

# Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives / \$1.75 a copy; \$70 a year

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**United puts insurers on notice after 11 die in airborne accident**  
 HONOLULU—United Air Lines Inc. put its hull and liability underwriters on notice Friday after as many as 11 passengers were killed and 12 others were injured when the fuselage of a flight bound for New Zealand from Honolulu was torn open.  
 Minutes after takeoff, a huge hole developed in the right side of the fuselage and the plane lost power in two of four engines, forcing the pilot to return to Honolulu and make an emergency land-  
*Continued on next page*

## AIDS claims soar, but still fraction of total: Survey

By JERRY GEISEL

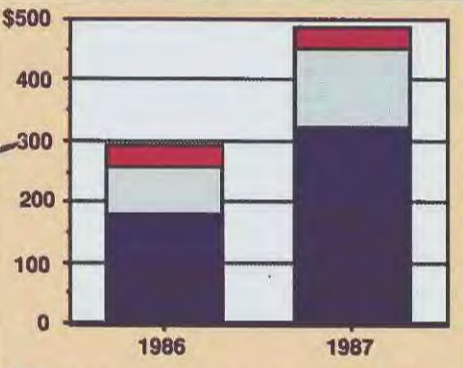
WASHINGTON—AIDS-related group health and life claims paid by insurers are soaring, but AIDS claims still are only a small percentage of insurers' total payments, a new survey says.

Meanwhile, another study projects that the cumulative medical cost of treating AIDS cases diagnosed in 1992 will be \$7.5 billion, more than double the \$3.5 billion projected to be spent on those diagnosed with the deadly disease this year, due to more cases of AIDS.

The new AIDS survey, released last week by the Washington-based American Council of Life Insurance and the Health Insurance Assn. of America, reports that AIDS-related group health and accident claims paid by insurers jumped to an estimated \$188 million in 1987, a stunning 121.7% increase from 1986 estimated payments of \$84.8 million.

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**Group insurers pay bulk of AIDS claims**  
 (In millions of dollars)



Source: American Council of Life Insurance/Health Insurance Assn. of America  
 Chart: Holly Seguire

## Ruling sets back case for Agent Orange cover

By DOUGLAS McLEOD

TRENTON, N.J.—Diamond Shamrock Chemicals Co. must prove that a polluted Agent Orange plant site presents a threat to third parties before it can attempt to collect cleanup costs from its liability insurers, a state appeals court has ruled.

A three-judge panel of the New Jersey Superior Court's appellate division last month overturned a lower court ruling that insurers may not bar coverage for cleanup costs on the basis of the "owned property" and "alienated premises" exclusions in Diamond Shamrock's liability insurance policies.

In granting summary judgment on the issue of the exclusions, the lower court had found that cleanup measures at Diamond Shamrock's Newark, N.J., plant site were not being undertaken for the benefit of the chemical company but were intended to comply with demands by environmental authorities.

However, the appellate panel concluded that "governmental compulsion" is not sufficient to render the two policy exclusions inapplicable and returned the case to the lower court for hearings.

In line with two earlier New Jersey cases, Diamond Shamrock must show that contamination at the plant poses a threat to the property of others before arguing that cleanup costs represent covered damages under the policies, the appellate panel ruled.

Diamond Shamrock will not appeal the appellate ruling and has already been in touch with the lower

court judge who presides over ongoing Diamond Shamrock coverage litigation about a hearing on the two exclusions, said Michael P. Tierney, a lawyer with Cahill, Gordon & Reindel in New York who represents Diamond Shamrock.

While saying he is happy with the decision, a lawyer representing several of Diamond Shamrock's excess liability insurers noted that the appellate ruling does not settle the issue.

"It's not a dispositive decision. It merely sends it back for further consideration by the trial court," said Stephen D. Cuyler, a lawyer with the Morristown, N.J., firm of Cuyler, Burk & Matthews. "But we're happy."

The appellate decision is the latest development in a long-standing dispute over coverage of Diamond Shamrock's Agent Orange-related liabilities.

The chemical company sued Aetna Casualty & Surety Co.—its primary liability insurer from 1951 to 1984—and scores of excess insurers in Morris County Superior Court in Morristown in 1984. The lawsuit sought rulings that Aetna and the other insurers must indemnify Diamond Shamrock for:

- Cleanup costs and bodily injury and property damage claims related to the dioxin-contaminated Newark plant, where Diamond Shamrock manufactured the toxic defoliant Agent Orange between 1951 and 1969.

- Diamond Shamrock's \$21.6 million share of the \$180 million settlement of a class-action suit filed

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**'It's not a dispositive decision. It merely sends it back for further consideration by the trial court,' says Mr. Cuyler.**

## Public brokers feel soft market punch

By LINDA J. COLLINS

The competition-battered publicly held insurance brokers reported lackluster revenue growth and earnings in 1988, and analysts predict results could worsen in 1989.

"It's a tough environment for insurance brokers and reinsurance brokers and since it doesn't look like it will turn around before 1990, I expect down earnings in 1989," predicted Ira H. Malis, securities analyst for Alex. Brown & Sons Inc. in Baltimore.

"Basically it's the same story as for the rest of 1988. It's a tough cycle out there and brokers are getting hit across the board," said analyst Michael A. Smith, vp of Shearson Lehman Hutton Inc. in New York.

For example, three of the four largest public brokers reported that revenue growth decreased in 1988 compared with 1987. And, industry giant Marsh & McLennan Cos. Inc.'s profits declined 1.9% last year.

Brokers point out that the competition that plagued brokers during the first three quarters of 1988 raged on during the final three months of the year.

"In the primary insurance market, the

fourth quarter showed a continuation of the pattern we saw in 1988—intense price competition, particularly in the U.S.," said J. Michael Bischoff, vp-corporate development group at Marsh & McLennan.

A random survey of Corroon & Black Corp. branch offices "shows the property and liability market is still soft, with some offices talking about large rate reductions among their larger accounts," said Robert P. Cuthbert, vp and controller for the New York-based broker.

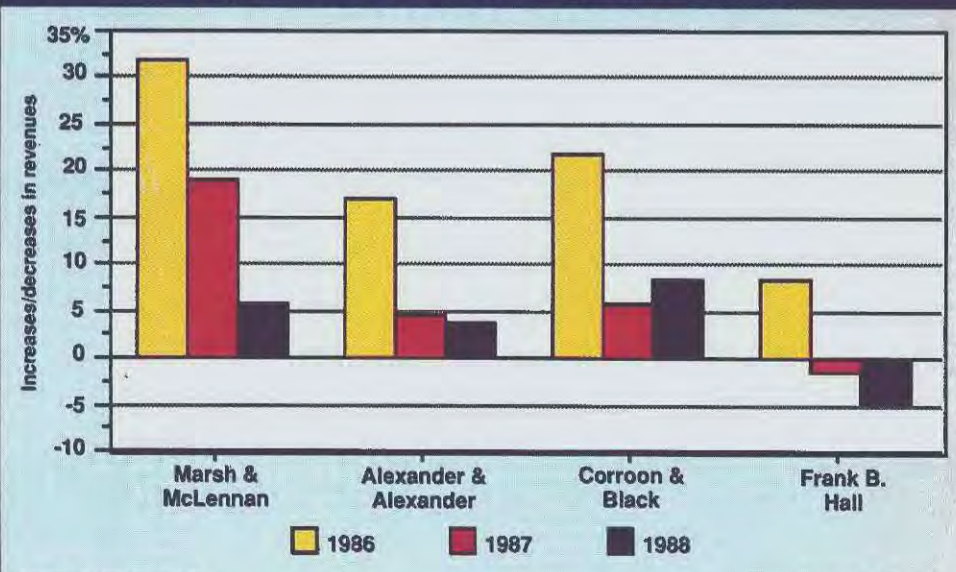
Three factors—higher interest rates, higher contingency commissions and lower tax rates—helped most brokers maintain at least relatively flat profits in 1988, noted analyst Thomas G. Rosencrants, senior vp of Interstate/Johnson Lane Inc. in Atlanta.

And in 1989, while "brokers will still have the benefit of higher interest rates, at least for the first half of the year, contingent commissions will be substantially moderated and tax rates will be unchanged after two years of substantial declines," Mr. Rosencrants observed.

Mr. Smith agreed that the "year-to-year

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**Top brokers' revenue growth stalls**



Source: Company reports

Chart: Holly Seguire

**Crum & Forster unit sues members of defunct ERAS**  
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**Ameritech VEBA pre-funds retiree health care liabilities**  
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**U.S. Treasury seeks changes in taxation of Lloyd's members**  
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## Update

## United insurers 'on notice'

Continued from previous page

ing. The plane was carrying 336 passengers and 19 crew members, said a spokeswoman for the Federal Aviation Administration.

A National Transportation Safety Board spokeswoman would not comment Friday on the possible causes of the incident.

United's broker, Rollins Burdick Hunter Co., placed the Chicago-based airline's war risk and all-risk hull and liability insurers on notice, confirmed Joyce Howard, an RBH assistant vp.

The airline's hull coverage insures it for a maximum of \$125 million for each aircraft. Last week's hull loss could total between \$35 million and \$95 million, London underwriters say.

United also has a maximum of \$700 million in liability coverage.

The airline's hull and liability insurance is led by United States Aircraft Insurance Group in the United States and by The Orion Insurance Co. P.L.C. in the London market, Ms. Howard confirmed.

London sources believe United's hull war risk insurance is led in Lloyd's, but Ms. Howard could not confirm that information.

United's current hull and liability coverage expires March 31. It already has been renewed for April 1 on an 18-month policy with a 60% reduction in hull rates and a 55% reduction in liability rates from the expiring coverage (BI, Feb. 13). Renewal terms do not allow underwriters to review the terms if there is a loss before the program takes effect, sources say.

United has not had a passenger fatality since December 1978, when a DC-8 crashed on approach to Portland, Oregon, airport, killing eight passengers and two crew members. United had a partial hull loss of \$10 million in 1988, London sources say.

## Supreme Court benefit ruling

WASHINGTON—Federal courts should not automatically give deference to decisions by pension and welfare plan administrators when reviewing cases involving denial or reduction of benefits, the Supreme Court unanimously ruled last week.

The case involved the denial of severance benefits by Firestone Tire & Rubber Co. to former employees. After Firestone sold its plastics division to Occidental Petroleum Co., the former Firestone employees were rehired by Occidental and then sought severance benefits from Firestone.

Courts generally have not modified decisions by benefit plan administrators unless the courts found that those decisions were "arbitrary" or "capricious." But the Supreme Court justices ruled that courts should give administrators deference only if plan documents explicitly give administrators authority to interpret plan terms.

As a result of the High Court's ruling, plaintiffs will have an easier time successfully challenging administrators' decisions, legal experts say. "I would not be surprised if there were a rise in suits against administrators. There is a greater incentive to file claims because there is a higher probability of success," said Seth Tievsky, an attorney with The Wyatt Co.'s Research and Information Center in Washington, D.C.

## Court limits scope of awards

ALBANY, N.Y.—A decision last week by the New York Court of Appeals that personal injury victims cannot be compensated separately for the "loss of enjoyment of life" could discourage the growth of jury awards in those cases, say attorneys.

Attorneys also said that the influential New York court could set the pace in other state courts.

In its rulings on two cases, New York's highest court said the loss of enjoyment of life should be considered only as part of an overall award for pain and suffering, not as a separate item.

While the decision will not necessarily lead to lower awards, it "prevents another explosion in the size of damage awards," said attorney Michael A. Ellenberg of Jackson & Nash in New York, who represented physician defendants in the appellate cases.

"It would prevent further increases in this amorphous land of non-economic damages," agreed Victor Schwartz, an attorney with Crowell & Moring in Washington, D.C.

But, attorney Brian Shoot of Schneider, of Kleinick & Weitz in New York, predicted that the decision "in most cases will reduce the award."

## Higher Cadiz award suggested

CHICAGO—Amoco Corp. and a group of French claimants are both expected to appeal a former federal judge's recommendation that Amoco pay between \$30 million and \$35 million in additional damages for the 1978 wreck of the supertanker Amoco Cadiz.

Former U.S. District Judge Frank J. McGarr, acting as "special master" in the Amoco Cadiz litigation since his retirement last year, recommended the additional damages last week in response to motions for reconsideration of his original \$85.4 million damage award against

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## Errors &amp; omissions

- Travelers Corp. has not sold its health insurance book of business as stated incorrectly in a Perspective article in the Feb. 20 issue. Travelers is the sixth-largest group health insurer in the United States with \$7.6 billion in employee benefit premiums and benefits under administration. Travelers underwrites indemnity health plans and operates 60 preferred provider organizations and 10 health maintenance organizations nationwide.

- PsychSelect is the name of the new benefit product expected to be introduced by TAO Inc., not PsychSystems as reported in the Feb. 20 issue.

- Listings in the directory of utilization review firms for Health Benefits Management Inc. and HealthCare COMPARE Corp. in the Feb. 20 issue were scrambled due to a production error. The correct listings for the two firms appear on page 31.

## U.S. pollution insurer sues ERAS members

By CAROLYN ALDRED

LONDON—A Crum & Forster Inc. unit is suing dozens of Lloyd's of London syndicates and other reinsurers that belonged to a now-defunct environmental impairment liability reinsurance facility for as much as \$13 million in reinsurance claims stemming from an underlying policy.

Chicago-based International Insurance Co. alleges the reinsurers will not reimburse IIC after it settled an EIL claim by Philadelphia-based SmithKline Beckman Corp. for \$19 million last year.

In countersuits, the reinsurers contend that damage at the SmithKline site occurred before IIC wrote the policy. The reinsurers also deny they approved the settlement.

The litigation is just part of the bevy of suits involving members of the shuttered Environmental Risk Assessment Service (International) Ltd. EIL reinsurance facility.

ERAS-related litigation against broker Bain Clarkson P.L.C. by dozens of Lloyd's syndicates and reinsurance companies rages on despite the \$6 million settlement paid last month by Bain Clarkson to three members of the pool (BI, Feb. 6).

The facility has liabilities exceeding \$100 million, according to attorneys for the reinsurers. However, total premiums paid to the facility during its seven-year history did not exceed \$40 million, sources say.

ERAS was formed by former London broker Clarkson Puckle Ltd., now part of Bain Clarkson P.L.C., and was fronted by Paris-based Societe Commerciale de Reassurance.

The initial capacity offered by the facility in 1977

was \$5 million per risk/\$10 million aggregate for a primary EIL insurance policy.

The underlying insurance was fronted in the United States by IIC and The Hartford Steam Boiler Inspection & Insurance Co. of Hartford, Conn. (BI, Dec. 7, 1987).

In 1980, Clarkson Puckle established two excess layers to boost the facility's capacity to \$20 million per risk/\$40 million aggregate.

The first excess layer provided \$5 million in coverage excess of \$5 million per risk with a \$10 million aggregate. The layer was led in the London company market by SCOR, which took 15% to 20% of each risk. Robin A.G. Jackson, underwriter for Lloyd's syndicate 799, managed by Merrett Underwriting Agency Management Ltd., led the Lloyd's syndicates that participated on this layer.

The second excess layer was \$10 million excess of \$10 million per risk with a \$20 million aggregate for each policy period. Various underwriters led this layer in different years.

From 1977 through 1982, the U.S. fronting insurers ceded 100% of their EIL risks to SCOR. But beginning in 1983, each of the U.S. insurers retained 7.5% of \$5 million of each primary policy it wrote and reinsured the remainder with SCOR, which retroceded a portion of the risk.

In IIC's lawsuit, filed in November in U.S. District Court in Chicago, the insurer is suing 30 Lloyd's syndicates and 12 reinsurers that were members of ERAS.

IIC wrote a claims-made EIL policy with \$20 million of limits for SmithKline from May 1983 until May 1984.

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## Treasury seeks to change taxation of Lloyd's names

By CAROLYN ALDRED and DEBORAH SHALOWITZ

LONDON—Acknowledging that a special taxing agreement is needed between Lloyd's of London and the United States, the U.S. Treasury Department nonetheless is looking for changes in the U.S. taxation of Lloyd's members.

Lloyd's and the U.S. Internal Revenue Service should maintain a special closing agreement to determine Lloyd's members' U.S. tax liability, but the agreement must be modified to ensure members are paying appropriate taxes reflecting recent U.S. tax law changes, recommends a Department of Treasury report to Congress published last week.

The report concludes that "the operations of Lloyd's of London are so unique, and so resistant to conventional tax categorization, that treatment under an appropriate closing agreement offers substantial advantages to both the In-

ternal Revenue Service and the taxpayers."

The Treasury acknowledges that without a closing agreement "the enforcement procedures that would be required to ensure collection of the appropriate U.S. tax (from syndicate members) . . . would be disruptive to the (members) and expensive for the IRS."

However, "the 1980 closing agreement between the IRS and underwriters at Lloyd's of London should be revised in light of changes in the law since 1980 for the taxation of both U.S. persons and foreign persons," the report states.

For example, "Lloyd's of London should not be permitted for U.S. tax purposes to use an accounting method that provides for reserves without being subject to a corporate tax level," the report states.

Congress ordered the Treasury study when it passed the Omnibus Budget Reconciliation Act of 1987, after killing a House-approved

provision in the budget bill that would have taxed Lloyd's syndicates as corporations and would have forced Lloyd's to scrap its three-year accounting system (BI, Dec. 21, 1987; Nov. 9, 1987).

OBRA directed the Treasury Department to renegotiate the 1980 closing agreement by Jan. 1, 1990.

Treasury Department reports tend to carry a lot of weight with the congressional tax-writing committees.

During tough negotiations that lie ahead, Lloyd's must convince the IRS and the Treasury that members are not paying lower taxes under its historic three-year accounting system than they would under a standard annual accounting system.

Under the existing 1980 agreement, all Lloyd's members—both U.S. and foreign—are deemed to have a "permanent establishment" in the United States and pay income tax on their dollar-based un-

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## Inside

✓ Waste site cleanup coverage litigation between W.R. Grace & Co. and 14 liability insurers will remain in state court in Massachusetts despite insurers' attempts to have the case moved to New York. **PAGE 7**

✓ The new FASB accounting proposal would provide a much more realistic way of measuring the cost of retiree health care, this week's editorial says. **PAGE 8**

✓ Some—but not all—of the strategies used to control group health plan costs can be used to cut workers comp costs, experts say at an International Workers' Compensation Foundation Inc. conference. **PAGE 14**

✓ Ohio, Indiana and New Mexico legislators are considering insurance reform legislation that largely mimics California's Proposition 103. **PAGE 29**

✓ The AIDS epidemic is not forcing dramatic increases in group health insurance premiums and probably will not anytime soon, according to a recent study of health insurers. **PAGE 32**

✓ Aggressive hiring by Frank B. Hall of top producers

and managers from other brokers in recent months now has cost the husband of one its new hires his job at Alexander & Alexander. **PAGE 34**

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Vol. 23, No. 9—Business Insurance (ISSN 0007-6864) is published weekly at 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to Business Insurance, Circulation department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 800-992-9970 or 313-446-1611. Copyright 1989 by Crain Communications Inc.

# Ameritech VEBA pre-funds retiree care

By DONNA DiBLASE

CHICAGO—American Information Technologies Corp. is adopting an unusual strategy to pre-fund billions of dollars of retiree health care liabilities in the wake of recently proposed accounting standards for retiree health care benefits.

Chicago-based Ameritech has contributed \$50 million to a Voluntary Employee Beneficiary Assn. established exclusively to pre-fund the liabilities, and it plans to contribute another \$50 million to the trust later this year, said Harry Malone, director of benefits-finance.

"With the VEBA, we hope to be able to offset some of that liability," Mr. Malone explained, estimating that the company hopes to be able to pre-fund the health care liabilities of a portion of the company's retirees within three to six years.

"Even though it is a taxable trust, there really are no funding alternatives," Mr. Malone said.

An employer's contributions to a VEBA—also are known as a 501(c)(9) trust—are tax-deductible to a limit under a complex formula. However, since the passage of the Deficit Reduction Act of 1984, employers that use VBAs to pre-fund retiree health care benefits are taxed on the investment income earned by the reserves in the trusts.

But, "the funding of retiree health care liabilities is not a

**'Ameritech is right out in front with this strategy. There are VBAs out there, but not many for retiree health care,' says Thomas S. Terry of TPF&C who advised Ameritech on the plan.**

tax-shelter issue. It's more an issue of companies wanting to get a handle on their liabilities," said Thomas S. Terry, a vp and actuary with TPF&C in Chicago, a unit of Towers, Perrin, Forster & Crosby Inc.

Mr. Terry, along with the St. Louis office of the investment firm of Goldman, Sachs & Co., consulted with Ameritech on the plan.

"Ameritech is right out in front with this strategy. There are VBAs out there, but not many for retiree health care," he added.

But, interest among employers in VBAs as funding vehicles for retiree health care benefits could increase because of proposed accounting rules that would require employers to recognize retiree health care liabilities and the cost of those

liabilities on their financial statements, benefit consultants predict.

These standards, developed by the Financial Accounting Standards Board, would require employers to accrue retiree health care liabilities as an expense against corporate earnings from the date an employee is hired until the employee is eligible for post-employment health care coverage beginning in fiscal years after Dec. 15, 1991.

The standards also would require employers to begin recognizing on their balance sheets a minimum liability for retiree health care benefits beginning in fiscal years after Dec. 15, 1996 (BI, Feb. 20).

Mr. Malone acknowledged that the proposed accounting standards contributed to Ameritech's decision to pre-fund these benefits.

But, "we have been looking at our retiree health care liabilities for a while now," he said.

Like most employers, Ameritech has funded its retiree health care benefits on a pay-as-you-go basis.

Ameritech retirees contribute nothing to the cost of their health care plan, which is self-insured and covers major medical, hospital and dental services, Mr. Malone said.

However, retirees pay an annual deductible of \$150 per person and a copayment of 10% of the first \$5,000 of claims.

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## Insurers overcharge Minnesota doctors, regulator contends

By MARK A. HOFMANN

ST. PAUL, Minn.—Rates for medical malpractice insurance in Minnesota are much higher than necessary, Minnesota Commerce Commissioner Michael A. Hatch charges.

"Despite unchanging claim frequency and declining loss payments and loss expense, on average physicians (in Minnesota) paid approximately triple the amount of premiums for malpractice insurance in 1987 than in 1982," says a recent report by the Minnesota Department of Commerce, which regulates insurers in the state.

"Rates are not reflective of risks," Mr. Hatch summed up. The study recommends that the Minnesota department—which generally does not review rate increases of less than 25%—"should review and, if necessary, regulate the premium."

However, Minnesota's two leading medical malpractice insurers—St. Paul Fire & Marine Insurance Co. and Midwest Medical Insurance Co.—dispute the report's contention that physicians are being overcharged for the coverage.

The report—"Medical Malpractice Claim Study 1982-1987"—examined 4,747 medical malpractice files from North Dakota, South Dakota and Minnesota. Seventy-eight percent—or 3,689—of the claims studied were closed.

All of the claims were filed against St. Paul or MMIC, which wrote nearly all medical malpractice insurance policies in Minnesota during the study's five-year period.

According to the report, the frequency and severity of claims did not change greatly during the period studied: The number of claims per 100 policyholders fluctuated from a high of 13.5 in 1985 to a low of 10.4 claims in 1982, with an average of 11.6 for the duration of the study.

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## Retain brokerage system, Lloyd's study recommends

By CAROLYN ALDRED

LONDON—Lloyd's of London underwriters should continue—at least for the next three years—to rely on Lloyd's brokers to obtain commercial insurance business, two Lloyd's working groups have concluded.

Despite increasing calls by Lloyd's underwriters to be allowed to deal directly with policyholders and non-Lloyd's brokers, known as direct dealing, the working groups believe Lloyd's can expand the amount of business it writes without introducing direct dealing.

In a joint report currently being examined by the Council of Lloyd's, the working groups—composed of brokers and underwriters—recommend that Lloyd's adopt ways of making its product more competitive "within the current framework" of Lloyd's brokers, like the establishment of a corporate advertising and marketing strategy and the introduction of a corporate premium financing unit.

The success of this approach should be reviewed "after the broker registration exercise is complete" in 1991, the task forces say, referring to re-registration of all Lloyd's brokers under new regulations affecting Lloyd's brokers (BI, March 7, 1988).

Many Lloyd's underwriters advocating direct dealing are keen to expand their product base and reduce their dependence on high-risk, high-premium business, in particular U.S. property/casualty insurance and reinsurance (BI, Dec. 14, 1987).

The underwriters believe the current system of producing business for Lloyd's through Lloyd's brokers is

unsuitable for high-volume, low-premium risks like small commercial lines and personal lines risks.

