings would be the most difficult. So, PG&E and TPF&C trained a group of employees to lead the Flex education and enrollment meetings.

The company held two successive 2½-day sessions with 200 employees, educating them about Flex in preparation for the meetings.

These employees received welcome packets that included buttons, information about the new plan, Flex shopping bags and special note pads.

They took quizzes testing their knowledge of the plan, participated in question and answer sessions, and practiced leading meetings and answering the audience of meeting leaders' questions.

"One of the keys to meeting leader training is to divide and conquer. We had the group split into four separate groups and had them come up with the meanest, nastiest, dirtiest questions about Flex" to stump the "flexperts" panel, explained Jeffrey Horn, a vp and communications consulting practice leader in the Denver office of TPF&C.

"This competition was all in pursuit of valuable prizes," such as Flex-label champagne and T-shirts, he added.

In the meetings, employees received their enrollment kits and Flex PC diskettes.

They also viewed a video set to a tune closely resembling Marvin Gaye's hit song, "Heard it Through the Grapevine."

To reinforce their knowledge of the Flex plan, employees received confirmations of their benefit elections, summary plan descriptions, bulletins about the results of the plan and enrollment and benefit statements.

In the end, PG&E experienced an enrollment error rate of less than 2%, Ms. Gottlieb said. ■



Mr. Horn



CAN HE REALLY HELP YOU SEE WHAT'S AHEAD?

When other reinsurers tell you, "It's just like General Re," consider this: How did the leader get so far out front? Innovation.

General Re was the first professional American reinsurer to write facultative reinsurance in the United States, develop excess of loss property reinsurance, pioneer rehabilitation advisory services, author an umbrella form that serves as a model for the industry, help clients capture exposure information as a management tool, introduce tax-planning models and the computer simulation tools ROSE®, PRIME® and STRIPE® to aid clients' forecasting, and offer CONFER®.

See what's ahead. Reinsure with the leader.

Call General Re today.

**General
& Re®**

THE LAMP OF EXPERIENCE®

**MULTI-MARKETS
PHYSICAL DAMAGE
CARGO
GROUP**

Call:
Richard D. Slautterback
Chairman

Telex: 80-4319

1-800-647-3769

**American Owner/Operator
Underwriters Inc.®**

P.O. Box 105257 Atlanta, GA 30348

STRUCTURED SETTLEMENTS

STRENGTHEN YOUR POSITION

You can count on Structured Financial Associates' experience in creative settlements as a unique resource for your use in personal injury claims. Our backgrounds in insurance, law, economics, claims, and financial planning, combined with our unwavering commitment to service, have proven instrumental in successful settlements. SFA's advantages extend not only to injured persons, but to you as well. Insurers, self-insureds, and attorneys repeatedly count on us to strengthen their positions in difficult claims, and that is why SFA was the fastest growing structured settlement firm in the industry last year.



With offices nationwide, an SFA settlement specialist can be with you at your next settlement conference, or as close as your phone, to respond immediately to your concerns,

keeping negotiations moving toward successful completion. SFA - Strengthening your position

Call today for your FREE Settlement Reference Manual.

1-800-638-5890



STRUCTURED FINANCIAL ASSOCIATES, INC.
OFFICES NATIONWIDE

Explaining the triple option

By DONNA DiBLASE

NEW YORK—Triple-option group health plans offer many advantages to both employers and their employees, but communicating these advantages presents a unique challenge to employee benefits communicators.

"Triple-option plans help employers to manage and control their benefits plans. They also offer employees an unprecedented range of choices. But, too much choice can be stressful for employees," explains Laura Fairman, director of product development and marketing research for the group insurance department of New York-based Metropolitan Life Insurance Co.

"We believe benefit communications should maximize the advantages of choices, but also must inform employees about the choices, she told attendees of the Business Insurance Employee Benefits Communication Conference, held Aug. 3-4 in New York.

A triple-option plan combines a traditional indemnity health care plan, a preferred provider organization option and a health maintenance organization under one experience-rated premium, making administration and cost control easier for the employer.

However, the plans also offer employees a range of choices.

For example, employees can

choose the indemnity plan, under which they can choose any physician or hospital and pay deductibles and copayments.

If indemnity plan users choose PPO providers, they have lower out-of-pocket expenses because deductibles or copayments are reduced or waived. If they choose the PPO option, employees still have complete freedom to choose any provider—PPO or non-PPO—and can make their choice at the

time they receive health care services. Employees also can choose the HMO option, often with the chance to enroll quarterly or once every six months instead of annually. The HMO option requires employees to pay



Ms. Fairman

the lowest out-of-pocket expenses but they can use only network providers, Ms. Fairman said.

"Most employers have three objectives in any managed care communication program. They are to enhance employees' appreciation for the significant investment the employer is making in health care; to maximize their use of managed care; and to inform employees so they know what choices to make," Ms. Fairman explained.

When communicating a triple-option managed care plan, "communication must set parameters about the plan for employees. These include informing employees about their access to quality doctors and that no matter which option they choose, employees are protected from catastrophic costs," she said.

Triple-option plans should be communicated in two phases, she explained, "When the plan is introduced, employees need to make a choice, so they need to be informed. Also, once the plan is in place, you must communicate the information employees need to use the plan on an ongoing basis."

When introducing the plan, "you must be wary of information overload. Give them only the information they need to make their choices," she said. And, instead of overwhelming employees with several communication pieces to introduce the plan, it may be more effective to provide employees with a single handbook or brochure about the plan, she added.

The communication should focus on the advantages of the plan, as well as highlight the financial incentives to use the managed care options in the plan, she said.

When the Jamaica, N.Y.-based Long Island Rail Road introduced a triple-option plan to its 7,000 employees, "We introduced employees to alternative delivery systems for the first time and encouraged them to move into managed care," said Edward J. Zeman, director of employee services for the commuter rail company who shared the podium with Ms. Fairman.

Along with the introduction of HMOs and PPOs, the triple-option plan marked the employees' first exposure to cost-containment features in their traditional indemnity plan, in the form of increased deductibles and utilization review procedures, he said.

The triple-option plan, underwritten by Metropolitan Life, was introduced April 1.

Employees first received information about the new plan in a letter from the railroad's benefits manager stressing the need for cost containment and managed care, along with a brochure summarizing and comparing the different options in the plan, Mr. Zeman said.

Next, employees received an HMO provider directory, which was mailed to their homes so that spouses could participate in the decision-making process, he said.

The company then held meetings wherever and whenever possible, he said. "While it was difficult to hold meetings in the rail yards, we sent HMO representatives out with hard hats," Mr. Zeman noted.

"This personalized contact is important. The employer must reach employees on this basis as often as possible. We must have touched at least 2,000 of our 7,000 employees in some form of one-on-one contact," he added.

The company also provided a toll-free number for employees to call to have their specific questions answered.

In the end, 789 employees enrolled in the HMO option, with the balance remaining in the traditional plan with the PPO option, he said.

To successfully implement and communicate a triple-option plan, Mr. Zeman says, "there must be a real commitment on the part of the employer that this new benefit plan can manage the quality and cost of health care." ■



The nation's leading supplier of drugs, medical supplies, DME and TENS to the long-term Workers' Compensation claimant.

PHARMACY MANAGEMENT SERVICES, INC.

4224 Henderson Boulevard □ P.O. Box 320178
Tampa, Florida 33679
1-800-237-7676 (Continental U.S.A) □ 1-800-282-7676 (Florida only)

Serving The Insurance Industry Since 1976

NATIONAL ASSOCIATION OF RISK RETENTION GROUPS
(Risk Retention & Purchasing Groups)

FOUNDERS MEETING

SEMINARS & WORKSHOPS
CHICAGO, SEPTEMBER 20-22

Workshops Include:

Forming, Reinsuring and Managing RRG's & PG's

For more information, call or write:

NATIONAL ASSOCIATION OF RISK RETENTION GROUPS
P.O. BOX 9289
CRYSTAL LAKE, IL 60014

ILLINOIS OFFICE
815-455-6602

WASHINGTON D.C. OFFICE
202-783-1135

Ford taps futuristic system

By KARI BERMAN

NEW YORK—Interactive audio-video communication is the wave of the future in employee benefits communications, a corporate benefit official and a consultant agree.

Ford Motor Co. already has successfully employed interactive video to increase benefit awareness among its salaried employees nationwide, said Jay Marchant, a principal at consultant William M. Mercer-Meindinger-Hansen Inc. in Stamford, Conn., which worked with Ford on its program.



Mr. Marchant

Ford wanted its employees to have more access to plans "so that our employees could become better benefit shoppers," explained Barry Wallman, an analyst in Ford's employee benefit department and the project's manager.

Mr. Marchant and Mr. Wallman spoke at the *Business Insurance*

Employee Benefits Communication Conference, held Aug. 3-4 in New York.

Employees using Ford's "infoACT" software program can simply touch a computer screen to view information about benefit options, eligibility requirements and the proper forms to file (*BI*, May 11).

Although the PC-based system is technologically complex—using a touch-sensitive video monitor, laser audio-video disc and digital audio player, which is stored in the computer's hard disk drive—it is easy to operate, Mr. Marchant and Mr. Wallman agree.

An employee who touches the screen can access a colorful menu of 13 graphically depicted benefit categories, Mr. Marchant explains.

If the employee is already familiar with the company's benefit plans, he can touch a selection on the screen and go directly to the personal modeling section of the program, Mr. Marchant explained.

"The computer will ask the employee the personal information necessary for calculating that individual's best alternative," such as age, marital status and pay, he said. In a matter of moments, an employee can obtain detailed information regarding the company's Stock, Saving and Investment Plan or pre-retirement financial planning, he said.

Special kiosks containing personal computers equipped with the touchscreens are available to all Ford locations, though each location must purchase the kiosk out of its own budget. The infoACT system can also be accessed through IBM-compatible personal computers, Mr. Walman said, noting that of Ford's 43,000 salaried employees, 80% have personal computers at their desks.

The "encyclopedia of benefits" contained in the interactive video program is only the first phase of a four-stage process Ford is implementing to improve employee benefits communication, he said.

"First, we needed a program that would take the employees logically through the benefit offerings. It follows the company's printed handbook, so it works," he said.

Steps 2 and 3 will focus on how to finance future retirement and explain insurance options, while the fourth and final stage will aim at creating a paperless benefit enrollment system, Mr. Marchant told the conferees.

"We will be adding laser printers so that forms can be printed directly and employees can do everything through the computer system," he said.

"We anticipate getting to Phase 4 in at least two years," Mr. Marchant added.

Mr. Wallman believes that infoAct's introduction campaign was fundamental to its success. "We brought in top benefit people, hung posters, held employee meetings and showed an audio-visual presentation with an address from a Ford vice president.

"We are very pleased with the way things are working," Mr. Wallman commented, "and upper management is pleased as well."

Although Ford chose not to comment on the cost of the system, Mr. Marchant said, "Hardware is going down in price and small as well as larger companies can take advantage of the system."

"I think that for a company interested in communicating benefit plans with employees clearly, this is a way to go," Mr. Wallman reported. "It is worth the investment."

RENT-A-CAPTIVES AVAILABLE

FOR PRODUCTS, D&O, E&O AND OTHER LIABILITY
FINANCIAL TECHNOLOGY INC.

Consultants specializing in Captives, Risk Retention Groups, Cash Flow, Self-Funded, Loss Portfolio Transfer Programs, Feasibility Studies, Formation and Management.

1888 Century Park East, Suite 910, Los Angeles, CA 90067
(213) 879-3991



MEDIEVAL CELLE

These buildings have withstood the ravages of time and we have withstood the ravages of the market. We are both rooted in the same traditions: Consistency, Craftsmanship, Creativity. We blend old virtues and skills with the innovation of today.

HANNOVER Re: your partner for the future.



Rated 'AAA' by Standard & Poor's

HANNOVER RE

Karl-Wiechert-Allee 50 · D-3000 Hannover 61 · West Germany
Telephone 49-511-5604-0 · Telex 922 599 (hanr)

INSURANCE FOR BANK AUTOMOBILE LEASING

We invite
your inquiry and
your business. Call
or write **Ron Ruane**



**PAIGE-RUANE, INC.
INSURANCE**

The Irwin Building, 460 N. Gulph Road, King of Prussia, PA 19406
(215) 265-4170

Allied with major carriers, we have extensive experience with this difficult-to-place insurance. We make it easier for you with a quality **Bank Auto Leasing** insurance program that provides broader coverages at substantial savings.

- Lessors Excess Liability
- Lessors Contingent Liability
- Lessors Contingent Physical Damage
- Interim Car Coverages
- Residual Value Insurance

Second helping satisfies appetite for benefit facts

By **DONNA DiBLASE**

NEW YORK—A follow-up communication effort that challenged employees' knowledge of Bank-America Corp.'s hospital utilization review program is credited with turning the program into a success for the San Francisco-based bank holding company.

By challenging employees to complete a crossword puzzle based on 64 clues about the utilization review program, the company was able to increase employees' compliance with the program to 82%, up from 52% only a few months earlier, says Victoria George, a benefits specialist in Bank-America's benefits planning de-

partment.

Ms. George described the bank's communication strategy at the *Business Insurance* Employee Benefits Communication Conference, held Aug. 3-4 in New York.

The company's initial communication of the utilization review program had been rushed and not very comprehensive, she said.

After selecting Wayne, Pa.-based Intracorp in September 1985 to administer its program, Bank-America implemented its utilization review program on Jan. 1, 1986, affecting about 25,000 of the bank's 60,000 employees who were covered under its self-insured indemnity plan.

"Because the selection of the

vendor took so long, we ended up having only one week to design the initial communication and introduction of the program. The communication was the most critical piece of the program and time had clearly run out," she said.

The bank designed a brochure detailing the program and "employees received notice of the program on Dec. 24, 1985—only a week before the effective date. We realized we were definitely in trouble and began to have meetings in locations with large numbers of employees," Ms. George explained.

Under the program, designed with the help of National Medical Audit, a San Francisco-based unit of William M. Mercer-Meindinger-Hansen Inc., employees must notify Intracorp of an elective hospital admission at least seven to 10 days before the admission is scheduled. And, they must contact Intracorp by the end of the second business day following an emergency hospital admission.

Employees must pay 50% of their hospital expenses if they fail to obtain a pre-admission certification or if they do not have an emergency admission reviewed and certified. They also must pay 40% of their expenses if they notify Intracorp and then do not follow the instructions of the review nurse or doctor, she said.

Normally, the plan pays 80% of eligible hospital expenses.

"We recognized that non-compliance would be a problem, so we waived the penalties for the first month," she added.

At the end of the first quarter of the program, National Medical Audit audited the results.

"We found that there was a large percentage of non-compliance. We found that utilization review occurred in only 52% of our elective hospital admissions and that 48% of emergency admissions escaped utilization review required within two working days after the admission," Ms. George noted.

The company decided that a new communication effort was indeed necessary if the program was to help control medical costs, she said.

"We first looked at changing the name of the program from the 'Utilization Review Program.'" The bank renamed it the "Hospital Utilization Review Program."

"Next, we designed a chart showing employees' role in utilization review, the vendor's job and what the penalties for non-compliance are," she added.

The chart was part of an eight-page brochure that also included a list of sample questions and answers about the program, such as what utilization review is, how it works, why it is necessary and what the procedures are for maternity or emergency admissions.

"We also found that employees were very intimidated about asking their physicians about utilization review. So, we designed a 'Dear Doctor' letter that they could give to their doctor," Ms. George noted.

The letter has blank spaces for the employee to enter his or her name, Social Security number and address. The text of the letter informs the physician that Bank-America's medical plan requires pre-admission certification for elective hospital admissions. The letter explains the necessary procedures and includes the toll-free

Continued on next page



Ms. George

J&H INFOLINE

INFORMATION AND IDEAS ON RISK MANAGEMENT AND BENEFITS FROM JOHNSON & HIGGINS

NO 24

New Forms of Capacity Signal Industry Change.

Risk retention develops as separate discipline.

Growth in non-traditional underwriting capacity—financed principally by U.S. corporations unable to secure sufficient insurance coverage—continues to be dramatic. Purchasing groups, i.e., unions of insurance buyers, are being formed with regularity. Passage of the Risk Retention Act of 1986 significantly accelerates this trend toward fundamental restructuring of the insurance industry.

Alternative capacity formation should be recognized as a separate insurance discipline requiring specialized resources and expertise in plan design, capital formation, reinsurance, marketing to prospective group members, general management, regulatory representation and liaison, risk assessment and loss forecasting, loss prevention, and claims supervision.

At J&H these services are provided through the coordinated efforts of J&H divisions, subsidiaries, and affiliates, including J&H Risk Management Services; Johnson & Higgins (Bermuda), Ltd.; Johnson & Higgins (Cayman Islands), Ltd.; Johnson & Higgins (Barbados), Ltd.; Johnson & Higgins Services, Inc. (Vermont); J&H Intermediaries (Bermuda); J&H/KVI; and others.

Long recognized as the world's leading manager of captive facilities, Johnson & Higgins is now a leading force in capacity formation through such programs as FIRL,¹ Primex, Drayton, CODA² and NACC.³ In addition, we have helped organize conventional insurance and financial market capital for projects such as AEIA⁴ and ERIC.⁵

For more information on individual or group risk retention options call your local J&H office.

1. Financial Institutions Reserve Ltd. 2. Corporate Officers & Directors Assurance 3. NACC Risk Retention Group 4. American Excess Insurance Association
5. ERIC Reinsurance Co.

Continued from previous page number for Intracorp.

Next, the bank designed a communications piece that would grab its banking and financially oriented employees' attention. A flyer with a picture of a check made out to "Unnecessary Medical Charges" for the amount of \$1 million urges employees to "help BankAmerica avoid writing this check—and you'll save too."

The flyer includes a sticker displaying Intracorp's toll-free number that employees can adhere to their medical plan identification cards. The flyer also includes a teaser asking employees to look for their chance to challenge their knowledge of the review program in the September employee newsletter.

The company then held focus group meetings with employees to find out exactly what employees were concerned about and to test the effectiveness of the communications materials, she said.

Next, "we wanted employees to read and understand how the utilization review program worked, so we designed a crossword puzzle contest. We had 64 clues—32 down and 32 across—and we offered prizes to winning entries," she said.

Two grand prize winners received picnic baskets; five first-place winners received travel alarm clocks; 10 second place winners received low-fat cookbooks; and 100 third place winners received a choice of two health care books.

"I designed the puzzle and was worried no one would respond. But, we had 500 responses and senior management learned that employee communications could be fun," Ms. George said.

"Because of last year's response,

we're now having a word jumble contest that recently appeared in the newsletter. We've already had 300 responses," she said.

"One thing we have learned is that there is a need to reinforce the communications of this program, because unless you use it, you forget about it. This is something we will continue to communicate to employees," she added.

Employers must effectively communicate the reasons for and procedures of a utilization review program to achieve the best results, noted Dr. Arnold Milstein, president of National Medical Audit and a managing director of Mercer.

National Medical Audit has performed more than 200 medical records audits of the cost-effectiveness and savings achievement of utilization review programs.

"How well you manage these programs has clear implications both for employee satisfaction and for your bottom-line," Dr. Milstein said. ■

Exchanges

NEW YORK:
220 EAST 42ND STREET/NY 10017/(212) 210-0133
CHICAGO:
740 RUSH STREET/IL 60611/(312) 649-5276
LOS ANGELES:
6404 WILSHIRE BOULEVARD/CA 90048/(213) 651-3710

business insurance

Update

Insurance Exchanges

International market report on Insurance Exchanges including Lloyd's, Illinois, New York and Miami.

Added exposure: distribution at Monte Carlo Rendez-Vous de Septembre!

publishing: August 31
ad closing: August 18

PACIFIC MUTUAL BELIEVES THERE'S NO SUCH THING AS A SMALL LIFE.



Small Lives Need Big Protection.

The big advantages of PPOs, like low cost and flexibility, have managed to elude the small life market—until now. Pacific Mutual has always believed there's no such thing as a small life. And every company, no matter how small, needs—and deserves—affordable protective coverage. That's why Pacific Mutual offers not one, but four, PPO swing plans for businesses with 2 to 34 employees.

At Last, Big PPO Advantages Tailor-made for Small Businesses...

This means that you can now offer your small business clients *all* the benefits of PPO protection. Pacific Mutual's PPO swing plans let you deliver the highest quality health care protection available at surprisingly low prices.

All PPO swing plans offer the benefits your clients are seeking, like lower monthly premiums, reduced physician and hospital fees, and, of course, flexibility to choose a plan-approved health care provider or a doctor of the employee's choice.

Pacific Mutual's PPO Pays a Higher Percent When a Plan-Approved Doctor Is Used.

All PPO swing plans deliver superior medical protection at the lowest possible cost. After satisfying a small deductible, PPO I pays 80 percent while PPO II pays 90 percent of all charges for basic medical services from an approved provider. The Star Care Plus plans will pay 90 percent or 100 percent of these charges and waive the deductible as well. If medical services are provided by an unapproved provider, employees still receive benefits but at

a lower co-insurance percentage. Both plans also include hospital and outpatient surgery "pre-certification" provisions, prescription drug card coverage, and a minimum of \$10,000 group life and AD&D insurance per employee.

If you'd like to learn more about Pacific Mutual's low cost PPO swing options for the small life market, contact a Pacific Mutual MET representative today at 1-800-854-8028. In southern California call 1-800-854-7434. In northern California call 1-800-872-9200.

And remember, at Pacific Mutual there's no such thing as a small life.

Discover the Power of the Pacific.



PACIFIC MUTUAL
Member Pacific Financial Companies

Experts gather at benefits conference

NEW YORK—Communicating employee benefits is increasingly challenging considering today's workforce demographics and benefits environment.

But, the 148 communications professionals attending the *Business Insurance* Employee Benefits Communication Conference, held Aug. 3-4, received insight from a variety of experts.

The interactive conference was held at New York's Grand Hyatt Hotel and featured sessions on benefits topics such as communicating utilization review programs, triple-option plans and surveying employees' opinions on their benefits.

Attendees also saw award-winning communication programs in case study sessions. Among the programs featured was San Francisco-based Pacific Gas & Electric Co.'s "Flex" communication program, which was a 1986 winner of *BI's* Employee Benefits Communication Awards.

In addition, *BI* Publisher Alfred Malecki presented the 1987 EBC Awards at a luncheon honoring the employers and their consultants who created outstanding benefits communication programs (*BI*, Aug. 3).

Information about next year's Employee Benefits Communication Conference can be obtained by writing Barbara Dalton, *Business Insurance*, Communications Services Department, 220 E. 42nd St., New York, N.Y. 11017.



In 1938, when a Martian invasion threatened the world,

Was it really happening? Or was it a ruse? One thing was certain. The resulting mass hysteria had proven the power of radio in America.

But on that uncertain October evening back in '38 when Orson Welles' incredible broadcast shocked the world,

Allendale had been a credible property insurer for 103 years.

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

Today at Allendale, we continue to shape the history of



Allendale had been insuring planet Earth for 103 years.

loss control with engineering, training, research and testing, responsiveness and fairness in the way we do business.

Throughout the years we've been more than an ordinary insurance company. Commitment to our insureds goes well beyond the property coverages we provide.

After a century and a half, that part of our philosophy is not about to change. Allendale Insurance, P.O. Box 7500, Johnston, Rhode Island 02919.

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

INSOLVENCY

Liquidators must weigh demands from many parties

By David H. Atkins
and Robert M. Holmes

IN THE PAST FEW years, much has been written about the "insurance crisis" and the fact that several insurance companies have gone into liquidation. Surviving insurers often consider the liquidation of a competing company with an optimistic belief that "it couldn't happen to us."

But insurers and reinsurers should recognize that the liquidation of another insurer could well adversely affect them.

Although an insurance company's viability is affected by several external factors—such as the litigation explosion, high court awards, competition and the resulting price-cutting—insolvency stems primarily from a combination of lack of capitalization, adverse underwriting, inadequate reinsurance and, at times, management judgment. Other reasons may include fraudulent and improper conduct, speculative investments, poor reserving and brokers' withdrawal of support.

The manner in which a liquidator is appointed obviously depends upon the rules and particular statutes that apply in the relevant jurisdiction. The insurance industry in most jurisdictions is regulated and monitored by a government agency with the superintendent of insurance (or his equivalent) often appointed the liquidator by the courts.

Depending upon the size of his or her operations, the superintendent may appoint an agent—usually an accounting firm or on occasion lawyers—to act on his behalf. For the purposes of this article, the liquidator and any agents will be referred to as one.

The burden on the liquidator is great, particularly given the severe time restrictions in which he is to operate initially. He is required to engage in a searching appraisal of the company's affairs. In the first few weeks, he is presented with an array of differing and complicated problems, all of which require immediate attention.

He must analyze the immediate challenges and marshal the various expertise to address the areas that can be segregated for initial action. Professional help may be needed, such as experts in legal matters, claims assessment, reinsurance, investment counseling and/or data processing.

The major assets—ignoring real estate—that an insurance company usually owns are investments, reinsurance recoverable and accounts recoverable from brokers:

- **Investments.** The liquidator will proceed to take possession of the insurer's investments as quickly as possible. The liquidator's job is to balance security with maximizing returns to secure funds to pay policyholder claims.

- **Reinsurance.** Reinsurers and intermediaries will find their relationship with the liquidator is different from that with the insolvent company. While the liquidator may improve and accelerate the reporting system, reinsurers become concerned about any increase in claims reserves practices made necessary by the cedent's reserves being found inadequate. Coverage questions will be more frequently raised, reservations taken and reinsurers will in some cases refuse to respond.

Alternatively, requests for reinsurance claims audits follow, placing a strain on the liquidator's resources.

Depending on the jurisdiction, policies may remain in force after the date of liquidation, continuing the exposure. In the initial stages, the liquidator likely will not be able to identify the

potential exposure for new claims. Assuming most policies are written on an occurrence basis, he must assess the need to maintain the reinsurance in force until the earlier of the insured's cancellation date or any applicable court order. This can be an expensive proposition.

Reinsurers, on the other hand, usually are owed premiums and may attempt to restrict or even cancel the reinsurance. This requires early resolution by the liquidator.

The reinsurance contract, once adopted, governs the relationship between the reinsurer and the liquidator. Most contracts require that the liquidator notify the reinsurers of claims. This may seem straightforward, but

if the reinsurance is in the form of proportional treaties, for example, the treaties may govern a large number of claims.

Since it becomes impractical to report on each and every claim, the intermediary can assist the liquidator by obtaining some form of understanding from the reinsurers that a list of claims in excess of a certain amount will fulfill the liquidator's obligations in this regard.

Most reinsurance contracts have an insolvency clause that provides that "any recoveries under the reinsurance contract must be paid to the cedent or its liquidator on the basis of the cedent's liability under the policy or policies reinsured, without reduction because of the cedent's insolvency."

This clause ensures that there is no diminution as a result of no actual claim payment by the liquidator and that there is no "cut through" to the insured. This is correct as the insured is not a party to the reinsurance agreement and probably did not enter into the insurance contract relying on any cut through of the reinsurance obtained by the insurer.

The liquidator, however, usually has to give written notice to the reinsurer of the claim to allow the reinsurer, if he so wishes, to investigate the claim and interpose in the proceeding for defense. The exercise of such an option by the reinsurer may be dependent on the liquidator's ability to retain expertise, to demonstrate acceptable control

standards or on the quality of defense undertaken by the insured.

