FEBRUARY 6, 1989

Business Insurance®

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Update

Jury says Continental Airlines not negligent in 1987 crash

DENVER—Plaintiffs' attorneys say they may appeal a federal jury's ruling that Continental Airlines did not act with malice or gross negligence in a November 1987 jetliner crash at Denver's Stapleton International Airport.

The U.S. District Court jury last week awarded $800,000 in compensatory damages—but no punitive damages—to Karen Johnson, a survivor of the crash, and her husband.

The Johnson case was tried as an "ex-

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Runaway costs

Health plan expenses leap 18.6% in '88

By DONNA DiBLASE

Group health care plan costs in 1988 rose more than twice as quickly as in 1987, despite widespread use of cost containment and managed care tools.

Total per-employee health care plan costs—including medical, dental and vision care expenses—averaged $2,354 in 1988, an 18.6% increase over an average of $1,985 in 1987, according to the "Health Benefits Survey: 1988," conducted by A. Foster Higgins & Co. Inc.

By comparison, these costs rose only 7.9% in 1987 and 7.7% in 1986, according to Foster Higgins.

Health care plan costs—which the survey defines as both employer and employee contributions—skyrocketed last year even though most of the 1,633 employers surveyed have adopted some type of utilization review and offered managed care programs like health maintenance organizations or preferred provider programs.

"We saw these kinds of double-digit health care cost increases in the early 1980s and that forced us to implement or invent cost management strategies to address the particular problems of the time," said John C. Erb, a managing consultant in Foster Higgins' Princeton, N.J., office.

"By the mid-1980s, it appeared that those strategies were effective, when increases were only 7% or 8%. So, today's increases signal to me that we're going to have to invent some new strategies that apply to a different set of circumstances," he explained.

If health care inflation in 1988 was not bad enough, the survey suggests that the problem could become worse before it becomes better for employers with insured plans.

Employers that purchased health care coverage from commercial underwriters reported an average cost increase of only 13.7% last year, while self-funded employers averaged a 24.8% increase. This suggests that actual health care costs—as reflected by the self-funded plans—were much higher last year than insurers projected when they calculated premiums. Thus, insurers likely will increase premiums in 1989 to make up for losses in 1988.

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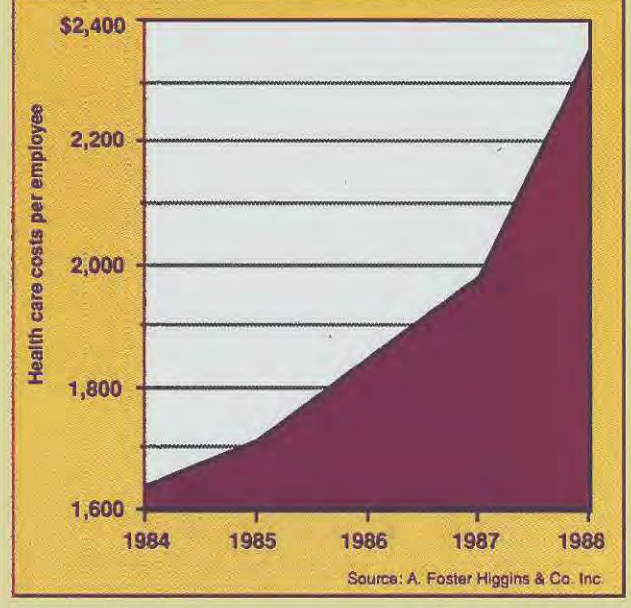
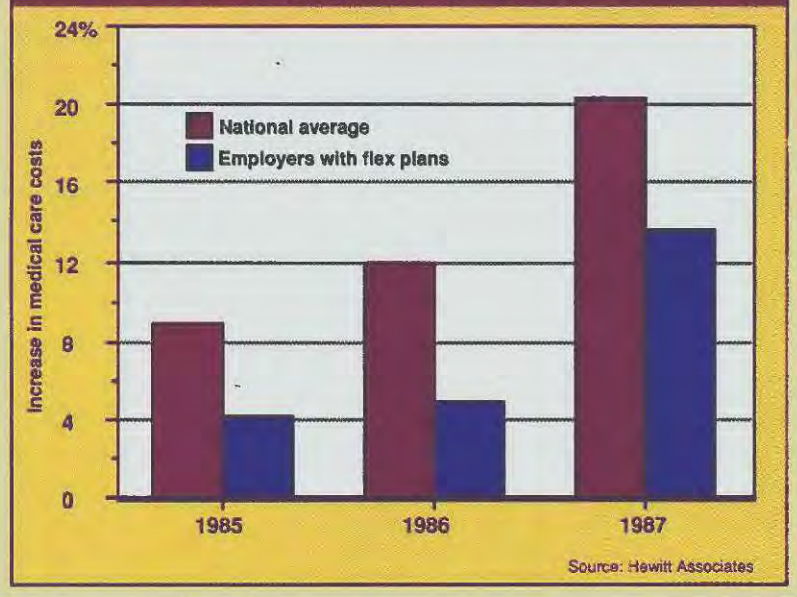
Employers' health care costs skyrocket . . .



Source: A. Foster Higgins & Co. Inc.

Increases smaller for flex plans: Study

. . . But flex plans provide some relief



Source: Hewitt Associates

By JERRY GEISEL

Medical care indemnity plan costs are rising more slowly for employers with flexible benefit plans than for employers that do not sponsor flex plans, according to a new survey.

Employer indemnity plan costs climbed 22.7% between 1985 and 1987 among 249 companies that give employees the opportunity to choose between different medical care options in their flexible benefit programs, according to the survey by Hewitt Associates, a Lincolnshire, Ill.-based benefit consulting firm.

By contrast, medical care indemnity plan costs increased 41.1% during the same three-year period for some 10,000 employers without flex plans, according to data provided by three insurers.

A major reason for the slower increase in medical care costs for employers with flexible benefit programs is that these firms allow employees to choose plans that require higher deductibles, coin-

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Tort reform outlook bright in eight states, ATRA finds
Page 3

Commutation plan may speed Constellation Re liquidation
Page 3

Court allows state safety prosecutions

By MARK A. HOFMANN

CHICAGO—Federal safety regulations do not pre-empt state criminal prosecution of businesses and their officers for allegedly exposing employees to unsafe workplace conditions, the Illinois Supreme Court ruled last week.

However, both business representatives—who criticized the ruling—and state prosecutors and safety advocates—who cheered the decision—say they hope the case will be reviewed by the U.S. Supreme Court to settle the controversy once and for all.

Attorneys for the defendant—Chicago Magnet Wire Corp. of Elk Grove Village, Ill., and its parent, North American Philips Co. of New York, could not be reached for comment. However, news reports said the companies indicated they would ask the U.S. Supreme Court to review the ruling.

"We think it is a very unfortunate decision. We're hopeful that the case will be appealed to the Supreme Court," said Art Gottschalk, president of the Chicago-based Illinois Manufacturers Assn., which supported the defendants' position that the federal Occupational Safety and Health Act of 1970 precluded state prosecution for workplace safety offenses.

"I would like to see the U.S. Supreme Court decide the matter so the question is cleared once and for all," concurred E. Michael McCann, district attorney for Milwaukee County, Wis. Mr. McCann had filed a brief supporting Cook County, Ill., State's Attorney Richard M. Daley's contention in the Magnet Wire case that state criminal charges were justified in workplace safety cases.

Mr. McCann, whose office currently is conducting investigations into workplace safety hazards, said a timely U.S. Supreme Court decision on the pre-emption question would

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Recovery limited in insolvencies

By STACY ADLER

CHICAGO—A policyholder unable to recover claims against an insolvent first-layer excess insurer cannot force its second-layer insurer to drop down and pay claims within the first layer, a federal judge has ruled.

As a result, New York-based Hudson Insurance Co., a unit of Skandia America Corp., does not have to drop down and provide coverage to a Michigan policyholder that cannot recover claims against now-insolvent Mission National Insurance Co.

Judge Brian Barnett Duff of U.S. District Court for the Northern District of Illinois ruled Jan. 20 that the risk of an underlying insurer's insolvency is borne by the policyholder, Gelman Sciences Inc. of Ann Arbor, Mich., not by insurers that write excess of the insolvent insurer.

Furthermore, Judge Duff said there is no presumption under Illinois law that an excess insurer should drop down when a policyholder cannot recover claims against an insolvent underlying insurer.

As a result of the ruling, Gelman Sciences cannot tap $4 million of second-layer excess coverage Hudson wrote above a $20 million excess policy written by Mission National, a unit of Mission Insurance Group Inc. The California Insurance Department declared Mission National insolvent by $56 million in 1987, when it also declared parent company Mission Insurance Co. and three other MIC subsidiaries insolvent (*BI*, Feb. 9, 1987).

For the period beginning Aug. 1, 1984, and ending Aug. 1,

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NEWSPAPER

Update

Crash ruling may be appealed

Continued from previous page

emplar" case to determine damage awards in remaining cases related to the 1987 crash, which killed 28 people and injured 54 others (*BI*, Sept. 19, 1988; Nov. 23, 1987).

Victoria Swanson, a partner with Schaden, Heldman & Lampert in Denver, which represents the Johnsons, said her firm has filed a position paper with U.S. District Judge Sherman G. Finesilver requesting that "inconsistencies" in the verdict be reconciled. While the jury did not say Continental was negligent, it did cite the airline for reckless misconduct, she noted.

If the judge agrees this finding is inconsistent, the plaintiffs will ask that a second phase of the trial be held to determine punitive damages, she said. Ms. Swanson said that if the verdict stands, her firm would appeal.

In a statement released after the court's decision, Continental said it has reached out-of-court settlements in 36 cases related to the crash for a total of more than $20 million.

Airline officials could not be reached for comment.

Brokers and consultants have estimated the crash could cost insurers as much as $50 million in liability claims. At the time of the crash, Texas Air—Continental's parent company—had up to $600 million of liability insurance placed in the U.S., London and French insurance markets.

Acquittals in benefit fraud case

CHICAGO—A federal jury acquitted a union official and two insurance brokers of charges that they conspired to defraud a union welfare benefit plan.

William J. Wire, a former administrator for the Service Employees International Union Local 1 Pension Fund, had been charged with taking a kickback to steer the union's life insurance business to North American Life & Casualty Co. of Minneapolis (*BI*, Oct. 3, 1988). Angelo T. Commito and Carl A. Mattison were accused of conspiring to arrange the kickback and to conceal their commissions from union trustees.

Mr. Commito, identified as an organized crime associate in a 1981 Pennsylvania Crime Commission Report, was a top officer of several Chicago brokerage and consulting firms, including: AnCom Group Services Inc. and Diversified Benefit Systems Inc., successor to AnCom; Labor Health Plans Inc.; and Special Vision Services Inc. Mr. Mattison is president of J.D King Corp., a Monterey, Calif., insurance brokerage.

A federal jury acquitted all three men Jan. 27 after two days of deliberations.

Mr. Commito, meanwhile, is awaiting trial on additional benefit fraud indictments in Baltimore, Atlanta, San Francisco and San Diego. Mr. Mattison awaits trial in Atlanta and San Francisco.

Separately, another Chicago-area union official has pleaded guilty and awaits sentencing on embezzlement and perjury charges contained in another benefit fraud indictment. William Hainsworth, 45, a former administrator of the Welfare Fund of Local 803 of the DuPage County Cement Masons, was accused of forging the signatures of welfare fund trustees on checks payable to a dental service provider run by Mr. Commito.

Handgun liability bill eyed

WASHINGTON—Manufacturers, importers and dealers of handguns would be held liable for damages caused by handguns under a bill being considered by the Council of the District of Columbia.

If enacted, the law would be the first in the nation to allow an individual injured by a handgun to recover damages from the gun's manufacturer, importer or dealer without having to demonstrate negligence or a defect in the firearm. Courts applying the district's laws currently do not recognize these rights to recovery.

The law would "put insurers in a very difficult position" because it would "essentially require insurers to underwrite the activities of criminals," said a spokeswoman for the American Insurance Assn.

The bill would not apply in cases when handguns are used by law enforcement officers, and it bars recovery of damages by anyone injured by a handgun while committing a felony.

The legislation was co-sponsored by 12 of the council's 13 members and is part of the district's efforts to combat the rising number of homicides, which reached a record 372 in 1988.

Intermediaries pare staff size

NEW YORK—Several reinsurance brokers are realigning operations and cutting staff, most citing shrinking demand for reinsurance and falling reinsurance prices.

Sullivan Payne Co. is merging its New York and Los Angeles domestic treaty operations into its Philadelphia and Seattle offices, respectively. The moves will result in some staff cuts, while operational changes in Seattle will result in 40 added layoffs, mainly among support workers, said Chief Operating Officer Lewis Hale.

The New York office will continue to handle London market excess, marine, international and facultative placements; the Los Angeles office will continue to do facultative business, Mr. Hale said.

But, he called the changes a "repositioning of assets" rather than cost-cutting moves, noting that a new Chicago office is planned.

Cole, Booth, Potter Inc., an Aon Corp. unit that is being merged into Aon Reinsurance Agency Inc., laid off 40 people in its Old Bridge, N.J., office last month, confirmed Aon Re President Paul R. Davies. Twenty-five more brokerage employees are being moved

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Errors & omissions

Information on Corroon & Black Management Corp., a property/casualty third-party claims administrator, was omitted from the directory that appeared in the Jan. 30 issue of *Business Insurance.* That company's listing appears on page 33 of this issue.

Health care panel's plan includes employer taxes

By JERRY GEISEL

WASHINGTON—A blue-ribbon panel's recommendation to create a universal health care program—partly financed with whopping new taxes on employers without health care plans—is drawing fire from corporate and insurer panel members.

The National Leadership Commission on Health Care released a report last week urging the creation of state-administered health care pools that would provide subsidized coverage to the uninsured.

These pools, which would provide comprehensive health care coverage, would be funded largely by payroll taxes on employers not providing group health care coverage to workers, according to the commission. The new taxes would be based on wages earned by both full-time and part-time workers.

The commission, formed in 1986 by a group of citizens concerned about improving access to health care, consists of 31 members, including nine physicians. Its honorary co-chairmen are former presidents Richard M. Nixon, Gerald Ford and Jimmy Carter.

However, panel member J. Bruce Johnston, executive vp-employee relations at USX Corp. in Pittsburgh, said USX could never support the proposals.

While the proposed pool system would increase access to health care, "the report contains no offsetting, concrete, identifiable, time-tested financial controls to keep aggregate medical cost from its currently reeling consumption of more and more of our gross national product," Mr. Johnston said.

Employers "would now have to carry in their product prices the cost of expanded medical benefits for everyone imaginable—all this while manufacturers fight for competitive survival in world markets," Mr. Johnston said in his written dissent.

Rather than being based on facts or scientific evaluation, "the recommendations are characterized by partial analysis, wishful thinking and bureaucratic tendencies," charged panel member Harry Garber, vice chairman of The Equitable Life Assurance Society of the United States in New York.

Mr. Garber said the recommendations also fail to address who would set the new tax rates for the proposed system, how the taxes would be collected and how the money would be distributed to the states and health care providers.

In its report, the commission said the new taxes would encourage employers to offer health care coverage.

"The plan proposed by the commission is designed to encourage everyone to have his or her own insurance coverage and to provide an incentive to employers to offer insurance coverage for a basic level of care," the report said.

"It is also designed to make the process fairer between employers, easing the burden on those companies who foot the health care bill," the report said.

While the commission did not recommend a specific payroll tax, it said the annual tax might be about 9% of the first $45,000 of each worker's salary.

The new payroll tax would be reduced by 60% for firms less than 1 year old. There would be a 40% reduction for firms up to 2 years old and a 20% reduction for firms up to 3 years old.

The tax for companies with fewer than six employees that do not provide health insurance would be capped at a level 20% lower than that for other employers.

Employers providing a "national basic package of (health care) services" would be exempt from the payroll tax.

The commission did not define what the basic em-

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Directory to list UR firms

The deadline for returning completed questionnaires for the *Business Insurance* directory of utilization review providers is Feb. 10. A spotlight report on benefit cost control also will be featured in the Feb. 20 issue.

The directory is published as an editorial service; there is no charge for companies to be listed. However, to be included, companies must fill out and return a questionnaire provided by *BI.*

If your company provides utilization review services directly to employers and you have not yet received a questionnaire, please request one by calling Directory Editor Marilou Jones at 312-649-5279.

California regulator assails legislators

By DONNA DiBLASE

SACRAMENTO, Calif.—The California Insurance Department is "breaking new ground" in enforcing the state's insurance code and will not swallow legislators' grandstanding with charges of footdragging, says Insurance Commissioner Roxani Gillespie.

In fact, California legislators need only look in a mirror to find the cause of the turmoil in the state's property/casualty insurance market, Ms. Gillespie charged last week in fiery testimony before the state's Senate Insurance and Claims Committee.

The committee called the hearing to investigate what it says are departmental delays in enforcing Proposition 103. The controversial insurance law narrowly passed by voters last November, among other things, prohibits insurers from canceling or failing to renew auto insurance policies in most cases and rolls back most property/casualty insurance "charges" to 20% below November 1987 levels.

The state Supreme Court, which has stayed the insurance charge rollback provision, is considering the constitutionality of the law.

In answering the committee's charges of a lack of response from the department, Ms. Gillespie pointed to swift action the department took against Hartford, Conn.-based Travelers Corp.

The department issued a notice of non-compliance to the company on Dec. 23, 1988, because four of the insurer's subsidiaries canceled personal auto policies or notified policyholders in November that their coverage would not be renewed.

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Inside

- Employers should protest rules currently under consideration by the Internal Revenue Service that would complicate the administration of flexible spending accounts, says this week's editorial. **PAGE 8**
- Property/casualty insurers must do a better job of communicating, say panelists at a conference sponsored by the Atlanta Chapter of RIMS. **PAGE 15**
- The European Community's Single European Act will encourage the economies of scale that can be achieved through global insurance programs, says Jerome Karter in International Issues. **PAGE 21**
- In Ask a Benefit Actuary, William J. Miner of The Wyatt Co., notes that last year's technical corrections act has made changes that affect Section 89 non-discrimination testing rules. **PAGE 22**
- Quality health care is difficult to measure and often is unrelated to the cost of health care, experts say at a conference co-sponsored by the Washington Business Group on Health and the National Assn. of Manufacturers. **PAGE 23**
- Stock analyst Myron M. Picoult of Oppenheimer & Co. assesses the impact of tax payments on insurers' combined ratios. **PAGE 34**

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Tort reform

Outlook 'encouraging' in 8 states: ATRA

By DEBORAH SHALOWITZ

WASHINGTON—The outlook for significant tort reform during current legislative sessions is "very encouraging" in at least eight states, according to the executive director of the American Tort Reform Assn.

Most of the eight states are considering several types of tort reforms, including the abolition of joint and several liability, caps on punitive damages and non-economic damages, limits on attorneys' fees and specific product liability and medical malpractice reforms, according to ATRA Executive Director Blair Childs.

The eight states are Delaware, Indiana, Mississippi, New Hampshire, New York, Rhode Island, Texas and Wisconsin.

Altogether, 28 states are expected to address tort reform legislation this year, Mr. Childs said at a conference of tort reform experts last week in Washington sponsored by ATRA. However, "because we're starting a new legislative round, it's going to be in many states a two-year effort" to pass reforms, he said.

"The chances for success are greater because of the new legislators" elected by many of the states, he added.

Last year, 14 states passed tort reforms, of which three passed particularly significant reforms, according to Mr. Childs.

Other tort reform experts at the conference also were optimistic about tort reform activity at the state level this year.

"There is a renewed interest" in tort reform, declared Ralph Wayne, executive vp of the Texas Civil Justice League in Austin.

"There is public support" for tort reform, agreed P. Maurice Bishea, executive director of the Wisconsin Coalition for Civil Justice in Madison.

Meanwhile, six states that in the past several years enacted a variety of tort reforms are battling efforts to repeal those laws, Mr. Childs noted.

States in a "highly defensive mode" are Idaho, Ohio, Oregon, South Carolina, Virginia and Washington, he said.

Five of the eight states that are expected to reform tort laws this year have enacted tort reforms in recent years: Indiana, New Hampshire, New York, Rhode Island and Texas.

In addition, 16 states that passed some tort reforms in recent years are expected to address additional reforms or strengthen existing laws this year. Those states are Alaska, Arizona, California, Florida, Hawaii, Illinois, Iowa, Louisiana, Maryland, Michigan,

Continued on page 11

Expected tort reform activity in 1989-90

Source: American Tort Reform Assn.

College program targets minorities

By COLLIN NASH

NEW YORK—The College of Insurance is gearing up to offer a minority work-study program that will allow college students to earn academic credit while working at some of the nation's largest brokerage firms in New York.

Under a pilot honors student program scheduled for one semester this fall, six minority students will take TCI courses for academic credit that will be transferable to their schools while working for pay at the metropolitan offices of brokerages that sponsor the students.

Each second-semester junior or first-semester senior accepted for the program will attend a TCI course in risk management and work 20 hours per week for one of the sponsoring firms under a mentor.

TCI and the sponsors will screen program candidates based on their academic records and work ethic.

In addition to industry-related classroom work, the work-study students will have the opportunity to take courses "designed to emphasize the educational and cultural dimensions" of New York, pointed out TCI President Ellen Thrower.

Such courses include contemporary theater that will offer visits to dramatic productions and a liberal arts course.