In addition, some underwriters believe direct dealing will become more viable for all types of business with the establishment of more sophisticated computer link-ups within the insurance industry.

Already several syndicates have set up underwriters outside the Lloyd's Underwriting Room on Lime Street in London and can accept some business from non-Lloyd's brokers using special arrangements that were individually approved by the Council of Lloyd's.

However, despite the task forces' recommendations against direct dealing, the debate over whether policyholders and non-Lloyd's brokers should be able to place business directly with Lloyd's underwriters is likely to become more vociferous, according to speakers at a recent London conference.

Lloyd's underwriters are faced with "very serious statutory restrictions because they have to do business through Lloyd's brokers in the Room," pointed out Peter Rawlins, managing director of Lloyd's underwriting agency E.W. Sturge & Co.

"Whilst reinsurance and some major risks insurance flow across borders, other buyers and brokers want to deal with underwriters directly," agreed Jim Bannister, chairman of Insurance & Reinsurance Research Group Ltd., which organized the Future Shape of the London Market conference, held Feb. 15-16.

Direct dealing would require Lloyd's underwriters to establish a presence outside the Lloyd's Under-

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# \$57 million hull loss unlikely to lift rates

By STACY SHAPIRO

LONDON—The loss of a \$57 million Flying Tiger Boeing 747 cargo plane is not expected to stem rapidly falling airline hull and liability rates.

Los Angeles-based Flying Tiger Line Inc. has hull coverage for the value of the aircraft and \$500 million of liability insurance to cover cargo lost when its Boeing 747-200F cargo jetliner crashed Feb. 19 into a hill in the Malaysian village of Puchong.

The crash killed all four American crew members, the only people aboard the aircraft.

The Flying Tiger cargo plane was carrying clothes, computer components and machinery on one of three weekly flights from the United States to Kuala Lumpur.

U.S. and Malaysian investigators last week began a joint probe into the crash.

The airline insured the hull for \$57 million, brokers and underwriters confirmed.

Flying Tiger's \$500 million of liability insurance has a cargo limit of \$5 million for each item.

The airline had not informed underwriters last week of the value of the cargo on board or whether any of the cargo could be salvaged.

The airline's hull and liability insurance was placed in the U.S. market by Frank B. Hall & Co. Inc. and in London by Hall affiliate Leslie & Godwin Ltd. A portion of the risk also was placed in the French market, according to London sources.

Forty percent of the hull and liability coverage was written in London, led by Lloyd's of London's Ariel syndicate.

Associated Aviation Underwriters, a consortium of insurers based in Short Hills, N.J., also wrote coverage for Flying Tiger.

French hull and liability insurance underwriters could not be identified.

The Flying Tiger crash was the fourth in a series of aviation disasters over the past three months.

Hull and liability losses stemming from the four crashes could reach \$500 million, close to the estimated \$600 million in premiums aviation underwriters are expected to receive this year.

However, the Flying Tiger loss combined with the other disasters will have "very little" effect on massive hull and liability rate reductions quoted for April 1 airline renewals, aviation market sources agree.

"The market is still in a downward spiral," said a London aviation underwriter.

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A Flying Tiger cargo plane crashed Feb. 19 in Malaysia, killing the four crew members. Photo: AP/Wide World

# Coverage ruling favors asbestos firms

By STACY ADLER

SAN FRANCISCO—Several key policy exclusions raised by liability insurers in their asbestos coverage battle with Armstrong World Industries Inc. would not bar coverage for property damage claims, the California state judge presiding over the coordinated asbestos coverage litigation has ruled.

California Superior Court Judge Ira A. Brown Jr. earlier this month ruled that the owned-products exclusion, the product-recall exclusion and the design-defect exclusion, among others, contained in Armstrong's comprehensive general liability policies would not bar coverage to the asbestos producer, which faces 163 asbestos property damage claims.

In addition, policies that do not

**Judge Brown's most recent rulings 'reinforce a clear trend in case law around the country' where courts are finding coverage for policyholders, says Armstrong attorney William Skinner. 'Insurers need to rethink their defenses.'**

specifically exclude coverage for punitive damages must cover those damages awarded because of Armstrong's carelessness, negligence or recklessness, Judge Brown ruled.

The decision comes on the heels of Judge Brown's landmark ruling that asbestos in buildings causes insurable property damage (*BI*, Sept. 12, 1988) and marks one of the first times any court has interpreted how standard comprehensive general lia-

bility policy exclusions apply to asbestos property damage.

Earlier in the litigation, Judge Brown also issued a precedent-setting ruling that asbestos producers are entitled to recover from all insurers that wrote liability insurance policies for them from the time a claimant was exposed to asbestos through the time the claimant files a claim or the victim's death (*BI*, June 1, 1987).

The coordinated litigation originally involved more than 75 insurers, but that figure has been pared to less than two dozen because of settlements—including the Wellington agreement.

The latest phase of the coordinated trial involves only Lancaster, Pa.-based Armstrong and more than a dozen of its liability insurers that covered Armstrong from as early as 1947.

But, attorneys say that because Judge Brown's decision is based on extensive records and a lengthy trial, it will influence not only asbestos litigation nationwide but also coverage disputes involving pollution.

Judge Brown's most recent rulings "reinforce a clear trend in case law around the country" where courts are finding coverage for policyholders, said Armstrong attorney William

Skinner.

"Insurers need to rethink their defenses," said Mr. Skinner, who is with Covington & Burling in Washington, D.C.

Attorneys for insurers could not be reached for comment.

In his decision, Judge Brown ruled that the owned-products exclusion would not bar coverage for asbestos property damage claims against Armstrong because claimants contend that Armstrong building products damaged the buildings in which they were installed.

The owned-product exclusion bars coverage for damage to a policyholder's own products and work.

"As a general rule, the underlying plaintiffs are not concerned with damage to the asbestos-containing building materials but, rather, seek compensation for the alleged contamination and diminution in value of their buildings by the asbestos-containing building materials," the judge said.

"Since damage to the asbestos-containing building products is not in issue, the owned-products exclusion does not apply," he ruled.

Judge Brown also ruled that the product-recall exclusion does not bar coverage, because Armstrong is not recalling its asbestos-containing products.

Rather, the asbestos producer is seeking coverage to respond to damage its products have caused, the judge said.

The product-recall exclusion, also known as the sistership exclusion, bars coverage when a policyholder withdraws, repairs or replaces his product because of an unknown or suspected defect.

"For the provision to apply, the insured's products must be 'withdrawn' from the market or from use. This has not occurred with Armstrong's asbestos-containing building materials," Judge Brown explained.

"In addition, the sistership exclusion does not apply where actual damage is caused by the defective product," he ruled.

The judge also ruled that the design-defect exclusion, which bars coverage for damage caused by a defect in a policyholder's product, does not apply because Armstrong's products never failed to perform their intended insulation function.

"The alleged defect in the asbestos-containing building products is not a 'passive' failure to insulate or perform any of the normal functions expected of floor tile, pipe insulation or surfacing material," Judge Brown said. "Rather...the building cases allege that a positive harm results from asbestos-containing building materials."

Also in the latest phase of the trial, insurers contended that specific policy exclusions and public policy barred coverage for punitive damage awards against Armstrong.

But, Judge Brown ruled that insurers could deny coverage for punitive damages only if either the policies specifically exclude coverage or if the punitive damages were awarded because of willful misconduct.

"The coverage of punitive damages is prohibited for public policy reasons in cases where punitive damages are awarded with a view to punish the defendant for misconduct and to deter the defendant and others from similar misconduct," Judge Brown ruled. Such misconduct would include fraud, oppression and malice, he said.

"On the other hand, where punitive damages are awarded for 'mere carelessness, characterized as negligence or recklessness' the public policy of this state does not prohibit coverage of such damages," he said.

Coordinated Asbestos Insurance Coverage Cases; San Francisco Superior Court, No. 1072.



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## Opinions

## The FASB challenge

WHILE NEW ACCOUNTING rules for retiree health care benefit plans will be traumatic for employers in the short run, over the long run the rules will be beneficial to companies and their workers.

For too long, retiree health care programs have been promised with too little thought about what they will cost in the future.

Indeed, many companies still haven't even begun to measure their future retiree health care liabilities.

One could understand why employers, until recently, paid so little attention to retiree health care plans. The costs of the programs often were minimal because medical care inflation was low and because the number of retirees was small compared with active employees.

But that no longer is the case. For example, health care costs for retirees under 65 in 1988 averaged \$2,397 per retiree, while costs for retirees over 65 who were eligible for Medicare benefits averaged \$1,372 per retiree, according to a recent survey by benefit consultant A. Foster Higgins & Co. Inc. (*BI*, Feb. 13). And, with the aging of the population, employers generally will find their number of retirees increasing.

Clearly, retiree health care benefits no longer are "mere gratuities." They are major costs and liabilities for employers.

And, that is the whole point behind the new accounting standards for retiree health care benefit plans proposed by the Financial Accounting Standards Board.

Recognizing retiree health care costs as they are paid, as is now the case, obscures the real cost of these programs.

But switching to accrual accounting and recognizing retiree health care liabilities on balance sheets, as FASB has proposed, will provide a much more realistic way of measuring the cost.

Over the short run, the FASB rules will be a shocker for employers. Many companies will see their profits slashed and their balance sheets wal-

loped.

But, the result will be that, at last, companies will know what their promise to provide benefits to retirees will cost.

Wailing against the FASB rules will be fruitless. Therefore, more employers should follow the lead of those already discussing how to redesign their retiree health care plans to make them affordable.

For example, employers are looking to replace the open-ended promises in their current programs with arrangements that limit their liability.

Under one approach now being widely discussed, an employer would limit its contributions to fixed amounts. Other approaches involve linking benefits to the number of years an employee works before retirement.

What all these approaches have in common is recognition that companies no longer can afford to provide virtually unlimited retirement health care benefits.

Undoubtedly, such approaches will mean that more costs, once absorbed by employers, will be picked up by retirees.

That may cause some pain, but is far better than the alternative: companies doing nothing about the cost of their retiree health care plans and then, down the road, finding they can't afford to pay the benefits and leaving retirees without warning out in the cold without benefits.

But, there is another aspect of retiree health care liabilities that FASB lacks the authority to address: tax incentives for employers to prefund their retiree health care liabilities.

That challenge is now in the hands of Congress.

While the FASB rules will provide more realistic information about the costs of retiree health care benefits, the rules, in and of themselves, do not assure that assets will be dedicated to meet those liabilities.

By giving employers tax incentives to prefund retiree health care liabilities, Congress will help assure that health care coverage promises to retirees can be met.

## Letters

## Proposed FSA rule would violate ERISA

To the editor: Jerry Geisel's article "IRS Considers Complicating FSAs" (*BI*, Jan. 30), and your editorial "Speak Up to Save FSAs" (*BI*, Feb. 6), were very informative but failed to mention the most important Employee Retirement Income Security Act rule regarding the proposed change.

The notion of employers being obligated to reimburse employees for medical expenses, absent sufficient funds in the employees' flexible spending account, appears to be a violation of ERISA Section 406 (a)(1)(B). That section provides that plan fiduciaries cannot *directly* or *indirectly* loan money to parties-in-interest (i.e., employees or owners).

In practical terms, the employer is loaning the plan money to advance to the employee-participant. It would be immaterial whether an employee remained with the employer or terminated because the prohibited transaction would have occurred the instant the employer paid

for the employee's medical claim.

While the article suggests "front loading" the employee's account or limiting the amount of medical expenses to be claimed, these ideas deviate from the law's original intent. Congress (and the Internal Revenue Service) would better serve the public by strengthening Section 125 and by adding dependent care under ERISA's protection.

Royce A. Charney  
Trust Fund Administrators Inc.  
San Francisco

## Fix insurer problems before shining image

To the editor: I read with great interest the story concerning the Insurance Information Institute: "III Seeks Big Money for Image Campaign" (*BI*, Jan. 23).

Having been an insurance agent for the past 42 years and still active, I feel that one basic concept needs to be understood before the problem of the industry's image can be approached.

The extremely erratic and confusing decisions reached by most insurance companies concerning underwriting, cancellations, pricing, distribution system changes and very arbitrary and unconcerned attitudes toward the customer must be addressed by top management. Major corrections must be made before any public relations campaign can even hope to be successful.

I have learned one thing in these last 42 years as a salesman and businessman: The customer always wins.

Our customers are angry at our industry as a whole and with much justification, in my opinion. I hope we can do better in the future.

H.H. Batjer Jr.  
Trimble-Batjer Insurance Associates  
San Angelo, Texas

## It's too late to lobby for Section 89 repeal

To the editor: Congratulations and amen to your "Too Late to Lobby" editorial on Section 89 (*BI*, Feb. 13). It was right on target and you deserve recognition for having the guts to chastise many of your readers with truth they don't want to hear. Let us hope that the last two short paragraphs of that editorial can become engraved in the minds of everyone involved in the benefits and insurance role or business.

You are absolutely correct that employers and even some associations involved in benefits acted like ostriches on the issue of the Consolidated Omnibus Budget Reconciliation Act of 1985 and Section 89. In the case of COBRA, we started warning our third-party administrator members—and they, in turn, their clients—more than a year before COBRA was passed. In the case of Section 89 non-discrimination tests, we had started the warning and lobbying process in the spring of 1983—three years before Section 89 was passed and six years before its effective date!

I give about 30 speeches a year to other  
Continued on page 10

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

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Published weekly at 740 Rush St., Chicago, Ill. 60611, Telex 6871241, Fax 312/280-3174, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017, Telex 640207, Fax 212/210-0704, CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231, Fax 214/696-1936; Suite 814, National Press Building, Washington, D.C. 20045, Fax 202/638-3155; 6404 Wilshire Blvd., Los Angeles, Calif. 90048, Fax 213/655-8157; 20-22 Bedford Row, London WC1R 4EB, England, Fax 01/430-2176. \$1.75 a copy. \$70 a year in U.S. Canada and all other foreign add \$32 for surface mail. Europe and Middle East only add \$72 for air delivery. First-class mail to U.S., add \$77; to Canada add \$87. Bermuda only, \$152 per year expedited delivery. WILLIAM STRONG, vp-circulation. SHEILA GORMLEY, circulation manager. JOHN HUFFMAN, fulfillment director. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich. 48207, or phone 800-992-9970 or 313-446-1611, Fax 313/446-1650. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611, 312-649-5303. For reprints or reprint permission contact: Reprint Department, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017, 212-210-0229, Fax 212/210-0704.

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## Letters

Continued from page 8

audiences and usually mentioned these trends. Each audience assumed I must be an alarmist or kook to predict such crazy things. Meanwhile, *Business Insurance* has done a superb job in keeping its readers in the absolute forefront of coming developments.

Employers and everyone in the insurance/benefits arena can justifiably say that they have been so buried by the massive complexity of each new requirement that they cannot focus on what's on the horizon. Your editorial points out that they *must* look to (and lobby) what's on the horizon. Short-sightedness is dereliction of duty and simply makes tomorrow's crisis worse. The coming years, because of the federal budget crisis, have equally harsh new developments evolving right now.

Everyone should read and heed their *Business Insurance* and communicate their views to Congress. Democracy works—but only if we the people tell it what we think in time for the system to act accordingly.

**Frederick D. Hunt Jr.**  
President  
Society of Professional  
Benefit Administrators  
Washington

### Prop. 103 equals 'asynetocracy'

To the editor: As an observer and participant in the insurance industry for over 25 years, I would like to offer a one-word description of the passage of California's Proposition 103: "Asynetocracy."

This word does not appear in any dictionary, but if it ever does, the entry will read something like this:

**asynetocracy** (uh-sinuh-tokruh-see): Government by stupidity (as in the passage of Proposition 103 in California toward the end of the 20th century) [From the Greek: a-syn-eto (stupid, unintelligent) and kratos (rule by)]

**S.J. Davidian**  
Hallmark Insurance  
Associates Inc.  
Fresno, Calif.

### Is mainframe RMIS better than PC?

To the editor: The Jan. 23 RMIS Commentary, "Anistics Decision Raises Questions," authored by David A. Tweedy and Michael N. Singer, maintains that mainframe computers and/or time-sharing on them is actually more economical and more useful than are stand-alone microcomputer systems.

The article's rationale for anyone selecting a microcomputer over a mainframe is both psychological and based on frustration with the data processing department. The psychological part is that "we" want a microcomputer on our desk, and "like" to control our resources. It goes on to say that if you forget the significant cost of the data communication, mainframes are cheaper because many microcomputers sit idle most of the time.

The implication is that one uses a microcomputer as a security blanket or for psychological satisfaction, and most of the time it just sits there.

In the space of one obtuse paragraph, the authors further manifest the ebb of their logic by stating that many microcomputers are idle most of the time; therefore, if you forget about the significant cost of data communication for time-sharing on a mainframe...the mainframe is cheaper! Incredible.

What the heck does one have to do with the cost of the other? Why are only microcomputers idle most of the time? If both computers are

being compared for cost based upon performing RMIS functions, why wouldn't you consider the significant cost of data communication? Why would you forget about literally thousands of dollars each and every month?

The authors' keen myopic insight becomes cataract clear when they find it purely "psychological" to desire and insure control over one's resources. This may come as a shock to the authors, but it is considered good business practice for a company to control as many of its resources as possible if it is to succeed. It also has escaped their wisdom that had Anistics' clients been on a microcomputer with access to the source code, it would be almost business as usual.

As for capability, there is no computer software function—RMIS or otherwise—now being performed on a mainframe that

**There is no computer software function—RMIS or otherwise—now being performed on a mainframe that cannot be duplicated and/or improved upon with the use of a microcomputer. . .for a mere fraction of the cost completed in 5% of the time.**

cannot be duplicated and/or improved upon with the use of a microcomputer. . .for a mere fraction of the cost, and completed in 5% of the time. For the amount of money most Anistics' clients paid for time-sharing over the past two or three years, they could have—and can—purchase an RMIS system of their own, including both hardware and software.

Let someone get the wrong impression, we are not against time-sharing on a mainframe. In fact, we

now offer this service. In some instances, clients would rather time-share as opposed to doing everything themselves; however, it is certainly more expensive to do so.

Current Anistics clients would be well-advised to evaluate numerous organizations that specialize in RMIS systems that can run on micro, mini and mainframe computers. They also should insist that the source code is available for purchase. Should the company go out of business or were in any way

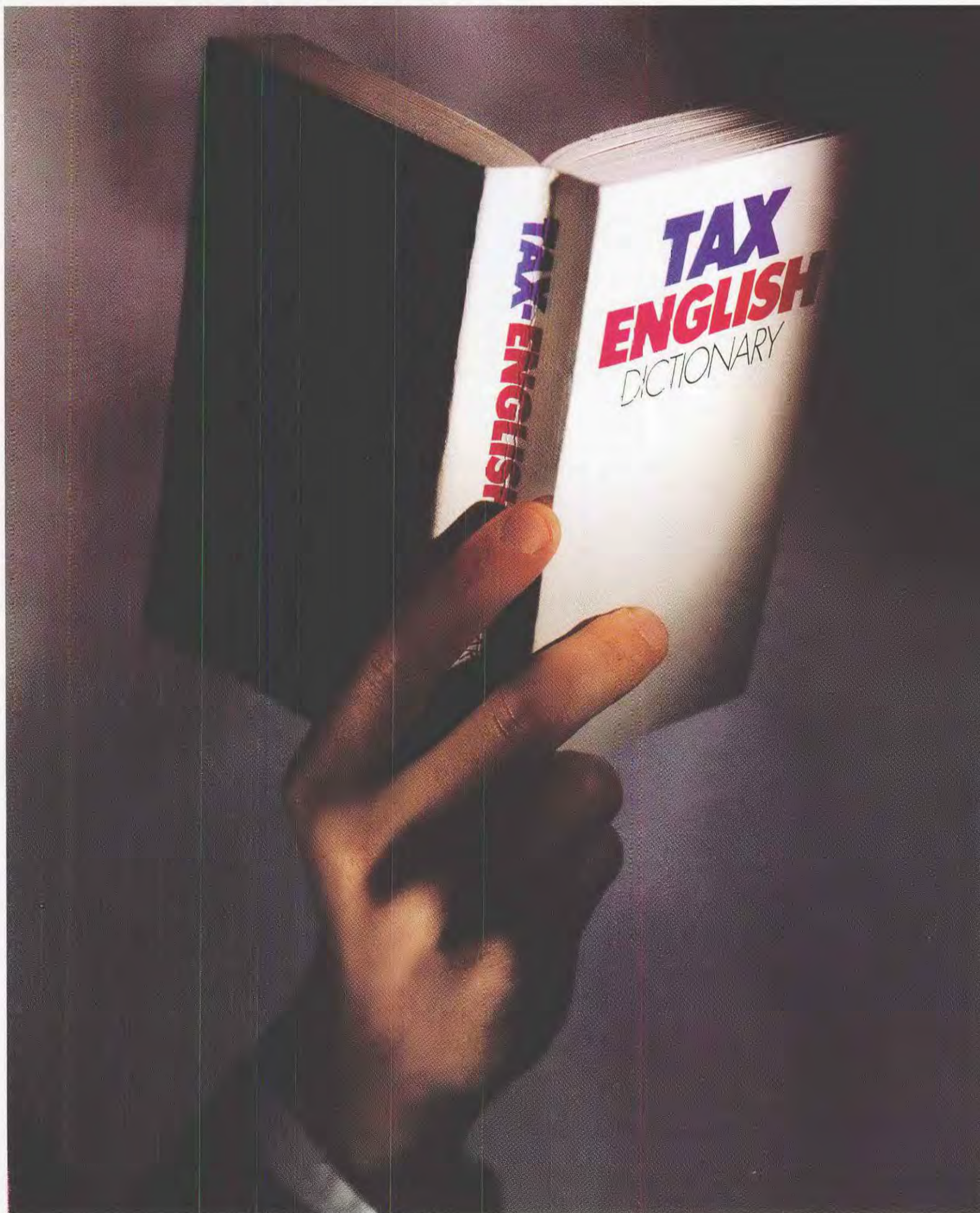
unable to service its clients, current copies of the source code should be kept in escrow, and made available—without additional cost—to all clients.

**Frank E. Amatelli**  
National Risk Management Inc.  
San Ramon, Calif.

■ Messrs. Singer and Tweedy respond: In response to Mr. Amatelli's letter, we are disappointed that he failed to understand the points raised in last month's column. We would like to offer some clarifications.

First, our point was not that mainframe/time-share systems are more economical and useful than stand-alone microcomputer systems. Rather, we said that time-sharing many tasks on a mainframe is cheaper (due to economies of scale) than the cost of many micro-

Continued on next page



Continued from previous page  
computers that may sit idle most of  
the time.

Secondly, we disagree with his  
statement that a micro is always  
superior to a mainframe in cost and  
efficiency. In corporate environ-  
ments, mainframes usually experi-  
ence little downtime as they pro-  
cess thousands of tasks while  
simultaneously supporting hun-  
dreds of users. Yet, despite their  
rapid sophistication, neither of us  
is aware of any RMIS/micro with  
comparable downtime and an abil-  
ity to simultaneously handle hun-  
dreds of users performing different  
functions.

Finally, we never said that the  
"rationale for anyone selecting a  
microcomputer over a mainframe  
was purely psychological." Rather,  
we said that the psychological fac-  
tor of controlling one's own re-  
sources and the frustration in deal-

ing with an unresponsive data pro-  
cessing department were major  
factors in opting for a micro solu-  
tion.

We both can attest to many client  
engagements proving these points.

### Industry needs complete overhaul

To the editor: How to resolve the  
insurance industry's problems?  
Having been in the business of of-  
fering advice for 35 years—some-  
time unwanted, to be sure—I am  
eminently qualified to advise the  
industry, to save it from the perils  
it faces.

We need an amendment to the  
McCarran-Ferguson Act that  
would suspend the act for 10 years  
but not terminate it. The deregula-  
tion of the airline industry, which  
has subjected travelers to the

squalor of the bus station, is suffi-  
cient argument against termina-  
tion. Just suspend it, so if the in-  
surers engage in collusion to the  
detriment of the public, Ralph  
Nader and the public defenders  
can go after them.

Also, prohibit the Insurance Ser-  
vices Office Inc. from issuing any  
rates for anything, even on an ad-  
visory basis. ISO should gather  
statistics to assist the insurers in  
developing rates and it should be  
able to develop suggested policy  
forms, but no insurer should be ob-  
ligated to follow them.

The state insurance departments  
should devote their energies to  
doing what they are supposed to  
do: Making sure some insurers  
don't go broke by stopping their  
operations as soon as their finances  
and method of operating indicate  
any danger. We don't want a bunch  
of insurers to follow the Texas

**The insurance  
industry, has no real  
competition and no  
real incentive to do a  
better job.**

S&Ls. The departments should no  
longer approve rates or forms.