While the reinsurance contract represents an asset to the estate, the contract does have some pitfalls. If the liquidator wishes to collect under that contract, he has to live with those clauses that are counterproductive to his aims. For example, the reinsurer is entitled to offset any sums that may be payable to the cedent in any other contract. In the initial stages, controls must be introduced to identify all such transactions.

In cases where a portion of the reinsurance has been placed with offshore companies and, depending on the respective jurisdictions' regulations, the cedent probably will have obtained at least some form of security for payment of claims known and reported to such reinsurers. This security can be in the form of funds withheld, letters of credit, trust accounts or outstanding claims advances or any combination thereof. These securities are based on the reserves of the cedent at a specific date, usually at the end of a quarter or year. The reserve may include a provision for loss development and losses incurred but not reported. The liquidator will, where he can, obtain increases in this security to include new claims.

Although most letters of credit are clean and

irrevocable, some letters of credit may inadvertently require a statement that the liquidator is unable to make, preventing the liquidator from drawing down on his security. The best that the liquidator can do in these circumstances is, at renewal time, to attempt to clear up the wording. Some letters of credit have "evergreen" clauses, i.e., automatic renewal. If these letters of credit have conditions not acceptable to the liquidator, he will have to negotiate changes, if possible.

Security in the form of trust accounts is obviously easier for the liquidator to draw down upon. Outstanding claims advances, on the other hand, do not represent an asset to the liquidator if these

funds already have been intermingled with the insolvent insurance company's funds. The liquidator has to exhaust the balances represented by the OCAs through set-offs before he can expect to receive any further funds from the reinsurer.

The amount realizable by the liquidator can be reduced further by the increasing number of insolvencies or other bad-debt situations. In addition, through the increasing use of reinsurance and retrocession covered by a number of non-related transactions, companies can end up insuring and reinsuring each other on portions of the same risks. The insolvency of any player in a chain obviously places a strain on the other insurers on that particular risk.

- **Amounts recoverable from brokers.** In most jurisdictions, brokers are subject to statutory trust obligations for premiums received. Generally, brokers' trust accounts contain premiums paid by their customers in the last 30 to 60 days. Those brokers who dealt with the insolvent insurer can find themselves exposed to claims not only for damages but for trust fund accounts, the same funds that the liquidator wants.

The liquidator obviously wants to recover these amounts in full and expects the policyholder to file a claim with him for the unearned portion of the claim. Brokers, however, are faced with a predicament when their clients ask them to replace the business with another insurance company. They must ask for another premium or pay the new premium, or deplete the trust accounts with the obvious consequences of having a later conflict with the liquidator.

But, what about those funds that have been paid out of the trust account in the period preceding the liquidation order? While case law and statute in each jurisdiction must govern, once the broker becomes aware of the impending insolvency it holds the funds in trust and disburses them at his own risk.

A number of accounting/legal issues have to be resolved. These include: the question of when the "account current" system of accounting ceased; the amount of commission that is refundable by the broker; interest on the brokers' trust funds subsequent to the date of liquidation; compensation for losses as a result of the insolvency; and whether the broker has the right to offset any amounts owed to it. Where any of these issues are not covered by the relevant jurisdiction's procedures, they generally become the subject of negotiation between the liquidator and the brokers.

The liquidator needs to be sensitive to the broker's position. The broker's income is directly affected by the loss of commission. Upon insolvency and/or cancellation of the policies, the unearned portion of the premium is reversed and brokers likely will be responsible to the liquidator for a refund of commission on the unearned portion. Brokers may

Continued on next page

The burden on the liquidator is great. . . . He is presented with an array of differing and complicated problems, all of which require immediate attention.

Although the liquidator's primary responsibility is to the policyholders, he has to bear in mind the effect each claim may have on reinsurers and excess insurers.

Liquidators struggle to untangle fallen insurers

Continued from previous page

well claim offsets, such as for damages through the loss of business, costs for administration of cancellation and replacement of clients' portfolios or for commissions not paid.

Further, the brokers may lose a substantial amount of premium business, particularly if the clients choose not to replace the new insurance through the same broker.

Through all this, clients still expect service on claims against the insolvent company.

- **Other assets.** Other assets available to the liquidator include recoveries from salvage and subrogation and from any preferential payments that may have been made.

The liquidator, therefore, very early in the liquidation reviews the records to ascertain all such opportunities.

The liquidator must realize that a substantial portion of any salvage and subrogation recoveries may accrue to the benefit of reinsurers.

The relevant statutes determine the amount of liabilities, but early assessment and implementation of controls may dictate the date for filing claims. The accuracy and reasonableness of the various types of claims have to be verified.

Although the liquidator's primary responsibility is to the policyholders, he has to bear in mind the effect each claim may have on reinsurance and any excess insurers:

- **Claims for loss.** In today's environment, most comprehensive policies are written on an occurrence basis.

The claims volume and amount of the "long tail" business may not be known for many years. Subject to any statutory prohibition, the policyholder may have a right to file a contingent claim for an estimated claim for losses that may later arise.

This, of course, creates a problem for the liquidator as it substantially increases the creditor base for which a reserve has to be maintained.

- **Claims for unearned premium.** The calculation of claims for unearned premiums also can be complex. Many policies today include some form of retrospective rating or adjustment clause. The liquidator will require that the necessary information

be supplied to facilitate verification. This information also is required to assist the liquidator in calculating the refund of any premiums that had been paid by the primary insurance company to the reinsurers.

- **Claims under excess policies.** The insurance company may have written excess policies and be unaware of claims that have not yet exceeded primary levels.

A policyholder, on the other hand, may wish to protect his position and, like policyholders with potential long-tail claims, the policyholder may file a contingent claim under his excess policy, subject to the regulations of the relevant jurisdiction.

- **Fronting, pools and facilities.** In each case, where the insolvent insurer was the company on whose paper the policy of insurance was issued, the liquidator has to seek recovery from the other insurers in the pool/facility or for whom the company was fronting.

Difficulties may arise in situations where reinsurance is payable by a captive reinsurer owned by the very policyholder making the claim against the fronting policy.

- **Other creditors.** These would include reinsurers seeking funds advanced to the company prior to liquidation or for premiums ceded but not paid at the time of liquidation, net of claims for loss. Adjusters, lawyers and trade creditors also will have a claim in accordance with the relevant statutes.

- **Multi-jurisdictions.** Many insurance companies operate in several jurisdictions that have different rules and regulations. The insolvency of the

insurer's head office usually results in the regulatory body in any branch jurisdiction taking control of the assets of the respective branch. In theory, the assets of that branch, particularly the statutory deposits, are supposed to be available for the creditors of that branch.

Policyholders, on the other hand, may wish to seek redress from both the branch and the head office. The head office liquidator will look to the governing statutes to determine which creditors can have access to the assets. It is highly unlikely that the branch assets will be returned to the head office for a consolidated liquidation.

To avoid duplication of claims, cooperation must exist between the various liquidators. In the United States, most liquidators accept without question most claims that have been paid by a guaranty fund of another state.

If no liquidator has been appointed over the branch, the head office liquidator may have to seek authority from the court in the branch jurisdiction. It also is important for him to endure what creditors in that jurisdiction are unable to attach the assets or interfere by any other judicial process that would give those creditors a preference in the estate.

Set-offs also can be a problem where a company operates in more than one jurisdiction. Reinsurers may wish to offset debts payable by one jurisdiction against the amount owed to the reinsurer to another jurisdiction.

- **Defense of third-party claims.** Most liability policies provide an additional agreement to defend the policyholder against any claims. It is accepted that, in general, the liquidator steps into the shoes of the company.

Does this, then, include the obligation to fulfill the contractual obligations provided in the policy of insurance, even though as liquidator he is unable to pay full indemnity?

In some jurisdictions the liquidator defends and also offers assistance on past and future claims. The advantage of assuming the

defense is that the liquidator now has control over the defense of the matter to ensure that the claim being presented is reasonable and valid.

To be prudent, he will make sure that the policyholder is fully conversant with the progress of the defense to reduce the possibility of the policyholder claiming negligence by the liquidator. Assumption of the defense also imposes an obligation on the liquidator to keep reinsurers and excess insurers fully advised.

In many jurisdictions, the guaranty fund assumes both the defense and ultimate claim payment, subject to fund limits. Thus, if the claim is within fund limits, the fund is not potentially exposed to unethical behavior by the policyholder or claims for negligence since the insured is fully indemnified with those limits.

In today's environment, it is not unusual to find that defense obligations exceed the actual policy limits. By electing to assume the defense obligations, the liquidator exposes the estate to these situations and finds himself in a potential conflict with the excess insurers, which obviously wish to see as much as possible of the defense cost debt incurred at the primary level.

By not defending, however, the liquidator loses control of the defense of the claim. Many insureds may not be able to afford the defense and, as a result, they may become insolvent. Claims against the liquidation, therefore, can be substantially increased by the inability or inadequacy of defense that is offered by the insured.

Some years ago it became popular for major

corporations to form their own captive reinsurers, most of which were created offshore in tax havens. To a degree, their usefulness was curtailed by tax changes in the United States and Canada, but they still play a significant role in today's insurance world.

The irony in an insolvency is that the captive reinsurer, usually a wholly owned subsidiary of the insured, is required to reimburse the liquidator in full within the terms of reinsurance; the insured parent company, however, receives only a percentage distribution of the claim that it has to pay in full. It may, therefore, be in the best interests of insureds that own captive reinsurers to withdraw

all claims immediately from the liquidation so that the liquidator no longer has a call on the captive reinsurer.

- **Intermediary reinsurance accounting.** The arrangements with most intermediaries are that the insurance company

reports paid losses to the intermediary who then, in effect, invoices the participants of the treaty or reinsurance contract for their share of the claim. Often, the insurance company does not keep an accounting by ultimate reinsurer as such information is available from the intermediary only.

Consequently, unless the intermediary provides detailed accounting records, the liquidator has great difficulty determining if he is recovering the full amount or if the broker is allowing set-offs between different reinsurers on different treaties. The liquidator must request a detailed breakdown of each treaty and other reinsurance balances owing by ultimate reinsurer and then at times establish his own accounting system.

In conclusion, the function of the liquidator is to liquidate assets, collect all debts, compromise and settle all claims and wind-up the insurance company's affairs.

He has an inherent duty to maximize realizations and distribute the assets to policyholders in accordance with the relevant statute or court order. He has a duty to act in good faith and deal with each claimant on an impartial basis.

His primary responsibility is to policyholders and creditors. At the same time, however, he has to maintain a delicate balance between the interests of reinsurers that may be responsible for contribution toward claims, excess insurers that may be required to take over and pay claims that have been partially administered by the liquidator and the individual claimant who is attempting to minimize any cash outlay.

The liquidator will have to deal with other parties such as brokers who have been affected by the liquidation and who are attempting to maximize their damages.

Liquidation is a time-consuming and expensive exercise. There are alternatives such as a runoff of claims, sale of portfolio, rehabilitation or arrangement with creditors, but these are beyond the scope of this article.

Hopefully, these and other alternatives will have been fully considered before the insolvency route is chosen.

But, often, there is no choice.

The liquidator must maintain a delicate balance between interests of reinsurers, excess insurers and the claimant who is attempting to minimize any cash outlay.

Most comprehensive policies are written on an occurrence basis and thus the claims volume and amount of the 'long tail' business may not be known for many years.



Mr. Atkins

David H. Atkins and Robert M. Holmes are partners in Coopers & Lybrand's Toronto office. Mr. Atkins is in charge of the insurance practice in Canada, while Mr. Holmes specializes in



Mr. Holmes

consulting and insolvency work for financial institutions. Gerald I. Lenrow, a partner in Coopers & Lybrand's Chicago office, edited this article.

Pest control for RMIS users

ONE OF THE BYPRODUCTS of the computer age is the colorful vocabulary of words and phrases: Bugs, worms, hackers, glitches, viruses, rats and other vermin. The dictionary defines "vermin" as "any of various small animals or insects that are destructive, annoying or injurious to health. . . ."

Interesting though they may be, each of these "creatures" creates a particular exposure to both users and designers of risk management information systems. Failure to deal with these pests and similar ones can both hinder and even ruin a well-designed and implemented risk management information system.

To get a better idea of how to both identify and control this "vermin exposure," it is helpful to start from the basics.

Each component of an RMIS is susceptible to vermin exposure but in different ways.

Here are the vermin that plague risk management information systems and ways to control them:

• **Bugs.** A bug is an unanticipated error in either the hardware or software. Bugs are the most common and generally the least troublesome vermin. Like mosquitoes, they are inevitable but can be controlled.

In computer folklore, the term "bug" was coined in the 1950s when an actual insect was found to have caused a computer malfunction. The key question when dealing with bugs is: How reliable is the hardware and software? Generally, the mainline products would have a smaller bug ratio than a new or custom-designed program. Certainly, a homegrown RMIS has the highest bug risk.

A better question involves the promptness and quality of response by the vendor or data processing department to correct the problem.

• **Glitches.** A glitch is a variation of the term "bug" and is defined as an intermittent failure in hardware and/or software. However, the problem with a glitch is that it rarely occurs when you most want it to: when your programmer or vendor is called to "fix" the problem.

Because of their unpredictability, glitches are the most troublesome of bugs. The best remedy is to try to document specifically what the problem is each time it occurs and recount it exactly to your hardware/software expert.

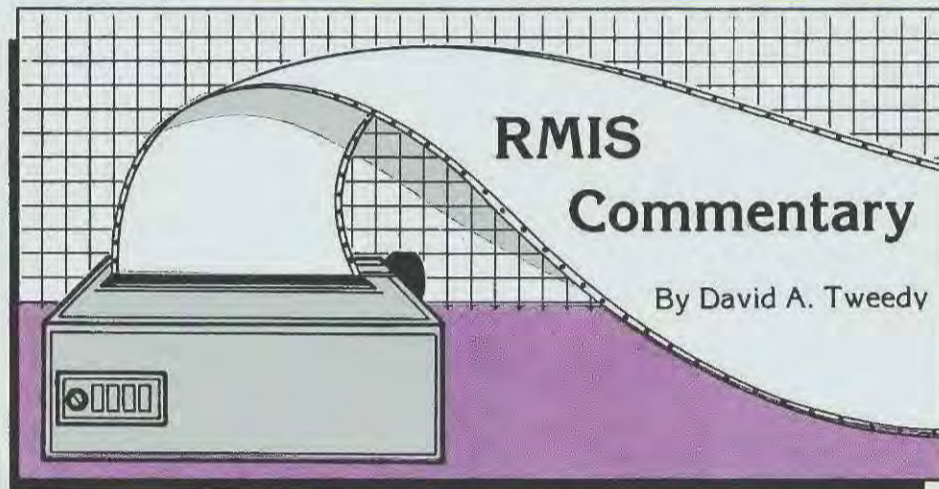
Unfortunately, it may take days or weeks before the problem recurs. It may take even longer to fix.

• **Worms.** A worm is a far more

insidious problem. Worms are programs intended to sabotage your software, data base and, in some instances, the hardware itself. They do this essentially by burrowing into your system unawares, distorting or destroying the data software and hardware in the process.

Worms are usually intentionally created by "hackers" or highly knowledgeable computer programmers (see below).

Risk managers with homegrown systems are most exposed to worms since they tend to expand and enhance their systems with other programs. For example, programs found on computer bulletin boards are potential sources



of a worm. The "worm" appears quite innocuous and useful in improving a home-made system. However, on the second or third—or perhaps later—use, the program begins its destructive sequence, gobbling up data and software, resulting in either no results or, worse, misleading results.

Further, you may not even know you have a worm in your system until it is too late and your data base and software have been irreparably affected. We are aware of some situations where the microchip powering the computer itself has been affected by a worm.

While worms are mostly an exposure to homegrown systems, they can also be a risk to vendors. Consider, for example, a disgruntled former employee at a vendor who happens to be a programmer. In revenge, he plants a worm that wreaks havoc with the system and end users.

Although RMIS worms are less frequent than bugs, the risk manager should exercise the proper caution in his/her use of unknown, home-made programs to add to the established RMIS.

• **Viruses.** The "virus" is a type of worm, according to Thomas Seligman,

president of Seligman Information Systems in Roslyn Heights, N.Y. In essence, the virus is a rogue program that, upon introduction to the system, slowly grows to destroy the software and data base. The same precaution in guarding against the worm applies here as well.

• **Hackers.** The hacker is generally regarded as a very sophisticated, ambitious and sometimes destructive computer programmer. Most are just innocuous capable programmers.

A few like to create worms and viruses. Still others have a decided knack for gaining unauthorized access to others' programs. Just recently, a 15-year-old hacker gained entry to a

risk management information system, hardware or software.

A rat may be a hacker. Usually, however, it is a person that has a certain level of access to the system and can wreak havoc with the data base, or even the software programs that comprise the system.

Or, the vengeful employee may not be that sophisticated in his or her approach. He or she may simply pour coffee into a computer terminal.

Again, this is not a very common occurrence. However, it should give the risk manager cause for concern in determining the optimum number of employees with access to the system. For example, the number of people with approved access to make changes to the data base should be limited to the minimum amount necessary. This action will not only reduce the rat exposure, but also the exposure of unforeseen accidents and mistakes.

• **Accidents.** Here I could not continue the analogy. However, accidents probably represent the greatest exposure to the RMIS in terms of frequency. Accidents can range from failure to back up key data or programs, spilling food or water onto machines and the much larger subject of faulty data entry (*BI*, Aug. 19, 1985).

This exposure, like the others, cannot be fully negated. However, a system that has been carefully selected with the proper security attributes, with limited access to only the key and necessary personnel, combined with standard and faithful backup procedures will mitigate this exposure.

In conclusion, the vermin exposure is nothing to laugh at. Like real vermin, they are impossible to eradicate. However, through good system planning and vendor/systems selection, combined with sound risk management principles, the exposure from these pests can be greatly reduced.

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



Michigan court approves exclusion for self-inflicted injuries

A Michigan appeals court ruled a group health insurance policy exclusion concerning self-inflicted injuries is not ambiguous.

In June 1985, Terrence Benike's 15-year-old son was taken into custody by the police and, after

This abstract was prepared by Cases Unlimited Inc. Copies of the decision 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.

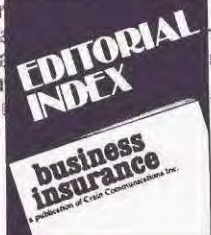
legal briefs

medical treatment, was released to his parents. That evening the boy shot himself. He was treated surgically. Mr. Benike's family was covered under a group health policy which provided that no benefit was payable for expenses for intentionally self-inflicted injury or sickness while sane or insane. The insurer refused to pay the medical bill on the basis of this exclusion. Mr. Benike sued and

won in the trial court.

The appellate court could find no ambiguity in the exclusion. The court noted the exclusion was included in the provisions for basic and major medical, comprehensive medical and accident coverage. The policy did not differentiate between employees and dependents with regard to this and all other limitations. The court held the insurer was not liable for the medical expenses. *Benike vs. Scarborough Insurance*, Court of Appeals of Michigan, April 9, 1986, (*BI/03/A.*—\$10)

ruptcy ... bombing ... taxation ... legislation ... war risk ...
 rage ... terrorism ... associations ... superbowl ... HMOs ...
 ... satellites ... chemical ... renewal ... retirement ...
 ent or ... drug ... asbestos ... employee ...
 insur ... maitime ... nuclear ...
 oliticia ... eaders ... insurers ... civil justice ...
 ... to London ... Zi ...
 te Ca ... Yuba County ... bankruptcy ... bom



GET TO THE SOURCE

**Need the facts fast?
 Order BI's
 Editorial Index now!**

Uncover the issues. Track the trends. Follow the changes and developments in risk management, employee benefits and the commercial insurance industry.

- all news reports and feature articles published
- indexed alphabetically, chronologically and geographically
- indexed by people, companies mentioned, and subjects
- continuous access—3 quarterly reports plus a cumulative annual edition

Whatever your needs, interests or curiosities, *Business Insurance* provides a wealth of news and information. Let BI's Editorial Index take you there in seconds.

business insurance Editorial Index
 220 East 42nd Street, New York, NY 10017

Please send me the following Index(es):
 Annual Index (hardcover) \$150* each:
 1981 1982 1983 1984 1985
 Annual Index (softcover) \$100*: 1986
 Full Index Service at \$100*: 1987
 *Foreign Postage Additional
PAYMENT MUST ACCOMPANY ORDER
 Visa Mastercard Check Enclosed

Account # _____
 Exp. Date _____
 Signature _____
 Name _____
 Title _____
 Company _____
 Address _____
 City _____ State _____ Zip _____
 Phone Number _____ EI 8/17

PCs guide employees through flex plan maze

By KARI BERMAN

NEW YORK—Personal computers can help guide employees through the complicated flexible benefits maze, experts say.

"Often, there is an overload of choices in flexible benefit plans and a personal computer can help employees sort through the options and make the right selections," explains Timothy Stentiford, a consultant at Hewitt Associates in Lincolnshire, Ill.

During an hour-long workshop at the *Business Insurance* Employee Benefits Communication Conference, held Aug. 3-4 in New York, Mr. Stentiford outlined how Sony Corp. of America used interactive personal computers to intro-

'The computer can sort complex information a lot faster,' notes Mr. Stentiford.

duce a flexible benefits program to its 5,500 employees.

Sony employees can access a wealth of personalized information about the company's flexible benefits plan by signing on to personal computers located in their workplaces.

"We stressed that it was a personalized, confidential system where all you had to do was plug in your personal information to get the answers," he said.

"The computer can sort complex information a lot faster and can project future numbers as well," Mr. Stentiford added.

Sony's system was developed in three phases, Mr. Stentiford explained.

In the first phase, software design focused on graphics, applications, user interface and standards for use.



Mr. Stentiford

"We had to make sure that everything was consistent throughout the program," Mr. Stentiford said.

Then, the system was executed with information coding, screen generation and additional support materials.

"It was important to have clearly printed support materials available for quick references if employees needed help," he explained. "We didn't want them to not use the computer because they were afraid of breaking it."

Finally, the system underwent a series of program testing to make sure that everything worked properly, followed by user testing.

"The user testing was a lot like test marketing a product," Mr. Stentiford explained. "We took it to a small group of Sony employees to see how they would respond and then listened to what they had to say."

After the system was debugged and working properly, Sony began promoting it to employees. Memos were sent out and education sessions were held to teach employees how to work the program, according to Mr. Stentiford.

"The employees who used the computer had a much better understanding of the flex benefits and were able to choose their plans easier," said Alfred Hayes, Sony's director of human resources.

Although Mr. Stentiford advocated creating a system that could incorporate new features into the program and adapt to new technological advancements, he warned the audience not to "over-tech" a system.

"Keep the software simple. You want it easy and quick to ease the computer fright that some people feel," he advised.

Employees should be able to put in the diskette, type in their information on the keyboard and quickly view their benefit options on the screen, he added.

"A good system doesn't have to cost a million dollars," Mr. Stentiford said.

It can be designed and implemented in three to five months and cost as little as \$10,000, without support materials, he said.

Make lemonade. How can you control employee benefit costs without souring employee morale? With



Jefferson-Pilot's innovative cafeteria plans like UniFLEX and products like Prime Universal Life. They're part of JP's nationally recog-

nized Total Cost Containment Program. For other ways JP can sweeten employee morale while improving your bottom line, call us.



For over 80 years, JP has helped large and small companies develop cost-efficient, attractive benefits packages. Call James E. Harshaw, CLU, Vice President. (919) 299-4720.

Jefferson-Pilot Life Insurance Company, Greensboro, NC 27420.



INSURANCE / FINANCIAL SERVICES

Low-budget effort can work

By KARI BERMAN

NEW YORK—Communicating health care benefits doesn't have to be a high-tech and expensive process, says James Biggerstaff, director of compensation and benefits for Pearle Health Services in Dallas.

Keeping costs down while successfully increasing participation in Pearle's 401(k) salary reduction plan and informing employees of the employee benefit changes in the Tax Reform Act of 1986 were Mr. Biggerstaff's goals when creating the company's "BUCKSAVER" campaign.

"With a small communications budget, low tech, no tech and creativity still works," he told fellow employee benefit managers attending the *Business Insurance* Employee Benefits Communication Conference, held Aug. 3-4 in New York.

Mr. Biggerstaff's point was well-taken as he addressed the audience while clad in a green superhero suit, complete with a bright yellow B on his chest and a flowing red cape.

After introducing himself as "BUCKSAVER," the son of "MEGABUCKS" and a descendent of Superman, he explained that his purpose at Pearle was to encourage employees to join the 401(k) plan.

"We decided to use humor as an attention getter," Mr. Biggerstaff said. "Once we got their attention, we thought they might adopt the behaviors we wanted."

"So, we created a 'BUCKSAVER' comic book and 'BUCKSAVER' posters, making work fun," he said. Employees loved it and are already asking when the second edition of the comic book is coming out, he reported.

Pearle wanted the employees' families to be involved as well, so "BUCKSAVER" contests were created for both adults and children to enjoy, Mr. Biggerstaff explained.

Adult contest participants were able to enter a ticket in the first contest drawing, making them eligible to win a 13-inch color television set with built-in video tape recorder, according to Mr. Biggerstaff. The second adult drawing gave away another 13-inch color TV.

The kids were also able to win \$50 and \$100 savings



Mr. Biggerstaff delivered his remarks in the guise of 'BUCKSAVER,' complete with flowing cape.

bonds by participating in both a "BUCKSAVER" poster coloring contest and a "BUCKSAVER" storytelling contest.

"We are very pleased with the results of the campaign," he said. "Participation in the plan went up from 68% to 76%, and the enrollment of eligible employees increased by 17%."

"We had lots of fun, accomplished our goal and did it all for under \$4,000," he said.

Identifying benefit trade-offs

By DONNA DIBLASE

NEW YORK—Surveying employees about the benefit trade-offs they are willing to make can help benefit managers successfully control benefit costs without risking employee dissatisfaction, according to one expert.

By applying a marketing research survey technique known as conjoint analysis, benefit managers can identify which benefits employees will give up or pay increased costs for in return for new or added benefits, such as receiving more employer-provided life insurance in return for having to pay an increased medical plan deductible.

This employee survey technique was discussed by John J. Parkington, practice director of The Wyatt Co.'s organization research and analysis services department, at the *Business Insurance* Employee Benefits Communication Conference, held Aug. 3-4 in New York.

Traditional techniques used by employers in designing benefit plans and cost-containment programs include the focus group meeting, in which a representative sampling of employees is polled about changes they would be willing to accept, he said.

Another method commonly used requires employees to rate their benefits according to the importance of each benefit. The goal in this method is to identify which benefits could be terminated—based on low importance ratings assigned by employees—without risking employee dissatisfaction.

"The problem with this method is that clever employees will rate all benefits as important" in the hope the employer will not change the benefits, he said.

Employers also can ask employees direct trade-off questions about

which proposed benefits changes they would accept.

However, by using this method, the employer risks damaging employee morale if employees anticipate receiving a new benefit that the employer decides not to offer after the research is completed, he said.

However, the conjoint analysis survey method helps employers to gather and analyze employee opinions on benefits without altering their expectations about their benefits, Mr. Parkington explained.

The survey method has been used in consumer research to analyze the qualities or changes in a product that consumers are willing to accept and which products they will buy. For example, the technique can show whether consumers will still buy a favorite cereal after the flavor has been altered.

To conduct the survey, the employer must first identify the benefits and levels of coverage to be studied, Mr. Parkington pointed out.

Next, all of the benefits and coverage levels to be studied are combined by a computer program, making sure that every level of every benefit appears at least once with every level of every other benefit, he said.

Then, verbal descriptions of each benefit and level of coverage are printed on a series of 16 index cards, creating 16 different benefit plans or profiles.

