

Business Insurance

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California high court limits cover under advertising injury clause

SAN FRANCISCO—Applying what it described as a “common sense” interpretation, the California Supreme Court ruled Thursday the “advertising injury” endorsement in comprehensive general liability policies does not provide broad coverage for lawsuits alleging unfair business practices.

The decision, which pitted policyholder Bank of the West against Industrial Indemnity Co., a Crum & Forster Inc. unit, was watched closely by insurers and policyholders nationwide. If the court had found the

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How RBH and Hall stack up

The acquisition of Frank B. Hall by Rollins Burdick Hunter would create the world's fifth-largest broker and the third-largest U.S. retail broker.

Gross revenues



U.S. retail brokerage revenues



Source: BI survey

GRAPHIC BY CHRIS ROY

More BC/BS plans in peril, panel told

By MARK A. HOFMANN

WASHINGTON—The events that led to the collapse of Blue Cross & Blue Shield of West Virginia could drive other BC/BS plans into insolvency, warns a senior Senate investigator.

“A valuable lesson has been learned from West Virginia: It could happen again,” said John F. Sopko, deputy chief counsel to the Senate Permanent Subcommittee on Investigations.

The subcommittee last week held two days of hearings into the failure of the West Virginia plan, which was declared insolvent by \$37 million when it collapsed in October 1990. It is the

only BC/BS plan ever ordered liquidated by state regulators (BI, July 13; Oct. 29, 1990).

Mr. Sopko, who has spent three months tracing the West Virginia plan's demise, told the subcommittee last week that “our short list has grown” of other Blues plans that might be in serious trouble.

The subcommittee staff is recommending that hearings be held into the operations of Blue Cross & Blue Shield of Maryland later this year, he said. He did not identify any other Blues plans.

Early last week, officials of the Maryland plan met with the Maryland House of Delegates' Economic Matters Committee in

an effort to dispel fears that it, too, is on shaky financial ground.

John Donaho, the state's insurance commissioner, had told the Nunn subcommittee in early July that the plan was engaging in unauthorized “profit-making schemes” and “has shown a wanton disregard for its obligations to Maryland residents.”

The Maryland plan disputes those charges.

The collapse of the West Virginia plan was “unique,” Bernard T. Tresnowski, president of the Chicago-based Blue Cross & Blue Shield Assn., said in written testimony to the committee.

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Hall acquisition seen as victory for Reliance, Aon

By JUDY GREENWALD

NEW YORK—Reliance Group Holding Inc.'s sale of Frank B. Hall & Co. Inc. to Aon Corp. for \$475 million is likely to be a “win-win-win” situation for all three companies.

Analysts, risk managers and Hall employees agree the sale will strengthen Reliance's balance sheet while significantly boosting the geographic reach and expertise of Rollins Burdick Hunter Group Inc., Aon's bro-

kerage unit. Observers also believe Hall will be better served by a parent with a strong commitment to the brokerage business.

And Hall clients are relieved to see the end of the period of uncertainty that began when Reliance announced in March it wanted to sell the brokerage.

The sale, which is expected to be completed by the fourth quarter of this year, will create what would be the world's fifth-lar-

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‘Play or pay’ may not pay off

Adverse selection could cause failure of public health plan

By CHRISTINE WOOLSEY

NEW YORK—If a national play-or-pay health care plan becomes a reality, the new public plan to cover the uninsured could face bankruptcy unless it adopts a risk-based financing approach, a new report warns.

The flat payroll tax rates pro-

posed under several pay-or-play scenarios would not adequately fund the government plan, the report predicts. That is because the plan would likely cover a large number of individuals whose health care costs exceed the contributions made by the private sector, the report says.

But, some consultants say risk-based financing couldn't work on such a wide scale. The costs associated with gathering data on which to base an employer's risk-based contributions to the public health plan would be as-

tronomical, they say.

“The current play-or-pay proposals are seriously flawed,” said Bruce Pyenson, a consulting actuary and author of the report put out by Milliman & Robertson Inc., a benefit and actuarial consulting firm in New York.

“The basic cause of the instability of play-or-pay is that, unlike the competing private sector, the proposed funding of the government plan—wage taxes—is not closely tied to the costs of medical care for the covered in-

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Uneasy vote of confidence seen at Lloyd's

By STACY SHAPIRO

LONDON—It is likely that the Council of Lloyd's of London will win a vote of confidence when ballots are counted late this month, Lloyd's insiders say.

But last week's emotional extraordinary general meeting and subsequent criticism of the proposed appointment of David Rowland as the next Lloyd's chairman likely will shake Lloyd's executives into making serious reforms.

These reforms may include increasing a proposed 50 million pound (\$96.5 million at current exchange rates) “hardship” fund. Sponsored by Lloyd's brokers, agents and other affiliated companies, the fund is designed to help beleaguered members pay their portion of billions of pounds in losses.

It is likely that the Council of

Lloyd's will win a vote of confidence when the votes are counted Aug. 28, summed up Charles Sturge, syndicate analyst for Chatset Ltd. and for external Lloyd's members.

Members are voting by postal ballot on a group of four resolutions, put forward by a group of dissident members headed by Claud Gurney (BI, June 29). The resolutions, the preamble to which expresses “no confidence” in the council, call for rescinding a special levy on members to boost the Central Fund to 1 billion pounds (\$1.93 billion), among other things.

“But I hope there will be enough ‘yes’ votes (in favor of Mr. Gurney's resolutions) to give the council a shock,” said Mr. Sturge.

In addition, members are voting on another resolution which

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Rowland selection praised by some, blasted by others

By STACY SHAPIRO

LONDON—David Coleridge will resign as Lloyd's of London chairman next year, to be replaced by David Rowland, chairman of the task force that proposed wide-ranging reforms Lloyd's currently is adopting.

That selection does not sit well with some members, who want an “independent” chairman, either from outside the market or at someone who has not served on the Council of Lloyd's.

Mr. Coleridge, who has been chairman for two years, was asked by executives of the Corporation of Lloyd's to stay another year to implement the changes in Lloyd's governing structure proposed by the task force and a recent report by a panel headed by Sir Jeremy Morse.

But Mr. Coleridge—who has always said he would serve for only two years—refused.

Mr. Coleridge announced his decision to step down at the ex-

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AP/Wide World Photo

David Rowland is expected to replace David Coleridge as Lloyd's chairman next year.

Update

Ad injury ruling favors insurers

Continued from previous page
advertising injury endorsement provided coverage for most types of
business fraud claims, the ruling could have created hundreds of
millions of dollars in coverage for policyholders (BI, May 25).

The CGL policy states: "Advertising injury means injury arising
out of an offense committed in the course of the named insured's
advertising activities, if such injury arises out of libel; slander;
defamation; violation of the right of privacy; unfair competition;
or infringement of copyright, title or slogan."

Reversing the appellate court, the California Supreme Court
ruled 7-0 that "unfair competition" includes only the common law
tort of palming off a rival's goods as one's own and does not
encompass other types of fraud claims (BI, Dec. 3, 1990).

In addition, the court said unfair competition claims must be
causally related to policyholder "advertising," which it defined as
"widespread promotional activities directed to the public at large."

Bill clarifies distribution rules

WASHINGTON—The Senate is expected to vote this week on a
comprehensive tax bill containing many employee benefit provisions,
including clarification of retirement plan distribution rules.

Under the Senate version of H.R. 11, approved by the Senate
Finance Committee last week, people who make hardship withdrawals
from 401(k) plans would be exempt from a new 20% federal withholding
tax on certain pension distributions (BI, July 20).

"If an individual were applying for a hardship withdrawal, he
needs the money, and imposing a 20% withholding tax would seem
counterproductive," observed Frank McArdle, a consultant with
Hewitt Associates in Washington.

In addition, the bill would simplify the definition of "highly
compensated employee" in non-discrimination tests and would also
simplify 401(k) and 401(m) non-discrimination tests.

Insurers sue hospital chain

WASHINGTON—Eight health insurers are suing National Medical
Enterprises, alleging that the psychiatric hospital chain filed
fraudulent claims that could run hundreds of millions of dollars.

The insurers' lawsuit was filed in U.S. District Court in
Washington under the Racketeer Influenced and Corrupt Organizations
act, which allows treble damages. The lawsuit seeks unspecified
compensatory as well as punitive damages, and lawyers for the insurers
would not estimate how much is at stake in the litigation.

The insurers, who say they paid the Santa Monica, Calif.-based
company a total of about \$490 million in claims from 1988 to 1991,
charge NME with "a nationwide scheme" to admit patients regardless
of whether care was needed. They also claim that NME billed the
insurers for services "that either were not provided, were provided
at grossly inflated levels or were entirely unnecessary."

In a statement, NME said that the suit is an expected response to
the suit it filed last month against three insurers that sought \$45
million in unpaid claims (BI, July 27).

The insurers are: The Travelers Insurance Co., Prudential Insurance
Co. of America, Mutual of Omaha Insurance Co., Massachusetts Mutual
Life Insurance Co., Northwestern National Life Insurance Co., Time
Insurance Co., Phoenix Home Life Mutual Insurance Co. and United of
Omaha Life Insurance Co.

House gets claims handling bill

WASHINGTON—The House Education and Labor Committee last
week approved a measure that would overturn the Supreme Court's
1987 ruling that the Employee Retirement Income Security Act pre-empts
state tort suits over wrongly denied benefit claims.

The substitute to the "Health Insurance Claims Fairness Act"
would allow non-economic damages, like pain and suffering, when
claims were wrongly denied. The measure, introduced by Rep. Pat
Williams, D-Mont., is a substitute for H.R. 1602, which would have
allowed punitive damage awards against group health and life insurers
that improperly denied claims (BI, June 15; March 9).

Under the Supreme Court ruling, penalties for claims handling
errors are governed by ERISA, which limits damages to lost benefits
plus legal costs.

The Williams bill would give those disputing claims three options:
binding arbitration, non-binding mediation and court action.

Updates continued on page 30

Errors & omissions

• Swiss Reinsurance Co. purchased Delta America Insurance Co.,
not Delta America Re-Insurance Co. as incorrectly reported in the
July 13 issue.

• International Risk Management (Bermuda) Ltd. incorrectly
reported the coverage limits offered by Transportation & Railroad
Assurance Co. Ltd. in the July 13 issue. The correct limits are
\$25 million per occurrence excess of \$25 million or applicable
underlying insurance, whichever is greater.

• Donald F. Smith & Associates reported premium volume of
\$175 million in 1991 and \$200 million in 1990 and gross revenues
of \$8.175 million in 1991 and \$9.04 million in 1990. The
information was incorrectly reported in the June 29 issue.

• Pavenstedt & Pauli (U.S.A.) Inc. derives 100% of revenues
from commissions. This information was incorrectly reported in the
June 29 issue.

California considers new surplus lines rules

By LOUISE KERTESZ

LOS ANGELES—From her motorized wheelchair, Jann Walker
argues passionately for tougher regulation of non-admitted insurers
operating in California.

Four years ago, she was run over by a semi as she crossed the
street near her Sacramento office. The company that owned the
truck filed for bankruptcy shortly after the accident. Its only
insurance was written by a

fraudulent Panamanian insurer.

Ms. Walker, who was 39 and completing college when the
accident occurred, is now destitute.

She, along with other victims of bogus insurers, told their
stories during Insurance Department hearings in Los Angeles and
San Francisco on proposed regulations governing non-admitted
insurers.

Allied against the proposed rules are surplus lines brokers
and insurers. They object principally to a proposed requirement

that a broker file a non-admitted insurer's rate and product
information before placing coverage with that insurer.

While brokers and insurers also decried surplus lines insurers
that have failed—or simply vanished—leaving policyholders
without coverage, the executives also argued that the proposed
regulations would drive many legitimate non-admitted insurers
out of California.

Offshore insurers—including Continued on page 4

Navistar asks court for permission to reduce costs

Retiree health benefit cuts

By CHRISTINE WOOLSEY

CHICAGO—In what may be the first case of its kind, Navistar
International Transportation Corp. is asking a federal judge to
give it advance permission to reduce its retiree health care
benefits.

Citing the danger of insolvency, Navistar filed a declaratory
judgment action in the U.S. District Court for the Northern

District of Illinois July 28 seeking confirmation of its right to
alter the retiree health benefits of 40,000 retirees and 23,000
dependents.

If successful, the Chicago-based truck manufacturer says it
could slash about \$90 million per year from its overall health
care costs, or roughly 71% of the \$126 million it spent on retiree
health care in fiscal 1991.

Retiree benefits experts say

Navistar may be the first company to seek court approval for
reducing health benefits before actually making any benefit plan
changes.

Other companies, including Detroit-based auto giant General
Motors Corp., have attempted to cut retiree benefits, only to be
hit with lawsuits filed by retirees and union representatives who
claimed the company ren-

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Rehabilitation, safety experts to be listed

Business Insurance will publish in the Sept. 28 issue its annual
directory of rehabilitation management service providers and its
annual directory of safety consultants.

The directories are published as an editorial service; there is
no charge to be included. To be listed, companies must provide
their services directly to employers on an unbundled basis.

Rehabilitation management services are defined as all services
included in the medical management or vocational rehabilitation of
an injured or ill individual under workers comp or liability
programs. It is not the delivery of physical rehabilitation or
treatment, or case management for group health and life cases.

Safety consultants specializing in protecting people from injury
also will be listed.

Companies wishing to be listed in either directory must fill
out and return a questionnaire provided by Business Insurance.
To request one, please call Cindy Bloom at 312-280-3195; fax:
312-280-3174.

The deadline for returning questionnaires is Aug. 17.

Senators negotiate program to finance retired miners' care

By MICHAEL SCHACHNER

WASHINGTON—After months of arduous negotiations, senators
from major coal-producing states have struck an agreement that
would fund health care benefits for about 120,000 unionized
coal industry retirees.

The measure also would introduce a basic managed care feature
to hold down future costs.

The long-awaited agreement was attached to the comprehensive
energy bill passed last Thursday by the Senate. The agreement
would require contributions to a new retiree health care fund
from any coal company that was a signatory to national wage
agreements with the United Mine Workers of America from 1950
to the present.

The accord also would establish a system of financing health
care benefits for "orphan" retirees—those who worked for coal
companies no longer in existence.

The agreement replaces a proposal that for months had been
championed by Sen. John D. Rockefeller IV, D-W.Va., and other
senators.

The Rockefeller proposal would have levied a tax on all coal
producers regardless of whether a company ever employed a
beneficiary of the 1950 or 1974 UMWA Health and Retirement
Benefit Funds (BI, Feb. 10). However, debate over this method
of paying retiree health benefits was stalling progress on the
energy bill, as senators from several

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Inside

✓ States should step aside and let the feds regulate offshore
insurers, this week's editorial says. PAGE 8

✓ Insurers must have the guts to walk away from unprofitable
business, industry executives said at the International Insurance
Society meeting. Conference copy begins on page 10. PAGE 12

✓ Natural catastrophes and man-made disasters generated huge
losses for insurers in 1991, a Swiss Re survey indicates. PAGE 23

✓ Walbrook Insurance Co. Ltd.'s last-ditch rescue plan has
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Vol.26, No.31—Business Insurance (ISSN 0007-6864) is published
weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill.
60611-2590. Second-class postage is paid at Chicago, Ill., and at
additional mailing offices. Postmaster: Send address changes to
Business Insurance, Circulation Department, 965 E. Jefferson
Ave., Detroit, Mich. 48207-3185; 800-678-9595 or 313-446-1611.
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Nominations for Risk Manager of the Year sought

The search is on for the 1993 *Business Insurance* Risk Manager of the Year.

Each year, an outstanding risk manager is selected as the Risk Manager of the Year by a panel of independent judges. Up to five other risk managers can be named to the *Business Insurance* Risk Management Honor Roll.

However, before the judges can begin the process of selecting the 16th Risk Manager of the Year and members of the 1993 Honor Roll, nominations must be submitted to *Business Insurance*.

The 1993 honorees will be selected based on information reported on special nominating forms, which now are available from *Business Insurance*. The deadline for submitting nominations is Nov. 19.

The 1993 honorees will be announced in the April 26, 1993, issue of *Business Insurance*, which coincides with the Risk & Insurance Management Society Inc. conference to be held in Orlando, Fla.

"There are many risk managers that deserve consideration for Risk Manager of the Year and the Risk Management Honor Roll. However, it's impossible to give these risk managers the recognition they truly deserve if no one nominates them," points out *Business Insurance* Editor James M. Burcke.

"Many risk managers and other insurance professionals express concern over the lack of visibility that risk managers have in their organizations. Being named Risk Manager of the Year or a member of the Honor Roll can increase an individual risk manager's standing in his or her organization as well as bring attention to the risk management profession in general," he said.

A risk manager can be nominated by anyone familiar with his or her work—the individual's boss, for example. Members of a risk management department also may nominate the organization's risk manager. And, a broker, insurer, consultant or some

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Miro extradited to U.S. to face fraud charges

By DOUGLAS McLEOD

NEW ORLEANS—Accused insurance con man Carlos I. Miro was being held in a New Orleans jail last week following his extradition from Spain on criminal charges related to the 1989 collapse of Anglo-American Insurance Co. of Louisiana.

Mr. Miro, arrested in the Spanish coastal resort city of Malaga last year, was returned to the United States last month and appeared at a preliminary hearing in U.S. District Court in New Orleans last Monday.

He did not enter a plea at the hearing, but was scheduled to be arraigned Friday on mail fraud charges leveled against him in a 1991 indictment.

A public defender who represented Mr. Miro at the preliminary hearing could not be reached for comment.

In the past, Mr. Miro has denied wrongdoing in his operation of Anglo-American, which was ordered into liquidation in March 1989 and is estimated to be insolvent by about \$28 million.

A New Orleans federal grand jury indicted Mr. Miro in June 1991 on a variety of charges related to Anglo-American, and a superseding indictment was filed in October 1991 (*BI*, Sept. 30, 1991; June 24, 1991).

The indictment alleges that

Mr. Miro paid \$45,000 to an elected public official in Louisiana to obtain a license for Anglo-American in 1986. Mr. Miro concealed the payments to the official's campaign by making it appear that the contributions were from several other individuals Mr. Miro selected, the indictment charges.

While not naming the official, the indictment notes that Anglo-American was licensed by former Louisiana Insurance Commissioner Sherman Bernard, who was defeated for re-election in 1988 by Douglas D. Green.

From August 1986 to December 1988, Mr. Miro defrauded Anglo-American policyholders, diverting millions of dollars in insurance premiums to his own benefit, the indictment alleges.

Several of the indictment's mail fraud counts relate to premium checks sent to Anglo-American by one policyholder, the St. Bernard Parish School Board in Chalmette, La.

The indictment also charges that Mr. Miro fraudulently concealed Anglo-American's true financial condition from regulators and others.

If convicted on all charges, Mr. Miro could face up to 80 years in prison, said Executive Assistant U.S. Attorney Robert J. Boitmann.

Separately, a federal grand

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Report hits safety record for L.A. subway project

By JOANNE WOJCIK

LOS ANGELES—The injury rate on the Los Angeles Metro Rail subway construction project is three times the national average, a report charges, even though the project's safety record has been trumpeted by its former insurance administrator.

The 43-page report released last month by engineering giants Fluor Daniel Inc. and Kellogg Corp. also revealed that not all contractors involved in the massive project have a written injury and illness prevention program. Those programs are required under a state law, S.B. 198, that took effect last year.

The report found that the project's insurance administrator—a joint venture headed by



Photo by Joanne Wojcik

The Los Angeles Metro Rail construction project involves extensive tunneling.

Sedgwick James of California Inc.—underreported work-related accidents to the Rail Construction Corp. The RCC is a subsidiary of the Los Angeles County Transportation Commission formed to direct the subway building project.

The report was released just after the expiration of Sedgwick's contract as administrator of the owner-controlled program that covers the subway project.

LACTC has hired a rival broker, Pasadena-based Willis Corroon Corp. of Los Angeles, to replace Sedgwick as administrator, though Sedgwick and an LACTC official deny the switch was prompted by the report's findings. Sedgwick will remain the project's broker.

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Tales from the front

Managed care is cutting companies' work comp costs

By MEG FLETCHER

DETROIT—Managed care is helping one of the nation's largest automakers and other companies to manage their workers compensation costs.

General Motors Corp. is reporting a 15% net savings on its workers comp medical bills after contracting with a managed care firm that specializes in workers comp claims.

The Detroit automaker in 1991 contracted with OUCH Systems, a West Sacramento, Calif.-based subsidiary of HealthCare COMPARE Corp. of Downers Grove, Ill., to oversee the medical care of GM employees with occupational illnesses or injuries.

OUCH examines workers comp medical bills to make sure



charges reflect limitations imposed by state fee schedules, provides a preferred provider network for injured employees in

Michigan and offers other utilization review services as needed.

"The combination of these services has worked out very well," and extends GM's own long-standing efforts to control the cost of workplace injuries and illnesses among its 300,000 hourly and 100,000 salaried employees in 33 states, said Alan Strohmaier, GM's director of unemployment and workers compensation.

GM's own programs include extensive in-house medical centers and return-to-work programs at major locations, he added.

The savings generated by the managed care program is notable because GM, which self-insures its workers comp program, was

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Old masters, new cover

Museum package policies offer innovation—at a price

By EILEEN P. GUNN

An insurer is offering museum owners the chance to buy several different types of specialized coverage in one package.

However, while fine art insurance experts generally praise the policy—and the accompanying loss control services—as an innovation, they point out that non-profit institutions' shallow pockets could make the program a hard sell.

The insurance program, offered by Chubb Corp. of Warren, N.J., is tailored for museums and cultural institutions. The program combines in one package traditionally separate insurance lines, like fine arts, boiler and machinery, and property coverage.

The package also included coverage for sources of income, including admissions, grants, donations and revenues from gift shops; and innocent misrepresentation coverage, which protects curators and other officials from lawsuits arising over negligent professional opinions on the origins of art or artifacts.

The program also includes new risk management software for policyholders.

These types of coverage have not been offered before in a single package, according to Michael Fischman, a broker at Hogg Robinson of New York Inc.

Though they will be sold together, several of

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Photo by Allan Hunter Shoemaker

Chubb's program offers museums software that scans the image of items so they can be accurately restored if damaged. For instance, this intricate chandelier at Montpelier, James Madison's home in Orange, Va., could be scanned by CHUBBMUSE.

Surplus lines

Continued from page 2
 captives—could request exemptions from standards governing licensing, minimum capital and surplus, and length of time in business.

Supporters say the regulations, which would become Section 2174 of the Insurance Code, are needed. In the past two years California has experienced "an invasion" of "unscrupulous" non-admitted insurers, assisted by "equally unscrupulous" surplus lines brokers, said Daniel Bethel, an officer in the consumer division of the California department.

Non-admitted auto premium volume in California has grown to \$128.1 million in 1991 from \$3.9 million in 1988. Over that time, policyholder complaints to the department about non-admitted insurers soared to more than 2,000

from 22, Mr. Bethel said.

Proposed Section 2174 is designed to be "a barricade—a wall to keep the invaders out," he said.

Surplus lines insurers and brokers counter that too many companies would be kept out by the proposal. The problem is not with non-admitted insurers as a group, they argue, but with certain non-U.S. insurers, especially those in the Caribbean. They urged regulators to target those companies rather than all non-admitted insurers.

At the hearings, representatives of the Surplus Line Assn. of California and the California Wholesalers Assn. argued that requiring brokers to file a non-admitted insurer's rate and product information would destroy the flexibility critical to the non-admitted market.

That requirement would "create an impossible regulatory frame-

work within which the California surplus lines market cannot operate," said attorney Thomas E. Burke of LeBoeuf, Lamb, Leiby & MacRae in New York. The firm is U.S. general counsel for Lloyd's of London and represents seven other offshore insurers that do business in California.

"The freedom of rates and forms used by non-admitted insurers is one of the basic concepts upon which the surplus lines market is founded and is fundamental to its continued existence," the Surplus Line Assn. argued in comments submitted at the hearing in San Francisco.

Requiring a surplus lines broker to submit rate and product information before placing coverage is a "prior approval mechanism" that violates surplus lines law, argued David R. Harrison, an attorney with Aguilar & Sebastinelli in San Francisco, which represents

surplus lines brokers and U.S. and offshore non-admitted insurers.

Non-admitted insurers and some brokers also object to the proposed \$15 million capital and surplus requirement for all non-admitted insurers.

David Anderson, president of the California Wholesalers Assn., concedes he has "misgivings" about any such requirement. But, if the requirement is approved, it would be more reasonable to phase it in gradually, said Mr. Anderson, president of Anderson & Murison Inc. in Los Angeles.

"The Illinois Insurance Exchange supports the intent of Regulation 2174, (but) we do not wish to be punished for the sins of others. And make no mistake about it, Regulation 2174, as proposed, will punish the exchange and its syndicates and many other well-managed, responsible insurers," said IIE President James M. Skel-

ton at the Los Angeles hearing.