Most, if not all, policies should  
be written on a claims-made form  
so the insurer has a reasonable  
handle on its exposure to loss for  
the payment it receives. The policy  
limit should include the cost of de-  
fense, that which is paid to outside  
counsel, to further set a limit on its  
exposure. On termination, the poli-  
cyholder should be able to buy an  
extension for possible claims that  
have not surfaced, and the cost

should be set at the inception of  
the first policy so the policyholder  
won't later be sandbagged.

The industry should be required  
to upgrade its personnel. First, in-  
surers' underwriting departments  
should be graded according to  
their percentage of Certified Prop-  
erty & Casualty Underwriters,  
other recognized professional des-  
ignations, candidates and the un-  
learned. Insurers should be re-  
quired not to merely make this  
information public, but to dissemi-  
nate it. It should be made part of  
the A.M. Best Key Rating Guides  
so agents and policyholders can  
make comparisons. This is just as  
much a part of making informed  
decisions as is the insurer's com-  
bined loss and expense ratio.

Then, after two or three years,  
the loss prevention departments  
should be similarly graded. After  
all, since policyholders pay for this  
service in their premiums, aren't  
we entitled to know the percentage  
of untrained, uneducated fatheads  
insurers employ to make their too-  
often fatuous recommendations?

The insurance industry, unfor-  
tunately, has no real competition  
and no real incentive to do a better  
job. It is riddled with incompetents  
who very literally just don't care.

There should be free competi-  
tion, as to rates and forms, gov-  
erned only by the insurer's under-  
writing competence and the  
pressures of the marketplace. One  
result: Dozens of insurers that  
shouldn't be in the business any-  
way, won't be. They'll be forced to  
merge or get out. The ones that  
stay in will have to do a much bet-  
ter job—a professional job of un-  
derwriting the risks they write.  
Then, in 10 years, we can consider  
whether a continuation of McCar-  
ran-Ferguson and ISO will in-  
crease efficiency and give us a bet-  
ter product or just add more layers  
of bureaucracy. And who will ben-  
efit? Everyone.

**Stanley C. Brock**  
The Lukes-Brock Co.  
Milwaukee

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## ERAS litigation

Continued from page 2

SmithKline submitted a claim during the policy period after it was ordered by the U.S. Environmental Protection Agency to clean up a site the company owned in Porterville, Calif., the lawsuit states.

IIC disputed the claim, and SmithKline sued the insurer in federal court in California seeking damages and a declaration that the policy covers the Porterville claim.

However, IIC last year agreed to pay SmithKline \$19 million after IIC's reinsurers in January 1988 authorized the insurer "in the amount of \$15 million to settle the Porterville claim," the lawsuit claims.

After subtracting IIC's and SCOR's retentions on the SmithKline policy, IIC estimates the reinsurers owe it about \$13 million for the SmithKline claim payment.

But, "all defendants have intentionally and maliciously delayed full reimbursement of plaintiff under the

contracts," IIC's lawsuit against the reinsurers states.

IIC is seeking unspecified compensatory and consequential damages, exemplary damages, statutory damages and legal costs from the reinsurers.

But, in two separate lawsuits filed in London's High Court in November and December, the reinsurers seek a declaration that they are entitled to void the policy.

Among other things, the reinsurers contend that IIC did not have to pay SmithKline because:

- "Prior to the issue and to the inception of the SmithKline Beckman policy, leakages of quantities of hazardous chemicals had occurred from a solar evaporation pond at the Porterville site, which (SmithKline) knew, or suspected, to have caused environmental impairment."

- "Prior to the inception of the policy, the Porterville site had been inspected by the California Regional Water Quality Control Board, the Californian Department of Health

Services and the United States Environmental Protection Agency, (which) suspected and found incidents of environmental impairment and violations of state and federal environmental regulations," the lawsuit claims.

"Any EIL liability arose out of (SmithKline's) non-compliance with regulations relating to environmental impairment, and its failure to take reasonable and necessary action in a timely and proper manner... and was therefore a risk expressly excluded by the policy."

- SmithKline did not disclose the suspected leakages at the Porterville site to IIC or its agents prior to the inception of the policy.

- A claim had first been made against SmithKline prior to the inception of the policy and "therefore its environmental impairment liability was expressly not within the risk covered by the policy."

Beginning in July 1984, "proceedings were initiated against (SmithKline) by some 224 individuals, alleg-

ing personal injury and or property damage as a result of the Porterville contamination," the papers say.

The lawsuit claims the reinsurers are not liable to indemnify IIC because, among other reasons, IIC did not inform the reinsurers of the \$19 million settlement "in respect of SmithKline's past and estimated future cleanup expenditure and its costs in defending the Porterville proceedings."

The reinsurers also allege that IIC:

- Failed adequately to investigate the causes of the leak from the pond when SmithKline became aware of the contamination.

- Gave inadequate or erroneous consideration to the prospects of successfully resisting SmithKline's claim.

- Acted unreasonably in agreeing to the payment of 95% of its maximum liability under the terms of the policy.

- Would not have agreed to a \$19 million settlement if it had not been reinsured.

Meanwhile, reinsurers that were members of ERAS are suing Bain Clarkson for damages following mounting losses on U.S. manufacturers' EIL policies the facility reinsured from 1977 through 1983.

Despite a settlement by Bain Clarkson with Bavarian Reinsurance Co. of Munich, Zurich Reinsurance Co. of Zurich, Switzerland, and subsidiary Alpina Reinsurance Co. involving one underlying policy, the three reinsurers will continue to litigate with the broker to recover EIL claims arising from other underlying policies.

Among other reinsurers that also are suing Bain Clarkson are at least two dozen Lloyd's syndicates including Mr. Jackson's syndicate 799; SCOR; London-based St. Katherine Insurance Co. P.L.C.; CNA Reinsurance of London Ltd.; British National Insurance Co. Ltd., of Sussex, England; The Dominion Insurance Co. Ltd., of Edinburgh, Scotland; Hannover Reinsurance Co. of Hannover, West Germany; Ancon Insurance Co. (U.K.) Ltd., of London; Insurance Corp. of Ireland P.L.C. of Dublin; Yasuda Fire & Marine Insurance Europe Ltd. of London; The People's Insurance Co. of China of Beijing; Scan Re Insurance Co. Ltd. of London; and Nisshin Fire and Marine of Tokyo.

The litigation filed in London's High Court includes:

- A lawsuit filed in December by 25 Lloyd's syndicates and nine reinsurance companies against 19 Bain Clarkson subsidiaries and three subsidiaries of Alexander & Alexander Services Inc. that were involved in placing EIL policies in the United States.

The lawsuit claims unspecified damages for breach of duty and negligence in "writing, accepting, supervising, managing and/or advising in and about the EIL cover." The reinsurers also seek "a declaration as to the liability" of the defendants.

The lawsuit does not include any further details.

- A lawsuit filed by four Lloyd's syndicates and two London-based reinsurers against 19 Bain Clarkson subsidiaries. The reinsurers are claiming damages for negligence and breach of duty and non-disclosure in relation to the management, supervision and payment of claims arising from the ERAS facility.

- A lawsuit filed by two London companies and three Lloyd's syndicates against SCOR as well as the Bain Clarkson units, claiming unspecified damages and seeking a declaration that the retrocessions are "voidable by reason of material non-disclosure and/or misrepresentation" by SCOR and its agents.

The lawsuit does not specify the nature of the non-disclosure.

The five facility members represent 10% of the capacity of the primary layer only, according to SCOR. "Companies and Lloyd syndicates involved in the first and second layers have no conflict with SCOR," a SCOR statement said.

- A lawsuit filed by SCOR against 11 Bain Clarkson subsidiaries claiming damages for breach of contract, negligence and breach of duty regarding the "operation and management of an environmental impairment liability risks program and/or reinsurance pool formed for the purpose of accepting reinsurance of EIL risks including without limitation the promotion, underwriting, claims handling and retrocession of such program."

- Three separate lawsuits filed by ERAS and various Bain Clarkson subsidiaries against A&A subsidiaries Alexander Howden Insurance Services Inc. of Atlanta; Howden Agencies Ltd. of Cranford, New Jersey; and The London Agency Inc. of Atlanta.

The lawsuits seek damages for breach of contract and negligence arising from the management the EIL program. The lawsuit does not specify the nature of the defendants' role in the operation of the facility in the United States.

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2. thing or quality having intrinsic worth.

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# Benefit cost controls can cut comp expenses

By MEG FLETCHER

NEW ORLEANS—Some—but not all—of the strategies employers use to control health care benefit plan costs also can be used to cut workers compensation costs.

Utilization review, disability case management, limiting employees' choice of providers and encouraging the use of managed care arrangements like preferred provider organizations are among the health care benefit cost control measures that can be applied to workers comp cases, experts say.

And, at least one other cost-containment technique not commonly found in employee benefit plans—mandated fee schedules—has helped reduce workers compensation costs, according to experts.

However, some of the cost containment measures applied in health care benefits, like cost-sharing with employees, generally are not transferrable to the work-

ers compensation system because they contradict the system's philosophy, said Philip Borba, assistant vp in the National

Council on Compensation Insurance's Economic and Social Research Department in New York.

The exclusive remedy doctrine of workers compensation requires employers to fully pay for the treatment and compensation of injured workers. In exchange, employees generally are barred from suing their employers in connection with workplace injuries.

While legislative or regulatory reform may seem an attractive means for controlling rising work comp-related medical costs, utilization review of serious claims and alternative provider arrangements are probably more effective, said Mr. Borba.

But, before establishing cost containment programs, state workers compensation administrators should evaluate the impact those changes will have on workers comp costs and rates, Mr. Borba advised those attending a panel discussion during the first conference presented by the International Workers' Compensation Foundation Inc., held Feb. 8-11 in New Orleans.

The Jackson, Miss.-based International Assn. of Industrial Accident Boards & Commissions, which represents work comp administrators, established the Indianapolis-based foundation last year as an educational and research affiliate.

But, even if work comp administrators do a superb job of medical cost containment, it would have relatively little impact on overall health care cost inflation, said other experts attending the conference.

The work comp system pays only 2% of health care costs, noted C. Clarke Imbler, senior vp, secretary and treasurer of the Schaumburg, Ill.-based Alliance of American Insurers.

The prospect of really controlling health care costs is rather "dismal," concurred Michael Morrissey, a professor at the University of Alabama's School of Public Health in Birmingham, Ala.

However, all of the workers comp experts speaking at the conference agreed that work comp administrators and payers will continue to explore the feasibility of using employee benefit plan cost containment measures, including:

- Utilization review.
- Typical UR techniques include

requiring second surgical opinions, preadmission certification, concurrent review of patient care and retrospective review of physician and hospital charges after a claim is closed.

"These utilization reviews require a great deal of support structure and the additional cost of these reviews must be considered in light of the potential for really

lowering medical expenditures," Mr. Borba said.

Utilization review has potential for reducing work comp medical costs, but it may best be left to employers and insurers to use this approach rather than have states establish such programs statutorily, he said. States have to be wary of creating "a large and potentially difficult-to-manage structure,"

Mr. Borba said.

And, any UR program should be used only for the most serious cases, which amount to only 10% to 20% of all work comp cases, Borba advised.

However, a UR program can generate significant savings.

Washington state's exclusive work comp fund expects to save about \$20 million annually

through cost containment programs that emphasize review of physicians, chiropractors, physical therapists as well as miscellaneous health care bills. Since the program costs about \$2 million, that equates to a savings of \$10 for every \$1 in administrative expenses.

Effective UR requires setting  
*Continued on next page*



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Continued from previous page goals and objectives, said Dr. Ronald Gots, founder and president of the National Medical Advisory Services and Medical Claims Review Services in Bethesda, Md.

He recommends a case management approach in which a claimant's case is supervised so that proper treatment is planned and no unnecessary testing, hospitalization or procedure is conducted.

Poor planning, excessive fees, misused technology or use of technology that is suspect are among the causes of waste, according to

**Companies should carefully review bills to ensure that health care providers have not unnecessarily fragmented or upgraded the workplace-related illness or injury or conducted an excessive number of tests, says Dr. Taricco.**

Dr. Gots.

In addition, employers and insurers need to be on the lookout for abusive or fraudulent practices, said Dr. Alfred Taricco, medical

director for Aetna Casualty & Surety Co. in Hartford, Conn.

For example, companies should carefully review bills to ensure that health care providers have not

unnecessarily fragmented or upgraded the workplace-related illness or injury or conducted an excessive number of tests, Mr. Taricco said.

• **Disability management.**

Good disability management requires employers to know—before an accident happens—which facilities offer the best medical treatment for specific types of job-related injuries, said Harlis McMurry, director of medical services for the southwest division of Liberty Mutual Insurance Co.'s claim department in Irving, Texas.

Post-accident treatment requires teamwork among the service providers, the employer and the employee's family, he added.

Work comp benefit payers should become prudent buyers of rehabilitation and disability management services, experts suggest.

For example, employers should examine providers' credentials; seek a program that meets not only the physical but the psycho-social needs of the injured employee; and establish good channels of communication between therapists and counselors, the treating physician and the employer.

Leaving control of an employee's case solely with the treating physician may delay his return to work because the physician may not understand the demands of the job site, said Dr. George Smith, president of G.M. Smith Associates Inc. in Bethesda, Md.

Employers should communicate with the treating physician to keep information, including medical records, flowing between the two parties, he urged.

And, employers should ask the physician to comment on whether it is appropriate for the employee to perform specific tasks rather than have the physician render a general opinion about the extent of the employee's disability, Dr. Smith said.

Such an approach can reduce short-term absences 40% to 60%, he said.

Liberty Mutual's Mr. McMurry recommends that target dates be set for a worker to return to work. He also suggested that a worker be encouraged to return on a Thursday or Friday to allow him to become re-acclimated to the job but still be able to rest on the weekend before beginning a full week.

Such an approach also can reduce work comp costs because the employer is not required to pay indemnity benefits after an employee returns to work, even if it is for only a partial week.

• **Limiting an injured employee's choice of physicians.**

While in most states employees have their choice of physicians for treatment of a workplace injury, some states, like California, permit employers to select a provider if the employee has not already done so prior to an injury.

But, having an employer choose a physician to treat an injured worker creates "a certain amount of animosity," Mr. Borba said.

It is "a very sensitive" issue for legislators to consider because there is often union opposition, he said.

In addition, it is not clear that such an approach will reduce medical costs because there is a "break-in" period during which the physician and the employee get acquainted, which may extend the length of some treatments, Mr. Borba said.

Employers that can choose physicians should emphasize quality medical care, which can be more cost-effective in the long run, experts said.

• **Encouraging the use of managed care arrangements like health maintenance organizations and PPOs.**

These alternatives can be used in states in which the law allows employers to choose the physicians that will treat injured employees.

However, the economic payoff is limited or non-existent for small insurers or small employers, Mr. Borba pointed out.

For example, such arrangements may not work in geographic areas where an insurer has a small or unstable book of business because there may not be enough volume for the HMO or PPO to realize a savings, he said.

But insurers that use such alternatives consider them to have at least minor value in containing

Continued on next page

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## Cost control

*Continued from previous page*  
work comp medical costs, according to preliminary results of a survey of 25 insurers performed by the Alliance.

Preliminary results of a study of California insurers by the California Workers' Compensation Institute offered even better news: Insurers reported saving about 22% over usual and customary fees or fee schedule amounts through the use of PPOs, said Michael Jones, the CWCI's assistant general manager.

- Use of medical fee schedules to compensate health care providers for treating workers who are in-

jured on the job.

While controversial, many people believe this has slowed health care cost increases, Mr. Borba said.

But exactly how well state-mandated fee schedules work may depend on the structure of the individual work comp system.

For example, Washington state,

**'In all candor, I must say that political pressure will prevent any kind of statutory change that would shift some of the medical care expenditure burden to the injured worker,' says Mr. Borba of the NCCI's Economic and Social Research Department.**

where the state work comp fund is the exclusive provider of insurance for employers that do not self-insure, may have an easier time setting fee schedules for physicians and hospitals than would a state in which many insurers write work comp insurance.

Currently, about 15 states use medical fee schedules and several other states have the authority to establish such schedules for treating workplace injuries, Mr. Borba said.

An NCCI study a few years ago comparing the average medical cost in three fee schedule states with eight states without fee schedules found that fee schedules reduced medical care expenditures by 9% to 15%.

But the exact savings depends upon the relative level of fees in the fee-schedule state vs. the market rate, according to Mr. Borba. For example, if fees are set at the competitive market level, the presence of a schedule won't slow down the rate of increase in medical care costs. But it will provide a means for stopping overcharges for medical services, he said.

A variation of the fee schedule concept that applies to hospitals relies on compensation through diagnostic related groups.

Washington state expects to save millions of dollars through the use of one such DRG-based payment program for hospital inpatient services rendered to injured workers, said Taylor Dennen, assistant director for medical services in Washington's Department of Labor and Industries.

In addition, the state also expects to save money on outpatient charges through a new fee schedule that applies to charges from laboratories, radiologists and physical therapists.

- Cost sharing.

While employees share in the cost of employer-sponsored health care plans by making contributions to premiums, deductibles and/or co-insurance, employees cannot be forced to share in the cost of workers compensation coverage and/or benefits.

However, a different type of cost-sharing arrangement is established between employers and their insurers through experience rating or retrospective rating of premiums, said Mr. Borba.

Such plans provide an incentive for employers to control medical costs or face higher premiums in the future, he pointed out. But full experience rating is only statistically valid for large employers, he said.

Requiring employees to share in the costs of their treatments under workers compensation programs is a touchy subject, experts agree.

"Frankly, there is little likelihood this will ever be accepted," generally because work comp has had a long tradition of the employer bearing the cost of care, Mr. Borba said. "In all candor, I must say that political pressure will prevent any kind of statutory change that would shift some of the medical care expenditure burden to the injured worker."

Contributing to the political pressure is the fact that labor representatives typically oppose deductible and copayment approaches and any other strategy that tends to "blame" the victim, said Karen Ignagni, associate director of the AFL-CIO's Department of Occupational Safety, Health and Social Security in Washington, D.C.