Employees are then given the deck of 16 index cards or benefits profiles and asked to place them in order of preference on a scoreboard with spaces numbered from one to seven—with one being the highest preference.

Employees are then asked to list the preference rank they assigned to each benefit card or profile.

"We've found that employees like this survey method—it's like a game. And, the administration time is short. It takes about 15 minutes to complete the ranking," Mr. Parkington said.

Benefits managers and commun-

icators attending the *BI* conference were asked to participate in a demonstration of the survey technique. Most completed the ranking within 15 minutes.

"Anyone can do this. We've administered this survey to blue-collar workers and lumberjacks, and we've found that even managers can do it," Mr. Parkington quipped.

The data from the survey is then analyzed by a computer program. The program calculates what is called a utility score for every benefit level for every employee surveyed, he said.

The utility score for each benefit level represents the importance the employee assigns to that benefit level, based on the employee's average placement of that benefit level on the scoreboard.

The scores are expressed in common measurement units. Life insurance coverage equal to one times annual salary would receive a score of .01, coverage equal to two times salary would receive a score of .02 and coverage equal to three times salary would equal .03. Other benefits and levels of coverage would be scored on the same range, so that the utility scores or levels of importance can be compared among benefits to determine the various benefits trade-offs, Mr. Parkington explained.

For example, if the utility score is the same or close for both increasing life insurance coverage to two times salary and for increasing the medical deductible to \$200, the employer has identified a trade-off. The employer would be able to increase employees' medical deductible—thus containing benefits costs—without risking employee dissatisfaction because employees will appreciate the increased life insurance coverage in return, he explained.

"The applications for computer simulation of benefits plans include evaluating what employees will pay for benefits, forecasting enrollment rates in specific plans and assessing likely changes in employee satisfaction," Mr. Parkington noted.

Some brokers laugh all the way to the bank over risky business.



Bill Rosenfeld, President, Canon Insurance Service
Richard Masters, President, Richard Masters Insurance Services, Canoga Park, CA

When Richard Masters needs to cover carpeting, furniture or pharmaceutical accounts, he calls Canon. And Canon responds with coverage that gives him a reason to smile. From property to casualty, we're the risky business specialists. We've earned a Ph.D. in pre-schools. Mastered surplus lines. And graduated with honors in condominium coverage. When it comes to degrees of difficulty, we're well-educated. If you're not calling Canon for hard-to-place lines, the joke may be on you. Canon: the placement professionals.

Canon
Insurance Service

9171 Wilshire Boulevard, Suite 509, Beverly Hills, CA 90210
213-859-8600 Fax: 213-278-3617 • Telex: 67 3616

FIRE... DESTROYS VEHICLES



... the expensive vehicles that you depend on to keep your business operating. But take heart! Ansul, the world's leading manufacturer of fire protection equipment, has developed new, ingenious, cost-effective solutions that you should know about.

Write for our new, useful (and free) "Vehicle Fire Protection Guide."

Ansul, Dept. V1, Marinette, WI 54143.
Or Call (715) 735-7411.

ANSUL

Time is money



You need a micro software system that handles defined contribution plans quickly.

Autofax/MPR offers fast and easy on-site processing.

Menu-driven data entry and on-screen prompts guide you to process more allocations more efficiently. It's simple.

Scrolling screens reduce the number of keystrokes and the possibility for error. Plus,

built-in editing features can immediately spot input errors allowing instant correction.

And, you can input multiple participant data or multiple funds and types on one screen.

Let us tell you about this system available to *trust departments, plan sponsors, plan administrators, legal and accounting firms, and insurance companies.*

AUTOFAX DIVISION
4822 Albemarle Road
Charlotte, NC 28205
(704) 568-5180

SUNGARD™
TRUST SYSTEMS INC

Think like employees: Zeltner

By KARI BERMAN

NEW YORK—Benefit managers and communicators must think like their employee target audiences if benefit communication presentations are to be effective, a marketing expert advises.

"You have to put yourself in their place. It has to make sense to them," explained Herbert Zeltner, president of the New York-based marketing and consulting firm of Herbert Zeltner Inc., at the *Business Insurance Employee Benefits Communication Conference*, held Aug. 3 and 4 in New York.

Back by popular demand, Mr. Zeltner led a session titled "You Be The Judge," in which benefit managers and communications specialists viewed five of the audio-visual presentations entered in this year's awards competition. The audience then judged the videos according to guidelines recommended by Mr. Zeltner. These guidelines are:

- Always knowing what your objective is.
 - "Make sure that the overall goal is clear and understandable and easily communicated," Mr. Zeltner says.
 - Planning a strategy.
 - "The approach should follow logically from the objectives," according to Mr. Zeltner.
 - Making the presentation honest and believable.
 - "Put yourself in their shoes. Would you believe it?" he asked the audience.
 - Striking a balance between too much and too little.
 - "Too often, people put too much emphasis on the sugar coating. Don't let the production values interfere with the message," he cautioned.
 - Making the program memorable. The presentation should grab and keep viewers' attention, he said.
- Participants rated each audio-visual presentation in five areas: objectives, strategy, contents, presentation and effectiveness.
- After the screening and judging, the benefit communicators shared their observations, including:

- Concern about videos that tried to cover too much material at one time.
- "It tried to do too much and I got lost in all the information," an audience member said of one video.

"I thought the basic flaw was that it was mixed. It was too long and tried to fulfill too many objectives, reducing the quality," another attendee commented.

The group agreed that the tone of a video is important and, if used incorrectly, could be unintentionally offensive to the employees.

"Likening an employee to a basically illiterate cartoon character with very little dignity" gave one presentation "an insulting tone," said one viewer.

• Mixed reviews for the use of high-tech graphic art as the primary means of communication.

For example, while one member of the audience said a presentation showed "excellent use of script and graphics" and concluded "I thought it was memorable; I gave it 100," another viewer was not as enchanted. "I thought it was too cutesy," that person said.

Others said they were bored with the use of high-tech graphics in videos.

Knowledge of the employee audience is also high on Mr. Zeltner's—and attendees'—list of benefit communications priorities.

For example, one company wanted its employees to relate to the speaker in the video, so he appeared in the uniform worn by assistant managers at the company.

"I liked the use of real employees and was impressed with the fact that they gave their real names," observed another conferee.

Mr. Zeltner agreed that the employees' perspective was a key element in any communication effort.

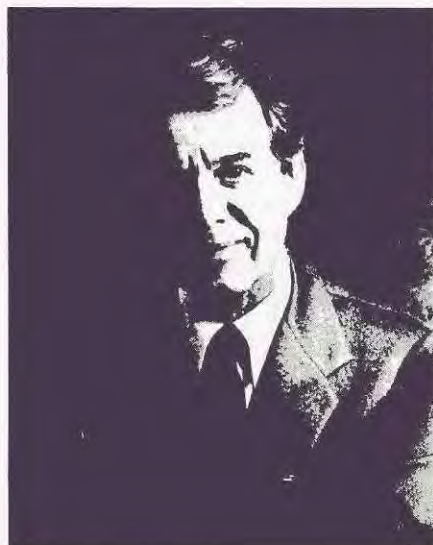
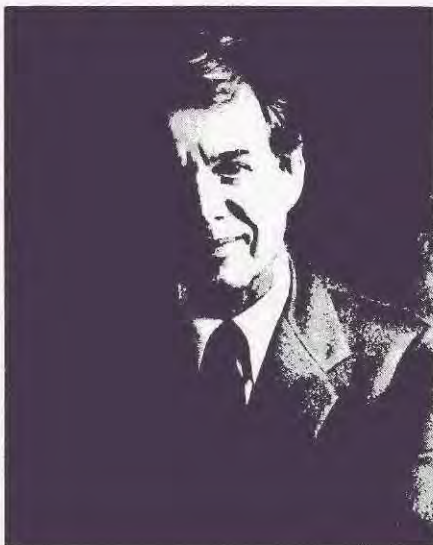
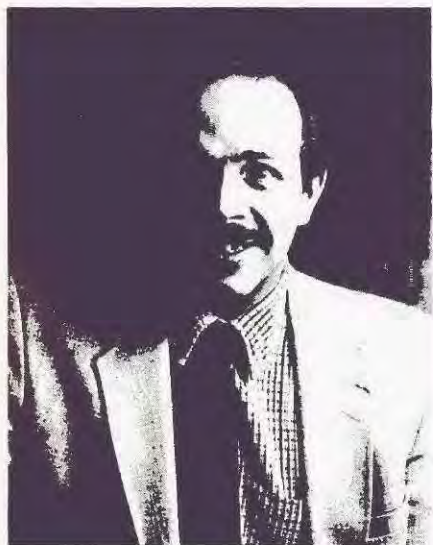
"You have to keep the employees in mind all time and give them what they want," he advised. ■



Mr. Zeltner

HERE TODAY.

HERE TOMORROW.



At Hilb, Rogal and Hamilton, we believe that a good insurance sales executive is persistent before the sale—but a great one is persistent afterwards. Most of our executives have been with us between 10 and 20 years, making new sales...and keeping the good clients we have. So, when an HRH executive sells you a program—he may be the last insurance agent you'll see. But you won't have seen the last of him.

Hilb, Rogal and Hamilton Company



agent/broker topics

A monthly editorial section sent exclusively to agents and brokers



Information avalanche

By LINDA J. COLLINS
and LAURA MAZZUCA

Insurers struggle to comply with states' reporting rules

Insurers—and many state insurance departments—are submerged in a sea of paperwork created by the deluge of additional data reporting requirements recently enacted in many states.

The requirements are being handled "with much travail, pain and difficulty," summed up Donald J. Tyrcha, assistant vp-statistical reporting for CIGNA Corp.'s property/casualty division in Philadelphia.

Crum & Forster Inc. is handling the requirements "with difficulty—clumsily," said David Flynn, senior vp-corporate actuarial and analysis for the Morristown, N.J.-based insurer.

"Companies are not vast reservoirs of data. . . Companies have to bend their processes to get the data. You use your resources as best you can," he says.

Legislators, under pressure from consumers who could not find affordable liability insurance for the past few years, have ordered insurers to open their books wider to state regulators' scrutiny, observers say (see story, page 32D).

But, the pressure constituencies placed on legislators was not the only impetus for increased insurer reporting requirements, others point out.

"The call for data was not totally tied with availability and affordability—it was also a result of the industry's push for tort reform," said Catherine Davidson, director of the regulatory and legal division for Travelers Corp. in Hartford, Conn.

Various reporting laws recently enacted are designed to "see the numbers backing the contentions" of the insurance industry "that the liability crisis resulted from the tort system. The tort system may exacerbate the problems, but I don't think it's the total cause," said David A. Gates, Nevada's commissioner of insurance.

Some insurers argue that state insurance departments already have a wealth of information about the admitted insurers doing business in their states and simply may not be making proper use of that information.

"There seems to be a perception by some people that there is not now adequate reporting by insurance companies, but that premise is completely wrong. We already report more information than any other industry," argued Phillip Schwartz, vp of fi-

ancial reporting for the American Insurance Assn. in Washington, D.C.

"I think there is a vast amount of information already available, but a lack of awareness as to what there is and how it can be utilized," stressed CIGNA's Mr. Tyrcha.

"It is unlikely that these special data collection efforts will provide more meaningful data than the insurance departments have already. What needs to be done is to make better use of the information that is out there," according to Larry Soular, manager of company operations policy for the Alliance of American Insurers in Schaumburg, Ill.

"Insurers (already) comply with hundreds of regulations and detailed reporting requirements in each of the 50 states by providing voluminous reports on a regular basis to states," said William Courtney, vp and general counsel for CNA Financial Corp. in Chicago.

"This financial information, provided by companies at considerable expense, is periodically checked for accuracy by teams of

state examiners," he said.

"This data should be used before more is requested, because it is expensive (for both parties) to collect and disseminate," Mr. Courtney pointed out.

Even some state regulators agree that some of the new reporting requirements are not necessary.

Robert Elconin, Wisconsin's deputy commissioner of insurance, said he views the reporting law recently enacted in his state as "just an information-gathering device. . . I'm not sure that we're going to gain new information from these reports that we don't already have.

"To some extent it's as much a part of political posturing as anything else," Mr. Elconin said.

To exacerbate insurers' problems, no two state reporting regulations are exactly alike. Because of the lack of consistency in the type of information sought and the way it must be reported to insurance departments from state to state, insurers are often finding it necessary to process the information on a piecemeal basis.

"The problem is that the states are requesting similar information in different formats," explained said Linda Bell, senior vp and chief actuary for Transamerica Group in Los Angeles. This additional effort

Continued on next page

New requirements

Continued from previous page

creates "a wasted expense that works itself into the price of insurance," she said.

"There is an incremental added cost. We've had to add people in general in the whole area of statistical gathering, and we've added people to help operate our commercial automation base," explained Richard W. Wratten, president of Transamerica Insurance Co.'s Commercial Insurance Division.

"For this year, because of the need to report on several past years' experience in some cases, we're estimating a 15% to 20% increase in workload for the year," said a spokesman for Chubb Corp. in Warren, N.J.

"So far we've only seen the front end of these bills," said Richard Neiley, senior vp of Harleysville Mutual Insurance Co. in Harleysville, Pa., explaining that the added costs and workload has not created "a significant problem yet, but it's beginning to show up."

Mr. Neiley said that while Harleysville is a relatively small insurer, in some cases, "even if we write one policy in a state, we still have to make the report." He added that the cost of complying with these regulations "is proportionately a lot more for a smaller company than a big one."

Some regulators note that insurers are doing their best to meet the requirements.

"Insurers have said the requirements were an additional burden and have entailed a lot of computer programming expense to capture the data, but they are complying as best as they can," said Donald Walker, chief examiner for the Georgia Insurance Department.

And, the burdens created by the new reporting requirements also are taxing insurance departments, some say.

Oklahoma's comprehensive reporting requirements will increase the Insurance Department's workload, and storing the additional documents will cramp office space, said former Assistant Commissioner Ron L. Kreiter, who resigned from the department a month ago.

"To regulate the information, it may take three additional people," Mr. Kreiter predicted.

"Our budget is \$200,000 less than it was last year," pointed out Anthony Fagiano, Idaho's director of insurance in Boise, adding that the department must assume the added workload created by new reporting requirements despite reduced funding.

"Somehow we'll make it," he added. Most insurers contacted say it is hard to quantify the extra expenses associated with the requirements because they are scrambling to meet the various deadlines and usually are using existing staff.

The effort often involves the work of several departments, including marketing, actuarial, claims and statistics, explained Thomas M. Waugh, vp and director of the products division for Zurich-American Insurance Group in Schaumburg, Ill.

"You don't have people out on the streets that you can hire to do this type of work. You have to use your experts," stressed CIGNA's Mr. Tyrcha.

Determining the costs "is not easy. The regulations are relatively new and insurers have established no cost accounting function to deal with" additional state reporting requirements, said David J. Brummond, assistant vp and assistant general counsel for the National Assn. of Independent Insurers in Des Plaines, Ill.

Harleysville's Mr. Neiley said that while the company's additional expenses are "not significant enough to raise prices on everything," they will "ultimately show up someplace."

While front-end costs for compliance will be greater than maintenance costs, "When our expenses level off, they will level off higher than they were before," said Ms. Bell of Transamerica.

And some of the costs are not measurable in dollars, insurers stress.

For example, because of the "additional amount of work at the field level" in complying with some state-mandated closed claim studies, "in the long run it's going to reduce the production of our claims force, which is still largely a manual operation," said William S. Gibson, vp and director of governmental and public affairs for Continental Corp. in New York.

In addition to dollar expenditures, Crum & Forster will experience "lost opportunity costs" because of time spent complying with requirements, said Mr. Flynn.

"What happens when you find your departments doing something that they have

never done before is lost opportunities," agreed CIGNA's Mr. Tyrcha.

Some of the new state requirements ask for information only on one or two problem lines of insurance. Others require detailed statistical breakdowns on a number of specified lines. In addition, some require closed claim studies that entail manual retrieval of the information.

Requests for information that "can be compiled through data that we have already captured, but are not reporting in the requested format, requires overtime work and reprioritization of computer workload. And when they request closed claim information where we have to go through manually and pull the information, this is very expensive and time consuming," said Transamerica's Ms. Bell.

And while one-time studies of closed claims to accomplish a specific purpose can be useful, annual closed claims studies are not, because regulators' concerns change and the old questions do not always match the new concerns, pointed out Carole Banfield, vp-government relations for the Insurance Services Office in New York.

"The kind of information you want out of a claim file is information responsive to the public policy concerns of the day. Public policy concerns change over time," Ms. Banfield said.

Another problem with some of the regulations is that they require insurers to gather

information from several prior years broken down on an annual basis. This creates problems because "we tend to summarize data in the data base and after five to seven years, the data is at a highly summarized level," said Mr. Waugh.

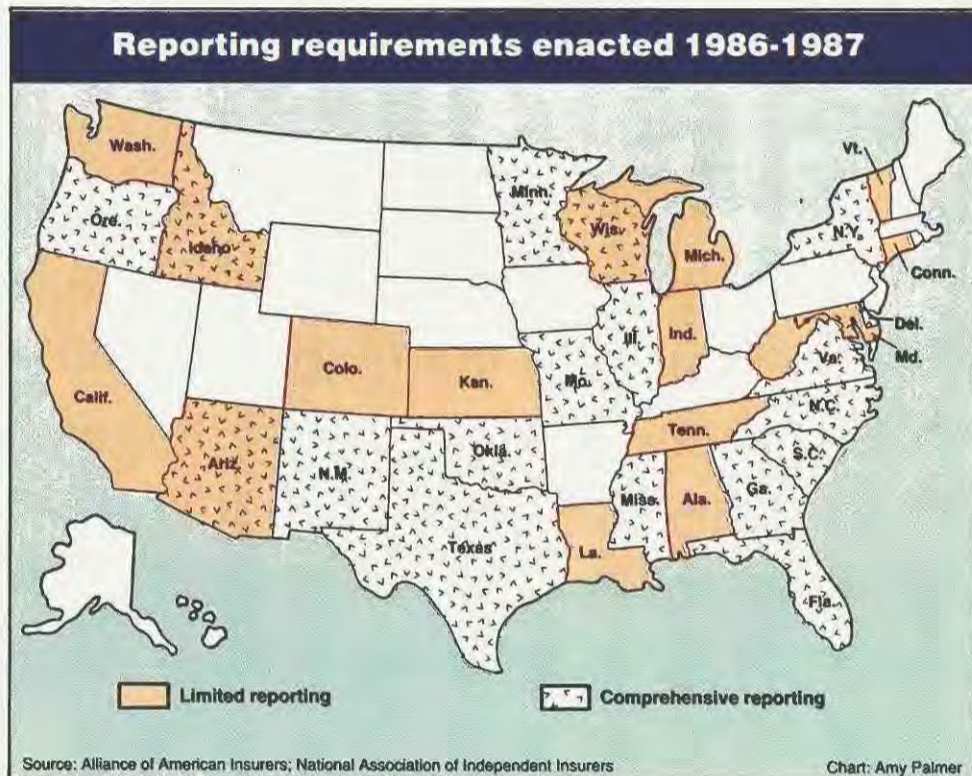
Because "times and people change" and the people checking files are not usually the same ones who handled a claim originally, information in those files often is subject to interpretation, and "certain categories of data will not be there in any shape or form," said Thom B. Miranda, government affairs officer-regulatory affairs for The St. Paul Cos. Inc. in St. Paul, Minn.

As a former regulator, Mr. Kreiter also considers the reporting requirements "a duplication of efforts. . . If you know a financial statement well enough, you can find the specific items" that are now required under the Oklahoma law, he explained.

Yet, "More states probably will pass insurer reporting laws. They are responding to insurance availability and affordability issues," adds CNA's Mr. Courtney. However, Harleysville's Mr. Neiley disagrees.

Because competition is returning to the commercial insurance marketplace, "some of the pressure is off" legislators to respond to availability and affordability problems, Mr. Neiley said. As a result, legislation passed in the latter half of this year or in 1988 probably will not contain some of the "insurance-bashing" language of earlier laws and will be "better thought-out," he predicted.

Insurers say they are hoping states will make their future information requests more realistic in terms of data sought and compliance deadlines.



information from several prior years broken down on an annual basis.

This creates problems because "we tend to summarize data in the data base and after five to seven years, the data is at a highly summarized level," said Mr. Waugh.

Because "times and people change" and the people checking files are not usually the same ones who handled a claim originally, information in those files often is subject to interpretation, and "certain categories of data will not be there in any shape or form," said Thom B. Miranda, government affairs officer-regulatory affairs for The St. Paul Cos. Inc. in St. Paul, Minn.

As a former regulator, Mr. Kreiter also considers the reporting requirements "a duplication of efforts. . . If you know a financial statement well enough, you can find the specific items" that are now required under the Oklahoma law, he explained.

Yet, "More states probably will pass insurer reporting laws. They are responding to insurance availability and affordability issues," adds CNA's Mr. Courtney.

However, Harleysville's Mr. Neiley disagrees.

Because competition is returning to the commercial insurance marketplace, "some of the pressure is off" legislators to respond to availability and affordability problems, Mr. Neiley said. As a result, legislation passed in the latter half of this year or in 1988 probably will not contain some of the "insurance-bashing" language of earlier laws and will be "better thought-out," he predicted.

Insurers say they are hoping states will make their future information requests more realistic in terms of data sought and compliance deadlines.

"Legislators don't seem, in many cases, to

be listening to their own insurance departments" in drafting these regulations, said the AIA's Mr. Schwartz. As a result, most of the regulations "are not well-directed and don't give the departments what they need or want," he said.

"Insurance departments understand this business. They're not the ones who are requesting this information and, financially, I don't know how some of the departments can put it together" into a useable format, Mr. Schwartz added.

Some insurers say that because of insurance commissioners' short terms in office, not all the regulators have a full understanding of insurance industry operations, while most legislators are even less knowledgeable of the industry.

"The problem is that when you get into requests for data not related to the business of insurance, particularly in regard to legal issues, there is a lack of awareness that the insurance industry is not the repository of information related to all of those problems," Mr. Brummond said.

Mr. Tyrcha agreed. "Different insurance departments have different levels of expertise, and there seems to be a general lack of knowledge on some regulators' and legislators' parts of what information really is available," he said.

According to CNA's Mr. Courtney, "Many of these new reporting laws are requiring information that insurers have not collected in

regulations.

While some insurance departments are gathering the information for a specific purpose and have budgeted accordingly, insurers worry that the information they have struggled to compile for other departments is merely collecting dust, because the departments don't have adequate funding to add personnel or equipment to compile the information into a useable format.

"Some states recognized early on that the additional data could pile up and addressed the problem," said the NAI's Mr. Brummond. But he predicted that "most states are going to be overwhelmed by the information."

"Some of the information that is submitted to the departments (is so extensive that) I don't see how the regulators can assemble the data and use it," said Transamerica's Ms. Bell. She added: "Most of the states don't have the staff to handle their day-to-day processes."

"Many of the laws come with the criteria that regulators present a report to legislators annually. Time spent putting this information together is time spent away from the area of solvency regulation," added ISO's Ms. Banfield.

"The average insurance department is no different than the average business. They're paring their staffs," which will make it difficult for the departments to process this additional information, according to Travelers' Ms. Davidson.

Mr. Kreiter said that while the Oklahoma department compiled information from the top 50 insurers in specified lines in February, no attorneys or other party had visited the department to examine the paperwork before he left his post a month ago.

While the Georgia Legislature enacted additional reporting requirements, "our department did not receive additional funding to comply" with a requirement that the department submit a report on the information for public record, said the Georgia department's Mr. Walker.

Such a report "does entail more work and more people, and it hasn't been implemented yet" because no funds have been allocated to cover the costs.

But not all insurance departments have been left scrambling.

Wisconsin's Mr. Elconin said the Legislature authorized additional funding for his department, which he estimated will total about \$50,000 annually: \$35,000 for a programmer/policy analyst and \$15,000 for processing costs.

Lee Jones, assistant director of research and information services for the Texas Insurance Department, says extra funds to process information will come from premium taxes and fees charged to insurers.

A bill pending in Massachusetts provides for direct assessment of insurers of up to \$1 million annually, based on their market share, to pay for data collection efforts, said Commissioner Roger Singer. The Insurance Department was responsible for most of the drafting and all of the technical work for the legislation in that state, he stressed.

Legislation in Pennsylvania stipulates that the data submitted by insurers be computer-ready and allows the commissioner's office to hire a statistical agency to help compile the data.

"With our current regulation burden, we just couldn't do it ourselves," said Insurance Commissioner Constance B. Foster.

The Pennsylvania department hopes the reports it compiles will prompt insurers to reduce rates in some lines where premiums do not accurately reflect experience, she said.

Catherine S. Mulholland, director of company regulations for the Delaware Insurance Department, said that ISO statistics have shown that "Delaware's loss ratio has always been much lower than the national average. If insurers look at our loss experience" prompted by the new reporting requirements, "I think they would want to write here, which should increase availability."

Ms. Mulholland added that the state will use new data collected to investigate the possibility of establishing a state pool for municipal and possibly business risks, in which insurers would be asked to participate. But if insurers do not respond satisfactorily, the state may sell bonds to raise capital for the pool, she said.

She also predicted that studies produced by the department "will become a weapon in the industry/trial bar fight over tort reform. The trial bar would like to show that in Delaware, tort reform is not needed." ■

Is your reinsurer what he appears to be?



Behind your reinsurer's smiling face, blue suit, and hearty handshake, is there a solid organization?

Or is your reinsurer some clown without the financial stability to back up his lofty promises?

Those are the kinds of reinsurers that collapse or quit, when costly reinsurance claims arise.

North American Re has been providing secure reinsurance for over 77 years.

We never find ourselves on the high wire of under reserved liabilities because we conservatively manage our risks.

North American Re.
When you want a solid reinsurer, not just a facade.

NORTH AMERICAN



**We Take Your Risk
Out Of Reinsurance.**

19 states adopt detailed reporting rules

The comprehensive reporting legislation governing property/casualty insurers adopted in 19 states in 1986 and in 1987 covers a wide range of lines of insurance and calls for information in various formats.

Generally, however, the legislation targets lines of liability insurance that were in short supply during the tight insurance market, such as medical malpractice, errors and omissions, insurance for public entities and day care centers and product liability.

Also, while requesting the information in various forms, generally the states demand, by line, information on: premiums written and premiums earned; investment income; incurred claims and expenses, broken down by various

methods; net underwriting gain or loss and net operating gain or loss, including investment income; and administrative expenses.

Following are the bill numbers, filing dates and brief descriptions of the comprehensive reporting requirements:

Arizona

H.B. 2375, effective May 1986, requires the director of insurance to develop rules and define classes for additional reporting by insurers.

The law authorizes the Arizona insurance department to designate one or more rate service organizations to gather and compile the information on behalf of the insurers.

Delaware

H.B. 470, effective May 1986, requires each licensed insurer in the state to submit an annual report on at least 18 classes of liability insurance, with some classes requiring reporting by subline. For example, medical malpractice must be broken down by specialty and directors and officers liability insurance must be reported separately for non-profit vs. for-profit entities.

The regulation requires a detailed description of closed claims and claims pending within these lines.

The first report was due March 1, 1987. The first year's report covered each of the preceding 10 years.

Florida

S.B. 465, signed in June 1986, originally required insurers to report claim information on each line of liability insurance as well as information on any claim against a policyholder resulting in judgment, settlement or final disposition.