In addition, candidates must participate in an independent research project to be selected and supervised by a TCI faculty member. Students would, for example, report on emerging trends in the liability insurance market or the likely impact of California's Proposition 103 on the property/casualty insurance market.

TCI so far has selected Spelman College in Atlanta, Le Moyne-Owen College in Memphis, Tenn., and the University of Georgia in Athens to nominate two candidates each for the college's pilot Minority Honors Program.

TCI is considering selecting one more college or university among the many interested in the program to nominate two more candidates for the pilot program, Ms. Thrower said.

Insurance industry sponsors will pay for the students' tuition, fees, books, room and board on TCI's Manhattan campus and transportation to and from New York.

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Reinsurers sue to void contracts

By CAROLYN ALDRED

LONDON—A dozen retrocessionaires—many now in liquidation around the world—are suing a Dutch reinsurer and a London broker for tens of millions of pounds, claiming that the business ceded to the retrocessionaires was misrepresented over more than six years.

In a London High Court room crowded with trial lawyers and tons of documents, retrocessionaires of Dutch reinsurer N.V. Rotterdamse Assurantiekas claim the underlying risks of policies ceded by the Rotterdam-based reinsurer were actually underwritten by London broker Hogg Robinson & Gardner Mountain (Reinsurance and Non-Marine) Ltd. and that information about the policies was misrepresented or not disclosed to them.

The retrocessionaires claim Hogg Robinson used RAK to front an arrangement that the broker managed in London. Hogg Robinson underwrote and administered the underlying business and RAK ceded almost 100% of the risks to the retrocessionaires from 1976 through part of 1982, the retrocessionaires claim.

Because neither RAK nor Hogg Robinson were licensed insurers in the United Kingdom, the contracts are illegal and therefore can be voided, the retrocessionaires claim.

In addition, the retrocessionaires say the defendants did not disclose or misrepresented how the risks were written and the claims history of the underlying risks.

The retrocessionaires also contend they were unaware that RAK was ceding almost 100% of those risks.

The retrocessionaires are suing RAK and Hogg Robinson for a declaration that the retrocessions are unenforceable and also are seeking the return of claims already paid.

The dispute is related to marine proportional reinsurance business with limits ranging from 6,500 pounds to 15,000 pounds ($11,420 and $26,355 at current exchange rates).

Although no amounts are specified in court papers, some lawyers estimate that the disputed claims could total between 30 million and 50 million pounds ($52.7 million and $87.8 million at current exchange rates), including interest.

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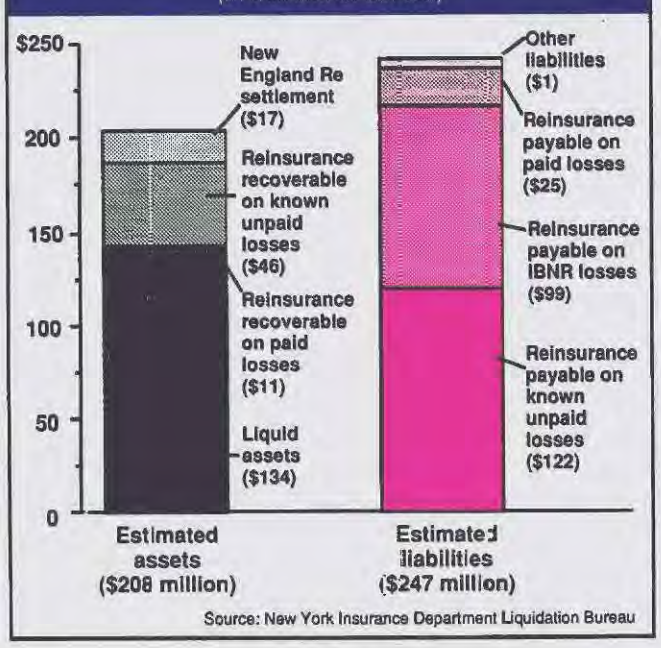
N.Y. regulators to try novel liquidation

Constellation Re's balance sheet
(In millions of dollars)



Source: New York Insurance Department Liquidation Bureau

By DOUGLAS McLEOD

NEW YORK—The New York Insurance Department hopes to speed the liquidation of the defunct Constellation Reinsurance Co. with a massive plan to commute all of Constellation's reinsurance contracts.

If the plan works, it may be applied to other similar U.S. reinsurer liquidations, observers say.

Under the two-stage plan, the department's Liquidation Bureau will first try to collect roughly $74 million in reinsurance balances owed to Constellation by commuting all of its hundreds of retrocessional contracts.

After marshaling the reinsurer's assets, the liquidator will begin making commutation payments to Constellation's hundreds of ceding insurer policyholders.

If the Liquidation Bureau's preliminary estimates of Constellation's assets and liabilities are correct, the reinsurer's creditors could end up collecting roughly 84 cents per dollar of losses under the plan.

Most of these creditors have written off balances collectible from Constellation since the reinsurer entered liquidation in February 1987.

The Constellation plan may mark the first time a state insurance department has attempted across-the-board commutations to dispose of all of the business of a U.S. reinsurer in liquidation, reinsurance sources agree.

The Liquidation Bureau has asked a New York State Supreme Court judge to approve the plan, and a hearing is scheduled for Feb. 16.

Meanwhile, the liquidator last month mailed descriptions of the plan to about 2,700 retrocessionaires, cedants and reinsurance brokers, according to Stephen Doody, executive assistant to the special deputy superintendent in charge of the Liquidation Bureau.

Initial responses from a handful of retrocessionaires have been favorable, and the Liquidation Bureau is waiting to hear from more, according to Mr. Doody, who added that so far no one has voiced objections to the plan.

Several reinsurance intermediaries contacted by *Business Insurance* also expressed approval of the plan's concept.

"We believe it's a sound plan and we are favorably disposed toward it," said Scott Goodell, general counsel for Seattle-based Sullivan Payne Co.

"From a philosophical standpoint, I think it's a good idea," added Paul Medza, senior vp with G.L. Hodson & Son Inc. of New Hyde Park, N.Y.

"One of the problems with these liquidations is that they tend to be very protracted and very costly," Mr. Medza said, explaining that a traditional liquidation can take several years during which administrative expenses eat up a large portion of the estate's assets.

"Commutations will result in more money going to reinsureds," he observed.

"The bottom line is: Take the money and run before the New York department spends it," noted one reinsurance broker who requested anonymity.

Constellation, formerly a unit of Santa Fe Southern Pacific

Continued on next page

Constellation Re

Continued from previous page

Corp., was at one point among the 20 largest U.S. reinsurers based on net premium volume, hitting a peak of $89.1 million in net premiums—all reinsurance—in 1984.

For 1985, however, Constellation reported a policyholder surplus deficit of $28.7 million, and the reinsurer was hit with a liquidation petition in June 1986 after talks between the New York department and Santa Fe Southern Pacific failed to resolve the deficit problem.

Several months of court delays followed before a state judge finally ordered Constellation into liquidation in February 1987.

New York department liquidators project they will be able to marshal a total of $208 million in assets under the commutation plan, according to an outline of the plan contained in an affidavit filed in state court last Dec. 27 by Andrew A. Alberti, the former New York special deputy superintendent who was in charge of the Liquidation Bureau.

Mr. Alberti, who headed the Liquidation Bureau during the time the Constellation plan was developed, resigned last month to pursue personal business interests.

Constellation's estimated assets include $134 million in liquid assets already held by the New York department and $74 million in reinsurance recoverables from Constellation's retrocessionaires.

Under the first stage of the plan, each retrocessionaire would immediately pay balances owed to Constellation on paid and known unpaid losses as of Dec. 31, 1986, after deducting any cash payments already made to Constellation and any premiums owed by Constellation to the retrocessionaire.

The proposal also would allow each retrocessionaire to offset credits and debits under various retrocessional contracts, a provision that grants the retrocessionaires more leeway than would normally be allowed in a traditional liquidation under New York law.

However, insurers that ceded business to Constellation as well as assuming reinsurance from it would not be allowed to offset amounts they owe Constellation on retrocessions against amounts they stand to collect from Constellation as creditors.

In addition, the Liquidation Bureau will waive recovery of incurred-but-not-reported losses from the retrocessionaires, a provision that Mr. Doody described as an incentive to the retrocessionaires to participate.

The total $74 million in estimated reinsurance recoverables from the retrocessionaires consists of:

- $11 million on paid losses as of Dec. 31, 1986, not including $1 million due from "problem companies."
- $46 million on known unpaid losses as of the same date, not including $4 million due from troubled reinsurers.
- $17 million from the settlement of two surplus relief treaties under which Constellation was reinsured by New England Reinsurance Corp., a Hartford Insurance Group unit. Funds from the settlement, which was reached last December, have not yet been paid to the liquidator, said Mr. Doody.

Money paid by the retrocessionaires will be placed in escrow until the liquidator determines that the total amount collected is sufficient to go ahead with the distributions to creditors, according to Mr. Alberti's affidavit.

If the amounts collected are deemed insufficient, the money in escrow will be returned with interest to the retrocessionaires, who will then remain liable for future Constellation claims.

However, New York department liquidators believe they will be able to collect enough to make the plan work, the affidavit says. Mr. Doody said the department will have to amass the full $208 million in assets to proceed with the plan.

Under the second stage of the plan, the liquidator will develop an estimate of the present value of the amount owed to each ceding insurer creditor as of Dec. 31, 1986.

The estimate will be based in part on reinsurance payable on paid losses plus the discounted value of Constellation's loss reserve liabilities as of year-end 1986.

The discounted loss reserve liabilities will include reinsurance payable on known unpaid losses as of year-end 1986 plus an estimate of IBNR losses based on industry development patterns and underwriting results by line of business.

If the liquidator amasses the $208 million in assets it projects and liabilities turn out to total $247 million as estimated, creditors—whose claims would be equally pro-rated based on available funds—could receive 84 cents on the dollar, Mr. Doody confirmed.

Constellation's largest creditors, according to its 1985 annual statement, include:

- Great American Insurance Co. of Cincinnati, by far the largest creditor with $22.8 million collectible on unpaid losses. Great American was also Constellation's largest retrocessionaire, with $23.6 million payable to Constellation on paid and unpaid losses.
- H.S. Weavers (Underwriting) Agencies Ltd., a Lloyd's of London underwriting agency, with $4.5 million collectible on unpaid losses.
- First State Insurance Co., another Hartford unit, with $3.9 million collectible on unpaid losses.

The Insurance Department has asked a New York State Supreme Court judge to approve the plan as proposed and specifically to approve the provisions of the first stage that would allow net offsetting and would waive the liquidator's right to recover IBNR losses from the retrocessionaires.

Under the plan, retrocessionaires would have 45 days after court approval to turn over commutation payments to the liquidator, which then hopes to distribute the funds to creditors within a few months.

If all goes smoothly, the New York department could complete Constellation's liquidation by the end of the year, Mr. Doody said.

Commutations are nothing new in reinsurance company liquidations, observers note.

For example, Illinois Insurance Department officials liquidating Pine Top Insurance Co. are selectively using commutations to settle contracts with troubled reinsurers, according to Joseph McCullough, a lawyer with Sidley & Austin in Chicago, representing the department (*BI*, March 21, 1988).

And a New York judge last year approved rehabilitation plans that commuted the business of three insolvent New York Insurance Exchange syndicates (*BI*, Aug. 29, 1988).

Meanwhile, liquidators of Bermuda-based Cambridge Reinsurance Ltd. are pursuing a plan to commute its contracts under provisions of Bermuda law (*BI*, March 16, 1987).

Nevertheless, the Constellation plan is believed by several reinsurance and regulatory sources to be the first to use mass commutations to liquidate a U.S. reinsurer.

If successful, such plans may be used more frequently by other state regulators facing similar liquidations, Mr. Doody said.

However, he added that successful commutation plans require a unique set of circumstances:

- The insolvent company must be a reinsurer rather than a direct insurer, meaning that the liquidator is dealing strictly with commercial policyholders without the involvement of state guaranty funds.
- The insolvent reinsurer must already have a relatively large volume of liquid assets.

"Constellation just happened to be less insolvent than others," Mr. Doody observed.

"It's a unique situation and we thought we had a great opportunity to do it." ■

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Opinions

Speak up to save FSAs

EMPLOYERS SHOULD immediately protest rules currently under consideration by the Internal Revenue Service that would unduly complicate the administration of flexible spending accounts.

As Senior Editor Jerry Geisel reported exclusively last week, the IRS is developing rules that would require employers to reimburse employees for claims against their FSAs, even if the employee has not yet accumulated sufficient funds in the FSA to cover the claim.

Currently, employers pay claims against FSAs only to the extent the employee has set aside funds.

The proposal being hammered out by the IRS is clearly another effort by the IRS to make FSAs too cumbersome for employers to offer. The IRS doesn't like the FSA concept, which permits employees to contribute a portion of their pretax salary to an FSA to pay for certain types of expenses, like uninsured health care expenditures and dependent care costs.

The IRS, searching for new revenues, obviously would like to see FSAs disappear so that employees won't be able to defer otherwise taxable income to these accounts.

If this proposal is adopted, it likely will accomplish the IRS' goal. Employers aren't going to want to pay out money on behalf of employees who have not contributed sufficient funds to their FSA since the will not want to take the risk that employees will incur big expenses against their FSAs and then quit without reimbursing the employer. As a result, employers likely will stop offering FSAs, but will not pay for the expenditures that employees could finance on a pretax basis through an FSA.

But, we believe the tax revenue to be gained by reducing the number of FSAs available to employees is not worth the broader public policy implications of this move.

Employers have successfully used FSAs to introduce larger deductibles under their group health plans

in an effort to control rising health care costs by making employees wiser and more careful consumers of health care, as shown in a new Hewitt Associates survey (see story, page 1). The survey found that health care cost increases were lower for employers with flexible benefit plans—which generally include an FSA feature—than for employers that did not have flexible benefit plans.

We urge all employers to write to the IRS objecting to the proposed rule.

Write to the Commissioner, Internal Revenue Service, 1111 Constitution Ave. N.W., Washington, D.C. 20224.

Send copies of your letters to your congressman and senators, too.

If you don't protest now, you can be sure the IRS will adopt the rule. ■

Letters

Punitive damages fail to meet goal

To the editor: William Shernoff's letter on punitive damages is incorrect in its conclusion (*BI*, Jan. 9). His letter indicates that punitive damages are needed to punish the intentional malefactor and to send a message to others that fraudulent or malicious conduct will not be tolerated. Punitive damages fail to do either.

The punitive sanction is of no value as punishment if it is uncollectible or if it is paid by a third party. Companies that are well-run are conscientious and will have assets. They will be more likely to make the effort to avoid injury to others. The outrageously negligent operator is unlikely to be a successful business entity. What sanction will the threat of punitive damages have on the operator without the assets to pay damages or the interest in acting in a responsible manner? As a threat, punitive damages only affect those who would be the most likely to try to operate safely and not those who operate in a careless manner.

Further, the tort system is slow and inconsistent in valuing damages. What use is there of either a punishment that cannot be enforced or a threat that is capricious in its enforcement? Other than another source of money for the injured, punitive damages have little useful value for society.

Robert L. Webster
San Francisco

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.

Consumers' desires clash with needs

To the editor: Your Jan. 23 editorial, "Insurers Accept Reality," raised some good points and, at the same time, contained some ominous foreshadowing.

While it is fair to say that the insurance industry has been a less-than-attentive listener to the hue and cry of its public, and that an awareness of and provision for the needs of consumers should be accomplished, a head-long stampede into the world of change and reform should not be undertaken without first counting the cost.

The facts are that new coverages are expensive to design and implement. Policies need to be printed. Employees need to be hired and trained. Legal requirements must be met. Agency forces need to be educated. A new product needs to be advertised. And, before the sun sets on any insurance industry change, the regulators need to be satisfied and a legal interpretation must be made of every term and condition of the new policy or coverage. The cost of this entire process will be immense, and the party who will pick up the check is the same body of consumers who cried for the change.

The whole scenario reminds me of the father who asked his child if he would like to design his own daily diet. The child responded affirmatively and proceeded to prescribe for himself a delectable array of junk food, sweets, sodas and ice cream—all the things he wanted. The rather obvious shortcoming of the arrangement is that what the child wanted —to be temporarily satisfied—and what the child needed—to grow strong and viable—were not the same. But the child was too young and unsophisticated to know this.

The truth that is illustrated by this analogy is that the consuming public will not help to shape a strong insurance industry by asking for new coverages and policies and, at the same time, mandating a rollback in premiums. Otherwise stated, that which the consuming public wants for itself may not be that which is in its own best interest.

In order to accomplish the task ahead of bringing the insurance industry and its consuming public into a united movement for the betterment of both, a lot of listening, planning, time and patience must be applied. And both sides need to count the cost.

Jerrold H. Paskins
President
Paskins, Ragnes & Associates
Minneapolis

Don't expect lawyers to be reasonable

To the editor: Your Jan. 16 editorial, "Lost Opportunity," expresses disappointment that the American Bar Assn. report on liability insurance was so "predictable." Something like 80% of the gross income of all of the lawyers in the United States comes from the tort/insurance system. Expecting lawyers to be reasonable and rational about the system is ludicrous. There certainly are problems with the insurance industry, but they are

Continued on page 10

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Letters

Continued from page 8
only half the magnitude of the problems with the legal industry.

While some more regulation of the insurance industry may be warranted, it is the legal business that needs thorough investigation and stringent regulation. There is far less reason to examine the finances of insurance companies than to examine the finances of the lawyers and law firms in the United States who are getting rich off death, disaster, disability, disease and destruction.

Repeal of the McCarran-Ferguson Act would be a great boon. It would be a boon to the legal profession and to no one else. On the other hand, applying the antitrust laws to the legal industry might be of substantial economic benefit to purchasers of insurance and to other consumers.

Eugene R. Anderson
Anderson Russell Kill & Olick
New York

Try alternatives to comp litigation

To the editor: Informal dispute resolution, as suggested by your Jan. 16 article, "Informal Dispute Resolution Popular Among Comp Officials," could be the "future" for resolving workers compensation disputes.

Other areas of the insurance industry, equally concerned over the delays and rising costs of litigation, have, over the past several years, opted for alternative dispute resolution programs to resolve their disputes. Close to 6,000 property and casualty claims were referred to one such program administered by the American Arbitration Assn. during 1988. The AAA's dispute resolution program has assisted many more thousands of parties to successfully resolve disputes through voluntary arbitration or mediation procedures since its inception in 1984. More than 150 insurers now participate in the program.

Currently, at least one major insurance company is considering the establishment of such a program to assist in resolving workers compensation disputes. The AAA strongly encourages other insurers to explore using alternative systems to resolve workers compensation claims.

Robert E. Meade
Vp-Program Development
American Arbitration Assn.
New York

Advertisement is off the mark

To the editor: There is plenty of upsetting news reported in the trade papers, and to make it worse, I had to review your Jan. 16 issue. Specifically, the PMA Group lightning ad, which is headed: "Zapping the client is a way of life at a lot of well-known insurance companies, but not with us."

I respect PMA's right to advertise any way it sees fit, but 42 years in the agency business tells me this is pure bunk. We all have differences with our companies, but I don't think "zapping the client" is prominently one of these differences.

On the contrary, with Proposition 103, banks in the business, recent lawyer attacks, new tax problems, declining loss ratios and punitive action of regulators, the only ones getting "zapped" are the companies and the balance of us are taking the fallout. This type of advertising will kill the industry faster than anything I know, because it emanates within the trade.

Charles Phelan
Charles P. Phelan Insurance Inc.
Silver Spring, Md.

PPO best route for employers

To the editor: The article by Paul Katz in the Dec. 19, 1988, issue concerning the need for preferred provider organizations to adjust to market realities implicitly recognizes one of the great advantages of the PPO form of organized health care: its inherent flexibility and its capacity to change to meet patient, buyer and market demands.

The success of health maintenance organizations can be attributed to lower costs, some of which have been achieved by rigid structuring and location of providers and facilities, a limited and inflexible range of services, and other administrative and professional strictures that ensure that the patient/consumer gets the type and amount of health care the HMO wants the patient to receive.

However, as many employers and benefit managers are learning, this may or may not coincide with the patient's personal needs or desires. As rising provider, technology and other costs drive up HMO premiums, their "rationing" of care through rigid structures and operations will make the HMO a less attractive option in the delivery of health care services.

At the other end of the spectrum, a PPO that offers an extensive network of providers and facilities, with a wide range of services at discounted fees, will not long remain competitive; excessive utilization will more than offset the premium cost reductions that can be achieved through discounted fees.