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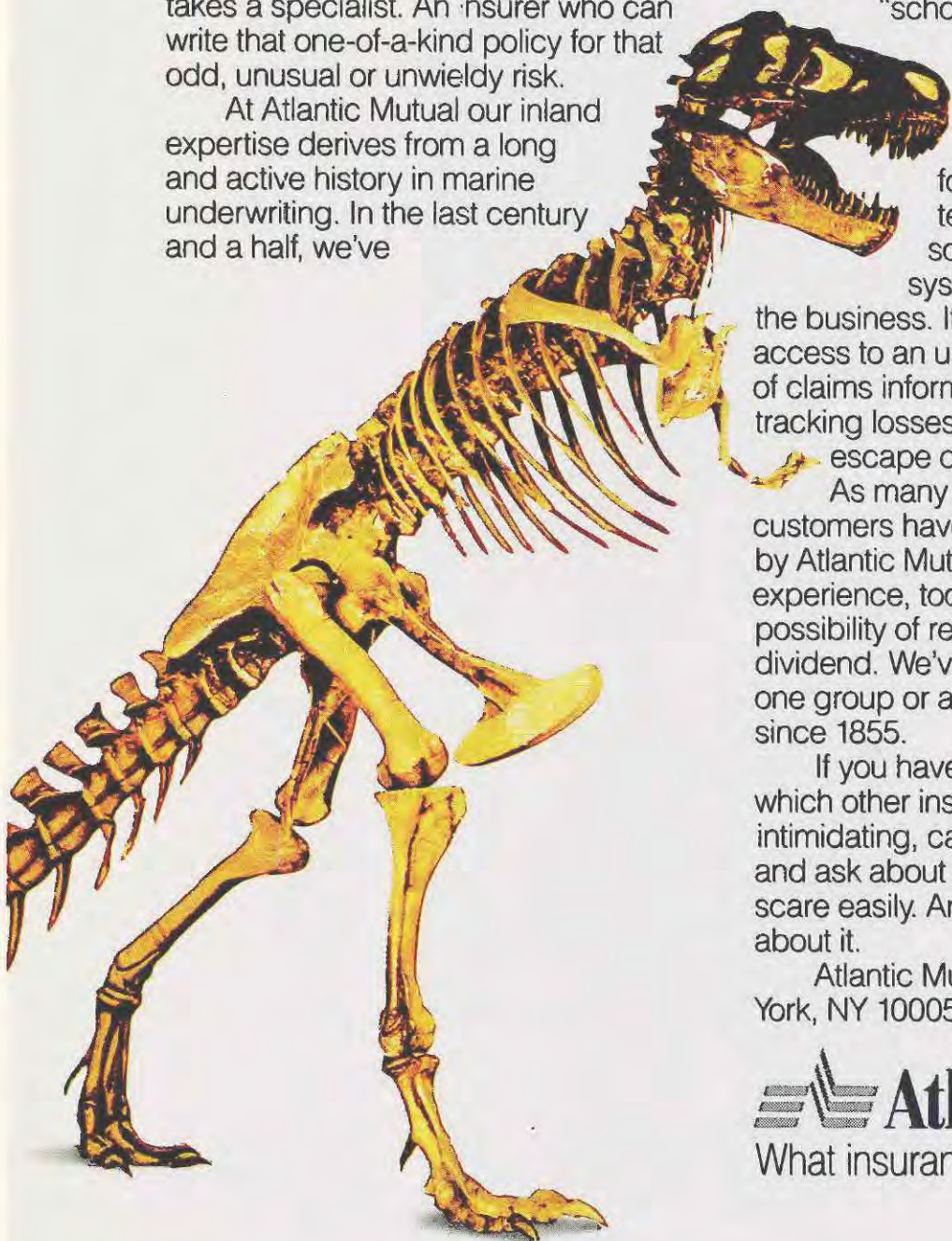
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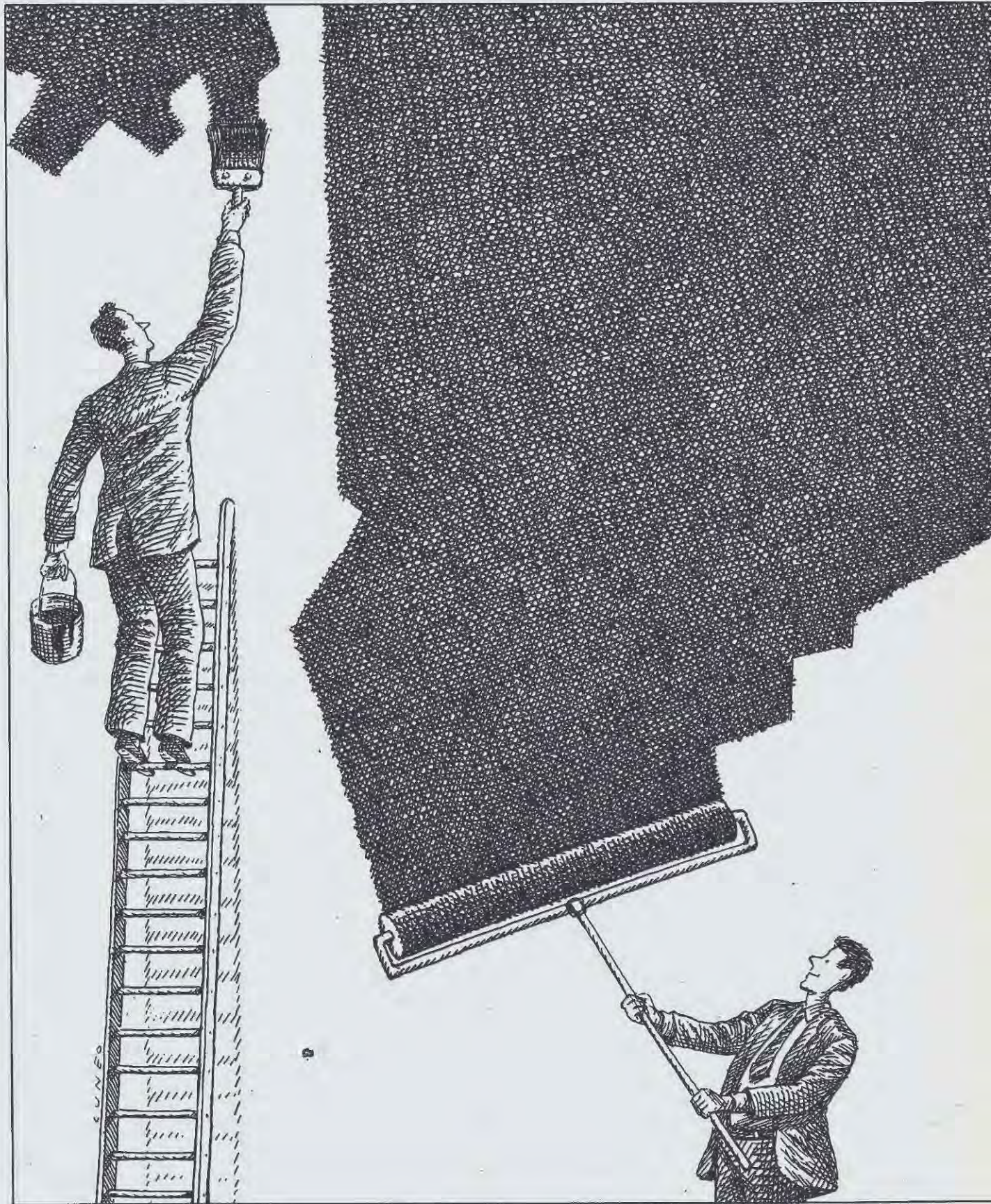
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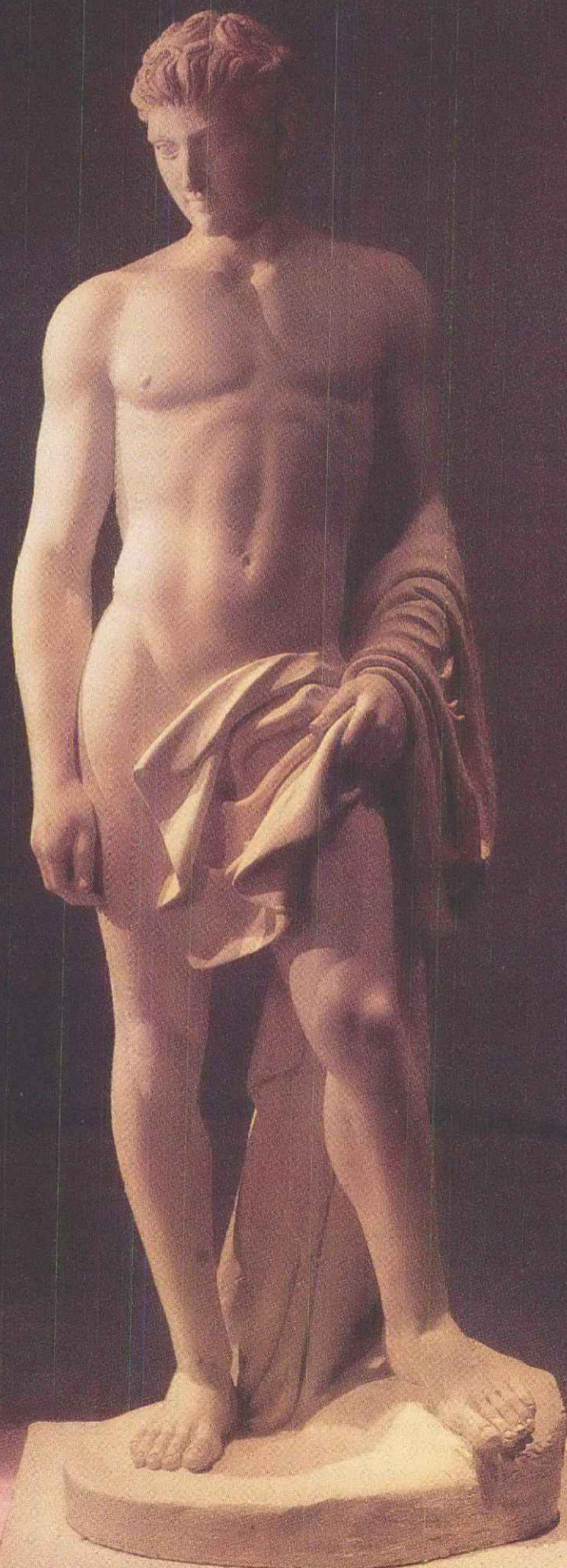
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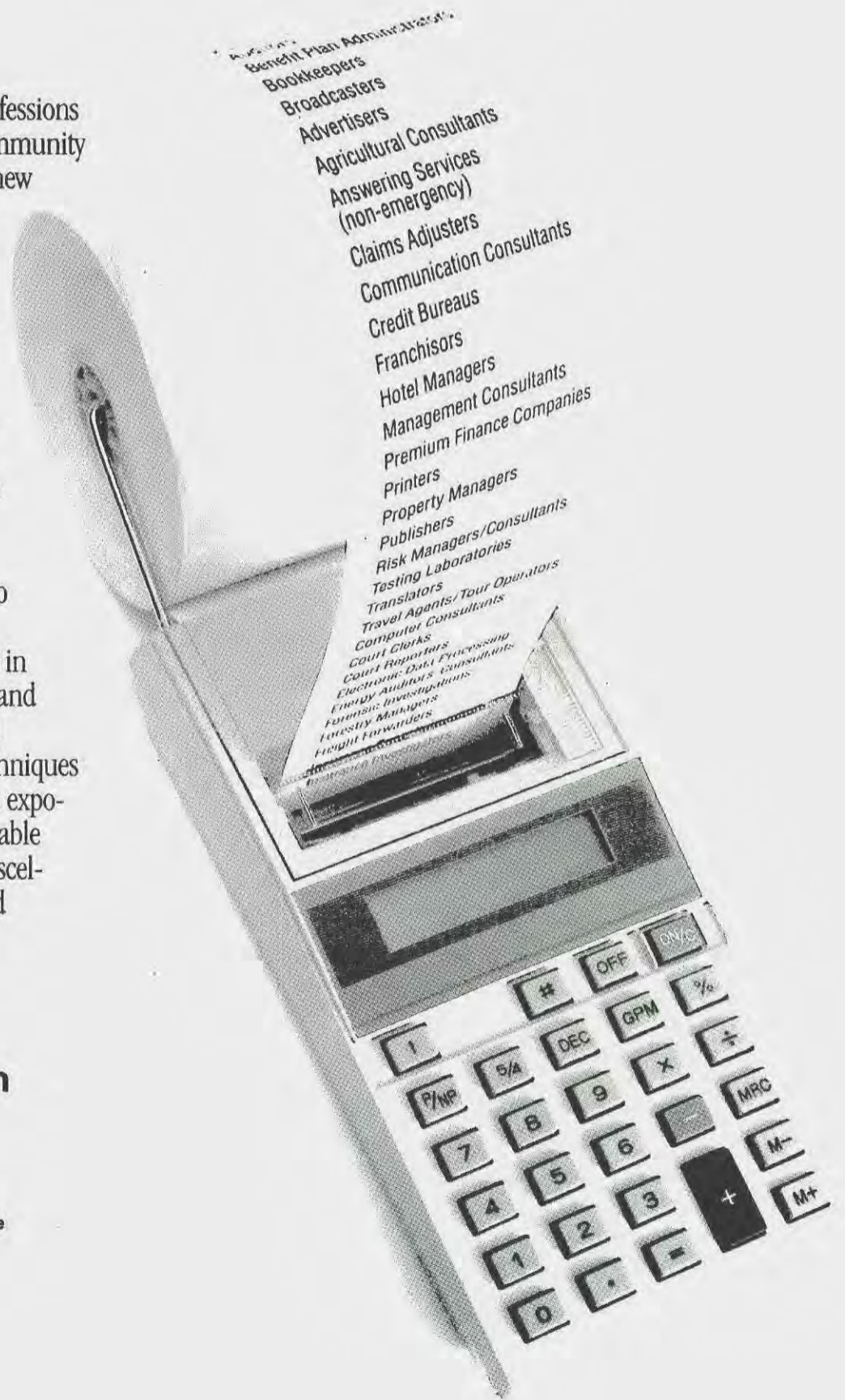
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# Planning eases RMIS vendor's exit

**WHAT DOES** a risk manager do when his or her information system vendor drops a product line or, worse, goes out of business?

In last month's discussion, we examined Anistics Inc.'s decision to phase out its mainframe risk management information system (*BI*, Jan. 23).

Anistics' clients are lucky because they are not being abandoned. Anistics has noted that mainframe clients will be guided through the transition phase in a planned fashion.

And alternative system solutions—be they mainframe or micro—will be explored by Anistics on behalf of its clients, according to the company.

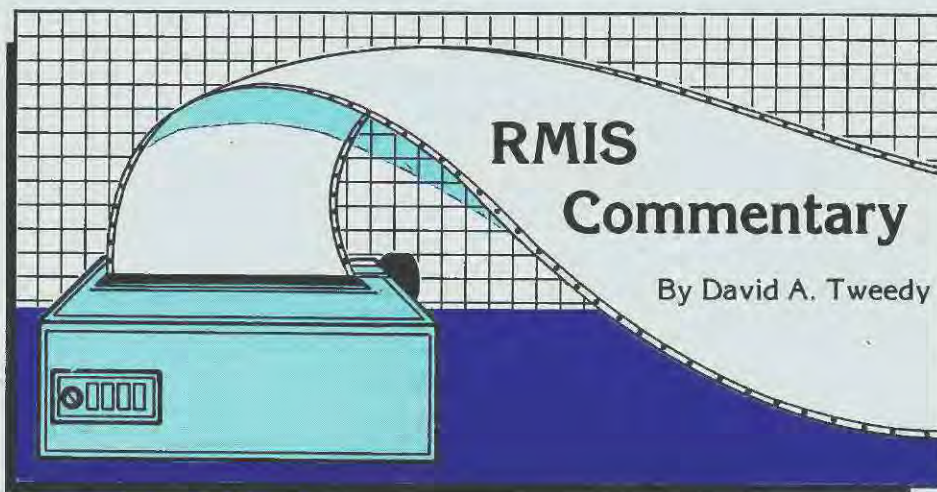
And, since Anistics is maintaining an active presence in the risk management information system industry in microcomputer product development, some current clients will continue to be supported.

In other cases—especially independent companies that need not worry about protecting their parent company's good name—the situation could be much worse when a vendor drops a product line. By then, of course, it is too late to do much of anything.

Thus, a risk manager must plan in advance for such a contingency. With advance planning, bad news from a vendor does not present an overwhelming problem.

The risk manager should be sure that:

- The source code (i.e., original computer instructions) is to be made



available.

- The source code is stored with an independent custodian.
- The software is written in a popular computer language.
- The system operates on a popular type of hardware.
- There is a true partnership between the client and vendor.

The above list just involves applying common sense to the vendor-client relationship. The first two recommendations deal with making the source code available to the client should the vendor go out of business. Most reputable vendors will readily agree to the first point.

The second item is hardly ever used, but should be. It protects the client in case things get out of hand when the vendor goes under. It is similar to a surety bond, and risk managers, above all, should have no trouble seeing the advantage of such an arrangement. There are organizations that provide

such services.

The idea behind these two items is that they should enable the client, or a third party, to take over the operation of the vendor.

The next two items also make it easier to take over the vendor's operation should it fail. After all, even if the source code is available, it will do little good if there are only two programmers in the world who know that language or if there are only three computers in the world that can run that particular system.

On the other hand, if the system is written in a popular language and runs on a popular type of computer, then it would be easy to find another vendor to run the system.

The last item is easily overlooked but deserves special attention. A prudent risk manager would never think of buying insurance from a troubled insurer.

Yet one might invest in a system that

could be equally as fragile. The results are the same: The risk manager is left holding the bag.

This can be avoided by working with the vendor. Vendors really do listen to clients. They want to make the system as good as possible for the clients. This requires that the risk manager spend some time with the vendor to make sure the vendor really understands what is needed.

Helping the vendor design the system means that the system will work the way you want it to. Volunteering to be a beta test site also will ensure that the system fits your needs. Insisting that your vendor use popular software and hardware will also protect your interests.

*Contributing to this article was Michael N. Singer, president of Risk Information Systems Consulting in Huntington, N.Y. Mr. Singer worked at Anistics Inc. for 10 years, most recently as deputy managing vp, overseeing applications development.*



Mr. Tweedy

*David A. Tweedy is a senior consultant for D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of Betterley Risk Management*

*Commentary and the author of RMIS Update, a yearly publication analyzing major risk management information systems and vendors. Mr. Tweedy's column on RMIS usually appears the third Monday of the month.*

# Plant safety reports hold many variables

By The Insurance Institute of America

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

*This month's exercise, drawn from a recent examination for ARM 55—Risk Control—shows how to take care in interpreting loss data that may or may not reflect real differences in the level of safety among an organization's various operations of facilities.*

**Q:** When the risk management professional for Big Blue Manufacturing Co. received the semiannual employee injury reports from two assembly plants located in different parts of the country, one of the reports indicated remarkably low work injury frequency and severity rates, while the other indicated extremely high rates. Because of a number of differences between the two plants, the risk management professional is unwilling to accept these reports as conclusive evidence that the level of safety management is better in one plant than in the other. Four of these differences are:

- The managers of the two plants use different classifications for identical employee injuries.
- The procedures for returning injured employees to work differ between the two plants.
- The environment in which the two plants operate are significantly different.
- The accident frequency and severity statistics

represent dissimilar dollar costs of injuries.

For each of these four differences, explain how each difference can create the mistaken impression that the level of safety management in one plant is better than in the other; and how the risk management professional could correct for the resulting distortion in the reported accident frequency and severity information.

**A:** • The fact that managers classify injuries differently—for example, one

## A.R.M. exercises

manager labeling a given disability as temporary-partial and the other considering the same disability to be temporary-total—means that the first manager's plant appears to have the better safety record (less severe disabilities). This distortion could be alleviated by eliminating such subjective classifications (using instead clinical descriptions of types of disabilities) or by asking one headquarters executive (such as the risk management professional) to classify all disabilities.

- If one manager is more demanding than the other in rushing disabled employees back to work, or if one manager has more "light-duty" opportunities for reassigning recuperating employees than does the other, the first manager's safety record will appear superior. This misleading record could be corrected by gathering more detailed, clinically descriptive information on the nature and causes of work-related disabilities. This would reduce the emphasis on "return to work" as a

measure of work safety.

• If significantly more dangerous activities are performed in one plant than in the other, or if the general level of health in the communities surrounding each plant is markedly different, these differing hazards arguably are beyond the control of the managers and, therefore, should not be considered in evaluating safety performance. Instead, the level of safety within each plant could be judged solely on the basis of those types of disabilities that are deemed to be within each manager's direct control.

• If the plants are in different states with different levels of workers compensation benefits, or if customary costs for the same medical or rehabilitative services differ between the locales of the plants, these statutory and economic differences alone could make one plant's safety record better or worse than the other, regardless of the managers' safety efforts or their effectiveness. Proper performance evaluation requires data on the clinical aspects of disabilities and the patterns of recovery, regardless of the medical costs incurred. Alternatively, appropriate price indexes can reduce reported injury costs to a common price level so that these outlays are more accurate indicators of the level of safety management.

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

# London insurance market

## Book offers detailed look at policies rather than practices

### "Guide to the London Insurance Market"

By Yvonne R. Paretzky

Published by The Bureau of National Affairs Inc., BNA Books Distribution Center, 300 Raritan Center Parkway, C.N. 94, Edison, N.J. 08818; 201-225-1900

\$45, plus \$3 shipping and handling

By Stacy Shapiro

U.S. corporate policyholders interested in a detailed analysis of the three main U.S. liability insurance policies written in the London insurance market should read "Guide to the London Insurance Market" by Yvonne R. Paretzky, head of risk management communications specialist Paretzky Information Network Inc.

But anyone who is coming to visit the London market for the first time and wants to know more than how these three policies work should probably contact a Lloyd's of London broker or underwriter to supplement Ms. Paretzky's abbreviated experience.

The 246-page, soft-cover book published in 1988 goes into great detail comparing the Lloyd's of London's claims-made excess liability insurance policy, H.S. Weavers (Underwriting) Agencies Ltd.'s claims-made excess liability insurance policy and the old 1971 Lloyd's umbrella liability insurance policy form.

About one-fourth of the book focuses on coverage, definitions, exclusions and key provisions, extended reporting periods and liability limits provided under

the three policies.

Ms. Paretzky at first oversimplifies the Lloyd's and Weavers' claims-made policies by saying that both policies are written so that "both a loss and its claim must occur during the policy period."

Only toward the middle of the book does she preface this oversimplification by pointing out that the claims-made policy limits apply to "claims presented during the policy period and any extension of that period."

### Books & ideas

For example, she notes that the Weavers form allows claims to be made during a 36-month extension period (which, since the book was published, has been extended to seven years) as long as the policyholder has informed Weavers that claims might arise from an incident that occurred in the policy period.

Only in the first 44 pages of the book does Ms. Paretzky try to tackle the make-up of the London market, its ambiance and how the market works. Several of her descriptions of the London market as a whole are very poignant.

For example, she says: "The activities and interactions in the London market combine to make it a mystery to most people. Those who for years have been involved in the insurance industry (in and outside of London) contend it is something that has to be experienced to be fully understood."

Ms. Paretzky points out that frequent face-to-face

contact between brokers and underwriters is a prominent feature in conducting business in the London market.

And, when giving "practical advice" to American risk managers visiting London, she notes that "the English have raised the Western concept of graciousness in business to an art form."

An American risk manager will arrive at Heathrow airport and be met by a broker's driver to drive the risk manager to his or her hotel, she says. "Often the car is a Rolls Royce, but Mercedes and more recently Volvos are not unusual," Ms. Paretzky notes.

From then on, the risk manager will spend between seven and nine days conducting business "in a highly social atmosphere. There is no meeting that does not involve food," Ms. Paretzky quips.

"Guide to the London Insurance Market" assumes that the U.S. policyholder is only interested in placing its liability insurance in the London market.

But Ms. Paretzky's book virtually ignores the huge market in London for catastrophe property insurance; the massive reinsurance market that London provides to U.S. ceding companies; as well as the aviation and marine insurance and reinsurance provided to U.S. policyholders.

Another 134 pages of Ms. Paretzky's book is appendices, in which she publishes verbatim the Lloyd's policy, the Weavers policy and the Lloyd's umbrella form along with amendments; plus a sample of a completed umbrella form and sample claims forms.

# Injury en route to doctor ruled compensable

When a worker is injured in an accident that occurs in a trip to see a physician for treatment of a compensable injury, the new injury is also compensable, an Oregon appellate court ruled.

Emma Fenton sustained a compensable injury to her back on Feb. 2, 1987, and worked until Feb. 8, when she took time off because of severe pain. She returned to work on March 1 and suffered an increase in symptoms by April 7. On May 3, while on her way to see a physician for treatment of her back, Ms. Fenton suffered a neck injury in an automobile injury. The physician treated her neck injury. Thereafter, Ms. Fenton had back surgery. She filed a claim for compensation for both her neck and back injury. She was awarded disability only for her back injury. This decision was affirmed by the compensation board.

On appeal, Ms. Fenton argued that her second injury arose out of an activity that was a direct and natural consequence of the treatment for her original compensable injury and, therefore, it also was compensable. The appellate court agreed that the concept of compensability for injuries during activities that are a direct and natural consequence of the original injury. According to the court, Ms. Fenton's trip to the physician was a direct and natural consequence of her compensable injury and, therefore, her neck injury was also compensable. *Fenton vs. SAIF*, Court of Appeals of Oregon, Aug. 26 1987 (BI/05/Oct.-\$10).

### Legal briefs

#### Job-related mental injury

Psychological disability caused by job-related emotional stress is compensable, according to a New Mexico appellate court.

Prior to his employment with Smith's Management Corp., Robert Lopez had a latent disorder, schizophrenia.

The trial court found that his condition was exacerbated by job stress, causing his schizophrenia to become patent and disabling. The trial court also determined that Mr. Lopez suffered an accidental injury to his mind and awarded compensation. The employer appealed.

The appellate court said that psychological injury arising from a sudden or gradual emotional stimuli "arises out of" employment when it is causally related to the performance of job duties. The court said that the fact that Mr. Lopez had a predisposition to mental injury did not serve to void his entitlement to workers compensation benefits. *Lopez vs. Smith's Management Corp.*, Court of Appeals of New Mexico, May 27, 1986, *certiorari quashed*, Oct. 15, 1987 (BI/02/Nov.-\$10).

#### Punitive award upheld

A \$100,000 award of punitive damages was upheld in a suit against an insurer for failure to timely process and resolve a claim even though

evidence of arson existed, according to a federal appellate court decision.

General Accident Insurance Co. of America issued a standard business owner's insurance policy to Michigan Foods Inc., which was owned by Mohammed Hamed and Khalil Awwad. The building was not owned by either Michigan Foods or the individuals and was not insured under the policy. The policy provided that General was not obligated to pay proceeds in the event of any fraud, misrepresentation or concealment on the part of Michigan Foods.

On March 25, 1985, Michigan Foods' business property burned down. A preliminary investigation by the local police and fire department revealed signs of a forced entry that seemed staged. An independent adjuster sent Michigan Foods a letter in May 1985 requesting they they submit a proof of loss. Such was filed on May 23. On June 21, 1985, a general manager of the insurer informed Michigan Foods by letter that a decision would be made within 30 days of their examination under oath. Mr. Awwad gave a sworn statement on June 11 and a second on Sept. 10. On Sept. 26, 1985, Mr. Awwad's attorney advised General Accident that the business' financial condition was very poor and requested a prompt settlement of their claim. General Accident neither replied nor responded until after this suit was commenced on Dec. 12, 1985,

almost nine months after the fire. General Accident filed its answer denying the claim and asserting arson as an affirmative defense. This was the first notification by General Accident that the claim was denied or that the plaintiffs were suspected of arson.

A jury awarded Michigan Foods \$75,000 in actual damages (the policy limit, although actual damages were stated to be close to \$90,000) and \$100,000 in punitive damages.

The appellate court noted that there was substantial evidence that the fire was the result of arson but there was no direct evidence that the plaintiffs were responsible for the fire. "The lack of evidence establishing a reasonably strong nexus between the plaintiffs and the alleged arson negated a good faith defense for General," the court said. Despite a possible basis for concluding that the fire in question was the result of arson, General Accident's delay in processing Michigan Food's claim and denying coverage was unreasonable, the court said. The trial court award was affirmed. *Hamed vs. General Accident Insurance Co. of America*, U.S. Court of Appeals for the 7th Circuit, March 11, 1988 (BI/01/Nov.-\$10).

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

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# Parties urged to band together to control comp medical costs

By MEG FLETCHER

NEW ORLEANS—Those that pay the cost of the workers compensation system should work together to control rising medical costs, experts say.

"Escalating medical costs are a major problem for workers compensation insurance and a major reason for the recent increase in rates," Philip Borba, assistant vp of the National Council on Compensation Insurance, told those attending a recent forum sponsored by the International Workers' Compensation Foundation Inc. The foundation is part of the International Assn. of Industrial Accident Boards & Commissions.

One reason for the escalation in medical costs among work comp claimants is that injured workers are treated differently by many health care providers who see them as a blank check, said Dr. Jeffrey S. Harris, president of consulting firm Harris Dibble & Makens in Nashville, Tenn., and co-chairman of the American College of Occupational Medicine's Cost Management Committee.

Providers know that an employer or its insurer must bear the total cost of a comp claimant's medical and rehabilitation care, he explained.

"Workers compensation is the last bastion of fee-for-service at its worst," said Dr. John Ott, a professor who also is chief executive officer of the George Washington University Health Plan.

In addition, employers and insurers complain that some providers try to recoup the cost of caring for non-paying patients by shifting the cost of their care to workers comp claimants.

"Cost shifting to workers compensation is the prime



motivation behind cost containment," said Alan Strohmaier, director of unemployment and workers compensation at General Motors Corp. in Detroit.

But it is harder to implement cost containment strategies in state work comp systems than in group health plans, the speakers said (see story, page 14.)

Also, work comp can be a "political issue," said Lisa Thornquist, a research analyst specialist with the Minnesota Department of Labor and Industry.

One of the reasons that worker comp issues are so political, she explained, is that professionals and providers who make their living from the work comp system do not want their livelihoods threatened.

Efforts to study how the work comp system operates often are hindered by a lack of good data on which to base recommendations, Ms. Thornquist said.

Representatives of all segments of the work comp system—employees, employers, insurers, administrators and health care providers—become frustrated that no "quick fix" is available, said Gaylen Young, director of the American Hospital Assn.'s Office of Health Coalitions and Private Sector Initiatives.

She urged employers and representatives of those other segments to join coalitions as a means of becoming better informed about issues and as a possible basis for joint action.

But while containing costs is important, it should not be done at the expense of quality care, speakers said. It is better to focus on cost-efficient care, which may be more expensive initially but produces better results in the long run, said Diane Bistany, second vp of General Reinsurance Corp. in Stamford, Conn.

"Getting good quality care for injured workers is the next frontier," said Taylor Dennen, assistant director for medical services of Washington State's Department of Labor and Industries.