The closed claim report was modified to require insurers to submit a "reasonable sampling" of closed claims, based on the insurer's size and must list the class of insurance, a profile of the policyholder and a summary of the incident, including policy number and names of all defendants. The first closed claim report was due Dec. 1, 1986.

Georgia

S.B. 384, effective July 1986, re-

quires each licensed insurer to submit an annual report for a broad selection of personal and commercial property and liability lines.

The first report was due March 1, 1987.

Idaho

S.B. 1223, effective July 1, 1987, amends statistical reporting requirements for medical malpractice, product liability and any other line of insurance designated by the director of insurance.

Insurers must also submit annual reports describing the disposition of closed claims, based on forms developed by the department.

The first report was due March 1, 1987.

Illinois

S.B. 1200, effective November 1986, authorizes the director of insurance to develop rules and regulations requiring licensed insurers to report loss and expense experience and other specified data, both in Illinois and companywide, on at least 12 lines of commercial liability insurance, with sublines. Among them are municipal liability insurance, dram shop liability, errors and omissions insurance, product liability insurance and motor vehicle insurance.

Interim reports are due August 1987. Annual reports to begin April 15, 1988.

Maryland

H.B. 238, effective Jan. 1, 1988, requires insurers licensed in the state to file specific information on municipal liability, child care liability, errors and omissions liability for public officials and officers and directors, professional liability, public carrier liability and any other designated risk.

In addition, H.B. 243, effective March 1, 1988, tracks closely with language included in H.B. 238, but requires additional information regarding the number of claims paid by final judgments and settlements.

Reports are due March 1 of each year beginning in 1988.

In addition, the commissioner is required to compile a report for the governor and General Assembly detailing the data and recommending, where appropriate, statutory or administrative changes to reduce or contain the costs of those lines of insurance.

Minnesota

S.B. 2078, effective March 1986, requires all authorized insurers to submit supplemental statistical reports in Minnesota and companywide for liquor liability, product liability, medical malpractice and any other line designated by the commissioner.

The first report was due May 1, 1987.

Mississippi

H.B. 1000, effective Jan. 1, 1988, requires licensed insurers to report for at least nine lines of liability insurance, including product liability, medical malpractice, attorneys malpractice and motor vehicle.

The state also requires information on closed claims with payment and without payment, including dollar amounts reserved.

The first reports are due in 1989.

Missouri

H.B. 700, effective July 1, 1987, requires licensed insurers to report the amount paid and amount reserved for closed claims and to submit information on the number of claims in which the insurer paid between \$300,000 and \$500,000 in

Continued on next page



Introducing a digging tool designed to save the insurance industry millions.

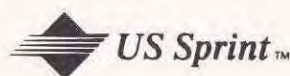
If you insure construction companies, you need our help. And we need yours.

We need your help to introduce a symbol designed to stop your clients from accidentally breaking our fiber optic cable. A break you may be liable for. And one that can be astronomically expensive to repair.

Because fiber optic cable is not ordinary phone cable. It's the key to America's future communications network. And it can carry thousands of times as many calls. Including emergency calls. Calls no one can

afford to cut off. Even if their insurance companies can afford the repair bill.

So tell your construction companies they can keep their rates down if they keep an eye out for this sign. And call before they dig. It's the least you can do to help us help you. For more information call 1-800-521-0579.



Continued from previous page
non-economic damages and punitive damages to one person or entity and those in which it paid more than \$500,000 in non-economic damages and punitive damages to one person or entity.

The first report is due March 1, 1988.

New Mexico

H.B. 226, signed March 1986, requires the superintendent of insurance to develop rules and regulations for authorized insurers to submit quarterly financial summary reports upon the superintendent's request for any line or subclass of insurance deemed necessary.

From this information, the commissioner will compile profit and loss statements by class, both companywide and in the state.

The reports are to detail all activities other than underwriting, including: claims incurred, both paid and reserved; interest earned, premiums charged, amounts paid to claims, a list of all pending claims and accumulative loss or claims reserves chargeable to the policy.

The first report, which included an annual report for 1985, was due in November 1986.

New York

S.B. 9351, effective June 1986, requires commercial property/casualty insurers to report on each commercial risk, public entity and professional liability line designated in the law or required by the superintendent.

Information also must be provided on the number and types of claims involving more than one defendant, detailing when the insurer pays more on the behalf of its policyholder than the policyholder's share of liability for the claim.

North Carolina

S.B. 873, effective July 16, 1986, includes two reporting sections.

One section requires insurers to report on almost any line of commercial liability insurance the commissioner designates. These reports are due beginning March 31, 1988.

The other section requires non-fleet private passenger automobile insurers to file reports before July 1 of each year detailing rates, losses, premiums, investment income, statistical plans and programs.

Oklahoma

S.B. 488 requires the 10 largest insurers in the state in each specified category—medical malpractice (broken down by type), product liability, attorney malpractice, architects and engineers malpractice, governmental liability, day-care center liability, premises liability, auto liability, libel and slander and any other tort liability—to file premium, investment, reserve, expense, underwriting and closed claim information by Jan. 31, 1988.

H.B. 1983, signed April 23, 1987, changed this reporting date to Feb. 28, 1988, to coincide with insurer annual statement filings.

Further, the 50 property/casualty insurers writing the most premium volume in the state and authorized to write liability insurance are required to report premium and loss information for: professional liability coverage written in the state, as well as the types of coverage written; and personal injury and wrongful death claims.

Information is also required providing the aggregate number of judgments or settlements over \$250,000 and dollar amounts of payments over \$1 million.

The first annual report is due February 1988.

Oregon

S.B. 323, signed July 1987, requires all authorized insurers to

report information on individual closed claims and aggregate financial and claim data. Information on individual open and closed claims is required for product and liquor liability claims, including: name and address of policyholder, type of product, rating classification code, state where settled, summary of occurrence, details on lawsuit and information on judgment or settlement amount and/or other damages.

The first reports are due May 31, 1989.

South Carolina

S.B. 593, effective June 1987, requires insurers to report on at least 12 lines of insurance, and sublines, including: political subdivision; public officials; officers and directors; dram shop; day care centers; errors and omissions; product liability; medical malpractice; and motor vehicle.

The reports also must include

detailed claim and closed claim information.

The first year's report, which must include reports for the three prior years, is due March 1, 1988.

Texas

S.B. 2, effective Sept. 1, 1987, requires admitted insurers to file, each May 1, liability insurance claim reports for general liability, medical malpractice, professional liability, commercial liability, the liability portion of commercial multiperil coverages and any other designated lines. Required information includes: premiums, net investment income, losses, reported claims, claims closed, reserves, loss adjustment expenses, expenses and dividends paid.

The legislation also requires insurers to file closed claim reports on the 10th day after each calendar quarter for: payments over \$25,000; payments more than \$10,000 but less than \$25,000; and

payments less than \$10,000, with a brief profile on each closed claim including: amounts paid by other defendants, non-economic losses (pain and suffering, etc.), defense lawyer fees and punitive damages. First reports due May 1, 1989.

Virginia

H.B. 1234, effective July 1, 1987, requires closed claim reporting for commercial liability claims. Information required includes: type of coverage; reserves; amounts paid by the insurer; attorneys' fees and expenses; and other relevant information.

The first report is due March 1, 1988.

In addition, H.B. 1235 gives the commissioner authority to require reporting by line and subline for types of insurance he designates.

Wisconsin

S.B. 100, passed July 31, 1987, as part of the omnibus budget bill,

became effective Aug. 1, 1987. It functions as parallel legislation to pre-existing laws regarding product liability and medical malpractice reporting, which passed in 1985.

Insurers are required to report by line data for each category or type of commercial liability insurance designated by the commissioner, but including day care center liability, municipal liability, recreational activity liability and professional liability. In addition to financial information, the number of claims closed for non-payment and the number of legal actions filed are required.

Reports are due May 1 of each year, the first of which is due May 1, 1989.

Limited reporting

Some states passed much more limited reporting laws in 1986 and 1987. These are listed in a box on page 32H.

INFOBOT™

PRACTICALLY HUMAN.

In a busy insurance company home office, customer service representatives answer your phone, key information into a CRT, and read the computer's answer to the waiting caller. INFOBOT works the same way without the human operator. Automatically. Quickly. Courteously. Accurately.

PRACTICAL CUSTOMER SERVICE ASSISTANCE.

INFOBOT combines artificial intelligence with information processing technology. It connects to your mainframe computer so information is immediate and up-to-date. The caller uses a touch-tone phone to access INFOBOT. INFOBOT responds. If the caller would like to speak to a human operator at any time, the call can be transferred to the appropriate customer service representative.



INFOBOT handles inquiries seven days a week, 24 hours a day. Time zone differences—a major problem for home office operations—are conveniently eliminated.

INFOBOT adapts to you. It may be used for all types of client communications. Once trained, INFOBOT is trained for life, solving the problem caused by personnel turnover. Messages or functions may be easily changed whenever you wish.

PRACTICAL COST EFFECTIVE HOME OFFICE OPERATION.

The initial cost of INFOBOT is so low that spread over 60 months, INFOBOT's operating cost is just 25 cents an hour.

Each INFOBOT can free up to four customer service people for more productive tasks, reducing administrative expenses.

INFOBOT never puts callers on hold. It handles local and long distance calls. A wide variety of telephone systems all interface with the same ease and efficiency.

Unlike conventional voice response systems, INFOBOT typically requires NO changes to your current software and no additional programming expense.

PRACTICAL INSTALLATION.

Anyone familiar with your unique CRT formats can have INFOBOT answering your phone within hours. No technical programming background is required.

Simply connect INFOBOT to your CRT controller. Then, train it to work with your existing CRT screen formats using a unique three-step process. Next, record the customer service voice you will use to prompt the caller, and plug INFOBOT in to your telephone system.

Continuum offers turn-key installation and training assistance, however, you can also easily install INFOBOT yourself.

PRACTICAL AUTOMATION FOR YOUR CLIENT INQUIRIES.

Continuum trained INFOBOT to work with their powerful copyrighted software packages (LIFE-70®, LIFE/COMM® and CLIENT/CONTRACT ADMINISTRATION (CCA™)), and then adapted INFOBOT to support property and casualty functions including:

- ◆ Coverage verification
- ◆ Mode premium quotes
- ◆ Billing information
- ◆ Pending claims status
- ◆ Agent commission inquiries

INFOBOT can be easily secured to prevent unauthorized access to client information.

Continuum's consultants are available to assist clients who wish to learn how to use INFOBOT with other software, including claims and employee benefit systems.

INFOBOT. PRACTICALLY HUMAN.

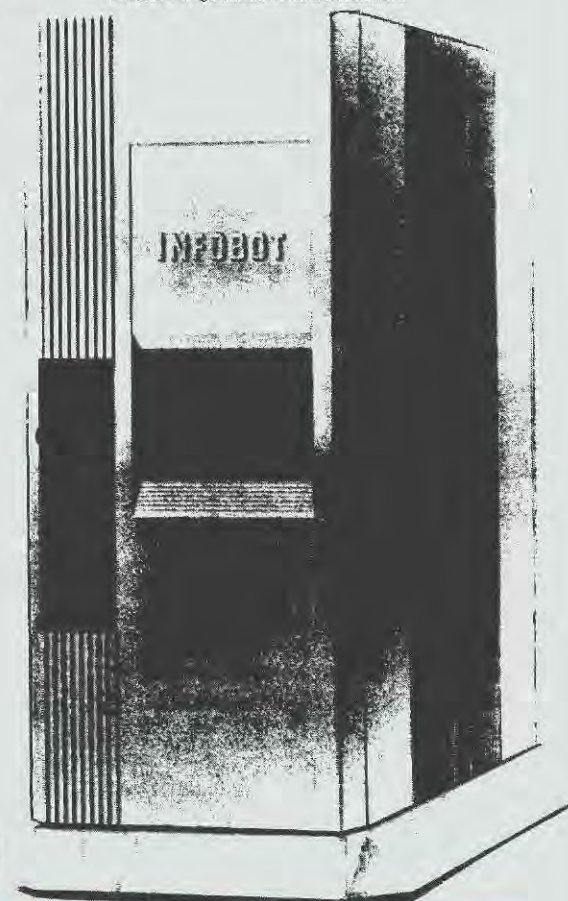
INFOBOT. A revolutionary automated telephone inquiry and response system adapted by The Continuum Company for the insurance industry. A product which reduces home office administrative costs and enhances the quality of customer service. Accurately. Courteously. Quickly.

For more information, call
(512) 345-5700.

CONTINUUM

9500 Arboretum Blvd.
Austin, Texas 78759

INFOBOT is a registered trademark of S-mellect, Inc.



CREDIBILITY CRISIS

Insurance industry must build trust to avoid extinction

By Davis Young

I AM GOING TO tell you the truth as I see it. . . the truth about what I perceive to be the insurance industry's precarious hold on its public franchise. I am not the maker of sad tidings but I am the conveyor of bad news. If you want to shoot the messenger, I'm your guy.

The bad news is this: America's insurance industry, as we have all known it in our lifetimes, may be on its way to becoming a dinosaur.

The insurance industry is being nibbled to death by ducks. No single nibble is that serious; however, the cumulative effect is devastating. The process is geometric; somewhere in the future—at a yet-to-be-determined moment—one duck too many will waddle into your business life for one last nibble. I don't know when that will be, but I can predict the scenario.

The scenario is not exotic, it is simple: Your franchise to do business will be revoked when the American people determine that you are over the line in terms of being out of sync with the public good. Trust me when I tell you that you are looking down the gun barrel of that type of scenario.

Is there time to alter such a course of action? Yes, although the hour is late. If I didn't believe you could turn it around, I would not be here.

I was asked to talk to you about how to survive the next crisis. You're not going to have a next crisis if you don't solve your current one. I make my living observing what's going on, assessing how people feel, developing strategies so that organizations like yours can win. Most of the people I come across are angry at your companies. They do not understand what you are doing and the reasons why.

I don't need to poll 1,200 homes across America to know these things; I hear them gratuitously advanced at luncheons, at parties, on airplanes and in business meetings. The bottom line of what I am hearing is that your companies and your industry are not perceived to be operating with the public good uppermost in their minds. That type of perception is very, very dangerous. Ultimately, if unchecked, it adds to precisely the situation I mentioned before: the loss of your franchise to do business in conventional ways.

When I lecture in journalism schools or college public relations sequences, I always ask the students to consider not only the specific communications challenge being described but also the environment in which we all live and in which their messages are conveyed.

Personally, I do not think we can

Davis Young is president of Young-Liggett-Stashower Public Relations of Cleveland. He is a former national chairman of the Counselors Academy of the Public Relations Society of America. This article is from a speech he delivered in June to the Insurance Marketing Communications Assn. at Cape Cod, Mass.

overestimate the effects the "Jim Bakkers," "Gary Harts," Wall Street inside traders and Irangate have on the public psyche. Such people and events serve to poison the air in the short term. However, it is their cumulative effect over the long term that is so insidious in terms of affecting trust in our governmental, religious and business institutions. Thus, in an environment such as that, it is particularly dangerous for any industry to be perceived wholly or in part as being out-of-step with the public interest.

My home base is Cleveland. That is also the home base of Sen. Howard Metzenbaum, D-Ohio, sponsor of legislation to amend the McCarran Ferguson Act. It is tempting to dismiss Sen. Metzenbaum as a liberal-thinking consumerist somewhere out there on the political fringes. It is sobering to realize that he has been elected and re-elected by the hard-working, solid, heartland people of Ohio. Although he obviously will win no popularity contest here, he indeed has a constituency. One of the great risks facing the insurance industry—along with a few other such as airlines and

banking—is that you do not have a popular constituency to which you can turn in times like these.

No matter where I go or the nature of the professional group I address, I always leave them with the same message. Rather than leaving you with that message, I want to start with it.

The message is this: The most important objective of any communications program is to enhance trust. Everything else, like raising awareness levels or making the phone ring with inquiries, is incidental to the overriding objective of enhancing trust.

This is such a simple, fundamental concept that it is tempting to dismiss it out of hand. Please don't do that. Permit me to say it again: The most important objective of any communications program is to enhance trust—trust in a project, trust in a service, trust in the integrity of a company, trust in quality, trust in the fairness of pricing. I absolutely, fundamentally believe that the creation of trust is the first commandment of communications in today's environment. Winners will earn that trust. Losers won't.

Our business—yours and mine—is the business of enhancing trust. The effectiveness with which we perform our jobs has a direct effect on winning and losing for our organizations. Lest you miss the corollary point, it is this: One person—any person in this room, for example—can and frequently does make a significant difference for his or her company. How challenging and how rewarding it is to realize that we are essentially in positions where we can make a difference.

The reason that I have ridden the "Trust Horse" for the last 15 years is because it is clear to me that we live in

a time of great mistrust. Therefore, those organizations and industries that are perceived as worthy of trust will stand apart from the crowd and achieve better-than-average success in business or in life. Examples abound of companies that have stood 10-feet tall in a sea of 5-foot competitors. One has to look no further than IBM or Xerox in less-than-stable industries that have prospered because they are trusted.

Without exception, organizations that are perceived as worthy of trust are those that place a premium on quality, service and fair pricing. But, beyond that, they are perceived as having a higher purpose than merely making the cash register ring. They are perceived, and correctly so, to be operating within conventional definitions of public good.

Before focusing upon survival, we first should agree upon the nature of the insurance industry's crises.

It appears to me that your next crisis really is going to be a continuum of the current crisis, which is based upon the increased cost and decreased

availability of insurance—especially among commercial liability lines. Never,

anywhere have I seen such a hue and cry as has been emanating from business, the professions, non-profit organizations and local government. Many commercial insurance customers no longer can obtain coverage for certain types of liabilities—and those that can find coverage say that they cannot afford it.

Yet, I understand that the worst is yet to come. Today's storm will seem like a refreshing summer shower when compared with the torrent of protests spawned by the significant increases forthcoming in personal liability insurance rates—such as automobile coverage.

To you within the industry, the next crisis—like the present one—will be viewed as a rate and availability crisis. To me, my friends and neighbors in Cleveland, to Sen. Metzenbaum and his associates in Congress and to people throughout the country, this will be seen as a *credibility* crisis—the insurance industry's inability to maintain the essential confidence and trust of its customers.

And, having lost its confidence in the insurance industry, the public will follow tradition and lodge its grievance with the ultimate arbitrator: Congress. You can then expect an attempt to resolve the crisis through the imposition of additional layers of legislation and regulation. The likely result is that the insurance industry will be burdened with further regulatory compliance costs and be deprived of the freedom to shape its own destiny.

Although you didn't participate in the creation of this crisis, you—as communicators—will be held responsible for extracting your companies and the industry itself from

its grip. For ultimately, virtually every crisis evolves into a communications crisis.

In analyzing the genesis of most crises, one finds a common pattern. Although rooted in different incidents—a break-in at Watergate; a death from Tylenol; the sale of arms to Iran; indiscretions with members of the opposite sex—crises develop into a credibility concern before emerging as a communications challenge.

In my opinion, the insurance industry already is in the midst of a credibility crisis stemming from the up-to-tenfold increases in commercial liability insurance rates. Future increases in personal liability insurance rates will not bring on a new crisis, they simply will exacerbate your existing credibility crisis.

Despite the efforts of individual insurance organizations—the Insurance Information Institute, the American Insurance Assn., state insurance institutes and other national and state industry associations—your credibility crisis persists.

Several months ago, for instance, the Cleveland Plain Dealer carried a report on insurance rate hearings held by the U.S. House of Representatives' Commerce, Consumer Protection and Competitiveness Subcommittee. Following conflicting testimony on the profitability of the insurance industry, subcommittee Chairman James Florio, D-N.J., was quoted as saying: "This casts doubt on the justification for tremendous rate increases in the troubled lines of insurance, such as medical malpractice."

Such statements incite the wrath of business people, such as those quoted in an article on the insurance crisis in the May issue of the Akron Business Reporter. The vp and general manager of a local company was quoted as saying, "My insurance is killing me. If they bill us anymore, it's going to put us out of business."

In the same article, the president of another local company was quoted: "Insurance companies have a lock on the market. They are not subject to antitrust laws."

To many observers, the insurance crisis—like the Wall Street scandals—is a reflection of the immorality and greed now permeating our increasingly materialistic society.

It seems as if the majority of today's society is pell-mell in pursuit of the mythical free lunch. As that delightful television commercial pointed out, the old fashioned way to make money is to *earn* it. In the modern world, we accumulate wealth through lottery winnings, insider trading or litigation, which legitimizes the picking of deep pockets of the insurance industry.

The latter course of action has proven to be so successful that now there actually are more lawyers than insurance agents.

When I launched my career 25 years ago, it seemed as if at least half of my callers, acquaintances and friends were insurance agents offering me

Continued on next page

speaking out

Continued from previous page protection, security and peace of mind for a small premium. Today, I'm besieged by radio, television and newspaper ads for lawyers offering happiness and wealth for a large contingency.

The Cleveland Yellow Pages contains 18½ pages of insurance agents and companies. In comparison, there are 42½ pages of attorneys. The lawyers outnumber you more than 2-to-1.

Although we can attribute a portion of the crisis to the greed of plaintiffs and their lawyers, some of the blame must also be placed on the insurers themselves.

When interest rates soared to a record high at the beginning of this decade—the prime rate hit 21.5% in the first quarter of 1981—many insurance companies slashed rates to compete for premium dollars to invest in high-yielding securities.

At that time, some people I know who work in the industry expressed their concern. Some insurers' rates were substantially below their underwriting costs, they pointed out, with the difference made up by investment income. Greed was driving these companies to cut rates to generate a stream of cash for investment.

They lost sight of the fact that chaos would reign when interest rates dropped and investment income no longer could cover underwriting losses. When the bubble burst, rates would have to return to realistic levels, which, by the way, are continuing to trend upward as the result of more claims, higher settlements, higher medical costs and so on.

They were rightfully concerned. Among the causes for the alarming surge in insurance rates is the necessity to bring them back into line with actual underwriting costs.

What began as a crisis of increasing rates and decreasing availability has become a credibility crisis and is about to mature into a communications crisis, or challenge.

The industry's credibility can be restored only through a comprehensive communications program, a program that will have to begin by informing the American public that it is following a false hope: There is no free lunch.

The American public appears to have lost sight of the basic principles of insurance: The sharing of risk by a group of people, each of whom contributes a small amount toward a collective pool of funds large enough to reimburse the relatively few people within the group who actually experience the risk and resulting loss.

In our eagerness to sue, to exploit the ample resources of the wealthy insurers, we forget those are our resources and wealth. We forget that those resources must be replenished if coverage is to continue. And we forget that those resources must be enhanced if the demands upon them increase. The purpose of insurance is to shield our assets from catastrophic losses, not to provide our daily bread.

Coupled with the public's propensity to "stick it to the insurance companies" is the forgotten effect of inflation. A modest family passenger car cost about \$1,000 in 1957. A similar car today will cost around \$10,000. A \$10 premium to insure against the loss of that car in 1957 would have to be increased to \$100 to provide the same protection for today's car, assuming all other factors don't change.

But other factors do change. Medical, legal and repair costs, for instance, have soared over the past 30 years and continue to climb.

Paradoxically, while these factors are driving up insurance rates, our economy is in a period of retrenchment. Basic industries—automobile, chemicals, oil, rubber, steel and transportation—are undergoing major structural reorga-

nization. Our standard of living and the personal income of many Americans is declining in real terms as the result of wage concessions and reductions in the workforce through layoffs and early retirement programs.

If present trends continue, it is conceivable that many Americans simply will not be able to afford any insurance within a few years. Nor will they be able to afford those goods and services whose pricing must absorb the high cost of high-risk insurance.

These are the "hard truths" that must be communicated to the public before the next episode in the continuing insurance crisis.

As I noted before, several insurance industry associations and insurance companies already have initiated communications programs—one of the most effective that I've seen to date is an ad from American International Group Inc. The headline reads, "The Best Way

Out of the Insurance Crisis is to Understand How We Got Into It."

This advertisement succinctly identifies the causes of the crisis, including the mistakes of insurance companies and society as a whole. It concludes by noting that the crisis won't be over until all of us in society stop pulling apart "and start pushing together."

Within your industry, there is a wealth of material upon which to construct a communications platform. What's apparently lacking is an industrywide commitment to communicate an action plan.

Begin at home, for example, with communications to shareholders, employees, agents and suppliers. Then reach out to your customers and the world-at-large, including the news media, educational institutions and the medical and legal professions.

Utilize key people from within your organization and your network of agents, reaching into every

community to supplement written communications with personal communications, speeches and talks, media interviews and other techniques.

Whatever you do, focus its tone in the public interest. As a consumer, I don't give a hoot if your company is profitable or whether you feel threatened by over-regulation. These are your problems. I care a lot, however, about your inability to meet my future needs.

Quite frankly, your next crisis is here and now. Robert E. Vagley, president of the American Insurance Assn., has diagnosed it.

In an article in an insurance publication last December, Mr. Vagley noted the industry has failed "to explain its work clearly and simply to its customers. In the absence of information, the public and legislators have to create their own ideas of what our industry is, does, and can or should do."

If the insurance industry is to

survive, you will have to get out front and lead the public to a workable solution acceptable to all.

If you fail, the public will rise up in anger and frustration and shackle the industry with oppressive controls.

Last August, for example, Consumer Reports said: "The lawsuit crisis may be phony but the insurance crisis is real. . . . What is needed to alleviate the problem is not tort reform but better regulation of the insurance industry."

That's kind of scary, isn't it?

In short, to survive is to communicate, beginning here and now. I will say it one more time: The objective of a communications program is trust. When the American people fully trust your industry and its companies, all good things will be possible.

Building trust starts with serious listening and includes a generous measure of straight talk. ■

Leading The Way...

For well over 100 years, Munich Re has been leading the way for clients, assuring them unparalleled service for every reinsurance situation. In good times and in bad times, Munich Re has quietly continued to achieve enviable quality in every aspect of service to the insurance industry. By any measure....Munich Re excels!



MARC
Munich Re Group

New York • Chicago • Atlanta
San Francisco • Dallas • Boston
Columbus • Hartford

Munich Re Group in the USA: MARC and MARC-Life

NAIC tackles data-gathering standards

By LINDA J. COLLINS

Relief may be in sight for insurers scrambling to comply with the new state data reporting requirements.

State insurance commissioners, wanting to better analyze market data on a regional and national basis, are striving for more uniformity in state reporting requirements.

More uniformity would make it easier for insurers to comply with state reporting requirements.

The National Assn. of Insurance Commissioners' Statistical Task Force is working on two standard methods to provide state insurance regulators with market data on property/casualty insurers.

First, with input from insurers, industry trade associations and statistical agencies that compile industry data, the NAIC is modifying an existing statistical handbook that state insurance departments can elect to use as a standard for gathering market data.

Second, an interim working group formed by the NAIC Statistical Task Force is developing a prototype accelerated quarterly report to provide insurance departments with premium and loss information on specific troubled lines.

The NAIC handbook would "provide a definition of what information should be collected, how it should be collected and how it should be reported to insurance departments," said David A. Gates, Nevada's Commissioner of Insurance.

If state insurance departments follow the standards under development by the NAIC and state filing requirements become more "uniform in their methodology," legislators and regulators will be able to get a "better handle on where the marketplace is" overall, said Mr. Gates.

The quarterly reports were modeled after the Insurance Services Office's Commercial Statistical Plan because the CSP provides "a common denominator in the commercial lines area," explained Commissioner Gates. "Now we are trying to determine what information to accumulate" in the new report.

"Our primary goal is to get something that is useful to all states," stressed Illinois Director of Insurance John E. Washburn, who with Commissioner Gates comprised the working group of the NAIC task force.