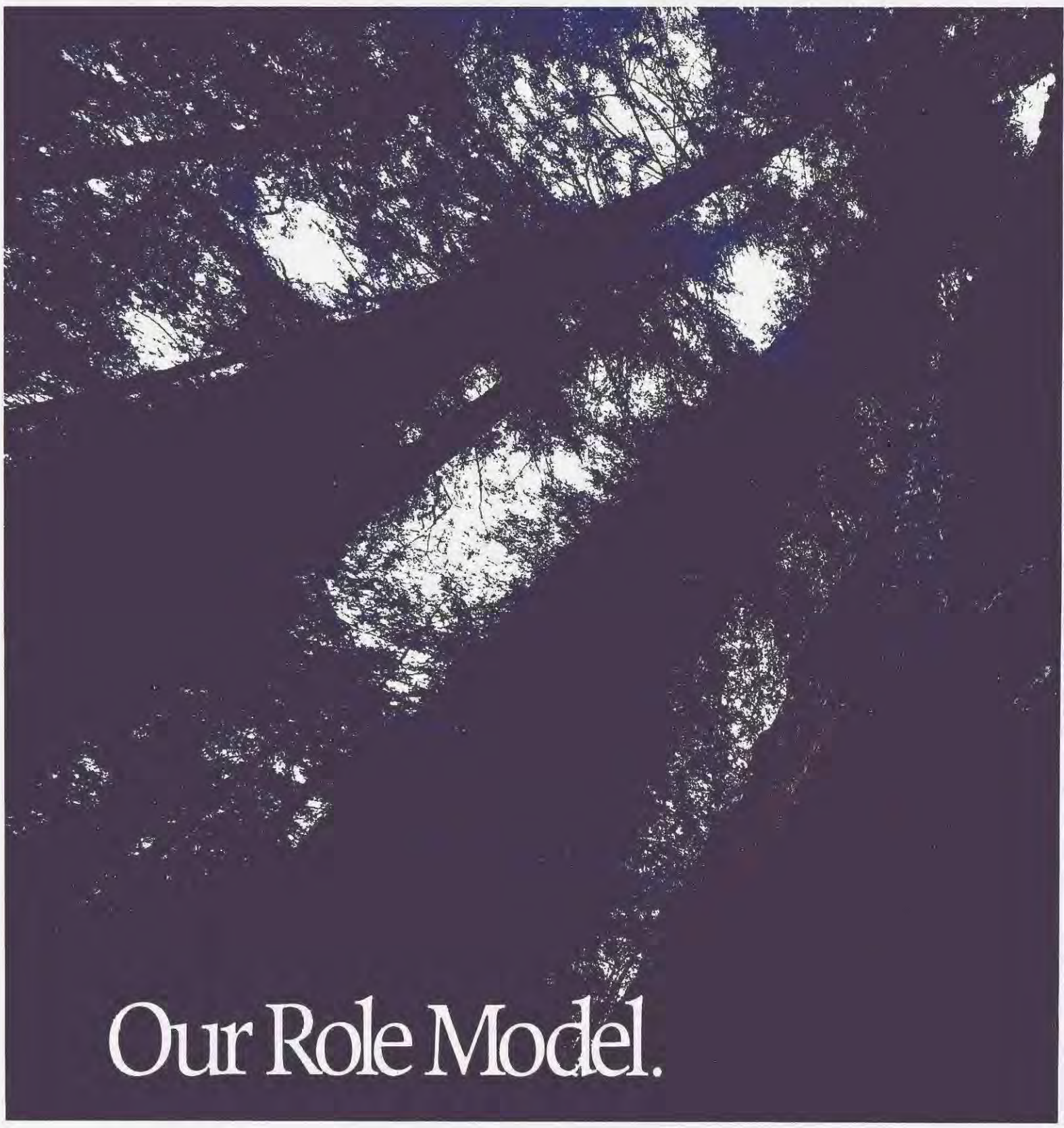
Nevertheless, the PPO remains the best basic organization to develop health care delivery systems that control costs while providing high quality services.

The flexibility of the PPO structure enables it to adapt to the legitimate needs of buyers and patients alike. The networks of providers and facilities can be altered with ease, both in size and in function; the development of an exclusive provider organization—EPO—blunts the incentive for providers to furnish excessive services by assuring a sufficient number of patients.

Advance planning of each patient's care—true case management—effectively contains the costs of care while assuring clinically sound treatment of the patient's injury or condition. Through careful planning and attention to operational details, the managed care that can be achieved through an EPO surpasses both the quality and the cost-effectiveness of care that can be obtained through other health care delivery systems.

The challenge to insurers and brokers, benefit managers and buyers, and others responsible for the provision of health care, is to recognize and take advantage of the flexibility of PPO/EPO services and adapt them to their specific needs. Our success in delivering a high quality ambulatory specialty service at a very reasonable cost has proven to us that the PPO and the EPO are best suited to meet the changing needs of the health care marketplace in the most competitive manner.

Harold Bradford
Director of Administrative Services
Chiropractic Health Plan of California
Concord, Calif.



Let's face it.

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At issue

What is your top risk management objective for 1989?

Barry Glaser
risk manager
Control Data Corp., Minneapolis

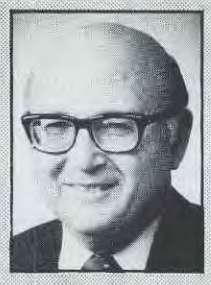
My No. 1 objective never changes: It is to minimize the cost of risk. Strategies vary over time, and this year, since I am relatively new to this firm, I am concentrating on identifying and evaluating risk and reviewing the effectiveness of administrative systems.

Christina D. Haley
director-risk/ insurance management
Levi Strauss & Co., San Francisco

My objective is to contain spiraling workers' compensation costs through heightened loss prevention and safety efforts, medical cost containment and legislative activities.

Ronald Stasch
corporate risk manager
Federal-Mogul Corp., Detroit

My personal concern is with the corporate takeovers and mergers affecting risk management jobs. I'm seeing a lot of talented people having to stop being creative and just deal with the brush fires. My main concern is to be more aware of macro issues over micro issues and to re-evaluate where I spend my time and how I perform my risk management functions.



Ralph Gentry
director-risk management
Times-Mirror Co., Los Angeles

My primary goal for 1989 is to become more knowledgeable about environmental factors involved in risk management. I don't believe the typical risk manager is prepared to handle these new risks.

Compiled by Christine Woolsey

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Tort reform

Continued from page 3

Montana, Nevada, New Jersey, Oklahoma, Utah and Virginia.

In addition, tort reform legislation will be considered by four states this year that have not passed any tort reforms in recent years: Arkansas, Maine, Pennsylvania and Tennessee.

Three of the states that are expected to enact significant tort reforms this year—Delaware, Wisconsin and Mississippi—have not reformed tort law in recent years.

The most common tort reforms that state legislatures are considering include:

- Amending or abolishing joint and several liability. Under this doctrine, also known as the "deep-pocket rule," one of several defendants may be required to pay as much as 100% of an award to a claimant—regardless of its degree of fault—if the other defendants are unable to contribute to the award.
- Limiting punitive damages or requiring that courts bifurcate liability litigation and consider awarding punitive damages in a separate trial only after defendant is found liable for actual damages. Some tort reform legislation also would allow only a judge—instead of a jury—to award punitive damages.

Product liability 'has become a very, very serious issue in Texas,' says Ralph Wayne.

- Limiting non-economic damages.
- Limiting awards in medical malpractice lawsuits.
- Abolishing the collateral source rule, under which a jury is not informed about sources of compensation—such as workers compensation—to which a plaintiff is entitled.
- Limiting attorneys' contingency fees—often to a sliding scale of fees based on the amount of damages recovered. For example, legislation in some states would limit attorneys' contingency fees to 33.3% of the first $150,000 recovered; 25% of the next $150,000 recovered; and 10% of any amounts recovered in excess of $300,000.
- Establishing fault-based principles of liability in product liability lawsuits. Legislation proposing product liability reform often establishes defenses manufacturers can use in a product liability lawsuit. Those defenses include that the product: was misused or altered; met state-of-the-art design standards at the time it was manufactured; or complied with government standards.
- Allowing damage awards to be paid to a plaintiff over a set period of time instead of in a lump sum.
- Shortening the period of time within which an injured party must file a legal action. Most tort reform legislation would establish that legal action would have to be filed within two years from the date of injury or discovery of injury.

Although current statutes of limitation run from one to six years, most already impose a two- or three-year limit.

The states that Mr. Childs believe most likely will reform tort law are expected to consider many of these reforms:

- Texas will address product liability reforms, joint and several liability, the collateral source rule and limits on attorneys' fees.

Mr. Wayne of the Texas Civil Justice League noted that "the products (liability) issue has be-

Continued on next page

Tort reform

Continued from previous page

come a very, very serious issue in Texas." He explained that "it's not just fairness and predictability—it's an economic issue."

For example, Mr. Wayne related that according to a study the Civil Justice League commissioned from an independent researcher, 3,200 of 12,000 manufacturers in Texas claimed they were considering shutting down or moving out of Texas because of the state's liability laws.

- Delaware will address joint and several liability, punitive damages, the collateral source rule and limiting attorneys' fees.
- Indiana will address punitive damages and product liability reform.
- Mississippi will address joint and several liability, punitive damages, non-economic damage caps, limiting attorneys' fees, product liability and medical malpractice reforms.
- New Hampshire will address joint and several liability and non-economic damages caps.
- New York will address product liability reforms.
- Rhode Island will address joint and several liability and the collateral source rule.
- Wisconsin will address joint and several liability, product liability and medical malpractice reforms.

Among the four states that have not reformed tort law in recent years, Arkansas will consider the collateral source rule; Maine will address joint and several liability and medical malpractice reform; and Pennsylvania will address product liability and medical malpractice. The reforms the Tennessee Legislature will be considering in its current session were not available.

Altogether, 28 states are expected to address tort reform this year, says ATRA's Mr. Childs. But, 'because we're starting a new legislative round, it's going to be in many states a two-year effort.'

Supporters of tort reform increasingly are using economic arguments to persuade legislators and the general public to support changes in tort law, Mr. Childs noted.

For example, states that have passed tort reforms are using the laws to woo businesses to their states, he pointed out.

Supporters of tort reform also are explaining to consumers that tort reforms, such as liability caps, could alleviate such problems as a lack of public recreation opportunities and obstetrical care and rising vaccine prices, he said.

While 14 states last year reformed tort law, three states passed particularly significant reforms, according to Mr. Childs.

For example, in a ballot initiative in November, Alaska voters abolished joint and several liability with an overwhelming 70.5% "yes" vote (*BI,* Nov. 14, 1988).

The law, which took effect immediately, restricts defendants' liability for damage payments in civil cases to their degree of fault.

Kentucky limited joint and several liability, imposed a standard of clear and convincing evidence for punitive damages to be awarded, abolished the collateral source rule and reduced the statute of limitations for seeking compensation for property damages to two years from five years (*BI,* April 11, 1988).

South Carolina passed reforms to establish a standard of clear and convincing evidence for punitive damages to be awarded, established sanctions for frivolous lawsuits and reduced the statute of limitations for filing any type of civil case seeking damages to three years from six years.

Other states that enacted tort reforms last year are Alabama, Colorado, Florida, Idaho, Kansas, Maine, Maryland, Minnesota, Mississippi, New Hampshire and West Virginia.

However, the reforms passed by several states—such as Maine and Mississippi—were not significant, according to Diane Swenson, ATRA's legislative director.

For example, one of the reforms Maine passed last year grants limited immunity from liability in certain cases to hospital emergency room workers, she noted. Therefore, ATRA considers that Maine still has not passed any significant tort reforms, according to Ms. Swenson. ■

Federal tort reform uncertain

By DEBORAH SHALOWITZ

WASHINGTON—Most legislators say prospects for passage of federal product liability reform legislation are bleak, but at least one legislator remains optimistic.

Product liability "really is not a federal crisis or problem," according to longtime federal product liability opponent Sen. Ernest "Fritz" Hollings, D-S.C., chairman of the Senate Commerce Committee.

"If we do go along with a federal product liability law, it will mean federalization of insurance itself," he declared.

However, he did not elaborate on what he meant by federalization of insurance.

"We don't have the votes in Congress to pass a federal product liability law," said Rep. Jim McCrery, R-La., speaking at a conference sponsored by the American Tort Reform Assn. in Washington last week.

Product liability legislation is "dead for all practical purposes now," said Rep. McCrery, a supporter of tort reform and product liability reform. "Product liability is not an issue that burns in the dreams of congressmen at night."

But, Sen. Robert Kasten, R-Wis., speaking with Sen. Hollings at a conference sponsored by the National Assn. of Wholesaler-Distributors in Washington last week, remains optimistic about the chances of Congress passing federal product liability legislation this session.

"I think we've got the votes," Sen. Kasten declared. However, he acknowledged that the difficulty for supporters of reform is how to proceed in the face of Sen. Hollings' opposition.

Perhaps because of the generally bleak outlook for reform of product liability laws on the federal level, the issue increasingly is being addressed at the state level, according to Blair Childs, executive director of ATRA.

Of the 28 states that will consider tort reforms this year, 14 specifically are considering reform of product liability laws, Mr. Childs said (see story, page 3).

UP, UP AND AWAY

Who would have thought that it was Karl Jatho, a son of our city, who ventured on the world's first powered flight in this fascinating flying machine on 18th August 1903? Admittedly, the distance covered was modest but it worked. A few years later his planes were already a familiar sight in the Hannoverian skies. We would like to match this spirit of innovation and excellence on our own field. From the humble beginnings not too long ago we have become major Reinsurers in Europe. No reason for us to rest on our laurels. We have set our sights higher and invite you to come on board.

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Communication

Continued from previous page

The public's lack of understanding about the insurance industry also has led to an ever-increasing interest in self-insurance among commercial insurance buyers, according to panelists.

Insurance buyers are indeed turning in greater numbers to self-insurance mechanisms, reported Charles L. Ruoff, senior vp at Fred S. James & Co. Inc.

Self-insurance "in all its forms," including captives, risk retention groups, pools and other alternative risk-financing mechanisms has "grown rather significantly, and it is our belief that by 1992, some $85 billion of risk financing will take place outside the commercial marketplace," Mr. Ruoff said (*BI,* Jan 30).

Property/casualty insurers wrote $198.9 billion in net premiums in 1988, according to preliminary A.M. Best Co. data released this month by the Insurance Information Institute in New York (*BI,* Jan. 9).

"The commercial insurer must compete with the risk management process with regard to its cost-effectiveness and stability," Mr. Ruoff said.

"Many of the alternative mechanisms that risk managers have introduced in their programs offer more stability than commercial insurance companies," he said.

And, both large and medium-sized companies are turning to self-insurance, he pointed out. "Not only are medium-sized companies taking more of their own risk, but in many cases they are joining with others who have similar problems and pooling their risks."

Insurance buyers began searching in record numbers for self-insurance alternatives during the hard market of the mid-1980s.

The property/casualty insurance market probably will harden again by sometime in 1990, and perhaps by as soon as the second half of this year, predicted Herbert E. Goodfriend, senior vp at Prudential-Bache Securities Inc. of New York.

As in previous cycles, the next hard market will be marked by a tightening of capacity, he said.

"In our opinion, capacity growth will slow significantly over the next two years due to the impact of tax reform and a drop in operating earnings," he said.

Mr. Goodfriend also pointed out that tax reform means insurers will become taxpayers for the first time "even near a cyclical bottom."

The panel discussion was moderated by James I. Murray, director of risk management at The Home Depot Inc. in Atlanta. ■

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250 gather for Atlanta conference

ATLANTA—The 1989 Risk Management Educational Conference sponsored by the Atlanta Chapter of the Risk & Insurance Management Society Inc. grows every year, reflecting the increasing interest in risk management in the Southeast, conference organizers say.

About 250 attendees who gathered for a day and a half of meetings at the Hyatt Regency Ravinia in north Atlanta heard a lineup of prominent speakers discuss "Risk Management—Preparing for the Nineties," the theme of the conference.

"Each year, the conference has gotten bigger and better," said Sheldon M. Roth, conference chairman and assistant treasurer-risk management for Contel Corp. in Atlanta.

Theodore L. Young, president of the Atlanta RIMS Chapter and corporate risk manager for Atlanta-based Cox Enterprises Inc., said the interest in the sixth annual meeting is indicative of the Southeast's growing interest in risk management and employee benefits.

"Needless to say," Mr. Young remarked before the sessions began, "if Siskel and Ebert were to review this program, they would probably give it four stars for entertainment value alone. There is a distinct possibility that fur could fly."

A panel discussing economic and political influences on the insurance industry featured Maurice R. Greenberg, president and chief executive officer of American International Group Inc., along with other notable industry executives.

David A. Olsen, president and chief operating officer of broker Johnson & Higgins, was a featured luncheon speaker and a volatile mix of trial lawyers and defense attorneys provided the punch in the conference's final session. ■

Risk manager, doctor blast tort system

By MICHAEL BRADFORD

ATLANTA—Insurance buyers will be at the mercy of insurers and both plaintiffs' and defense attorneys until meaningful tort reform is enacted, a risk manager and a physician agree.

To obtain meaningful tort reform that ensures fair rather than excessive compensation for claimants, insurers and attorneys must work toward a "kinder, gentler" relationship, an insurance industry attorney says.

However, one plaintiffs' attorney —noting the leap in contract litigation—says tort cases are not the sole culprit for the litigation explosion.

And another plaintiffs' attorney believes that insurers' call for tort reform is only a "smokescreen" to cover up insurer price-gouging.

But until significant tort reform is enacted nationwide, insurance buyers will continue to be "suckers" for insurers and attorneys, charged Walter H. Buce, staff vp-insurance at National Service Industries Inc. of Atlanta, whose units manufacture industrial lighting fixtures and industrial cleaning chemicals and provide industrial laundering services.

Mr. Buce moderated a panel discussion on tort reform at the 1989 Risk Management Educational Conference in Atlanta last month, sponsored by the Atlanta Chapter of the Risk & Insurance Management Society Inc.

"Not only are the insurance companies ripping us off, the plaintiffs' trial lawyers are into our pockets and even our own defense lawyers with their high hourly rates are into our pockets," Mr. Buce said.

For example, he said, the cost of National Service Industries' umbrella liability coverage increased more than 1,000% during the last hard market. And, the cost of defending claims filed against the company has increased 800% in the same period, Mr. Buce said.

In addition, out-of-court settlements have risen 1,000% over that same time period because the company is "afraid to go to trial before a jury," Mr. Buce said.

"So let us fully understand that this risk manager really has no appreciation for domestic insurance carriers."

Mr. Buce has a similar attitude toward attorneys. "I'm saying this for the benefit of the lawyers: There's nothing lower in my mind than an underwriter—unless it's a lawyer."

Pointing out that the number of lawyers continues to increase, Mr. Buce said that "we need more lawyers like we need more flies at a July 4th picnic."

Risk managers feel the tort system is "not fair—it's out of control," Mr. Buce said. "Also, the risk manager has no confidence with the U.S. insurance industry, the underwriters. But there's one difference between (underwriters) and lawyers: We need risk transfer capacity through the insurance mechanism. I'm not sure if we need lawyers."

A. Cullen Richardson, an Atlanta physician, warned that if tort reforms are not enacted that will reduce the cost of medical malpractice insurance, physicians will continue to leave their practices and specialties.

Dr. Richardson said he currently pays more than $70,000 per year for medical malpractice insurance.

About 40% of the doctors who were delivering babies in Georgia five years ago have since quit practicing obstetrics altogether because of medical malpractice problems, he pointed out.

"You're always aware that each time you go into the delivery room, you could deliver a child handicapped through no fault of your own and litigation could wipe out every worldly possession you have," Dr. Richardson said.

"I'm familiar with only one small portion of the tort system—that is the area of medical malpractice," Dr. Richardson said. So, he said, he is not qualified to offer suggestions on how to change the tort system.

Instead, he urged the attorneys on the panel to do something about the tort system.

William E. Bailey, special counsel to the New York-based Insurance Information Institute, suggested that insurers and plaintiffs' attorneys could work together for change, noting that "trial lawyers and insurance companies have battered each other long enough."

"Trial lawyers are a very necessary part of the legal system, and people need insurance," he said.

Mr. Bailey said he hoped that in the "era of a kinder and gentler people, we might try to dialogue with each other just as the new president turned to Speaker (of the House James) Wright and said, 'It's time that we had some dialogue.' "

Although insurers' push for tort reform is not now as intensive as in past years, Mr. Bailey said there are a few areas that property/casualty insurers say "still need review in terms of tort reform": elimination of joint and several liability, modification of the collateral source rule and caps on punitive damages.

Regarding joint and several liability, he referred to figures re-

Continued on next page

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Consolidated Statutory Financial Information

RLI Insurance Company and Mt. Hawley Insurance Company

STATUTORY SURPLUS (000 Omitted)	COMBINED RATIO
1983 – $12,238	1983 – 94.9
1984 – $16,739	1984 – 97.0
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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Tort reform panel

Continued from previous page

leased by the Insurance Services Office Inc. that show plaintiffs in multidefendant cases recover three times the amount awarded to plaintiffs in single-defendant suits (*BI*, Dec. 12, 1988).

"We also know that in multidefendant cases the average compensation paid is now over $70,000 as an average for all plaintiffs." And the legal costs in those cases are twice the costs incurred in single-defendant cases, Mr. Bailey noted.

He also pointed out that ISO figures show the great majority of courts do not reduce awards to plaintiffs to take into account collateral sources of compensation, such as workers compensation.

And "the third area that the insurance industry would like to have examined is the area of punitive damages," Mr. Bailey said. ISO's figures show that plaintiffs seeking punitive damages are receiving much bigger court and jury awards and settlements than plaintiffs that do not seek punitive damages, he noted.

"The average claim with punitive damages is $133,000; without punitive damages, it's $83,000," he said.

Mr. Bailey acknowledged that the issues of punitive damages and the litigation explosion need to be looked at from the perspectives of both claimants and insurers.

"These gentlemen," he said, referring to plaintiffs' attorneys on the panel, "represent people who have been injured in some fashion and are entitled to seek the best legal counsel they can get, to get whatever they are entitled to."

A prominent trial lawyer told the conference that attorneys are not the only party gumming up the U.S. tort system.

"We've heard a lot about the litigation explosion, and then we hear about insurance prices and some of us think, 'Well, that must be all those greedy plaintiffs out there claiming things they're not supposed to be claiming,' " said Bill Wagner, president of the Assn. of Trial Lawyers of America.