"The regulation, as proposed, simply fails to solve the problem it addresses. It will do more harm than good. And, as a practical matter, it goes beyond the authority of the department, and fails legal tests of reasonableness, necessity, economic analysis and impact," he added.

Only four IIE syndicates have more than \$15 million in surplus.

An earlier version of Section 2174, submitted on an emergency basis last year, was disallowed by the Office of Administrative Law. Earlier this year, the department voluntarily withdrew another version of the emergency regulation.

Those earlier versions applied only to non-admitted insurers outside the United States, requiring them to have a minimum capital and surplus of \$5.4 million and to maintain a U.S. trust account of \$5.4 million (*BI*, Nov. 11, 1981; July 8, 1991).

Then, in June, the department submitted the latest version of the emergency regulation. The rule is not limited to offshore insurers and requires non-admitted insurers doing business in California to have a minimum capital and surplus of \$15 million. However, the emergency regulation only applies to insurers that had not done business in California before June 2.

On the other hand, the proposed permanent regulation—the subject of last week's hearings—would apply to all non-admitted insurers doing business in California. The department hopes to have the permanent regulation in place when the emergency regulation expires Oct. 10.

Among the documents that the rule would require brokers to file before placing coverage with a non-admitted insurer are:

- The insurer's annual statement and an audited financial report.

These documents must demonstrate minimum capital and surplus of \$15 million. Non-U.S. insurers must have a minimum of \$5.4 million in a U.S. trust account.

Letters of credit can be used to satisfy the trust fund requirement but cannot be used to meet the minimum capital requirement.

An exemption from the minimum capital and surplus requirement may be granted by the department if the insurer serves specialized markets.

- A certified copy of the insurer's license issued by the jurisdiction where it is based, along with a certificate of good standing and other market conduct information. Captives could request an exemption from this standard.

- A verified statement that the insurer is not in conservation or the subject of any regulatory action.

- A list of the products the insurer wants to sell in California along with rates or, alternatively, "rating plans used to set the rates."

For each submission, the filing fee would be \$1,500. Brokers would also be required to "keep the documents current by submitting... more recently dated versions of documents as soon as such updated documents are available," along with a filing fee of \$250 per document for updates of financial documents and \$35 per document for all other updates.

Among the industry representatives speaking at the Los Angeles hearing in support of Section 2174 as currently written were Irwin Cheldin, president of Crusader Insurance Co. in Woodland Hills, Calif., and Robert A. Chick, president of Lawyers Mutual Insurance Co. in Burbank. Both insurers are admitted in California. ■

"The Tooth Fairy told us to Speak Up."

Tooth Fairy: What is Dental Network of America, or DNoA, as you refer to yourselves?

DNoA: Dental Network of America is the Nation's premier managed dental care organization. We serve 1,000,000 members through our dental HMO products and our new discount dental services programs.

Tooth Fairy: Then why haven't we heard about you by now?

DNoA: Because our products are marketed by Blue Cross and Blue Shield Plans. So we're sort of the name behind their names.

Tooth Fairy: Who are some of your customers?

DNoA: We administer managed dental care programs for 2,300 accounts, including 32 Fortune 500 companies.

Tooth Fairy: How large is your dental network?

DNoA: We have more than 6,600 dental providers. We can deliver our products in more than 40 states, Canada and the U.S. Virgin Islands.

Tooth Fairy: So why are you just starting to advertise?

DNoA: Because we wanted to establish a successful track record first.

Tooth Fairy: Well you have. So speak up.

Leading the Way to Quality Dental Care



**Dental Network
of America**

For more information,
call 1-800-323-6840,
Ext. 255

or write:
Marketing Department
Dental Network of America
Two TransAm Plaza Drive
Oakbrook Terrace, IL 60181

YOU DON'T HAVE
TO CONTROL
THE WEATHER TO
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PROPERTY • HPR • SPECIAL RISK

Firms expand employee assistance: Study

By DEBORAH SHALOWITZ

Offering resource and referral services is the most popular way employers assist workers in need of counseling, a new survey says.

Employers rely on that format to provide drug and alcohol abuse counseling, wellness programs, family counseling, dependent care programs and stress management, the survey shows.

The survey also found that employee stress levels are on the rise, thus increasing the demand for some of these services.

The most popular type of counseling companies provide is for drug and alcohol abuse treatment, according to the survey by The Olsten Corp., a Westbury, N.Y.-based temporary personnel firm.

Sixty-five percent of 578 human resources executives surveyed by Olsten reported offering some type of drug and alcohol abuse program.

And of those companies, 56% offer a resource and referral service. Nineteen percent offer financial assistance, 18% offer workshops and counseling and 7% offer an on-site facility, according to the survey. In addition, 9% have a program under consideration.

More than half of the employers—57%—also offer stress management programs for employees, while 56% offer family and marital counseling programs and 54% offer some type of wellness program.

Like the drug and alcohol abuse programs, a large percentage of these programs are delivered by resource and referral services, the survey finds: 46% of both stress management and family/marital counseling programs, and 31% of wellness programs, are offered as resource and referral services. The next most popular format is workshops and counseling, followed by financial assistance and on-site facilities.

Thirty-two percent of the companies surveyed offer some type of child care assistance and 17% offer some type of elder care assistance for employees, according to the survey.

In both instances, resource and referral services was the most popular format for providing employees with these services.

Meanwhile, 57% of the human resources executives said workers at their companies had "above normal" levels of stress and another 6% said workers at their companies had "severe" levels of stress.

However, the survey noted that the definition of "normal" varies from firm to firm and from individual to individual.

Those firms in industries hit hardest by the recession reported the greatest increases in employee stress levels over five years ago.

For example, 81% of human resources executives at banking and finance firms and 79% of executives at insurance companies reported greater stress levels among employees than five years ago. And, 75% of respondents at manufacturing and public or non-profit organizations also reported increased stress among employees.

The greatest increases in employee stress levels were reported by executives in the Northeast, while the lowest increases in employee stress levels were reported by executives in the Southeast.

In other survey findings:

• 34% of the human resources executives surveyed said their employee counseling and dependent care programs have increased employee productivity and morale.

Benefit beat

Another 22% noted decreases in absenteeism as a result of these programs.

• Almost one-third of the firms—31%—offer paid maternity leave, while 70% offer unpaid maternity leave.

For a free copy of the 12-page survey report, "Workplace Social Issues of the 1990s," contact

Loretta Schorr, The Olsten Corp., 1 Merrick Ave. T62, Westbury, N.Y. 11590; 516-237-1665.

FAS 106 obligation

About four out of 10 U.S. companies plan to immediately recognize their Financial Accounting Standard 106 obligation on their balance sheets, rather than amortize the amount over many years, according to a new survey.

"Many organizations are consid-

ering immediate recognition as an opportunity to put the worst behind them," said Marsha Venturi, a consulting actuary in the Secaucus, N.J., office of Buck Consultants Inc., which conducted the survey. "By taking the big hit all in the first year, ongoing expense can be noticeably reduced over the remainder of the amortization period."

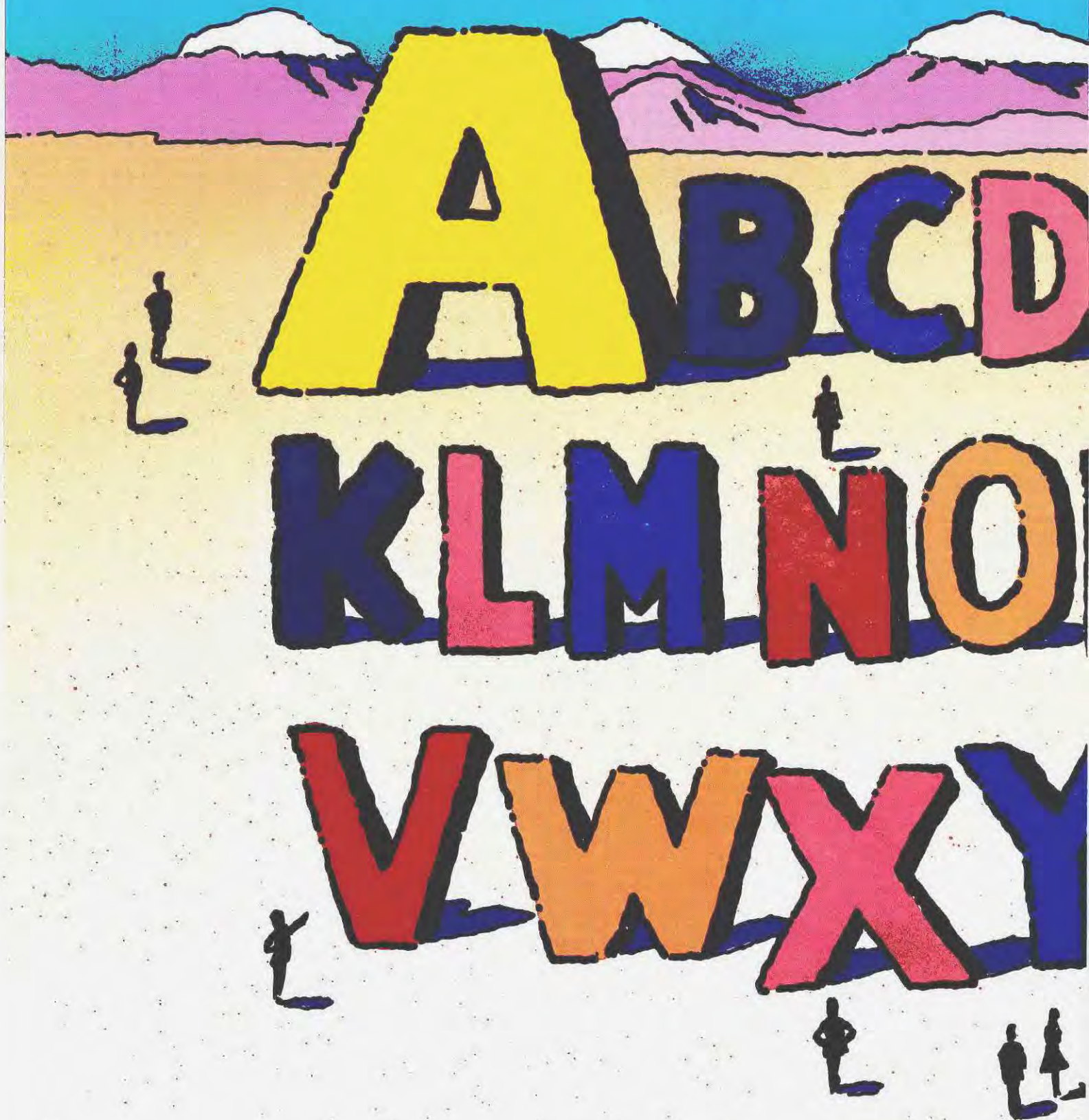
Buck's survey of 96 companies found, though, that an equal percentage of respondents—44%—still

have not decided how they will recognize their FAS 106 obligation.

The remaining 12% of companies plan to delay recognition by amortizing the transition obligation.

The survey, "FAS 106: Implementation Options, Economic Assumptions, Effect on Retiree Medical Benefits" is available for \$50 from Carolee Martin, manager of marketing, Buck Consultants Inc., 500 Plaza Drive, Secaucus, N.J. 07096-1533; 201-902-2555. ■

When your service is this complete, it makes a very big impression.



Navistar

Continued from page 2
aged on past promises (BI, Aug. 14, 1989).

The court action names several retired union and non-union employees of Navistar and two unions—the United Automobile Workers and the United Plant Guard Workers of America—to act as representatives of the interests of all retirees.

Navistar, formerly International Harvester, "is asking the judge to affirm that its changes in retiree health care benefits do not breach any law or any col-

lective bargaining or other agreement," a Navistar spokeswoman said.

As part of the benefit restructuring, the company's retirees—both union and non-union—and their dependents will be enrolled in a new health care program. The new plan includes a reduced level of benefits and for the first time will require retired union workers, who comprise about two-thirds of its total retirees, to pay a share of their health benefits through premiums, deductibles and copayments.

"This was a tough decision to make, but we must face the real-

ity of Navistar's disproportionately high health care costs," Navistar Chairman and Chief Executive Officer James C. Cotting said in a statement.

The company spends a higher percentage of its sales on retiree medical benefits than its competitors because it has an unusually high ratio of retired employees to active employees and offers a rich benefit plan, the Navistar spokeswoman explained.

After reducing its active workforce from nearly 100,000 in 1980 to about 13,000 today, Navistar has three retirees for every active worker, compared with an indus-

try average of less than one, she said.

Upon completing an internal study to determine how to control its skyrocketing health care costs, Navistar officials estimated the company had a \$200 million "cost disadvantage" when compared to other companies in the same general line of business.

To correct that situation, Navistar says it must cut \$150 million from its health care costs for active and retired employees and another \$50 million from operating costs.

Navistar plans to introduce

various managed care programs, including preferred provider networks, to control health care costs for active employees, the spokeswoman said.

Mr. Cotting said the company can meet current retiree medical costs, but that permanently reducing future medical care obligations is the only way Navistar can meet future benefits payments and escape the threat of insolvency.

Under the new indemnity plan, retirees less than 65 years old will pay about \$1,400 per year in health insurance premiums, the spokeswoman said. They also must meet a \$400 per year individual deductible for all health care services or an \$800 per year family deductible, she said. And, they are required to pay for 20% of all medical expenses they incur, up to a maximum of \$1,600 per individual and \$3,200 per family.

Retirees over age 65 will pay an average of about \$330 per year in health insurance premiums, the spokeswoman noted. And, they will be required to pay the first \$2,000 of Medicare and Medicaid copayment fees and deductible charges, after which Navistar will pay 100%.

All retirees also will be required to contribute toward the cost of prescription drugs and mental health services.

The company, which currently operates hundreds of different retiree medical plans throughout the United States, will merge its retiree medical policies into one plan.

UAW Secretary-Treasurer Bill Casstevens said he was "surprised" by Navistar's court action.

"We will take all appropriate action to protect the rights of our retired members at Navistar," he said in a statement.

The United Plant Guard Workers had not yet been served with court papers, said Lou Scohy, international vp of the Roseville, Mich.-based union.

Meanwhile, retiree benefits experts say this may be the first time a company has attempted to ward off potential lawsuits by getting a court to grant it advance permission to cut benefits.

"I am not familiar with any other company going to court first to ask permission" to reduce benefits, according to Henry Saveth, a principal in the New York office of A. Foster Higgins & Co. Inc.

"So far, companies seem more willing to make (benefit plan) changes and then react to the lawsuits that follow," he said.

"Navistar's approach puts a novel twist on things," said Bill Miner, an actuary in the Chicago office of The Wyatt Co. This may mark the beginning of a "trend of distressed companies taking a hardline position and seeking relief through the courts," he added.

The court likely will examine Navistar's benefit plan documents to ascertain what promises it made to retirees concerning their medical care benefits, Mr. Saveth said.

And, while the company maintains that its benefit documents explain to employees that it has the right to alter its health plans at any time, the final interpretation of summary plan language will be left up to the judge, he pointed out.

"Ultimately, the courts may decide what benefits we'll be getting, rather than the unions, the companies or even Congress," Mr. Miner said. ■

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Opinions

Let feds run border patrol

THE DEBATE OVER whether the federal government or state insurance commissioners should have primary authority for insurer solvency regulation is a battle that will rage for some time. But we do not see how any segment of the insurance industry—including policyholders—could oppose federal regulation of offshore insurers and reinsurers as long as some protections are included in such a law.

A proposal is contained in a recent report by the Senate Permanent Subcommittee on Investigations, chaired by Sen. Sam Nunn, D-Ga. (*BI*, July 20).

Business Insurance has published dozens of stories over the years that have detailed fraudulent schemes whose linchpins were foreign insurers or reinsurers. Unsuspecting policyholders—especially those for whom insurance is largely unavailable or unaffordable—pay premiums to these insurers, whose "assets" often consist of worthless mining leases, stocks of questionable companies based in Third World nations or other dubious investments. No one knows where the premiums go, but very seldom are they used to pay claims.

Bogus offshore reinsurers follow much the same script.

It is simply impossible for state insurance regulators to keep up with these companies. State insurance departments' budgets and regulatory authority do not stretch to Belgium, the Caribbean, Micronesia and other faraway domiciles.

And while the National Assn. of Insurance Commissioners does track "alien" insurers and reinsurers, the kinds of companies that pose problems never show up on the NAIC's screens—until it is too late.

Crooks hopefully would be wary of a federal regulatory system, but reputable offshore insurers and reinsurers would have nothing to fear. In fact, dealing with one central authority would probably be easier for the giant offshore underwriters that do business in the United States than dealing with separate state insurance departments.

While the federal government has had its problems in regulating the solvency of financial institutions, we're convinced that a single federal office regulating overseas insurers and reinsurers doing business in the United States would be much more effective than 50 separate systems. Paul Brown, director of government and public affairs for the Risk & Insurance Management Society Inc., put it so simply: "The feds are in a better position to regulate this."

However, the federal government should not reg-



ulate captive insurers owned by U.S. parents and based in established offshore domiciles like Bermuda and the Cayman Islands. Indeed, captives likely could be regulated out of business if they were held to federal standards.

But to scrap federal oversight of most offshore insurance and reinsurance companies because of concerns about captives would be to throw the baby out with the bath water. An exemption for bona fide captives can easily be included in legislation calling for federal oversight, though it must be carefully worded so that unscrupulous operators do not set up sham offshore companies and attempt to pass them off as "captives."

Of course, there are those who oppose any type of federal regulation—even if it makes sense. Some insurer organizations are going to stick to their guns and automatically fight against any incursion into states' regulatory authority.

And, while the NAIC says that there is much in the subcommittee's report "to commend" and realizes that state regulators are not doing the best job possible investigating overseas underwriters, its president maintains that reforms being implemented by state regulators are enough to solve the problem.

We agree that state regulators are doing their best to improve the protection they provide to policyholders. However, we're not sure that that will be enough to adequately regulate offshore underwriters.

This is one area where the states should step aside in favor of the feds.

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tion correspondence to Circulation Department, Business Insurance,

965 E. Jefferson Ave., Detroit, Mich., 48207-3185, or phone 800-678-9595

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What is your biggest job headache?



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Communicating the intricacies of our insurance program to those outside the organization who must understand it. This is compounded by the abundance of obsolete "boilerplate" material in circulation, and the outdated perceptions about insurance. Trying to reduce our risk transfer/insurance program to a certificate of insurance is also a challenge.

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Parental responsibility

How liable is parent for captive's failure?

By SARA MARLEY

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TORONTO—The boom in captive insurance companies requires a re-evaluation of their corporate parents' legal obligations, according to two risk management professors.

In the 1970s, up to 90% of all captives were owned by a single parent and wrote business for that parent only, said M. Moshe Porat, who is chairman of the department of risk management, insurance and actuarial science at Temple University in Phila-

delphia.

Today, only 60% of captives are single-parent, while half of all captive insurers write unrelated business, he said.

General growth in captives was spurred by "changes in the tax environment, strong promotion of captives as profit centers and ego-tripping by risk managers," Mr. Porat said here last month at the International Insurance Society's annual research roundtable.

"In the late '70s many captives began writing unrelated business," he said. "Some aggressive captives saw fantastic yields, better than their parents. Risk managers couldn't resist the urge to pursue unrelated business."

But, he said, "In the mid-'80s,

captives hit bottom like the rest of the industry." About 300, or 10% of all existing captives, discontinued writing during the decade, with half of those being forced into liquidation.

Despite those insolvencies, courts have not agreed about whether a corporate parent is liable for a captive's losses.

Some courts have held that the "corporate veil" should be pierced only "when the management of the parent instructed the captive to engage in risky behavior," said Michael R. Powers, an assistant professor in Temple's risk management department.

The professors recommend devising a spectrum for determining the extent of corporate involvement in captive management.

450 attend annual IIS meeting

TORONTO—Approximately 450 people from 45 countries attended the 28th annual International Insurance Society meeting in Toronto last month.



The Tuscaloosa, Ala.-based association is a group of more than 1,200 property/casualty and life insurance company executives and academics from 80 countries.

Next year's meeting will be July 11-15 in Tokyo.

For more information, contact IIS Executive Director Mary B. Silberberg at P.O. Box 870223, Tuscaloosa, Ala. 35487; 205-348-8974; fax 205-348-8973.

Important factors include the level of capitalization and whether involuntary creditors bear a disproportionate share of insolvency costs. Mr. Powers says all shareholders become involuntary creditors if they are deceived by management.

"Limited liability gives the parent incentive to take greater

risks," Mr. Powers said. "They realize all the rewards but have a limited cost of failure."

Limited liability also has advantages, he said. Limiting the parent's liability for the captive eliminates excessive monitoring of the captive's management and allows the parent to focus on its own business.

Fisher named to Insurance Hall of Fame

TORONTO—Nationwide Mutual Insurance Cos.' John E. Fisher is the newest inductee to the Insurance Hall of Fame.



Mr. Fisher, who is general chairman and chief executive officer of the Columbus, Ohio-based

insurer, was honored at the recent annual meeting of the International Insurance Society.

The hall of fame, begun by the IIS in 1957, honors outstanding contributors to the industry.

Mr. Fisher joined Nationwide in 1951 as an underwriter in the home office. He held various management positions until being elected vp-public relations in 1969. He was president of the company from 1972 through 1981, when he was named general chairman and CEO.

During his tenure as chairman, Nationwide has grown from an organization with \$6 billion in assets to a \$33 billion group of more than 100 companies.

Mr. Fisher served as chairman of the International Cooperative Insurance Federation from 1985 to 1990. During that time, he also was chairman of the board for Allnations Inc., which provides loan guarantees to developing insurance cooperatives and monetary assistance for employee training.

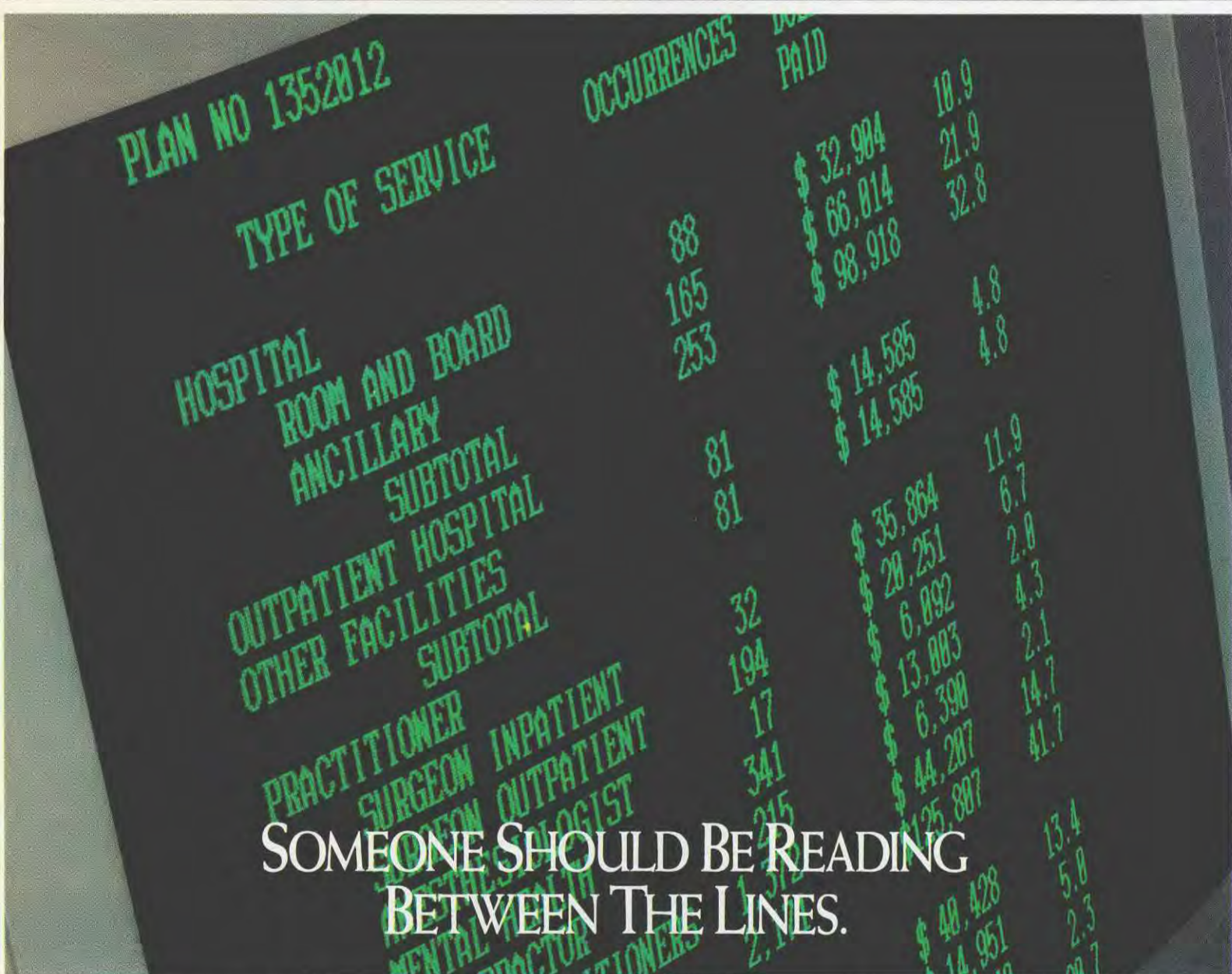
In addition, Mr. Fisher is a past chairman of the American Institute of Property & Liability Underwriters, the Insurance Institute of America, the Property Casualty Insurance Council and the American Council of Life Insurance. He holds the Chartered Property & Casualty Underwriter, Chartered Life Underwriter and Associate in Risk Management designations.