"We will (present a report) before the end of this year on how the NAIC wants to collect this information," Mr. Washburn added.

ISO's CSP provides market information on broad classes of insurance on a quarterly basis from a sampling of insurance companies.

"The new report will be by class for all companies reporting. We thought for this report that we needed the entire data base rather than a small sampling of companies," said Carole Banfield, vp-government relations for ISO and chairwoman of the industry advisory committee to the Statistical Task Force.

"The more detail you sacrifice, the more rapidly you can get a report," Ms. Banfield explained. "We get the fast track information from a limited amount of companies, so it can be published very quickly—60 days for personal lines and 75 days for commercial lines," while the new report "will be published three months after the close of each quarter."

According to Ms. Banfield, the reports will list only premiums collected and losses reported during the given quarter, so "the premiums and losses don't match for the quarters. They are out of sync, but represent the latest information that came in the quarter."

But while the reports will not adequately reflect an insurer's loss ratio for a given line, it will give regulators some

indication of current market conditions. And ISO will "continue to produce statistical reports that do match premiums to losses, they just take longer to publish," Ms. Banfield pointed out.

"The NAIC, by putting a lot of emphasis on this area, has tried to design a report that has more meaning and that allows for detection of trends and a description of premiums and losses by detail as an indicator of industry problems," said Ms. Banfield.

She explained that the task force "went through all of the data reporting bills that have been proposed to come up with the broadest list of troubled lines and categories."



Ms. Banfield

"This list is not static," said Ms. Banfield. She said the advisory committee she chairs will remain intact to work closely with the NAIC in anticipating industry problems. The groups also will determine if this type of a report might be needed for other lines of insurance and if some existing reports are no longer necessary.

"To the extent that we can bring uniformity (to the picture), it cuts costs for insurers and departments and makes the data more meaningful," Ms. Banfield explained.

"Uniformity allows for comparisons of data on a country-wide or regional basis. This is helpful, particularly when you are trying to discern patterns," she added.

"We are trying to come up with a statistical plan that will satisfy... a number of state reporting laws," stressed David J. Brummond, a member of the advisory committee and assistant vp and assistant general counsel for the National Assn. of Independent Insurers in Des Plaines, Ill.

Larry Soular, manager of company operations policy for the Alliance of American Insurers in Schaumburg, Ill., said that his association "fully supports" this quarterly reporting mechanism for troubled coverages.

"That's a better way for commissioners to get information in a cost-effective manner. I hope states will look to see what information that data will provide and give that a chance to work" rather than adding reporting requirements, he added.

"I think the NAIC has come up with a good product that responds to what states are looking for," agreed Phillip Schwartz, vp of financial reporting for the American Insurance Assn. in Washington, D.C.

"There would be two benefits to standardization," said

Linda Bell, senior vp and chief actuary for Transamerica Insurance Group in Los Angeles.

One is that regulators could examine this information as a group to pinpoint industry problems and attempt to find solutions. "Regulators could make better decisions as a group than they do independently. It would make sense for the NAIC to have this information available to help it make decisions," Ms. Bell commented.

In addition, insurers "would only need to create one system for compiling the requested information," Ms. Bell stressed.

"When you're trying to set up computer systems to meet the demands of state insurance departments, it would be easier to write one (program) rather than 50," said William S. Gibson, vp and director of government and public affairs for The Continental Corp. in New York.

"There is a real case to be made for collecting the same information from state to state," agreed Richard Neiley, senior vp of Harleysville Mutual Insurance Co. in Harleysville, Pa. This would "benefit not just insurers, but also regulators, who would have a better handle on what's going on."

Pennsylvania Insurance Commissioner Constance B. Foster agreed. She says the wide divergence in state requirements is a potential problem. "We want consistency in reporting nationwide instead of a patchwork quilt," she said.

But not all insurers are optimistic that state insurance departments will adopt the standards put forth by the NAIC.

"From a sense of history, I don't have a lot of confidence that they will be successful," said David Flynn, senior vp-corporate actuarial and analysis for Crum & Forster Corp. in Morristown, N.J.

Citing the "unique needs reflected in state requirements," he said it is hard to coordinate standardization efforts. But, he stressed, it would be "just terrific" if it happened.

"We will ask legislators to try to target data reporting requirements that track what we have done," but "I expect legislators will enact something totally different," the AIA's Mr. Schwartz said.

If the NAIC is successful in persuading states to consider the standards it has developed, "each state will want to tailor the standards" to its own needs, agreed Thom B. Miranda, government affairs officer-regulatory affairs for St. Paul Cos. Inc. in St. Paul, Minn.

"As a guideline it would probably have some benefit, but unless you could mandate (the standards) in every state, I doubt you could get the states to adopt them as is," Mr. Miranda added.

16 states enact limited reporting standards

In addition to the 19 states that introduced comprehensive insurance company reporting requirements during 1986 and 1987, 16 other states have enacted some form of limited reporting. The states and the types of insurance involved include:

- Alabama H.B. 202, medical malpractice, 1986.
- Arizona H.B. 2065, medical malpractice, 1986.
- California A. 3378, auto liability, 1986; A. 4406, specified classes upon commissioner's request, 1986.
- Colorado H.B. 1358, closed claim studies for troubled lines upon commissioner's request, 1986.
- Connecticut S.B. 116, designated lines upon commissioner's request, 1987; H.B. 5400, disclosure of data for rate approval, 1986.
- Idaho H.B. 460, product liability/medical malpractice, 1986.

- Indiana S.B. 235, political subdivision/liquor liability, 1986.
- Kansas S.B. 247, expanded loss and expense reporting, 1987.
- Louisiana H.B. 1623, expanded reporting in specified lines; direct writings, foreign and alien, 1986.
- Maryland H.B. 672, medical malpractice, 1986.
- Michigan H.B. 5209, professional/municipal liability, 1986.
- Tennessee S.J.R. 167, day-care centers, 1987.
- Vermont S.B. 5, liquor liability, 1987.
- Washington S.B. 4749, loss and expense data, specified lines, 1986.
- West Virginia S.B. 714, medical malpractice, 1986.
- Wisconsin A. 4XX, medical malpractice, 1986; A. 387, product liability, 1986.

letters

Strategic communications plan means more than shot in arm

To the editor: "A New Look" (IT, June 8) brought the recent image changes in the insurance industry to the attention of your readers. The pressure to change to new names, graphic designs, nomenclature systems and advertising programs has increased in all areas of financial services. However, based on past experience of other industries going through similar pressures, it is clear that overall communications planning must achieve a greater level of importance to accomplish the objectives of management and to succeed in competitive environments.

Strategic communications planning means more than a periodic shot in the arm. Traditionally insurance companies have put less emphasis on routine marketing ammunition such as branding, brochures, etc. A new logotype, shortened name or new graphic identity program have often met management's need for something new. Yet fulfilling the need to sell highly intangible services under competitive pressure only comes about when there is an integrated and carefully orchestrated effort throughout the marketing organization. Today, strategic communications planning means a long-term interest by top management and the installation of an overall commitment:

- All communications are strategic. That means every item has a basis for how it should be prepared and delivered. The level of quality follows from the direction established by management.

- Everything is big. Customer materials are clear and prepared based on the target audience's interests,

questions are answered politely and promptly and every avenue of service is carefully delivered.

Strategic communications planning means weighing the risk of putting the Prudential name along with the Bache name, yielding Prudential Bache Securities, and supporting the image with a copy line: "Rock Solid. Market Wise." It also means carrying the overall image objectives through thousands of ways. Top marketing efforts take vision, commitment and day-to-day managing.

There is also a greater emphasis on new products, cross selling and new distribution channels in the insurance industry. Fidelity Mutual Funds have a number of products, but Citibank, with over 20% of its branch display space devoted to insurance, may be a more vivid indicator of competition today. Insurance faces a complex environment that may not be satisfied with corporate identity concepts developed by product conglomerates of the 1960s.

The new world of successful insurance marketing means making change and implementing a strategic communications orientation. Yes, it means that new components such as names, graphics and systems must be carefully planned—but the danger of not orchestrating the whole marketing communications mix from the top down is a threat to the lifeblood of the competitive insurance industry. A clear and positive image is achieved when strategic communications as well as new components function together. Corporate profits are the rewards this combination produces.

Charles A. Moldenhauer
President
Moldenhauer Group Inc.
New York

Reporting service helps screen agents

A new credit bureau reporting service helps non-captive insurers, premium finance companies and managing general agents screen independent agents.

Dallas-based General Agents Information Network Inc. collects and stores in its computer data base information on independent agents' payment practices, underwriting habits, financial status, complaints and/or disciplinary actions, lawsuits and reasons for cancellation, explains Carla Michele, president.

The reports are a "first alert," she adds, warning insurers and managing general agents when to "cut their losses before something happens," such as an agent filing for bankruptcy.

So far the data base includes information on approximately 13,000 agents nationwide.

For a one-time membership fee, plus quarterly dues, each GAIN member receives a comprehensive report at enrollment with quarterly updates that include only derogatory information.

For a nominal additional fee, members can request comprehensive report updates or make phone inquiries on agent prospects.

Members also are provided with agent update forms, which they complete and return to GAIN so that new information can be added to the data base, Ms. Michele explains.

Membership fees and dues vary according to the type of member and the number of states in which it operates, she says.

For more information, contact Ms. Michele at GAIN, 7210 Elderberry, Dallas, Texas 75249; 214-296-2196.

products & services

Peru

Continued from page 3

of Congress, the Chamber of Deputies. These committees will produce a final report, of which one insurer said: "It is a fait accompli what the end result will be—of course it will be 'yes' to nationalization."

President Garcia's earlier nationalization decree called for boards of directors and shareholders of all insurers and banks to be suspended immediately.

According to Peruvian insurance company officials, all of whom requested anonymity, the superintendent of banks and insurance confiscated the accounts and check books of companies.

When government-appointed administrators arrived at one insurer, La Vitalicia, all the employees—except two senior directors—walked out in protest, sources report.

But following the court order, the government officers have left the insurers' offices, allowing employees to work normally.

Under the proposal now under consideration, the government will appoint new directors and general managers to all of the "intervened" companies. Insurance sources say that this does not mean the government will dismiss existing management, but other insurer officials speculated the government will attempt to replace the middle and top management at the companies.

Insurers question whether the government will find sufficiently qualified personnel to appoint to managerial positions at insurers. And, they don't know if the government will compensate the owners and shareholders of companies taken into state control.

The Peruvian Constitution stipulates that compensation must be made in cash. However, during the Peruvian land reform in the late 1960s, land owners were compensated by the government through equity in financial institutions.

The 17 insurers that face nationalization are: El Pacifico, La Fenix, El Sol, Peruana-Suiza, Atlas, Rimac, Internacional, La Positiva, La Colmena, La Vitalicia, La Universal, La Nacional, Panamericana, Italo-Peruana, America Terrestre y Maritima, La Real and El Condon.

The Peruvian domestic insurance market, including life insurance, totaled \$246 million in 1986.

Reinsurance ceded to foreign insurers, which totaled \$30 million to \$40 million last year, is exclusively placed through the state-owned Reaseguradora Peruana S.A.

Peruvian insurers say most underwriters in the country try to retain as much risk as possible, but earthquake and oil installations risks and coverage for the national airline Aeroperu are almost 100% reinsured through Reaseguradora Peruana to international reinsurers.

President Garcia said nationalization is necessary because the country's financial system has discriminated against the rural poor, contributed to the flight of capital out of the country and was used to "launder" or disguise the proceeds of drug sales.

Insurers vehemently deny the government's assertion that they have been discriminatory in their operations, pointing out the government already controls 70% of the nation's financial system.

Furthermore, the government already directs 90% of insurance company investments, insurers say. Companies are obliged to invest 90% of their investment funds in real estate, government securities and paper traded by state enterprises. The remaining 10% is left to the companies' discretion.

Nationalization of the financial system could severely erode the ruling Alianza Popular Revolucionaria Americana party's sup-

port, insurers note. A large proportion of the financial community supported APRA in the state elections in 1985, following Mr. Garcia's promise that financial institutions would not be nationalized should APRA come into power.

Although there were some rumors that the government would try to seize insurers and banks days before it happened, the move came largely as a surprise.

Sources say there is no comparison between the government's present action against the financial system and its earlier moves against the oil industry.

In August 1985, the government issued a decree rescinding operating agreements it had with Sucursal del Peru (OPC-Peru), a subsidiary of Occidental Petroleum Corp. Occidental later promised to pay the government \$68.1 million to continue the Peruvian operations.

In January, Occidental filed suit in Los Angeles, seeking to recover \$9.1 million in claims payments

and an additional \$125 million in punitive damages from four of its political risk insurers and their claims representatives for failing to reimburse it for the payment (BI, Feb. 2).

Insurance sources point out that in the Occidental case, the company had some choice: pay or lose assets. The insurers and financial institutions facing nationalization have no choice, they say.

Although the ruling APRA party is divided on the issue of nationalization, observers say the move probably will be approved by Congress with the support of opposition United Left Alliance, which is dominated by the Marxist-oriented United Mariategui Party.

In addition, Luis Alva Castro—a former prime minister and the current chairman of the Chamber of Deputies who is expected to run for president in the 1990 election—expressed his support of the government action two days after the president's announcement. ■

DENTAFITS, INC.

Reinsurance manager for

►Dental ►Vision

►Prescription Drug

Group Insurance Programs



For quotes or information call:
Renny Thomas Executive Vice President
 Managing Underwriter
 P.O. Box 3209, 527 E. Rowland Ave.
 Covina, CA 91722 (818) 967-2878

With skyrocketing hospital costs, HOW CAN YOU AFFORD TO GIVE EMPLOYEES OR POLICYHOLDERS THE BEST IN HEALTH CARE?

The Answer Can Be Found at Home.

- Quality Care, a leader in home health care for almost two decades, provides highly skilled, trained personnel — R.N.'s, L.P.N./L.V.N.'s, home health aides, home managers, high-tech specialists, others
- Quality Care, with over 200 corporate-owned offices nationwide, provides the widest variety of home health care services: for patients recovering from acute illnesses, accidents, operations, chronic diseases
- Quality Care is staffed with professionals who provide insurers with on-site, prompt case assessment and consultation

Find Out About the Home Care Alternative.

Millions of dollars have been saved, in thousands of cases, as a result of Quality Care services to insurance carriers, TPA's and self-insured companies. Find out for yourself. Call our National Resource Center Hotline at 800-645-3633 (in NY State 800-632-3201) or write Marketing Dept. B.



QUALITY CARE®
 "The Complete Homecare Service"

100 N. Centre Avenue
 Rockville Centre, NY 11570

Group health insurance rates

Continued from page 2

In addition to utilization and inflation, "cost shifting from the federal government to the private sector is also a concern," Mr. Horn says. "The government doesn't do its share so we have to pick it up and increase rates."

Most insurers offering indemnity plans are raising rates between 10% and 20%.

"We are seeing rate increases coming through at 12%-16%," observes Jennings L. Hart, a senior vp at McDonough Caperton Insurance Group in Charleston, W Va.

Although Charles A. Schoenster, executive vp and regional benefits director at Fred S. James & Co. in Short Hills, N.J., does not think rates will climb to their record high of the early 1980s, when some group health plan rates increased more than 40%, rate increases for "typical indemnity programs are trending at 10% to 15%."

"The underlined reason for the increase is inflation, the price of higher technology and the overabundance of doctors," according to Mr. Schoenster.

Experts concur that advances in medical technology and increases in health care costs go hand and hand.

"Technology is more expensive, and with high tech comes high cost," says James Purdy, vp at the Hartford, Conn., office of The Travelers Insurance Cos. "Indemnity rates increases could go as high as 20%," he added.

"Everything is more technologically advanced," says Don Diffenderfer, an executive vp in Fred S. James' West Palm Beach, Fla., office. "Open-heart surgery and organ transplants are common treatments now and very expensive. Insurers have to work the potential costs into the rates."

John Wickens, vp of group underwriting at Prudential Life Insurance Co. of America in Roseland, N.J., says advanced medical procedures, like organ transplants and other technological advancements are among the catalysts behind Prudential's average 14% rate increases for indemnity plans.

"Transplanting is considered automatic treatment and is a general practice," says Jack Savulich, a consultant in group benefit services at the New York office of The Wyatt Co. "Insurance companies have to raise the rates in order to cover the claims."

"In 1984, there were 676 transplants involving the heart, lungs or liver. In 1986 there were 2,337 (such transplants) and 1,350 bone marrow transplants," Mr. Savulich said. "Prices are rising because advanced, expensive treatment is more readily available."

Mr. Savulich says some indemnity plans may impose rate increases of up to 22% by the end of the year.

In addition to the medical cost increases created by advanced technology is concern that the growing number of acquired immune deficiency syndrome cases will increase insurers' costs.

"There is a lingering concern over AIDS, which is also

affecting the increases everyone is seeing," says Mr. Hart at McDonough Caperton. "Now we have a new concern to think about when establishing a variance factor. Whatever margins insurance companies incorporate into their rates are allowing for possible AIDS claims."

"AIDS is becoming a significant factor in increases in group health plans," Prudential's Mr. Wickens confirms. "Now, in group health, there is little protection for insurers regarding AIDS victims."

James' Mr. Diffenderfer agrees that AIDS is partly responsible for increasing rates, pointing out that a client "had one recent AIDS claim that cost \$250,000."

"When you're talking about covering a significant number of AIDS cases the costs get high very quickly," says Joe San Filippo, vp-managed health care at Pacific Mutual Life Insurance Co. in Fountain Valley, Calif.

"An average AIDS claim will cost \$48,000 and this contributes to a higher number of larger claims and, in turn, higher rates," he says.

Rates for managed care plans also are rising, though some of these increases are not as steep as the rate hikes for traditional indemnity plans. Generally, rate increases imposed by HMOs fall below 10%, while PPO plans are demanding larger rate hikes, though not as large as those set by traditional indemnity plans.

"The HMO increase is not as high as either the indemnity rates or the PPOs," according to Ronald Cameron, senior vp at Corroon & Black Corp.'s Benefits and Specialty Sales Group in Nashville, Tenn.

For instance, Kaiser Permanente Health Plans in Oakland, Calif., the nation's largest HMO, is raising its rates 6% to 6.5%, says Charlie Goldberg, assistant director of marketing for the HMO's Northern California region.

Likewise, Maxicare Health Plans Inc. in Los Angeles, an HMO with more than 2 million members, is raising rates an average of 6% so far this year, a spokesman says.

"HMOs are subject to the same costs as traditional plans and like any other plan, their rates will increase as well," explains Dave Ogden, a consulting actuary at Milliman & Robertson Inc. in Milwaukee, who says HMO rates are rising an average of 7% to 9%.

HMOs can survive with lower rate increases than indemnity plans, he adds, because "they have some control over expenses. Most are better than traditional indemnity plans at controlling hospital utilization because they have more bargaining power with the hospitals."

Some HMOs now are increasing rates despite competition in the HMO industry that has kept a lid on their prices.

HMOs "are getting wiser and not pricing as low," says Dr. Jack Mahoney, vp-health strategies at the Westport, Conn.-based Alexander & Alexander Consulting Group, who reports HMO rate increases ranging from 10% to 20%.

"We all learned a lesson from the Humana situation—the HMO product is good, but it has to be paid equitably for

services delivered," he said, referring to Louisville, Ky.-based Humana Inc., which lost about \$25 million on its Humana Care Plus plans in 1986 after guaranteeing employers that rates would not rise above the increase in the medical care component of the CPI (BI, Sept. 29, 1986).

Milliman & Robertson's Mr. Ogden agrees HMO rates are rising in response to last year's excessively low prices. "Rates were too low, so now there is a high percentage increase in order to compensate," he explains.

Corroon & Black's Mr. Cameron also reports HMO rates are increasing because "some HMOs underestimated previous rates in order to compete."

"They sold memberships at a wholesale rate and then had to increase the price in order to compensate for the losses. They are in such a hurry that they jump the gun," he adds.

He says HMOs are raising rates at least 7% to 10%, and rate increases can range as high as 40% if the plans have been mismanaged in the past.

But some suggest that competition will still keep HMO rate hikes relatively modest.

"Increased competition among HMOs may have a tendency to depress the amount of rate increases," says Metropolitan Life's Mr. Waldron, adding that HMO rate hikes are averaging about half of indemnity plan rate increases.

Meanwhile, rates for plans with PPO options also are increasing at a rate somewhere between the indemnity plans' and the HMOs' hikes, Mr. Ogden says.

"PPOs have a looser system that provides discounts but doesn't control utilization as significantly as the HMO because it offers more flexibility," he explains.

"PPOs' experience is similar to indemnity plans'. If there is good utilization (controls), then they can keep increases at 7% to 10%, but if it is bad, then increases can go over 40s2%," Mr. Cameron says.

"We are seeing overall increases of 14% in both indemnity and PPO's," says Mr. San Filippo. "Everyone is holding their breath to see what will happen in the third and fourth quarters of 1987."

As health costs continue to rise and both employers and employees become more aggressive in the attempt to control these costs, participation in traditional indemnity plans will decrease, observers predict.

"Within two years, indemnity plans will be the minority player," predicts Peter Boland, president of Boland Health Care Consultant Co. in Berkeley, Calif. "By 1990, at least two-thirds of the population will receive care from a managed care plan."

But other observers point out that employers and insurers must find new cost-control tools to fight the latest surge in health plan rate increases.

"We need to find new means of cost containment," says Pacific Mutual's Mr. San Filippo. "We have to be more serious about preventive medicine and try to cut costs by stopping the problem before it occurs." ■

Employees turn sleuths for hospital overcharges

By KARI BERMAN

NEW YORK—Employers are saving money on group health plan costs by offering cash reimbursements to employees who report errors on their medical bills.

"These kinds of mistakes always lead to an increase in rates," says a spokesman for New York Life Insurance Co. of New York, which has calculated hospitals overcharged its group health insurance clients an average of \$851 per claim nationwide in 1986.

Ralston Purina Co. of St. Louis has been saving money through a voluntary hospital auditing program since 1984, according to Janet Sanders, the company's supervisor of health plan operations.

"When we started the program, we sent out a newsletter with instructions on how to find errors on bills, advising employees to always request an itemized copy. We followed up with periodic reminders in the newsletters," she explains.

If a Purina employee finds an error and reports it, the employee receives one-half the amount of the discrepancy, up to \$500, according to Ms. Sanders.

"We are happy with the results of our employee hospital audit program. Last year, employees discovered between \$10,000 and \$15,000 in overcharges," she reports.

Foodmaker Inc. of San Diego was so impressed with Purina's plan that it modeled its own pro-

gram after it, according to Beth Davis, claims supervisor at Foodmaker.

"We wanted to get our employees more involved in their personal health care," she said.

"We sent out fliers announcing the hospital auditing program and now, if an employee finds an error, he can get back either one-half of the savings or up to \$500," Ms. Davis reports.

Also pleased with the results of a voluntary audit program are officials of American Express Travel Related Services Co. in New York.

"It is encouraging to know that employees care enough to check," says Karen Manning, vp of employee benefits and personnel operations. "If they find a mistake

and have it corrected, they receive one-half of it, but not more than \$500."

Discoveries of simple mathematical errors earn employees \$50, Ms. Manning explains.

Insurance companies are equally concerned with hospital billing errors. Last year, after auditing group policyholders with hospital bills ranging from \$5,000 to more than \$10,000, New York Life identified approximately \$1.4 million in overcharges, according to a New York Life spokesman.

"We will counsel companies and their employees on what to look for when evaluating a bill, but both have to take the initiative in order for it to work," he said.

For clients who do take the initiative, New York Life offers a "Keeping Tabs" program, which can be implemented at the request of the employer, according to Janice Spillane, assistant vp of group insurance and cost containment at New York Life.

Ms. Spillane explains that the program can be applied two ways: "The employees can do the footwork and get the adjusted bill. We will then pay them one-half of the recovery or up to \$500 in the case of a hospital stay and up to \$100 for out-patient care.

"If the employee does not want to pursue it on his own but still reports the mistake," Ms. Spillane explains, "we pay them 20% of the amount—up to \$250 for a hospital stay and \$50 for outpatient treatment."

However, voluntary auditing programs do have inherent difficulties. "Hospital charges aren't like groceries. Most people won't recognize if they are being overcharged," says Ms. Spillane. "A \$50 electrocardiogram can be mistakenly billed at \$500, but since

patients don't know what an EKG should cost, they don't detect the error," she reports.

Aetna Life & Casualty Group of Hartford, Conn., has noted an even higher hospital overcharge rate—an average of \$1,118—than New York Life in 1986, according to an Aetna spokesman. "Our average overcharge is higher than New York Life's, but experience indicates that it is running steadily and not rising," he said.

Like New York Life, Aetna also offers an employee reward program entitled "Second Look" for companies with a minimum of 2,000 employees. Aetna's program differs, however, in that it is completely employer-funded, the spokesman said. "We will help the companies set it up, recommending that they offer employees up to 50% of the discovered error," he explains.

Hospital bills also are audited by the many utilization review and disability cost management service firms.

"We look at the hospital bills to see if the person actually received what they are charged for," explains Cathy Johnson, vp of marketing at Conservco, a Tampa, Fla., affiliate of The Travelers Corp. that provides medical and disability cost management services.

"Once, we saved a company \$90,000 on a \$120,000 bill because the hospital charged him for an entire shipment of a drug rather than for (an employee's) dosage." "We have 70 registered nurses nationwide who go to the hospitals and do on-site reviews of the records to see if the charges are substantiated," Ms. Johnson says. "When there is a problem," she added, "the hospital business office is informed and steps are taken to rectify it." ■

Do you have to return it?

If you're racing through this issue of Business Insurance because you have to return it soon, why not have your own personal subscription?

Use the card in this issue or the coupon to **SUBSCRIBE TODAY.**

Business Insurance
Circulation Dept. 965 E. Jefferson Detroit, MI 48207



Business Insurance gives you total news coverage of loss prevention, risk financing and benefit management. Every week. Annual subscription (52 issues) in U.S. dollars.

(Check here:)

	Surface Mail	By Air
USA	<input type="checkbox"/> \$68	<input type="checkbox"/> \$115
Canada	<input type="checkbox"/> \$84	<input type="checkbox"/> \$115
Bermuda (air only)		<input type="checkbox"/> \$115
British Isles		<input type="checkbox"/> \$115 or £82
Europe/Middle East		<input type="checkbox"/> \$115
All other foreign		Rates on request

new subscription. renewal. payment enclosed.
 bill me. bill company.
 Please send information on your special 20%-off group rate for five or more subscriptions.

name _____ (please print)
title _____ telephone _____
company _____
nature of business _____
 business or home address
city _____ state/country _____ zip/postal code _____
 I prefer not to receive information or advertising by mail from companies not affiliated with Crain Communications.

Mail to: Business Insurance, Circulation Dept., 965 E. Jefferson Ave., Detroit, MI 48207 IBCB7

Manville loses

Continued from page 3

Bethlehem Steel Co. River Shipyard in Quincy, Mass., and Consolidated Steel Co. Shipyard in Orange, Texas.

The case only involved shipyard workers exposed during World War II, which—for purposes of the trial—was deemed to end Jan. 1, 1946.

Among the major issues in the case were whether the government:

- Had agreed to indemnify Manville for third-party liabilities.
- Breached an implied warranty that the asbestos-containing products purchased under Manville's supply contracts were free from defects and safe for use.
- Breached its duty to reveal superior knowledge by failing to reveal to Manville the conditions in which asbestos products were used in the shipyards.
- Failed to enforce its own health and safety standards concerning the application and removal of asbestos-containing products.