But Mr. Wagner said a report produced by the Institute for Legal Studies shows that contract litigation makes up the largest category of lawsuits filed in federal courts.

"Since 1960, contract filings rose twice as rapidly as tort suits," Mr Wagner pointed out. "Whereas torts used to account for 38% of federal court filings in 1986 they made up only 17% of such filings.

"So, yes there's been a litigation explosion, and yes, there have been more suits," he said. "But you don't have to take the next jump to believe that's because plaintiffs are bringing the lawsuits" in tort cases.

James E. Butler Jr., president of the Georgia Trial Lawyers Assn., was not moved by Dr. Richardson's remarks or Mr. Bailey's call for civility among panel members. In fact, he expressed surprise that a panel at the conference was even discussing tort reform.

"I haven't paid a lot of attention to this issue since the Georgia Legislature closed down in 1987 and tort reform ended as a legislative issue here in Georgia," Mr. Butler remarked. "I didn't realize there was any ongoing controversy.

"I really believed, perhaps naively, that when groups as divergent as Consumers Union (which publishes Consumer Reports magazine) and Business Week magazine, Ralph Nader and James J. Kilpatrick all declared the tort reform campaign a fraud, that everybody pretty well realized what the dickens had been going on," Mr. Butler said.

"The tort reform campaign was never anything but a smokescreen erected by the Insurance Information Institute and the insurance industry which founded that group to cover up the activities of the insurance industry in trying to gouge American business and American consumers," Mr. Butler charged.

But, Thomas M. Gose, president of Atlanta-based MAG Mutual Insurance Co., a physician-owned medical malpractice insurer, disagreed.

"Tort reform is not for insurance companies" but instead is intended to make the civil justice system more equitable so insurers' losses are more predictable, he said.

"Insurance companies can protect themselves, as you well know. They raise their prices, they limit coverage to ensure their own profitability."

Mr. Gose noted that when insurers are prevented from raising rates enough to offset losses, insurers shift their capital to other, profitable markets.

"Tort reform is to, hopefully, flatten the upward trend being caused by the growth in losses so that people have available the products and services" insurance companies provide, he said.

"Insurance companies are going to stay in business as long as the law will let them, and they're going to be profitable," Mr. Gose said. "That's what tort reform's about."

Also on the panel was Hunter S. Allen, a partner in the Atlanta law firm of Allen & Ballard. ■

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Broker sees fewer players in year 2000

By MICHAEL BRADFORD

ATLANTA—A continuing trend of mergers and acquisitions will leave the insurance market with fewer—but larger—insurance companies and brokers by the end of the 20th century, predicts an executive of a major broker.

Insurers also may face added competition from banks and overseas-based insurers by the year 2000, according to David A. Olsen, president and chief operating officer of New York-based Johnson & Higgins.

'Big brokers will definitely be operating globally and hopefully finding a way to serve their clients better. . . I think that will give foreign risk managers and U.S. multinational risk managers an advantage' amid competition, says David Olsen.

"In the year 2000, I think we all agree that companies will be larger and there will be fewer of them, not only in our industry, but in all industries," Mr. Olsen said, pointing to the acquisition and merger craze of the 1980s and "probably the early '90s."

Mr. Olsen offered his views about the future of companies that survive the 20th century at the 1989 Risk Management Educational Conference sponsored by the Atlanta Chapter of the Risk & Insurance Management Society Inc. last month

Successful insurers will be operating internationally, while others will "wither away" or find an underwriting niche and operate on a smaller scale, he predicted.

Brokers face a similar fate, he said.

"Big brokers will definitely be operating globally and hopefully finding a way to serve their clients better and in broader areas. I think that will give foreign risk managers and U.S. multinational risk managers an advantage in a competitive European and worldwide market."

Conversely, there may be more foreign insurers underwriting business in the United States in the year 2000 if courts turn away from expansive interpretations of liability, Mr. Olsen observed.

The entry of more foreign insurers "could be good, could be bad," he said. "Obviously, if they want 50% of the world's premium, which is here in America, they have to compete for it. And, indeed, if the market permits and the cycles change, I think they'll be here in a bigger way. I think we would all do that if we were foreign underwriters."

In addition, U.S. insurers in 2000 probably will have some competition from new sources, Mr. Olsen said. "We'll have some banks in our business, we'll have some financial institutions in our business."

The entrance of those new players will provide needed capacity and will give the marketplace new participants that were not responsible for the insurance crises of the 1970s and 1980s.

Because many businesses probably will be operating globally by the end of the century, "we will face some very difficult and interesting and probably new exposures," Mr. Olsen remarked.

"Insurance brokers and consultants will continue to be challenged—more than ever before—to provide a wider variety of services to their clients and help them solve their problems."

Brokers and consultants will "have to be smarter and more sophisticated than ever before," he said. "We'll have to make sure that we convince risk managers that we as intermediaries hustle and add some value."

Brokers still in business at the end of the 20th century will find new opportunities for profitability, Mr. Olsen believes.

"I perceive, happily, opportunities for brokers in the year 2000 will be more profitable, but again, only if they serve their clients well," he said.

But, brokers will have to charge an adequate price for their services if they expect to make money in the next century, Mr. Olsen pointed out. "And that is a little difficult," he said. "We're in an industry where it's very hard to know how much to charge for the products and services that we all use."

In addition, as the insurance industry heads toward the next century, both insurers and brokers must be concerned about cleaning up its tarnished image, Mr. Olsen said.

"We simply must satisfactorily answer questions about the merits of our industry," he said. "What does it provide? Where does it help?"

There is a need for reform of the insurance industry, Mr. Olsen charged. He suggested that a presidential commission be formed to study the industry and suggest ways to change the way it operates (*BI*, Jan. 30).

"I say we go right to President Bush" with the idea of putting together a commission of risk managers, underwriters, regulators, agents, brokers and others to study the industry and "the function it performs, or the function that it's supposed to perform, and the advantage to our economic system by having a properly run insurance industry," he said. ■

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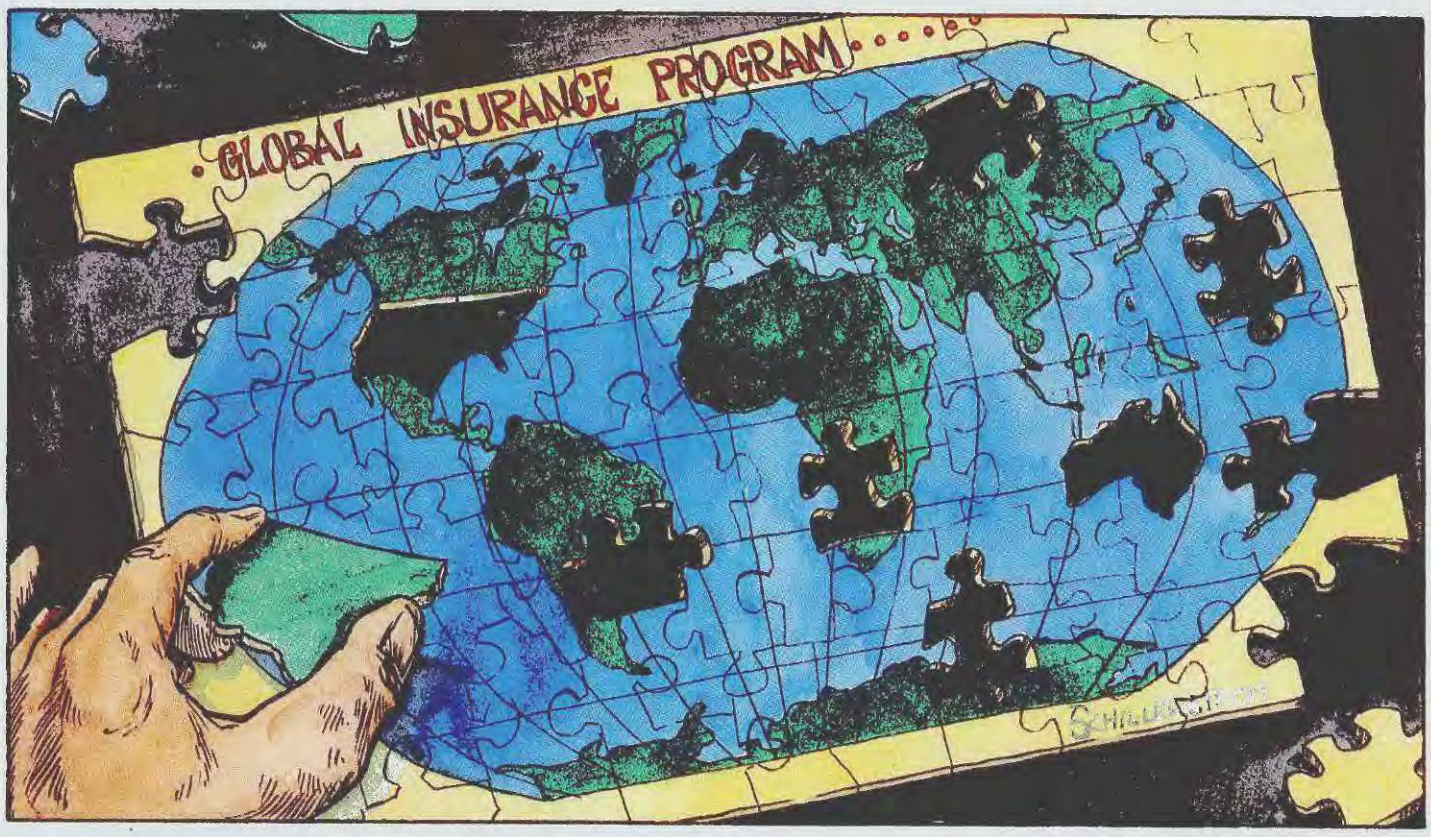
Global approach

Examine benefits of single program in light of EC changes

By Jerome Karter



OFTEN, U.S. MULTINATIONALS get cold feet at the thought of marrying their domestic and foreign property exposures under one global insurance program. Instead, risk managers have usually preferred to put all their eggs into two protective baskets: one domestic and one foreign.

U.S. risk managers have cited many reasons for resisting the global concept. Some fear that capacity restrictions will ultimately unravel a global insurance program. Others fear the loss of a competitive edge when premiums are pooled with one insurer.

Today, however, global program advocates are predicting that the Single European Act will encourage the economies of scale that can be achieved through "spread of risk" and "bulk buying."

Why? You ask.

To begin with, the European Court of Justice—the European Community's "Supreme Court"—decided on Dec. 4, 1986, that the Treaty of Rome grants an insurer based in the European Community the right to provide free service in another EC country without having to establish itself in that country. The Court of Justice's decision, along with the Single European Act's package of treaty reforms that took effect July 1, 1987, helped set the stage for the June 22, 1988, passage of the Second Directive on Non-Life Insurance.

The stated aim of the Second Directive is to "make it easier for (non-life) insurance companies having their head office in the community to provide services in member states, thus making it easier for policyholders to have recourse not only to insurers established in their own country but also to insurers which have their head office in the community and are established in other member states."

International issues

The directive does not apply to life insurance, motor vehicle liability, workers compensation, construction insurance or pharmaceutical products liability such as the coverage afforded by the West German Pharma Pool for a limit of 200 million deutsche marks ($107.4 million). A separate life insurance directive is being passed and plans are under way for a separate motor vehicle liability directive.

Under the second directive, an EC-established insurer will be allowed to directly underwrite large industrial risks within the EC without having to establish itself in other member states, beginning July 1, 1990.

The directive defines a large risk as:

- Railway rolling stock, aircraft, ships and goods in transit.
- Credit and suretyship insurance, when the policyholder is engaged in a commercial activity.
- Fire, general property damage, general liability and pecuniary loss.

In addition, a large risk must satisfy two of the following three criteria:

- A minimum of 500 employees.
- Net turnover of not less than 24 million European Currency Units ($26.9 million).
- Assets of not less than 12.4 million ECU ($13.9 million).

These first-stage criteria, which take effect beginning July 1, 1990, will be reduced by 50% as of Jan. 1, 1993, thereby allowing an even greater number of firms to fall under the large risk category.

Most member states are required to fully implement the second non-life directive into law by Dec. 31, 1992. Spain, however, is allowed to enforce the first stage between Jan. 1, 1995, and Dec. 31, 1996, with full implementation set for Jan. 1, 1997.

Portugal, Greece and Ireland have been granted until Dec. 31, 1998, to implement the first stage into law, with full implementation taking effect as of Jan. 1, 1999.

With July 1, 1990, rapidly approaching, some U.S. risk managers are studying the benefits of a pan-EC insurance program that dovetails with domestically purchased property coverages. It is important for them to analyze what a global program does.

Global programs stem from the hypothesis that ultimate consolidation yields ultimate benefit. Essentially, global insurance programs allow U.S. multinationals to share state-of-the-art risk management with foreign subsidiaries.

U.S. multinationals that have married their U.S. and foreign insurance exposures successfully into a global program are enjoying:

- Worldwide insurance rates that reflect the size and experience of the global program.
- Liberalization of coverage.
- Common worldwide standards for conserving assets.
- A corporate insurance philosophy geared to worldwide financial strength.
- Good citizen status with respect to local insurance laws and exchange-control regulations.

Each of these can represent a benefit to U.S. multinationals and their foreign subsidiaries. For example, it is easier for a U.S. multinational to achieve adequacy of coverage at competitive prices when all of its assets, earnings and liabilities are insured with one worldwide insurer. The worldwide insurer can mirror "all-risk" master policy coverage in non-tariff-market countries. Assets in tariff-rated countries can be protected through a combination of admitted and non-admitted "all-risk" master policy coverage.

Historically, centralized bargaining power has allowed the worldwide insurer to control policy rates in non-tariff countries. This concept will gain added importance if, as expected, EC tariff rating structures disappear as a result of Second Directive-inspired, cross-frontier competition between insurers. Already, Lloyd's of London is planning to open a branch in West Germany and non-EC insurers like Winterthur Swiss Insurance Co. Ltd. and Zurich Insurance Co., both Swiss companies, are expected to use an existing branch or affiliate to underwrite cross-frontier risks.

Global programs also afford consistency of coverage, deductibles, limits of liability, value reporting and claims handling procedures.

In addition, the U.S. multinational's relationship with one or more worldwide insurers lays the groundwork for a stable long-term relationship that can survive future market swings.

Moreover, the global concept offers the added benefit of liberalized coverage. As every risk manager knows, the consequences of a big fire are not necessarily confined to one country. Often, a foreign U.S. multinational subsidiary is dependent upon supplies from another country. Thus, the effect of a fire in Illinois may be felt in Japan or Belgium, or vice versa. Separate programs may not always respond to these exposures.

In many cases, potential coverage gaps are eliminated when U.S. and foreign exposures are united under one contract.

Global property insurance policies, for example, can cover the worldwide interdependency exposure that exists between parent and subsidiary, as well as between one subsidiary and another. Worldwide extensions to suppliers, customers, and utilities are another example of broadened global property coverage.

Asset conservation can be enhanced through a global program, too. Potential loss situations can be identified more easily when all subsidiaries are insuring to a common standard and losses are pooled through a global insurer. Under such a global program, a solution to a loss-causing event at one location can

Continued on next page

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

ASK A BENEFIT ACTUARY

Technical corrections affect Section 89 tests

Q **Can an executive medical plan pass the Section 89 non-discrimination tests?**

A This question comes from the benefit manager of a corporation sponsoring an executive medical plan. The plan covers a select group of highly compensated employees and reimburses the costs of physical examinations, deductibles and copayments that the executive must pay out of his own pocket under the corporation's medical insurance plan.

Because of the passage of the Technical and Miscellaneous Revenue Act of 1988 (better known at the technical corrections act), the benefit manager is re-examining his earlier conclusion that the plan would fail the Internal Revenue Code Section 89 non-discrimination tests.

The surprising answer is that after technical corrections, it may be possible for this executive plan to pass the non-discrimination tests, or to have something less than the full employer-provided value imputed to the income of highly compensated employees.

However, prior to technical corrections, this plan would have failed the Section 89 tests. This failure was directly tied to the pre-Technical Corrections concept of a "plan" for non-discrimination testing purposes. Prior to technical corrections, any variation in health insurance coverage, including variations in employee contributions, resulted in a separate plan.

So, for example, separate plans existed in the following instances:

- Two comprehensive major medical plans that were identical except for their deductible were considered to be separate plans.
- Each health maintenance organization was considered to be a separate plan due to differences in service providers.
- Each health insurance coverage or HMO would comprise two or more plans if family members of employees were eligible for coverage.

For example, if one employer offered coverages of "employee only," "employee plus one family member" and "employee plus two or more family members," there were three health plans: employee coverage, coverage of one family member and coverage of additional family members.

Because the executive medical plan would be considered a separate plan with only a select group of highly compensated employees eligible and covered, it would have failed the Section 89 non-discrimination tests before amendment by technical corrections.

Specifically, it would have failed the 50% eligibility test, which requires that at least 50% of the employees eligible to participate in the plan are non-highly compensated employees; or, alternatively, that the ratio of highly compensated employees eligible to participate in the plan to all highly compensated employees of the employer is less than the ratio of non-highly compensated employees eligible to participate in the plan to all non-highly compensated employees of the employer.

The executive medical plan also would have failed the 80% alternative test, which requires that at least 80% of the non-highly compensated employees of the employer are covered under the plan. As a result of failing both the 50% eligibility test and the 80% alternative test, the full value of the executive medical plan would have been imputed to the income of the highly compensated employees covered by the plan.

However, the aggregation rules of the technical corrections act (contained in the legislative history) have apparently made a drastic change to the concept of a plan for Section 89 non-discrimination testing purposes.

The legislative history indicates that under rules prescribed by the Treasury secretary, if an employee is eligible for (in the case of the 50% eligibility test) or receives coverage under more than one accident or health plan, then for the purposes of the 50% eligibility test and the 80% alternative test, such plans are required to be considered one plan with respect to the employee for testing purposes.

The legislative history contains an example of the application of this changed concept of a plan. The example illustrates that the full value of a plan benefiting only highly compensated employees is not imputed to the income of highly compensated employees.

The legislative history states, "For example, assume that an employer maintains two plans: one benefiting all employees with a value of $950 and a second benefiting only highly compensated employees with a value of $1,000. The highly compensated employees receiving benefits from both plans are to be treated for purposes of the 50% eligibility test and the 80% alternative test as receiving $1,950 of benefits from one plan while the non-highly compensated employees are to be treated as receiving $950 of benefits from a separate plan.

"Under the comparability rules (Section 89(g)(1)), these plans would satisfy neither the 50% test nor the 80% test. (Under both tests, the discriminatory excess would be $950 for the highly compensated employees receiving benefits from both plans.)"

It is interesting to note that the discriminatory excess does not include the full value of a second plan covering only highly compensated employees and valued at $1,000. The discriminatory excess is determined as the excess of the total value for highly compensated employees ($1,950) over $1,000, which is the value of a plan for highly compensated employees that would be comparable to the $950 plan for non-highly compensated employees. If the value of the second plan (benefiting only highly compensated employees) was $50 instead of $1,000, presumably this $50 plan would have passed the tests, resulting in no imputed income for highly compensated employees.

The implications of this little known change made by technical corrections are significant:

- Executive-only plans will not automatically result in the imputation of income to executives covered by the plan. Only a portion of the plan's value may be imputed to income, or possibly none at all. Benefit managers should re-examine the conclusions that they reached before technical corrections regarding "executive only" plans.
- Because this change in plan concept is little known and was recently made, many computer systems for testing Section 89 compliance probably do not accurately perform the tests or impute income for "executive only" plans. Plan sponsors that have purchased these systems or are contemplating doing so should scrutinize this aspect of any computer system.

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

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

Mr. Miner

This month's column on actuarial issues in the benefits field is written by William J. Miner, an actuary with The Wyatt Co. in Chicago. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. And, Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions.

Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Duva's and Ms. Werner's columns appear alternately on the second Monday of each month. Mr. Miner's next column will appear in April.

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

Global insurance

Continued from previous page

be identified and shared with other facilities that may have similar exposures.

Thus, it makes sense that assets and earnings should be protected through centralized risk management decisions, just as major investment decisions are made or approved centrally.

Of course, there are some obstacles to putting together a global program.

First, only a limited number of worldwide markets have the capacity to underwrite a global program. And, those that have sufficient capacity will underwrite through separate U.S. and foreign treaty facilities. Fortunately, this practice allows the global insurer to wrap-around a primary U.S. property program underwritten by a highly protected risk insurer.

On the other hand, the Single European Act, in conjunction with the Second Directive, is expected to encourage coinsurance arrangements; that is, leaving longstanding highly protected risk or worldwide insurers as the lead insurer with a major EC-based insurer acting as a coinsurer. Such arrangements would allow U.S. multinationals to structure additional capacity behind a global property program.

Next, the "all-risk" manuscript form must be carefully written to ensure that all worldwide exposures are covered and to relegate limits, deductibles and peril/property exclusions to the appropriate U.S. or foreign coverage sections.

Another obstacle occurs when foreign facilities have a long-term agreement in force. For a nominal rate discount, LTAs lock a local policy into a three- to 10-year period. Any facility with an existing LTA will be barred from the global program for the duration of the policy period, unless a loss occurs or the LTA insurer seeks a policy change before the expiration of the policy—two conditions that allow the LTA to be canceled.