The IIS also awarded its John S. Bickley Founder's Gold Medal for Excellence to Robert L. Posnak, vice chairman of Delphi Financial Group Inc. in New York.

The society's service award was presented this year to Kenneth Black Jr., who is stepping down after four years as president and CEO of IIS. The award also was renamed in his honor. Mr. Black, who is a regent's professor of insurance at Georgia State University in Atlanta, will serve as vice chairman of the board.

He will be succeeded by John P. Meyerholz, a lawyer, executive-in-residence at Georgia State University and former executive vp of The Home Life Insurance Co.

—By Sara Marley



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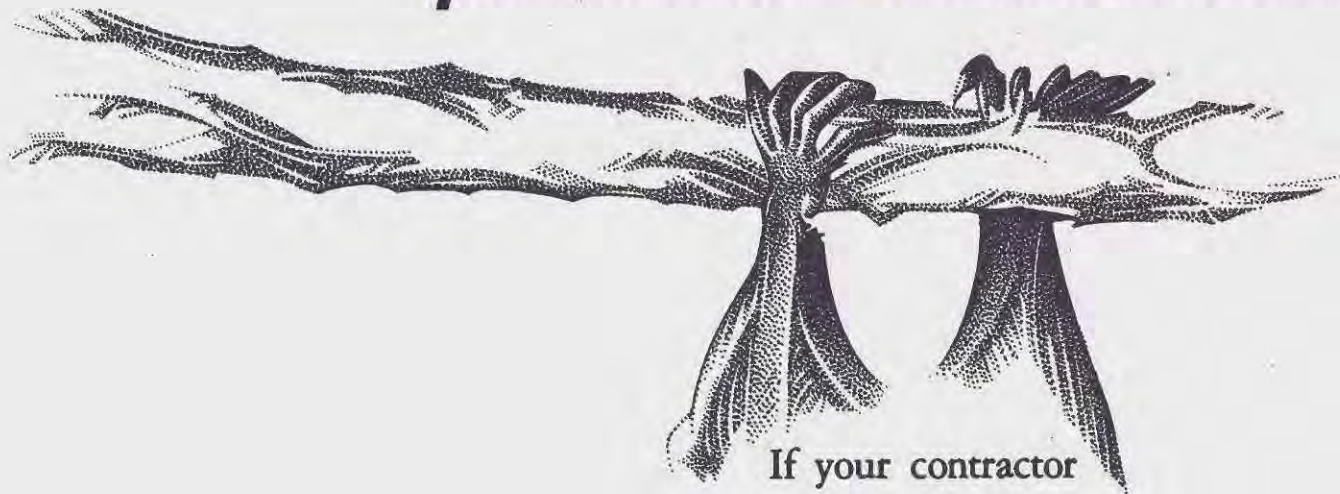


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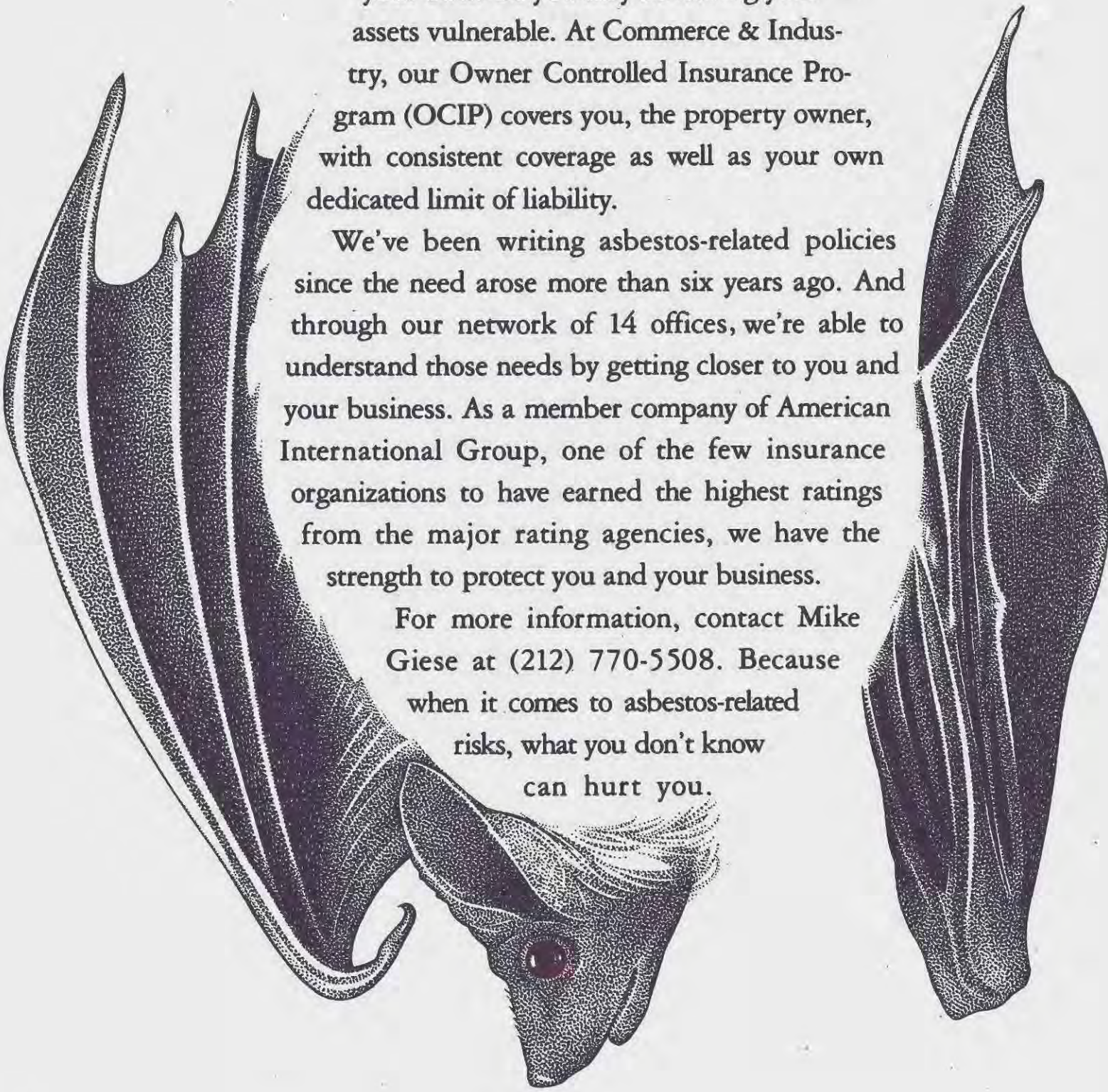
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Return to profitable underwriting: Execs

By SARA MARLEY

TORONTO—Insurers need to return to underwriting profitability, even if it means walking away from business, several top insurer executives contend.

"We need to be disciplined in our underwriting. We need to manage, not just handle claims," said Peter Spalti, chairman and chief executive officer of Winterthur Group in Winterthur, Switzerland.

"We need to make an effort to improve our core business: insurance. We can't rely too much on financial results," Mr. Spalti said last month at the annual International Insurance Society meeting in Toronto.

Noting that it takes "willpower" to price above competitors, Mr. Spalti said, "We have to have the competence to lose business."

"There are certain risks you simply shouldn't take," agreed R. Fred Richardson, president and chief executive officer of Crown Life Insurance Co. in Toronto.

European executives also advised their North American counterparts to force a market change by underwriting profitably.

"Don't wait too long for the market to turn around. Don't wait as long as Europe did," warned Klaus Conrad, a member of the board of management of Munich Reinsurance Co. "We are the market. We have to make it turn. Don't wait so long you weaken your company's core."

Inadequate pricing has led to di-

minished capacity in some lines, he added.

"There are uncertainties about the future supply of catastrophe insurance without correct pricing," Mr. Conrad said. "Capacity is shrinking from the top down, starting with high-layer retrocessional. The wave will slowly reach insurers and insureds."

With capacity shrinking, insurers must scrutinize their reinsurers. "Make sure they are not overextended and have sound underwriting. Beware the catastrophe reinsurer who asks no questions," Mr. Conrad advised. "Uncollectable reinsurance is worse than none at all."

Insurers also should avoid the temptation to retain business by offering unreasonable terms and conditions, according to Mr. Conrad.

"The importance of a sufficiently high deductible is often underestimated," he noted.

The profitability philosophy means walking away from entire markets when necessary, not just individual accounts, Mr. Richardson added.

"You have to be prepared to exit a market if it's a market you can't compete in," he said. "Management's number one commitment has to be to run the company at a profit."

"Many companies don't know if they're making money in a market or not," Mr. Spalti noted.

One way insurers can profit is by becoming more customer-minded, said Claude Bebear, chairman of AXA Group in Paris.

"It's difficult to be an insurance company. You have to satisfy policyholders and stockholders," he noted. But "without customers, there is no company."

"Our job is to pay claims," Mr. Bebear said. "Good claims settlement is good publicity."

Customer education must also become a greater priority, Mr. Bebear said. Insurers should inform policyholders of procedures before a claim is ever filed.

"When you settle a claim, pay what you have to pay, but don't

tially" lower, he noted.

Churchill further trims costs by doing its own crash testing, contracting with body shops for repair work and reselling usable parts of totaled vehicles.

Another Winterthur subsidiary, General Casualty Co. of Wisconsin in Sun Prairie, has made a commitment to underwriting profit, Mr. Spalti said.

"We will surrender market share rather than price inadequately," Mr. Spalti said.

The insurer's combined ratio has been below 100% for eight of the last 10 years, he said.

While insurers might be forced out of some markets, cautious exploration of new ones also can boost profitability.

Eastern Europe has not developed into the profit center many insurers were hoping for, Mr. Spalti said.

Initial euphoria about the fall of communism and the prospect of new business has waned, and insurers must now assess the real prospects in Eastern Europe.

"Everyone thought the move to a free market economy and some kind of democracy would develop quickly. But it's the problem of a generation at least," Mr. Spalti said.

"On the economic chain, the insurance business is one of the last positions," he said. Economic and legal systems must be fully in place for insurers to succeed.

"A good insurance industry builds up in an economic environment that is stable. It's very difficult if the economy is in bad shape,

with high inflation. That's one of the worst situations for insurance companies," Mr. Spalti said.

While Winterthur is serving existing international clients with operations in the former Soviet bloc, it is "extremely hesitant" to begin writing business there. It passed up an opportunity to purchase a former state insurer, he noted.

An exception is in the former East Germany, where Winterthur built onto existing organizations in West Germany.

"I think (former East Germany) has the best chance to make the move to a free market within a reasonable time," Mr. Spalti said.

In all foreign markets, cultural and language differences make local managers and employees necessary, Mr. Spalti said. Managers from Winterthur in Switzerland should also be present, but they too should speak the local language and understand the culture.

"A local presence is necessary in each market," he claimed.

Mr. Conrad advocated governmental intervention to once again make property/casualty underwriting profitable.

"The government would have the power and duty to enforce loss prevention," funded through taxes and levies, Mr. Conrad said. Already, Belgium, France, New Zealand and Spain practice this sort of intervention, he noted.

He acknowledged, though, that "Government involvement is not without danger. Governments have a tendency to extend power unnecessarily."

'We are the market. We have to make it turn,' says Klaus Conrad of Munich Reinsurance.

pay more. Explain what you have to pay" to the customer, Mr. Bebear said.

Winterthur subsidiary Churchill Insurance Co., a London-based auto insurer, has taken a direct marketing and customer service approach, Mr. Spalti said. The insurer contains costs by selling over the phone to households selected through a data base.

The sales force is trained to spot bad risks and can underwrite a risk over the phone in just eight minutes, Mr. Spalti said.

This cuts costs 15% compared with a traditional sales call, and the average claim cost is "substan-

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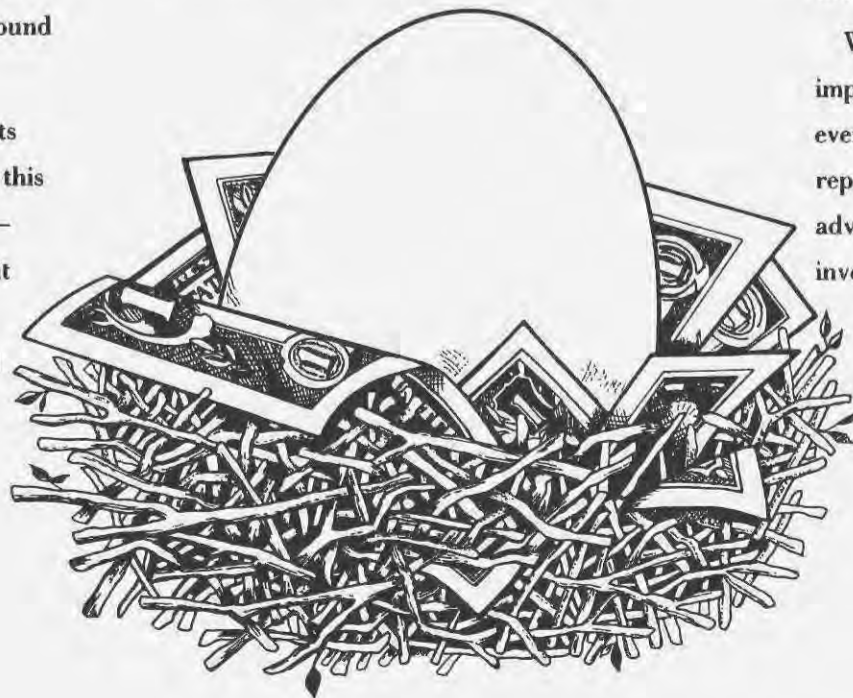
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Managed care

Continued from page 3
 "already doing a good job" of controlling costs, primarily through careful in-house administration of claims, Mr. Strohmaier said.

GM is one of several companies identified by the National Assn. of Manufacturers as taking steps to control its workers compensation costs.

GM is by no means alone. Other companies are turning to managed care to combat the rising tide of workers comp medical claims.

For example, The Gillette Co. of Boston in January began using RxComp, a managed workers comp program offered by Philadelphia-based CIGNA Corp., for many of its 8,000 U.S. employees, chiefly those outside of Massachusetts.

Gillette uses a mix of RxComp services, including a preferred provider network; claims management, including detailed cost data; utilization review; medical case management; rehabilitation services; and a risk management information system.

However, the manufacturer prefers to provide its own loss control and safety engineering services, which are also offered through RxComp.

While the managed care program is too new to evaluate, Mr. Welgass said he is already impressed with the "broader" perspective and service coordination capabilities of claims handlers for CIGNA, which is its principal casualty insurer. They efficiently and effectively manage all aspects of a workers compensation

Mr. Welgass doesn't expect 'material' cost savings on Gillette's already low workers comp claims costs.

injury or illness claim from the time the claim is filed until the worker—when possible—returns to the job, he said.

However, Mr. Welgass said he does not expect "material" cost savings because the company's U.S. workers comp claim costs already are a low \$3 million annually on net annual sales of \$4.7 billion.

On the other hand, Eastman Kodak Co. of Rochester, N.Y., primarily relies on its own resources and programs—rather than programs developed by an insurer or outside vendor—to control workers comp costs.

Those include experienced claims examiners, concurrent utilization review, encouraging outpatient treatment when possible and using in-house medical departments at some company locations. These managed care techniques are coupled with Kodak's long-standing tradition of finding appropriate work for injured employees on the mend.

When possible, the company refers injured employees to qualified professionals who provide medical or other services to injured employees, either independently or as part of an informal panel of preferred providers, said Gregory A. Saxum, director of workers compensation.

Insurers are stepping up to the demand by policyholders to apply managed care to workers comp claims.

San Francisco-based unit of Crum & Forster Inc., provides more than 8,000 employers in 10 Western states with a full range of managed care services when they purchase workers compensation coverage.

Industrial Indemnity's Medical Cost Containment program features a preferred provider network of more than 4,700 health care providers and hospitals; peer review of network physician providers; precertification to curb unnecessary medical and diagnostic testing; bill auditing; and hospital utilization review.

Using the insurer's existing preferred provider network keeps employer costs low because there is no need to pay a fee of 25% to 30% of annual medical billings to a third-party vendor, said Greg Johnson, a San Francisco-based principal with

Continued on next page

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Managed care

Continued from previous page
consultant William M. Mercer Inc. who works with Industrial Indemnity.

Policyholders using the program "are saving, on the average, more than 20% in paid medical losses, or 5.5% of their premiums," Industrial Indemnity reports.

And Industrial Indemnity policyholders' cumulative medical claims savings total more than \$125 million, including \$35 million in savings generated by the PPO network, since the program was implemented in 1986, according to Mr. Johnson.

The varied approaches that companies can take emphasize the broad range of programs that can be considered part of managed care and how employers can combine them.

"A managed care program seeks to ensure the necessity of treatment; to deliver care cost-effectively; and to prevent health problems that can be caused by excessive uncoordinated utilization of medication, radiological and other medical services," according to the Workers Compensation Research Institute in Cambridge, Mass.

Managed care can accomplish these goals through a variety of means, including preadmission certification, second surgical opinion programs and use of treatment protocols, among other things.

"I think what we are seeing is the beginning of a significant trend in how workers compensation is being approached," said Gillette's Mr. Welgass. There now is a concentrated effort to apply the full range of appropriate managed care techniques to more claims earlier than in the past, he said.

Previously, such techniques were primarily used only with serious, unusual or expensive claims, he noted.

In addition, Mercer's Mr. Johnson said: "The industry is moving slowly from discounts on unit price to true management of care through precertification and managed care."

Like the companies identified

'The industry is moving slowly. . .to true management of care,' Mercer's Mr. Johnson says.

by NAM, most employers support the concept of managing the health care component of workers comp claims.

"The importance of managed care is to have some reasonable control over all of the costs that are involved in workers compensation matters and some assurance that employees are getting appropriate care," said Kodak's Mr. Saxum.

"We think there are real cost savings there," said GM's Mr. Strohmaier.

Despite the cost savings potential, the cornerstone of managed workers comp programs remains the delivery of quality care, most employers agree.

"We are frankly more concerned with quality of care than immediate dollar cost," though the company is cost-sensitive, said Kodak's Mr. Saxum.

Good care ultimately benefits all parties, he said. Workers who receive better care recover more quickly, while employers benefit by having a needed and valued employee return to work faster, which reduces workers compensation medical and indemnity costs as well as production costs, he added.

GM's emphasis on sending employees to quality health care providers kept "doctor shopping" at a minimum, even before it engaged the services of a managed care vendor, pointed out Dan Osborne, assistant director of unemployment and workers compensation.

"We hand pick each of our providers," said Will Murphey, Industrial Indemnity's vp of medical management. The insurer chooses providers on the basis of its own data and includes those providers specifically requested by its major cli-

Continued on page 16



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Managed care

Continued from page 14
ents, he said.

In addition, Industrial Indemnity conducts an annual quality review of its major providers, according to Mercer's Mr. Johnson.

However, employers' ability to implement managed care strategies for workers compensation cases varies from state to state.

The differing legal requirements reflect workers compensation's historic role as a social insurance program dedicated to returning injured workers to full functioning with little regard to

cost.

General Motors, which employs almost half of its 400,000 U.S. workers in Michigan, is fortunate because that state has "one of the most comprehensive laws in the country," Mr. Strohmaier said.

Under Michigan's workers comp law, employers are allowed to choose a health care provider for an injured worker for 10 days. That state has implemented a "realistic" medical fee schedule, encourages utilization review and requires employers to report data to the state, Mr. Strohmaier said.

On the other hand, Kodak, which employs nearly half of its 80,000 U.S. employees in New York, has much less control over the providers its employees use.

For example, New York law essentially gives employees free choice of health care providers as long as they are authorized by state workers compensation regulators. The providers include doctors, chiropractors, podiatrists, physical therapists and psychologists.

"New York has the most restrictive law in the nation regarding an employer's ability to guide employee choice of health care provider," Mr. Saxum said. "It gives the employer or insurer no effective control."

However, the law gives an employer or insurer the opportunity to evaluate the appropriateness of tests or surgical procedures costing more than \$500 that are recommended by a health care professional.

Currently, 40 of 51 U.S. jurisdictions limit provider choice for workers compensation treatment by either restricting the employer's initial choice or limiting the employee's ability to change providers, according to a WCRI report.

In addition, 13 states encourage or authorize workers comp insurers to contract with selected provider groups at discounted rates, according to the WCRI.

Employers also face other difficulties in implementing managed care programs for workers comp cases.

Employees need to be geographically concentrated to make some PPO arrangements feasible and cost-effective, employers say.

A lack of geographic concentration for Kodak field representatives "mitigates against the use of a PPO" in many states, Mr. Saxum said. For example, it may be too inconvenient for employees in a sparsely populated state like New Mexico to visit the health care providers that participate in a certain PPO, he said.

Award

Continued from page 3

other vendor can nominate a client.

"The important thing is to identify a risk manager whose accomplishments deserve recognition and to request a nominating form from *Business Insurance*," Mr. Burke said. "The judges require detailed information in order to evaluate the nominees, so now is the time to begin collecting information and prepare a nomination."

Ten independent judges will select the 1993 Risk Manager of the Year and Risk Management Honor Roll. The judges will include the four 1992 honorees:

- Millicent W. Workman, director of corporate risk management at Belz Enterprises in Memphis, Tenn., the 1992 Risk Manager of the Year.

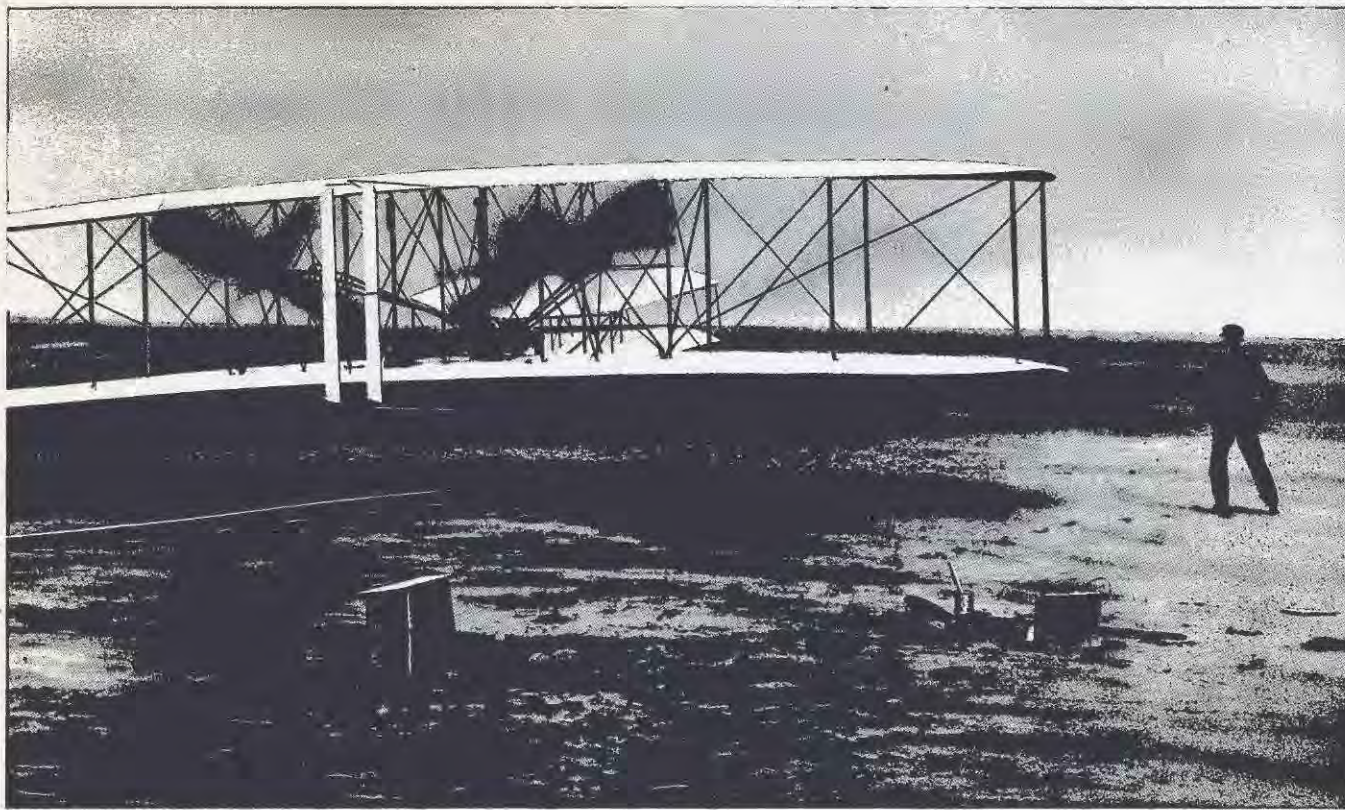
- Marc Darby, director of risk management and insurance at Bombardier Inc. in Montreal, who was named to the 1992 Risk Management Honor Roll representing large corporations.