Initially, Judge Nettesheim ruled that Manville was not compelled to perform its supply contracts with the Navy and the Maritime Commission, but rather its actions "can be characterized as voluntary compliance—in fact, exploitation of business opportunities—without a compulsory system or system of mandatory controls."

Judge Nettesheim also found that Manville failed to prove that the government agreed to indemnify it for suits brought by third parties.

Judge Nettesheim ruled that during World War II the Navy did not have a policy of assumption of risk with respect to fixed-price supply contracts other than for specified risks involving government-owned property. And, the Navy's policy of assumption of risks was always written into the contracts, she said.

In addition, she denied Manville's contention that it deliberately excluded the costs of insurance from its contracts with the government because it assumed the government would pay all third-party claims.

On the issue of breach of implied warranty of specifications, Judge Nettesheim rejected Manville's contention that the government should pay for additional costs incurred by Manville as a result of defects in the government specifications for purchase of its products.

Except for one product, Manville participated to a significant degree in the government's writing of the specifications for asbestos products, Judge Nettesheim said.

"By joining in the process of the drafting of specifications... Johns-Manville vitiated any implied warranty of specifications running in its favor from the government because Johns-Manville could no longer claim to be

relying on the government's expertise with regard to the safe production of a suitable product," she added.

Judge Nettesheim also ruled the government's knowledge of the health hazards of asbestos was not superior to Manville's and thus the government did not breach its duty to reveal superior knowledge to the company.

"In essence, Johns-Manville knew over a decade before the government, in the macrocosm of Johns-Manville's asbestos plants, that exposure to asbestos in heavy concentrations over short periods of time led to asbestosis and that low-dose exposures could also be hazardous.

"The evidence does not establish superior knowledge of asbestos health hazards and shipyard working conditions on the part of the government," the judge said.

Nevertheless, Judge Nettesheim noted that the federal government had a "questionable track record," in its health and safety activities in the shipyards and that the Navy was aware by the 1930s of the nature of asbestosis and that shipyard workers were at risk.

In addition, she ruled that the court should not reform the government's contracts with Manville so that the government would share damages because the contracts were based on erroneous beliefs that workers would not be exposed to hazardous levels of asbestos and that there was no link between asbestos and cancer.

Last week, attorneys for asbestos producers expressed disappointment with Judge Nettesheim's decision.

According to Keene Corp. attorney John E. Kidd, the extent that Judge Nettesheim's findings will apply to other producers will depend on the facts of each case.

"I would expect that each of the parties should be able to show a factual distinction from Johns-Manville," said Mr. Kidd, who is with the New York firm of Anderson Russell Kill & Olick.

For example, smaller producers, including Keene, could show that the government had superior knowledge of asbestos dangers, whereas Manville—which was the world's largest producer—could not, he said.

However, Mr. Kidd said Judge Nettesheim's decision will make it more difficult for producers to recover from the government than if Manville had prevailed.

"If J-M had won, it would have made the other six defendants' cases obviously easier," he added.

Fibreboard attorney Robert M. Chilvers, with the San Francisco firm of Brobeck, Phleger & Harrison, said there "are significant factual differences" between the Manville and Fibreboard cases.

Mr. Chilvers also pointed out that the producers' actions in U.S. Claims Court are only part of a "multi-prong" effort to seek redress from the government, including actions under the Federal Tort Claims Act and other federal legislation. ■

Massachusetts

Continued from page 3

Frank Gallo, an employee benefits manager at Wang Laboratories Inc. in Lowell, Mass., complained that in some cases, the payroll tax will cost employers more than the 13.5% surcharge.

Several months ago when a 1% payroll tax was under consideration, he calculated that the cost to Wang would have been "significantly greater" than the amount Wang pays under the 13.5% hospital bill surcharge. Wang employs about 10,000 people in Massachusetts.

However, the bill's 0.5% payroll tax on companies like Wang that provide health benefits might not yield the same results, he noted.

Mr. Gallo also pointed out that payroll taxes are easily increased.

In addition to the payroll tax, a cigarette tax of 3 cents per pack would generate another \$19 million for the pool, and a 2.28% tax on premiums of health maintenance organizations would raise almost \$6 million.

Commercial health insurers, which already pay a 2.28% premium tax, would continue to be assessed that amount, which generates about \$230 million annually. Initially, the bill would direct 5% of that amount, or \$15 million, into the health insurance pool. By the third year after enactment of the legislation, 50% of that amount, or \$115 million, would go into the pool.

In addition, the approximately 600,000 Massachusetts residents eligible for pool coverage would pay income-based premiums.

For example, employed individuals would pay a premium equal to 1.5% of their salary, while the unemployed would pay premiums based on a sliding scale depending on income.

Premiums are not included in the pool revenue estimates.

The pool would be administered by a seven-member governor-appointed board called the Massachusetts Health Partnership Authority.

Board members, each serving a five-year term, would include: the secretary of the executive office of human services; the state treasurer; a chief executive officer of a business in the state; an actuary with expertise in health insurance; a labor representative; an individual with a pre-existing condition who was unable to find insurance; and a university or college faculty member with expertise in health care financing.

The authority would be mandated by the bill to contract with managed health care providers whenever possible.

The health insurance pool would cover physician's services, inpatient and outpatient acute hospital care, emergency medical care and preventive health services. However, long-term care, such as nursing homes and hospices, would not be covered.

Employers would begin paying the additional payroll taxes 21 months after the bill becomes law. At that time, the 13.5% hospital bill surcharge funding the uncompensated care pool would be eliminated.

A spokeswoman for the Boston Chamber of Commerce, which in the past has opposed efforts by the state to mandate employee benefits (BI, Aug. 5, 1985), said the group has not yet developed a position on the proposal. ■

REINSURANCE

August 31
Insurance Exchanges
Distribution @ Monte Carlo Rendez-Vous
ad closing: August 18

September 21
Monte Carlo Rendez-Vous Report
ad closing: September 9

November 16
Reinsurance
Intermediaries Directory & Distribution @ NAI
ad closing: November 3

the professional marketplace

RATES AND CLOSING TIME:

Rates: Display classified is \$86.25 per column inch, minimum of one inch. Straight classified is \$7.00 per line, minimum of 5 lines. Count 34 characters per line (include each space and punctuation as a character). Additional \$13.00 charge for blind box ads. Only those responses which fit into a business size envelope will be forwarded. Responses are forwarded daily.

Closing: Published every Monday. Copy must be in typewritten form by noon Tuesday, 6 days preceding publishing date. No verbal phone copy accepted. Prepayment required for straight advertisements. Mail ads to Margaret Hikido, Classified Advertising, 740 N. Rush St., Chicago, IL. 60611. For more information call 312-649-5340.

INSURANCE AGENCY WANTED ALL CASH AVAILABLE

Major N.Y. real estate development firm wishes to acquire a Westchester, N.Y. based ins. agcy. holding agcy contracts with at least 2 of the following companies: Aetna C&S, General Accident, Zurich, Continental Ins., Royal Ins., TransAmerica, Travelers, CIGNA, CNA. With or without your building. Decision within 72 hrs.
Box 2329, Business Insurance
740 Rush St.
Chicago, IL 60611-2590

HARVARD AIMES GROUP Executive Search

Risk Management, Benefits and Insurance Professionals
6 Holcomb St PO Box 16006
West Haven, CT 06516
(203) 933-1976

WANTED

Fronting Property & Casualty Companies. ALL States. We will reinsure you 100%. Please write P.O. Box 11-1505, Miami, FL 33111.

**BI Classifieds
assure
top quality
results!**

BUSINESS OPPORTUNITIES

PROGRAM BUSINESS
Brokers and Agents looking for an insurance company to support their program or association should contact Box 2134, Business Insurance, 740 Rush St., Chicago, IL 60611. We are a firm specializing in program placement, development and control.

REQUEST FOR PROPOSAL FOR EMPLOYEE BENEFITS CONSULTANT
The City of Orlando is seeking proposals for an Employee Benefits Consultant. The City has initially established three tasks: a review of its Long Term Disability Program, development of a possible Defined Contribution Program and a Variable Benefit (Cafeteria) Program (and phases within each for which it is seeking proposals). Parties interested should contact the Purchasing Agent, City of Orlando, Municipal Justice Building, 100 South Hughey Avenue-Second Floor, P.O. Box 440, Orlando, FL 32802-0440 or call (305) 849-2291 to request a copy of the RFP for Employee Benefits Consultant. A pre-proposal conference will be held at 10:00 a.m., Friday, September 11, 1987, in the Orlando City Council Chambers, 400 S. Orange Avenue, Orlando, Florida. Responses are due to the City on or before 3:00 p.m., September 30, 1987.

HELP WANTED

INSURANCE UNDERWRITER
The N. C. League of Municipalities is seeking a Mgr. of Technical Services to provide underwriting and other technical services to a governmental self-funded property and casualty insurance program with more than 225 members. Minimum of 5 years experience as a multiple line or commercial lines underwriter. Certification as a Risk Mgr. or CPCU designation desired. Salary range: \$26,844-\$40,266 based on experience and qualifications. Reply to: NCLM Dir. of Risk Mgmt. Services, P.O. Box 3069, Raleigh, N. C. 27602 by 8/31/87. Equal Opportunity Employer.

GLENN, NYHAN & ASSOCIATES, INC.
We are a rapidly growing, national insurance brokerage and consulting firm, specializing in developing and implementing solutions to insurance and risk management problems. We currently have several openings for key positions in a new national program headquartered in San Francisco.

VICE PRESIDENT UNDERWRITING: Manage underwriting function. Experienced in prof. liability underwriting with 5 yrs mgmt. responsibility.

CLAIMS MANAGER: Manage claims department. 3 to 5 yrs experience in professional liability claims mgmt.

REGIONAL MARKETING MANAGERS: Represent national program at conventions. Cultivate and maintain client relationships. Extensive travel. 3 to 4 yrs experience in insurance or related health industry marketing/sales preferred. Salary positions available in San Francisco, Washington, D.C., Chicago, Vermont and Mid-Atlantic offices. If you are a self-motivated, high energy, results oriented professional, interested in an opportunity to become an integral member of a dynamic organization, we would like to talk with you. Forward resume and salary history to: Jan Lester, American Insurance Services, P.O. Box 42905, San Francisco, CA 94142-2905

HELP WANTED

RISK MANAGEMENT CONSULTANT
Insurance/Risk Management consulting firm in Orange County adding to staff. Desired qualifications/3 to 4 Yr. underwriting or risk management, some CPCU/ARM exams, college degree knowledge of Lotus 1-2-3 or similar, good communications skills, self-starter. Salary 32,000+ depending on qualifications. Respond to: Box 2328, Business Insurance, 740 Rush St., Chicago, IL 60611-2590

BENEFITS/RISK ANALYST

The Department of Defense has an opening for an Insurance/Pension specialist. In-depth knowledge in group insurance, and/or pension, and/or casualty risk management. Review and report on major DOD contractors, employee benefit and risk management systems. Federal experience not required. We are an equal opportunity employer. Submit resume and/or standard form 171 to: DCASR, CHI-AFI/W. Smith, O'Hare I.A.P., P.O. Box 66475, Chicago, IL 60666-0475, 312/694-6433.

SITUATION WANTED SR. FIN. OFFICER
12+ yrs. exp. P/C Ins./Reins. Company Agency, intermediary bkgnd inclds finance, planning, control, regulatory. Team player w/effective management and communication skills. Will reloc. Box 2330, Business Insurance, 740 Rush St. Chicago, IL 60611-2590

CHIEF EXECUTIVE OFFICER

A rare and challenging opportunity is available to the professional insurance executive with a progressive history of successful accomplishments and growth in CASUALTY/PROPERTY and MARINE INSURANCE, including USL&H, P&I and HULL. This candidate will have at least 10 years of either insurance company experience and/or brokerage experience in the aforementioned lines of business. As the CEO of this new reciprocal insurance company your responsibilities will include the organizational structuring, staffing and control of the entire operation. Please direct your resume to: CEO, PSPIE 4019 21st Ave. W, Suite 201, Seattle, WA 98199.

INSURANCE OPPORTUNITIES

- **COMMERCIAL PRODUCERS.** Many fine opportunities country-wide, including the West Coast, Southwest, Upper Midwest, Central States, South, Southeast and East for Commercial lines producers with a track record. Clients include the major brokers and many dynamic, growing medium to large agencies.
- **AGENCY MARKETING MANAGERS.** 2 Fine opportunities available with large agencies in highly attractive Southern cities. Requirements include heavy commercial lines agency marketing and management of a good sized staff. Prefer regional candidates but might consider other areas. Salary 75k range.
- **AGENCY GENERAL MANAGER.** Our client, a well established Rocky Mountain agency, seeks a GM with impeccable management credentials to oversee this 60+person operation. Salary to 70k. Area candidates given priority.

GILBERT — HAFNER & CO.

6060 N. Central #470, Dallas, TX 75206, (214) 361-9341

For a
**Concise
and
Logical
Approach
to
Risk
Management
Recruiting**

LOGIC

Associates, Inc.
170 Broadway
New York, N.Y. 10038
(212) 227-8000

BRANCH MANAGERS

Strong established Regional P&C broker with age gap in senior management has developed openings N/E, S/E and South. Dynamic, stable company offers excellent opportunity. Area of expertise flexible however construction/contract bonding a big plus. Salary, bonus open, excellent benefits. All search costs paid by client.

Bob Reece, Insurance Consultant
Hale Search Group
2596-C Reynolda Road
Winston-Salem, NC 27106-4618
(919) 724-0234

Manager, Risk Management & Insurance

NCR

NCR, an international computer industry leader, is forming a risk financing unit to identify and evaluate exposure to loss and to finance risks through self-insurance, risk transfer and/or insurance procurement.

Reporting to the Director, Risk Management and Insurance, you will be responsible for planning, organizing, staffing and implementing this key function. If you're ready for new career challenges, join our top caliber team.

The successful candidate will have a minimum of three years of industry experience in risk management, strong oral and written communications skills, plus a familiarity with computer-based information systems' concepts and terminology. Position requires a Bachelor's degree in Business with a major in a financially oriented discipline. Graduate degree, CPCU and/or ARM will be a plus.

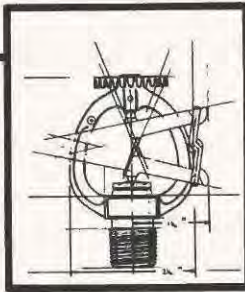
We offer a competitive salary, outstanding benefits and the chance to move up within a \$4.8 billion high-tech corporation. To find out more, send your resume and salary history to:

Margaret H. Knight
Personnel Resources
NCR Corporation
Dept. X39
Corporate Finance & Administration
1700 S. Patterson Blvd.
3rd Floor West
Dayton, OH 45479

When you know where we're going,
you'll choose NCR.

An equal opportunity employer.

HPR Account Engineering and Underwriting Opportunities



Indianapolis • Chicago • Minneapolis

If you know loss prevention engineering, you know Protection Mutual. For more than 100 years our clients have come to expect the best in insurance, loss prevention and property conservation. Our continued emphasis on client service combined with current growth has created the following opportunities:

HPR ACCOUNT ENGINEER

As a Protection Mutual Account Engineer, you'll have every opportunity to grow as you make full use of your analytical, technical and decision-making skills. To qualify, you'll need an engineering degree and at least 3 years' HPR property engineering experience. Exposure to large, sophisticated risks is desired. Positions available in Indianapolis, Chicago and Minneapolis.

HPR UNDERWRITER

This position requires an individual with at least 3-5 years' HPR underwriting experience and/or exposure. We will also consider an HPR Engineer who would be interested in underwriting. CPCU or course work is strongly preferred. Position available in Indianapolis.

B&M REPRESENTATIVE

In this position you will be involved in prospect inspections, assist in rating and underwriting, and maintain an ongoing liaison with our clients. You will also assist in the development of new B&M accounts. Qualified candidates should have 3 or more years' experience in B&M inspection and loss prevention engineering, or 3 years' in B&M underwriting. Strong communication and negotiating skills are necessary. Applicants should have a current national board commission. Position available in our suburban Chicago corporate headquarters.

If you're an HPR professional interested in growing with a quality company, we would like to hear from you. We offer an extremely attractive salary/benefits package including company car/auto allowance. For confidential consideration, send your resume or a letter of qualification to: Charles Lanham, Personnel Director, Protection Mutual Insurance Company, 300 S. Northwest Highway, Park Ridge, IL 60068. An equal opportunity employer.

**Protection Mutual
Insurance Company**

Insurance

ASSISTANT MANAGER GROUP INSURANCE

Textron, Inc., a Fortune 100 Providence-based, multi-industry company, seeks an Assistant Manager-Group Insurance.

Successful candidate will assist the Manager-Group Insurance in managing and supervising the domestic group insurance functions of the Risk Management and Insurance Department. This includes advising divisions with respect to proposed plan changes.

Qualified candidates should have a minimum of 5+ years related group insurance experience plus a Bachelor's Degree in Business or Insurance. MBA or CLU is a plus. Excellent verbal and written communication ability required.

We offer an excellent starting salary and an outstanding benefits package. Forward resume, salary history and starting salary requirements in complete confidence to: Employment Manager. Only those resumes with starting salary requirements will be considered.

Textron Inc.
Human Resources Department
40 Westminster Street
Providence, RI 02903

TEXTRON

An Equal Opportunity Employer M/F

Congressional action

Continued from page 1

nuclear accident by more than tenfold to about \$7 billion.

Experts also expect Congress will approve bills requiring the notification of employees who are or have been at high risk of contracting an occupational disease. Business groups have charged the bills, which would require employers to pay for medical screening, could cost billions (BI, April 27).

But, observers say it is unlikely Congress will revise the McCarran-Ferguson Act, the 1945 federal law giving insurers limited immunity from federal antitrust law and giving states primary authority to regulate the insurance business.

Business groups hope that the House Commerce, Consumer and Competitiveness Subcommittee will vote next month on federal product liability reform legislation, H.R. 1115, introduced by Rep. William B. Richardson, D-N.M.

But even if the subcommittee does vote, enactment of the legislation—in either the House or Senate—is considered an extreme longshot, observers say.

Medicare expansion

It is only a matter of time before the Senate approves legislation expanding the federal Medicare program to provide retirees with greater protection from catastrophic health care expenses, observers say.

Both the House bill, H.R. 2470, and Senate proposal, S. 1127, would provide beneficiaries with 365 days of coverage for acute care expenses compared with current law, which provides 120 days of Medicare coverage (plus a 30-day lifetime reserve) per year.

In addition, the measures would limit a beneficiary's maximum annual out-of-pocket expenses for covered services to less than \$2,000. Currently, a beneficiary can face \$12,220 in out-of-pocket expenses for a 120-day hospital stay because

of Medicare deductible and coinsurance requirements.

These improved benefits would be financed by a supplementary annual premium based on a beneficiary's income and an increase in the Medicare Part B monthly premium.

For many employers, enactment of the Medicare legislation would be beneficial because an expanded Medicare program would mean employer-provided supplemental retiree health care plans—which often cover Medicare deductibles and coinsurance requirements—would be tapped less often.

But some employers—depending on the design of their supplemental plans—could face new liabilities if a House provision adding a new prescription drug benefit wins congressional approval.

Under that House provision, which is not contained in the Senate bill, Medicare would pay 80% of a beneficiary's outpatient prescription costs after a \$500 annual deductible. Medicare does not now cover outpatient prescription costs.

But this provision could hurt employers with retiree health plan plans that reimburse retirees only for Medicare covered services. Under these plans employers would pay retirees a portion of the cost for service not fully covered by Medicare, notes Larry Lenahan, a benefit consultant with Buck Consultants Inc. in Harmon Meadow, N.J.

Since outpatient prescription drugs would become a benefit partially covered by Medicare, some employers would be obligated to pick up the portion of prescription drug costs not assumed by Medicare, Mr. Lenahan said.

Mandatory health care plans

In September, Sen. Kennedy's staff will begin a new round of meetings with business groups in an effort to reduce opposition to the Massachusetts Democrat's proposal to require all employers to offer at least a minimum health care plan.

For example, on Sept. 9, David Nexon, Sen. Kennedy's top health staffer, will meet with representatives of the Assn. of

Private Pension & Welfare Plans to iron out objections.

The APPWP objects to a provision in the Kennedy bill that would require employers to extend their group health care plans no later than 30 days after an employee begins work.

Carson Beadle, a managing director at William M. Mercer-Meindinger-Hansen Inc. in New York, says such a liberal eligibility requirement could cause significant administrative problems for employers in high-turnover industries.

Some industries, like fast-food, may face 30% employee turnover during a three-month period, Mr. Beadle notes. Such employers not only would have to offer health insurance coverage to employees who stay on the job for such a short period of time, but also would then have to offer continuation coverage under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

The concept of mandatory employer-provided health insurance, though, has drawn support from such major corporations as Dallas-based American Airlines Inc., Baxter Travenol Laboratories Inc. of Deerfield, Ill., and Chrysler Corp. of Highland Park, Mich., which say a federal mandate requiring minimal coverage would ensure that health care costs are shared equitably by all employers.

Some organizations, though, say that small companies would be unable to afford to provide even a minimum plan. In addition, companies like retailers and fast-food chains, whose workforces typically have a high percentage of part-time employees currently not covered under a group health plan, would face especially high, new health care costs.

Under the Kennedy proposal, annual deductibles for hospital and physician services generally could not exceed \$250 per person or \$500 for family coverage.

Employers though, could charge higher deductibles if employees receive services outside of a preferred provider organization or do not comply with health care cost management

Continued on next page

the professional marketplace

The Professional Marketplace TARGETS your BEST JOB Candidates

DENTAL HMO PARTNER SOUGHT
Dental HMO Certificate of Authority with Tx. SBI deemed "Complete" awaiting "Approval" prior to business. Company now seeks venture partner in insurance or related industry. Once licensed, Plan provides vehicle to market dental products in Texas and potential to expand service area nationally. Reply to:
Box 2327, Business Insurance
740 Rush St.
Chicago, IL 60611-2590

MANAGEMENT OPPORTUNITY
High profile computerized agency/consulting firm in business 35 years: Seeking mature person with strong insurance background and top-notch management skills for position of Vice-President-PIC Underwriting/Claims who will report directly to firm's president; CPCU or equivalent; stable employment history; salary in \$50,000 range. Send resume to: Personnel, P.O. Box 220, Park Ridge, NJ 07656.

Wanted
Insurance Marketing Sales Executive Licensed as Agent - Broker - Excess & Surplus - Holding License. Willing to work hard to build a Surplus Lines Agency. Office facilities provided. Opportunity Unlimited. You will earn commissions on what you produce, plus have an equity position built into your contract. Send your resume with cover letter to: Jacqueline Parker, P.O. Box 11-1505, Miami, FL 33111, Ph. 1-800-237-5404. Positions available in 17 states and Canada.

RETAIL TRUCK PRODUCERS WANTED
Due to program expansion, we are currently seeking experienced, licensed, retail producers to represent "A" rated truck physical damage program in the following states: Florida, Georgia, Kentucky, Mississippi, Oklahoma, Virginia and W. Virginia.
Please reply to:
Box 2320, Business Insurance
740 Rush St.
Chicago, IL 60611-2590

RISK MANAGEMENT CONSULTANT
Established independent insurance consulting firm seeks individual with good academic and insurance credentials, 3-5 years large commercial lines property/casualty experience, for Indianapolis staff. Excellent technical writing ability and communicative skills required. 30% travel. Send resume and salary history to:
Box 2331, Business Insurance
740 Rush St.
Chicago, IL 60611-2590

OPERATIONS MANAGER
Progressive, established Palo Alto Agency seeks a people oriented "hands on" operations manager. Must be organized, technically competent in personal and commercial lines and a proven leader. Responsible for all aspects of internal operations excluding sales and accounting. Three to five years operations, supervisory or management experience required. Agency and company experience a plus. An exceptional career opportunity for the right person. All benefits including pension and profit sharing plans funded by employer. Send confidential resume to:
Virginia Brennan
Flinn, Gray & Herterich
PO Box 60009
Palo Alto, CA 94306-0009

SENIOR WORKERS' COMPENSATION CLAIMS EXAMINER
AC Transit is seeking an experienced, highly-motivated individual to examine, review and monitor workers' compensation claims in the Risk & Insurance Department. Requirements: graduation from an accredited four (4) year college or university with major course work in Business Administration, Insurance or related field. Salary Range: \$34,690 to \$46,840.
To apply, contact: AC Transit, Personnel Dept., 1600 Franklin St., Oakland, CA 94612, 415/891-4783, beginning Monday, August 17, 1987—completed applications must be returned by 5:00 p.m. Friday, August 28, 1987. (Resumes, without completed application, will not be considered.)
Equal Opportunity Employer
Male/Female

THE INTELLIGENT TEMPORARY REMEDYTEMP ASSISTANT RISK MANAGER
One of the nation's leaders in employment growth is expanding its corporate staff. Full-time position available for self-directed individual, requires aptitude for detail, figures, handling multi-deadlines. Responsibilities include liability determination within policy retention levels, policy reporting requirements, data base maintenance.
5 yrs. min. risk mgmt. exp., property/casualty, work. comp. prof. liability, ARM, CPCU preferred.
Salary commensurate with exp. Excellent benefits. Send resume with salary history to:
Shelley Moeller, D. of Human Resources
P.O. Box 699
San Juan Capistrano, CA 92693
INQUIRIES WELCOME
(714) 661-1211
EOE

PRODUCER/MANAGER WANTED:
Mature commercial producer with experience or interest in sales management. Position involves new sales as well as sales management and training for large, professional agency.
MINIMUM REQUIREMENTS:
CPCU, CLU or ARM degree. Stable employment history. \$200,000-book (commission income) to be purchased by our agency at a multiple paid based on retention over four (4) years.
POSITION:
Sales manager, leading to vice president. Sales benefits: Salary in \$50,000 range, plus 30% new/renewal commission on book of business; Car: expense account; bonus: profit sharing; Chicago/suburban area.
"We're Building the Best"
Reply to:
Box 2321, Business Insurance
740 Rush St.
Chicago, IL 60611-2590

MANAGER, STATE WORKMEN'S INSURANCE FUND SCRANTON, PENNSYLVANIA
The Pennsylvania Department of Labor and Industry is seeking applicants for Manager of the State Workmen's Insurance Fund (SWIF), a state-operated provider of workers' compensation insurance. SWIF presently underwrites over 17,000 policies and has annual revenues of nearly \$200 million.
The Manager is responsible for the administration and supervision of 160 employees in the Scranton central office and eight field offices. The Manager coordinates with the Pennsylvania Compensation Rating Bureau, the Coal Mine Compensation Rating Bureau and other related agencies. He or she will play a vital role in implementing a major initiative to bring SWIF's data processing capability up to "State-of-the-Art."
This position requires eight years of managerial experience, including executive level expertise in occupational compensation, liability, and/or casualty insurance. Salary to \$51,951 per year, depending on qualifications and experience, plus comprehensive benefit package, including pension.
Qualified applicants should forward a comprehensive resume by August 31, 1987 to:
Mr. Frank Beal, Special Assistant to the Secretary
1721 Labor and Industry Building
Seventh and Forster Streets
Harrisburg, PA 17121
Information Phone No. (717) 787-7074

PRODUCER PROPERTY/CASUALTY
Frank B. Hall & Co., Inc. has an immediate opening for a property/casualty insurance producer for our Morristown, New Jersey office. Background should include a track record of successfully dealing with clients and prospects in a sales capacity. The successful candidate will demonstrate the desire and self-confidence to solicit, develop and close new business.
We offer an excellent compensation and benefits package with the opportunity to develop virtually unlimited earnings from new business production.
If this opportunity to control your career and earnings potential appeals to you, please send your resume and earnings history in confidence to:
William D. Pringle
Chairman
FRANK B. HALL & CO. OF NEW JERSEY
55 Madison Avenue
P.O. Box #1059R
Morristown, New Jersey 07960
An Equal Opportunity Employer M/F/H/V



Business Insurance

Circulation Breakdown*

Commercial Consumers

Administrative:
CEO's Presidents and Owners 2,426
Vice-presidents, General Managers and Other Administrative Personnel 3,136

Financial:
Chief Financial Officers and Vice-presidents of Finance 2,583
Secretaries, Treasurers, controllers and other Financial Personnel 4,888

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 8,144

Sub-total 21,277

Associations 506
Government, Unions and Educational Institutions 1,400

Commercial Consumers

Sub-total 23,183

Insurance Agents and Brokers 11,009
Insurance Companies 7,111
Financial Institutions 989
Actuaries, Attorneys, Adjusters, Appraisers and Consultants 5,560
Others Allied to the Field 1,442
TOTAL 49,294

* Source Business/Occupational breakdown of qualified circulation, November 24, 1986 issue, as submitted to BPA for December 1986 BPA Publisher's Statement.