Finally, the global concept is obstructed when a program rate is higher than a local market alternative. Unfortunately, there is usually a market somewhere in the world that will undercut at any price. Thus, U.S. risk managers must help the foreign managers to understand that a global program operates to the best interests of all concerned, even when it may not be the least expensive alternative at a given location.

None of these issues represents an overwhelming obstacle to adopting the global concept. Global property insurance programs are relatively easy to structure and to market.

The future of global insurance programs is far from bleak. If special attention is paid to design, marketing and management, the global concept may suit your needs—both now and from July 1, 1990, on.

Quality care hard to quantify: Experts

By DEBORAH SHALOWITZ

'It isn't very easy to measure quality" in health care, says Dr. R. Heather Palmer, associate dean of the Harvard School of Public Health in Boston. 'The measures that we have are very crude' and need careful interpretation.

WASHINGTON—Quality health care is difficult for employers and employees to measure and often is unrelated to the cost of health care, experts say.

"It isn't very easy to measure quality" in health care, said Dr. R. Heather Palmer, associate dean of the Harvard School of Public Health in Boston. "The measures that we have are very crude" and need careful interpretation.

For example, observers often measure the quality of health care by examining mortality rates at hospitals around the country collected by the federal Health Care Financing Administration, Dr. Palmer said.

However, some hospitals—particularly some very highly regarded hospitals—receive referrals of the sickest patients, leading to a high mortality rate for those institutions, she said.

Robert Hungate, manager of government affairs for Hewlett-Packard Co. in Arlington, Va., noted, "Quality in health care means different things for the employee and the employer."

For instance, group health care benefits often are undervalued by employees, Mr. Hungate said, adding that employees "don't think they're getting value."

Therefore, "quality" has to appear as value "in order to work in any of our benefit programs," he concluded.

Furthermore, differences in the quality of health care often are unrelated to cost, Mr. Hungate said

Health Agenda 1989

in a speech at "Health Agenda 1989," a conference last month in Washington, D.C., sponsored by the Washington Business Group on Health and the National Assn. of Manufacturers.

For example, the fewest mistakes in diagnosis and treatment of an illness means the best care is being provided, he said, adding that such care coincidentally costs the least.

Donald Davis, chairman of The Stanley Works in New Britain, Conn., agreed. "The highest-quality health care providers do the least unnecessary procedures and have the lowest infection rate."

Mr. Hungate related that when Hewlett-Packard decided to add a heart transplant benefit to its health care coverage, the Palo Alto, Calif.-based company talked to representatives of hospitals around the country about the procedure.

The cost of the procedure and the percentage of patients that survive for five years following the procedure differed significantly from hospital to hospital, he said.

According to Mr. Hungate, a university hospital in the Bay Area charged $181,000 for the transplant and had an 81% five-year survival rate, while an East Coast hospital charged $230,000 for the operation but reported only a 41% five-year survival rate. An Arizona hospital charged $77,000 for a heart transplant and had an 86% five-year survival rate, he said.

Hewlett Packard qualified the Arizona hospital to perform the procedure for its employees, Mr. Hungate said.

The same comparisons theoretically could be applied to other procedures, but statistics generally are hard to come by, he noted.

"We have almost no data to prove whether high-tech procedures work better than" other alternatives, Mr. Davis stated. "We must get better data from (insurance) carriers and hospitals" to improve the quality of care.

Harvard's Dr. Palmer suggested that information necessary to evaluate quality health care includes:

- The technical competence of the treatment provided. This would include an accurate diagnosis of the problem and the selection of the proper treatment. Then, proper implementation of the treatment is necessary.
- Accessibility of care. This would include whether the right specialist is available.
- Acceptability of care for patients. This would include a physician's bedside manner and the privacy and dignity patients are afforded during their treatment.

Computers could be used to analyze clinical data concerning the results of different treatments for similar health problems, but there is a strong risk that the health problems would be too uniquely individual to provide for an accurate comparison, said Steve Bandeian, a staff member of the House Ways and Means Health subcommittee. Ten to 20 years of data would be necessary for adequate comparisons, he said.

A better approach would be to have experts review medical literature and recommend treatment strategies, Mr. Bandeian said. ■

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Quick action unlikely on benefit issues: Congressional staff

WASHINGTON—Discussions about whether to delay or repeal last year's landmark law that expanded the federal Medicare program and how to give the uninsured access to health care will be among the top employee benefit issues for the 101st Congress, congressional staffers and a legislator predict.

Health Agenda 1989

However, quick action on these issues is unlikely because Congress' first priority must be to take measures to reduce the budget deficit, the congressional staff members agreed.

Rep. Willis Gradison, R-Ohio, and congressional staffers could not agree on whether Congress will reconsider last year's expansion of Medicare, which gave retirees more protection from acute care catastrophic health care costs.

Rep. Gradison and the congressional staff members spoke to a conference last month sponsored by the Washington Business Group on Health and the National Assn. of Manufacturers.

Rep. Gradison

Thousands of retirees have written to their congressmen complaining that the cost of the expanded program—which is funded through increased retirees' taxes and Part B premiums—is too high (*BI*, Jan. 16).

This law "hasn't turned out to be as popular as I had hoped," admitted Rep. Gradison, who is ranking minority member of the House Ways and Means Health subcommittee.

'The catastrophic bill will be revisited during the first session,' says Dr. Edwin Froelich.

However, "I don't think it's going to be changed and I don't think it should be changed," he added.

"I don't foresee revisiting this financing issue," said Bruce Kelly, counsel to the Senate Finance Health Subcommittee.

However, Dr. Edwin Froelich, physician adviser to the Senate Labor and Human Resources Committee, predicted that "the catastrophic (health care) bill will be revisited during the first session of Congress."

Other employee benefit issues that may be addressed by Congress in the coming year include:

- Health care coverage for the uninsured.

Senate Labor and Human Resources Committee Chairman Edward Kennedy, D-Mass., plans to re-introduce in mid-March legislation that would require all employers to offer a health care plan that meets minimum federal standards, according to Darryl Cox, a committee staffer.

"We're seeing a lot more interest in pushing through legislation like this," Ms. Cox commented.

- Long-term care.

Because of the backlash against last year's Medicare reforms, action on long-term care anytime soon is unlikely.

"The reaction to (the Medicare) legislation has already had a chilling effect on the concept that the government should do anything soon on long-term care," said Rep. Gradison.

—By Deborah Shalowitz

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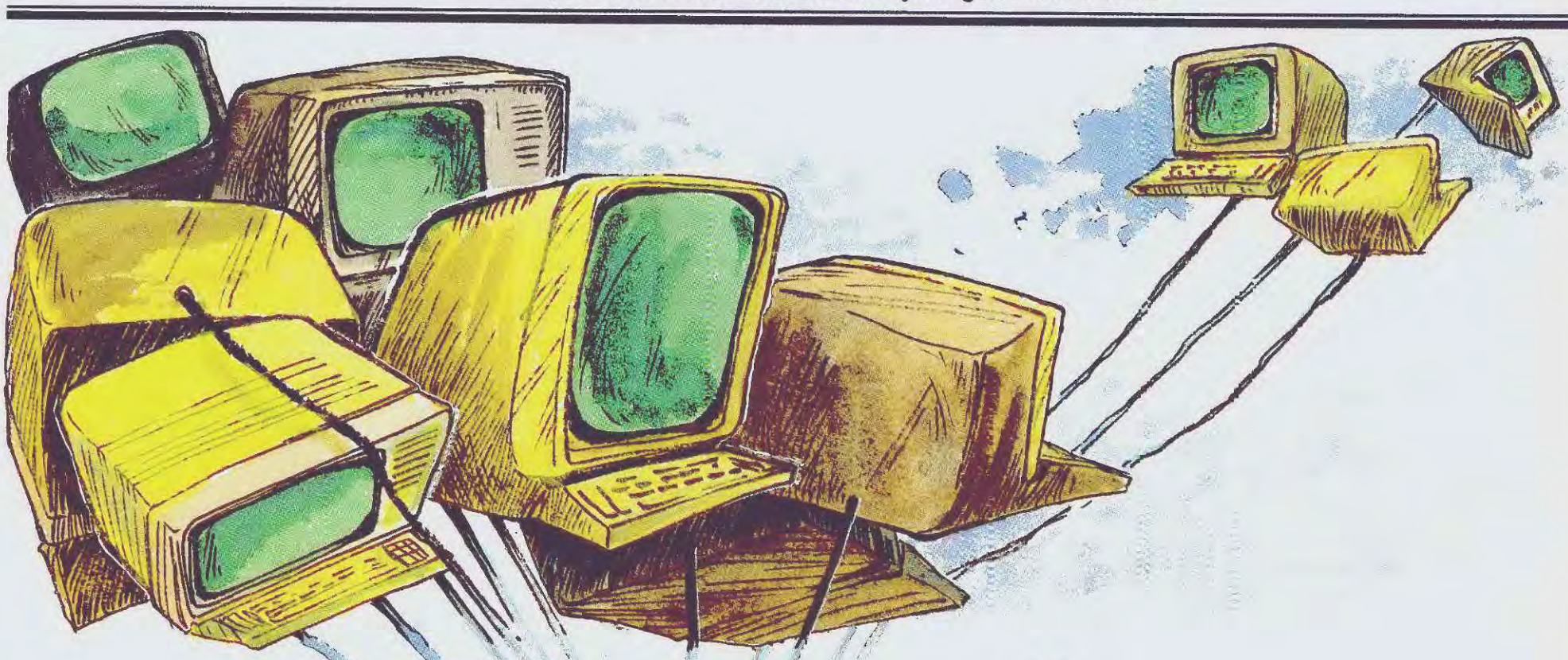


Plugging in

Agents seek link between management, rating systems

By LAURA MAZZUCA

Most insurance agents and brokers rely on automation to keep their books, file their records and print out their letters.

But now many are looking for even more from their computer systems. They want *one* system that not only will integrate these tasks, but also be able to quote a price for a specific policy with the touch of a few keystrokes.

The agents' search is coming to an end. Several companies that specialize in agency automation have either recently released or currently are testing fully integrated systems that combine agency management systems—which provide word processing, spreadsheet, data base and other functions—with automated rating capabilities (see story, page 24H).

Many agencies already use "stand-alone" automated rating systems, which have been on the market for several years. However, in most cases, information cannot be transferred from an agency management system to the rating system. Instead, information culled from the agency's data base must be manually input into the rating system and information produced by the rating system must then be input in the data base for storage.

While some vendors in the past have touted integrated systems that include rating functions, consultants point out that these older products are not truly integrated.

Rating system integration occurs on three levels, explained Rick Morgan, vp of Automation Management Group Inc. consultants in Boulder, Colo.

In its most basic form, the agency management system and the rating system are accessible on one computer, but cannot pass information back and forth.

The second level allows an operator to access both the rating system and the management system on the same computer menu, but they still must use two different data bases.

The third level—true integration or what Mr. Morgan calls "seamless"—only is present when both programs use the same data base.

Most so-called "integrated" rating systems on the market today only allow data to be passed one way. For example, in most agency management systems, client information can travel to the rating system, but the rating system cannot send its calculations back to the general data base.

This means the data must be entered again into the other data base, said Mr. Morgan.

Integrated functions still "have not come to bear in the marketplace the way we'd like to see it happen," said Demmie Hicks, senior consultant for Hales & Associates of Atlanta.

Most of Hales' consulting clients are large agencies and brokerages that could really use a truly integrated system, she said, "but it's just not there. I'm looking at a list of the best agencies in the country, and if it was there, they'd have it."

What agents want—and what vendors just are beginning to deliver—are seamless integrated rating systems that will allow an agent to respond to a client's phone request for a quote by pulling client information from a data base, calling up on the same screen five or six insurers' rates and converting this information into a policy application.

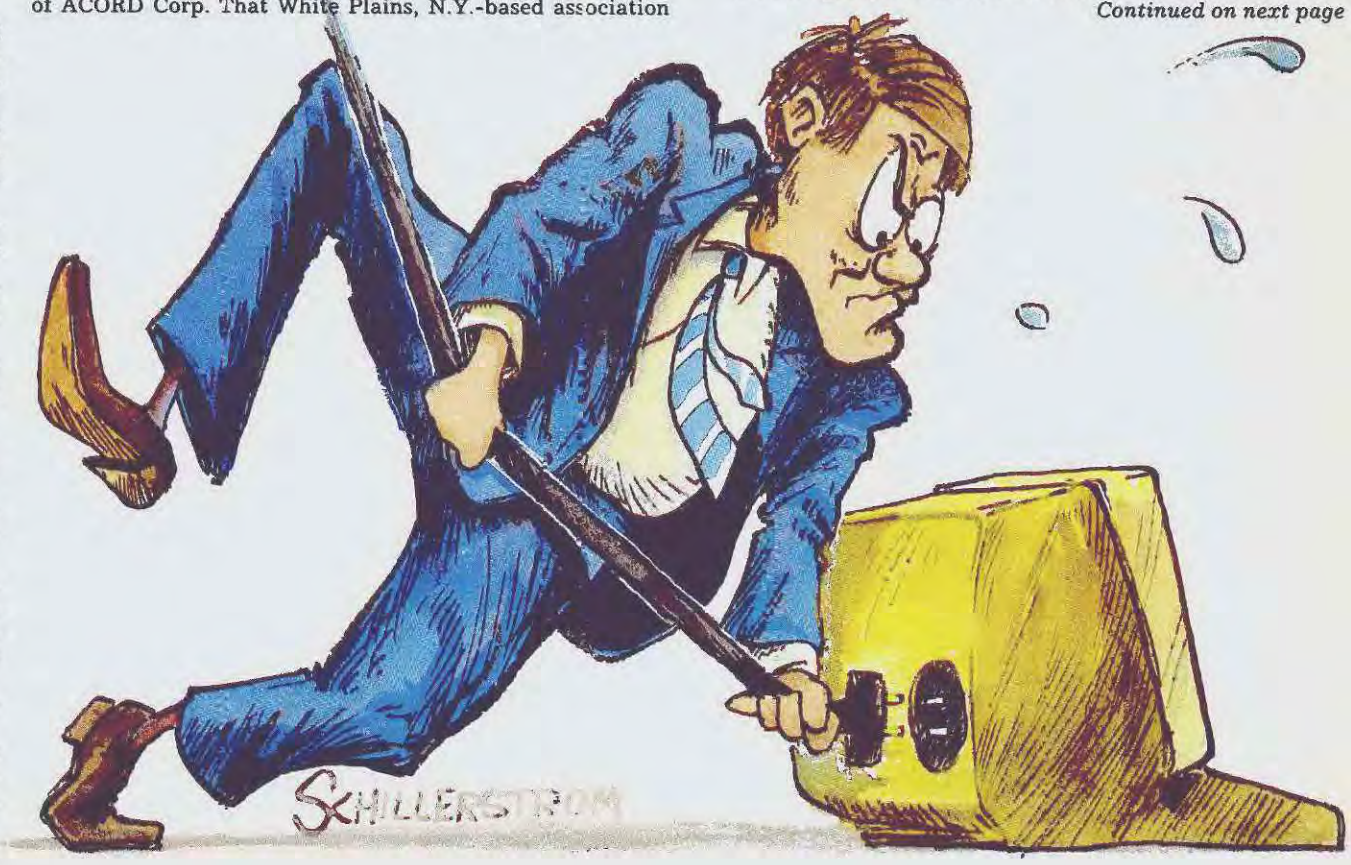
"It's a one-step operation, done one time," said Herbert G. Treweek, chairman and chief executive officer of Cannon-Treweek Agency Inc. in Gainesville, Fla., and also a director of ACORD Corp. That White Plains, N.Y.-based association develops standards for insurance automation, including integrated rating systems.

The development of integrated rating capabilities is the direct result of computer user groups' demands, as well as the standardization of ACORD forms, said Shirley Lukens, automation director for the Independent Insurance Agents of America, based in New York.

For instance, the user group for Pittsburgh-based Redshaw Inc. agency automation products has been pushing for integrated rating systems "ever since they've had the system," said Phyllis Heitefuss, executive director of the Redshaw user group.

The user group's executive committee meets with Redshaw

Continued on next page



Agent/broker topics

Automated rating

Continued from previous page
biannually and holds regular meetings to present the vendor with suggestions for updating the system.

Redshaw currently is testing a two-way product that integrates existing stand-alone rating systems with Redshaw's agency management system, which operates on Wang computer hardware.

The product will be in use at pilot agencies later this month, with general distribution expected by the end of the first quarter, commented William G. Mitchell, manager of custom programming for Redshaw.

Other agency management system vendors also have jumped on the integrated-rating system bandwagon by either developing their own systems, or by forming joint ventures with the vendors that market stand-alone rating systems.

For example, Agency Management Services Inc. based in College Station, Texas, now offers products that integrate with stand-alone rating systems marketed by three companies it acquired last year: Savage; Micromagic of Bolivar, Mo.; and Austin Micro Systems Inc. of Austin, Texas.

And, McCracken Computer Inc. of Burlington, Mass., late last year developed an integrated rating system in conjunction with Programming Resources Co. of Hartford, Conn.

Applied Systems Inc. of University Park, Ill., now is conducting pilot programs of its personal lines integrated rating system and expects to market the product by the middle of this month.

"We've been under a lot of pressure for about three years to have integrated rating," said Doug Johnston, vp, product development. "We kept telling our users that we wanted to address it, but we weren't ready."

The system is "completely" integrated; featuring "two-way," single entry capabilities, said Mr. Johnston. "Two-way" capabilities means that information from the agency's data base can be input into the rating program, and information generated by the rating program can move to the data base.

With new integrated systems coming soon to the market, consultants—and agents already using stand-alone rating systems—advise agents looking for automated rating capabilities to make sure the system they purchase fits their needs.

And, despite the advantages of automated rating, there is a downside as well.

One drawback is the expense. Even if an agency management system is already in place, an agency might have to spend from $20,000 to $35,000 to add an integrated rating feature for 12 work stations, said Mr. Treweek.

To start up a completely new system is even more costly, with the new Redshaw and McCracken agency management and rating systems costing $100,000 and up, depending on the peripherals.

Support and maintenance costs also can be expensive. Depending on the system and the number of insurers, types of coverage or states being rated, maintenance for a stand-alone rating system can average $675 per year, according to an ACORD survey.

Another limitation of automated rating systems, whether stand-alone or integrated, is their traditional bent toward personal lines, because there are more variables involved in the commercial rating process. For instance, according to an ACORD survey, 66% of automated rating systems had personal auto rating capabilities, while only 52% had commercial auto rating capabilities and 45% could rate small commercial package business.

Moreover, compatibility with existing agency management systems can be a problem.

For example, ISU/Hastings-Tapley Insurance Agency Inc. in Cambridge, Mass., added a stand-alone rating system several years ago that was not compatible for integration with the agency's management system designed by Delphi Information Systems Inc. of Westlake Village, Calif., said agency President Frederick J. England Jr.

Although Delphi now is offering an integrated rating capability, the Massachusetts agency says it can't use it because of the state's competitive auto insurance market, which would necessitate having information from 22 different insurers entered into the system, added Executive Vp Marsha Burridge.

ISU/Hastings-Tapley purchased its agency management system in 1985 for $700,000, and since then has spent an additional $1.3 million for enhancements, including the rating capability.

Some agency principals report they are limited to using a stand-alone rating systems while they wait for their agency management system vendor to install a system upgrade that includes integrated rating.

For example, Associated Insurers Inc. in Raleigh, N.C., currently is using a stand-alone rating system on which the customer service representative calls up information on a terminal, downloads the data, then goes to another terminal to rate the policy, said Vp Durant G. Vick.

He expects the newest McCracken "Insight" system—the agency's third update since installing McCracken automation in 1979—to be up and running by spring, complete with integrated rating capabilities.

Mergers, acquisitions and agency purchases can also change the status of an agency's automation system, and therefore its automated rating functions.

For instance, Crowder Jacobs Fendig Insurance in Tampa, Fla., is in a "transitional mode" since its purchase last year by ABI Management Inc. of San Francisco, the 13th-largest U.S. brokerage based on 1987 revenues, said Vp Richard B. Wheeler.

Crowder Jacobs Fendig, which produces $30 million in premium volume, will scrap its automation system—a McCracken agency management system using IBM System 36 hardware—for the Delphi system that ABI uses, said Mr. Wheeler.

The situation is similar at Frederick Rauh & Co. in Cincinnati, which was also purchased by ABI last year, said Marketing Manager Robert G. Slovin.

Rauh, which had used a Redshaw agency management system, installed a Delphi system in November 1988, "and we're still crunching" to input data because there is no program that can automatically download the data, according to Mr. Slovin.

Rauh, which reports $55 million in annual premium volume, currently is using a stand-alone CAIR QUICKRATE ratings system, but will probably add an integrated rating module after it is online with Delphi, he added.

In spite of the apparent advantages of adding automated rating, most agents agree that it's difficult to quantify the time and/or money savings that arise from integrated rating —or automation in general.

While the ACORD survey found that non-automated agencies generate one-fourth the premium volume of automated agencies—$99,000 vs. $378,000—true cost efficiency is impossible to determine since true agency automation depends on "synergy" rather than "isolated pieces," said Mr. Morgan of Automation Management Group.

"In fact, you can create more work and confusion because you're caught in an environment where you're doing some tasks in manual and some in an automated way," Mr. Morgan explained.

"Technology by itself doesn't do anything," he maintains.

William M. Rue, president of Rue Insurance in Trenton, N.J., agrees. His agency, with a premium volume of $24 million, currently uses a stand-alone rating system that he hopes will be upgraded to integrate with the agency's management system from Insurnet Inc. of Emeryville, Calif.