- Jerry Newsom, risk management administrator for the state of Georgia, who was named to the 1992 Honor Roll representing government entities.

- Judith Tornese, vp-risk management at Transamerica Corp. in San Francisco, who was named to the Honor Roll representing

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Agent/Broker Topics

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Go forth and specialize

Having preached target marketing for years, insurers now back agents who heed their call

By LAURA MAZZUCA

NICHE MARKETING HAS long been a mantra for insurance agencies. But many agencies have taken up the rallying cry of specialization only to find the going rougher than expected. Mustering the resources to effectively promote their chosen specialties has been the major trouble for agencies that want to pursue a niche marketing strategy. Now agencies are finding help—in the form of marketing programs and support services—from insurance companies.

The reasons are not difficult to discern.

In today's competitive market, "it's just smart business to give support to agents," said Mike Policastro, vp in the agency support division of Travelers Corp. in Hartford, Conn. "We believe in supporting our core group of top agents to help them market when times are tough."

Many major multiline insurers are even searching out specialty markets that could provide profitable business for their agents.

Following a major restructuring in 1989, Aetna Casualty & Surety Co. has made niche marketing an important part of its reorganization plan, featuring products such as commercial programs for food wholesalers (A/BT, April 6). Chubb Corp. and SAFECO Corp. are among the insurers seeking clients for high-end homeowners coverage. Travelers is working with its agents to research, develop and prospect specialty business.

"Target marketing is clearly one of the areas we are looking at for growth," said Richard Barbieri, vp for specialty insurance target marketing and product development for Travelers' agency operations.

Developing niche markets is not easy, especially in these times. With earnings down, the amount insurers can spend in researching new markets is in question, Mr. Barbieri said.

Promotional assistance for agents is an integral part of many insurers' target-marketing plans.

"Over the last five to 10 years, agency companies are in fact doing more things to help both themselves and their agents in marketing," said Mr. Barbieri of Travelers.

Travelers, in fact, is increasing its niche-marketing support for agents in part because of demands from the agents themselves, added Mr. Policastro.

The emphasis on niche marketing means that insurers need their agents more than ever to sell to those specialized prospects. This requirement is especially true of agencies that already have expertise—and a client list—in a specialized area.

Take Lindo Hanna & Abbott, for example. The Chico, Calif., agency, with annual premium volume of about \$100 million, has specialized in agribusiness for 18 years, said Vp Timothy J. Hanna.

Years ago, it was hard to find insurers that understood the nuances of the industry. Only Fireman's Fund Insurance Co., Continental Corp. and a handful of others knew

enough about the business to underwrite successfully, said Mr. Hanna.

But over the past several years, more insurers—including Chubb and Zurich Insurance Co.—are targeting the food-processing and related agricultural markets, "and their presence is very welcome in the agribusiness area," he said.

Lindo Hanna & Abbott also specializes in racquet clubs, fitness centers and related risks, and insurers have caught up with it there, too. St. Paul Fire & Marine Insurance Co. approached the agency with its "Eagle 3" program for PGA golf courses three years ago. And the agency worked with Continental to develop its "Fitpac"

program for health clubs, Mr. Hanna said.

"Any progressive agency today which knows consumer needs, and which can market those needs with (an insurer), knows that it's the most cost-effective approach," Mr. Hanna said.

As they have recognized the profit potential in niche markets, some insurers, in fact, have been willing to act on agents' suggestions for specialized programs.

Travelers, for instance, is now considering insurance for welding supply dealers after an agent suggested it.

Travelers began evaluating the niche by talking to welding supply dealers the agent identified.

The insurer is now seeking to determine if their needs are being met in the admitted market and, if not, it will design a program around that, he said.

If a resulting product for welding supply dealers seems feasible, Travelers would begin regional test marketing. Next would come national distribution, if it is warranted.

Once a product is available, Travelers assists agents in finding business by providing a prospect list, a direct-mail program, or a telemarketing program, Mr. Barbieri said.

Financial assistance is available through the insurer's "Tower Voucher Incentive Program," which was started in February. About 600 of Travelers' preferred agencies have received about \$2.5 million in vouchers, based on the agency's profitability and the size of their book of business with Travelers.

These vouchers can be used to pay for any marketing service provided by the company, such as: telemarketing, a list vendor, Travelers-related advertising, an agency newsletter, and management consulting to develop target-marketing plans, Mr. Policastro said.

Vouchers are not restricted to marketing; they can also be used to pay for an employee's continuing insurance education expenses.

Travelers also offers a telemarketing service designed to compete with outside marketers generally hired by agencies. Its 18 telemarketers can get qualified leads or make appointments for producers. These services, which are available at "competitive" rates, are payable either in cash or vouchers, Mr. Policastro said.

Cooperative advertising, promotional materials and direct-mail programs are approaches insurers use to help their agents market special programs or certain geographic regions.

SAFECO has been offering direct marketing programs "that speak to our agents' needs for growth" since 1980, said Edward F. Drake, national manager of direct marketing for the Seattle-based insurer.

Independent agents are losing 1% of the personal lines market per year, he estimates, adding that direct writers have 65% of the market.

Like Travelers, SAFECO offers its more than 4,000 property/casualty agents services like direct-mail programs for a fee. In personal lines, SAFECO generally targets ZIP codes or demographics rather than specific in-

Continued on next page



Target marketing

Continued from previous page dustries.

To personalize its mailing, SAFECO prints the agency name on the literature. People who return mail cards to SAFECO are sent a gift like an atlas or flashlight.

SAFECO then forwards these leads back to the agent, and offers further assistance with a lead-management guide and a SAFECO marketing representative in developing a lead-management program, Mr. Drake said.

The cost to the agent for this service varies, depending on the number of mailings sent, or type of program, he said. Basic mailings start at 25 cents per household; more personalized mailings

run about 50 cents.

About 700 agencies—or 20% of SAFECO's force—use this direct-mail program. "What's important is that they continue to use them, and they do," he said.

"SAFECO is a forerunner in helping agents to prospect. It's a tremendous assistance to agents," said Sandra Wilson, personal lines manager at Conover Insurance Inc., a Redmond, Wash., agency with annual premium volume of about \$16 million. "Their direct-mail program is our No. 1 source of personal lines leads for the year."

Conover has used SAFECO mailings for personal lines auto and homeowners for the past four years. She attributes the agency's average 15% annual growth in new business to the

program.

Conover recently bought 21,000 direct-mail pieces and received about 800 "quality" responses. Conover paid SAFECO 25 cents per piece, she said.

Before the mailing is even sent out, SAFECO conducts a radio and print advertising blitz in the area. "It complements the program," added Ms. Wilson.

Preferred agencies can use the insurer's co-op advertising program to run their own ads locally along with SAFECO's, she said.

SAFECO guarantees a 2% response on its mailings, and Conover's responses have been as high as 7%. In fact, the biggest "problem" with the program is that the agency's three producers have trouble handling all the leads, Ms. Wilson said.

Before representing SAFECO, Conover did its own direct-mail program, she said.

Direct-response mail programs can get pretty specific.

John Sise & Co. of Portsmouth, N.H., markets Travelers' restaurant program. Recently the agency, which has annual premium volume of \$10 million, began trying to add to its eight Chinese restaurant clients in the area, said Alexander Hanson, marketing manager.

Travelers provided brochures on its restaurant program—written in Chinese—to give to prospects, said Mr. Hanson.

Only recently, he adds, did the agency begin using such programs. "We realized we weren't working as smart as we could, and using these prepackaged

ideas is a lot easier than reinventing the wheel."

Sise & Co. also buys a quarterly newsletter from the National Assn. of Professional Insurance Agents, which is designed for both personal and commercial clients. "We get a ton of responses and reply cards from that," said Mr. Hanson.

Other insurers offer partial payment to help agencies defray the cost of producing and mailing their own brochures.

For instance, Sise & Co. decided to promote Pennsylvania Mutual's annuity program with a two-step direct-mail program, Mr. Hanson said. The agency bought data bases for income and age, had brochures printed out, and targeted 2,000 households. The program cost \$4,000, excluding postage, Mr. Hanson said. In this case, Pennsylvania Mutual paid higher commissions to offset the promotional costs.

Other insurer programs focus primarily on providing leads.

For instance, since 1987, Zurich American Insurance Group's agency compensation strategy has focused on helping agencies develop a specialized agency as part of their overall agency business plan, said Joseph T. Basta, president of commercial insurance for the Schaumburg-based insurer. About half of Zurich's agents take advantage of this assistance, he said.

These agencies may or may not already have expertise in an area, he said. Focus groups, book analysis, visits with agents and program development help Zurich determine the right agency for the right niche.

Most Zurich specialties are based first on geographic region. For example, in California, Oregon and Washington state, Zurich is bullish on large agribusiness, from dairy farmers to growers to food processors, Mr. Basta said.

Other niches Zurich has targeted are cheese and sausage processors in Wisconsin, hydroelectric plants and pest control operators in New York, catfish farmers in the South, and historic hotels in New Orleans.

In fact, Zurich recently approached Lindo Hanna & Abbott with a contact list for food processors, agricultural packaging facilities and production farms, said Mr. Hanna.

The agency's internal telemarketing staff goes after the leads. "We've been very successful in target accounts we've gone after," said Mr. Hanna, who boasts of a 97% "hit ratio" for Zurich products.

And when an agent does not have the expertise in a specialty but wants to pursue it anyway, Zurich will provide training, Mr. Basta said. Zurich will introduce the agent to the program, give him an analysis of the market segment, competitors and type of claims service and loss control required. Then, the insurer works with the agent to choose prospective customers and offers the service of its 40 "territorial teams" to go on joint calls with the agent, he said.

Much of Zurich's book of business remains general business, but about 54% is segmented, Mr. Basta said. Results for the segmented programs tend to be better than the general book because underwriting, loss control and everything else is "crisper" and more focused, he said.

SEPTEMBER Most Productive Agencies

Issue: September 7
Ad Closing: August 25

What sets the most productive agents and brokers apart from the pack? *BI's Agent/Broker Topics* section will once again rank the most productive U.S. agents and brokers and examine how these agents rose to the top of the class. Agency executives will explain how to use niche marketing, automation and producer incentives to maximize staff productivity.

OCTOBER IIAA Conference Report

Issue: October 5
Ad Closing: September 22

Is there a merger in the works between the Independent Insurance Agents of America and the other large agent trade group, the National Association of Professional Insurance Agents? *BI's Agent/Broker Topics* section will assess the state of the IIAA and analyze the potential for such a union and the impact on independent agents. What's more, *BI* will cover the IIAA conference in New Orleans and report the big stories emerging from that meeting.

NOVEMBER Relations With Direct Writers

Issue: November 2
Ad Closing: October 21

Are direct-writing insurers friend or foe? Independent agents have long feared direct-writing insurers because of their growing market share. However, some independents are now acting as agents for direct writers. *BI's Agent/Broker Topics* section will look at what independent agents can learn from direct writers ... how they can promote customer loyalty and improve efficiency.

Agent/Broker Topics

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* An Audience Profile of the Business Insurance 'Agent/Broker' Subscriber, 1990.

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Worcester sales reps suit up

Insurer makes the handoff to agencies trying to target market

By LAURA MAZZUCA

WORCESTER, Mass.—Insurers don't have to be multinational giants to help agencies with their target marketing.



Consider Worcester Insurance Co. and its "huddles."

The regional company, a unit of Harleysville Mutual Insurance Co., has 750 agents throughout the Northeast.

Worcester patterns its huddles for 20 to 25 agency employees on football team huddles. At the meetings, which are led by one of Worcester's 11 sales representatives, agents are simply asked what sort of marketing assistance they need. The meetings are "a small group of people deciding what to do next," said Frank J. Herberg, vp-sales and marketing.

The huddle concept is especially useful, because "pitifully few" agencies have their own marketing managers, said Mr. Herberg.

Since 1985, agents have been going to the meetings and taking home a "playbook"—a three-ring binder filled with marketing tips, not only from consultants, but also from other agencies.

Geared toward either commercial or personal lines marketing, the meetings also are helpful for customer service representatives, "because they always come back with good sales ideas," he said.

One Worcester goal is to encourage target marketing. The meetings help agencies pinpoint their strengths, "so they don't write just one of everything," he said.

If, for instance, an agency has written a few barber shops, funeral parlors or apartment houses, Worcester wants to parlay the experience into a niche market.

"We encourage agents to do this," Mr. Herberg said. "Once they know the nomenclature and the exposures of a line of business, after they've written three, they're experts."

Unlike other insurers, he said, Worcester prefers to let its agents choose their own specialties rather than dictating from the home office.

It offers other marketing assistance as well. Through an ad agency specializing in insurance, Worcester also offers its agents six prototype agency brochures that can be personalized with the agency's name, as well as a custom-designed brochure, Mr. Herberg said.

Worcester's program is winning the praise of agents.

"(It's) the best marketing department going" because the ideas are offered to agents whether or not the business goes to Worcester, said Deborah Buckley, executive vp and general manager of Goss & McLain Insurance Agency in Holyoke, Mass.

"Regional insurers really seem to have their fingers on the pulse in this area," she added.

Goss & McLain, which has annual premium volume of \$10 million, has been using Worcester's direct mail program for the past two years, mailing 1,500 pieces per week every six weeks. The agency gets better than a 2% response rate on expiration dates, Ms. Buckley said.

The agency also created a special promotional program through Worcester's ad agency when it developed a life/health department. Mailings were sent to commercial clients.

A Worcester representative also came to the agency's office to conduct a huddle for its 18 employees, Ms. Buckley said.

"The Worcester treats us like a customer by providing us with excellent service. I can't say that about all our companies," Ms. Buckley said.

John Sise & Co. in Portsmouth, N.H., is another Worcester backer. The agency, which has annual

premium volume of \$10 million, has set up a sales center as described in the Worcester "playbook," said Alexander Hanson, its marketing manager.

The agency identified new prospects for commercial lines business and has hired a telemarketer to set up appointments for producers. While Sise & Co. researched the demographics for the program, the local Worcester field representative showed Worcester employees how to do it and helped them set up the sales center, Mr. Hanson said.

"Other companies might offer co-op advertising programs, but nothing like this," he said. ■



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THE SPECIALIST LLOYD'S BROKER FOR NORTH AMERICA

Why one brokerage is hoping for rain at the old ball game

Advertiser cleans up when Sox wash out

By LAURA MAZZUCA

CHICAGO—Most business executives who advertise their wares at sporting events dread the sight of a rain cloud on the horizon.

Not Michael Segal, chairman



and chief executive officer of Near North Insurance Brokerage Inc. in Chicago.

When storms roll in, threatening to spoil the fun at Comiskey Park, the glitzy new granite home of the Chicago White Sox, Near North's name is rolled out—across the infield, on the ballpark's tarpaulin.

"Some people don't think it's very professional, but a lot of people identify and know it," said Mr. Segal. "Baseball fans throughout the country see it on a rainy day."

The tarp, at 250-by-200 feet, requires a crew of six to unroll it across the infield.

Emblazoned with Near North's name and logo, the tarp is actually a very appropriate piece of advertising for a brokerage with a large and growing specialty in sports and entertainment insurance.

The niche now comprises 8% to 10% of Near North's book of business. With \$33 million in gross revenues last year, the brokerage is the nation's 25th-largest. Its annual premium volume is \$294 million.

Among its clients are several major league baseball teams, including the White Sox, the Milwaukee Brewers and the Atlanta Braves, as well as several minor league teams, according to Mr. Segal.

Near North also places insurance for filmmakers and televi-

sion producers, he said.

About eight years ago, the White Sox came up with the idea for the tarp advertisement, said Mr. Segal. Because the Sox are one of his clients—and because Mr. Segal himself also is an investor in the team—it seemed like a good idea.

Near North bought a \$10,000 tarp and had its name printed on it. When the White Sox last year moved across the street and into their new ballpark, the brokerage bought a new custom-fit tarp to replace the worn old one,

All he wants is a little attention

By LAURA MAZZUCA

PROVIDENCE, R.I.—Mention direct-mail advertising and what typically comes to mind? Reams of brochures, return cards, and mailing labels addressed to "Occupant" and destined for the wastepaper basket.

Or, if it's a "classy" promo, it might include pens, desk sets or paperweights bearing a company logo.

Very nice, but not necessarily thought-provoking.

And Richard A. Bentfield wants to provoke.

When the president of Starkweather & Shepley Inc. in Providence, R.I., contacted a local advertising agency last year, he wanted help to put together a mailing that targeted the top executives of large area businesses.

What he got was a broken pencil in a box.

"We could have sent out Cross pens, paperweights or crystal, but they're not attention-getters," said Mr. Bentfield, whose brokerage generated \$69 million in premium volume and \$8.4 million in gross revenues in 1991. "We were looking for chuckles—or even anger. All we were looking for was attention."

The mailing consists of a bright-yellow cardboard box the size of a videocassette, with the headline, "Your business insurance. A brief analogy."

Sliding the box open reveals a pencil with a broken tip, and the words, "Think of this as your risk management."

Lift a tab to find a silver pencil sharpener and the words "Think of this as Starkweather & Shepley," followed by a few lines of copy written by

he said.

Although Near North represents other teams, Mr. Segal said the White Sox tarp arrangement is one-of-a-kind for the agency, which maintains no other promotional programs with the other teams it represents.

In sports and entertainment insurance, Near North doesn't really need to advertise, said Mr. Segal: Word of mouth gets the name around.

Besides placing the liability and player disability coverage for athletic teams, Near North

Mr. Bentfield, briefly describing the services the brokerage offers. Last comes the brokerage's phone number.

That's it. No business cards, no brochures, no cover letters. In some cases, there isn't even a return address on the plain brown wrapping on the box.

Starkweather & Shepley had 500 of the boxes manufactured at a cost of about \$21.50 each and began mailing them May 1. So far, 120 have been sent; the goal for the year is 200.

No representative per se is used; the agency's sales mailing list provides the names of the mystery box. The only criteria is that they must not be current customers and must generate \$25,000 or more in annual premiums.

Typically the boxes are sent in the mail on Thursdays or Fridays, for a Monday or Tuesday delivery. The sales reps or Mr. Bentfield then follow up with a phone call to the CEO by the end of the week.

"We just say, 'We're the guys who sent you the pencil,'" he said.

The box is followed by a brochure and a cover letter written specifically for the CEO by the sales rep.

What's the response been so far? Pretty good for a broken pencil, Mr. Bentfield said. From the 120 boxes sent so far, the agency has gotten 34 expiration dates and 10 appointments.

He admits that the mailing is "not cheap": Postage alone runs \$2.90 for the weighted box. But Starkweather & Shepley recruited nine insurers to help defray the expense, so the brokerage pays only 50% of the total cost of the mailing, he said.

Credit for the box concept goes to Mariani, Hurley & Chandler Inc., an advertising agency in Providence.

also places disability insurance covering individual players with London market underwriters or Chubb Corp.

A fairly new wrinkle in insurance is for athletes with specialized negotiated contracts.

For instance, the father-and-son auto racing team of Mario and Michael Andretti has a two-year non-performance contract. The modified disability coverage Near North places for event sponsors ensures payment if the Andrettis collect and don't show, Mr. Segal said.

Another twist confronting the brokerage: frequent claims against minor league teams. The major league teams are liable for claims incurred by their farm teams.

To help cut down claims, Near North offers claims and loss control seminars for minor league coaches, he said.

Near North got into the entertainment specialty business three years ago, when it acquired Cohen Insurance & International Film Guarantors Inc. in New York, which specialized in television commercial filmmakers.

Today, Near North owns its own bond completion company and has made the move to theatrical productions with a branch office in California. The brokerage is now working on "Bronx Tale," Robert DeNiro's directorial debut, which is being filmed in New York, Mr. Segal said.

For projects like this, Near North places insurance for cast insurance and for the film itself. Near North also issues completion bonds, which guarantee the budget and schedule of a feature film. Primary underwriters for the coverage are Fireman's Fund Insurance Cos. and Transamerica Corp., he said.

"It's a fun niche and getting more sophisticated," Mr. Segal added.

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Agent/Broker Topics

Debunking the marketing myths

By SARA MARLEY

SANTA FE, N.M.—Marketing myths are hurting American business, says a marketing expert.

"American business is in trouble—and the problem is not Japan," said Kevin Clancy, former chairman of Yankelovich Clancy Shulman in Boston. "Marketing, in practice, doesn't work nearly as well as it should."

Problems in American marketing are due in part to the reliance on myths, Mr. Clancy said last month at the annual meeting of the Insurance Marketing & Communications Assn.

One is that high-volume buyers are the best prospects. In reality, the largest consumers tend to be price-conscious and disloyal because they are constantly courted by competitors, Mr. Clancy said.

A related marketing myth is that the middle market is shrinking.

"The middle market is thriving," Mr. Clancy countered. Those consumers tend to be practical and look for value and quality. They avoid status sym-

bols and are open to new products.

Another myth is that whether or not consumers like a company's advertising is irrelevant, so long as the advertising is memorable.

"The attitude toward advertising is the best predictor of success," Mr. Clancy said.

Advertising helps shape a company's reputation. "Buying decisions are based on the reputation of a corporation," Mr. Clancy said. "A well-done corporate reputation has a pay-off."

A company's compelling, attention-grabbing message also must be backed up with enough media exposure to break through the clutter of information the consumer receives, he noted.

In addition, marketing campaigns must be monitored after they are introduced.

"Marketing and advertising are more science than art," Mr. Clancy said. "You don't have to rely on mythology."

As a result of reliance on myths, Mr. Clancy said, "Entire

industries are failing. Product categories are overcrowded. Once-dominant players are slipping."

Companies are not cultivating the growth of their core products. The 1980s were more about shuffling assets than a true business boom, Mr. Clancy said. Many losses, including losses in the insurance industry, were "hidden within consolidated business reports," he claimed.

"For the average company, take away the mergers and acquisitions, and the core business is limping along. There was no organic growth" in the '80s, Mr. Clancy said.

Like other aspects of a business, marketing and advertising should show a "reasonable return on investment," he said.

But, according to Mr. Clancy, "Marketing efforts are rarely successful."

In fact, 80% of new products fail, mainly because they are not distinguished from competitors, Mr. Clancy said. And a poorly executed marketing effort can ruin even an established product.

"Most promotion is unsuccessful. You see a one-time increase in sales," usually because the price is lowered as part of the marketing effort, Mr. Clancy said.



Mr. Clancy

Agents access new market

Specialists in niche programs approach reinsurer-owned insurers

By ANDREW BARILE

IN LIGHT OF THE current market, insurance agents, wholesale insurance brokers and managing general agents who



have specialty "niche" insurance programs should explore using a new, emerging insurance company market—

primary insurance companies owned by reinsurers.

Reinsurance company groups have been increasing capital. At the same time, there is less reinsurance premium available.

This development forces reinsurance companies to look at other types of business opportunities. First there was alternative risk transfer business—or captives, purchasing groups and risk retention groups—all of which require reinsurance. Now there is specialty-niche program business. Reinsurance groups are beginning to either have their reinsurance units write direct insurance for specialty niche programs or acquire primary insurance companies to do this.

Let's examine one large reinsurance company group. One of its primary companies, a surplus lines insurer, wrote \$165 million in direct business. It is only licensed in Connecticut. Another primary insurer, with 46 state licenses, wrote \$3 million of premiums in 1991. This company has two more primary insurers, one surplus lines and the other a 50-state licensed company with almost \$60 million of direct premiums

A/BT Perspective

written for 1991.

Agents can directly approach reinsurer groups with the capability to write primary insurance. Those looking to access this new market should be prepared to present a complete business plan of the niche program they plan to write. Some of the areas of the business referred to as "niche" specialty programs may include:

- Professional liability.
- Non-standard auto or specialty auto.
- Tow truck programs.
- Trucking for specific industry groups.
- Association programs, including real estate errors and omissions.
- Long-haul trucking programs.
- Rental car programs.