Congress

Continued from previous page techniques.

Copayments for covered services generally could not exceed 20%, with a maximum out-of-pocket expense of \$3,000 per year.

Employers generally would be required to pay 80% of the premium for individual and family coverage. In the case of low-wage workers—those earning less than 125% of the federal minimum wage—employers would have to pay the full premium.

Coverage would have to be extended to all employees working at least 17.5 hours a week.

Sen. Kennedy estimates the cost of the minimum plan at \$1,186 per employee.

Observers say Sen. Kennedy still needs to muster more business support as well as support from middle-of-the-road Democrats and Republicans if his proposal is to have any chance of passage.

"There is no evidence yet of middle-of-the-road support," said Sharon Canner, director of employee benefits at the National Assn. of Manufacturers.

But employer interest in the

Kennedy bill could increase if enactment of another proposal allowing states to require employers to subsidize health care pools to provide coverage for the uninsured threatens to become a reality.

"The specter of risk pools could result in serious examination of the Kennedy bill," said Mr. Beadle.

State risk pools

Under the risk pool proposal, states could set up pools to provide comprehensive coverage for the uninsured. If premiums paid by participants are insufficient to cover the pools' costs, as is almost certain, employers with more than 20 employees would be assessed to make up the difference.

Employers that refuse to pay the assessments would be liable for a special excise tax equal to 5% of gross wages.

Employers with health care plans have assailed the pool proposal, arguing they would be forced to pay for health care coverage twice: once for their own employees and once for those covered by the pools.

While a similar proposal died last year in a conference committee, some say the proposal now has a good chance of passage.

"Congress likes proposals that expand coverage (and) that have no direct impact on the federal budget deficit," said James Klein, manager of pension and employee benefits at the U.S. Chamber of Commerce in Washington.

But business groups, like ERIC, are urging members to write to Senate Finance Committee members, where the proposal will be considered, and urge rejection of the pool proposal.

PBGC proposals

Most observers agree that Congress this session will pass legislation to shore up the finances of the PBGC, which currently has a \$4 billion deficit, but a consensus has yet to emerge on the bill.

"Clearly, there is momentum on the part of congressional staff and members to do something," said Edward J. Davey, a vp with John-

son & Higgins in New York.

But there is doubt that a key part of the PBGC/pension funding legislation—giving the PBGC authority to charge a variable-rate termination insurance premium rather than the current flat premium—will survive.

Under the variable-rate proposal, which is supported by the administration and a wide array of business groups, premiums would be based on the financial condition of a pension plan.

For example, under a proposal passed by the Ways and Means Committee, the PBGC annual premium would range from \$14 to \$50 per plan participant.

Plans that are less than 100% funded would pay an additional funding charge of \$5.50 per \$1,000 of underfunding, up to a maximum premium of \$50. Plans with fewer than 100 participants would pay only a \$14 premium.

By contrast, a measure approved by the House Education and Labor Committee would simply raise the current flat-rate PBGC premium to \$19 from \$8.50.

This approach is expected to be adopted by the Senate Labor and Human Resources Committee, observers say. The Senate Finance Committee is not yet far enough along on pension legislation to judge what proposal it will support.

Whether the PBGC can charge a variable- or flat-rate premium ultimately will be decided in a conference committee, and some experts are placing their bets that a variable-rate premium will not be approved by conferees.

"I don't think we will get a variable-rate premium. It is too radical, too different at this point," said Gerald Uslander, a principal in Mercer's Louisville, Ky., office.

But administration officials disagree. "I would bet that a variable-rate premium—similar to the Ways and Means Committee proposal—will be enacted. Members understand the equity in logic of a variable-rate premium," said David Walker, assistant secretary of Labor.

Opponents of a variable-rate premium, such as House Labor-Management Relations Subcommittee Chairman William L. Clay, D-Mo., say it would put too much financial pressure on those employers least able to afford a higher premium.

Business lobbyists also are concerned that Congress could end up including in the PBGC/pension bill provisions that would make it more difficult and expensive for employers to recover excess assets from overfunded pension plans.

For example, the Ways and Means bill would impose a 20% excise tax on reversions employers recover when terminating an overfunded plan, up from 10%.

And, the Education and Labor Committee proposal would require employers terminating overfunded plans to give participants a share of excess assets.

Under that proposal, an employer terminating an overfunded plan could recover only those assets exceeding 125% of plan liabilities, with plan participants getting the remaining 25%.

Some believe that the final bill will not contain any provisions on asset reversions because the issue has little connection with the basic problem of protecting the PBGC from a financial collapse.

"This is a separate issue and has to be dealt with separately," said Mr. Uslander.

But Mr. Klein says discouraging terminations is an easy issue for Congress to grasp and one that could have political appeal.

"Legislators could say: 'We helped stop pension plan terminations,'" Mr. Klein noted.

Product liability reform

House Commerce, Consumer

Protection and Consumer Protection Subcommittee staffers will meet this month to reach a consensus on product liability legislation introduced by Rep. Richardson.

If a consensus can be reached, the subcommittee and the full Energy and Commerce Committee could approve a bill sometime this fall, said Liberty Mahshigian, co-counsel for The Product Liability Alliance and an attorney with Crowell & Moring in Washington.

But the Richardson proposal already has drawn fire from Rep. Henry A. Waxman, D-Calif., an influential member of the Energy and Commerce Committee who has raised numerous objections.

Among other things, Rep. Waxman opposes as unfair to consumers provisions that would bar product liability suits after 25 years in accidents involving capital goods and abolishing the doctrine of joint and several liability for non-economic damages.

The measure still has not attracted sufficient support from congressional Democrats, noted Robert Vagley, president of the American Insurance Assn. in Washington. He added that the proposal faces opposition from powerful House leaders like Rep. Waxman and House Judiciary Committee Chairman Peter W. Rodino Jr., D-N.J.

Even if a product liability bill passes the House, it would then face Congress's most outspoken critic of product liability reform: Senate Commerce Committee Chairman Ernest Hollings, D-S.C.

But Ms. Mahshigian says committee members might put pressure on Sen. Hollings to schedule a vote on a bill if a reform measure clears the House.

Nuclear liability

Congress almost certainly will amend the Price Anderson Act, which limits the liability of the nuclear power industry in the event of a nuclear accident.

Technically, the current Price Anderson Act expired Aug. 1. However, a grandfather clause covers all operating nuclear power plants and those under construction, limiting the current liability of the nuclear power industry in the event of an accident to about \$700 million.

Tim Peckinpaugh, an attorney in the Washington law firm of Preston, Thorgrimson, Ellis & Holman who represents the nuclear insurance pools, said he expects Congress to renew the Price Anderson Act this fall, pointing out the differences between bills already passed by the House and a Senate panel "are relatively small."

Under the House bill, H.R. 1414, utilities could be assessed up to \$63 million per reactor, not to exceed \$10 million per year, to pay for nuclear accident claims and administrative costs that exceed insurance coverage (BI, Aug. 3). This maximum would be adjusted for inflation every five years.

If the total amount recovered from utilities does not cover claims and administrative costs, each reactor can be assessed an additional \$3.15 million, after which Congress would decide how to pay any remaining costs.

The House bill, sponsored by Interior and Insular Affairs Committee Chairman Rep. Morris K. Udall, D-Ariz., would extend the Price Anderson Act for 10 years.

The Senate's version, sponsored by Environment and Public Works Nuclear Regulation Subcommittee Chairman Sen. John B. Breaux, D-La., and Sen. Alan K. Simpson, R-Wyo., passed the Environment and Public Works Committee immediately before Congress' recess (BI, Aug. 10).

The Breaux-Simpson bill would raise the retrospective assessment per reactor to \$60 million, not to exceed \$12 million per year.

The Senate bill, which would extend Price Anderson for 30 years, indexes the maximum assessments to inflation each year. If claims exceed the amount raised by the assessments, Congress would have six months to determine how to handle additional claims. If a solution is not determined within that time, claims would be paid by a judgment appropriations fund established by the Treasury.

Disease notification

Congress also is expected to vote on high-risk occupational disease notification legislation this fall.

The legislation requires establishment of a Risk Assessment Board to determine when, where and what hazardous substance has been used in a workplace and the National Institute for Occupational Safety and Health to notify current and former workers that they are or have been exposed to the substance.

An employer that exposed workers to a hazardous substance would be required to pay for medical monitoring of current and past employees and the health costs associated with any resulting illnesses.

Also, if an employee's doctor requested, the employer would be required to transfer the worker to a position not involving the hazardous substance and pay him the same wages and benefits. An employer also could let the worker go after paying a severance benefit equal to one year's salary.

The Senate bill, S. 79, contains two provisions that the House bill, H.R. 162, does not.

The Senate bill says medical monitoring does not have to go back farther than 30 years, while the House bill does not specify a time limit. The Senate bill also exempts employers with 10 or fewer employees from having to transfer a worker to a different job, provided the hazardous substance is removed from the workplace.

It is likely that the legislation will pass Congress, although the vote in the House probably will be close, says Susan Spangler, associate director of loss prevention and control for the NAM.

Ms. Spangler noted that a substitute bill, sponsored by Reps. Paul B. Henry, R-Mich., and James M. Jeffords, R-Vt., will be offered on the House floor. The proposal mandates expansion of the Occupational Safety and Health Administration's hazard communication standard to cover all employers.

McCarran-Ferguson Act

A Congressional vote to amend the McCarran-Ferguson Act is unlikely this fall, observers say.

Tom O'Day, associate vp of the Alliance of American Insurers, noted the Senate Judiciary Committee will address the Supreme Court nomination of Robert Bork when it reconvenes, which could delay action on amendments to McCarran-Ferguson.

Mr. O'Day added, however, that Sen. Howard Metzenbaum, D-Ohio, who is sponsoring legislation to amend McCarran-Ferguson, "doesn't give up easily."

Under the Metzenbaum bill, insurers' would no longer have a limited exemption from federal anti-trust law, but insurers would be allowed to jointly collect and exchange some data on paid claims and reserves and band together to provide coverage through pools (BI, June 8).

On the House side, Mr. O'Day predicts the Judiciary Committee will hold more hearings on the act.

"Some of the steam has been taken out of the national push" to amend the act, but "the issue is still there," he concluded.

Robert Hunter, president of the National Insurance Consumer Organization, in Alexandria, Va., predicts the full House will address the issue by year-end.

GENERAL AGENT (WHOLESALE) TRUCK PROGRAM

Admitted and non-admitted markets available to established GA, MGA and E + S Brokers with established transportation book of business.

Richard D. Slautterback
Chairman
Telex: 80-4319

1-800-647-3769


AMERICAN TRUCK
UNDERWRITERS, INC. ©
P.O. Box 105257 Atlanta, GA 30348

© 1987 American Truck Underwriters, Inc. ®
All Rights Reserved

Effective communication of
Benefit Plans is

Critical!



Learn *Why* and *How* at

1987 Benefit Communication Institute

October 4-7, 1987

Williamsburg Hilton and National Conference Center
Williamsburg, Virginia

Because effective communication is a critical element of
employee benefit plan management and administration.

Program Topics Include

- Maximizing Your Benefit Communication • Workshops—Specialty Applications • Attorney's Heaven—Communicator's Nightmare • Retiree Communications • Future Trends/"High Tech" Communications

For information and registration call: (414) 786-6700 and ask for the
Registration Department.

Presented by the
International Foundation of Employee Benefit Plans



Broker results

Continued from page 1

nitude of pricing changes in the past three to four months," added analyst Thomas G. Rosencrants, senior vp of Johnson Lane Space Smith & Co. Inc. in Atlanta. "Their expense budgets did not anticipate this. They were pretty much on target in the first quarter, but the second quarter caught them by surprise."

"It is clear that they have to act faster this time around," said Harvey H. Bundy III, a partner at William Blair & Co. in Chicago. He pointed out that Corroon & Black Corp. has "the most specific expense control program that I've heard expounded by any of the brokers."

"Basically the cost controls we're putting in are just good business sense (for) approaching the soft market," said Robert Cuthbert, vp and controller at New York-based Corroon & Black.

"We're going right down every line item of expenses—advertising, accounting procedures, temporary help, capital expenditures and professional fees—all the way down to postage and overnight deliveries," he explained.

"If any positions can be consolidated or eliminated, we will do so, but we are more likely to do this through attrition. Hiring of support staff will really have to be justified," Mr. Cuthbert added.

Frank B. Hall—whose chairman, John F. McCaffrey, resigned last month because of differences of opinion with his successor, financier Saul P. Steinberg, over how to improve the company's performance—is implementing the most stringent expense measures of the public brokers, according to John Addeo, senior vp of finance for the Briarcliff Manor, N.Y., broker (BI, Aug. 3).

"There will be reductions in staff across the board. We've already begun the process and by the end of this quarter we will have completed it," Mr. Addeo said, stressing that Hall plans to keep the staff cuts to a level where "we can still provide the level of service to our clients that we did before."

However, he predicted that in cases in which cuts involve producers who are generating low volumes of business, the brokerage may lose some accounts that "follow those producers."

The expense controls put in place by A&A include "selected hiring freezes and reduced salary increases," said Peter M. Densen, A&A's senior vp and chief of staff in New York.

"Early this year, we began to focus on this problem and we began to take action in the first quarter," he said.

"We are being very careful and we're trying to make the reductions in areas where it won't affect client service," Mr. Densen said, adding that the financial impact of expense controls employed by A&A should "begin to show in the second half."

Michael A. Smith, research analyst with Shearson Lehman Brothers in New York, agreed that expense controls take awhile to show up on a brokerage's bottom line.

"Expenses are like a locomotive. They take a long time to slow down and bring to a stop," he said.

Tampa, Fla.-based Poe & Associates has attempted "since the end of the first quarter to appropriately contain expenses," said Chairman William F. Poe.

However, Poe is finding it difficult to isolate the effects of the competitive market from other problems, he said. The brokerage also faces market problems in Florida created by the insurance and tort reform law passed last year, "and a shift to claims-made from occurrence forms that is still taking place on some of our professional liability lines that results in a substantial decrease in first-year revenues," Mr. Poe said.

This multiplicity of problems "clouds the issue and makes it hard to anticipate what the next six months will bring," Mr. Poe added.

Executives of the other publicly held brokers—Marsh & McLennan Cos. Inc., Arthur J. Gallagher & Co. and Hilb, Rogal & Hamilton Co.—say they have been examining expenses on an ongoing basis.

The "rigors" of the expense controls "we went through in the last soft market have been applied consistently in the past few years," said J. Michael Bischoff, vp-corporate development group for M&M in New York.

"We have maintained the same type of awareness of our costs and were attentive to this issue even during strong market conditions."

"Costs controls have continued to be monitored and will continue as market pricing begins to slope," echoed Michael Cloherty, vp of finance for Gallagher in Rolling Meadows, Ill.

"We are on a continuous cost control program," said Robert H. Hilb, president of Richmond, Va.-based Hilb, Rogal & Hamilton. "This issue becomes more important as premiums may dwindle."

Hilb, Rogal & Hamilton, the 12th-largest U.S. broker, is the newest member of the public brokers, having completed its public offering July 15.

All of the publicly held brokerages are focusing on new business growth and retaining accounts to attempt to maintain revenue growth in the changing market.

M&M, the world's largest broker, reported the strongest revenue growth of all the publicly held brokers in both the first half and the second quarter.

M&M's gross revenues grew 22.4% in the first half of 1987 to nearly \$1.1 billion from \$897.6 million in the first six months of 1986. Net income during the same period grew 32.5% to \$171.8 million from \$129.7 million.

During the second quarter of 1987, M&M's gross revenues

grew 18.9% to \$539.1 million from \$453.4 million in the second quarter of 1986. Net income for the quarter was \$78.9 million, up 22.1% from \$64.6 million.

"Marsh has had an excellent history of new business development in the insurance brokerage arena in all phases of the market," Mr. Bischoff explained. "Clients have come to us in every change of the cycles. We have not had to incorporate any new approaches."

William Blair's Mr. Bundy agreed. "What's impressive is Marsh & McLennan's ability to maintain new business gains and to keep expense growth slower than revenue growth," Mr. Bundy said.

M&M is "clearly the premier broker out there," Shearson's Mr. Smith said.

Since much of M&M's retail business is "compensated by fees, they have insulated themselves more from rate changes, and they keep bringing in big and small accounts," Mr. Keefe said.

"I continue to be quite optimistic about M&M's ability to retain its growth margins," added Mr. Rosencrants of Johnson Lane.

M&M's revenues were: up 13% in insurance brokerage operations; down 4% in reinsurance brokerage operations; up 12% in group associates business; up 45% in benefit consulting; and up 56% in investment management, Mr. Bischoff said, adding that acquisitions—including the purchase of A.S. Hansen Inc.—generated the bulk of the benefit consulting growth.

Alexander & Alexander reported first-half gross revenues of \$564.2 million, an 8.7% jump from \$519.0 million in the first six months of 1986. First-half net income rose 1.4% to \$42.3 million from \$41.7 million.

A&A's second-quarter gross revenues grew 9.5% to \$294.7 million from \$269.2 million in 1986. Net income for the quarter grew 29.7% to \$27.9 million from \$19.6 million.

About \$11.5 million of A&A's second-quarter net income was related to the sale of two office buildings located in the United Kingdom. However, Mr. Densen stressed that results for the quarter were "roughly in line with what we expected. We think it is a credible performance."

A&A compiled "strong growth in reinsurance and in employee benefits services. We are still seeing very large new business growth, but we're (also) still seeing... people switching brokers. We need to work on retention," Mr. Densen said, noting that competition causes clients to shop around at renewal time.

Mr. Rosencrants said he is concerned that A&A "is suffering from much more rapid expense growth than revenue growth. Expense controls surely will help, but the unanswered question is will they be sufficient enough to eliminate the substantial margin erosion?"

A&A's second-quarter figures "looked quite a bit better" than the first quarter's, Mr. Keefe said. "If they can come up with a couple of new-business quarters like the second, they should be in OK condition."

A&A was "hard-hit last year, particularly in the second half, because they are major players in oil pack business. Now, they are getting a little business back there," Mr. Smith commented. But A&A will not "see the real benefit" of expense controls until year-end, he added.

Frank B. Hall's revenues increased a meager 0.8% in the first half to \$202.2 million from \$200.7 million in the first half of 1986. Hall's net income fell 60% in the first half of 1987 to \$5.6 million from \$13.9 million in the first half of 1986.

Hall's second-quarter revenues totaled \$96.6 million, a 3.5% decrease from \$100.1 million in the second quarter of 1986. Hall reported a second-quarter net loss of \$2.2 million, compared with \$4.8 million in net income in the second quarter of 1986.

Hall's 1986 results were restated following its decision earlier in the year to treat subsidiaries Adjustco Inc. and Frank B. Hall of California's Stockton division as discontinued operations (BI, March 23).

Mr. Addeo said with the omission of Adjustco and the Stockton division, "we're 99% back to being a retail property/casualty broker and employee benefits consulting company, which is where we want to be."

Hall's second-quarter results were "slightly under expectations" for three reasons, he said: the softening of property/casualty insurance rates; account attrition due to market competition and, to a lesser extent, litigation pending against Hall; and lagging new business efforts.

Hall faces several lawsuits, including at least three actions seeking damages stemming from the collapse of Union Indemnity Insurance Co. of New York, a Hall-owned insurer now in liquidation, and several shareholder suits (BI, Aug. 10; June 22).

While they concede that Hall may recover from its problems, analysts underscored the seriousness of the problems it faces.

"Hall has been somewhat of a disaster," said Shearson's Mr. Smith. "I think Hall will recover under Saul Steinberg's tenure, but it will require time and additional capital. I think current shareholders will have to pay for that."

"Hall may not be terminal, but it's in trouble," Mr. Bundy added.

Corroon & Black's first-half revenues rose 11.3% to \$185.0 million in 1987 from \$166.2 last year. First-half net income, though, fell 8.2% to \$18.7 million from \$20.4 in 1986.

The decrease in net income was attributable to a first-quarter \$4.7 million charge for discontinued operations for its share of the cost of a settlement between Lloyd's of London and members of loss-riddled Lloyd's syndicates formerly managed by PCW Underwriting Agencies Ltd., a now-defunct subsidiary of Lloyd's broker Minet Holdings P.L.C. Corroon & Black holds a 25% equity interest in Minet.

Under the settlement offer, which was accepted by 98.4% of the PCW names, Minet will contribute 11.65 million pounds (\$18.4 million) toward the settlement (BI, June 29).

For the second quarter, Corroon & Black reported a 7.1% increase in gross revenues to \$87.8 million from \$82 million in the second quarter of 1986. Net income rose 2.6% to \$9.4 million from \$9.2 million.

"We weren't totally pleased with our second quarter," Corroon & Black's Mr. Cuthbert said, attributing problems to the "tremendous erosion in the marketplace. It turned so rapidly."

However, "Our account retention has been good and we haven't seen an increase in lost business," he said.

Corroon & Black's "results were a little lower than I'd anticipated and clearly lower than they had anticipated," said Shearson's Mr. Smith, predicting expense control measures will not show up in the brokerage's results until next year.

"Slower revenue growth is causing a decline in Corroon & Black's operating profits," said Mr. Bundy, but he feels expense control measures will help in the second half.

Arthur J. Gallagher reported first-half revenues of \$60.9 million, a 9.5% increase from \$55.6 million in the first half of 1986. Net income decreased 11% to \$6.2 million from \$6.9 million.

Gallagher's gross revenues grew 9.8% in the second quarter to \$29.3 million from \$26.7 million in the second quarter of 1986. Second-quarter net income rose 10.7% to \$2.7 million from \$2.5 million.

"This is absolutely a buyer's market, which has impacted our revenue growth. But our new business this year has been very, very strong," said Mr. Cloherty.

"Our biggest growth has been in risk management services, and the fastest growing new production is in our stand-alone services," explaining that Gallagher began to offer unbundled risk management and claims administration services to clients "who do not use Gallagher as their broker" earlier this year.

Mr. Rosencrants said he had "faith in the management of Gallagher because of their long-term record," pointing out that 1981 was the only time in the past 22 years that the brokerage "did not show revenue growth. They are working hard on new business and I expect them to report substantially improved earnings in the second half."

Mr. Bundy said Gallagher's results show "a complete reversal of its first quarter numbers. I don't know if they can keep this up."

Gallagher's first-half results are probably "more indicative than either quarter," he added.

Hilb, Rogal & Hamilton reported revenues rose 21.2% in the first half to \$18.4 million from \$15.1 million last year. First-half net income grew 92.1% to \$1.8 million from \$940,000.

In the second quarter, HRH's gross revenues grew 11.5% to \$8.6 million from \$7.7 million in the second quarter of 1986. Net income for the quarter rose 31.9% to \$554,000 in 1987 from \$420,000 in 1986.

"Our performance for the first six months of the year is on target and satisfactory," Mr. Hilb said.

Because of a 90-day moratorium imposed by the Securities and Exchange Commission on financial commentary by newly public companies, Mr. Hilb could not talk in-depth about the brokerage's performance.

Mr. Rosencrants, the only analyst contacted who is currently tracking Hilb, Rogal & Hamilton, said he was "very excited about the prospects for this company. I am delighted to see another good, high-class broker become public."

The brokerage's mix of business and geographic concentration "in cities that are not only rapidly growing" but also lack the presence of many other major brokers will help Hilb, Rogal & Hamilton in new business development, he said. "They have positioned themselves very well."

Poe & Associates, the smallest of the public brokers, reported first-half revenues of \$16.1 million, a decrease of 0.6% from \$16.2 million in the first half of 1986. Net income dropped 21.8% during the first half to \$1.8 million from \$2.4 million.

Revenues for the second quarter dropped 4% to \$7.7 million from \$8 million in the corresponding period of 1986. Net income dropped 44.4% to \$660,000 from \$1.2 million.

Mr. Poe said the expense control measures Poe & Associates has enacted will "probably begin to show in the second six months." The brokerage currently is focusing its efforts on new business production, he added.

No analyst contacted tracks Poe's financial results.

Chicago-based Rollins Burdick Hunter Co., a subsidiary of publicly traded Aon Corp., the former Combined International Corp., reported a 26.1% increase in first-half commissions and fees to \$101.8 million. It also reported that commissions and fees rose 28.9% in the second quarter to \$52.5 million.

RBH's gross revenues and net income are not reported separately from its parent corporation.

"Obviously we are pleased" with both RBH's second-quarter and first-half results in "these tough, competitive times," said Harvey N. Medvin, Aon's chief financial officer. He added that a series of acquisitions made by RBH in the latter half of 1986 "seem to be working out favorably for us."

The 'rigors' of the expense controls 'we went through in the last soft market have been applied consistently in the past few years,' says M&M's J. Michael Bischoff.

The expense controls put in place by A&A include 'selected hiring freezes and reduced salary increases,' says Peter M. Densen, A&A's senior vp and chief of staff.

Pollution rulings

Continued from page 2

premature to rule on whether the insurers owed a duty to indemnify.

In his decision, Judge Eugene P. Spellman first rejected insurer arguments there was no coverage because there was no "occurrence" under the policies.

The policies provided the insurers will pay damages stemming from bodily injury or property damage caused by an "occurrence," which is defined as an accident "neither expected nor intended" by the policyholder.

"From the insureds' point of view, the release of PCBs into the environment was not the natural and probable result of their business activities," Judge Spellman said. "Plaintiffs are in the business of recovering scrap metals, not disposing of toxic wastes. 'The release of PCBs into south Florida's aquifer underlying plaintiffs' own property and the property of adjoining owners was undoubtedly the unexpected or unintended result of the intentional acts which comprised their business' daily operations. Such an event is an 'occurrence.'"

The court also rejected insurer arguments that there was no coverage under the pollution exclusion clause. This clause provides that discharges or releases into the environment are not covered unless they are "sudden and accidental."

The insurers argued that because Pepper's and Mr. Bloom were "active polluters," the pollution was neither sudden nor accidental.

However, the court said because the release of the PCBs was neither expected nor intended, it was "sudden and accidental."

"Plaintiffs intentionally caused the dumping of oil, but the release of PCBs into the aquifer was . . . an unintended result from the plaintiffs' point of view," the judge

said. Finally, the court held coverage was not barred by an exclusion for damage to property owned or controlled by the policyholder.