The repeated inputting of data required by the non-integrated system is not time-efficient and "we can't cost-justify it.

In some cases, rating systems and automation in general are not cost-efficient, especially when an agent considers the original cost of the systems, monthly maintenance fees and personnel costs, said Ms. Hicks of Hales & Associates.

For instance, hiring a system manager can cost an agency up to $35,000 a year, and that position may require a clerical support person as well.

Ms. Hicks believes the industry has "talked the ideas to death," about automation, "But what every agency needs to do is to look at their situation individually. Forget what system is better than others. . .find a system that works for you."

Consultants and principals of automated agencies also point out that no matter how sophisticated the technology, no automation system will work without a fully loaded data base and strong support from the agency principals.

And in spite of the level of automation, common sense still has to prevail when using rating systems, especially because automation can make an agent complacent about the rating process.

"You still have to be sensible and smart and pay attention to what you're doing," warned Mr. Morgan. "Otherwise there's a lot of danger, and a waste of a lot of time and energy" in automating rating systems.

"We do what we think is practical for us; we don't do it just because it's the thing to do," said Mr. Rue, who is currently using a stand-alone rating system. "I'm pleased at the progress my people have made. They're on computers every day, unlike two years ago. . .We just want to learn to use what we have." ■

Waiting game may pay off for agents

New advances in agency automation mean that an agency that waited to become automated actually may have an advantage over those with long-standing automation systems, suggests Frederick J. England Jr., president of ISU/Hastings-Tapley Insurance Agency Inc. in Cambridge, Mass.

A new, widescale agency management system—complete with integrated rating capabilities and hardware—can cost an agency anywhere from $300,000 to $400,000, compared with the $700,000 ISU/Hastings-Tapley spent in 1985 on its current system, said Mr. England.

In some cases, larger agencies and brokerages that automated early in the game are now stuck with obsolete systems—too large, too slow, with fewer functions and limited storage capacity —because they are too expensive to scrap, added Mr. England.

One agency that fits into that category is Cannon-Treweek Agency Inc. in Gainesville, Fla., says Herbert G. Treweek, chairman and chief executive officer.

Cannon-Treweek currently is using a 12-year-old agency management system that runs on IBM Series 1 hardware "the size of a refrigerator," he explains.

Mr. Treweek remarked that he has to decide in the next several years whether to scrap the system and start from scratch.

Automated rating systems enhance service offered by insurance agency

Agents who automate their rating system —whether through an integrated system or a stand-alone computer—can reap big rewards, experts say.

"The main advantage is service to the customer," said Herbert G. Treweek, chairman and chief executive officer of Cannon-Treweek Agency Inc. in Gainesville, Fla. "The agent cuts his costs by doing this as well."

Additionally, because of the ability to generate ACORD forms, proposals and other paperwork, automated rating systems can also enhance an agency's professionalism in the eyes of the insurers it represents, said Vernell Hogan, principal, chief chief operating officer and chief financial officer of The BAL Group, a property/casualty agency with $15 million in premium volume in Virginia Beach, Va.

Forty-five percent of the agents with comparative rating systems cited "greater accuracy and efficiency" as the systems' most valuable function, according to the "American Agency System 1987 Automation and Interface Study," published by ACORD Inc. Other advantages cited by the agents surveyed included identifying the best price, marketing client proposals, quick response and generating ACORD applications.

Ms. Hogan's agency, which uses Travelers Corp.'s EBS agency management system, currently is using the stand-alone QUICKRATE program marketed by CAIR Systems of Irvine, Calif., for its commercial lines business and has just added a stand-alone rating system for personal lines business that is marketed by Savage Computers of Avon, Conn.

The addition of the rating systems "puts us in a more competitive position with our carriers" because of the ability to produce automated proposals and applications, as well as speeding up the process of getting quotes from insurers, Ms. Hogan said.

However, most agents with automated rating capabilities seem to agree that the systems' main attribute is "the speed; it's much quicker than it is manually," said Ms. Hogan. "There is also more credibility when people know the system and that it's accurate."

Stand-alone rating systems began to appear on the agency scene over the past two years and are still the system of choice—36% of all agencies have stand-alone automated rating systems, while only 14% have automated rating systems that are part of the agency management system, said Robert E. Merriman, president of ACORD.

And, most of the rating systems that are part of the agency management system are not integrated—data from one part of the system cannot be entered into the rating module, said an ACORD spokeswoman.

"It just got to be a pain rating from the manuals," explains William C. Hartnett, principal at Interstate Insurance in Tiverton, R.I.

The agency, which has a premium volume of $2 million, predominantly from personal lines business, began using a stand-alone Savage personal lines rating system a month ago. While the system can access information from the agency's Gemini agency management system, marketed by Aetna Life & Casualty Co., it cannot return the information to the data base, Mr. Hartnett explained.

Interstate Insurance started out with a "quick and dirty" rating software system, but the service became poor after the software company was bought by another firm, recalled Mr. Hartnett. Savage solicited the agency and made it an attractive offer: $250 for installation and training, and monthly fees of $80 per company per month.

The agency now can access rates from four insurers on the Savage system.

Mr. Hartnett says he is pleased with the Savage system, even though it is not fully integrated with the agency's data base.

"I don't think rating belongs directly on the agency management system," he said, adding that he believes rating programs written specifically for PC use are better than those integrated with agency management systems.

The existing integrated rating systems are "a quick fix giving people what they think they want," Mr. Hartnett observed.

Stand-alone PC rating systems are quicker and the commands used on them are easier to learn, he added. But he is optimistic that technological improvements will make integrated rating systems more attractive and efficient in the future.

Although the agency has not performed studies on the efficiency of automated rating, Mr. Hartnett called it a "big time-saver" compared with manual rating systems.

"It's amazing how quickly you get away from the manual rating process," noted Robert G. Slocum, vp of The Slocum Insurance Agency Inc. in Warwick, R.I. His agency's stand-alone Savage personal lines rating system was recently expanded to include commercial auto business. ■

'Paperless' agencies facing roadblocks

By LAURA MAZZUCA

In the automated agency of the future, paper files and file cabinets bulging with policy information may go the way of the manual typewriter, some consultants predict.

However, several obstacles stand in the way of the "paperless" insurance agency, observers agree.

First, computer technology is alien to many agents and brokers.

Moreover, many agencies that are at least partially automated do not yet have interface capability with insurers' computer systems.

Furthermore, many insurers require agents to retain a certain about of paperwork, such as policyholder signatures.

And, the technology required to make agencies fully automated often is not available or is prohibitively expensive, observers say.

"Maybe (the paperless agency) will happen in somebody else's lifetime, but not mine," says Robert G. Slovin of Cincinnati-based Frederick Rauh & Co., a unit of San Francisco-based broker ABI Management Inc.

The concept of a paperless agency is "bunk," agrees Richard B. Wheeler, vp of Crowder Jacobs Fendig Insurance in Tampa, Fla., another ABI unit. "I was gung-ho on it up to two years go, but the more I know, the more I'm sure I won't see it in my lifetime."

The true definition of "paperless" is when an agent does not have to pull a file to update a policy, says Jack Fries, an automation consultant in Glendale, Calif.

While most computer systems would allow an agency to become paperless by that definition, "agents can't think through to that environment," Mr. Fries said.

"I would like to think there could be a paperless agency," says William M. Rue, president of Rue Insurance in Trenton, N.J. "My generation is not as attuned to computers as the generations coming up, (but) we don't need hard copies of all the data we receive."

Rue Insurance's customer service representatives have had a difficult time working from a computer screen, at least initially, "because we've been looking at paper files for years. . . .My computer sat in my office and collected dust for six months before I used it. And, after I did, I wondered what the big deal was."

But Rick Morgan, vp of Boulder, Colo.-based agency consultant Automation Management Group Inc., maintains that paper files will eventually become a thing of the past. Even now, in the transitional period, it's "stupid" for an agency to maintain both paper and electronic files and attempt to perform customer service functions from both, he says.

Some would simply like to see agencies become less reliant on paper, rather than going entirely paperless.

"It's paper-less, not no paper," said Barbara Longenberger, assistant manager at Clair Insurance in Plymouth Meeting, Pa. "I can't imagine anyone thinking there will be no paper."

"It's an uphill battle to wean people from paper," admits James Thomas, vp and chief information officer of ABI Management, the nation's 13th-largest insurance broker (*BI*, June 20).

"As of yet we haven't even tried. We just want them to get their systems loaded and see that there's another way," Mr. Thomas said.

The main obstacle to the paperless agency is that, in most cases, computerized interface with insurers does not exist, which means paperwork must still be sent to insurers, according to Mr. Slovin (*A/BT*, Feb. 1, 1988).

In addition, many insurers require agents to retain a certain amount of paperwork, such as policyholders' signatures.

For example, automobile insurance policies in Florida must have the policyholder's signature on a specific state form, said Herbert G. Treweek, chairman and chief executive officer of Cannon-Treweek Agency Inc. in Gainesville, Fla.

Continued on next page

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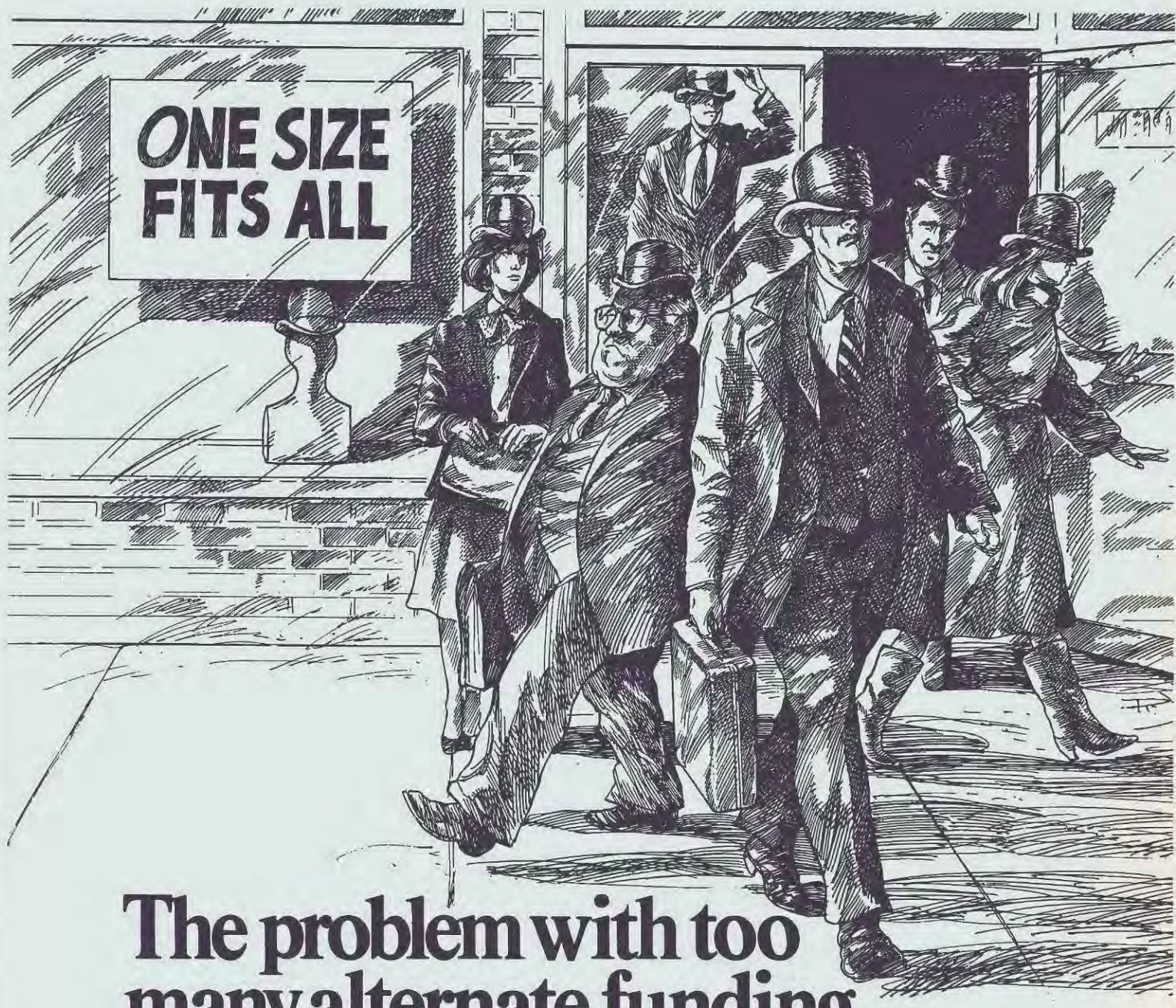

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Agent/broker topics

Paperless agency

Continued from previous page

Many agencies like to keep hard copies of information received from underwriters, "since they have a tendency of saying black is white," said Mr. Wheeler of Crowder Jacobs Fendig Insurance.

In some cases, the limits of the technology itself can preclude many agencies from going paperless, consultants say.

For example, while it is true that some agency information, like correspondence, could be entered into a computer, that means the addition of more storage capacity, which can be expensive. Mr. Wheeler's agency spent $26,500 on a 358-megabyte hard disk drive for its IBM System 36 to add more storage capacity.

"It would require an incredible amount of storage" in the computer if our brokerage went paperless, commented William Schuhmann, quality control coordinator at Curtis Day & Co., a San Francisco brokerage that specializes in large commercial clients.

And, even with such extensive electronic storage, Curtis Day still plans to retain hard copies of some paperwork, like incoming correspondence, he added.

"It's going to be a long time before we reach the truly paperless office," Mr. Schuhmann said.

Another technology-related drawback lies in the incompatibility of old and new computers.

When a vendor changes to a new system, or when agencies merge, there frequently is no way to retrieve data from the old system because the two systems are incompatible, said Mr. Wheeler.

In fact, Crowder Jacobs Fendig is facing that very problem now because it maintains an electronic daily log in its computer system, manufactured by McCracken Computer Inc., and that data cannot be transferred into the new Delphi system that ABI Management uses.

However, some agencies believe they are inching closer to achieving the goal of going paperless.

"I would say we have a good start on it," said William Cadenhead, principal of Cadenhead Shreffler Insurance in Bedford, Texas.

For example, Cadenhead Shreffler system's schedule and rate screen can be interchanged with the policy unit screen.

The agency's Gemini system was designed by Aetna Casualty & Surety Co. of Hartford, Conn., to use only schedule information. However, the agency reformatted the program to increase flexibility and to add the non-standard information that typically overflows into paper files.

So, when an operator calls up an account, he is referred to another screen for this additional, non-standard information, Mr. Cadenhead explained.

Remaining on paper are signatures on applications, photos, hard copies of motor vehicle records, appraisals, copies of audits and worksheets, Mr. Cadenhead said. However, he is hoping to add optic scanning—or image-to-disk capabilities—as soon as the technology allows.

Of course, this will require more system capacity, he added. The agency's IBM Series I hardware has a 64-megabyte hard disk; which so far has been adequate for the agency's needs. But, storage capacity will have to be expanded soon to maintain the agency's growing mass of electronic data, Mr. Cadenhead said.

The Sutter McClellan Agency in Atlanta is "insisting that our people use their computers more and more," said Karen Koskinas, secretary/treasurer.

"It was hard for anyone not growing up in a computerized society. . .but as they see that they can do their work without paper, they rely on the computers more and more," Ms. Koskinas said.

Although transaction filings—or listings of transactions by date—are not yet part of the system, the agency plans on adding the feature soon, Ms. Koskinas said. In the meantime, the agency's suspense system, which flags upcoming policy renewals and correspondence, is automated.

The main items in the agency's paper files are customer correspondence and appraisals, she said.

James Thomas, vp and chief information officer of ABI Management, also thinks the agencies ABI has acquired are moving closer to becoming the paperless operations of the future.

If a rating scale could be applied —with a paperless agency being a 10 and an agency with no automation a one—"I'd have to say that ABI is a three," he said.

However, Mr. Thomas predicts that ABI's rating will be up to eight in two years and 9.5 by the year 2000.

Fisher Brown Inc. of Pensacola, Fla., has about 2 million policy details in its data base, encompassing such information as bodily injury and property damage claims, said Kirk Ball, vp and general manager.

"This means that the file department is literally sitting on your desk in the computer," rather than each agency department "tugging" the paper file away from another, said Mr. Ball.

Because of the Fisher Brown's large data base, the system also can generate a "transactional inquiry" function, in which each monetary transaction on a policy or an account can be documented, he said. In addition, policy changes can be made on screen.

While this has "aspects of single entry," the agency still must maintain stand-alone terminals for dealings with insurers, since there is no total interface with insurers, Mr. Ball said.

When first loading the data base, "we took one of our best raters and processors and taught her how to key policy detail into the system," starting with Mr. Ball's own book of business.

This took "a great deal of time" at first, costing the agency the availability of this rater.

However, over the past year, "we have become as close to a fully automated agency as you can get," and paper file use has "vastly decreased," Mr. Ball said.

And, Rauh & Co.'s new Delphi Systems Inc. computer system will enable the agency to store and access more information electronically, a capability the agency currently does not have on its Redshaw Inc. system, Mr. Slovin said.

Rauh & Co. is in the process of loading information into the new Delphi system, which was supplied by ABI Management when it acquired the agency in 1987.

Ten times more policy information can be loaded into the new system than into the current system, which will enable Rauh & Co. to store information previously restricted to paper files, such as letters to clients, certificates and schedules of insurance, Mr. Slovin said.

Nevertheless, Mr. Slovin maintains his skepticism.

"We will rely on papers with our files. The computer is still secondary to the file," he said. ■

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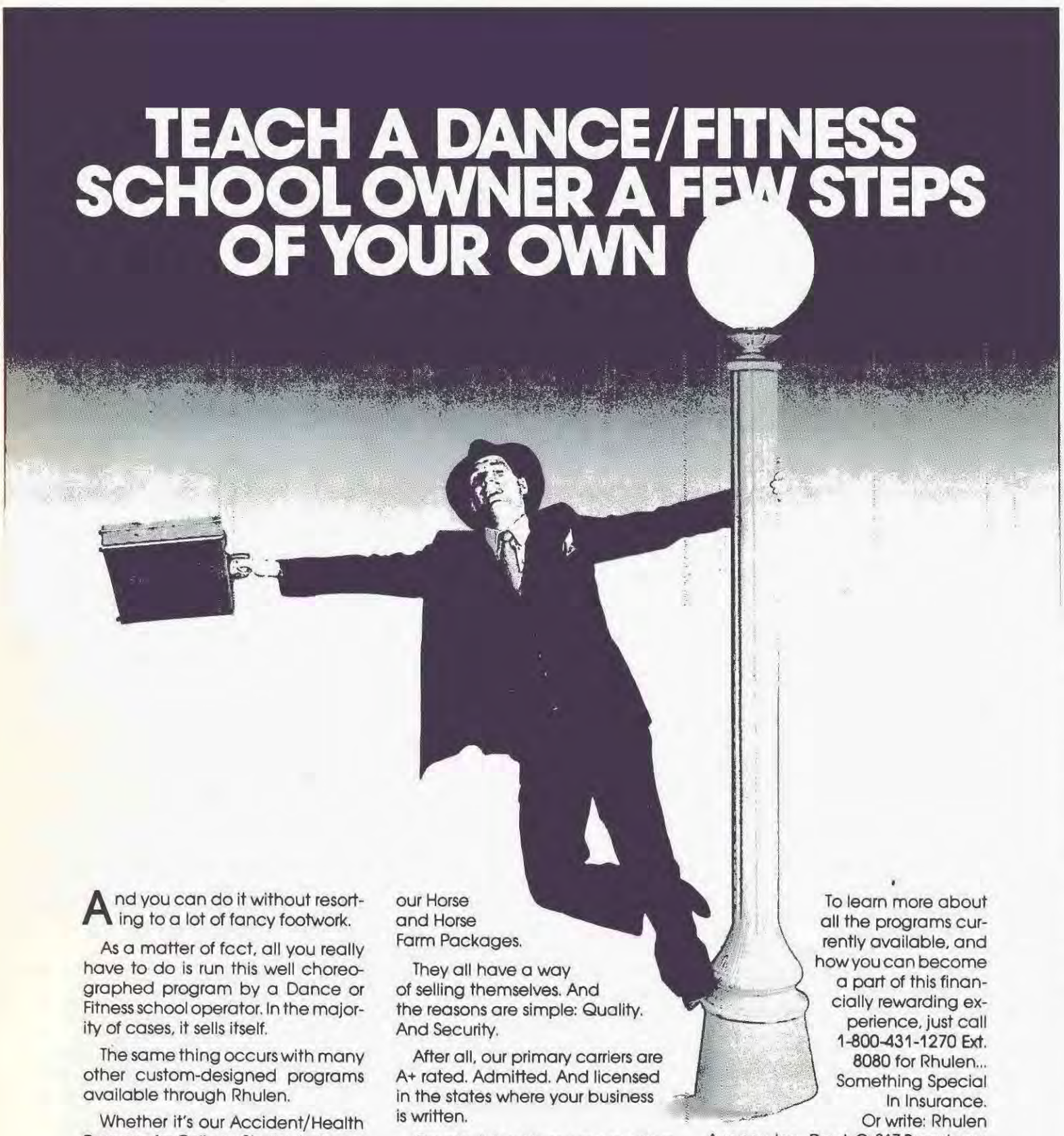

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Automation can deter E&O suits: Experts

By LAURA MAZZUCA

An automated agency management system—when properly used—can help protect an agent or broker from errors and omissions liability exposures, experts say.