Insurance agents should be prepared to demonstrate their expertise in the designated area of business. Corporate agency resources may have to include policy issuance, but generally not claims handling for the particular program. The program should demonstrate how it is going to make an underwriting profit for the reinsurance company.

Interestingly enough, the reinsurance requirements may also be listed. On this basis, if the primary insurance company is writing the program, it may have no option but to reinsure with its reinsurance company parent. And reinsurance company professionals are careful to avoid conflicts of interest between a class of business written by their new

agent client and the same class of business written by their existing insurer clients.

For example, a reinsurance company that reinsures a truck insurance company has an intimate knowledge of the underwriting and pricing of truck insurance. An agent specializing in trucking insurance seeking an insurer for that coverage could conceivably approach the primary insurer owned by that reinsurer.

From the agent's viewpoint, reinsurance companies make very attractive markets because they do not have other agents to contend with. Agents will be given not only exclusive insurance products, but also exclusive territories in which to distribute those products. Rating philosophy and underwriting criteria for the program are all worked out beforehand. Reinsurance company markets seeking more business and new opportunities are writing direct insurance business. Agents should begin to look at this new market for their program business.

Andrew Barile is president and chief executive officer of



Insurance Agency Programs, Inc., a New York consulting firm to corporations, insurance agents and law firms, and a reinsurance intermediary.

Insurers told to remember agents in advertisements

SANTA FE, N.M.—Insurers need to design their advertising and marketing programs with agents in mind, says a former agent.



Rather than promote the insurers themselves, advertising should "help agents develop new business" said Karl L. Peterson, secretary of Insurance Training & Risk Management, a continuing education and textbook publishing firm in Springfield, Ill. Mr. Peterson had been an agent for Overheul, Peterson & Co. in Decatur, Ill., until 1986.

"The consumer does not do business with the company. The consumer does business with the agent," Mr. Peterson told insurer marketing and advertising professionals at a recent Insurance Marketing & Communications Assn. meeting.

Claiming that most promotional material that insurers send to agents is discarded, Mr. Peterson identified weaknesses in current insurance advertising.

Most ads are too generic, he said. Insurers should develop different campaigns for various sizes of agencies and markets.

"An agent in the Midwest does not need pictures of the New York skyline," Mr. Peterson said. "He needs a picture of himself, his staff, building and logo."

While ads should be geared toward agents, they should not attempt to explain entire policies, Mr. Peterson cautioned.

"All too often you see ads designed to educate the consumer. You can't condense a policy into a one-page printout. You can't cover exclusions and provisions. It's the agent's job to educate the consumer," he said.

Other problems in insurer advertising include a failure to incorporate underwriting concepts and priorities into insurer marketing and lack of market analysis and input from agents, Mr. Peterson said.

Insurers should focus their marketing efforts on agencies with \$1 million to \$4 million in

annual premium volume, Mr. Peterson said. Smaller agencies will have limited advertising budgets and sales programs, while larger agencies will likely have their own marketing staffs, he explained.

Finally, insurers should take the time to explain advertising and marketing strategies to their agents.

"In 25 years as an agent, I never saw an insurance company representative," Mr. Peterson said. "Use your talent to help agents. Sell the advertising to the agent himself."

—By Sara Marley

AUGUST CLOSINGS

issue: August 17 — Reader Service — Bonus Distribution: ARIA
closing: August 4
editorial feature: Surplus Lines — Directory: Surplus Lines Insurers & Wholesalers
demographic section: Insurer Topics: Education/Recruiting & Personnel Development

issue: August 24
closing: August 12

issue: August 31 — Bonus Distribution: Monte Carlo Rendez-Vous
closing: August 18
editorial feature: Reinsurance: International Markets — Directory: Leading Reinsurers Worldwide

issue: September 7 — Bonus Distribution: SIIA
closing: August 25
editorial feature: Benefits: Pensions/Retirement Plans — Directory: 401(k) Plan Administrators
demographic section: Agent/Broker Topics: Most Productive Agencies

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Assurex appoints Harvey

By LAURA MAZZUCA

COLUMBUS, Ohio—Thomas W. Harvey, a venture capital firm executive with no background in insurance, was recently named president and chief executive officer of Assurex International Corp.

Mr. Harvey succeeds Robert P. Ashlock, who served as Assurex president from 1984 until his death in January of this year (A/BT, March 2).

Assurex, based here, is an insurance and financial services organization owned by 64 independent agencies in the United States, Canada and Europe.

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Continued on next page

Assurex

Continued from previous page
 vp and co-manager of Scientific Advances Inc., a venture capital arm of Battelle Memorial Institute, a technology development organization headquartered in Columbus. He served in several posts with Mr. Ashlock at Xerox Corp. before joining Battelle.

Mr. Harvey holds a bachelor's degree in economics from Georgetown University in Washington and holds a master's degree in business administration from George Washington University, also in Washington. He has taught business and sales management, salesmanship and marketing communications.

Lacking a background in insurance will not hinder his work, Mr. Harvey says. He points out that Mr. Harvey was also "one of an entrepreneurial and marketing guy" who had no experience in the insurance industry when he joined Assurex in 1977.

"The insurance industry is going through the same cycle as the venture capital industry, which has been on the slide since 1983 and is just now rebounding," he said. Al-

though the "drivers are somewhat different," both industries are connected to the economy, he said. His experience in "helping build small companies into medium-sized companies" is well suited to the needs of Assurex members, Mr. Harvey said.

Mr. Harvey and Mr. Ashlock met in 1964 when both were at Xerox, Mr. Harvey said. They went their separate ways but came together again in 1971 to start an enterprise helping university professors start a business, he said. The two were friends as well as business associates.

When Mr. Ashlock developed lung cancer several years ago, he began looking for a successor and asked Mr. Harvey to consider taking the position. Although he turned Mr. Ashlock down the first time, Mr. Harvey told Mr. Ashlock before his death in January that he would consider the offer. He accepted the position in May.

Mr. Harvey currently spends half of his time on the road, visiting Assurex members around the country and "trying to understand what Assurex partners do," he said. He plans to have visited at least a dozen by the end of this month.

The Assurex executive committee has plans to expand internationally over the coming months, especially in Europe, Mexico and Canada, Mr. Harvey said.

Assurex's sound financial condition, high-quality staff, and solid business philosophy have made the organization successful, he said, so any forthcoming changes will be "forthrightly modest."

"We have a good, strong base here; the basics are here," said Mr. Harvey. "Bob left some large shoes to fill, but he helped me understand the business better." ■

Fight over exclusive deal leads to fines, jail terms

Two San Diego brokers, a 'sleazy trick' and a fateful letter

By LOUISE KERTESZ

SAN DIEGO—Relations are often strained when ambitious employees leave one company to start a competing business.

But seldom do these disputes escalate as rapidly or as severely as a recent fight among an established local brokerage, a start-up broker and a specialty insurance company.

A Superior Court judge in San Diego in June handed down a \$125,000 fine and a 625-day jail term against each of two officers in the start-up brokerage—Jeffrey W. Cavignac and Robert R. Supple—and two officials with the specialty insurer, Design Professionals Insurance Co. All the penalties have been stayed pending an appeal.

Their offense? Violating a court order to solicit a court of the established brokerage, Robson, Cavignac & Associates Insurance Agency.

The temporary order was issued after Robson, Cavignac and its new owner, Lawrence Agency Corp. of Schenectady, N.Y., alleged that the start-up brokerage was part of a "conspiracy" to "steal" Robson, Cavignac's book of DPIC business. The conspiracy began, they allege, when Jeffrey Cavignac's father sold his interest in Robson.

In handing down the contempt sentences, the judge offered this summary: "What I see here is a legitimate business buying another legitimate business with full expectations of getting the full benefit of this bargain and ending up—because of what I would only call a sleazy trick—with only half a bag.

"I find it to be outrageous." Until February, Messrs. Cavignac and Supple were employees of Robson, Cavignac, which had an exclusive agency agreement for the San Diego area with DPIC. Then the two left to form Jeffrey W. Cavignac Insurance Brokerage.

Soon Robson, Cavignac's exclusive agency contract was terminated, as was the contract of Lundberg Insurance Agency Inc. of Fresno, Calif. Both contracts ultimately went to Jeffrey Cavignac's brokerage.

On May 5, Robson, Cavignac, its parent—Lawrence Agency Corp.—and Lundberg sued. The crux of their 25-count complaint: Mr. Cavignac, Mr. Supple and the new brokerage all conspired with DPIC to terminate both agreements and shift the business to the new brokerage.

Also named as a defendant was Mr. Cavignac's father, Frank G. Cavignac, who had retired and sold his interest in Robson, Cavignac to Lawrence in 1985. Three years later, Lawrence completed the buyout.

When Mr. Cavignac retired, according to the suit, he persuaded Robson, Cavignac to let his son handle the "extremely valuable" book of DPIC business that he had been handling.

"After receiving substantial consideration" in the agency

buyout, the suit charges, "Frank G. Cavignac then charges, 'Frank G. Cavignac maintained ties with DPIC, including doing some consulting work.'"

After retiring, Frank G. Cavignac maintained ties with DPIC, including doing some consulting work.

During this time, the suit alleges, the father used his influence to convince the insurer to switch agencies.

According to court papers, the insurer terminated Robson, Cavignac's exclusive agency agreement in February and Lundberg's two months later. Then DPIC entered an exclusive agency agreement with Jeffrey W. Cavignac Insurance Brokerage.

On May 7, Judge Kapiloff J. Kapiloff granted a temporary restraining order enjoining the start-up brokerage from soliciting Robson, Cavignac clients, according to Anthony M. Stiegler, a lawyer for Robson, Cavignac.

On May 22, Judge Kapiloff granted a preliminary injunction against DPIC, "which trampled the language of the temporary restraining order," said Mr. Stiegler, a senior associate with Gray, Cary, Ames & Frye in San Diego.

Then, on May 25, "DPIC called for oral arguments to clarify what it could do pending the outcome" of the suit, Mr. Stiegler said.

Oral arguments were set for May 30.

But on May 28, DPIC sent out a letter soliciting the clients of Robson, Cavignac.

"DPIC decided to change

agencies in the San Diego area," said Vincent Papa, vp and treasurer of Orion Capital Corp., parent of DPIC. "The disagreement we ran into—which is the same as any company would face (in changing agencies)—is a new situation for DPIC. In all of our prior agency transitions, we were able to negotiate acceptable terms" with the terminated agency, he said.

David Pendarvis, an attorney in San Diego with Gibson, Dunbar & Crutcher, who represents Jeffrey Cavignac, Mr. Supple and their brokerage, said, "There's no merit to the underlying suit."

The letter DPIC sent its policyholders was an announcement of the change in agency, "written with the advice of our counsel," said Mr. Papa. "We had no reason to believe the announcement was in violation of the temporary restraining order, and we were surprised at the outcome (of the contempt trial).

"We continue to believe the announcement was within the parameters of the temporary restraining order."

On June 26, Judge Kapiloff found Messrs. Cavignac and Supple, as well as the two DPIC officials—President Peter B. Hawes and Senior Vp James V. Atkins—in contempt of his order.

Though he stayed the fine and jail terms pending appeal, he ordered DPIC to send a retraction letter to Robson, Cavignac clients.

Judge Kapiloff also ordered Jeffrey W. Cavignac Insurance Brokerage to refrain from doing business with any client that has contacted the agency as a result of the letter sent by DPIC, according to court papers. ■

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Business Insurance

Continued from previous page
senting financial institutions.

"We're proud to have these outstanding risk managers judge this year's competition," Mr. Burcke said. "Their accomplishments represent the excellence in risk management the awards were intended to recognize."

The other six judges will be announced shortly.

Business Insurance created the Risk Manager of the Year award in 1977, on its 10th anniversary of publication. Four years later, it created the Risk Management Honor Roll to recognize achievements in risk management in different types of organizations.

The judges score each nominee on 10 criteria (see box). The nominee with the highest score is named Risk Manager of the Year. The top-scoring nominees in each employment category not represented by the Risk Manager of the Year are named to the Risk Management Honor Roll, subject to the judges' discretion.

The categories are: corporations with sales exceeding \$300 million, corporation with sales of less than \$300 million, government entities, tax-exempt or non-profit institutions, financial institutions, and self-insurance funds and pools.

Risk managers from organizations worldwide can be nominated. A candidate must be a full-

time employee of the organization for which he or she directs the risk management program. However, the candidate need not handle risk management functions on a full-time basis.

In addition to the completed nominating forms outlining the risk manager's accomplishments, each nomination must include a nomination letter from the sponsor and a letter of endorsement by either the risk manager's superior or another higher-ranking executive of the organization. The letter must certify the accuracy of the information contained in the nomination.

All nominations will be held in confidence, with only the honorees' names announced.

For a Risk Manager of the Year nomination form, write Karen Brown, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590 or call 312-649-5319. ■

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- Innovatively applies the diverse tools of risk management and insurance.
- Creatively and effectively uses the insurance markets to structure an insurance program that serves the needs of the organization.
- Established a workable intelligence system inside and outside the organization, culminating in a flow of information about events and activities that affect the organization's risk management and insurance.
- Skillfully performs the functions of management in the overall organization and within the risk management/insurance department.
- Achieves the most effective program at the optimum cost over the long term.
- Developed technical expertise in any or all of the broad categories included within risk management, leading to a better managerial grasp of the operations aspects of the job.
- Exhibits an attitude and performs activities fostering the advancement of the risk management profession.
- Develops in his or her career.

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For The Record

Labor delays deadline for filing pension report

WASHINGTON—Administrators of so-called "top hat" pension plans have until Sept. 30 to take advantage of a filing break given to them by the Department of Labor.

After the Labor Department in April announced a new program to assess civil penalties of up to \$1,000 per day for pension plan administrators who didn't file timely Form 5500 annual reports, it received many queries as to whether the penalties applied to top hat plans.

A top hat plan is an "unfunded pension plan primarily for a select group of management or highly compensated employees," says Scott Tucker, a consultant with William M. Mercer Inc. in Washington.

The department said that top hat administrators who had failed to file a required statement will not have to submit the Form 5500 annual reports for plan years 1988 or later, provided that they file a statement by Sept. 30 containing a list of specified information about the plan and pay a penalty of \$50 per day up to a maximum of \$1,000 per filing.

Survey finds judges sympathetic to plaintiffs

ITHACA, N.Y.—A study by two Cornell University law professors challenges the belief that juries are more sympathetic than judges toward plaintiffs in medical malpractice and product liability suits.

Plaintiffs actually win more often before judges, and the difference in damage awards is often negligible, reports the study by Kevin M. Clermont and Theodore Eisenberg. Their research included all medical malpractice and product liability trials in federal district courts from 1979 to 1989.

In medical malpractice suits, plaintiffs won 29% of cases heard by a jury, but 50% of cases before judges. Product liability suits produced similar figures: 28% and 48%, respectively.

Average damages awarded in malpractice suits were almost identical—\$1.4 million from juries and \$1.44 million from judges. Bigger differences, though, emerged for product liability damages: Juries awarded an average of \$1.2 million, judges only \$91,000.

But, the professors caution against assuming that juries are generally "more favorable toward plaintiffs." Because of beliefs that juries are more sympathetic, only 10% of these two types of tort cases go before a judge, the professors note.

Woodward succeeding Tebb as CWCI manager

SAN FRANCISCO—Edward C. Woodward, former executive vp of Enan & Co., a reinsurance intermediary in Burlingame, Calif., has succeeded Alan Tebb as general manager of the California Workers' Compensation Institute.

From 1981-1984, Mr. Woodward was assistant general manager of CWCI, a non-profit, insurer-supported research organization whose members write 95% of California's workers comp premiums.

Mr. Tebb will serve as vice chairman for the next 1½ years.

Work comp premiums flat in California: Study

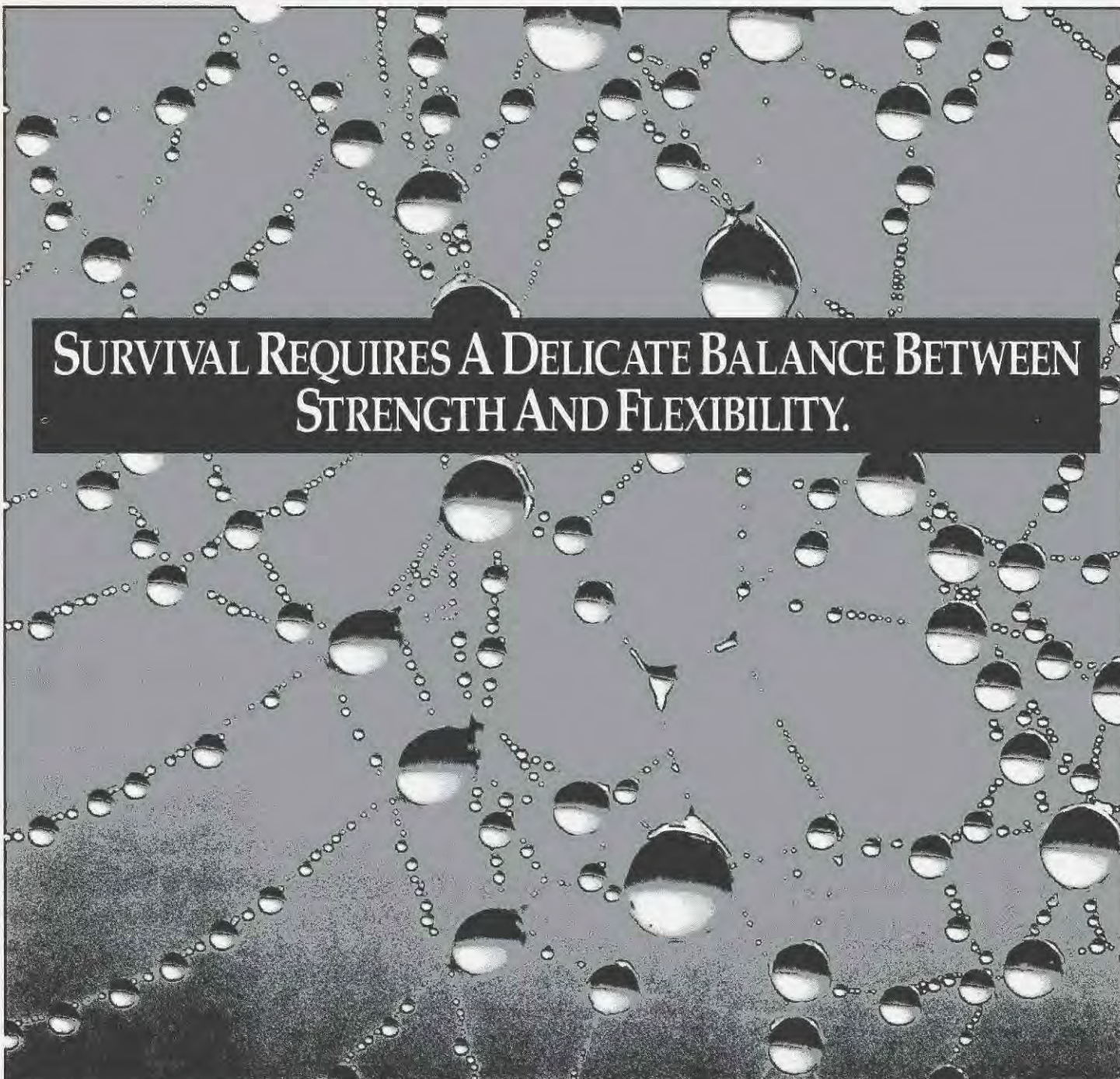
SAN FRANCISCO—California workers compensation premiums remained virtually flat in 1991 as a recession-driven decline in payrolls canceled out the effects of a 5.8% premium rate increase, the California Workers' Compensation Institute reported.

Direct written premiums were \$8.49 billion, a scant 0.3% above 1990 levels.

Halliburton to sell its Highlands unit

DALLAS—Halliburton Co. says it will sell its Highlands Insurance Co. unit to refocus on its energy, engineering and construction business.

The Houston-based underwriter of commercial property/casualty and workers comp coverages reported net premiums of approximately \$400 million in 1991. Total assets at year-end were about \$1 billion, and surplus totaled about \$300 million.



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South Korean market

U.S. intervenes in insurance reform efforts, liberalization

By Douglas N. Smith

THE TREND TOWARD liberalization of insurance markets that accompanied the growth of free market models in both Latin America and Asia has been the topic of several recent International Issues columns. The U.S. government has encouraged deregulation of financial markets, privatization of state-controlled entities and increased trade in services and goods throughout the 1980s and now in the 1990s. U.S. leadership and individual countries' goals to develop professional and fiscally strong insurance markets have been the primary reasons for the liberalization trend in insurance.

But restrictions or barriers to international trade in services continue in many countries, and increasingly U.S. trade officials have been forced to take a more active role in assisting U.S. corporations, including insurers and brokers, in penetrating foreign markets. Unlike the imposition of quotas or tariffs on international trade in commodities or goods, barriers to trade in services are not as easily identifiable.

In South Korea, the insurance industry historically has been characterized by unwieldy standards and regulations, problematic customs or administrative procedures and restrictive local market practices.

U.S. governmental assistance in encouraging South Korea to liberalize insurance standards indicates the importance of the Asian insurance market. Recent data indicates that although this region accounted for only 25% of world premiums in 1990—less than North America's 38% and Europe's 34%—its growth rate and potential are vast. The South Korean insurance industry grew more than 20% in 1990 and in terms of the percentage of gross domestic product—production from within the country's borders—spent on insurance, it became the world's leader at 11.5% that same year.

The relationship between economic growth and the use of insurance in South Korea is noteworthy. In the early 1960s, South Korean exports amounted to less than \$50 million and per capita GDP was about \$100. By 1991, notwithstanding interim cycle upswings and downturns, Korean exports reached \$70 billion and per capita GDP hovered just above \$6,000. The increase in South Korean GDP, therefore, has been matched by increased insurance purchasing and illuminates the future potential of this market as its economy expands.

U.S. insurers in Korea did not participate in the gains resulting from this trade explosion, because South Korea permitted only two branches of U.S. companies to operate in non-life business. The inequality of this situation, however, did not go unnoticed. To remedy this, U.S. trade officials began talks with South Korea in 1985. In July 1986, South Korea agreed to liberalize the operating conditions of the two U.S. insurers and to permit new applications for licensing as well as joint ventures between U.S. and South Korean insurers. The major market affected, however, was life insurance, with the number of insurers increasing from six to 32, including three foreign firms and six foreign joint ventures.

The government subsequently dropped a requirement that all reinsurance be placed with the Korean Reinsurance Corp. However, like other previously discussed markets, including Indonesia, the market has largely continued operating through, or according to the dictates of, the state insurance company.

The mandatory use of the Korean Fire Protection Assn.—also known as the Fire Pool—for specified risks also has been slowly phased out. Multinational corporations purchasing insurance are now seeing

International Issues

more reflective ratings for their exposures. The Fire Pool is now only mandatory for buildings with more than six floors and factories in nine designated cities, but even this requirement will probably be terminated by Oct. 1.

It is only recently, however, that real reforms affecting property/casualty insurance have been enacted, again as a result of intervention from the United States. Although for the moment there continue to be only 11 South Korean insurers and two foreign branches, another foreign firm has received provisional approval to open a branch. Though new product approval continues to be highly regulated and pricing is still subject to tariff and/or KRC rating, recent talks between U.S. and Korean representatives are thought to be addressing this issue as well.

Financial policy talks are now being held between the U.S. government and the South Korean government regarding both the financial services and insurance industries. The South Korean Ministry of Finance has agreed to prepare a "blueprint" to liberalize the insurance industry, which is expected to be concluded within the next five years.

In South Korea, the insurance industry has been characterized by unwieldy standards and regulations, problematic customs or administrative procedures and restrictive local market practices.

The Korean Institute for International Economic Policy, a government macroeconomic think tank, expects the Uruguay Round of the General Agreement on Trade and Tariffs talks to require freedom of services including insurance and reinsurance. Since Korea is unlikely to resist the agreement in the area of insurance so as not to threaten more important trade issues, it should only be a matter of time before liberalization is achieved. The Ministry of Finance, whose immediate concern is that excessive competition could damage the domestic insurance market, will prepare a schedule for liberalization of pricing and products. The introduction of a brokerage system is not expected until after pricing has been liberalized.

Another important insurance-related change is that the Ministry of Labor intends to extend mandatory participation in its national workers compensation plan. Until recently, all service firms were exempt and could buy private insurance. As of July 1, all service firms with 10 or more employees are required to enter the government plan. Banks, insurers and charitable institutions are still exempt, but they may lose their exemptions in the future. It appears that the ministry may soon lower the minimum for mandatory participation to five or more employees.