"This exclusion is not applicable insofar as the underlying complaints allege damage to the property of adjoining landowners and the public," the court said.

"This court holds that where the property damage alleged constitutes damage to the environment, in this case the Biscayne Aquifer and the underlying waters which are the very source of the drinking waters for much of south Florida, such property in truth belongs not to the plaintiffs, but rather to the state and the citizens thereof."

Last week, an attorney for Pepper's said the decision was "favorable to policyholders," noting the ruling not only provides for a defense but is sufficiently broad so that there likely will be indemnification for Pepper's.

"This decision confirms what policyholders' expectations are—that is, if an intentional act and the specific harm caused was not intentional, comprehensive general liability policies will be available to indemnify them for that loss," said R. Hugh Lumpkin, with the Miami firm of Keith, Mack, Lewis, Allison & Cohen.

An attorney for CNA and officials at USF&G had not yet seen the decision and declined comment. An attorney for The Home could not be reached for comment.

The AMICO vs. General Host decision dealt with whether coverage existed for suits filed by neighboring landowners against American Salt Co., a General Host unit that operates a salt company in Lyons, Kan.

The landowners claimed beginning in 1977 that because of American Salt's careless operation of its plant, tons of salt brine polluted the environment, resulting in

the aquifer becoming unfit for irrigation purposes. According to the decision, the salt pollution took place over 50 to 75 years.

The landowners were awarded \$3.06 million in actual damages and \$10 million in punitive damages in an underlying case.

AMICO, a Kemper Group unit, wrote CGL policies for Stamford, Conn.-based General Host between Nov. 1, 1981, and June 15, 1985. Although the policies were manuscript, the language at issue was the standard pollution exclusion found in most CGL forms.

In 1984, AMICO sued American Salt and General Host in a declaratory judgment action for a determination of coverage.

Similar to the Pepper's case, the court in the AMICO case analyzed the policy language applying to occurrence and pollution incidents, but came to a different conclusion.

AMICO argued that because the discharges by American Salt into the environment were "sudden and non-accidental," there was no coverage for defense or indemnification costs.

However, General Host argued it was inappropriate to decide the case on a summary judgment motion because the pollution exclusion clause was ambiguous, because the "unexpected and unintended" portion of the "occurrence" definition must be decided from the standpoint of the policyholder and because additional factual information was required.

But, Judge Frank G. Theis ruled the pollution exclusion clause is not ambiguous and that General Host and American Salt were not entitled to coverage.

Judge Theis relied on an earlier court use of dictionary definitions for the "sudden" and "accidental" language in the policy.

That court defined "sudden" as "happening without notice or very brief notice; unforeseen; unexpected; or unprepared." It defined "accidental" as happening unexpectedly or by chance.

Applying these definitions to the facts in the underlying cases, Judge Theis said the pollution could not be considered "sudden."

"No use of the word 'sudden' or 'suddenly' could be consistent with an event which happened gradually or over an extended time, nor could it be consistent with an event which was anticipated or predictable," Judge Theis said.

"Defendants have not explained how the 50 to 75 years of salt pollution can be characterized to fit under the objective definition of 'sudden.'"

"The court . . . cannot conclude that the pollution exclusion clause is ambiguous," Judge Theis said. "The language is clear and plain, something only a lawyer's ingenuity could make ambiguous."

He added that even those courts that rule coverage should be provided because of ambiguity in the policy would not make that ruling under the facts of this case.

These courts found that even intentional discharges were "neither expected nor intended," because the occurrence clause dealt with whether the "damage" was expected or intended and not the discharge or dispersal.

"To argue that the damage resulting from defendants' discharge of salt was unexpected or unanticipated by them is unsupported," he added.

Alfred K. Kenyon, Kemper's senior vp-claims, said in a statement the ruling "encourages us to stand fast in defense of the standard pollution exclusion."

Robert Kuhbach, General Host's general counsel, said the company was reviewing the decision and had not yet decided if it would appeal. He also said the company believes it is entitled to coverage under the policies based on the facts and situations during the policy years.

update

Ambassador review sought

Continued from page 2

Whinney, \$131,141; Warren, McVeigh, Griffin & Savage, \$30,402; Independent Actuarial Services of Connecticut Inc., \$48,080; and Sheehey, Brue & Gray, \$45,628.

"The applicant (Ambassador Group Inc. and Ambassador Insurance Co. Inc.) did not act in good faith for the benefit of policyholders, claimants and creditors when it sought to reduce its stated reserves by negotiating downward loss claims of these beneficiaries by taking advantage of the impaired financial condition of the company in hopes that something might ultimately be left over" to form a new insurance company, Judge Meaker said in a June 29 decision.

Judge Meaker also rejected Ambassador's numerous allegations of misconduct against the agent for the receiver, George K. Bernstein, a Washington, D.C., attorney.

Judge Meaker accepted the final accountings submitted by Vermont insurance commissioners during the liquidation proceedings.

The liquidation is continuing, although Vermont's high court also is considering whether the liquidation order should be reviewed.

Ambassador is insolvent by about \$100 million.

National Gypsum settles claims

DALLAS—National Gypsum Co. has agreed to pay \$8.4 million to approximately 155 school districts in 19 states that sued to recover the costs of removing asbestos materials in their buildings.

In addition, 25 other schools and school districts will pursue their claims against the asbestos maker through a national class action suit pending in federal court in Philadelphia—not through individual lawsuits, the company said.

The settlement was charged to reserves created from the proceeds of a settlement with one insurer and National Gypsum funds.

National Gypsum is in litigation with other insurers in U.S. District Court in New York over coverage for property damage claims.

Robins OKs Rorer merger

RICHMOND, Va.—A.H. Robins Co.'s board of directors approved a definitive agreement to merge with pharmaceutical manufacturer Rorer Group Inc. of Fort Washington, Pa. (BI, July 6).

The proposed \$2.6 billion merger and a reorganization plan due Aug. 21 must be approved by the U.S. Bankruptcy Court.

Details of the merger were not disclosed, but a letter of intent signed last month said Rorer would establish two trusts totaling \$1.75 billion to pay claims filed by women injured by the Dalkon Shield intrauterine device formerly manufactured by Robins.

Robins filed for reorganization in August 1985 because of an overwhelming number of claims filed by Dalkon Shield users.

Tennessee licenses Hypercept

NASHVILLE, Tenn.—The Tennessee Department of Commerce and Insurance has given license approval to Hypercept Insurance Co., an association captive insurance company that will specialize in environmental impairment liability coverages.

The captive is a joint-venture between Monticello, N.Y.-based Rhulen Agency Inc. and Aralie Inc., a risk management consulting firm specializing in EIL insurance in Pequannock, N.J.

The facility will be capitalized by one-time assessments of members equaling three times the first-year premium, payable as one-third cash and the remainder as a letter of credit. The average premium is estimated at \$100,000, while the minimum premium will be \$25,000. The average deductible will be \$25,000.

Hypercept, which has 35 paid participants, will write a claims-made policy covering both sudden/accidental and non-sudden/gradual pollution. Limits eventually will be \$3 million per claim with a \$6 million annual aggregate. The captive will specialize in small to medium-sized manufacturers, distributors and service firms with similar environmental exposures.

OSHA sets toxic waste rules

WASHINGTON—The Occupational Safety and Health Administration has proposed rules to protect the almost 1.2 million workers who could be exposed to hazardous waste materials.

The proposed rules cover site analysis, training, medical surveillance, personal protective equipment, engineering controls, maximum exposure limits, information programs, materials handling, new technology programs, decontamination procedures and emergency response.

OSHA estimates the annual cost of compliance to be about \$148 million, with \$71 million of that for training.

About 1.12 million workers covered by the rules are firefighters; the remainder treat, store and dispose of hazardous materials.

The deadline for comments on the proposal is Oct. 5.

Briefly noted

President Reagan signed into law an omnibus banking bill barring federal regulators until March 1, 1988, from granting banks broader authority in the insurance, real estate and securities industries (BI, Aug. 10). . . . The U.S. Court of Appeals last week upheld a 1985 jury verdict against New York-based CBS Inc. awarding \$2.05 million in punitive damages to Louisville, Ky.-based Brown & Williamson Tobacco Corp. The court also reinstated \$1 million of the \$3 million in compensatory damages assessed against CBS for libeling the cigarette maker in a 1981 anti-smoking commentary by Chicago anchorman Walter Jacobson, who must pay \$50,000 of the punitive damages. . . . Stewart Wrightson Holdings P.L.C. shareholders representing more than two-thirds of the company's share have approved Willis Faber P.L.C.'s purchase of the company. However, Willis Faber has extended the deadline for accepting the offer until Aug. 21.

insurance services guide

NEED SPECIAL REPORTS? OFFERING A NEW PRODUCT?

For experienced insurance data processing support call or write:

Sandra Lowry
P.O. BOX 744 / LONDONDERRY, NH 03053
(603) 437-5731

Excellent references / Reasonable rates

ENVIRONMENTAL CLAIM AUDITS & RISK ASSESSMENTS

ACTUARIAL CONSULTING

Financial Evaluation of Environmental Losses

TILLER CONSULTING GROUP, INC.
2833 N. Geyer Road / St. Louis, MO 63131-3320 314/567-7480

TOXIC CHEMICALS HAZARD IDENTIFICATION ENVIRONMENTAL IMPACT INVESTIGATION AND EXPERT TESTIMONY

HAROLD I. ZELIGER, Ph.D.
CHEMICAL & ENVIRONMENTAL SERVICES
18 Spring Hill Terrace
Spring Valley, NY 10977
(914) 356-9448

DENTAL CLAIMS MANUAL

All-Inclusive 402 Page Manual
Featuring All Major Specialties
(213) 681-3300

J.P. Kennedy Publishing Co.
776 E. Green Street
Pasadena, CA 91101

HEALTH CLAIMS COMPUTER SYSTEM FOR IBM PC XT/ AT

Eligibility & Benefits Calc., Checks, EOB's, Correspondence, Provider Utilization Reviews, & More. Ideal For Self Insured's & TPA's. Single and Multi-User Versions Available

INSTALLATIONS COAST TO COAST ALL FUNCTIONS AND STATE FORMS

Insurance Software Packages, Inc.
5118 NORTH 56TH STREET
TAMPA, FLORIDA 33610
(813) 621-6069 (FL)
(800) 237-8133 (U.S.)

Use the Insurance Services Guide to reach your best prospects.

The Risk Manager's #1 Reference

Practical Risk Management

"The Professional's Handbook"

Send \$275 (\$10 more if we bill; add postage overseas)

To: **Practical Risk Management**
P.O. Box 10093
Oakland, CA 94610
Telephone (415) 653-3637

For advertising information in the INSURANCE SERVICES GUIDE Contact: Margaret Hukdo, 740 N. Rush Street, Chicago, Illinois 60611 Telephone (312) 649-5340

Brokers must take steps to sustain profit margins

By **LEONARD M. WILSON**
Special to Business Insurance

IF THERE ARE any optimists about the direction of commercial property/casualty insurance premium rates, they may have second thoughts after seeing the second-quarter results for the publicly owned insurance brokers. Each of the five companies we track have posted earnings modestly below expectations. Profit margins also slipped, a sure sign that all is not well with commercial insurance pricing.

U.S. direct insurance brokerage results tell the story. The average gain in second-quarter commissions amounted to an estimated 5%. Frank B. Hall & Co. Inc. posted lower commissions, which brought down the average. Three brokers, including Marsh & McLennan Cos. Inc., recorded single-digit commission growth, a far cry from the powerful rise of last year. Alexander & Alexander Services Inc.'s domestic commissions advanced about 10%, the best of the group.



Mr. Wilson

Interestingly, we do not believe much has changed in the variables that influence commission growth except for premium rates. New business continues to be robust despite the softening in the market. Perhaps new business was easier to get a year ago, but apparently producers are working diligently to sustain the flow.

Loss business is a little higher than the historical average for the public brokers. The surge in new business over the past three years may have introduced a slightly greater degree of turnover in brokers' client base. But lost business has not escalated materially in recent years.

Therefore, the swing in performance clearly is attributable to rates. While it is impossible to be precise about the extent of rate competition, contacts suggest property insurance rates are declining 15% to 20% and liability rates are dropping 5% to

10%—with an increasing number of anecdotes about major price reductions. The increased willingness of underwriters to quote is another sign of easing in the market.

Reinsurance brokerage has lost its momentum as well. This business segment grew faster than primary insurance brokerage in both soft and hard markets over the last decade. Now the underlying growth rate in reinsurance commissions seems to have slipped beneath that of primary brokerage. Higher retentions by ceding companies is the explanation. Premium rates in treaty reinsurance seem to be stable.

Soft rates in primary markets and higher retentions that affect demand for reinsurance both reflect the same phenomenon: increased capacity at the primary level.

Single-digit commission growth is a recipe for profit margin erosion. Expenses in insurance brokerage grow at an embedded rate of around 10% to 15%, depending upon a broker's employee growth, the inflation rate and management initiatives. In periods of rapid commission gains, costs will expand more rapidly than the embedded range. When the year-over-year commission gain recedes to less than 10%, profit spreads come under pressure. Second-quarter results attest to this relationship.

Brokers started 1987 with the view that premium rates over the course of the year would be neutral to mildly positive. Budgets now have to be adjusted to recognize the more sober reality of a deteriorating market. Managements have now begun to gear up for tougher times. Cost controls are being tightened to reduce the year-over-year pace of expense increases.

It takes time, though, to achieve the desired effect. Two—and more likely three—quarters will elapse before new expense guidelines are fully implemented throughout the organization. This raises the specter of profit margin erosion for upcoming quarters over the balance of 1987. If market softening continues in 1988, which is a genuine possibility, closer attention to costs should arrest the narrowing in margins.

We have a sense of *deja vu* about the slippage in profit margins. During the last soft market, profitability suffered for most of the public brokers. Many were late in gearing costs to the marked slowdown in revenue growth. This lagged response probably is rooted in the normal human tendency to be optimistic. When markets are tight and

rates are rising, disciplines are inevitably eased. Head count moves up, incentive formulas kick in, budgets become more generous across the spectrum of cost categories. It becomes difficult to justify an ethic of tight cost control.

When soft markets arrive, they do so without fanfare and often sooner than expected. Usually, it takes several quarters of soft rates before there is a consensus on the true nature of the market. Then a shift in organizational attitudes requires a further period of conditioning. The upshot is a lagged response to a slowing in revenue growth and profit margin pressure.

We do not want to paint an overly gloomy picture, though. Brokers' earnings performance still will benefit from a lower corporate tax rate, growth in employee benefits revenues, rising contingent commissions, the continuing thrust for new business and higher investment income.

There may be considerable variation, however, in the performance of individual brokers, a condition that has been noticeable for several years.

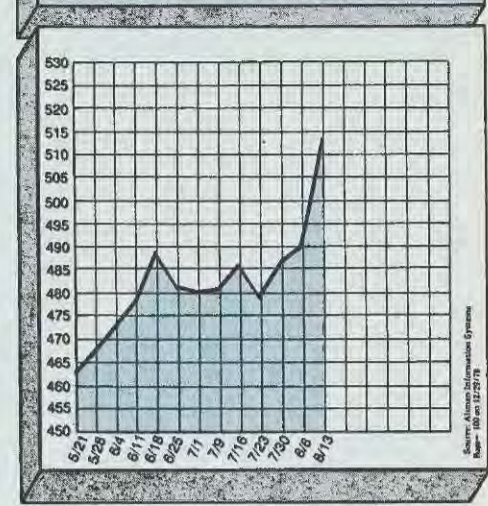
How long and how deep are the burning questions for most observers of the property/casualty insurance business? Past experience indicates that no one really knows. Underwriters have tended to downplay the severity of recent rate competition. Brokers have seemingly been more objective.

The hypothesis that this cycle will not degenerate into chaotic price competition draws strength from a lower level of interest rates and restrained reinsurance capacity. We receive no comfort from a widely held view that improvements in underwriter information systems will contain price cuts.

For the brokers, the twin safeguards to earnings progress in a soft market are new business and cost restraint. The new business record is reassuring, even allowing for the greater difficulty in securing new business during soft markets when professional skills often count for less in the clients' eyes.

The results of cost restraint will be delayed a few quarters, but there is no inherent reason why expenses cannot be geared to the growth in revenues, at high single-digit levels. If we are right, then the public brokers should be able to sustain their profitability in this cycle. Brokers will have to adopt the view that the soft market is only in its early stages, and therefore manage with appropriate discipline.

BI Insurance Index



Insurance industry stocks soared with the rest of the market as the *Business Insurance* stock index climbed to 522.8 on Aug. 13, up 22.3 points from 493.6 on Aug. 6. The stocks posting the biggest gains during the rally included Torchmark Corp., up 16.5%; Fireman's Fund Corp., up 15.6%; Kemper Corp., up 12.6%; W.R. Berkley Corp., up 11.9%; and Nobel Insurance Ltd., up 11.8%. The companies that lost the most ground were: Baldwin & Lyons Inc., down 10.0%; Business Mens' Assurance Co., down 7.0%; AVEMCO Corp., down 3.1%; Zenith National Corp., down 2.2% and Argonaut Group Inc., down 1.9%. The most active insurance stocks included Aetna Life & Casualty Co., ITT Corp., USF&G Corp., General Re Corp., American International Group Inc., Kemper Corp., Fireman's Fund Corp., Travelers Corp. and American General Corp. The *Business Insurance* stock index jumped 3.9% during the trading period, roughly on par with the major stock averages. The Standard & Poor's 500 advanced 3.9%; the Dow Jones 30 Industrials rose 3.7%; and the NYSE composite increased 3.6%.

British Issues

Aug. 11 Companies	Price	P/E	Div. pence	Yield %	1 Week High-Low	
					High	Low
Comm'l Union	359	12.4	17.8	5.0	365	344
Gen'l Accident	1025	11.1	38.3	3.7	1025	983
Gdn Royal Exch	1006	12.6	46.5	4.6	1006	952
Royal	536	9.1	21.2	4.0	554	533
Sun Alliance	1025	11.8	32.2	3.1	1050	1012


Brokers	Price	P/E	Div. pence	Yield %	1 Week High-Low	
					High	Low
CE Heath	503	15.0	34.5	6.8	508	488
Hogg Robinson	225	12.5	15.7	4.3	232	219
JH Minet	388	12.7	12.9	3.3	408	382
Sedg Grp	313	14.2	16.4	5.3	325	304
Stew Wrightson	573	17.7	17.8	3.0	604	588
Willis Faber	398	14.0	14.8	3.7	408	390

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

Aug. 13, 1987 8/7/87 thru 8/13/87

Company	Exchange	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Company	Exchange	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
					High	Low												High	Low						
BROKERS																									
Alexander & Alexander Svcs	NYSE	25.88	2.0	-2.3	32.00	22.38	942	1.00	3.9	22.9	2.62	9.88	Continental Corp.	NYSE	47.75	4.1	6.7	73.50	53.75	955	1.68	2.5	9.5	1.54	43.83
Baldwin & Lyons Inc.	OTC	18.00	-10.0	-18.2	27.00	18.25	0	0.20	1.1	7.2	16.40	1.10	Kemper Corp.	OTC	32.50	0.0	17.5	54.88	40.38	1279	2.60	5.4	9.5	41.62	1.15
Corroon & Black Corp.	NYSE	31.75	3.3	-2.7	37.25	26.63	183	0.84	2.6	14.8	5.39	5.89	Durham Corp.	OTC	50.00	10.5	29.0	34.00	27.38	6	0.92	2.8	21.2	39.22	0.83
Gallagher Arthur J & Co.	OTC	21.00	0.0	-20.0	31.00	19.00	131	0.40	1.9	15.8	4.81	4.37	Farmers Group Inc.	OTC	50.25	38.75	942	50.25	38.75	942	1.20	2.4	15.2	19.95	2.51
Hall Frank B. & Co.	NYSE	11.38	2.2	-21.5	19.00	8.75	266	0.00	0.0	15.8	0.00	N/A	Fireman's Fund Corp.	NYSE	39.88	15.6	13.5	42.75	33.50	1925	0.40	1.0	15.2	23.55	1.69
Marsh & McLennan Cos. Inc.	NYSE	69.75	8.3	14.8	71.88	56.00	1214	2.40	3.4	18.1	5.15	13.54	Fremont Gen Corp.	OTC	17.75	0.7	10.0	20.50	14.75	314	0.60	3.4	15.2	0.00	N/A
Poe & Assoc Inc.	OTC	11.75	0.0	-2.1	13.25	11.75	0	0.00	0.0	18.1	0.00	N/A	Home Group Inc.	AMEX	18.50	2.8	-11.9	24.88	17.50	835	0.20	1.1	4.0	16.36	1.13
AVERAGE			0.8	-7.4					1.8	15.7			Hanover Ins Co.	OTC	35.50	10.9	11.8	36.88	29.50	164	0.36	1.0	8.1	20.22	1.76
CONGLOMERATES & HOLDING COMPANIES																									
Berkley W.R. Corp.	OTC	28.25	11.9	7.6	37.00	24.25	468	0.28	1.0	8.0	14.08	2.01	Hartford Steam Boiler	OTC	32.25	8.8	36.8	36.63	23.50	247	1.00	3.1	13.3	10.17	3.17
Berkshire Hathaway Inc.	OTC	4040.00	-0.5	43.3	4022.00	2510.00	192	0.00	0.0	31.0	62.53	4.20	Kansas City Life	OTC	29.75	0.0	15.5	31.00	25.75	0	0.00	0.0	13.3	0.00	N/A
CIGNA Corp.	NYSE	68.75	4.4	25.0	68.63	55.00	1372	2.80	4.1	8.8	37.79	1.82	Kemper Corp.	OTC	33.50	12.6	34.0	38.75	25.00	2203	0.60	1.8	10.7	23.48	1.43
CNA Financial Corp.	NYSE	60.25	9.5	12.1	64.38	47.25	237	0.00	0.0	12.2	36.16	1.67	Liberty Corp S.C.	NYSE	47.00	3.9	27.9	46.75	36.50	78	0.80	1.7	18.2	19.96	2.35
General Re Corp.	NYSE	59.63	9.7	7.4	68.88	47.63	2725	1.00	1.7	16.0	23.47	2.54	Lincoln Nat'l Corp.	NYSE	57.13	7.3	23.2	58.88	44.38	348	2.16	3.8	11.5	44.85	1.27
ITT (Hartford Group)	NYSE	66.13	2.3	23.9	65.88	50.00	3419	1.00	1.5	14.4	44.08	1.50	NAC Re Corp.	OTC	24.75	5.3	-5.7	32.25	22.50	359	0.00	0.0	31.7	18.12	1.37
Sears Roebuck & Co. (Allstate)	NYSE	58.75	5.4	47.8	59.25	39.88	5103	2.00	3.4	14.3	32.94	1.78	Nobel Ins Ltd.	OTC	14.25	11.8	-12.3	18.50	10.75	250	0.00	0.0	31.7	0.00	N/A
Transamerica Corp.	NYSE	44.88	3.8	37.5	45.75	31.50	1530	1.76	3.9	9.1	26.94	1.67	Northwestern Nat'l Life	OTC	27.38	1.4	-11.7	32.38	24.00	674	0.96	3.5	7.8	33.26	0.82
AVERAGE			5.8	25.6					2.0	14.2			Ohio Cas Corp.	OTC	45.50	2.2	17.8	49.25	38.50	216	1.68	3.7	11.1	26.80	1.70
INSURERS																									
Aetna Life & Cas Co.	NYSE	61.50	5.3	8.6	68.13	55.75	3534	2.76	4.5	8.7	44.75	1.37	Old Rep Int'l Corp.	OTC	32.50	4.4	18.7	33.63	23.63	145	0.80	2.5	9.8	21.79	1.49
American General Corp.	NYSE	41.13	7.2	11.5	44.75	34.88	1848	1.25	3.0	11.0	27.13	1.52	Orion Cap Corp.	NYSE	23.75	3.3	-12.5	31.00	20.00	50	0.76	3.2	9.8	9.39	2.53
Amer Heritage Life Invl.	NYSE	31.50	0.0	22.7	34.00	25.75	9	0.96	3.0	15.5	20.37	1.55	Protective Corp.	OTC	15.00	0.8	-16.7	21.25	12.38	333	0.70	4.7	12.9	16.51	0.91
Amer Ind'y Fin'l Corp.	OTC	13.63	2.9	-24.3	19.00	12.75	194	0.56	4.1	15.5	20.40	0.67	Provident Life & Acc Ins Co.	OTC	22.75	5.2	-7.6	28.75	19.13	421	0.84	3.7	17.8	27.00	0.84
American Int'l Group Inc.	NYSE	78.38	6.8	28.2	82.00	60.00	2570	0.25	0.3	15.6	0.00	N/A	St. Paul Cos. Inc.	OTC	53.00	4.4	-31.7	55.00	40.25	1659	1.76	3.3	9.8	29.89	1.77
AONCO Reins Ltd.	OTC	3.00	2.0	40.8	4.38	2.13	67	0.00	0.0	15.6	2.27	1.32	SAFECO Corp.	OTC	30.50	8.0	-43.0	32.50	24.38	1266	0.96	3.1	10.6	39.36	0.77
Argonaut Group	OTC	28.38	5.6	7.6	28.38	23.25	996	1.20	4.2	9.9	6.94	4.09	SCOR US Corp.	OTC	15.00	3.4	30.4	16.25	11.00	216	0.00	0.0	13.8	8.08	1.86
AVEMCO Corp.	NYSE	23.50	-3.1	-10.5	25.25	13.25	81	0.28	1.2	14.8	0.00	N/A	Seibels Bruce Group Inc.	OTC	16.00	1.5	8.5	19.00	14.25	193	0.60	5.0	10.6	11.88	1.35
Business Mens Assur Co.	OTC	40.00	-7.0	-54.6	48.25	25.25	363	1.10	2.8	14.8	39.52	1.01	Selective Ins Group Inc.	OTC	26.75	0.9	23.0	27.50	21.00	209	1.08	4.0	8.5	16.02	1.67
INSURERS																									
Washington Nat'l Corp.	NYSE	33.88	-1.1	5.9	34.88	23.25	71	1.08	3.2	19.8	32.80	1.03	Statesman Group Inc.	OTC	6.63	2.0	39.6	7.06	3.88	296	0.05	0.8	8.5	5.71	1.16
Zenith Nat'l Ins Corp.	OTC	22.75	-2.2	-14.2	26.25	18.75	30	0.80	3.5	12.3	11.19	2.03	Tokio Marine & Fire Ins	OTC	74.63	7.4	33.5	103.38	63.88	70	0.19	0.3	63.2	0.00	N/A
AVERAGE			4.4	13.0					2.5	14.0			Torchmark Corp.	NYSE	34.38	16.5	32.5	33.00	23.75	1253	1.20	3.5	12.3	13.01	2.64
ALL COMPANIES	AVERAGE		4																						



**The Hartford gives you
on-the-spot response to claims
through hundreds of offices
around the country.**

It hits home every time you file a business claim: insurance is not an abstraction. It's an obligation to pay for covered accidents and disasters, and to take every appropriate step to lessen the human and financial impact of those losses.

At The Hartford, we take that obligation very seriously. Unlike many insurance companies, we handle our own claims through our own offices around the country. Of nearly a million and a half claims handled during a

recent year, we settled 99.9% without a written complaint.

Responsive claims service is one more reason independent agents and their business customers

turn to us, year after year.

They get our best, and so will you.

That's what makes the difference.

The Hartford difference.



When you need us most, we're at our best.