"Automation can guard against E&O (liability) if it's properly programmed by operators who know what they're doing," said Mark Harty, an attorney with Morrison Mahoney & Miller in Boston, who specializes in agency E&O litigation.

But the move toward agency automation has a flip slide: Some experts warn that inputting data in a system can increase the margin for error.

Failure to document transactions is what produces most E&O liability suits against agents and brokers, according to Frank T. Murae, vp and regional claims manager for Utica National Insurance Group. The New Hartford, N.Y.-based insurer underwrites E&O coverage for approximately 12,000 agents through a program sponsored by the National Assn. of Professional Insurance Agents.

Thus, a fully automated agency management system that provides documentation of agency activities can reduce E&O liability exposure, experts say.

Some of the basic functions of an agency management system help eliminate oversights—like not notifying a policyholder of a pending expiration—that can lead to suits.

For example, a fully automated system that tracks policy activity will indicate when policies are about to expire, according to Rick Morgan, vp of Automation Management Group Inc. in Boulder, Colo.

With an automated system, an agent can quickly and automatically generate expiration lists, he said. The system also can generate lists of all policies that failed to renew, and then investigate why the policies lapsed, he explained.

In addition, newer integrated functions, like transactional filing diary systems, enable an agent to display or print policy data by date, transaction code or data entry employee.

The fact that such notations cannot be deleted in most of these systems further safeguards the integrity of the data, said Shirley Lukens, director of automation for the Independent Insurance Agents of America in New York.

Because of this, electronically generated data is not only admissible evidence if an agent is brought to court, but it frequently is considered more reliable than paper-based data by judges and juries, according to Mark F. Horning, an attorney with the Washington, D.C.-based law firm of Steptoe & Johnson.

Courts increasingly are accepting electronically generated information as admissible evidence in business litigation, he said.

As a result, agencies no longer need to keep backup paper files, he said. "You don't need a belt-and-suspenders approach."

However, it is a good idea to maintain back-up computer files in the event of a system crash, Mr. Horning pointed out.

As automated systems become easier to operate, agents are finding they can reduce other errors that can lead to E&O liability claims by inputting much of the data themselves, according to attorney Mr. Harty.

For example, a producer handling a lot of paperwork for a client with multiple locations and risks can enter policy changes into the system himself, thus ensuring the accuracy of location additions or deletions, Mr. Harty explained.

To guard against E&O exposures arising from agency automation, Mr. Horning recommends that agents and brokers take the following steps:

- Thoroughly archive information on a back-up disk in case of computer failure.
- Generate a set of written procedures as evidence that the agency's employees follow specific standards regarding automation and data entry.
- Take security measures, such as passwords and limited access, as "a good safeguard" against E&O exposures.
- Stress the importance of avoiding E&O exposure to all employees, especially those who input data.
- Ensure that the agency's hardware and software systems are backed by reliable vendors to prevent problems such as accidental erasures and hardware failures.

While automation can eliminate costly oversights and some data entry errors, it produces other potential problems for agents.

For example, the opportunity for embezzlement and misappropriation can be increased with automation, experts warn.

But built-in safeguards such as passwords and the restricting the ability to perform certain functions to certain terminals or personnel can protect the agency against such exposures, according to IIAA's Ms. Lukens.

Some systems even make it easier to detect some tampering by producing a "ripple effect," she said.

"You touch something here and you don't realize it's changing something else you can't detect," she said. ■

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Agent/broker topics

Experts leery of do-it-yourself systems

By LAURA MAZZUCA

Agents and brokers that can't find the right agency management system can bypass software vendors and design their own systems.

However, many experts warn that unless an agency employee is a computer whiz—or unless the agency hires a consultant with both automation and agency expertise—the agency may be headed for trouble.

"People have tried it, and it's crazy," said Rick Morgan, vp of Automation Management Group Inc., an agency automation consultant in Boulder, Colo.

Mr. Morgan explained that aside from the time, trouble and expense involved in developing a customized agency automation system, the agency also must deal with the subsequent inability to integrate the system with other systems when enhancements are needed. Customizing a vendor's system even slightly creates the risk that the customization could be ruined when peripherals are later added, he said.

"If an agent wants to design his own agency management system, then he should be in the business of agency automation," suggests John McCauley, president of McCauley Co., agency automation consultants in Carmel, Calif. "The question has to be, what business are you in?"

'If an agent wants to design his own agency management system, then he should be in the business of agency automation,' suggests Mr. McCauley. 'You just don't even know the hours it takes. It's worse than building your own house.'

Mr. McCauley, who helped design custom systems for brokerages using "primitive packages" in the early 1980s, warns against anything more complicated than customizing prepackaged systems.

"You just don't even know the hours it takes," he said. "It's worse than building your own house."

Do-it-yourself automation systems generally are undertaken only by the largest agencies, those with more than $100 million in premium volume, experts said.

"They think they're so unique," said Mr. Morgan. "It's an ego problem, not a reality."

Mr. Morgan

While several large brokers have tried to design their own management systems, most would have been better off simply by using prepackaged systems and modifying them to their needs, said Mr. McCauley.

For example, he suggested that agents can "shorten the legs and let out the shoulders" of a prepackaged system by choosing to modify functions such as diary dating, which retains transaction information and serves as a "tickler" system to remind the agent to follow up on service.

Later, the agency can add peripherals such as more printers, work stations, and rating capabilities.

"I try to discourage" agents from building their own systems "because it's probably an expensive way to go," commented Shirley Lukens, automation director for the New York-based Independent Insurance Agents of America.

However, she added that as agency management software prices continue to rise, and as technology improves, custom-designed systems may become more feasible. For example, some new technology allows users with few programming skills to create a flowchart that can be translated into an actual computer program, she explained.

Mr. Sinkoff

While many observers discourage agents from designing their own systems, other automation experts say that the effort may be worth a try.

"Absolutely, if they want to spend the time," said Morton D. Sinkoff, president of M.D. Sinkoff Associates, an agency automation consulting firm based in White Plains, N.Y.

Since the technologically proficient agent can use any data base or spreadsheet software to generate his or her own management system, it might be fun if the agent "became enamored with machines" to combine existing software to create a custom package, said Mr. Sinkoff.

The process seems to be more feasible for small agencies, since the functions needed to operate a large one are too complex to program.

But even agency principals who have created their own systems don't necessarily recommend it to their peers.

"I don't recommend that you do what I did because you do have to have a propensity to get involved," said Robert G. Slocum, vp of The Slocum Agency Inc., a personal lines-oriented agency in Warwick, R.I.

Because the agency is relatively small—$2.3 million premium volume and 10 employees—there was "no way could we run this agency with that few people without automation," he commented.

Mr. Slocum designed his own agency system in the early 1980s out of sheer necessity.

The Slocum Agency decided to automate before IBM PCs debuted, when products offered by agency automation vendors were geared toward large agencies. At the time Slocum was using a batch accounting system, in which hard copies of the agency's billings and filings were sent to a Florida company for data entry and storage.

"The time lag was a real problem," he added.

When he first set out to design the system, Mr. Slocum's agency simply needed an accounting system, word processing capabilities and an agency data base—the bedrock of all agency management systems, he explained.

Mr. Slocum initially planned on using a microcomputer, like an Apple system, for these basic functions, but the machine's capacity was too small.

As a result, the agency used a small local company's generic software program as a "shell" upon which to build its data base, and bought a Commodore 8032 hard disk system on which to run the software.

Mr. Slocum, who had studied the FORTRAN computer language in college as a business major, then programmed the system himself.

After using this system successfully for five years, the hardware was phased out, and Mr. Slocum replaced it with an IBM AT and another generic data base shell, which he reprogrammed to meet his specifications.

This process took six to eight months "at my leisure" to complete. The system switch-over took less than a week, he added.

Although he is still adding "refinements" to the system, it is working fine, said Mr. Slocum.

Today, the agency uses Wordstar word processing software, which is sold by Micropro International Corp. of San Rafael, Calif., and a Savage stand-alone rating system, neither of which are integrated with the customized system.

The latest system cost the agency about $15,000, not counting Mr. Slocum's programming time. "The indirect cost? God only knows," he commented.

However, "I had acquired a liking for computer programming" after setting up the first program, and creating the second system was less a hardship and more of a challenge.

Mr. Slocum is not concerned about incompatibility of his system, either. Since many systems are based on the IBM, it could be compatible to an outside vendor's data base—at least theoretically.

However, if he had known in the early '80s that IBM would introduce its own PCs and that compatible independent agency management systems would follow, he would have waited for packaged programs rather than designing his own system, he said.

Another do-it-yourselfer—Vic Worthington, president of Security Insurance in Sundance, Wyo.—has been using a self-programmed system for the last eight months. The system runs on an "old, beat-up IBM XT that I bought five years ago," and he calls the system itself "more a prototype than anything else."

But the self-made system boasts a single-entry, integrated rating system, and it works just fine for his three-person agency (himself, his wife and an assistant) which specializes in farm-related coverage for about 5,000 clients.

"I'd like to see this software made generic," said Mr. Worthington, who took four years to develop the system.

Like Mr. Slocum, Mr. Worthington didn't buy an integrated agency management system because, at the time, none of the systems available met his needs. At the time, he was using a computerized rating system and wanted to add a data base to track clients.

Since he had worked in the aerospace industry and did contract work for the National Aeronautics and Space Administration in the 1960s, "that possibly shaped my view on automation," he said.

Mr. Worthington realized the need to link rating and client data bases together. "I thought if these other guys (vendors) could do it, I could, too."

The system, which allows the operator to move back and forth from the rating system to the client data base, "rates, issues and files" policies and produces endorsements and renewals, said Mr. Worthington. All policy or quote information is accessible by client name.

"Clients want to know how much it's going to cost before they buy," he said. "It's too much trouble to rate, then translate the information into a file for the data base system."

With Mr. Worthington's system, quotes can be transformed into a policy file, which can be moved back and forth between endorsement, renewal and other data functions.

The rates themselves are on separate disks for each line of insurance—similar to the manual system he previously used. Therefore, if rates change, he can simply discard the whole diskette.

The automated rating system is more simple than working with manuals because the computer does the necessary calculations, Mr. Worthington said.

The system saves time, but its most attractive ability is to sell policies.

For example, if a farmer calls from the tractor salesman's office as he is buying a tractor, the agency can generate a policy immediately for the new property. The policy is effective on the computer data base immediately, since Mr. Worthington has binding authority. The agency then sends the insurer a hard copy of the policy and the insurer updates its data base accordingly. Mr. Worthington calls this "primitive interface."

Ideally, he would like a vendor to perform maintenance for his own system. If a vendor-maintained system was available that does what his system does, he'd buy it.

"If they did, we'd throw the file cabinets out the back door," he said. ■

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Many advances made in word processing

By LAURA MAZZUCA

Word processing—the workhorse of agency automation—is not standing still.

Enhancements that help perform claims sorting and marketing functions are making word processing systems more versatile and valuable to agents and brokers.

Agents are using both stand-alone, "off the shelf" word processing software—like Wordstar, made by Micropro International Corp. of San Rafael, Calif., and Lanier by Lanier Business Systems of Atlanta—as well as word processing systems that are integrated with their agency management systems.

"Almost everyone" has word processing, and almost everyone uses it efficiently, said Demmie Hicks, senior consultant for Hales & Associates Inc. in Atlanta.

Small to medium-sized agencies tend to use the word processing systems that are already integrated into agency management systems; while larger agencies, those with $2 million to $5 million in gross revenues, use a combination of both integrated and stand-alone systems, said Ms. Hicks.

Frederick Rauh & Co. in Cincinnati, a unit of ABI Management Inc. of San Francisco that produces $55 million in annual premium volume, has a separate word processing department that uses a Redshaw Inc. word processing system that can be integrated with an agency management system, said Marketing Manager Robert G. Slovin.

However, word processing is kept separate from the agency management data base because of the volume of word processing work that would otherwise tie up the system, he explained.

The agency is now in the process of switching to ABI's Delphi Information Systems Inc. After the transition, the agency management system data base will be accessible through the word processing system, said Mr. Slovin.

Curtis Day & Co. of San Francisco, an agency generating $55 million premium volume that specializes in large commercial clients, uses a stand-alone Displayright 36 word processing system that is partially integrated with an agency management system from McCracken Computer Inc., said William Schuhmann, quality control coordinator.

For example, an operator can plug in information from the agency management system's data base into the word processor's menu of correspondence to generate letters using specific client data, he said. However, information from the word processor cannot be transmitted back to the agency management system, Mr. Schuhmann added.

Even small agencies without agency management systems have stand-alone word processing systems, said Shirley Lukens, automation director for the Independent Insurance Agents of America in New York. To these agencies, word processing is an essential element that adds an aura of professionalism to the business, making the agency more attractive to insurers, she said.

While many large agencies use stand-alone word processing systems, some large agencies that purchased early agency management systems still are using the word processing packages that were integrated into the original system.

Many of these were "atrociously bad"—difficult to use and narrow in their capabilities, said Ms. Lukens, noting that agency management system vendors have since improved integrated word processing functions.

At Sutter McClellan Agency in Atlanta, which operates on an Agency Management Services Inc. system, word processing was part of the original package purchased in 1984, and has since been upgraded several times, said Karen Koskinas, secretary/treasurer.

Even now, though, the integration is only one-way; data base information can be merged into word processing files but not vice versa, she said.

However, improvements have been made in the areas of marketing, diary and claims functions, Ms. Koskinas added.

For example, enhancements in the system's marketing program speeded up the sorting capabilities for use in cross-selling to existing clients, she said. In addition, prospect lists can be loaded into the system for generating "canned" marketing letters.

In the claims area, enhancements updated the reporting capabilities, enabling the system to break down claims by client, insurer, customer service representative and producer, said Ms. Koskinas.

The diary alerts the operator to actions—such as correspondence, policy expirations and renewals—that must be followed up by a specific date. This, too, is now faster with the enhancements and more "user-friendly," she added.

Sutter McClellan started out with a 30-megabyte hard disk drive, which seemed "huge" at the time, Ms. Koskinas said. Now, the agency has 230 megabytes of storage capacity, "and we're worried about running out of space," she said.

However, in spite of improvements to integrated word processing systems, "in a lot of cases, they're still not as good as the little stand-alone programs," according to IIAA's Ms. Lukens.

For example, the Slocum Agency of Warwick, R.I. uses the fourth edition of Wordstar word processing software.

"Some would say that Wordstar is a dead horse, but we stick with it because he know it," said Robert G. Slocum, vp.

His agency purchased its word processing software in 1985, when Wordstar was the top of the line. It only cost "a couple hundred bucks," which made it very cost-efficient. Since then, the agency has upgraded the software twice.

The last upgrade highlighted functional improvements over Wordstar's original "archaic" command system, said Mr. Slocum. The software's spell-checking function has been improved as well, he said.

Continued on next page

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Agent/broker topics

Word processing

Continued from previous page

The agency uses Wordstar for generating paperwork such as proposals. "If it fits my needs I'm not about to jump onto something else," said Mr. Slocum.

Vic Worthington, who designed his own automation system for his Security Insurance Agency in Sundance, Wyo., also uses a stand-alone word processing system with spreadsheet, data base and word processing capabilities. However, the system doesn't allow for the transmission of data from the main agency management data base to the word processor.

Agency marketing functions have taken advantage of word processing advances in recent years, with impressive results. Expanded agency data bases, word processing programs that can access that information and laser printer technology have teamed up to make marketing easier.

At Fisher Brown Inc., a predominantly property/casualty agency in Pensacola, Fla., management is taking advantage of a data base containing more than three years of claims and policy information to expand its marketing department, said Kirk Ball, vp and general manager.

Word processing is an integrated function of the agency's McCracken software package, purchased six years ago, and recently upgraded to the manufacturer's "Insight" system.

The agency's laser printer allows operators to generate ACORD forms on plain paper, as well as produce schedules of insurance and renewal documents in 30 seconds, enabling the producer to look at the entire account rather than a specific policy, he added.

Additionally, if the producer is going on a call, the printer and data base can create a "call packet," containing rates, limits, descriptions, loss run and copy of certificate holders as well as claim information.

Rue Insurance in Trenton, N.J., uses Insurnet Inc.'s integrated word processing system for "almost all communications" with clients and insurers, said President William M. Rue. "Everything we can do on the computer, we do."

The agency also has a claims tracking function on the system that is integrated with the word processor and allows agents to send standardized letters.

Mr. Slocum's agency also uses the word processing system in conjunction with the agency's data base to "actively" solicit new clients. Although the systems are not integrated, the agency management system can isolate client data, such as by ZIP code or name, which is retained in a temporary text file that can be merged with standardized letters on the Wordstar system. ■

Automation vendors offer variety of rating products

By LAURA MAZZUCA

Agents or brokers scouting out an automated rating system, or an agency management system in general, should remember that they are purchasing "an investment in their business," an automation expert says.

Consider it a vital part of "the functioning of the very business. It's the lifeblood, the handler of information in an information-intensive business," said Morton D. Sinkoff, an independent automation consultant in White Plains, N.Y.

Also, Mr. Sinkoff suggests that agents deal with reputable vendors selling well-known products and that agents look for good support and maintenance contracts from vendors.

"If you buy a piece of junk, you'll get a piece of junk," he said. "Buy quality and service."

Several vendors offer agents either integrated or stand-alone rating systems, for both personal and commercial lines.

Listed below are several of the best-known rating system vendors. Prices vary, especially for maintenance and support, such as regular rating information updating:

• **Agency Management Services Inc.,** 1 Heritage Drive, Boston, Mass. 02171; 617-982-9400. Contact: Sales center.

Last year AMS acquired rating specialists Savage Computers, Avon, Conn.; Micromagic, Bolivar, Mo.; and Austin Micro Systems Inc. of Austin, Texas. The company offers integrated personal lines rating on its low-end system software, and commercial rating applications are optional on its mid- to high-end systems.

AMS' rating system includes a bridging system that allows operators to access material from the management system to the rating system and vice-versa. The bridge also allows other software, such as marketing and prospecting programs, to be integrated into the management system.

Prices for stand-alone rating systems start at less than $1,000; rating systems that can be integrated with management system cost $7,995, including hardware and software. Monthly maintenance and support services average about $100.

• **Agena Corp.,** 9709 Third Ave. N.E., Seattle, Wash. 98115; 800-456-1080. Contact: Sales department.

Agena's "Premiere" agency management system includes one-way integrated rating capabilities for personal lines automobile coverages, achieved by a bridging process between the data bases.

The vendor also has developed a commercial lines rating system in an agreement with Norick Data Systems Inc. of Oklahoma City.

Prices for the entire Premiere software system are $8,595. The integrated rating program alone costs $750 for personal lines applications and $1,000-$1,500 for commercial lines applications. The monthly support fee is $15 per insurer for the personal lines module; $86 for the commercial lines module.

• **Applied Systems Inc.,** 2500 Bond St., University Park, Ill. 60466; 312-534-5575. Contact: Doug Johnston, vp, product development.

This new rating system, which should be available later this month, is completely integrated: a two-way, single entry system for personal lines business. The rating module also can be used on a stand-alone basis.

In addition, a rating system for small commercial lines risks will be available early this spring.

ASI's systems use a bridging element to link the main data base and the rating capabilities.

Prices start at $2,995 for the personal lines system, and $1,995 for the commercial lines system; both base prices include one year of maintenance and support.

• **CAIR Systems,** 16815 Von Karman Ave., Irvine, Calif. 92714; 714-863-1240; 800-877-2247. Contact: Brenda Johnson.

CAIR's integrated "EVOLUTION" agency management system for three to 250 terminals includes a fully integrated (two-way) personal lines rating capability that uses a bridging system between the two data bases.

EVOLUTION is specially designed for medium-sized to large property/casualty insurance agencies.

CAIR also will offer its users a one-way automated rating system for commercial lines later this year.

Also available is the QUICKRATE commercial stand-alone rating system.

Prices vary according to system requirements and capabilities.

• **Delphi Information Systems Inc.,** 31416 W. Agoura Road, Westlake Village, Calif. 91361; 800-251-7385; 800-325-9450 in California. Contact: Kathy Bordner.

The Delphi Information System is an agency management system for property/casualty agents that includes claims tracking, word processing and the production of ACORD forms.

Delphi has contracted with Automated Insurance Resource Systems Inc. (AIRS) of Chicago to produce "RaterCalc," a one-way integrated commercial rating system compatible with Delphi system.

Start-up cost for the system, including hardware, is $55,000 and up. For the addition of RaterCalc there is a one-time license fee of $1,500, with software maintenance costs averaging $25 per month.

• **Leader Systems,** 814 Livingston Court, Marietta, Ga., 30067; 404-428-7971; 800-762-9509. Contact: Celeste King.

The vendor is developing a system for two-way rating interface (using a bridging system) to be called "MVP." It is expected to be on the market by the fourth quarter of 1989.

The single-user price will be $4,995, while the multi-user price will depend on number of users on the system.

• **McCracken Computer Inc.,** 10 Mall Road, Burlington, Mass. 01803; 617-273-0010. Contact: Julie McGrath, rating project manager.

McCracken late last year introduced an rating system for commercial lines through a venture with Programming Resources Co. of Hartford, Conn., which created the software. The rating system and McCracken's Insight agency management system data bases can be bridged to enable two-way integration between the systems.

The rating system can handle many lines of business, including inland marine and workers compensation risks.