Because the government workers comp plan is not the sole remedy and does not cover employers' liability, it is important that companies discuss this risk carefully with their representatives. Companies should comply as soon as possible if the ministry goes through with its plan, because last year, when the government plan was extended to service firms, many firms that were purchasing private insurance were charged back premiums and penalized for not switching over immediately.

Two issues are important to mention regarding foreign investment in South Korea: the issue of

reunification of North and South Korea, and the civil unrest that has resulted from protests against the governing Democratic Liberal Party.

The unification of North and South Korea takes on a particular economic interest—especially in South Korea—as the increasingly burdensome cost of German reunification becomes more evident. Most experts agree that North Korea's economy has suffered tremendously since the dissolution of its former patron, the Soviet Union. Soviet trade with North Korea is believed to have represented between 30% and 50% of North Korean foreign trade.

The loss of its primary trading partner leaves North Korea with few options for reforming its faltering economy; trade with South Korea, though desired, is not viable, because South Korea continues in most instances to ban trans-border business transactions. From the South Korean perspective, North Korea offers little more than an alternative source of cheap labor in a region saturated with workers. However, from a long-term view, an economically healthy North Korea would have a two-fold benefit. It would:

- Lessen the cost of unification, which could reach an estimated \$140 billion.
- Minimize the possibility that an economically broken North Korea under the rule of Kim Il Sung might lash out at South Korea.

The Sung government recognizes the potential economic benefit of trade with the South. However, recent border incidents and North Korea's refusal to allow South Korea to inspect on "short notice" its nuclear facilities leave many South Koreans wary of North Korean intentions.

In the last decade, there has been well-publicized civil unrest in South Korea, though political protests by activist students appear to be declining.

In the presidential elections in the fall of 1992, Kim Young Sam, the former opposition leader who changed to the ruling Democratic Liberal Party, will probably run against his former ally, Kim Dae Jung. This may inspire new rounds of protest by students who consider Sam a political opportunist. For multinational investors wary of the situation, however, expropriation of either equity or investments is highly unlikely, since the South Korean economic miracle, which is based on exports, would be affected.

The trend toward liberalization of South Korea's insurance industry will probably continue in the short to medium term, spurred by an activist U.S. trade policy which has contributed greatly toward the elimination of barriers to U.S. insurers' entry into this market. By linking progress in the GATT negotiations with deregulation of the insurance market, negotiators have pushed South Korea to initiate opening of the market. South Korea, wary that its export-led economy might be affected by U.S. retaliatory trade practices, has responded favorably.

For the insurance purchaser, the opening of the insurance market will increase professional standards as new players enter the market. And access to foreign markets, along with the likely tariff reduction or elimination and the lessening of the KRC's monopoly, should portend better pricing for multinational companies. ■



Douglas N. Smith is senior vp and manager of the International Department of Johnson & Higgins in New York. His column appears the first Monday of every month.

ASK A BENEFITS ACTUARY

Beware Uncle Sam's withholding tax trap

Q

Has Congress set a trap for the American taxpayer with a new law that imposes a withholding tax on non-periodic qualified plan distributions?

A

This question arose when a client called the other day, wanting some additional information about a new law enacted July 3 that deals with withholding taxes on non-periodic qualified plan distributions. After my client

understood the new law, his response was the same as mine: Yes, Congress has set a trap for the American taxpayer.

Beginning in 1993, non-periodic qualified retirement plan distributions, such as a plan distribution to a terminated employee, can be rolled over to another qualified retirement plan or to an IRA without the current law's restrictions on total and partial distributions.

For example, these restrictions currently require that at least 50% of the balance to the credit of an employee had to be moved into an IRA in order to qualify as a rollover. Beginning in 1993, though, a terminated employee will be able to roll over less than 50% of his account balance and still avoid taxation on the rollover amount. In addition, retirement plan sponsors will be required to transfer distributions directly to an eligible plan—either another qualified retirement plan or an IRA—at the participant's request.

The downside from a participant's perspective is that a 20% withholding tax will be imposed on distributions that are eligible to be rolled over, but are not directly transferred to an IRA or another qualified retirement plan (BI, July 13). Congress' intent in imposing this 20% withholding tax is to partially finance an extension of unemployment payments for long-term jobless workers.

Undoubtedly, many deserving people will benefit from this extension of unemployment compensation. But the withholding tax is a cynical and deliberate

trap set by Congress to glom onto the savings of the U.S. taxpayer.

The trap for the U.S. taxpayer is best understood by considering a hypothetical example. Suppose an employee terminates in 1993 with a single-sum benefit under a qualified retirement plan of \$100,000. If the distribution check is made out to the terminated employee, the check will be for \$80,000 and \$20,000 will be withheld. At this point, the terminated employee has fallen into the trap set by Congress and is going to make a contribution in one form or another to the U.S. Treasury. This would not be the case under current law.

The employee, though, still has 60 days to roll over up to the full \$100,000 into an IRA or a qualified plan. If the terminated employee has \$20,000 in personal savings outside of a qualified retirement plan, he can combine that with the \$80,000 received and roll over the maximum amount into another plan. However, the employee will lose investment income on that \$20,000 for a period of time. The terminated employee will get back the \$20,000 that was withheld when his 1993 income tax return is filed and the \$20,000 is included in the tax refund. But, the employee won't see that refund until 1994. So the terminated employee has lost the investment earnings on the \$20,000 held in personal savings outside of the qualified retirement plan, and effectively contributed those investment earnings to the U.S. Treasury.

But not all terminated employees will have \$20,000 in personal savings that they can use to make the maximum rollover and eventually recover the amount withheld. Many individuals in the United States don't have significant personal savings outside of qualified retirement plans. And those who do may want to hang onto the money, especially if our hypothetical terminated employee expects to be out of a job for a period of time. He may roll over only \$80,000 into another qualified retirement plan or IRA and therefore will increase his taxable income in 1993 by \$20,000. A terminated employee in this circumstance will be making a contribution to the U.S. Treasury of the tax due on the \$20,000.

These contributions to the Federal Treasury can be easily avoided. The terminated employee needs only to direct the plan to make the check payable to either another qualified retirement plan or an IRA.

The infuriating aspect of this trap is the cynicism with which it has been set by Congress. Congressional estimates of revenue from rollover

and withholding on non-periodic distributions betray their cynicism: approximately \$2.1 billion is anticipated in 1993, \$26 million in 1994 and inconsequential amounts thereafter. Why does the estimated revenue from the change in law drop off so rapidly after 1993? Because Congress realized that the American public will not fall into this trap for more than one year. Congress might as well be saying to American taxpayers that you are stupid or uninformed, but only for one year.

The new law requires that plan administrators inform participants about the new rules. In addition, the Treasury Department is responsible for developing a model explanation for employees. However, it seems to me that plan sponsors ought to respond pro-actively to this change in law and communicate it to their employees immediately and forcefully. Employees need to understand the implication of the law, and perhaps even the cynical message that Congress is sending to the American public. The more people who learn of Congress' tactics, the greater chance that Congress may be more circumspect with future legislation. ■

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

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



Mr. Miner

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

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

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

CGL excludes coverage for pesticide spraying

A pollution exclusion in a comprehensive general liability policy applied to relieve an insurer of the duty to indemnify a city for damages allegedly caused by chemicals the city sprayed as part of its service to control insects and pests, said the Supreme Court of Michigan.

The city of Woodhaven, Mich., periodically sprayed pesticides to control insects and pests. The city's CGL policy with Protective National Insurance Co. excluded coverage for pollution that was not sudden and accidental.

In 1984, the city was sued for damages allegedly caused by the pesticide spraying. The city submitted the defense to its GCL insurer, which brought this action seeking a declaration that it had no duty to defend. The trial court ruled for the insurer; the appeals court reversed.

The state Supreme Court said that the application of the pollution

Legal Briefs

exclusion depended exclusively on the discharge, dispersal, release or escape of the pesticide into the atmosphere. "The behavior of the pesticide in the environment after this initial release, is irrelevant," the court said. The court added that since the city intentionally released the pesticide into the atmosphere, the release cannot be accidental.

Therefore, the court found that the pollution exclusion applied and the city was not entitled to coverage. *United Parcel Service of America vs. Fetterman*, Supreme Court of West Virginia, Nov. 27, 1985 (BI/02/D.-\$10).

Employee slander suit allowed

Is an employee's tort action for slander against her employer barred by the exclusive remedy provision of

the Workers' Compensation Act? The Supreme Court of South Carolina ruled that it was not.

Rhonda B. Dockins worked for Ingles Markets Inc. In front of other employees and customers, a store manager allegedly implied that Ms. Dockins was having an adulterous affair with another employee and was carrying his child. Some statements were made over the store's public address system.

Ms. Dockins filed a slander suit, rather than a work comp claim. The trial court dismissed the suit, ruling that Dockins' remedy was to file a workers compensation claim.

The appellate court said that the act bars all actions against employers when a personal injury to an employee comes within the act. However, the court concluded that an injury in a slander action was not a personal injury under the act.

The court said that the "gravamen

of a defamation action, however, is injury to the reputation." In the opinion of the court, an injury to reputation affects a proprietary interest and is not a personal injury.

"We hold injury to one's reputation is not the type of injury envisioned by the Workers' Compensation Act," the court said, "and it is, therefore, inapplicable."

Ms. Dockins' slander suit was reinstated. *Dockins vs. Ingles Markets Inc.*, Supreme Court of South Carolina, Dec. 9, 1991; rehearing denied, Jan. 7, 1992 (BI/05/S-\$10).

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

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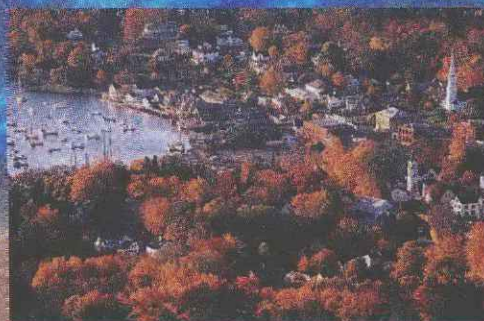
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INTERNATIONAL

Walbrook plan collapses

Transit presses for provisional liquidators

By GAVIN SOUTER

LONDON—The directors of Walbrook Insurance Co. Ltd. are considering their options after a last-ditch rescue plan failed to win sufficient support from creditors.

And one of the troubled insurer's major creditors, Transit Casualty Co., is pressing ahead with a petition to wind up the company.

Meanwhile, Bermuda Fire & Marine Insurance Co. Ltd. is petitioning the London High Court to wind up H.S. Weavers Underwriting (Agencies) Ltd., an affiliate of Walbrook.

In a brief statement issued Thursday, Walbrook directors said, "The level of support for the directors' proposals, whilst encouraging, (was) insufficient to continue developing the plan, even though the number of those replying adversely was small. The directors are considering their position."

Under the directors' original rescue plan, Walbrook would pay all of its outstanding claims in full. But larger claimants would be required to bolster Walbrook's capital by buying redeemable preferred stock with 60% of their claims payments (BI, June 8).

Walbrook, a unit of London United Investments P.L.C., was the leading insurer on the U.S. casualty line slip underwritten by Weavers. The slip stopped underwriting in March 1990 (BI, April 2, 1990).

Transit Casualty and other major creditors have opposed the preferred stock plan (BI, July 27; July 20).

Transit has petitioned the English High Court to wind up Walbrook. The application will

'One, two, three strikes and you're out,' Transit's Mr. Arnold says of Walbrook's efforts.

be heard Tuesday. Transit says it would save costs if Walbrook were treated the same as other companies on the Weavers slip and placed in provisional liquidation with the aim of establishing a scheme of arrangement for the companies.

"The directors of Walbrook have tried three things to help

the company, and they have all failed. . . one, two, three strikes and you're out," said Burleigh Arnold, the court-appointed special deputy receiver of Transit.

The directors have tried and failed to keep Walbrook solvent through commutations; they have not established a scheme of arrangement for the company; and now the preferred stock plan has failed, he said.

Meanwhile, neither company would comment on the Bermuda Fire & Marine petition.

However, some sources say that BF&M is citing a specific amount of \$28,000 owed to the company by Weavers.

"But nobody can believe it's just being done for that debt," said one source.

BF&M may want to see Weavers wound up and placed in an independent liquidator's hands in order to more quickly disentangle the claims problems that followed the Weavers collapse, another source speculated. ■

Australian names sue Lloyd's of London

By KATE McILWAINE

BRISBANE, Australia—Three of Australia's 650 Lloyd's names are taking legal action against Lloyd's of London, and others are considering litigation, attorneys say.

Among the allegations made by the Australian names, who face sizeable losses from their membership, are that Lloyd's brokers misrepresented the profit potential from membership in Lloyd's and that the market's operations were not fully explained to the investors.

Hearings in the first case, brought by Melbourne anesthesiologist Dr. Emlyn Williams, will begin Aug. 10 in the Supreme Court in Victoria. Dr. Williams' attorney, Brendan Fleiter of Brian Ward & Partners in Melbourne, said he was unable to discuss the case because it is before the courts.

However, Mr. Fleiter said Dr. Williams and two other members the attorney represents contend they should not be required to pay syndicate losses because of Lloyd's members' agencies' alleged misleading and deceptive conduct in violation of Australia's Trade Practices Act and for breaches of the Australian Companies' Code.

"Membership of Lloyd's and its syndicates is a prescribed interest under the code, and (Lloyd's) therefore must comply with certain provisions relating to the issue of a prospectus. . . and other matters," Mr. Fleiter said.

Mr. Fleiter will argue that under the law, Lloyd's was supposed to provide a prospectus and never did.

Lloyd's general counsel in Australia, Ian Hutchinson with Sydney law firm Freehill Hollingdale & Page, said the Williams case, which is expected to take five days, will determine whether the Australian courts have jurisdiction to hear names' complaints against Lloyd's.

Mr. Hutchinson noted that in similar cases in the United States and Canada, the courts ruled that they had no jurisdiction (BI, July 27, June 22).

No dates have been set for Australian courts to hear jurisdiction cases for the other two Australian names who, through Mr. Fleiter's firm, have filed complaints against Lloyd's.

Mr. Fleiter said he also has spoken with other names in Australia and overseas, but has not been instructed to take action.

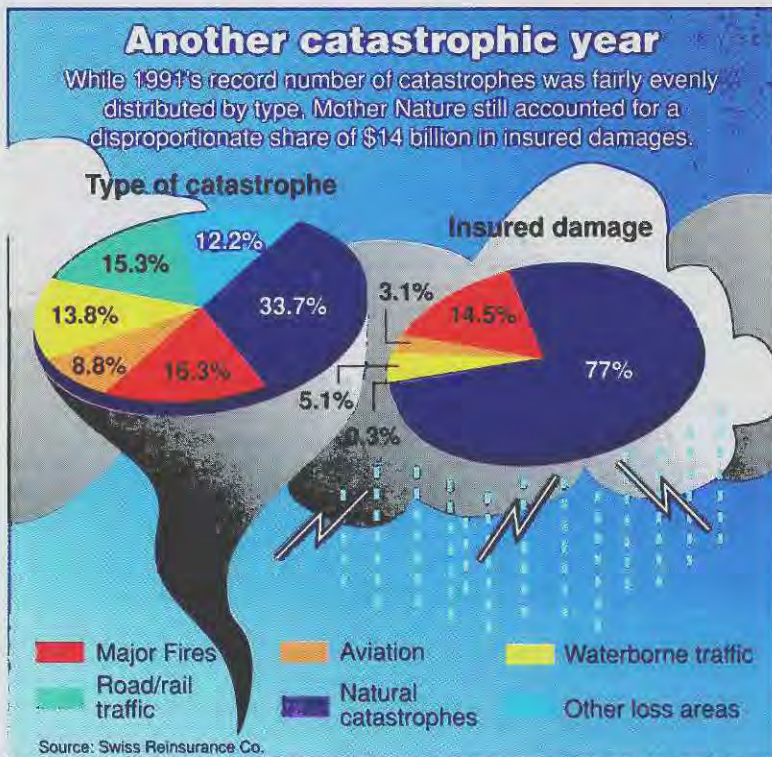
Paul Robinson of the Sydney law firm Sly & Weigall, which in November advertised in Australian newspapers its willingness to take cases on behalf of Lloyd's names, would not comment on whether his firm is taking any court action.

However, Mr. Robinson said names are "in the situation that they have been advised of substantial losses, and therefore they have nothing to lose if they take action."

He said some names told "incredible tales" of representations made but not fulfilled. Many are awaiting the outcome of Dr. Williams' case before deciding what action to take, he noted.

Dr. Williams won a temporary injunction to stop Lloyd's from drawing on his money invested with a major Australian bank. But the bank, Westpac, has started legal proceedings to have the injunction lifted.

In New Zealand, a partner in an Auckland law firm that represents Lloyd's names said two cases are before the courts, but he would give no further information without instructions from his clients.



1991 catastrophe toll hits \$14 billion: Study

By GAVIN SOUTER

ZURICH, Switzerland—Insurers will draw little comfort from last year's moderate decline in insured losses from natural catastrophes, because the total still far exceeds the long-term average.

The 1991 total of \$14 billion, as calculated by Swiss Reinsurance Co., is \$3 billion less than the record \$17 billion it tallied in 1990 (BI, Sept. 23, 1991).

And insurers' losses from natural catastrophes were compounded

by the continued above-average losses from manmade disasters last year, says a new Swiss Re report.

More catastrophes were recorded in 1991—108—than in any other year on record.

"The year 1991 is the worst so far as regards the frequency of all loss events and holds second place for insured damage on our list that dates back to 1970," the survey report said.

Leading the 1991 losses was Typhoon Mireille in Japan, which

Continued on next page

UNI Storebrand exec quits

Shareholders press for more changes at insurer's helm

By MARIA KIELMAS

OSLO, Norway—UNI Storebrand A/S's chief executive is the latest victim of the fallout from the insurer's failed attempt to create a pan-Nordic insurance group.

Jan Erik Langanen resigned last Monday after five months of pressure from UNI Storebrand shareholders, who were dissatisfied with his management of the insurer.

"This has been a real scandal," said Martin Imbach, chairman of Swiss Insurance Services Holding in Zollikon, Switzerland. A subsidiary of SIS Holding, Zurich-based Capital Bank, holds a 5.5% stake in UNI Storebrand, making it the insurer's largest foreign shareholder. Mr. Imbach has spearheaded a campaign to oust Mr. Langanen and the current UNI Storebrand board of directors.

According to UNI Storebrand, Mr. Langanen resigned voluntarily.

Per Terje Vold, formerly deputy managing director of life insurer UNI Storebrand Livsforsikring, was appointed acting chief executive.

At an Oslo press conference on the day of his resignation, Mr. Langanen said his departure comes at a time when UNI Storebrand's situation is "becoming more and more invidious and undignified day by day." He said that when he

became aware that shareholders had threatened to make the resignation of the board of directors a condition of contributing to a proposed capital increase, he decided to resign.

Mr. Langanen criticized certain "anonymous UNI Storebrand shareholders in unattributed statements to the Norwegian press" who said they would contribute to the capital increase only under certain conditions.

"A finance institution such as UNI Storebrand cannot and should not live with a situation where the media drags down the company day after day," he said.

Mr. Langanen said that other resignations should not follow his, stressing that continuity of management is of paramount importance. He added that the proposed capital increase should allow UNI Storebrand to survive the aftermath of its scuttled bid to take over Skandia Holding A.B.

But some shareholders see the situation very differently.

The removal of Mr. Langanen was due not only to the Skandia takeover fiasco, but also to mismanagement over the last five or six years, charged Mr. Imbach. As a result of that, he said, UNI Storebrand is losing about 2% to 3% of its market share in Norway each quarter.

"Everybody is taking losses while the management is playing

about with ideas. It's a political power game," he said.

Mr. Imbach said he and other shareholders object to the highly political way in which Mr. Langanen led UNI Storebrand, contending that he and top management had no real understanding of the insurance business.

There also is little "sound, solid business experience" on the board of UNI Storebrand as well, since Mr. Langanen nominated nearly all board members, according to Mr. Imbach.

While Mr. Langanen was chief executive of UNI Storebrand, which is Norway's largest financial institution, he also was chairman of state oil company Statoil, which is Norway's largest company.

Mr. Langanen, who was appointed by the Norwegian government to the Statoil post, at one time wanted the oil company to contribute to Storebrand's capital, but Statoil shareholders refused, according to Mr. Imbach.

"You would have all these state funds moving more and more into Storebrand so it all becomes like France: semi-state controlled by state funds, state industry and state financial industries," Mr. Imbach said. "We are very against this, because you don't know who controls it and it is very political. The chief executive (Langanen) has

Continued on next page

Catastrophe toll

Continued from previous page
caused insured damage of \$5.2 billion—the largest catastrophe loss ever (BI, Nov. 18, 1991).

Losses from the Oakland, Calif., fires also topped the \$1 billion mark with insured damage of \$1.2 billion (BI, Oct. 28, 1991).

Insured damage from natural catastrophes in 1991 was well above the average level in the 1970s and early 1980s, the report said.

"The last five years have shown a loss burden above the long-term trend, both in the natural catastrophe and also the major loss sectors. If this development continues, the world insurance system will face a huge challenge," the report said.

Every year since Swiss Re began its reports in 1970, storms have caused the largest losses to insurers, the report said. 1991 was no exception, with 49 catastrophic storms resulting in insured damage of more than \$9 billion.

In North America alone, 1991 storms caused damage totaling nearly \$3.1 billion, according to the report. Of those, the three most costly were: Hurricane Bob, which hit the Eastern United States on Aug. 18, resulting in a loss of \$620 million (BI, Sept. 2, 1991); torna-

does in the Southern and Midwestern states that occurred between April 26-29, resulting in a \$350 million loss; and a hail storm in Calgary, Alberta, on Sept. 7, causing \$347 million of insured damage.

The 48 loss events under the flood category led to insured damage of \$1.6 billion in 1991, the report said. The "flood" category includes catastrophes caused by heatwaves or cold spells, snow and bush and forest fires.

The 10 worst catastrophes in 1991 also included: winter storm Undine, which blew into Great Britain and Ireland on Jan. 5-6, causing \$480 million in damage; Typhoon Kinna, which battered southern Japan on Sept. 14, wreaking \$272 million in damage; and storms, hail, tornadoes and floods that lashed the United States March 26-28, leaving \$210 million in damage in their path.

But it was not just claims for losses from natural catastrophes that piled into insurers' offices in 1991, according to the report.

"In the past few years, the frequency of man-made major losses has also increased continuously. The number of events, which reached 212 in 1991, is also approximately double the long-term average," the report said.

Industrial fires produced large

losses. In the 31 major industrial fires in 1991, more than \$1 billion in insured damage resulted, the report indicates.

Fires in chemical and petrochemical plants caused \$383 million in insured damage. The largest loss in this sector occurred on Dec. 10 at an oil refinery in Gelsenkirchen, Germany. An explosion caused property damage and business interruption losses of \$118.7 million.

The largest 1991 commercial fire loss in the U.S. was \$148 million from a fire in a Philadelphia office tower on Feb. 23, the report said (BI, March 4, 1991).

UNI Storebrand

Continued from previous page
backing from the government and is a very powerful person. It is difficult to force him to step back."

When it became clear in February that UNI Storebrand would need shareholders to subscribe to a proposed capital increase, Mr. Imbach said SIS Holding and its supporters indicated they would subscribe only on the condition that Mr. Langanen and the board resigned.

With Mr. Langanen's departure, the shareholders have won half of the battle and will continue fighting, he said, noting that they be-

lieve UNI Storebrand could be turned into an effective company. Meanwhile, Skandia Chief Executive Bjorn Wolrath has suggested that a UNI Storebrand capital increase could be combined with a one-for-four stock option for UNI Storebrand's 28% stake in Skandia.

A Skandia spokesman said the option could be priced at about 120 Swedish krona (\$22.32) per share. Skandia was trading at about 90 Swedish krona (\$16.74) per share at the end of July, while UNI Storebrand has accounted for the shares it holds at 150 Swedish krona per share (\$27.90).

"Storebrand would have to take the loss," the spokesman said.

Another fire ranking among the year's top 10 catastrophes burned the London Underwriting Centre, which was still under construction, causing \$290 million in damage (BI, Aug. 12, 1991).

The report also indicates:
• 1991 aviation catastrophes held at 1990's total of 28.

Hull aviation losses fell by more than half to \$442.5 million, compared with \$949.3 million in 1990, the report indicates. Figures for liability losses are not available.

"The largest individual loss in the aviation/space category occurred during the launch of the Atlas Cen-

taur rocket on April 18, when the second stage had to be blown up due to a malfunction, also destroying the Japanese telecommunications satellite that was to be sent into space. The insured damage totaled over \$96 million," the report said (BI, April 22, 1991).

• The 44 major losses in the waterborne traffic sector caused insured damage of \$714.2 million.