# Doctors favor simple back treatment

By MEG FLETCHER

NEW ORLEANS—Workers with lower back injuries should be encouraged to avoid surgery in favor of more conservative treatment, medical doctors and chiropractors agree.

However, that is one of the few points on which medical doctors and chiropractors agree, which is not unexpected given their different perspectives.

Specialists in both fields presented their views in separate panel discussions during a recent forum on health care cost issues presented by the International Workers' Compensation Foundation Inc. The foundation is part of the International Assn. of Industrial Accident Boards & Commissions.

Conservative treatment of most lower back ailments with very limited bed rest is the most effective approach, medical doctors agreed.

Bed rest should be limited to two days for most ailments or two weeks for ruptured discs, said Dr. Henry Feffer, director of medical research for Health Care Excellence Inc. in Washington, D.C.

He cautioned against physicians' use of extensive tests to diagnose back ailments, because many of the tests are designed to confirm rather than evaluate such conditions. He also cautioned against liberal use of drug therapy, which can make patients addicts, although he acknowledged that anti-inflammatory drugs and some injections can be helpful in specific situations.

A short period of chiropractic manipulation can be helpful in selected cases, but excessive manipulation should be avoided, Dr. Feffer said.

Acupuncture also can relieve acute pain and back supports can provide some relief from pain if used properly, Dr. Feffer added.

Psychotherapy can be "very important" in the early stages of treating traumatic stress syndrome; for example, in the case of a utility lineman who injured his back falling off a pole, he said.

Studies have shown that returning to work can be very helpful in getting workers' minds off their back problems and restoring function, but only if it is biomechanically and ergonomically possible, Dr. Feffer said.

Studies also have shown that structured programs geared to functional restoration have helped patients with chronic spinal problems, said Dr. Tom Mayer, an associate professor at the University of Texas who is medical director of the Productive Rehabilitation Institute of Dallas for Ergonomics.

While it would be helpful to prevent back injuries, many pre-injury programs are not cost-effective, Dr. Feffer said. Pre-employment physicals have had disappointing results for a variety of reasons, including employees lying about their medical histories, he said. In addition, education programs for workers must be repeated every six months to be effective, and program costs tend to outweigh the benefits of preventing the relatively few back injuries that do occur.

The best approach is to identify difficult back injury cases early and treat them well, he said.

In presenting the chiropractic perspective, Ronald Harris, a chiropractor who is executive vp of the American Chiropractic Assn., discussed a study released last fall by the Foundation for Chiropractic Education and Research. It was based on data collected by the Florida Division of Workers Compensation on temporary total disability claimants, some of whom had surgery.

The study found that "chiropractic case management, compared with standard medical case management, minimizes the impact of work-related back injuries and illnesses on prolonged absence from work and excessive treatment costs."

In addition, routine chiropractic treatment for a mild case of a simple back strain should take between two to four weeks, said Kenneth Murkowski, a chiropractor who is a member of the board of

the International Chiropractic Assn. During that time, the patient may require between four and 10 visits, depending upon his height, weight, size and mobility, he said.

In some cases, chiropractors emphasize the importance of follow-up care as well as vitamin therapy, he added.

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Business  
Insurance

# Watch costs of early rehabilitation: Study

By MEG FLETCHER

NEW ORLEANS—Efforts to reduce injured workers' disabilities through very early rehabilitation intervention are not always cost-effective, a researcher says.

The "Very Early Intervention Research and Demonstration Project" by the West Virginia Workers' Compensation Fund found that risk assessment programs may be instituted too early in some cases for the benefits to outweigh the cost of the program.

The study was discussed at a forum on health care cost containment issues sponsored by the International Workers' Compensation Foundation Inc. earlier this month in New Orleans. The foundation is part of the International Assn. of Industrial Accident Boards & Commissions.

In studying 284 West Virginia underground coal miners with back injury claims, the researchers examined the cost-effectiveness of offering rehabilitation services to the workers about one week after they reported the injury.

The West Virginia Workers' Compensation Fund is the sole source of work comp insurance for West Virginia employers that do not self-insure.

Workers in the experimental group were given health and psychosocial attitude evaluations by a rehabilitation nurse. Those claimants judged to be at risk for extensive disability and for problems returning to work would be placed in a rehabilitation program.

The program may have included guidance for workers compensation procedures; diet, exercise and medication regimens; and communicating progress to employers, according to Judith Greenwood, the fund's director of research.

The study, which lasted more than a year, found that the experimental and control groups "were similar with regard to hospitalizations, permanent partial disability awards, rate of litigation and return to work," said Ms. Greenwood, who also chairs the Medical Committee of the IAIABC.

The only difference between the two groups was associated with the costs of the intervention services the experimental group received, including the initial evaluation and recovery management services.

For those claims that resulted in high costs and truly extended disability, "both the medical and disability benefits averaged lower for the experimental group, suggesting that in these cases the case management intervention may have helped to reduce costs, but not enough to influence the group as a whole," she said.

Besides the cost study, researchers also tested 25 factors to see if they could be used to predict extended disability and return-to-work problems for workers off the job a week or more.

The study found that common characteristics among workers who accumulated disability benefits were: lack of self-responsibility, poor use of leisure time, a physician's negative attitude, poor physician-patient communication, poor travel conditions for workers living a distance from services and poor non-verbal communication.

Characteristics that predicted high medical benefit costs for those same workers were: poor work behavior; negative physician attitude with poor communication; poor travel conditions with the worker at a distance from services; severe pain and poor pain management with the use of narcotics; and medications including pain pills and muscle relaxants.

Four factors that predicted med-

ical and disability benefits for the entire experimental group were: lack of self-responsibility, alcohol abuse, stressed family situations and poor or unsafe living conditions.

Ms. Greenwood, who oversaw the project, noted that finding that early intervention was not cost-effective was unexpected. However, "there is evidence that the intervention was too early and the risk assessment by the predictive fac-

tors allowed recovery management services to be provided to workers not at risk for extended disability. . .thereby increasing medical costs unnecessarily," she said.

In addition, Ms. Greenwood concluded that the very early intervention approach was not cost-effective because it could not overcome a "sociocultural inertia" regarding disability.

Specifically, claimants often felt that "a level of temporary or per-

manent disability is to be expected as a result of work and that when a disabling injury occurs, there is little to be done about it or little that should be done about it," she said.

Long-term improvement may depend upon "improved education whereby people can learn problem-solving skills and develop a sense of self-purpose and control over their lives," she said.

"In the short term, only a com-

prehensive approach of aggressive disability management that begins with and extends from the administrative agency and includes rigorous monitoring of medical care can be recommended," she added.

However, "caution needs to be exercised in adopting early intervention programs. . .to determine at what points in time and under what conditions interventions yield cost-effective benefits," she said.

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1985 - \$37,037	1985 - 99.7
1986 - \$53,063	1986 - 84.1
1987 - \$57,243	1987 - 84.2
*1988 - \$64,951	*1988 - 93.9
	5 YEAR COMBINED RATIO: 89.8 (1983-1987)
ASSETS (000 Omitted)	LOSS RESERVES (000 Omitted)
1983 - \$ 35,156	1983 - \$ 4,985
1984 - \$ 48,719	1984 - \$ 9,150
1985 - \$105,993	1985 - \$22,784
1986 - \$159,568	1986 - \$46,243
1987 - \$168,859	1987 - \$59,712
*1988 - \$173,861	*1988 - \$63,544
	*Six months results ended June 30, 1988

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# Skandia forms reinsurance brokerage unit

Skandia America Group, a unit of Skandia International Insurance Corp. of Sweden, is forming a new reinsurance brokerage subsidiary.

The new company, Pegasus Advisors Inc., will specialize in developing and placing non-traditional reinsurance products like finite risk reinsurance, loss portfolio transfers, financial quota shares and prospective aggregate covers.

Simsbury, Conn.-based Pegasus also will operate as a reinsurance intermediary for both insurers and alternative risk financing vehicles.

Pegasus will be headed by Gregory E. Leonard, president and chief executive officer. Mr. Leonard comes to Pegasus after 12 years with the Tillinghast division of Towers, Perrin, Forster & Crosby Inc., where he was most recently the manager of the Northeast region for the risk management and casualty division based in New York.

"I decided to do this because I feel that there is a void of technical brokers in the area of placing non-traditional reinsurance," Mr. Leonard said.

Pegasus, which will begin operations Wednesday, plans to offer business to both domestic and Bermuda underwriters, he said, stressing that Pegasus does not have an exclusive arrangement with Skandia America Group.

## Markets

Prior to Tillinghast's 1986 merger with TPF&C, Mr. Leonard served on the Tillinghast board of directors, was the international practice leader for the risk management and casualty division and was responsible for forming and managing Tillinghast's Bermuda unit.

Mr. Leonard is currently the unit's only employee, though he said he expects to increase staff this year.

For more information, contact Steven J. Bensinger, Executive Vp and Chief Financial Officer, Skandia America Group, 280 Park Ave., New York, N.Y., 10017; 212-490-0500.

## New IIE syndicate

The Illinois Insurance Exchange Board of Trustees has approved the operation of Agora Syndicate Inc., making it the 12th active syndicate on the exchange.

The Agora Syndicate, which is managed by Chicago-based Criterion Management Co., has been capitalized at \$4.5 million and will focus on writing professional and product lia-

bility coverages.

Agora expects to write \$3 million in premiums during its first year of operations.

The newly formed syndicate is owned by Laurence L. Lacaillade and Roger A. Mitchell, who are both managing directors at the investment banking firm of Adams, Viner & Mosler Ltd. in Chicago.

Mr. Lacaillade and Mr. Mitchell also are principals of Criterion.

For more information contact Mr. Lacaillade or Mr. Mitchell at Adams, Viner & Mosler Ltd., 919 N. Michigan Ave., Suite 3101, Chicago, Ill. 60611; 312-649-5577.

## Mergers/acquisitions

New York-based **Corroon & Black** has merged its Atlanta office with **The Harty Co.**, an independent employee benefits consultant in Atlanta.

**Cardiff Group Inc.**, a Sherman Oaks, Calif.-based surplus lines broker, has acquired **Cowan Surplus Lines Insurance Services Inc.**, a surplus lines brokerage specializing in earthquake, errors and omissions and other hard to place liability lines. Cardiff helped form Cowan in 1968. ■

## RISK MANAGEMENT SERVICES

publishing: March 13

### Spotlight Report

#### ► Risk Management Services

On March 13 Business Insurance editors will take an in-depth look at market conditions affecting risk management services. With potential rate hikes in the property/casualty market at stake, editors will report on the types of special risk management projects that companies are currently using as well as projects which should be considered.

In this highly competitive marketplace, risk management consultants are becoming increasingly important to business operations. To keep readers up-to-date, BI will rank the top independent risk management consultants and profile major risk management consulting units of brokers and insurers.

### Directory

#### ► Risk Management Consultants

Included in this spotlight report is BI's Directory of Risk Management Consultants — serving as the information center for 155,346\* Business Insurance readers. Our annual listing provides important information on approximately 300 consultants and types of services they offer.

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# Business Insurance

## Agent Orange

Continued from page 1

against Agent Orange producers by Vietnam veterans exposed to the defoliant during the war.

Diamond Shamrock and the insurers have raised various coverage issues in several summary judgment motions ruled on by Superior Court Judge Reginald Stanton over the past year (BI, June 27, 1988; Feb. 15, 1988; Jan. 25, 1988).

A trial on some of these issues was held last September and October, Mr. Tierney noted.

Among the issues covered at trial were whether Diamond Shamrock expected or intended the contamination at the Newark plant site and whether pollution exclusions added to Diamond Shamrock's policies after 1970 barred coverage of the Newark plant claims.

The two sides also argued over how Diamond Shamrock's liability policies should be triggered by the Agent Orange class settlement and how many separate occurrences

**Diamond Shamrock will not appeal the appellate ruling, according to attorney Michael P. Tierney.**

the Vietnam veterans' claims represent.

Judge Stanton heard final arguments in the trial in December and is expected to issue a ruling shortly, Mr. Tierney said.

A hearing on the applicability of the owned property and alienated premises exclusions will probably follow Judge Stanton's ruling on the issues already tried, Mr. Tierney said.

Judge Stanton had granted summary judgment to Diamond Shamrock on the applicability of the exclusions in a Feb. 4, 1988, order, finding that the exclusions do not bar the company's claims for cleanup costs.

The owned property exclusion states that Diamond Shamrock's general liability policies will not cover damage to property owned, occupied, rented, used or in the care, custody or control of the policyholder. The second exclusion bars coverage for property damage to premises alienated by Diamond Shamrock.

Diamond Shamrock acquired the Newark plant site in 1951 and sold it in 1971, court papers show. It bought back the plant and adjacent property in 1984 and 1986 as part of a cleanup program ordered by the New Jersey Department of Environmental Protection.

A 1984 consent order required Diamond Shamrock to reacquire

Continued on next page

## Agent Orange

*Continued from previous page*  
 the site and finance a study of potential remedial actions for the area. The only remedial actions taken so far have been the installation of a tarpaulin-like ground cover and a fence around the site, court papers say.

Diamond Shamrock has estimated that the cleanup plan it recommends will cost \$8 million. The most expensive remedial option—offsite thermal treatment of contaminated soil—would cost \$248 million, court papers say.

In granting summary judgment for Diamond Shamrock on the issue of the two exclusions, Judge Stanton differentiated the Diamond Shamrock case from two previous pollution cleanup cases in which coverage for cleanup costs was allowed only to the extent that it remedied or prevented damage to the property of third parties.

Unlike policyholders in the previous cases—which continued to use their property for productive purposes—Diamond Shamrock bought back a plant site it had previously sold solely for the purpose of mandated cleanup efforts.

Thus, whether Diamond Shamrock was cleaning up its own property or the property of others was immaterial, since the remedial actions were being undertaken to

tion to indemnify, not merely a coercive claim by the government," the court ruled.

"In the present case, there has been no showing, certainly no showing beyond genuine dispute, that anyone else besides Diamond has yet been injured in his person or property by the dioxin on Diamond's site," the court ruled.

Diamond Shamrock could conceivably show at trial that the contamination at its Newark plant poses an imminent threat to others' property interests, the court added. In this case, the trial court would have to decide whether the costs of eliminating this threat represent "property damage" under Diamond Shamrock's policies.

The question of whether "property" includes the state's interest in preserving air, land and water—and whether the cost of remedying an "unrealized threat" to that property represents covered property damage—is best decided at trial, the appeals court ruled. ■

**Diamond Shamrock has estimated that the cleanup plan it recommends will cost \$8 million.**

comply with government demands and not to benefit Diamond Shamrock, the judge concluded.

On appeal, the insurers argued that a state-imposed cleanup effort does not make the exclusions inapplicable and that a trial should be held to distinguish costs of cleaning up Diamond Shamrock's own property from those of remedying damages to third parties.

The appellate panel agreed that the exclusions were not necessarily inapplicable, and sent the issue back for hearings before Judge Stanton.

In reaching its decision, the appeals court relied heavily on two New Jersey precedents: *Broadwell Realty Services Inc. vs. Fidelity & Casualty Co.* and *CPS Chemical Co. vs. Continental Insurance Co.*

In both cases, the state appeals court ruled that the policyholders were entitled to coverage for the cost of cleaning up pollution damage to the property of third parties. However, the court noted in the *Broadwell* case that "to the extent that all or a portion of the response expenses pertain solely to damage to the (policyholder's) site itself and not to prevent off-site contamination, the owned property exclusion clearly applies, and such damage is not within the coverage provided."

While agreeing with Judge Stanton that the facts of the Diamond Shamrock case can be distinguished from the previous two cases, the appellate panel ruled that "the fact that Diamond's expenditures for remediation have been and will be made only because of governmental compulsion does not establish that the 'owned property' and 'alienated premises' exclusions are 'inapplicable' to a determination of the scope of the insurers' obligations."

Instead, the two previous cases "establish that under the language of a public liability policy like those upon which Diamond's rights rest, it is a claim against the insured for damage to property of someone other than the insured which triggers the insurers' obliga-

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## Lloyd's task forces

Continued from page 3  
writing Room, he said. "This is slow to happen and some Lloyd's brokers bitterly oppose Lloyd's expanding the ranks of brokers with whom it does business in the U.K. and overseas," he added.

While Lloyd's underwriters in the past have overcome the problem of having to deal with a Lloyd's broker in the Underwriting Room by establishing binding authority arrangements with managing general agents, this is no longer enough, Mr. Bannister and Mr. Rawlins agreed.

However, Lloyd's brokers at the conference argued that Lloyd's could not, on the one hand, place increasing cost and regulatory burdens on Lloyd's brokers and, on the other hand, allow unregulated intermediaries or policyholders to place business directly with Lloyd's underwriters.

"I find it unacceptable that Lloyd's should consider dealing with anybody other than Lloyd's brokers to get more business. . . . Being a Lloyd's broker imposes not only great benefit but also responsibility, costs and regulation. I believe that the Lloyd's broker who works within the market rules is entitled to the exclusivity which he presently enjoys," said Ken Carter, chairman of Lloyd's broker Lloyd Thompson Ltd.

In addition, some speakers at the London conference expressed concern that the issue of direct dealing could cause a rift in the market.

"I do not believe that Lloyd's should seriously consider opening its doors to any other form of broker, but I suspect we may be faced with the thin end of the wedge. This may well prove to be a major point that will test the unity of the market," said Mr. Carter.

"There is a nervousness among Lloyd's brokers (about) di-

rect dealing," noted Lloyd's underwriter George Lloyd-Roberts, a director of underwriting agency Lloyd-Roberts & Gilkes Ltd.

The Committee of Lloyd's is attempting to diffuse the situation by trying to control underwriters' enthusiasm for direct dealing, according to Mr. Lloyd-Roberts.

However, "at the end of the day we have to make Lloyd's more accessible to more risks," he said, adding that he hoped "the threat of direct dealing will encourage Lloyd's brokers to bring more risks to Lloyd's."

In an attempt to increase Lloyd's business, Lloyd's Chairman Murray Lawrence last August set up two task forces—composed of underwriting and brokerage executives—to examine "what could be done to make the Lloyd's market more attractive to business, while maintaining the mutually beneficial relationship with Lloyd's brokers."

In particular, the task forces examined how the market could increase its ability to attract more commercial risks from the United Kingdom and Europe, as well as how to lure more British-based personal lines insurance.

According to the task forces' report, "the general conclusion reached was that within the current framework—i.e., with a Lloyd's broker somewhere in the chain—there was potential for expanding small lines and European business, without jeopardizing (Lloyd's) core business."

However, Lloyd's brokers need to "demonstrate their commitment to Lloyd's by establishing their positions in new markets and channeling business back to Lloyd's," and Lloyd's must make its product more competitive, the report notes.

To increase the flow of business into the market, the report recommends:

- Encouraging more intermediaries, particularly from Europe, to become Lloyd's brokers.

- Adopting measures to make it "easier or cheaper for all Lloyd's brokers to comply with Lloyd's broker regulations and place business at Lloyd's."

- Permitting Lloyd's syndicates to open local offices "either individually or collectively and to use the name of Lloyd's to promote themselves."

- Allowing syndicates to write British personal lines insurance using non-Lloyd's brokers through special arrangements under which all premiums are guaranteed by a Lloyd's broker and additional safeguards are adopted. A further study also is being conducted on extending these arrangements to include small British commercial lines business.

- Introducing a corporate promotion and advertising strategy.

- Relaxing the restrictions on the use of Lloyd's name for promoting business "particularly to address the question of the use by syndicates permitted to open local offices."

- Forming a "central market research service" for underwriters and brokers to jointly consider entering new markets.

- Examining with further study the "feasibility of a premium financing facility, possibly operated by the Corporation of Lloyd's, which will enable underwriters to offer competitive credit terms to (policyholders), via Lloyd's brokers."

Meanwhile, "the success or otherwise of the approach taken in this report in attracting more business to Lloyd's should be reviewed in the future, after the broker registration exercise is complete" in 1991, the report states.

This issue must be "revisited on a regular basis as part of the Lloyd's planning process" since "some underwriters have expressed reservations about whether Lloyd's brokers can continue to add value to all types of insurance transaction in the insurance market of the future," it advises.

## Separation of markets decried as outdated

LONDON—The traditional separation of non-marine, marine and aviation insurance within the London market is outdated and unpopular with policyholders, market leaders say.

"The current market divisions between marine, non-marine, aviation and (automobile insurance) have served the London market very well but are now, without evolution, likely to inhibit business growth," said Ken Carter, chairman of Lloyd's of London broker Lloyd Thompson Ltd.

Mr. Carter addressed the Future Shape of the London Market conference earlier this month, organized by Insurance & Reinsurance Research Group Ltd.

Traditionally, commercial insurance business in London is written by marine, non-marine or aviation underwriters according to the nature of the risk involved.

However, corporate risk managers increasingly want one policy to cover a spectrum of risks and do not want separate policies as dictated by London underwriters, the speakers explained.

Recently, marine underwriters in the London market have been criticized for writing so-called package policies, which allow corporate policyholders—particularly major energy companies—to include non-marine liability and property risks in a marine policy (BI, Dec. 7, 1987).

"People complain about package policies, but we need to start thinking about our customers. We are obviously failing to address what our customer needs," said Peter Rawlins, managing director of Lloyd's underwriting agency R.W. Sturge & Co.

"There are too many market divisions in Lloyd's; it's an anachronistic system but there are personal fiefdoms at stake," he noted.

Lloyd's now is investigating the possibility of introducing "composite syndicates" that would be able to write different types of risks, Mr. Carter pointed out.

"Personally, I am a great advocate for the introduction of composite syndicates," he said, adding that "there would be much more insurance business available to the London insurance market if Lloyd's were to eliminate some classification barriers."

—By Carolyn Aldred

## London execs ignore impact of technology: Sturge official

By CAROLYN ALDRED

LONDON—London insurance executives must come to grips with new technology that soon will dramatically alter the way insurance business is conducted in the London market, experts say.

While the introduction of a computer system linking the entire London market could make placing insurance in London more cost-effective, London market executives largely are ignoring the issue of technology and its likely impact, warns Peter Rawlins, managing director of Lloyd's underwriting agency R.W. Sturge & Co.

Mr. Rawlins spoke at The Future Shape of the London Market conference sponsored earlier this month by Insurance & Reinsurance Research Group Ltd.

The marketwide computer network—dubbed LIMNET—will reduce face-to-face negotiation in the London market with the introduction of electronic claims settlement and risk placement (BI, Oct. 17, 1988).

Insurance companies in London already have begun processing claims via the network, and Lloyd's underwriters plan to begin claims processing via LIMNET by 1990.

"The most fundamental change



to the London Market. . . will be the replacement of paper-based communication by modern computer-based communication for most classes of business," said John Tattersall, a London-based partner of accountant Coopers & Lybrand.

"The main improvements that are occurring in our market at present are to do with technology," agreed Philip Evans, deputy chairman and chief executive officer of English & American Insurance Co. Ltd.

The London market "must individually and corporately come to terms with and recognize that LIMNET offers London. . . the opportunity to apply the new technology of so-called electronic trading, which in itself seems inevitable and I feel an essential development to the London market of tomorrow," said Jim Morgan, managing director of Highlands Underwriting Agents Ltd.

However, "I do not believe the London market as a whole, or its leaders, have grasped the technology challenge and its implications," said Mr. Rawlins.

In order to take advantage of the new technology, London underwriters and brokers will have to change many of their traditional methods and practices, he said. "The strategic use of information technology is a business decision, not a technological one. What worries me is that there is an awful lot of technology being talked about, but people haven't looked at the (business issues)," he told the conference.

There is no point in using information technology simply to streamline back office administration functions when "we don't look at possible changes in the way we do business at the front end," said Mr. Rawlins.

Savings and other advantages can be gained from electronic risk placement and the large expenditures in man-hours created by brokers lining up to see underwriters

would be eliminated, he continued. But, the issue largely has been ignored by the market's decision-makers because underwriters and brokers simply see technology as a threat, said Mr. Rawlins.

"It's only a threat if we don't take control of it. The market structure clearly is going to change, but who is going to direct it?" he asked.

Mr. Rawlins cited a recent Lloyd's report discussing Lloyd's competitiveness and how to bring more business into the market that devoted just a few paragraphs to technology under the heading "Other Points Arising" (see related story).

This is a "profoundly disappointing ostrich-approach to a strategic initiative," he said.

"We must ensure the technology we adopt is market technology and not a fragmented one or we will cease to be a London market—physically together but electronically apart when the physical market is an anachronism," he explained.

The "use of technology must be part of an intelligent and coherent strategy that looks at the whole picture and doesn't focus only on what is technologically possible," agreed Andrew Duguid, head of market group services at Lloyd's. "We must look at what is commercially necessary."

However, decision-making regarding a "development of any initiative which requires changes to the systems used by all the market firms" is bound to be a long process, he added.

"Quite understandably, many people feel that they have a right to be consulted and to influence policy," explained Mr. Duguid.

To accomplish this, Lloyd's has established a Network Steering Group, consisting of market practitioners and technical experts, which is examining the "best way of doing things for all types of business and sizes of risk, given the potential offered by modern technology and the methods adopted by our competitors," said Mr. Duguid.

However, there are many issues involved before Lloyd's can embrace the technology, said Mr. Duguid.

"Solutions must be politically acceptable, commercially appropriate and costs justified," he stressed.

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# Three states mull Proposition 103 clones

By KARI BERMAN and LINDA J. COLLINS

Ohio, Indiana and New Mexico legislators are considering insurance reform legislation that largely mimics California's Proposition 103.

All three of the bills would require rates for property/casualty insurance to be rolled back from 10% to 20% below July 1, 1988, levels.

And, like Proposition 103, which was narrowly approved by voters last Nov. 8 (BI, Nov. 14, 1988), all three bills are being blasted by the insurance industry.

"Ohio is a solid Midwestern state with a strong insurance presence and they should leave it alone and not risk future problems," said Dee Ann Bernhard, regional manager of the Mid-Atlantic region for the Alliance of American Insurers in Washington, D.C.

"In light of what happened in California (with Proposition 103), I'm not surprised to see such a bill introduced in any state," noted Alliance Regional Manager Peter Friedmann at the insurer association's Schaumburg, Ill., headquarters.

However, observing that insurance rates are more favorable in Indiana than in many other states, Mr. Friedmann noted that an insurance rate rollback bill might discourage insurers from writing business in the state.

The Alliance also opposes New Mexico's version of Proposition 103, said Wayne R. Stratton, the Southwestern regional vp for the Alliance in Dallas.

"There is really no reason why this bill has come about other than people thinking that it is a good idea after the (Proposition) 103 victory in California. The Alliance views this bill as unenforceable... and would expect it to be challenged in the courts," Mr. Stratton said.

He added that the mandated rate rollback proposed in the bill would force some New Mexico insurers into insolvency.

Under the Ohio legislation, H.B. 76, which was introduced last month by Rep. Ronald M. Mottl, D-Parma, rates for automobile and other lines of property/casualty insurance would be rolled back to 10% below July 1, 1988, levels. The rollback would only apply to policies issued or renewed on or after July 1, 1989.

Rep. Mottl originally intended to propose a 20% rate rollback but said that he reconsidered, deciding on a 10% rate decrease "to give the bill a better chance of being ratified" (BI, Nov. 28, 1988).

Although Rep. Mottl admitted that "passing the bill will be an uphill fight because of strength of insurance lobbyists in Ohio," he added that he is optimistic about the bill's fortunes.

H.B. 76 would require insurance companies to maintain the reduced rates for one year, ending June 30, 1990.

However, if an insurer is threatened with insolvency while the mandated rollback is in effect, rates could be increased if, after a hearing, it is recommended by the Ohio insurance commissioner, according to the bill.

After the initial year, the Ohio bill also would mandate an additional 20% rollback on private auto insurance rates for "good and qualified drivers," according to Rep. Mottl.

Ohio Insurance Commissioner George Fabe said he opposes most of the bill's provisions in light of the controversy that Proposition 103 caused in California.

"California has been left in a chaotic position as a result of Prop.

103. Why copy something that has created chaos?" he said.

The Ohio bill, scheduled to be considered by the House Insurance Committee in early March, also would require that:

- The state insurance commissioner be an elected rather than an appointed post.

- An insurance consumer advocate be appointed by the Ohio attorney general.

The appointee would act as a mediator in administrative proceedings regarding insurer rates or rating plans filed with the insurance commissioner.

- Insurance companies be subject to the Ohio Antitrust Law.

- The commissioner provide consumers with automobile insurance rate comparison data.

Although the Ohio Legislature's

Insurance Committee Chairman, Rep. Mike Stinziano, D-Columbus, could not speculate on how the committee will respond to the bill, "We will consider each of Rep. Mottl's ideas seriously and decide if Ohioans can expect better rates. If they can do better, then we will react favorably."

Insurance industry representatives point out that "better" rates for Ohio consumers may not be possible.

"Whenever you mandate a rollback, you assume that the industry can absorb the decrease, but this isn't always true and it is not the way to regulate rates," said Noreen Johnson, executive vp at the Ohio Insurance Institute in Columbus.

The Alliance's Ms. Bernhard agrees: "The insurance industry's rate of return isn't as high as the

public thinks and it really can't absorb the decrease."

Meanwhile, H.B. 1298 was introduced in the Indiana Legislature last month by Rep. Paul Hric, D-Hammond, and subsequently was referred to the Insurance Committee. A hearing has not yet been scheduled.

Indiana's H.B. 1298 would:

- Require a minimum 20% rate reduction from July 1, 1988, levels for any property or casualty insurance policy issued or renewed on or after July 1, 1989.

- Make property/casualty rates set after June 30, 1989, subject to the insurance commissioner's approval. The commissioner would be required to notify the public any time an insurer applied for a rate change.

- Permit rates reduced under the

legislation to be subsequently increased between July 1, 1989, and July 1, 1990, only if the commissioner determines after a hearing that the insurer was substantially threatened with insolvency.

- Require insurers to offer a driver who has been licensed for three years with no more than one moving violation an insurance rate of 20% below the rate the driver would otherwise have been charged, regardless of whether the driver had previously held an insurance policy.

- Require that insurers base auto insurance premiums on driving records, number of miles driven and number of years of driving experience.

- Subject insurers to the state's antitrust laws.

Continued on next page

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## Business Insurance

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## Proposition 103 clones

Continued from previous page

- Change state law to make the insurance commissioner's office an elected four-year position.
- Require that the commissioner provide consumers with rate comparisons for personal lines of insurance.
- Permit insurance agents and brokers to offer their clients discounts or rebates.

Kathy Carlson, executive director of the Indiana Forum for Civil Justice in Indianapolis noted: "There is insufficient supporting data to justify this unwarranted regulation of legitimate business."

"I feel Hoosier legislators are too perceptive to buy into such a misguided and short-sighted bill," the Alliance's Mr. Friedmann said.

However, Jim Boorman, director of the Hoosier Alliance for Consumer Rights in Indianapolis, supports the bill.

"We did not initiate the bill but there are good points to it and we do support the antitrust portion," he said.

**'New Mexico does not have a problem with rates relative to other states, but some people don't want to pay anything,' says Fabian Chavez Jr., the state's superintendent of insurance.**

The Indiana Legislature is expected to adjourn sometime in April.

New Mexico legislators earlier this month introduced their version of Proposition 103.

In addition to the mandated 20% rate reduction, New Mexico's S.B. 310—initiated by Sen. Joe Page, a Democrat who represents San Miguel, De Baca and Guadalupe counties—also would:

- Limit property/casualty insurers' ability to increase

rates and premiums on policies written between July 1, 1988, and June 30, 1990. Under the bill, rates could only be increased if a public hearing is held and the insurance commissioner determines that the insurance company is threatened by insolvency.

- Require good driver discount policies for individuals with outstanding driving records. Each candidate would be given a discount based on risk factors such as number of driving years and miles driven annually.

- Restrict private automobile insurance policy cancellations. An insurer could only cancel a private passenger auto policy due to non-payment of premiums; misrepresentation of policy information by the policyholder; or a substantial accident that significantly increases the insurer's risk.

Joining the Alliance in opposing the bill is New Mexico Superintendent of Insurance Fabian Chavez Jr., who said he does not think it will pass. "New Mexico does not have a problem with rates relative to other states, but some people don't want to pay anything. Some changes in the system may be necessary, but this is not the way," he said.

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## Malpractice study

Continued from page 3

The average loss payment for closed medical malpractice claims in 1982 was \$22,906, compared with \$7,550 in 1987. The average loss payment for the entire study was \$14,542.

The average beginning loss reserve was \$12,405 per claim examined from 1982-1987, while the average ending reserve was \$40,831 per claim examined over the same period of time.

"Although the beginning reserve has, on average, been less than the eventual loss payment, the beginning reserve is significantly closer to the average loss than is the ending reserve. The average loss payment for the six-year period is 117% of the average beginning reserve but only 36% of the average ending reserve," the report said.

"It is apparent from our data that the insurers have consistently and significantly overreserved," concluded the report.

When both payments for closed claims and the insurers' reserves for open claims are taken into consideration, the average cost per claim rose to \$44,027 in 1987 from \$32,361 in 1985 and \$25,783 in 1982, according to the study.

However, "although this would seem to indicate an upward trend in severity... inflated reserves distort these figures. The more claims that are open, the greater the upward distortion," the report said.

Nearly 75% of the closed claim files studied ended with no loss payment, the study revealed. Of 110 cases that went to trial, 90—or 81%—were decided in favor of the defendant. And, no punitive damages were awarded in any of the cases.

"It is obvious that insurers are charging considerably higher rates than are necessary to cover losses and expenses and also realize a healthy profit," the report says.

"The ratemakers have not accounted for the historically consistent disparity between actual loss payments and loss reserves," the report adds. "The data on file indicates that when all claims are closed, the 1985-87 loss ratios will be substantially lower than the 80%-85% range targeted by the carriers. Indeed, when the reserves are properly calculated, the loss ratio will likely be under 50%."

The report drew immediate fire from the two insurers.

"The conclusions drawn by the department are inaccurate and inappropriate from the data they used," wrote MMIC President D.K. Beach in a letter to his company's policyholders.

The report is "more a political document than an attempt to make an unbiased study of the state of malpractice insurance in Minnesota," he said.

Mr. Beach said the insurer's reserves "are proper and conservative."

"Existing liabilities for claims that may not be settled for years is not and never will

be an exact science. We do the best job we can and hire outside experts—actuaries and accountants—to assist us."

St. Paul Fire & Marine said that the report's analysis and conclusions "exhibit a shocking lack of understanding of the insurance industry. More disturbingly, it provides the public with inaccurate information, paid for with taxpayer dollars."

A St. Paul spokeswoman added: "One of the major problems with the study is that it doesn't look at claims that are still open for the years covered. They're the biggest, toughest claims—and the study is very misleading for that reason."

The spokeswoman also said that if reserves are higher than actual payouts, this is taken into account in the ratemaking formula. She said that St. Paul "absolutely disagrees" with the report's contention that it overcharges its policyholders.

Although neither insurer disputed that premiums in Minnesota had risen by about 300% during the period covered by the survey, both held that the average claim payment also has increased dramatically during recent years.

The average paid claim, including defense costs, in Minnesota has risen to \$120,000 in 1987 from \$68,400 in 1983, according to St. Paul. That compares with the study's finding of average costs for open and closed claims of \$44,027 in 1987 and \$25,783 in 1982.

MMIC's average closed claim payment, although smaller than St. Paul's, jumped to

\$108,212 in 1988 from \$38,218 in 1982, the company said.

In an interview, Commissioner Hatch said the report could lead to significant changes in the way Minnesota and other states regulate insurance.

For example, he said the Minnesota department may seek to review future medical malpractice rate increases and return a portion of the premium to policyholders if deemed unjustified.

The report shows that "we need better data," particularly about specialty lines of insurance, Mr. Hatch said. He added that the report calls for the creation of a data-gathering center within the department.

A bill backing such a center has already been introduced in the state Senate, he said.

In addition, Mr. Hatch recommended in the report that if the medical malpractice insurance market contracts, the state government should "establish underwriting pools to make coverage available."

The study's impact should reach beyond Minnesota's borders, Mr. Hatch said. Within a few days of the study's release, Mr. Hatch said he received calls from several other state insurance departments concerning the collection of data on medical malpractice rates.

Mr. Hatch also predicted that the report could have an impact on current efforts to repeal or alter the McCarran-Ferguson Act, though he said he has not been contacted by any congressmen regarding the report. ■

# ABA panel member hits reserve practices

St. Paul Fire & Marine Insurance Co.'s medical malpractice insurance reserving and rating practices are highly criticized by a member of an American Bar Assn. commission that recently studied the liability insurance system.

In an appendix to the recent report by the Commission to Improve the Liability Insurance System submitted to the ABA, attorney Thomas F. Londrigan of Springfield, Ill., accuses insurers—and St. Paul in particular—of deliberately manipulating reserves and then charging their customers excessive premiums (BI, Jan. 2).

But a St. Paul spokesman says "the allegations are completely untrue."

Mr. Londrigan made his charges in a dissent to a portion of the report dealing with insurance data collection and reporting.

The report's most significant recommendation—that the ABA urge Congress to repeal the McCarran-Ferguson Act and thus eliminate insurers' limited immunity from federal antitrust laws—was adopted by the ABA earlier this month (BI, Feb. 13).

Mr. Londrigan dissented from the commission's final report and its failure to recommend independent monitoring and regulation of insurance industry reserving practices, citing his "disappointment with the failure of the report to adequately address the blatant manipulation of reserves by segments of the insurance industry."

Calling insurance "an unregulated industry," Mr. Londrigan wrote: "As long as the reserving practices of the insurance industry are neither monitored nor regulated by an independent agency staffed by competent casualty actuaries, reserves will be manipulated to serve the short-term interest

of the industry and defeat the long-term interest of the insurance consumer."

He was particularly critical of the concept of underwriting losses, which he wrote "are not real losses but are actually valuable assets to insurers for two reasons: (1) Federal income tax is avoided; (2) The need to increase future premium income is declared."

Mr. Londrigan found particular fault with St. Paul's medical malpractice reserving and rating actions during the

**'As long as the reserving practices of the insurance industry are neither monitored nor regulated by an independent agency... reserves will be manipulated,' says ABA panelist Thomas Londrigan.**

1970s.

He charged that the insurer built up large reserves and subsequently hiked medical malpractice insurance premiums even though physicians won an overwhelming percentage of malpractice cases during that decade.

"With premium levels at an all-time high, St. Paul finally began reducing reserves, thereby increasing capacity, in order to participate in the grossly overpriced medical malpractice market," Mr. Londrigan said.

And, following a two-year moratorium on writing medical

malpractice in 15 states during the mid-1970s, "St. Paul was able to dictate its own terms" in those states as it had been able to do in the other states it wrote medical malpractice business, Mr. Londrigan charged.

He also accused St. Paul of pushing for tort reforms as a way of avoiding claims.

The insurer has not prepared a point-by-point answer to the attorney's dissent, but a St. Paul spokesman said the insurer did not take an active role in promoting civil justice reforms.

"It's not our place to be proponents or opponents of any particular tort reforms," he said.

Mr. Londrigan also criticized the insurer for promoting the use of the claims-made policy form rather than the occurrence form for medical malpractice insurance.

But, in a St. Paul background statement on medical malpractice insurance issues, the insurer says: "Although claims-made policies do take some of the guesswork out of medical liability insurance pricing, they do not overcome the problem of continued increases in frequency and severity of losses, which are chiefly responsible for the present decade's rising liability insurance costs."

The statement also notes that the insurer pioneered the use of the claims-made policy for medical malpractice coverage.

The St. Paul spokesman—stressing that Mr. Londrigan's opinion was not shared by the ABA commission's 11 other members—said the dissent raised no new points.

"This is typical trial bar rhetoric that's been leveled against the insurance industry for years," the spokesman said.

—By Mark A. Hofmann

## UR directory listings corrected

Due to a production error, information on two companies was scrambled in the directory of utilization review vendors that appeared in the Feb. 20 issue.

Readers are encouraged to photocopy, cut and paste the following correction in their copy of the directory.

### Health Benefits Management Inc.

P.O. Box 8125, Camp Hill, Pa. 17089; 800-441-2330 in Pennsylvania; 800-441-2333 outside Pennsylvania

Year founded: 1984.

Parent company: Pennsylvania Blue Shield and Capital Blue Cross.

Services provided: 95% of gross revenues from providing utilization review services to employers, including frequent preadmission certification, concurrent hospital treatment review, length of stay determination, second surgical opinion, outpatient service predetermination, disability certification; occasional discharge planning, retrospective review, case management; 5% of gross revenues from other services.

Services reviewed: Group health

services, psychiatric and substance abuse services.

Staff: 21 total staff members who are professionals, including two physicians, 16 registered nurses. One physician on a retainer basis.

Clients: 216 total clients; 214 employer clients; 62% with fewer than 500 employees, 20% with 500-999 employees, 11% with 1,000-2,499 employees, 4% with 2,500-4,999 employees, 3% with more than 5,000 employees. 675,000 total lives serviced in 1988.

1988 gross revenues: \$1.7 million total; \$1.6 million from utilization review services to employers.

Charges: Per employee, 95 cents-\$1.25; by the hour.

Principal officers: Jerry Boyer, vp/chief operation officer; Elizabeth A. Galitski, program administration director; Susan Bunting Bianchi, information systems director.

### HealthCare COMPARE Corp.

3200 Highland Ave., Downers Grove, Ill. 60515-1223; 312-719-9000

Year founded: 1982.

Services provided: 55% of gross revenues from providing utilization review services to employers, includ-

ing frequent preadmission certification, concurrent hospital treatment review, length of stay determination, discharge planning, retrospective review, second surgical opinion, outpatient service predetermination, outpatient psychiatric and substance abuse services, case management, workers compensation and disability management, medical information hot line; occasional hospital bill audit; 45% of gross revenues from other services.

Services reviewed: Group health services, dental services, psychiatric and substance abuse services, chiropractic services.

Staff: 433 total staff members; professional staff members include 27 physicians, 300 registered nurses, 10 licensed practical nurses and 15 medical records technicians.

Clients: 12,000 total clients; more than 5 million total lives serviced in 1988.

Branch offices: Sacramento, San Francisco and Los Angeles, Calif.; Portland, Ore.

1988 gross revenues: \$20.8 million total.

Charges: Per employee, per case.

Principal officers: Dr. Robert J. Becker, chairman/chief operating officer; James C. Smith, president/chief executive officer; Daniel Brunner, president-Affordable Health Care Concepts. ■

## Wisconsin studies malpractice claims

MADISON, Wis.—The state Insurance Department will suggest medical malpractice reforms in the 1991 legislative session if a current study of closed malpractice claims justifies doing so, says Commissioner Robert D. Haase.

The existing system of medical malpractice compensation is inefficient, costly and not seem to distribute money particularly fairly, Mr. Haase said. The study is designed to find any readily apparent remedies, he said.

Mr. Haase said the study should be completed by April, "but we don't expect to have a report to issue until 1990."

He stressed that the department is gathering information on closed claims and is not attempting to prove or disprove a predetermined theory on how the medical malpractice system should be revised.

Last fall, the state sent questionnaires to leading writers of medical malpractice insurance in Wisconsin between 1975-1987 to determine what types of claims had been filed and what the cost of settling those claims had been, Mr. Haase said. Some of the companies contacted no longer write medical malpractice insurance, he said.

Insurers contacted for the study include Aetna Casualty & Surety Co.; Chicago Insurance Co., a unit of Fireman's Fund Insurance Co.; Continental Casualty Co., a unit of CNA Financial Corp.; Federal Insurance Co., a Chubb Corp. unit; Medical Protective Insurance Co.; National Chiropractic Mutual Insurance Co.; Professionals Insurance Co., a unit of Physicians Insurance Co. of Ohio; St. Paul Fire & Casualty Co.; and St. Paul Fire & Marine Co.

—By Mark A. Hofmann

# AIDS not hurting group health costs: Study

By KARI BERMAN

The AIDS epidemic is not forcing dramatic increases in group health insurance premiums and probably will not anytime soon, according to a recent study of health insurers and employers in five states with large concentrations of AIDS patients.

Despite initial fears, AIDS has had a "negligible" effect on both individual and group health insurance premiums, the study revealed.

And, case management programs are being developed to keep the cost of treating acquired immune deficiency syndrome to a minimum in the future, according to the 1988 study, "Response to AIDS in the Private Sector: Case Studies of HMOs, Insurers and Employers."

The study, written by Warren Greenberg, associate professor in health services administration and health care sciences at George Washington University in Washington, D.C., consisted of telephone interviews that yielded "mini case studies" with employers as well as insurers, health maintenance organizations and Blue Cross/Blue Shield plans in California, Florida, New Jersey, New York and Texas—all states in which there are large numbers of AIDS cases.

"Of the 15 major providers (insurers and HMOs) that participated in the survey, all of them found that AIDS accounts for very little of their total costs and that the disease has not had nearly the financial impact expected," he said.

Because many group health insurance policies are experience-rated, an AIDS claim might increase one particular group's premium, the study's author pointed out. But the overall impact on premiums would be insignificant, he noted.

"AIDS is just another risk and should be treated like any

other illness," Mr. Greenberg said.

On the average, the study found the AIDS component to account for less than 1% of claims paid by insurers with a limited number of AIDS cases in relation to total enrollment.

And, the insurers and HMOs reported that their average cost for lifetime treatment of an AIDS patient ranged from \$35,054 to \$60,000.

"In comparison to other claims like organ transplants and premature births, treating an AIDS patient is not as costly as initially thought," said William Wukovitz, an assistant director in product management at Travelers Insurance Co. in Hartford, Conn.

Travelers, a study participant and whose group health care programs cover 5 million employees, has paid an estimated 465 AIDS claims since 1986.

"Although the insurance industry was frightened and may have overreacted, we have found that the impact of the illness has been minimal and therefore the impact on the premiums has been minimal as well," Mr. Wukovitz said.

"Overall, AIDS has not been the horror story that we thought it would be and has not affected premiums significantly," said John Elsenhandler, project manager-actuarial of Empire Blue Cross & Blue Shield of New York.

Empire, which covers 8.5 million employees in its group health insurance plans, has paid claims in connection with 6,000 identified AIDS cases, he said.

One reason health insurers anticipated astronomical medical costs for treating AIDS victims was the huge cost of treating the first reported AIDS cases.

For example, the Centers for Disease Control in early 1985 estimated the cost of inpatient care for an AIDS patient from diagnosis through death at \$147,000 (BI, Sept. 7, 1987).

While the number of AIDS cases may increase in the future, there also will be "more cost-effective treatments, helping to keep expenses at a minimum," predicted David Taffe, director of group underwriting at The Prudential Insurance Co. of America in Newark, N.J.

"At Prudential, we have special programs designed to deliver quality care in the most cost efficient way," he said.

For example, keeping AIDS patients out of the hospital unless absolutely necessary is imperative for reducing costs, Mr. Taffe said. "We arrange to give them good continuous care through either in-home care or hospice care, and this eliminates the often unnecessary expense of hospitalization."

Other group health insurance experts agreed that proper case management is the key for controlling AIDS claims.

"Initially nobody knew what to do, and long and extensive acute care was administered in the hospital, bringing up the cost. Now more cost-effective alternatives are available and case management can help control the cost," said The Travelers' Mr. Wukovitz.

"I think that case management is essential for keeping both insurance rates and claims controlled," said Maddy Bowling, vp of medical case management at Intracorp, the medical case management subsidiary of CIGNA Corp. in Berwyn, Pa.

"We have handled about 600 AIDS cases and saved an estimated \$4.8 million in unnecessary costs," she said.

Copies of the report, "Response to AIDS in the Private Sector: Case Studies of HMOs, Insurers and Employers," are available for \$88 each from Pamela Taulbee, Capitol Publications, 1101 King St., Suite 444, Alexandria, Va. 22314; 703-739-6444.

## Ameritech VEBA

Continued from page 3

Retirees are eligible for coverage when they reach age 65 or when they meet certain age and years of service requirements for early retirement, he said.

The company paid about \$78 million for retiree health care in 1988, up 13.4% from \$68.8 million in 1987 after a 12.2% increase from \$61.3 million in 1986.

Those costs probably will continue to increase at about the same rate given health care cost inflation and other factors, he said.

Mr. Malone declined to estimate Ameritech's retiree health care liabilities.

Actuaries estimate that most employers face retiree health care liabilities of about \$30,000 per active employee and \$15,000 to \$20,000 per current retiree.

Ameritech currently has 78,000 active employees and 47,000 current retirees. Therefore, it could face about \$2.3 billion in retiree health care liabilities for current employees and \$705 million to \$940 million in liabilities for current retirees.

The company is in the preliminary stages of examining a defined contribution approach to provide retiree health benefits but does not expect to make any plan changes in the near future, Mr. Malone said.

He could not estimate when Ameritech would be able to totally pre-fund its retiree medical liabilities.

However, he explained that the VEBA initially will pre-fund benefits for employees that Ameritech expects will retire within 10 years, beginning in 1990. Benefits for this group could be fully funded between 1992 and 1995.

So, "benefits for current retirees will be funded on a pay-as-you-go basis. Those who retire in 1990 and after will be pre-funded," he said.