The largest loss in this sector amounted to \$334.5 million and was caused by the faulty construction design of the concrete base of the gas platform Sleipner A in Norway, the report said.

In a separate development, a stock offering by Hafnia Holdings A/S, which was UNI Storebrand's partner in the bid for Skandia, closed July 20 (BI, July 13). Hafnia offered 7.1 million A-shares and 12 million B-shares, underwritten by Banque Paribas and Bjornskov & Co.

Almost all the A-shares were purchased, leaving the offering's underwriters with 7,874 shares, or 0.1%, to cover, said Hafnia Chairman Holger Lavensen.

However, the underwriters were left with 9.3 million, or 77.4%, of the B-shares.

Still, Hafnia reported that the issue increased capital by 1.9 billion Danish krone (\$335.2 million).

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Lloyd's meeting

Continued from page 1
expresses confidence—as opposed to no confidence—in the council.

Lloyd's problem is that "it's short of cash," said Mr. Sturge. "It needs more money, not more regulation."

Lloyd's needs less than 800 million pounds (\$1.54 billion) in excess of members' reserves and deposits to meet government solvency requirements by the end of August, Chairman David Coleridge told the extraordinary general meeting last week. That figure includes the 200 million pounds (\$385.8 million) of unpaid cash calls for the 1988 underwriting year plus outstanding cash calls from the 1989-1991 underwriting years.

The additional levy of 5% of each member's stamp capacity spread over 1990-1992 was drawn from members' premium income deposits on July 15. The goal: to boost the Central Fund to 1 billion pounds to allow Lloyd's to pay this shortfall and meet the government solvency standards.

Last week's extraordinary general meeting—attendance at which wasn't really representative of the market with many hecklers in the audience—was really about "who's going to pay and how much," said Mr. Sturge.

Sir Peter Miller, former chairman of Lloyd's, also said he believes the Council of Lloyd's will win the vote by a vast majority.

"The vote will show that the dissident (members) are small in number," Sir Peter told *Business Insurance* last week.

Still, the market should "cobble up" more than 50 million pounds from brokers, underwriting agents and others to help

beleaguered members, according to Sir Peter.

The former chairman says he would be willing to help collect the funds if asked.

His own Lloyd's brokerage—the Miller Insurance Group, of which he is chairman—would be willing to provide its share of additional needed funds. But so far no one has asked for any money, he said.

Although maintaining that Lloyd's owes no legal duty to members to pay their losses, "clearly there is a moral duty which cannot be neglected," said Sir Peter in a letter written after last week's meeting.

The 50 million pound market fund, wrote Sir Peter, "simply does not sound (large) enough, and even if it means looking more largely to those with the money—namely, the brokers—surely it is worth more than that in their own interest to bind up the market's wounds?"

Meanwhile, dissident members say their proposals have been misunderstood.

"We do not have a vote of no confidence in the council as a resolution," said Mr. Gurney at the meeting. It was Mr. Gurney who instigated the extraordinary general meeting and who proposed four of the five resolutions before the members.

"We believe... that it is the duty of the present council" to organize a smooth transition to a new order, he said. "We think it would be totally inappropriate for anyone to resign immediately, because we don't want turmoil (any) more than anybody else."

In fact, Mr. Gurney admitted he rather liked Mr. Coleridge, "which doesn't make my task any easier."

Nevertheless, Mr. Gurney began his address at the meeting saying, "Outgoing chairman, outgoing council, ladies and gentlemen." In fact, many council members come up for election in November for next year and Mr. Coleridge is stepping down (see story, page 1).

"We are here at an historic moment to say goodbye to the old order," Mr. Gurney said.

Lloyd's members expect the market's losses from 1988 to 1991 to total 5 billion pounds (\$9.64 billion), bringing the market "on the brink of insolvency if not beyond," said Mr. Gurney.

The story could have been different if wise men on the council had put more money aside in the Central Fund in 1986 when the market was earning huge profits, he said. "Alas, our society has not been blessed with wise councils or wise (working member) committees," he said. "We are owed something better."

The 32,802 members on Lloyd's electoral roll will have until Aug. 28 to vote on the five resolutions proposed by Mr. Gurney and the Assn. of Lloyd's Members. Some 5,915 members work at Lloyd's, while 26,887 members do not.

The total number of voters is more than the 22,162 members currently writing this year because it includes members who are in the process of resigning from the market.

Some 2,500 members—about half the total at the annual general meeting in June—attended last week's 3½-hour extraordinary meeting.

Speakers on behalf of the Lloyd's council appeared to be coached beforehand; they were more orderly and formal than the dissident members. Often there

Continued on next page

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Lloyd's meeting

Continued from previous page
 were fewer members to speak on behalf of the council than against it.

Mr. Gurney's contingent, on the other hand, seemed more organized and emotional in its attack, although members did not always speak specifically on the resolutions.

Arguments broke out continuously by Mr. Coleridge—who was chairing the meeting—and disgruntled members when the members wanted to speak of their own plights.

Several of the disgruntled members at the meeting spoke in support of the four resolutions proposed by Mr. Gurney.

The resolutions call for:

- An "effective mechanism affordable to names" by which they could be released from open underwriting years.

- Rescinding the special Central Fund levy.

- A register giving "fully, frankly and unambiguously" all interests held by or on behalf of council members since 1982.

Member Dr. Alexander Monk said this should include whether any of the council members were Freemasons. Mr. Coleridge replied that he's never been a Freemason, mainly because he's never been asked.

Many have alleged over the years that Freemasons exert an undue influence on the Lloyd's Council.

- The council to work with all groups representing names, including the 17 action groups that have been set up members of syndicates facing large losses.

Much of the discussion focused on rescinding the levy, a vital issue for the survival of Lloyd's.

John Rew, Lloyd's member and syndicate analyst for Chatset, pointed out that the special levy

may not be enough because it is likely that a third of the membership will become insolvent because of the 1989 losses recently announced.

He projects that another levy—twice as large—will be needed next year as more members become insolvent. And by 1994, the members who are left will "face a really grim future," said Mr. Rew. Many by then will have lost everything.

The levy, he added, should be spread across the entire market to firms like brokers and agencies and not just assessed on members.

Lloyd's member Julian Tarrant added that it was unrealistic for his wife to pay the special levy since she resigned last year. "A committee who thinks this is reasonable is not one which I would support," said Mr. Tarrant.

Mr. Coleridge rejected that reasoning. The levy, he said, is vital to the future of every member at Lloyd's because it is needed for Lloyd's to survive.

Without the levy, "there will be 1,200 open years which won't be closed until well into the next century" because Lloyd's would not meet its solvency requirement this year and be bust, according to the chairman.

"If Lloyd's doesn't trade in 1993 and 1994... there will be 32,000 members who will be affected" whether or not they resigned, he said.

With the levy, Mr. Coleridge said, "we will pass solvency at the end of August."

Mr. Gurney said Mr. Coleridge breached an agreement they made before the meeting by presenting this "scare" story to urge members to support the special levy. The levy was already collected on July 15 so there's little reason to argue, he implied.

Mr. Gurney argued that the

council has a "moral responsibility" to spread the losses fairly over the market, including the brokers, agents and other companies.

"We want a bigger contribution from the market and a fair sharing of the burden," Mr. Gurney said.

Meanwhile, a fifth resolution, put forward by the Assn. of Lloyd's Members, calls for a vote of confidence—as opposed to no confidence—in the Lloyd's Council. However, the resolution also calls for the council "without further delay" to:

- Implement the essential recommendations of the Lloyd's

The current council, though, has instituted investigations, task forces and recommendations "that are far-reaching in their effect," he said.

"When implemented, they will produce a new Lloyd's that is stronger and much more efficiently run than heretofore," Mr. Shaw added.

The resolution has caused "considerable anguish" among many of the 9,000 ALM members because it calls for confidence in the council, Mr. Shaw admitted.

But the resolution "was not to approve all past actions of the present council and its predecessors, or to condone their failure

pounds "would fall well below the expectations and indeed the needs of those concerned," said Mr. Shaw, to resounding agreement, at the meeting.

"The intention of this part of the resolution is to urge the council to set a much higher target than 50 million pounds—if that is the one they now have in their sights. To attain a much higher target it may be necessary to contemplate payment over two or three years, and I believe that this would be a practical possibility," said Mr. Shaw.

Several members spoke against the ALM's confidence in the council.

Samuel Salbstein, for one, said members looked to the council "for protection... and found a protection racket."

The council is the sole regulator of the market and yet did nothing to stop underwriters of London market excess-of-loss reinsurance, which has ruined so many people. He called the council "negligent" and "impotent."

"Self-regulation," concluded Mr. Salbstein, "has failed."

"Lloyd's is a can of worms and a hornet's nest," added Graham Watson, a member since 1959. "It couldn't regulate a flea in a flea circus."

However, others support the ALM vote of confidence.

In a recent report on the so-called LMX spiral, Sir David Walker found that the reinsurance was used to "spread losses," said Paul Archard, chairman of Lloyd's Underwriting Agents Assn (BI, July 6).

Insisting that he was no "puppet of the 12th floor"—home of the Lloyd's executive offices—Mr. Archard said the council inherited these problems—they were not of the council's making. Mr. Coleridge, in fact, should be applauded for what he has done. ■

Mr. Gurney argues that the council has a 'moral responsibility' to spread the losses fairly over the market, including the brokers, agents and other companies. 'We want a bigger contribution from the market and a fair sharing of the burden.'

task force, particularly those on governance (BI, Jan. 20).

- Encourage the Lloyd's working community to make a substantial financial contribution to the problem of distressed names.

The resolution is supported by the Lloyd's Council.

"Lloyd's must change," Neil Shaw, chairman of the ALM, said at last week's meeting.

Mr. Gurney's proposals "look backward and not forward to the changes we must make to ensure a stronger and sound future for Lloyd's," said Mr. Shaw, who is the U.S. chairman of Tate & Lyle P.L.C.

"Lloyd's problems today have been caused by lack of change in governance and management control over many years, not just one or two years," said Mr. Shaw.

to act when they might or should have done," said Mr. Shaw.

"Our resolution was, and is, intended to give a qualified expression of confidence in the council and the changes they will make. These changes will in effect change the council. I give you my assurance that this will be the case," said Mr. Shaw.

The ALM favors implementing most of the task force recommendations. "In effect, Lloyd's names want the formal recognition of the primacy of names' rights," said Mr. Shaw. "The names at Lloyd's want to know that they are dealing with members agents who are competent and capable of recommending syndicates based on performance and degree of risk."

The ALM also believes that a market fund of only 50 million

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Lloyd's chairman

Continued from page 1

traordinary general meeting last week, which was called to vote on the market's confidence in him and the Council of Lloyd's.

When Mr. Coleridge became chairman in 1990, he knew the market was headed for troubled times with the announcement of major losses in 1988 and 1989, but he didn't know the scale of the losses. "I must confess, however, that I never imagined that it would be quite so tumultuous," he said.

He told members last week that he has accomplished "more change (at Lloyd's) in the past 18 months than has ever been before." His duties have included setting up loss review panels, forming Mr. Rowland's task force, spending hours with members' action groups and writing more than 100 personal letters to aggrieved members.

"A course has been set," said

Mr. Coleridge, referring to the task force's recommendations for change. "It is a course which must be followed."

Mr. Coleridge has recommended that the council appoint Mr. Rowland, chairman of Sedgwick Group P.L.C., as chairman in 1993. Under the changes in governance that are being implemented, Mr. Rowland would become the first full-time, paid chairman of Lloyd's.

After council elections in November, the new council would vote on whether to name Mr. Rowland chairman. If elected, his term would begin Jan. 1.

"His enthusiasm, leadership, and understanding of the dynamics of this marketplace are qualities which will be of enormous benefit to our society and to its growth," said Mr. Coleridge.

Mr. Rowland, 59, is one of the best communicators in the market, observers say. Working at brokerages since 1956, Mr. Rowland

was chairman of Stewart Wrightson Holdings P.L.C. until 1987 when it merged with what was then Willis Faber P.L.C.

As deputy chairman of the new group Willis Wrightson, Mr. Rowland was targeted to be the next chairman. However, after a difficult merger, Mr. Rowland left the company in 1988 to become chief executive of Sedgwick. He was named chairman in 1989.

Last year, Mr. Rowland was named to chair the Lloyd's task force that subsequently called for radical changes, including restructuring the governance of the market and expanding Lloyd's capital with corporate membership.

Mr. Rowland had just signed a three-year contract with Sedgwick, but the board of Sedgwick supports his decision to take the Lloyd's post. Saxon Riley, vice chairman of Sedgwick, was appointed chief executive following last week's announcement.

After much thought, Mr. Rowland said he accepted Mr. Coleridge's nomination.

"I believe that the future prosperity of Lloyd's is of great importance to this country and to the insurance industry, and that it would be wrong of me not to take this opportunity to try to do what I can to encourage confidence in this unique insurance market," he stated last week.

Some in the market, however, do not support Mr. Rowland as Lloyd's next chairman. They want an underwriter, rather than a broker, to head the market, with some suggesting that Stephen Merrett, chairman of Merrett Holdings P.L.C., stand for the office.

And Claud Gurney, the Lloyd's member who called for last week's extraordinary general meeting, wants neither man.

"We deserve an independent chairman of Lloyd's," Mr. Gurney said on the steps of Lloyd's before

the meeting. That chairman should be selected from executives who don't work in the market, he implied.

The Lloyd's Act of 1982 calls for the chairman to be a working member of the market, however. In that case, Mr. Gurney said John Charman, managing director of Charman Underwriting Agencies Ltd., would be a better chairman.

"Rowland is a nice man. . . better than David Coleridge. . . but he is still an insider," said Mr. Gurney. Sedgwick was heavily involved in brokering London market excess-of-loss reinsurance business which is causing such horrendous losses, Mr. Gurney noted during the meeting.

Mr. Charman, on the other hand, is "one of the most successful underwriters at Lloyd's," has a large following of external members and "would be the best of a bad bunch," Mr. Gurney said outside of the meeting. ■

Museum insurance

Continued from page 3

the lines will still be managed separately, because fine arts coverage demands a high level of expertise, said Joan Deshima, product planning and development manager at Chubb.

To highlight its emphasis on loss control, Chubb is offering clients a risk management guide written for museums, substituting familiar museum jargon for some insurance terms. According to the insurer, the guide enables facilities to prepare, implement and maintain a loss control program.

Loss control is crucial at cultural institutions because collections are irreplaceable, but generally only the biggest museums can afford to hire risk managers. Insurance-related responsibilities are usually divided between the registrar and chief financial officer, who rely on outside experts for assistance.

"The idea is to get the clients to do loss control themselves and to not have to do it for them," Ms. Deshima said.

The most innovative aspect of the guide is the CHUBBMUSE software program, a compilation of several types of programs museums now buy separately to handle collection inventory, financial and maintenance record-keeping, and disaster recovery planning.

A scanning component allows museums to electronically store images of artwork or details of historic architectural features, which specialists can refer to before repairing a damaged work or building.

Chubb also provides off-site storage for copies of inventory files and disaster recovery plans in case the originals are lost during a disaster.

"In small museums where people wear many hats, this computer program will be a tremendous boost," said Constance Lowenthal, executive director of the International Foundation for Arts Research in New York.

IFAR helps museums recover stolen items. According to Ms. Lowenthal, who has tested CHUBBMUSE, museums using the software should "have all the elements necessary to give police the right information to facilitate recovery."

Although brokers have only had glimpses and previews of the new product, its potential for success in the marketplace already is under debate.

"I'm confident Chubb's policy will be the best because it always is, but the cheapest price is not Chubb's strong point," said Bruce

Perkins, president of Washington-based brokerage Flather & Perkins. "In the museum business, it's the bottom line that counts."

Huntington T. Block, a Washington-based broker who specializes in collections coverage, agrees.

"Museums will be interested in what Chubb has to offer," said Mr. Block of Huntington T. Block Insurance, a subsidiary of Chicago-based Rollins Burdick Hunter Co. "But we're in a competitive market and a soft economy, (so) if the price isn't right, it won't sell."

In fact, one of Chubb's selling points is that in these tough times, investing in a loss-control-oriented program in the long run will save museums money they cannot afford to lose.

"Because there is a recession, people are not as free about giving donations," said Ms. Deshima. "You cannot afford to lose money when you don't have a lot to work with to begin with, so there is a rising business need by museums to look into insurance."

Brokers speculate that the package coverage will be more economical than buying the policies separately. Under the new Chubb program, property, general liability and collection coverages can be purchased as a package or unbundled, according to Gail McGiffin, commercial lines product manager at Chubb.

General liability rates will be based on exposure according to square footage and attendance. The collection coverage has a loss limit, because most museums don't insure 100% of their collections' value.

But a single coverage plan means buyers will have to centralize their insurance between one museum officer and one broker.

Collections coverage is typically handled by the registrar and a specialist broker. Other insurance matters are handled by the museum's chief financial officer. Some brokers believe it is not to their advantage to try to handle both specialized and common lines.

"Most brokers would want to get their hands on the whole package, but the collection is the jewel in the crown," said Robert Salmon, vice president of Allen Insurance Associates in Los Angeles.

"By being specialists, we've got something no one else has to offer in that area," he said.

"There is an advantage to having it all under one broker if the broker can handle it competently, but if the broker is in a city with only one or two museums, it's a lot to read up on" for just two clients, he said.

Some museum officials also believe collections coverage cannot be handled alongside other types of insurance.

"Our collections policy changes more than any other because we have yearly appraisals," said Richard Moxley, director of Agecroft, a manor house transplanted from England to Richmond, Va. "I would prefer to keep that separate, because it's so volatile."

A number of factors have contributed to the heightened need for museum insurance. Public interest in museums increased in the 1980s, and as the number of visitors grew, public and private funding became available for renovations and investment in upgraded loss control. Government agencies demanded more streamlined inventory, accounting and tax records, for which museums developed data bases.

The 1980s also saw a series of high-profile art thefts worldwide.

These factors led museum personnel to become more professional, according to Mary Sue Sweeney Price, deputy director of the Newark Museum in Newark, N.J. They became more interested in and able to buy insurance and outside risk management.

On the other side of the fence, insurers thought collections coverage was an appealing niche in the "era of niche marketing," because an emphasis on loss control is inherent to museum work, according to Mr. Block of Huntington T. Block Insurance.

"We're good risks because museums don't want a loss as much as an insurance company doesn't want a loss," Ms. Price pointed out.

Curators' and directors' "whole livelihood is to preserve this art," agreed Joe Coffey, an underwriting specialist in the marine unit at Aetna Life & Casualty Co. in Hartford, Conn.

Chubb, Aetna and The St. Paul Cos. Inc. are the three top rivals in the domestic collections market, brokers say. Lloyd's of London specializes in fine arts coverage as well.

For the past year, all three companies have been developing variations of museum-oriented packages in an effort to create a product that will give them an enduring place in a market with few competitors and a history of good loss experience, according to Aetna's Mr. Coffey.

Chubb's policy comes on the tail of another package program introduced by St. Paul in May 1991, which combines liability coverage with two levels of collections coverage.

St. Paul also developed a general risk management guide that field representatives can tailor to a client's specific needs.

Although, unlike Chubb, St. Paul did not custom design its guide, St. Paul has a reputation for "excellent" loss control, according to Mr. Perkins of Flather & Perkins.

Aetna is right on Chubb's heels with a program due out later this summer. Aetna expanded its collections coverage earlier this year and will do so again with its latest program, which also will include building evaluation and endorse-

ment, general liability and directors and officers coverage.

Aetna also will offer a risk management guide that will outline exposures specific to museums. The guide will be supplemented by regular visits from an engineering consultant.

In the museum field, risk management is usually put ahead of insurance.

"I tell my clients to put their money into safety and security, to cut down their probable maximum loss and then worry about insurance," said Mr. Block. ■

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Play or pay

Continued from page 1

dividuals," he said. "Whether those proposals should be dropped or changed is a political question, but we think it's necessary to discuss the actuarial issues involved," Mr. Pyenson said.

A national play-or-pay plan was suggested by a blue-ribbon panel, the Pepper Commission, in 1990 (BI, March 12, 1990). Since then, several bills calling for a national play-or-pay system have been introduced in the House and Senate (BI, Nov. 18, 1991; Aug. 19, 1991; June 10, 1991).

Under a play-or-pay scenario,

employers would be required to provide employees and their dependents with a minimum level of health benefits through the existing private system. Employers that did not provide basic coverage would have to pay a payroll tax to finance a public plan that would cover the uninsured. The proposed payroll tax rates range from 7% to 8%.

But, Mr. Pyenson says, a flat tax rate of 7% will not generate enough revenue to support the medical costs a public plan would incur. "There is no right number, because the tax isn't associated with risk," he said.

When deciding whether to "play" or "pay," most employers will cal-

culate the costs of continuing to provide private health insurance and compare that with the aggregate cost of a payroll tax, he said. "Groups for (which) risk-based premiums are less expensive than wage-based premiums will not join the government plan." But "groups for (which) risk-based premiums are greater than wage-based premiums will join the government plan."

As a result, the public plan will find itself overburdened with low-wage, unhealthy individuals, while private sector plans will cover a healthy population, he said.

Other consultants agree that most employers likely would dump their

current health plan if it were cheaper to pay a wage-based tax, which could weigh down a government plan with poor health risks.

"All companies will look at the bottom line and which is cheaper," said Rich Sinni, director of the health and management practice of Buck Consultants Inc. in New York. Employers with younger, highly-paid employees in good health would be more likely to continue providing health benefits, while those with older, low-wage workers with families would be more likely to opt for the payroll tax.

A study commissioned by the Bush administration also found that

many employers would find it cheaper to pay the tax and terminate their plans, shifting millions to the public plan (BI, Jan. 13).

However, some employers say the decision to dump their private plans will not be entirely based on finances, but on what benefits a public plan will offer (BI, March 30).

"I think the actuaries overestimate the stampede into the tax-financed plan," said Walter Maher, director of federal relations for Chrysler Corp. in Washington.

Mr. Pyenson said one way the government plan could guard against financial instability is by adopting a risk-based financing system rather than relying on a flat tax rate. "There are a number of possibilities the government could look into," including using age, sex and geographic location as a basis for determining payments to the plan.

Basing the tax on wage rates alone is not practical, because demographics strongly affect health care costs, the report pointed out. For example, single women, on average, incur higher medical costs and are paid lower wages than single men. And, family medical costs are higher than individual costs.

Therefore, "if only one parent works, an employer of average workers with families would be better off 'paying' to join the government plan, regardless of the age of the workers," he said in the report.

In addition, "both medical costs and wages vary by area, but do not vary in the same way," Mr. Pyenson noted. "Under the play-or-pay government plan, an employer's payment would reflect the local relative wage level. However, a risk-based private premium would reflect local medical costs.

"In areas where medical costs are relatively higher than wages, the flat wage tax will generally be a bargain compared with private coverage." But, "if all employers in such areas opted to 'pay,' the 7% wage tax would not generate enough revenue for the government plan."

Moreover, "in areas where medical costs are relatively lower than wages, the flat wage tax will tend to be more expensive than the private system," he said.

Other government programs, including the Pension Benefit Guaranty Corp., have abandoned flat rates in favor of a risk-based approach, Mr. Pyenson pointed out.

The PBGC in 1987 changed its flat rate system of payments covering employees in underfunded U.S. pension plans and adopted a "variable rate premium." Under the new plan, employers with overfunded defined benefit plans continue to pay a flat annual premium, but employers with underfunded plans must pay the flat rate plus an additional premium based on the amount of the plans' unfunded vested benefits (BI, March 30, 1987).

But, some consultants say risk-based financing on such a large scale would be too complex to administer.

"I don't see how it would work; there are so many variables in assessing the health risks of employers," said John Hickey, a partner with Kwasha Lipton in Fort Lee, N.J. "If you use experience rating, you'll have to get into looking at (health claims) experience of each employer over the last few years. That would be too complicated. The government would be mired down in a morass of data gathering and calculations."

A copy of the report, "Actuarial Issues in Play-or-Pay," is available at no charge by contacting Bruce Pyenson, Consulting Actuary, Milliman & Robertson Inc., 2 Pennsylvania Plaza, New York, N.Y. 10001-0016; 212-279-7166.

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BC/BS hearing

Continued from page 1

"What occurred there was in part the result of local conditions, including a depressed economy and high health care prices. Regulatory impediments also were a factor. The best management in the world can't overcome inappropriate regulation. We're working with our plans and with state regulators to prevent recurrences," he said.

"I want to stress that mismanagement and impropriety have no place in our system and will not be tolerated. The great majority of plans are rock solid, both in terms of their finances and their management practices," he added.

The subcommittee also heard from a former West Virginia plan official, who testified that key plan officials were also at the helm of Blue Cross & Blue Shield of New Hampshire when it had severe financial problems in the 1970s.