Ameritech expects its current retiree population of 47,000 to increase slightly in the near term. But, it expects that figure to decline over the long-term.

Mr. Malone could not predict how Ameritech's pre-funding strategy would affect the company's financial statements.

"We really haven't done this yet. So much will depend on the growth in the fund," he said.

While some employers already use VEBAs to fund their retiree health benefits, Ameritech took a special approach, Mr. Malone pointed out.

In designing Ameritech's VEBA, both Goldman Sachs and TPF&C worked together to analyze the company's liabilities and develop an investment strategy that would best meet these liabilities, he said.

Ameritech plans to make investments so that changes in investment interest rates balance the effects of inflation on health care liabilities, Mr. Malone explained.

For example, initially, the com-

pany's contributions will be invested in Treasury securities, Mr. Malone said.

The company has not yet estimated how much it will contribute annually to the VEBA.

However, Mr. Terry of TPF&C estimated that Ameritech could have \$1 billion in the fund 10 years from now.

Benefits consultants point out that Ameritech's use of a VEBA to pre-fund retiree medical benefits is unusual. VEBAs mostly are used to fund disability and other health benefits for active employees, benefits consultants say.

"Not too many employers are doing this, but I wouldn't be surprised if the popularity of this funding method grows," said Herry Saveth, a principal in the New York office of A. Foster Higgins & Co. Inc.

"One advantage of the VEBA is that you can take the deduction now for a liability you would pay in the future. But, you can't take into account health care inflation when making a contribution," he said.

And, some consultants predict that taxable investment income will not be a stumbling block for employers interested in establishing VEBAs to pre-fund retiree health care liabilities.

In fact, some say that mounting pressure to recognize and fund these liabilities will supersede em-

ployers' concerns about the tax status of the trusts.

"Even before the tax status of these trusts changed in 1984 under DEFRA, employers still didn't use VEBAs to pre-fund retiree health care benefits. That tells me that there were other reasons than that employers didn't pre-fund these benefits," said TPF&C's Mr. Terry.

"VEBAs were not utilized for retiree medical before DEFRA," agreed Edward J. Davey, a principal with Foster Higgins in New York. "Employers just were not addressing the pre-funding of retiree medical benefits."

He also noted that "the FASB

rules raise not only the issue of funding, but also the issue of benefit plan design. The combination of FASB and rising medical costs will force more companies to look at a defined contribution approach. This way, employers will not be pre-funding an open-ended liability" like the one that exists with traditional defined benefit retiree medical plans, he said.

Other consultants concur that employers will gradually eliminate plans with open-ended commitments to provide a fixed level of contributions—regardless of medical inflation or a retiree's age or length of service.

## Aviation market

Continued from page 3

"The aviation market is soft and getting softer," concurred a Lloyd's of London aviation broker.

For example, Lufthansa German Airlines has just received a 61% reduction in its hull insurance rate and a 44% liability rate reduction when it negotiated its April 1 renewal, sources in London confirm.

And, like United Airlines and British Airways, Lufthansa has secured an 18-month hull and liability insurance program that provides that limits, policy conditions and underwriters will remain the same over the length of the policy (BI, Feb. 13). However, unlike United and British Airways that locked in their rates for 18 months, underwriters will review the rate charged to Lufthansa on April 1, 1990.

The Flying Tiger loss brings total aviation hull claims since Dec. 22 to \$130 million. The other hull losses were:

- A \$32 million Pan American World Airways Boeing 747 loss, paid by hull war risk underwriters. Investigators recently concluded that a terrorist bomb hidden in a radio/cassette player exploded aboard Pan Am Flight 103 over Scotland, killing 270 people (BI, Dec. 26, 1988).

- A \$35 million British Midland Airways' Boeing 737-400 loss. The plane crashed while attempting to make an emergency landing near Kegworth in the English county of Leicestershire in early January, killing 45 people and injuring 73 passengers (BI, Jan. 16).

The cause of that crash has not been determined. Investigators have ruled out an initial theory that faulty wiring caused the pilot to shut down the wrong engine—leaving the aircraft without power—after reporting an engine fire.

- A \$6 million Boeing 707 leased by Smyrna, Tenn.-based Independent Air Inc. that crashed in February into mountains four miles from an airport in the Azores where it was to refuel. The 137 Italian passengers and seven American crew members killed in the crash were flying from Bergamo, Italy, to resorts in the Dominican Republic.

Underwriters estimate that the liability losses from the four crashes could amount to as much as \$382.2 million.

Pan Am's leading underwriter, United States Aircraft Insurance Group, estimates that liability underwriters should reserve \$60 million for personal injury and death claims, based on the limits on airlines' liability contained in the Warsaw Convention and the Montreal Protocols. However, London underwriters, concerned that the limitations will not apply, believe the reserve should be closer to \$300 million.

A London underwriter says that underwriters are reserving a total of 7 million pounds (\$12.2 million) for the personal injury and death claims from the British Midland disaster.

And the liability loss reserve for Independent Air has skyrocketed because no liability limitations as specified in Italian law were written into tickets issued to passengers. As a result, the airline faces unlimited liability for passenger claims, sources confirm. Condon & Forsyth, the New York law firm representing Independent Air, has recommended that underwriters reserve \$70 million for liability losses stemming from the crash.

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# Broker results

Continued from page 1

comparisons are going to be very tough in 1989, because in 1988 brokers had a little bit of a benefit due to a drop in taxes from 1987. They won't get that in 1989."

Mr. Rosencrants sees no indication of prices firming in the property/casualty insurance market in 1989 "except for workers compensation in selected states and surety business. In all commercial lines, pricing is lower."

"Hope springs eternal, and there are people in certain quarters who hope for a moderation of rate competition" in the second half of 1989, under the assumption that "after three years of declining prices, they won't decline nearly so much," Mr. Rosencrants said.

However, "the same reasoning applied in the last cycle would have caused one to be two to three years too early in predicting a return in pricing," he was quick to add. "Furthermore, there is little evidence that underwriters are showing much attention as a group to stabilize and then firm pricing."

On a more positive note, Mr. Smith pointed out that as brokers "are becoming more realistic" in recognizing that a turn in the market is remote, "they are becoming more conservative in their expenses and we are seeing a better synchronization of expenses with revenues."

Mr. Rosencrants agreed that "for the most part, brokers are doing a pretty good job in expense control," with some brokers—most notably Marsh & McLennan—doing a better job than others.

Marsh & McLennan, the largest publicly held broker, reported a 5.8% increase in gross revenues in 1988 to \$2.27 billion from \$2.15 billion in 1987. However, net income dropped 1.9% last year to \$296.3 million from \$302.1 million in 1987.

In the fourth quarter, M&M reported a 5.9% gain in gross revenues to \$544.4 million from \$514.3 million in the fourth quarter of 1987. Net income fell 3.8% in the fourth quarter to \$50.6 million from \$52.6 million in the fourth quarter of 1987.

Breaking down its fourth-quarter revenues into business groups, M&M's primary insurance brokerage revenues fell 2.8% to \$189.4 million

from \$194.9 million; reinsurance brokerage revenues rose 3.6% to \$58.3 million from \$56.3 million; group associates business, which includes association and mass-marketing programs, dropped 2.1% to \$32.1 million from \$32.8 million; investment management revenues fell 2.3% to \$64.6 million from \$66.1 million; and consulting revenues jumped 25.5% to \$169.7 million from \$135.2 million.

New business contributed 13% to 15% of M&M's domestic retail brokerage revenues last year, said Mr. Bischoff, while non-renewals equaled 6% to 8% of revenues. "If pricing had been neutral, we would have showed fairly decent (retail brokerage) revenue growth" in light of the strong new business development, he said.

On the reinsurance brokerage side, Mr. Bischoff observed that rate reductions have begun to level off, which enabled M&M to report slight gains in reinsurance brokerage revenues in both the third and fourth quarters.

M&M's Putnam Inc. investment management subsidiary "had a very, very good year and we are very pleased with its performance," Mr. Bischoff said, noting the extreme difficulty in comparing its profitability in 1988 with a record year in 1987.

The broker's consulting operations reported "very good growth," Mr. Bischoff stressed. He also pointed out that "acquisitions and staffing for internal growth" in its consulting business, in combination with foreign currency exchange translation, accounted for all of the broker's expense growth in 1988.

Mr. Rosencrants said M&M is operating "about as well as it can" in the current marketplace and its performance in the fourth quarter was "in line with my expectations."

"Overall, M&M's revenues were right where I expected," agreed Shearson's Mr. Smith. He also predicted that its modest increase in reinsurance brokerage revenues was "a confirmation that things are starting to improve in that market."

However, Mr. Malis pointed out that M&M's "pure numbers were deceiving," in that they included a \$52 million recovery from insurers over bond trading losses the broker experienced in 1984 (BI, Nov. 14, 1988; May 28, 1984), as well as several small write-offs.

New York-based Alexander & Alexander Services Inc. reported 1988 gross revenues of \$1.23 billion, a 3.8% increase from \$1.18 billion in 1987. Net income fell 1.3% to \$67.5 million from \$68.4 million in 1987.

In the fourth quarter, A&A's gross revenues rose

6.3% to \$317.9 million from \$299 million in the comparable quarter of 1987. Net income rose 34.6% in the fourth quarter to \$14.4 million in 1988 from \$10.7 million in 1987.

A&A recorded an aftertax gain of \$18.2 million in the fourth quarter of 1988 from the sale of its TIFCO Inc. premium finance subsidiary. But, that gain was partially offset by a net provision of \$12.1 million to cover estimated losses from the sale of two small operations and costs related to its sale of Evanston, Ill.-based Shand, Morahan & Co. in January 1988.

In addition, A&A made a \$6 million provision in the fourth quarter for the finalization of a \$50 million reinsurance agreement that would be triggered if losses from A&A's discontinued Atlanta and Bermuda underwriting operations exceed current reserves.

Excluding these non-recurring items, A&A's earnings were "better than expected," said Mr. Malis, though he is predicting "pretty flat earnings for next year."

Mr. Malis added that A&A's new business growth was a little stronger in the fourth quarter than in previous quarters and that its expenses would have been flat had it not been for a \$9 million write-off related to the discontinuation of a mainframe-based risk management information system marketed by its Anistics Inc. subsidiary (BI, Dec. 26, 1988) and the effects of exchange rates.

A&A's insurance services revenues "were up over 5%. That's a little stronger than I had been looking for and I was reasonably satisfied with their quarter," said Shearson's Mr. Smith.

"We are reasonably pleased with the fourth-quarter results, given the conditions of the overall market. We worked hard at expense controls and it seems to be having some good results," said Donald L. Seeley, A&A's vp-financial management.

"When A&A's fourth quarter is adjusted for the non-recurring items, its results were right in line with my expectations," Mr. Rosencrants said.

Corroon & Black's 1988 gross revenues rose 8.3% to \$424.9 million from \$392.2 million in 1987, while net income jumped 161.3% to \$115.9 million from \$44.4 million in 1987. However, 1988 net income was inflated by a \$73.9 million aftertax gain from Corroon & Black's sale of its investment in London-based Minet Holdings in the first quarter.

Corroon & Black's fourth-quarter gross revenues rose 17.6% to \$106.6 million from \$90.7 million in the fourth quarter of 1987. Net income for the quarter rose 28.4% to nearly \$8 million from \$6.2 million in 1987.

Mr. Cuthbert attributes the broker's improved earnings partially to the reduction in the federal income tax rate in 1988.

However, he pointed out that the broker saw "significant new business activity in the fourth quarter" in both its retail brokerage and special services groups.

In addition, the brokerage completed eight acquisitions in 1988. "We are now getting the added impact from that," Mr. Cuthbert said. The acquisitions were all accounted for as purchases.

In preparation for continued market competition in 1989, "we are emphasizing new business and account retention and are constantly managing our expenses on an office-by-office basis," Mr. Cuthbert added.

Mr. Smith said that it's difficult to make a comparison between 1988 and 1987 results because of the number of acquisitions Corroon & Black has made in the last year. However, he noted that the broker's new business production was up in the fourth quarter and "lost business is beginning to stabilize."

Corroon & Black's "numbers were slightly better than I was expecting," said Mr. Rosencrants, observing that revenues were up 8% in the fourth quarter, excluding acquisitions.

Corroon & Black's results were "better than most of us anticipated, mostly because of the acquisitions they have been doing," Mr. Malis said. He expects Corroon & Black's earnings to increase slightly in 1989 as well due to the acquisitions made late in 1988.

Briarcliff Manor, N.Y.-based Frank B. Hall & Co. Inc. reported a 5% drop in gross revenues in 1988 to \$366.9 million from \$386 million in 1987. It also reported a \$30.5 million net loss in 1988, following a \$66.9 million loss in 1987.

1988 marked the fifth consecutive year the beleaguered brokerage reported a year-end loss.

In the fourth quarter, Hall's gross revenues dropped 1% to \$96.6 million from \$97.6 million in the fourth quarter of 1987. And it reported a \$14.4 million net loss in the quarter, compared with a \$6.8 million loss in the fourth quarter of 1987.

However, Hall did report a 0.2% increase in net commissions and fees in the fourth quarter. "We thought that was a positive factor, reversing a trend that has

# Update

## Higher Cadiz award suggested

Continued from page 2

Amoco in January 1988 (BI, Jan. 18, 1988). Judge McGarr had found Amoco liable to the French government and scores of other French claimants for the wreck. Some 68 million gallons of oil were dumped off the Brittany coast in the wreck.

The additional award of 117 million francs (\$18.7 million at current exchange rates) plus interest represents upward adjustments of damages payable to the French government, two associations of oyster growers and several other claimants, said attorney Frank Cicero of Kirkland & Ellis in Chicago, representing Amoco.

But, the total award is still far smaller than the hundreds of millions of dollars in damages the claimants had sought.

The revised award must be entered by U.S. District Judge Charles Norgle. Afterward, Amoco and the French claimants will appeal the damage award, lawyers for both sides say. Amoco also will appeal Judge McGarr's earlier liability ruling, Mr. Cicero said.

## BC/BS Rhode Island rate boost

PROVIDENCE, R.I.—Blue Cross & Blue Shield of Rhode Island will raise group health indemnity plan rates between 17% and 25% over the next 18 months to recover from a \$19 million loss in 1988.

The loss left with the insurer with only \$9 million in reserves at year-end 1988, which is enough to pay about seven days' worth of future health care claims. The state requires health insurers to maintain reserves large enough to pay at least a half-month's claims.

BC/BS of Rhode Island attributes the 1988 loss to health care cost inflation and a higher than anticipated increase in the use of hospital and physician services by its 663,000 policyholders. In addition, the insurer lost more than \$4 million on its "Plan 65" Medicare supplement product, a spokesman said.

The rate increase is in line with projected 20%-50% premium hikes for indemnity plans nationwide in 1989 (BI, Dec. 19, 1988).

## PWS reports loss in 1988

LONDON—The purchase of San Francisco-based broker Glenn, Nyhan & Associates Inc. and poor North American performance account for the grim results of Lloyd's of London broker PWS Holdings P.L.C., which were released last week.

After delaying the announcement a week to deal with \$1.3 million in disputed debts unrelated to the GNA acquisition, PWS announced Feb. 24 that pretax operating profits dropped 68% to 2.3 million pounds (\$4 million) for the year ended Sept. 30, 1988, from 7.2 million pounds (\$12.7 million) at year-end Sept. 30, 1987.

And the write-off for the GNA acquisition has jumped to 5.5 million pounds (\$9.7 million) from the 4.4 million pounds (\$7.8 million) estimated last September by Chairman and Chief Executive Malcolm Pearson (BI, Sept. 12, 1988).

After the write-off and taxes, the PWS group lost 5.5 million pounds (\$9.7 million) in 1988 compared with a 2 million pound (\$3.5 million) profit for the prior year. A dividend will not be paid.

After release of the results, the price of PWS shares collapsed to 82.5 pence (\$1.45) per share, from 110 pence (\$1.94) per share.

## High court reviews Mead case

WASHINGTON—The U.S. Supreme Court heard arguments last week to decide whether companies must use excess assets of a terminated defined benefit pension plan to pay employees the value of early retirement supplements they were not eligible for when the plan was terminated.

The case, *Mead Corp. vs. B.E. Tilley, et al*, involves an April 1987 ruling by the 4th U.S. Circuit Court of Appeals in Richmond, Va., that entitled six former Mead employees to early retirement supplemental benefits although they had not reached the age required for early retirement when the plan was terminated.

Mead recovered approximately \$10.7 million in excess assets from the plan termination (BI, Oct. 10, 1988; Aug. 17, 1987).

An early retirement benefit "is not earned until both (age and years of service) requirements have been satisfied," Mead attorney Patrick McCartan told the justices.

But, Clifford Harrison, who represents the Mead employees, argued the employees were entitled to those funds because Mead had been funding for the early retirement benefit when the plan was terminated.

The justices questioned the attorneys on: the facts of the case, when a benefit becomes accrued, how cliff vesting works, what a contingent liability is and funding requirements for pension benefits under the Employee Retirement Income Security Act.

Several amicus curiae briefs were filed in support of Mead, including briefs by the Pension Benefit Guaranty Corp., the U.S. Chamber of Commerce, the National Employee Benefits Institute and the American Society of Pension Actuaries.

## Briefly noted

The 6th District California Court of Appeals has agreed to review pollution cleanup coverage litigation between Chicago-based **FMC Corp.** and 174 of its general liability insurers. The appeal stems from a Jan. 3 Superior Court judge ruling that cleanup costs incurred by FMC are insurable "damages" under its CGL policies (BI, Jan. 9). . . . An arbitration umpire has ruled that Lloyd's of London underwriter **Richard Outhwaite** does not have to reimburse Lloyd's underwriter Michael Cockell for costs related to the now-defunct Asbestos Claims Facility under a runoff reinsurance policy written by syndicate 661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. The syndicate's liability under the disputed contract—which the umpire earlier ruled could not be voided (BI, Oct. 24, 1988)—will be determined this spring. The syndicate has reserved \$40 million to \$50 million to pay claims owed on the policy. . . . **Forum Re Group Inc.** no longer plans to make its Forum Re Group (Bermuda) Ltd. unit the group's flagship company. Instead, it is opting to merge with the Bermuda holding company to form a single U.S.-based company.

### Year-end 1988 broker results

(In thousands of dollars)

Broker	Gross revenues	% change	Net income	% change
Marsh & McLennan	\$2,272,400	5.8%	\$296,300	-1.9%
Alexander & Alexander	1,227,700	3.8	67,500	-1.3
Corroon & Black	424,902	8.3	115,892	161.3'
Frank B. Hall	366,913	-5.0	-30,471	N/M
Arthur J. Gallagher	156,035	8.9	16,895	3.5
Hilb, Rogal & Hamilton	49,139	18.0	4,376	43.4

'Reflects gain from sale of investment in Minet Holdings P.L.C.

N/M - Not meaningful

Continued on next page

## Broker results

Continued from previous page  
gone on for several quarters," noted Joel C. Kornreich, vp-corporate development.

"The highlight of Hall's results was that (commissions and fees) were up in the quarter for the first time this year. Its new business was up 18% in the quarter," said Mr. Malis.

Mr. Kornreich also noted that the company has been making substantial investments in personnel, employee education, automation and added incentives for new business production. He said Hall's acquisition over the past year of a number of top producers and managers from within the brokerage community (see related story) helped bolster revenues in the fourth quarter.

"We're hoping and believe that we can have improved revenue growth in 1989 despite current market conditions" due to "these new people, existing producers and a strong account retention effort," Mr. Kornreich added.

Mr. Malis acknowledged that Hall has "hired a lot of talent from other brokers," but also observed that it "paid a lot of money for these people. The company is retaining its revenue base and it has to spend money to do that."

Hall's "new business was the strongest it has been in two years," said Mr. Smith, who viewed the quarter as "mildly positive."

But Mr. Rosencrants was more pessimistic. "I see no material change in the trend for Hall. Its losses continued and I expect its losses to continue, keeping in mind

that the first quarter of the year is its strongest quarter," he said.

A portion of Hall's fourth-quarter loss was created by non-operational factors.

The termination of various safe harbor leases that Hall purchased in 1981 and 1982 resulted in the write off of unamortized investment in those leases, amounting to \$9.1 million.

"A number of years ago, we entered into these tax-driven leases and terminated them in the fourth quarter, which enabled us to use some of our tax loss carryovers which would have otherwise expired. If we hadn't done so, we would have paid significantly higher taxes in future years," explained Ronald Shapiro, Hall's vp and director of taxes.

Rolling Meadows, Ill.-based Arthur J. Gallagher & Co. reported an 8.9% increase in gross revenues in 1988 to \$156 million from \$143.3 million in 1987. Its net income rose 3.5% in 1988 to \$16.9 million from \$16.3 million in 1987.

In the fourth quarter, Gallagher's gross revenues rose 9.1% to \$38.2 million from \$35 million in the fourth quarter of 1987. Its net income in the quarter rose 27.9% to \$3.3 million from \$2.5 million in the comparable quarter of 1987.

"We had a good fourth quarter and new business bodes well for us. We're still out there selling risk management products—claims management, safety engineering and risk management consulting," said Michael J. Cloherty, vp-finance.

"Those are all products the buyer needs when he enters the alternative insurance market and we

## Hall hiring from competitors

By LINDA J. COLLINS

NEW YORK—Aggressive hiring by Frank B. Hall & Co. Inc. of top producers and managers from other brokers in recent months includes a woman whose husband then lost his job at a competing broker as a result of her move.

Tracey A. Carragher, formerly a senior vp of A&A of Connecticut Inc. in Greenwich, was hired by Hall earlier this month. She is now president of Frank B. Hall & Co. of Fairfield/Westchester in Briarcliff Manor, N.Y.

Three weeks after Ms. Carragher was hired by Hall, Alexander & Alexander Services Inc. dismissed her husband, Richard B. Hall, as president of its New York-based risk management consulting subsidiary, Anistics Inc.

"I was told I was dismissed for conflict of interests. I was told it was corporate policy," Mr. Hall explained, adding: "Tracey resigned Jan. 23 and I was terminated Feb. 14."

Asked to comment on the dismissal, a spokesman for New York-based A&A said: "We are not able to address a personnel issue. This is a company policy."

Hall has recruited other top producers and executives from the retail brokerage division of A&A, leading some to view Hall as making a particular effort to raid A&A of employees.

"There is no concerted effort by Hall to go after A&A people," said Joel C. Kornreich, vp-corporate

development for Hall.

Other A&A people hired by Hall include:

- Joseph E. Morahan III, president of Frank B. Hall & Co. Financial Services Inc. in Denver, hired last July to establish that office. Mr. Morahan was formerly a Denver-based vp of A&A Inc.

- Michael E. Schwander and Stephen M. Sanford, both vps of Hall's financial services division, hired last July along with Mr. Morahan. They were both vps of A&A Inc.'s Denver office.

- Scott R. Isaacson, president and chief executive officer of Frank B. Hall & Co. of Columbus, Ohio, hired last December. He had been vp of A&A of Ohio Inc. in Columbus.

- Barbara Stern and William J. McGreevy, vps of the Fairfield/Westchester facility, hired this month, were formerly vps of A&A of Connecticut Inc.

A Hall spokesman stressed that Hall also has hired from other brokers, including: New York-based Marsh & McLennan Cos. Inc., Fred S. James & Co. Inc., Johnson & Higgins and Chicago-based Rollins Burdick Hunter Co.

"It's an impressive list" of people, said Mr. Kornreich.

While he would not divulge the names of all of the producers Hall has hired from other brokers over the past several months, he said that "to the greatest extent, these people have come to us," rather than Hall pursuing them.

Hall is paying top dollar for its new employees, according to industry sources.

haven't seen a decrease in demand for that business" due to competitive market conditions, Mr. Cloherty stressed.

"We're still seeing new business growth on both sides of the house," Mr. Cloherty said, referring to risk management services and retail insurance brokerage business.

"We anticipated finishing with a strong fourth quarter. We needed a good one and we're happy that it came through," he added.

Mr. Rosencrants said that Gallagher's 9% revenue growth in the quarter "was better than any of the other brokers" that he tracks, when one excludes the effect of acquisitions on other brokers' results.

"Their best performer was their risk management business," he added.

Mr. Malis said that because of Gallagher's poor performance in the third quarter of 1988, he had expected the fourth quarter results to be worse than they were. "They reported better than a lot of us thought they would," he said.

Richmond, Va.-based Hilb, Rogal & Hamilton Co. reported 1988 gross revenues of \$49.1 million, an 18% increase from \$41.7 million in 1987. Its 1988 net income rose 43.4% to \$4.4 million from \$3.1 million in 1987.

In the fourth quarter of 1988, HRH's revenues rose 21.6% to \$12.2 million from \$10.1 million in the fourth quarter of 1987. Fourth-quarter net income rose 176.4% to \$821,000 in 1988 from \$297,000 in 1987.

Results for both years were restated due to a pooling of interests stemming from HRH's acquisition of Savannah, Ga., based Jones, Hill & Mercer Inc. in November.

"We were very pleased with our results for the fourth quarter and the year. We have been able to enjoy continued growth... primarily because of our acquisition program" and strong new business efforts, said Timothy J. Korman, senior vp-finance. He noted that HRH completed 18 acquisitions in 1988, including the Jones, Hill & Mercer acquisition.

The other 17 acquisitions were accounted for as purchases.

"We're optimistic about 1989 and think we will show continued strong growth, although possibly at a slower pace," Mr. Korman added.

Mr. Malis agreed that HRH's "overall results were good," although an increase in its stock dividend and the restatement for pooling made the results "confusing." He also noted that its stock has performed better than any of the other brokers he tracks.

However, Mr. Rosencrants viewed HRH's results for the quarter as "disappointing for the first quarter since the company became public." But he pointed out that the pooling negatively affected the quarterly results and reduced its earnings per share.

"Going forward, we expect Hilb to enjoy a pretty good 1989, despite industry conditions," Mr. Rosencrants added.

Tampa, Fla.-based Poe & Associates Inc. reported a 12% increase in revenues in 1988 to \$34.7 million from \$31 million in 1987. Net income rose 175.8% to \$4.1 million from \$1.5 million in 1987.

However, in 1987, the stock market crash and a third-quarter loss of \$800,000 from discontinued underwriting operations hurt Poe's net income and distorted any year-

to-year comparison.

In the fourth quarter of 1988, Poe's revenues rose 8.8% to \$7.6 million from \$6.9 million in the fourth quarter of 1987. Fourth-quarter net income was \$384,000, compared with a loss of \$413,000 in the fourth quarter of 1987.

"On a per-share basis, it was our best year ever," said Chairman William F. Poe.

"It was a record year for us and we reasonably maintained our expenses," he said, adding that the year was "particularly positive because of the soft insurance market."

Mr. Poe attributed Poe's growth to new business gains in both its retail and specialty lines operations and to some commission increases in its specialty programs.

Analysts contacted do not track Poe's results.

Besides the publicly held brokers, Chicago-based Aon Corp. reported that revenues from its Rollins Burdick Hunter Co. brokerage subsidiary rose 19.5% in 1988 to \$266.9 million from \$223.5 million in 1987. Its pretax operating income rose 9.3% to \$32.2 million from \$29.5 million in 1987.

In the fourth quarter, RBH's revenues rose 14.8% to \$66.8 million from \$58.2 million in 1987. Pretax operating income for the quarter dropped 3.8% to \$2.6 million from \$2.7 million in the fourth quarter of 1987.

Aon President and Chief Executive Officer Patrick G. Ryan attributed the drop in fourth-quarter pretax operating income to continued property/casualty insurance rate competition and attributed some of the increase in revenues to acquisitions made in mid-1987 and late 1988. ■

## U.S. taxation of Lloyd's members

Continued from page 2

derwiring income and investment income on those premiums. Most U.S. dollar-based business is subject to U.S. taxes, even if the business stems from non-U.S. risks.

Investment income earned from premiums placed in U.S. trust accounts is taxed annually. Underwriting profits and losses are taxed based on Lloyd's three-year accounting system.

Under Lloyd's accounting system, profits or losses for an underwriting year are determined after three years. At that time, a syndicate transfers a reinsurance premium—known as reinsurance to close—into the following underwriting year to cover future liabilities.

The reinsurance to close for future U.S. liabilities is placed in a U.S. trust fund. In addition, members may place part of their profits into U.S.-based reserve funds to provide for future U.S. liabilities.

However, the Treasury states that it is "not persuaded... that individual underwriters should be sub-

ject to only one level of tax but be permitted to claim reserve deductions (or to delay recognition of premium income by placing premiums in a trust, which is similar in effect to establishing a reserve)."

Although the report does not specifically recommend a change in Lloyd's three-year accounting system, the Treasury plans to re-examine and, if necessary, modify "the tax accounting rules... to ensure that use of special accounting rules does not result in a material difference in the tax due."

Lloyd's is confident it will convince the IRS that its historic three-year accounting system is "not a tax break" and should remain in the new agreement, Lloyd's Chief Executive Alan Lord said last week.

Lloyd's syndicates, together with many reinsurance companies in London, are required by the British Department of Trade to use the three-year accounting system as a means of better assessing their liabilities, noted Tim Boatman, a senior partner at the London office of accountant Coopers & Lybrand. ■

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# AIDS claims

Continued from page 1

At the same time, group life insurance claims associated with acquired immune deficiency syndrome increased to an estimated \$132.5 million in 1987, up from an estimated \$79.4 million in 1986, a 66.9% rise.

But the surge in AIDS-related claims is not forcing dramatic increases in group health insurance premiums and probably will not anytime soon, according to another recent study conducted by a George Washington University professor (see story, page 32).

Total group life and health insurance claims related to AIDS in 1987 amounted to \$320.5 million, about double the \$164.2 million in estimated claims payments in 1986.

AIDS-related claims involving individual accident and health policies in 1987 were an estimated \$35.9 million, up slightly from \$34.7 million in 1986. AIDS-related claims involving individual ordinary life policies increased to an estimated \$130.8 million in 1987, up 40.2% from an estimated \$93.3 million in 1986.

These estimates are based on the reports of 275 insurers that responded to a 1986 ACLI-HIAA survey and the 265 companies responding to a 1987 survey conducted by the two trade groups.

The HIAA and ACLI then extrapolated the reports from responding insurers to come up with estimated results for the entire commercial life and health industry.

Such extrapolation is valid because the HIAA and ACLI believe that the claims experience of reporting companies are representative of commercial insurers that did not respond to the survey, said Charles Eby, the HIAA's director of research.

This big increase in AIDS claims payments for group life and health claims is not surprising, given the surge in AIDS-related deaths and cases diagnosed in 1986 and 1987.

For example, in 1986, some 13,055 persons were diagnosed with AIDS, while 8,161 died from AIDS-related complications, according to the Centers for Disease Control in Atlanta.

In 1987, 20,740 individuals were diagnosed with AIDS, while 11,608 persons died from the disease.

As of Feb. 20, the cumulative total of AIDS-diagnosed cases was 87,188 with 49,976 deaths.

And, those numbers are expected to rise sharply in the years ahead. The CDC projects that by the end of 1992, some 365,000 AIDS cases will have been diagnosed while 263,000

**As of Feb. 20, the cumulative total of AIDS-diagnosed cases was 87,188, with 49,976 deaths linked to the disease.**

persons will have died from the disease.

While group health and life insurance payments related to AIDS have risen sharply, those payments comprise a small, but growing percentage of total claims payments.

For example, group life insurance claims related to AIDS equaled 1.4% of total life claims for insurers responding to the 1987 ACLI-HIAA survey, up from 0.9% in 1986.

In addition, group accident and health claims related to AIDS equaled 0.6% of total accident and health claims of responding insurers in 1987, up from 0.3% in 1986.

"No one is forecasting that AIDS ever will be a huge percentage of the nation's health care bill," said the HIAA's Mr. Eby.

"The costs have been manageable so far as we learn how to address the medical needs of AIDS patients through careful case management," said Suzanne Mulstein, director of policy development with Blue Cross/Blue Shield Assn. in Chicago.

Indeed, the cost of medical care for individual AIDS cases has decreased sharply.

For example, the average health care costs of patients diagnosed with AIDS in 1986 was \$67,279, down from \$87,636 in 1984, according to statistics compiled by Independence Blue Cross and Pennsylvania Blue Shield.

A major reason for that sharp decrease in the cost of medical treatment was a drop in hospitalization for AIDS patients in favor of less costly but equally high quality forms of treatment, said Richard Briggs, director of information services at Independence Blue Cross in Philadelphia.

For example, AIDS patients diagnosed in 1984 were hospitalized an average of 50.1 days, while those diagnosed with AIDS in 1986 were hospitalized an average of 43.1 days, according to Independence Blue Cross and Pennsylvania Blue Shield.

Aside from more deaths and more cases, it also is possible that AIDS-related health and life insurance payments climbed steeply between 1986 and 1987 because of growing sophistication in properly coding AIDS claims.

"The carriers are improving the coding and identification of AIDS claims," said Glenn Meister, a managing consultant in the

Los Angeles office of benefit consultant A. Foster Higgins & Co. Inc.

Still, the ACLI-HIAA notes that its surveys may significantly understate the number and amount of AIDS-related life and health insurance claims.

For example, some diagnoses may be intentionally misstated, while the cause of death may not be precisely stated, the survey said.

While AIDS payments are increasing, not all group health and life insurers are being hit with AIDS claims.

For example, some 41 companies out of 128 respondents did not report any AIDS-related group accident and health claims in 1987, while 67 insurers out of 161 respondents did not report any group life insurance claims related to AIDS.

Other findings of the ACLI-HIAA include:

- Surveyed insurers reported \$109.8 million in AIDS-related group accident and health insurance claims in 1987, up 255% from \$30.9 million reported by insurers surveyed in 1986.

- Surveyed insurers reported \$77.4 million in AIDS-related group life insurance payments in 1987, up 73.1% from \$44.7 million in 1986.

Meanwhile, another newly published study indicates big future increases in the costs of medical treatment for AIDS patients.

Fred Hellinger, an economist at the National Center for Health Services Research and Health Care Technology Assessment in Rockville, Md., estimates that the lifetime medical costs of treating individuals diagnosed with AIDS in 1992 will be \$7.5 billion.

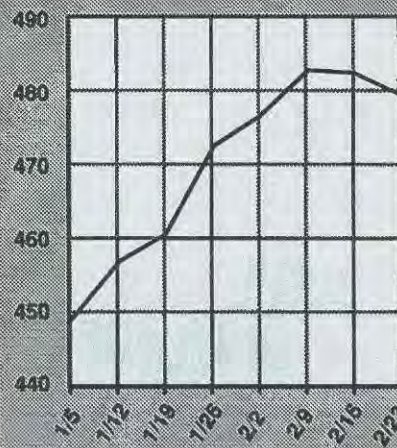
By contrast, Mr. Hellinger estimates cumulative medical treatment costs of the estimated 54,000 AIDS cases that will be diagnosed this year at \$3.5 billion.

This increase is largely due to the rise in newly diagnosed cases—Mr. Hellinger projects 114,000 cases will be diagnosed in 1992 compared with 54,000 in 1989—rather than the cost of treating individual cases, which should remain steady at about \$60,000 (as expressed in 1988 dollars).

Mr. Hellinger's article was published in the winter issue of "Inquiry," a quarterly magazine published by Blue Cross & Blue Shield Assn.

Free single copies of the 1987 "ACLI/HIAA AIDS-related Claims Survey" are available from either Debbie Randolph Chase, American Council of Life Insurance, 1001 Pennsylvania Ave. N.W., Washington, D.C. 20004; 202-624-2414; or Judy Finney, Health Insurance Assn. of America, 1025 Connecticut Ave. N.W., 20036; 202-223-7786.

# BI Insurance Index



Insurance industry stocks continued to slide last week, as the *Business Insurance Index* dropped 2.4 points to 480.3 on Feb. 23, from 482.7 on Feb. 16. Advancing issues were led by Belvedere Corp., up 10.2%; Frontier Insurance Group, up 8%; and U.S. Healthcare, up 6.6%. Decliners followed Western Health Plans Inc., down 11.1%; Maxicare Health Plans, down 8.7%; and United Medical Corp., down 7.7%. The most active issue during the period was Sears, Roebuck & Co. (Allstate) with 2.1 million shares traded. The *Business Insurance Index* fell a slight 0.5% for the period; the New York Stock Exchange Composite fell 0.9%; the Dow Jones 30 Industrials lost 1%; and the Standard & Poor's 500 fell 1.3%.

# British Issues

Feb. 23 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High-Low pence
Comm Union	389	12.5	25.3	6.5	391-388
Genl Accident	940	9.3	58.0	6.2	985-935
Gdn Royal Exch	208	11.2	13.1	6.3	217-208
Royal	422	13.8	30.0	7.1	433-420
Sun Alliance	1091	8.3	54.7	5.0	1095-1089

Brokers	Price pence	P/E	Div. pence	Yield %	1 Week High-Low pence
Bradstock	234	13.2	9.0	3.8	234-230
CE Heath	465	14.8	34.5	7.4	472-465
Hogg Robinson	150	13.9	8.0	5.3	157-150
Lloyd Thompson	209	16.5	8.0	3.8	209-207
PWS Holdings	108	15.4	4.6	4.8	110-108
Sedgwick Grp	259	21.6	16.0	6.2	261-257
Steel Brl Jones	238	21.3	13.3	5.6	238-234
Willis Faber	245	16.7	15.3	6.3	248-245

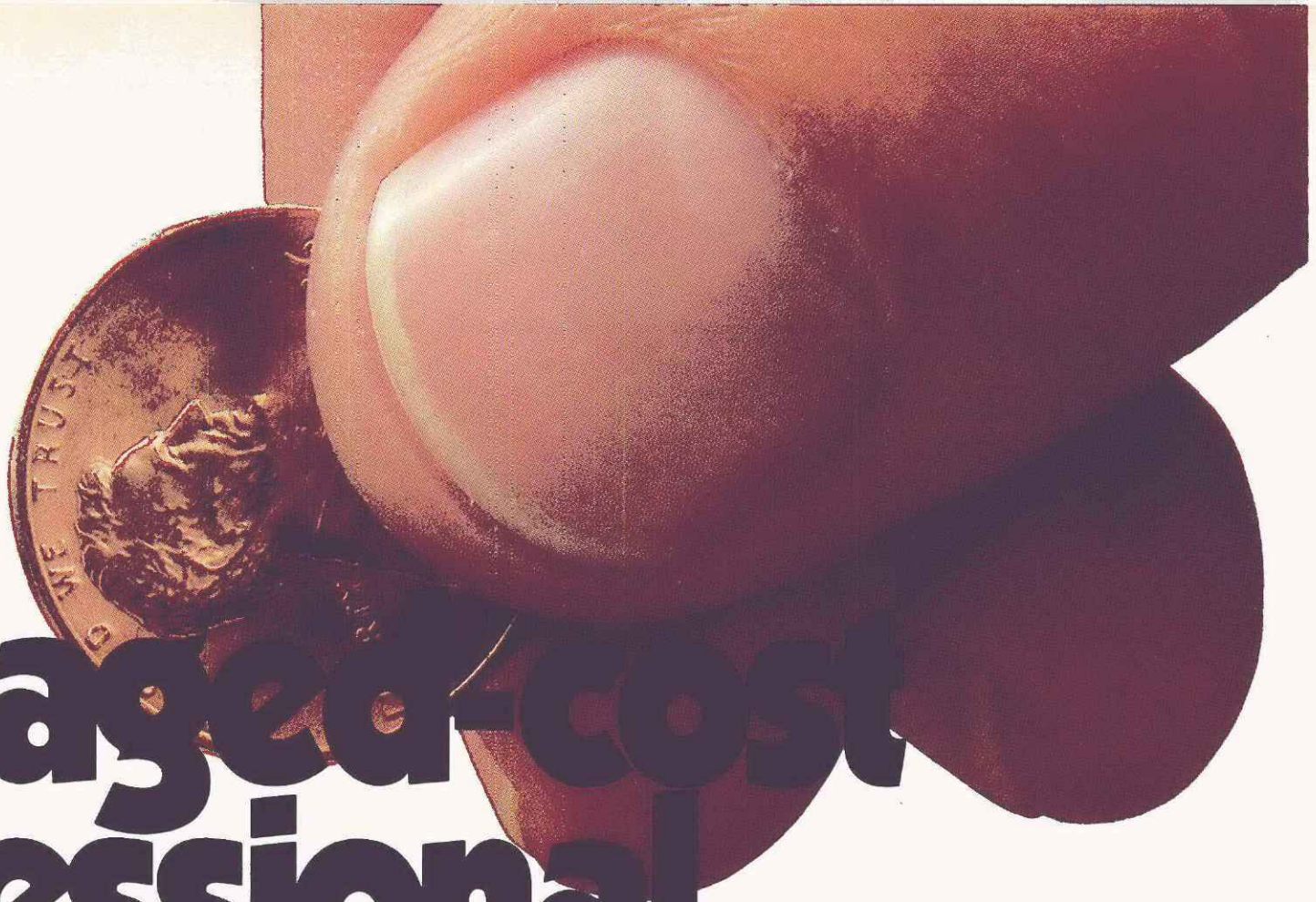
Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

# BI Industry Stock Report

FEBRUARY 23, 1989

2/17/89 THRU 2/23/89

	Weekly Price	% change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Weekly Price	% change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
				High	Low										High	Low							
<b>BROKERS</b>																							
Alexander & Alexander Svcs	23.63	0.6	0.6	28.13	17.75	274	1.00	4.2	15.1	3.71	6.37	Kemper Corp.	30.25	0.0	26.0	0.00	0.00	262	0.84	2.8	8.6	28.91	1.05
Corroon & Black Corp.	32.75	-0.8	5.2	34.75	28.00	180	1.08	3.3	4.9	12.40	2.64	Lawrence Ins. Group	7.88	3.3	0.0	11.63	4.50	3	0.24	3.0	17.5	2.90	2.72
Gallagher Arthur J. & Co.	18.25	0.7	9.0	19.13	13.88	38	0.48	2.6	12.9	5.46	3.34	Liberty Corp. S.C.	36.13	-1.0	0.4	47.25	33.88	11	0.80	2.2	14.2	20.76	1.74
Hall Frank B. & Co.	2.88	0.0	0.0	5.50	2.50	44	0.00	0.0	-1.7	0.00	N/A	Lincoln Nat'l Corp.	49.75	0.0	13.1	53.50	40.25	92	2.48	5.0	12.7	37.11	1.34
Hib. Rogal & Hamilton	15.00	0.0	-1.6	0.00	0.00	9	0.00	0.0	13.0	4.60	3.26	NAC Re Corp.	34.50	-3.5	8.7	35.75	18.50	68	0.00	0.0	13.7	22.06	1.56
Marsh & McLennan Cos. Inc.	58.25	-1.9	3.6	60.00	45.25	222	2.50	4.3	14.2	6.48	8.99	Navigator's Group	21.25	-2.3	6.3	22.00	14.50	3	0.00	0.0	10.3	12.88	1.65
Poe & Assoc. Inc.	8.25	0.0	0.0	9.25	6.75	13	0.40	4.8	9.3	0.27	30.56	Nobel Ins. Ltd.	4.50	-2.8	-5.3	9.50	3.75	117	0.02	9.3	-17.3	7.76	0.58
BROKERS AVERAGE	-0.2	2.4						2.7	9.6			Northwestern Nat'l Life	29.13	2.2	-6.4	0.00	0.00	246	1.12	3.8	7.3	35.05	0.83
<b>CONGLOMERATES &amp; HOLDING COMPANIES</b>																							
Berkley W.R. Corp.	31.50	-2.3	6.8	0.00	0.00	119	0.36	1.1	6.8	17.63	1.79	Ohio Cas. Corp.	39.75	-2.5	11.2	45.25	32.25	74	2.08	5.2	6.1	31.53	1.26
Berkshire Hathaway Inc. DEL	4825.00	-0.5	38.2	5050.00	4625.00	30	0.00	0.0	19.4	2492.68	1.94	Old Rep Int'l Corp.	26.63	-0.9	11.0	28.88	19.13	142	0.74	2.8	13.3	27.82	0.96
ITT (Hartford Group)	53.00	-1.4	5.7	55.75	43.25	1021	1.48	2.8	8.8	52.23	1.01	Orion Cap. Corp.	19.38	-1.9	26.0	20.88	13.13	27	0.76	3.9	6.6	9.34	2.07
Sears Roebuck & Co. (Allstate)	41.13	-2.9	0.6	46.13	32.25	2101	2.00	4.9	17.1	34.74	1.18	Phoenix Re Corp.	10.00	-2.4	5.3	0.00	0.00	59	0.00	0.0	5.2	12.49	0.80
CONGLOMERATES AVERAGE	-1.8	12.8						2.2	13.0			Protective Life Corp.	13.50	-3.6	1.9	15.13	12.25	103	0.70	5.2	16.5	17.25	0.78
<b>INSURERS/REINSURERS</b>																							
Aetna Life & Cas Co.	50.13	-0.7	6.1	52.50	39.50	580	2.76	5.5	8.6	53.56	0.94	Re Capital Corp.	9.75	3.9	6.8	11.75	7.88	59	0.00	0.0	21.7	11.93	0.82
American General Corp.	33.50	0.4	12.1	36.38	27.50	819	1.50	4.5	9.7	28.04	1.19	Provident Life & Acc Ins Co.	21.75	-2.8	13.0	25.00	15.63	370	0.68	3.1	11.9	21.96	0.99
Amer Heritage Life Inv	25.75	0.0	0.0	27.00	24.00	1	1.08	4.2	10.7	22.47	1.15	St. Paul Cos. Inc.	47.63	1.1	9.5	51.00	38.25	1267	2.20	4.6	6.6	30.64	1.55
Amer Indty Fin'l Corp.	10.25	2.5	-2.4	12.00	8.25	1	0.56	5.5	6.7	17.06	0.60	SAFECO Corp.	27.13	2.4	14.8	30.00	22.75	463	1.08	4.0	7.6	23.94	1.13
American Int'l Group	71.38	-2.1	5.4	74.63	49.00	783	0.40	0.6	10.5	33.55	2.13	SCOR US Corp.	8.13	-5.8	-11.0	9.50	6.63	40	0.20	2.5	5.8	9.38	0.87
Aon Corp.	28.88	-1.3	3.1	29.25	21.88	100	1.28	4.4	9.1	15.13	1.91	Selbels Bruce Group Inc.	11.75	0.0	3.3	14.25	11.00	51	0.80	6.8	7.5	13.42	0.88
Argonaut Group	53.25	1.4	21.7	0.00	0.00	122	0.00	0.0	7.9	34.94	1.52	Selective Ins Group Inc.	22.75	2.2	-1.1	26.50	19.25	146	1.24	5.5	5.1	22.33	1.02
AVEMCO Corp	25.13	-0.5	-2.9	28.75	17.88	19	0.40	1.6	12.3	9.20	2.73	Stalesman Group Inc.	3.31	-3.8	5.8	2.75	1.38	31	0.05	1.5	331.0	3.48	0.95
Baldwin & Lyons Inc.	15.63	0.0	5.0	16.38	12.13	5	0.20	1.3	6.5	17.57	0.89	Takia Marine & Fire Ins	94.75	3.6	3.7	98.00	63.25	15	0.22	0.2	57.4	0.00	N/A
Belvedere Corp.	5.38	10.2	19.6	6.00	4.00	5	0.04	0.7	7.8	8.43	0.64	Torchmark Corp.	32.00	-1.5	4.9	33.50	24.50	65	1.20	3.8	10.4	12.24	2.61
Chandler Insurance	9.75	1.2	5.4	0.00	0.00	40	0.00	0.0	4.7	6.65	1.47	Transamerica Corp.	33.63	-2.2	-0.7	36.75	29.75	309	1.88	5.6	7.9	27.36	1.23
Chubb Corp.	64.13	-2.1	10.6	66.38	51.25	404	2.16	3.4	7.2	46.13	1.39	Travelers Corp.	37.88	-1.6	9.0	40.00	33.00	463	2.40	6.3	9.1	45.28	0.84
CIGNA Corp.	53.38	-1.6	13.3	55.38	42.75	477	2.96	5.5	9.4	51.37	1.04	Trenwick Group Inc.	14.50	0.0	0.0	15.25	9.75	4	0.24	1.7	9.0	16.91	0.86
CNA Fin'l Corp.	59.50	-0.8	-1.7	66.13	51.00	232	0.00	0.0	9.4	46.40	1.28	United Fire & Cas Co.	30.00	-2.4	-1.6	0.00	0.00	3	1.07	3.6	5.0	22.56	1.33
Continental Corp.	33.88	0.0	4.6	41.63	31.50	450	2.60	7.7	16.2	42.10	0.80	United States Fid & Gly	31.38	-1.6	10.1	34.38	28.50	984	2.64	8.4	8.8	22.15	1.42
Durham Corp.	31.75	-0.8	-3.8	36.75	21.50	21	0.92	2.9	33.														

A close-up photograph of a hand pinching a coin between the thumb and index finger. The coin is a US dime, with the words 'ONE DIME' and 'LIBERTY' visible. The background is a soft, out-of-focus light color.

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