And a surprise witness called to testify during the final hour of the second day of hearings added another twist to the tale of the West Virginia plan's demise. That witness alleged that state officials knew the plan was in trouble in 1985, and may have used that knowledge to squeeze political contributions from its officers.

That allegation added to an already lengthy litany of explanations for the plan's failure presented by Mr. Sopko in his report to the subcommittee.

"The staff has spent three months in an attempt to determine the factors that led to the demise of Blue Cross & Blue Shield of West Virginia. When we started this study, we were hopeful that we would be able to report to the subcommittee that exact cause of death, but if there was a single fatal blow, it has eluded us thus far," said Mr. Sopko.

"Unlike your normal coroner's inquest, the failure of an ongoing concern like the West Virginia plan is more complex and the conclusions not as scientific or exact. The staff cannot absolutely state the 'cause of death.' At best, the staff can conclude it died of multiple wounds, some of which may have been self-inflicted," he said.

He listed seven key factors contributing to the plan's failure:

- Creation of subsidiaries and affiliates for the personal gain of officers and board members.
- Mismanagement by senior plan officers.
- Inadequate oversight of management policies and actions by the board of directors.
- Diversion of resources and attention to activities not related to the plan.
- Conflicts of interest by senior managers and board members.

- Inadequate state regulation.
- Rising health care costs.

Jack Sturms, a former executive vp of the West Virginia plan who currently serves as director of the Monongahela County Health Department in Morgantown, W.Va., testified that he left the plan in 1986 because he did not like where it was heading under the direction of senior managers led by President James Heaton.

Mr. Sturms had worked with Mr. Heaton at BC/BS of New Hampshire in Concord, N.H., during the 1970s and followed him to Wheeling, W.Va., in 1980 to become executive vp of the Wheeling plan.

The Wheeling plan merged with a Charleston, W.Va., plan to form BC/BS of West Virginia shortly thereafter.

Mr. Sturms told the subcommittee that during the 1970s, the New Hampshire plan created a subsidiary corporation called Northeast Consolidated Services, or NECS, "to manage its day-to-day activities."

The tactic wasn't financially successful, he said.

"It is my recollection that during these years, NECS and the New Hampshire plan were close to entering Chapter 11, and they were in that situation for a number of years," said Mr. Sturms.

But a very short time after Mr. Heaton and other former officials of the New Hampshire plan began doing business in West Virginia, the West Virginia plan began sprouting subsidiaries, Mr. Sturms said.

"In the early 1980s, we began developing not-for-profit subsidiary operations," he said.

Eventually, Mr. Heaton created Southland, a holding company set up to oversee the BC/BS plan as well as for-profit subsidiaries he was developing, according to Mr. Sturms.

Certain officers of the plan were made shareholders of the for-profit subsidiaries so they would have a vested interest in the success of the operations, he explained.

The subcommittee staff found that Mr. Heaton and other officers created several "subsidiaries and affiliates for their personal gain."

These included a computer company and an investment firm. According to the investigators, Mr. Heaton and his associates also planned to form a travel agency and an insurance agency.

Mr. Sopko said the subcommittee staff "questions the propriety of senior management's decision to create subsidiaries and affiliates for their own personal use. Heaton and his associates were under a duty to use their positions for the benefit of the Blue Cross and Blue Shield's policyholders, not their own personal gain."

The accusations made against Mr. Heaton were such that Sen. William Roth, R-Del. and the ranking minority member of the subcommittee, asked whether Mr. Heaton would be available to testify.

"That's a thorny problem; Mr. Heaton appears to have disappeared," said David Buckley, the subcommittee's chief investigator.

Mr. Buckley said that Mr. Heaton's wife claimed not to have seen him for six weeks and his employer said that he hadn't shown up for

work for a week or so.

The next day, though, subcommittee Chairman Sen. Sam Nunn, D-Ga., said the subcommittee had been contacted by an attorney claiming to represent Mr. Heaton. The attorney said that his client did not think the subcommittee's directive for him to appear was binding. Sen. Nunn assured the rest of the subcommittee that Mr. Heaton would eventually testify.

The former chairman of the West Virginia plan's board of directors did testify.

"I did not steal any money nor did I gain any advantage," said Donald Wagenheim. Mr. Wagenheim added that he had taken a polygraph test to underscore his innocence of any wrongdoing in the operation of the plan.

Of particular interest to the subcommittee was the fact that Mr. Wagenheim's construction firm had received a contract to renovate the plan's headquarters even though his company's bid was not the lowest.

Mr. Wagenheim said that he hadn't influenced the plan's decision, contending that it had been made by Mr. Heaton alone.

When asked by Sen. Nunn if he saw anything wrong with the deal, he said that he was "concerned" but had not mentioned those concerns to anyone.

Mr. Wagenheim also told the subcommittee that he had been concerned about an alleged love affair between Mr. Heaton and a female employee. The plan ultimately paid more than \$240,000 to settle damages from a paternity suit brought by the employee, he said.

New York BC/BS plan sues for rate hikes

NEW YORK—Citing diminishing loss reserves and "cherry picking" by commercial insurers, Empire Blue Cross & Blue Shield is suing New York regulators in order to force the approval of a three-year plan designed to restore Empire's reserves to half of statutory requirements.

At the center of the lawsuit, filed Thursday in New York State Supreme Court, is a demand that Superintendent of Insurance Salvatore Curiale approve a 12.4% rate increase by October. Empire insists that it needs to raise small-group and individual health rates by at least this amount in order to remain solvent.

Also included in the three-year recovery plan outlined in the suit is a demand for another 21% rate hike in April.

In a recent letter to Mr. Curiale, Empire Chairman Albert Cardone said the non-profit insurer's loss reserves are currently more than six times below statutory levels.

Without the rate hikes detailed in the lawsuit, the company's liabilities will exceed assets by as much as \$40 million by the end of the year, said Mr. Cardone.

As of May 31, Empire's loss reserves stood at

\$81.6 million, or only 16% of the \$492 million required by state law. The 12.4% rate hike would generate roughly \$125 million and would bring Empire's reserves up to half of the state's requirement, according to the suit.

Empire blames mounting losses on rates it says are too low and commercial insurers that cherry-pick—that is, take only the best risks. In April, commercial insurers in New York will be required to accept all risks—regardless of health conditions—and offer community rating (BI, June 15). Empire currently must accept all risks.

Lawmakers said they designed the open enrollment/community rating law to place all insurers on a more even playing field. Upon passage of the bill, a 14.4% rate increase Empire had sought was turned down by regulators.

Several legislators say Empire can get by with inadequate reserves until the new law takes effect next year, but Empire disagrees. A spokesman said the idea that the new law will make further rate hikes unnecessary is a "false illusion."

The requested rate increase would apply to 1.2 million small-group and individual policyholders.

—By Michael Schachner

Coal industry fund

Continued from page 2

states contested the blanket taxation.

These senators, led by Sen. Wendell Ford, D-Ky., argued that most coal companies in their states had no ties whatsoever to unionized retirees, and requiring them to foot the bill for retirees of other unionized companies was unfair.

Under the agreement, the 1950 and 1974 funds would be merged when the current National Bituminous Coal Wage Agreement expires on Jan. 31. The new combined fund would use a complex "reach-back" formula to determine which coal companies must make payments. Companies that could be found to have signed the 1950 agreement or any subsequent agreements would be required to pay a per-beneficiary premium for

retiree health benefits.

The U.S. Department of Health and Human Services would be in charge of tracing employer responsibility. The department hopes to determine by October 1993 which companies are responsible for all retirees.

Sen. Rockefeller's office estimates that the fund will total about \$250 million per year. Traceable employers would be responsible for their proportionate share of the new fund.

In addition, from fiscal years 1993 through 1995, about \$70 million would be withdrawn annually from the UMWA's overfunded pension plan to cover part of industry orphans' health care costs.

For the industry's estimated 40,000 to 60,000 orphans, health care costs also would be covered

by contributions from companies that acquired former coal producers, even if those companies are no longer involved in the coal industry. This would include dozens of large corporations that hold or once held a financial interest in a coal producer.

And beginning in fiscal 1996, as much as \$70 million in interest from the industry's Abandoned Mine Lands Trust Fund, which is used to reclaim abandoned mines, will be used to finance most costs of care for industry orphans.

The new combined fund would maintain the current level of health benefits for all retirees, but the fund's trustees would be required to contract with prepaid capitated health plans to hold down costs. Currently, retirees are not subject to any managed care practices.

"This agreement for us is progress," said a spokesman for the Bituminous Coal Operators Assn. in Washington, which represents major unionized coal companies.

"We have been telling everyone for a long time that the BCOA has been victimized by companies that have dumped their retirees in the funds and then have shirked their payment duties," he said.

Currently, only 30% of the nation's coal industry is paying the freight of 100% of the retirees, the spokesman said.

The comprehensive energy bill now goes to House-Senate conferees for review and then to President Bush for approval. Senators key to the agreement vow it will remain on the final energy bill.

In a related matter, a federal appeals court panel in Washington

Sen. Nunn asked Mr. Wagenheim if he confronted Mr. Heaton when he learned of the affair.

"I had a discussion with him about getting his life in order," said Mr. Wagenheim. Under intense questioning from Sen. Nunn, Mr. Wagenheim said that he did not at the time recommend that Mr. Heaton be punished.

A surprise witness who did recommend that Mr. Heaton be subject to sanctions long before the plan collapsed told the subcommittee that in early 1986, a report holding that the plan was three days from insolvency was suppressed for political reasons.

John King, a former West Virginia Insurance Department auditor and a political operative for former Gov. Arch Moore, said he had been directed by the governor's office to give the plan's books a thorough examination because Mr. Heaton and others had supported Gov. Moore's Democratic opponent in the 1984 election.

Mr. King had not been scheduled to testify because the staff could not find him. Mr. King, under contract to a Washington area veterans' group, learned of the hearing and contacted the subcommittee last Thursday morning, volunteering to be deposed and to testify that day.

Mr. King said he had called Mr. Heaton a "crook" to his face, and filed a very critical report on the plan's operations around Christmas 1985.

"I said they were insolvent; I used that word," said Mr. King. But then Insurance Commissioner Fred Wright told him not to be so hasty, Mr. King testified.

Shortly afterward, Mr. King said he was pulled off the BC/BS case.

But he saw a man who collected illegal campaign contributions for Gov. Moore at the BC/BS building right after his report was filed.

Mr. Moore in 1990 pleaded guilty to charges of extortion and campaign finance violations (BI, April 16, 1990).

"They wanted me to put as much pressure as I could on Jim Heaton. I think a deal was struck. They paid money and the dog was pulled off," said Mr. King. He added, however, that he could not prove his allegations.

Former Insurance Commissioner Wright denied that anything untoward had happened.

"It's not true. The only thing that was called off was Mr. King's participation," said Mr. Wright, who denied that the governor or anyone in his office had contacted the Insurance Department concerning Mr. King's report.

The subcommittee intends to hold additional hearings into the operations of individual Blues plans beginning this fall. ■

last month ruled that coal companies that signed the 1978 national wage agreement cannot abandon their pension responsibilities because of a so-called evergreen clause designed to prevent changes in subsequent contracts.

The case involved two coal companies that had subsequently negotiated individual contracts with UMWA that allowed them to contribute reduced amounts to the union's pension funds in exchange for job guarantees.

Ruling on a lawsuit brought by pension plan trustees, the court overturned a lower court ruling upholding the cuts and remanded the case to district court for retrial. The trustees claim Island Creek Co. and Drummond Coal Co. owe \$16 million in back contributions. ■

Hall sale

Continued from page 1

gest insurance broker, based on 1991 revenues (see chart, page 1). And the acquisition will create the third-largest U.S. retail brokerage.

The \$475 million purchase price includes \$125 million in cash, \$225 million in Aon 8% preferred stock and \$125 million in Aon 6.25% preferred stock. Reliance said it will record a \$50 million after-tax gain on the sale. Under terms of the complex agreement, Aon will not assume liability for any errors and omissions claims against Hall, but will assume some of its operating liabilities.

Lowell C. Freiberg, Reliance senior vp and chief financial officer, said: "I look at it as a very positive move by Reliance." He noted there always has been a question about the viability and value of the investment in Hall.

Hall shares represented 46.3% of Reliance Insurance Co.'s year-end 1991 surplus, which was a concern Marsh & McLennan Cos. Inc. recently raised in a letter to clients regarding Reliance's finances (*BI*, June 22).

Hall was also always considered part of Reliance's investment portfolio, while it represents a strategic acquisition for Aon and RBH, Mr. Freiberg noted.

Now, he said, Reliance is selling its investment in a company that has had only one year of profitability since it was acquired. In exchange, the insurer is getting both cash and Aon's double-A rated securities, "which I think the world is going to look at very positively."

Furthermore, he said, Reliance's 85% stake in Hall is replaced by assets that can be readily sold. "It really liquefies the portfolio."

"I would think (Reliance is) pretty happy. At least they'll liquefy themselves" more and shed a lot of the burden that Hall represents, agreed David Wells, an analyst with Fitch Investors Service.

And Russell R. Miller, chairman of San Francisco-based investment banking firm Russell Miller Inc., said Aon's cash and securities are "much more acceptable assets on their balance sheet to make insurance commissioners happy."

Other observers say the transaction also will significantly strengthen RBH's brokerage operations. However, since the sale was announced, some have questioned whether Aon paid too much for Hall.

"That's obviously something which won't be known for a while," said Charles Ronson, an analyst with New York-based Balesro Capital. "It's undoubtedly a good deal for Reliance. I tend to be a little more non-committal to mildly negative in the case of Aon."

While Aon may have paid more than it should have, "there's some very good offices being bought by Aon," said David Seifer, vp with Donaldson, Lufkin & Jenrette Securities Corp. in New York. In general, "where Hall is strong in terms of people, RBH isn't—and vice versa."

Patrick G. Ryan, Aon's chairman

and chief executive officer, said he has been getting compliments from people in the industry "who think we made quite an attractive deal."

The acquisition presents "quite attractive synergies for both Hall and RBH, he noted. He said, for instance, that Hall has "very, very fine offices" on the East Coast, particularly in New York and Boston, where RBH has smaller offices. The combination of the two operations in New York, he noted, will make RBH's operation among the biggest in the city.

Both brokerages, he added, already have very strong operations on the West Coast, and these will be strengthened by the combination.

In terms of benefits consulting, Mr. Ryan noted RBH has been building this business from scratch since early 1987, but has had no international capabilities. Now, he said, with the acquisition of Hall's London brokerage unit, Leslie & Godwin Ltd., RBH acquires gains a "wonderful" benefits consulting business in the United Kingdom that can be used as a base for a consulting business in Europe.

Alan Murray, an analyst with rating agency Moody's Investors Service Inc. in New York, said the rating agency has put Aon's ratings up for review for a possible downgrade while it conducts a thorough review of assets transferred and earnings capacity, among other issues. He said much of a brokerage's assets, like goodwill, are intangible and must be carefully analyzed.

The "real key issue," he said, "is (whether) Aon is able to forge a unified brokerage operation with good international capabilities."

"Long term, I think it's going to be a good deal" for Aon, said Adam Klauber, an analyst with Duff & Phelps Co. in Chicago. "I think it really positions them for when the market does turn around," he said.

Observers also believe Hall will flourish in its association with RBH.

"Hall is now part of a large (brokerage) organization, and I think its position in the marketplace will be enhanced by the linkup with Aon," said Michael Smith, an analyst with Lehman Bros. in New York.

Hall is better off as an Aon unit, agreed Duff & Phelps' Mr. Klauber. It has not done well with Reliance, which is not a brokerage organization and did not maximize its potential, he said. "They're getting much better value this way."

Ira Malis, a securities analyst with Alex. Brown & Sons in Baltimore, wondered whether the deal will slow the exodus of talent from Hall that began when Reliance said in March it would sell the brokerage. "Has it stopped?" he asked.

Meanwhile, Frank B. Hall clients say they are happy to have a clearer picture of their broker's future.

"I think it's pleasing to see that the uncertainty is removed," said Carl Paxton, manager of insurance and benefits investments for Tulsa, Okla.-based MAPCO Inc., a diversified energy firm.

Its uncertain position "was a little disconcerting, and we certainly did have some concerns in that regard," he said.

Rouge will await the outcome of the New Orleans trial before deciding how to proceed, said P. Raymond Lamonica, U.S. attorney in Baton Rouge.

Meanwhile, the Louisiana Insurance Department is pursuing a suit against attorney Melvyn A. Stein of the London law firm Finers and a suit against attorney J. Albert Kroemer and his firm, Maloney & Smith, in Dallas (*BI*, March 16).

The department alleges Mr.

Describing a conversation with Hall's Tulsa office, he said, "I sensed a favorable response. I didn't sense any negativity."

RBH also has an office in Tulsa, he noted, and "it would appear that there would be some good opportunities for consolidation." Hall, he said, tends to specialize in large energy clients in Tulsa, while RBH's office focuses more closely on medium-sized clients.

George Mills, risk manager for the New Jersey Highway Authority in Woodbridge, N.J., was also enthusiastic about the acquisition. "We're hopeful that this will be to everyone's advantage," he said.

Dennis D'Oca, vp-risk management for New York-based CBS Inc., a company which has worked with Hall as well as RBH, said, "I see it as a positive. I think it is very comforting" to both clients and employees that the period of uncertainty has ended, he said. "It's unfortunate it took so long."

"I'm hoping the same people that service our account will continue to service our account. I don't see much of a change. They've done a good job, and I expect they'll continue to do a good job."

Theodore Surdam, manager of corporate insurance for Cambridge, Mass.-based Polaroid Corp., was more cautious. "I think it's probably too soon to tell" the impact of the acquisition. It will depend on what changes are made, he said.

Aon's Mr. Ryan said he has "no idea" how many brokerage offices will be closed as a result of the acquisition. "I don't think there will be a lot, though. There's no decision at this time there will be any closings of offices," he added.

In terms of layoffs, Mr. Ryan said, "I think it's clear in our bottom line analysis of this that there are redundancies in terms of corporate support requirements." There will be a severance package, and "these people will be treated very fairly." One Hall claims specialist confessed he is "very nervous" about layoffs. "They have some capable claims people at RBH."

"Other than that, it's very good for most of the company," he said.

As for the merged broker's name, Mr. Ryan said, "We're in the process of working on that." He noted that RBH, Hall and Hudig-Langevedt Group bv, which RBH acquired last year, have a combined history of 500 years and none will be discarded.

Hall employees, who spoke on a not for attribution basis, generally were positive about the acquisition.

"I'm delighted. I think it's good for the company," said one Hall employee. "We're happy with the acquisition. Perhaps it was time for Reliance to sell. We're happy with Aon. They have a good reputation."

Another Hall employee said, "As far as I'm concerned, it's business as usual. We've received no instructions one way or the other. . . . I think the main message is the fact that we're moving right ahead. We haven't missed a beat."

The employee said he is not concerned about layoffs in his office. "We're down to the bare bones operating level." ■

Stein formed "dummy corporations" used to funnel money out of Anglo-American. The department charges Mr. Kroemer with negligence and professional malpractice, and alleges that he and Maloney & Smith retained Anglo-American funds in a client trust account after the insurer was ordered into liquidation.

Continental Casualty Co., Mr. Kroemer's legal malpractice insurer, also was named in the suit. ■

Update

CNA denies some flood claims

CHICAGO—CNA Insurance Cos. has notified the Illinois Insurance Department that it will not pay most claims stemming from the April 13 underground flooding in Chicago's Loop.

CNA says it will not pay claims from policyholders that bought standard Insurance Services Organization Inc. commercial property policies. It said covering those claims may set a precedent.

"We did not deny any claim except where we firmly believed there was no coverage under the terms of the contract. These decisions were confirmed by outside counsel," a CNA statement said.

The insurer has paid \$2 million on 32 of the 95 flood-related claims it has received, a spokeswoman said.

Illinois insurance regulators met with CNA and other insurers shortly after the event and appealed for a "liberal" interpretation of policies (*BI*, April 27).

But, according to the CNA statement, "Making gratuitous payments to one group of policyholders as has been suggested will not be fair to all other policyholders."

Some other insurers also have not paid all flood claims, the Insurance Department said.

TWA jet insured for crash

LONDON—A Trans World Airlines jetliner that caught fire and ran off the runway in New York last week is insured for \$16 million, insurance market officials believe.

The Lockheed L-1011 jetliner aborted takeoff at Kennedy International Airport after flames were seen coming from the fuselage. All 291 passengers and crew were evacuated with only minor injuries.

According to the Department of Transportation in Washington, TWA has at least \$750 million of liability coverage for last week's crash. The underwriters on the coverage and their share, the DOT says, are: Associated Aviation Underwriters with 20% of the coverage; Aviators International Insurance Group Inc., 10%; U.S. Aviation Insurance Group, 20%; Mutual Marine Office Inc., 3.5%; Lloyd's of London and London insurers, 26.5%; and French insurers La Reunion Aerieenne, 15%, and CAMAT, 5%.

The airline's hull and liability coverage renews Oct. 1, London aviation insurance officials say. TWA's London broker Crawley Warren & Co. Ltd. did not return calls.

Briefly noted

The Resolution Trust Corp. on Friday filed a \$400 million lawsuit against **Arthur Andersen & Co.** alleging negligent audits of the failed Benjamin Franklin Savings Assn. in Houston from 1984 to 1987. The suit, filed in U.S. District Court in Chicago, also alleges "other acts of accounting malpractice and negligence." . . . **Aetna Life & Casualty Co.** posted a net loss of \$20.1 million in the second quarter, compared with net income of \$159.5 million in the year-earlier period. The results include a \$96 million charge for restructuring and for a financial guarantee written for bankrupt Olympia & York Developments Ltd. (*BI*, July 6). . . . A federal judge has found Martin I. Hoffman, owner of a former **managing general agency** of Cadillac Insurance Co., personally liable for \$6.2 million in damages to the defunct insurer's estate. U.S. District Judge Bernard A. Friedman in May entered a default judgment against Corporate Risk Management Corp., the New York agency owned and headed by Mr. Hoffman. . . . New Jersey Gov. James Florio signed legislation that establishes policyholders as priority creditors in cases of insurer rehabilitations and liquidations (*BI*, June 22). As a result, **Mutual Benefit Life Insurance Co.**'s bailout plan is expected to be submitted this week for court approval. . . . **Employee leasing companies** in Texas must pay workers compensation insurance premiums based on the client's loss experience, under a rule adopted by the state's Board of Insurance (*BI*, July 13). . . . Two **Kemper National Insurance Cos.** subsidiaries are appealing a \$39.2 million jury verdict in a bad faith case. The verdict stems from allegations that the insurers refused to pay for the defense of Childcraft Education Corp. and its president in an underlying intellectual property and copyright case. . . . Standard & Poor's Corp. raised the claims-paying ability rating of **The Equitable Life Assurance Society of the United States** and its Equitable Variable Life Insurance Co. unit to A+ from A. . . . Dennis Smith was named president of the claims group at **Crawford & Co.** Mr. Smith, who will remain president of Crawford's Graham Miller International unit, replaces Frank Semancik, who is retiring. . . . **Joseph J. Prochaska**, chief executive officer of Shand Morahan & Co. and Evanston Insurance Co., will resign Sept. 30. Anthony Markel, president of parent Markel Corp., will assume the titles. . . . The New Jersey Supreme Court upheld the insurance commissioner's right to ban insurers that seek to **stop writing auto insurance** from writing all other property/casualty coverages. . . . A jury in Baltimore last week ruled that four **asbestos companies** should be held liable for punitive damages in the latest phase of the landmark consolidated asbestos litigation (*BI*, July 27; July 20). . . . **Lloyd's of London** this week will formally unveil its proposed new governing structure. . . . **CentreWrite Ltd.** plans to quote premiums to run off the 1988 and prior open underwriting years of 52 Lloyd's syndicates with a total of 1 billion pounds (\$1.92 billion) of capacity. . . . USF&G Corp. says it will return to the **Mississippi workers compensation market** on a selective basis in September. It had withdrawn in January. . . . **Wind, hail, tornadoes and flooding** caused an estimated \$150 million in insured property damage to portions of 12 states July 6-15. . . . An Ontario appellate court has upheld a lower court ruling that 70 **Canadian members of Lloyd's of London** must sue Lloyd's in English courts (*BI*, Nov. 25, 1991). . . . **Dow Corning Corp.**'s second-quarter earnings fell 84% to \$6.3 million because of a \$45 million pretax charge to cover expenses related to silicone breast implant liabilities (*BI*, April 20; March 9).

Miro arraignment

Continued from page 3

jury in Baton Rouge handed up a 20-count mail fraud and money laundering indictment against Mr. Miro in June 1991.

While the broad allegations in the Baton Rouge indictment are similar to those leveled in New Orleans, several of the mail fraud charges are based on premium checks Anglo-American received from other Louisiana school board policyholders.

Federal prosecutors in Baton

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