Prices start at about $5,500 per office for information in five states, plus a monthly maintenance and support fee of about $275.

A complete Insight agency management system starts at $60,000.

• **Redshaw Inc.,** 680 Anderson Drive, Foster Plaza 10, Pittsburgh, Pa. 15220; 412-279-3732. Contact: Lisa Brooks.

Redshaw is integrating rating capabilities directly into its agency management system, which operates on Wang hardware. The systems is expected to be on the market by the end of next month.

Redshaw's acquisitions of the products of two ratings vendors—and joint ventures with two others—means more insurance companies and lines will be immediately available to clients.

Both the agency management system and the rating system operate from a single data base.

The new system is currently available only for commercial lines, although Redshaw has a personal lines rating system on the drawing board.

One-time licensing fees average $1,500, with monthly rate updates ranging from $75 to $150. All future enhancements and rule changes are included in the licensing fee. A "typical" Redshaw Model 10M/04 agency management system starts at $19,990. ■

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Agent/Broker Topics

Health care plan costs

Continued from page 1

"This is not a totally black-and-white issue. But, if you're on a self-funded basis, then you've paid the piper already. However, if you're someone who insures your plan, you'll be paying for it next year," said David P. Rahill, a principal consultant in Foster Higgins' Princeton, N.J., office.

Reflecting the huge increase in health care costs in 1988, 44% of the employers participating in the survey said cost containment is this year's most important health benefit issue. By comparison, only 25% selected compliance with the Internal Revenue Service's controversial Section 89 non-discrimination rules as the most important health care issue for 1989.

The big jump in health care costs last year can be partially attributed to the rising cost of mental health and substance abuse care and the cost of treating increased numbers of employees with acquired immune deficiency syndrome, Mr. Erb said.

The average cost of mental health and substance abuse benefits rose 27% to $207 per employee in 1988 from $163 per employee in 1987, he said. In fact, mental health and substance abuse benefit costs now account for 9.6% of total health plan costs.

In addition, 34% of the employers reported AIDS cases among plan participants, with an average of three cases per employer.

Health plan cost increases were virtually unescapable last year, the survey points out: 88% of the surveyed employers reported higher plan costs in 1988.

And, costs for some employers are far above the national norm. For instance, 18% of the surveyed employers reported that health plan costs per employee topped $3,000 last year.

The average health care plan cost 8.6% of payroll in 1988, according to the survey. However, 10% of respondents said their plans cost 15% or more of payroll.

Employers in the North Central region of the country reported the highest average cost per employee in 1988: $2,570. The lowest average cost per employee, $2,108, was reported by employers in the South Atlantic states.

"Some of the differences in plan costs among the regions can be explained by the predominance of a particular type of industry in a region and the degree of unionization within that industry," the survey points out. Employers with workforces that are more than 50% unionized reported plan costs that were 24% higher than the national average.

By industry, energy and petroleum employers reported the highest average cost per employee in 1988: $3,110. The lowest cost by industry, $1,915, was reported by wholesale and retail trade employers.

By size, employers with 40,000 or more employees had the highest average cost per employee in 1988 at $2,605. Employers with 500 or fewer employees reported the lowest cost: $2,256.

Among all responding employers, the average indemnity plan cost per employee in 1988 was $2,160, or 8.5% higher than the average HMO cost of $1,991 per employee.

In addition, employers reported that dental plan costs in 1988 averaged $278 per employee.

Again, employers in the North Central region of the country reported the highest average indemnity plan cost per employee— $2,875—and the highest average per-employee HMO cost—$2,372. And, employers in the South Atlantic states reported the lowest indemnity plan cost—$1,996 per employee—and the lowest HMO cost—$1,837.

Dental plan costs were highest in the Pacific region, at $349 per employee. Dental plan costs were lowest in the South Atlantic states, at $217 per employee.

Average per-employee HMO costs were highest among employers with 5,000 to 9,999 employees, at $2,087. These costs were lowest among employers with 20,000 to 39,999 employees, at $1,731.

Indemnity plan costs were highest among employers with 40,000 or more employees, at $2,486 per employee. Indemnity plan costs were lowest among employers with fewer than 500 employees, at $2,054 per employee.

The survey reports that most employers—86%—have adopted some type of utilization review program. And employers agree that these plans do save money: Respondents estimated that the use of UR programs produced an average savings of 5.6% of total plan costs.

Specifically:

- 73% of surveyed employers had a second surgical opinion program. These employers reported that second surgical opinion saved an amount equal to 2.2% of total plan costs.
- 68% had a hospital precertification program in place. These employers reported that precertification saved an amount equal to 4.7% of total medical costs.
- 49% said they had a concurrent review program. These employers reported that concurrent review saved an amount equal to 4.0% of total plan costs.
- Case management programs are used by 50% of the respondents. The employers said case management saved an amount equal to 3.2% of total plan costs.

Employers in the South Central states reported the highest percentage of savings as an overall result of utilization review: 6.3%. Employers in the Mid-Atlantic states reported the smallest percentage of savings: 5.3%.

Most of the employers surveyed—61%—also said they offered at least one HMO to employees in 1988, with these employers offering an average of nine HMOs to workers.

Larger employers were much more likely to offer HMOs: 98% of the employers with 20,000 to 39,999 employees offered an HMO, compared with only 35% of the employers with fewer than 500 workers.

An average of 33% of workers at employers that offer HMOs enroll in an HMO. Twenty-three percent of the employers offering HMOs say more than half of their workforce is enrolled in HMOs. HMO enrollment is highest in the Mountain states, where 42% of eligible employees are enrolled. HMO participation is lowest in the Mid-Atlantic states, where only 20% of those eligible enroll.

Employers with HMOs reported that 6% of HMO enrollees re-enrolled in indemnity plans last year. And, an average of 7% of HMO enrollees switched to a different HMO in 1988.

Of the employers offering HMOs, 41% said their indemnity plan premiums were higher than their HMO premiums, while 35% said HMO premiums were higher and 24% said their HMO and indemnity premiums were about the same.

Eighty-four percent said their HMO premiums increased in 1988, while 12% said the premiums were about the same, and only 4% said their HMO premiums decreased. The average HMO premium increase in 1988 was 11.1%.

Continued on next page

Some employees to pay more

Despite an 18.6% rise in group health care plan costs in 1988, relatively few employers reported definite plans to increase health plan deductibles.

However, more than one-third of the employers surveyed by A. Foster Higgins & Co. Inc. are considering an increase in deductibles.

According to the survey, conducted in August 1988, only 8% of respondents will increase deductibles in 1989, but 36% were considering higher deductibles. The remaining 56% ruled out any increase in deductibles.

In addition, 23% of respondents said they would increase employee contributions toward individual coverage in 1989, while 22% were considering such an increase. Sixty-five percent had ruled out any increase.

More employers are seeking higher contributions for dependent coverage. Twenty-one percent said they definitely will seek increased dependent coverage contributions, while 26% more were considering an increase. Fifty-three percent said they would not increase these contributions.

Almost all surveyed employers—98%—said their plans included a comprehensive deductible. Fifteen percent said they also require a separate deductible for hospital confinements, and 7% reported they also require a deductible for emergency room visits.

The highest percentage of employers—44%—require a deductible of $100 for individual coverage. The next most common amount—$200—is required by 22% of the employers. Sixteen percent require a $150 deductible. Only 5% said they had deductibles of less than $100.

Eighty-three percent said they had increased deductibles once in the last 10 years, while 13% had increased deductibles twice in 10 years.

Fifty-five percent of the employers also require a 20% copayment under their indemnity plans, while 34% require no copayment. Six percent require a 10% copayment; 2% require 15%; and 3% require some other percentage.

An employee out-of-pocket maximum expense is included in 87% of the plans. The most common amount is between $1,000 and $1,499 for individual coverage and between $1,000 and $1,999 for family coverage.

Sixty-one percent of the plans require no employee contribution for employee-only coverage. Employees in plans requiring a contribution pay an average of 22% of the plans' cost.

However, only 31% of employers do not require employee contributions for dependent coverage. Employees in plans that require a contribution for dependent coverage pay an average of 38% of the plans' costs. ■

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Flexible plans

Continued from page 1

surance payments and premium contributions.

"Employees are given an opportunity to accept more responsibility for their first-dollar medical care costs through higher deductibles and coinsurance" in flexible benefit programs, said Marianne Gellatly Brackey, national practice leader with Hewitt.

"Flexible benefit plans are an easier tool for employers to use to get employees to absorb more cost sharing," said John Hickey, a partner at consultant Kwasha Lipton in Fort Lee, N.J. "The elements of choice and tax-effectiveness make cost sharing more palatable to employees."

As employees are liable for more costs, they tend to become more careful consumers of health care services, Ms. Brackey said.

Ms. Brackey acknowledges that employers offering indemnity plans also could slow the rate by which their own medical care costs increase simply by making employees pick up a greater share of the cost through increased deductibles, coinsurance and premium sharing.

But such changes are much more palatable to employees if they come with a flexible benefits program, she said.

"Employers with flex plans feel more comfortable increasing employee cost sharing because employees have the ability to choose from different benefit options. In a flex plan, it is not a take-it-or-leave-it approach," Ms. Brackey said.

In a typical flexible benefit plan, an employee receives a certain amount of "flex dollars" or "flex credits" that can be used to "buy" different benefit options with assigned values. An employee might, for example, conserve flex dollars by selecting a lower-cost medical plan with a high deductible so he or she can apply unused dollars for a richer dental plan or simply take unused dollars in cash.

In addition, flexible benefit plans provide significant tax advantages for employees to ease the bite of more cost-sharing.

Most flexible benefit plans include flexible spending account features. Under such an arrangement, employees can make pretax contributions to a special account, which then can be used to pay the employee's share of the medical care premium or other uncovered health care expenses.

Aside from giving employees more benefit choices, employers also are likely to make major design changes to their medical plans when they establish a flexible benefits program, the survey shows.

For example, 44% of surveyed employers boosted deductibles when they implemented their flexible program, while 28% increased employee contributions for dependent coverage and 25% boosted contributions for individual coverage.

In addition, 23% added health maintenance or preferred provider organization options and 21% increased the maximum annual out-of-pocket expense for employees.

Cost management techniques also may be ushered in with flex plans: Some 59% of surveyed employers introduced such techniques when they established flex plans, according to the survey.

For example, 43% added second surgical opinion features when they set up the flex plan, while 37% added coverage for outpatient surgery for certain conditions.

In subsequent plan years, some 58% of employers added case management features, while 56% added pre-admission certification procedures.

With flex plans meeting employers' objectives to restrain medical care cost increases, while giving employees the opportunity to tailor a benefit package to meet individual needs it's not surprising that the popularity of such plans is soaring.

In the last year alone, the percentage of Fortune 100 companies with flexible benefit programs has climbed to 45% from 27%, according to information compiled by Hewitt.

In addition, as of Jan. 1, some 942 companies with more than 500 employees each sponsored flexible benefit programs, up from 648 on Jan 1, 1988, and 505 on Jan. 1, 1987, according to Hewitt.

Among the 330 employers and organizations with flexible plans included in the new Hewitt survey, more than half established their programs during the last three years.

"Flexible benefit programs have become a mainstream approach in providing employee benefits," Ms. Brackey said.

Just as flexible benefit plans are growing, their design also is changing, with companies less likely to establish stand-alone FSAs.

For example, among the 330 employers surveyed with flex plans, 23% offered only a flexible spending account, while 72% offered an FSA, plus choices among different types of ben-

Continued on next page

Health care study

Continued from previous page

Thirty-four percent of employers said they thought their HMO premiums fairly reflected the cost of providing health care to their employees enrolling in an HMO, while 26% said they disagreed. Forty percent more had a neutral opinion.

However, only 14% said they had performed an actuarial study to determine whether an HMO premium was appropriate.

Thirty-three percent of employers offering HMOs said they offered an HMO that offered experience-based rates, in which only an employer's own experience is taken into account when setting premiums, compared with the more widespread community rating, which bases an employer's premium on the experience of the entire community.

Employers were fairly evenly divided on whether HMOs effectively control costs: 33% said they were effective, 32% said they were not and 34% had no opinion.

However, 54% of the respondents said that HMOs do attract better risks, while 19% did not believe this was true. Twenty-seven percent had a neutral opinion on this question.

Also, 48% said they did not think HMOs offer higher-quality care than indemnity plans, while only 8% thought they did. Forty-four percent were neutral on the issue.

PPOs are offered by only 25% of the respondents. Eight percent said they planned to offer a PPO by 1990, while 29% said they were not sure if they would offer a PPO.

Of the employers offering a PPO, 65% offer it as a component of their indemnity plan, while 19% offer the PPO as a separate plan and 16% offer the PPO as a replacement for an indemnity plan.

PPOs are perceived as more effective than HMOs in controlling health care costs, the survey shows.

Sixty percent of the employers with PPOs say their health care costs decreased as a result of the PPO, while 33% said the PPO had no effect on costs and 14% reported their costs increased. Employers with PPOs attributed an average savings of 3.3% of total plan costs to the PPO.

And, 60% of employers with PPOs agreed that PPOs are effective at controlling costs, while only 33% said HMOs were effective in controlling costs. Eight percent said PPOs were not effective cost-control mechanisms, while 32% were neutral.

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Copies of the "Health Care Benefits Survey: 1988" findings are available for $25 from Pamela Blake, A. Foster Higgins & Co. Inc., 212 Carnegie Center, CN 5323, Princeton, N.J. 08543-5323. The complete survey report, including tables of responses and monthly reports, costs $500.

Next week, Business Insurance will report on other areas covered by the survey, including retiree health care and plan administration topics.

Continued from previous page
efits. Five percent offered choices of benefits, but not an FSA.

By contrast, among the 55 surveyed employers that established a flexible program in 1988, only 15% offered solely an FSA, while 83% offered benefit choices with an FSA. Two percent offered benefit choices without an FSA.

"Employers today are looking at flexible plans as far more than tax-effective vehicles for employees," Ms. Brackey said, explaining the decline in the percentage of employers sponsoring stand-alone FSAs.

"Employers are emphasizing the choice-making opportunities that are inherent in a full-fledged flexible program," she said.

In addition, employers now are much more likely to introduce a full-fledged flexible benefit program rather than follow a phase-in approach, in which a company initially may offer only an FSA or choices among only one or two benefit areas before expanding.

For example, among employers establishing flexible programs in 1988, some 62% implemented the entire program at once, up from 55% in 1987, 52% in 1986 and 40% in 1985.

"Employers weren't as convinced of the merits of flex plans four years ago. They were more cautious," Ms. Brackey said, explaining the trend toward immediately implementing full-fledged flex programs.

The survey also found employers currently establishing flex plans are much less likely to use internally developed software to administer their programs.

For example, just 28% of employers establishing flex plans in 1988 used internally developed software to administer their programs, while the remainder either purchased software or contracted with an outside firm to administer their plan.

By contrast, in 1983, some 79% of firms used internally developed software, while the remainder contracted with an outside company to administer their plan. None of the companies surveyed in 1983 bought software.

"There is a lot more high-quality, versatile, reasonably priced flex software out there," Ms. Brackey explained. "Employers we talk to say that in view of the software that is out there, it no longer is practical for them to start administration systems from scratch."

Not surprisingly, larger firms incur the highest cost in setting up a flexible benefit program.

"Setup costs generally increase with the number of program participants because complex computerized administration systems become necessary for larger organizations," according to the survey.

For example, companies with fewer than 1,000 employees eligible to participate in a flex plan that offers choices among benefits reported average setup costs of $40,000, compared with average setup costs of $103,000 for companies with between 1,000 and 5,000 employees, $179,000 for companies with between 5,000 and 10,000 employees and $348,000 for firms with more than 10,000.

Once a flex program is in place, though, ongoing administration costs decline.

For example, employers with between 5,000 and 10,000 eligible employees reported annual administrative expenses of $83,000, compared with the $179,000 in start-up costs. Meanwhile, companies with more than 10,000 eligible employees reported annual administrative costs of $158,000, compared with $348,000 in start-up costs.

However, average external first-year communication costs, as expressed as an amount per employee, are less for larger firms than for smaller companies with flex programs.

For example, external communication costs for companies with flex plans with fewer than 1,000 eligible employees averaged $93 per employee. That compares with external communications costs of $31 per employee for companies with between 1,000 and 4,999 employees, $26 for employers with between 5,000 and 9,999 employees and $11 for firms with more than 10,000 employees.

Larger firms' communications costs, as expressed on a per employee basis, may be less than for smaller firms because some of those costs may be fixed and can be spread out over a higher number of employees.

According to the survey, employers said they needed an average of six months to plan their flexible benefit plan's communications campaign and materials.

However, 13% of surveyed employers said they needed between seven and nine months for communications preparation, while 13% said they needed more than 10 months.

Other survey findings include:

- Eighty-six percent of employees in surveyed plans reported favorable or somewhat favorable employee reactions to their programs. Twelve percent reported that employees had mixed reactions and 2% reported unfavorable reactions from workers.
- Among employers that implemented flex plans before 1986, 77% said the plans had met their objective of containing medical costs, while 13% said that objective had not been meet and 10% said it was too soon to tell.
- Among employers with FSAs, the average annual salary reduction allowed to cover health care expenses is $3,700, while the average maximum limit on salary reduction for dependent care expenses is $4,900.
- Among employers with FSAs included with a broader flexible benefit program, the average FSA contribution for health care expenses in 1988 was $493 per participant. By contrast, contributions for health care expenses to stand-alone FSAs averaged $712 per participating employee.

The average contribution for health care expenses to all FSAs was $547 per participant.

Similarly, the average 1988 contribution for dependent care for FSAs included as part of a broad flex plan averaged $2,138 per participating employee, while the average contribution for stand-alone FSAs averaged $2,650 per participant. For all spending accounts, the average contribution for dependent care was reported at $2,260.

- In 1988, some 21% of eligible employees participated in health care FSAs, while 3% of eligible employees participated in dependent care FSAs.
- For health care FSAs, the average amount forfeited by participants in 1987 was $27, while the average forfeiture for dependent care participants was $15.

Forfeitures of participants' unused FSA balances are required under the Internal Revenue Service's 1984 "use it or lose it" regulations.

- Some 37% of employers revert forfeited FSA funds back to the company's general assets, while 28% revert funds for a specific employer purpose.

In addition, 11% of employers donate forfeitures to charity, while the remainder use forfeitures for other purposes, such as increasing the next year's benefit credits for employees.

•

Copies of the "1988 Survey of Flexible Compensation Programs and Practices" are available for $100 from Cathy Schmidt, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.

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Karter takes helm at Scor Reinsurance

Jerome Karter has been named president and chief executive officer of Scor Reinsurance Co., the operating subsidiary of SCOR U.S. Corp. in New York.

In addition, **Sylvain Boueil** was named senior vp and chief underwriter of Scor Re.

Mr. Karter replaces Francois Negrier, president of Societe Commerciale de Reassurances of Paris, who served as interim president and chief operating officer after the resignation of Pierre D. Croizat (*BI*, Nov. 14, 1988). SCOR Paris is the majority shareholder of SCOR U.S.

Mr. Karter most recently served as senior vp and manager of the New York international department of Johnson & Higgins, which he joined in 1984.

Late last year Mr. Karter was named president and managing director of UNISON S.A. in Brussels, Belgium, a subsidiary of the UNISON network of international insurance brokers, of which J&H is a member. Mr. Karter was to assume the new post this month (*BI*, Dec. 12, 1988).

Mr. Boueil since 1983 has headed casualty underwriting operations for SCOR Paris.

In other reinsurance changes:

John N. Lombardo has been named president of Munich American Reinsurance Co. in Woodhaven, N.Y. Mr. Lombardo succeeds **James Inzerillo**, who retired Dec. 31. Mr. Inzerillo will continue to serve on the board of MARC and Munich Management Corp., the U.S. manager of Munich Re. Mr. Lombardo joined Munich Reinsurance Co., the U.S. operations of Munich, West Germany-based Munich Reinsurance Group, 24 years ago in treaty underwriting. In his most recent position, Mr. Lombardo was senior executive vp.

Gregory R. Cuilwik joined Unione Italiana Reinsurance Co. of America Inc. in New York as senior vp-underwriting. Most recently, Mr. Cuilwik was vp-treaty reinsurance at Metropolitan Reinsurance Co., a subsidiary of Metropolitan Life Insurance Co.

Patricia W. Parks promoted to vp from assistant vp of Fortress Re Inc. of Burlington, N.C.

Gary Lukens promoted to vp of Hartford Re Management Co. of Hartford, Conn., an independent affiliate of Hartford Insurance Group.

Karl J. Mayr promoted to executive vp of Frankona Reinsurance Co. in Kansas City, Mo.

Michael J. Wybar promoted to executive vp of intermediary Sullivan Payne Co. of Seattle. Mr. Wybar is based in the Philadelphia office.

Royden A. Grimm appointed vp of General Reinsurance Corp. of Stamford, Conn.

John M. Wilson named senior vp at North American Reinsurance Corp. of New York. Also, **Gary Patrik** named senior vp and actuary, and **Robert J. Persichette** appointed vp-operations.

James D. Wickwire Jr. joined National Reinsurance Corp. of Stamford, Conn., as vp and chief actuary. Previously, Mr. Wickwire was vp/chief actuary with Orion Capital Corp.

William L. Aldred named president and chief executive officer of Devco Mutual Assn. of Media, Pa. Most recently, Mr. Aldred was director-property with Prudential Reinsurance Co.

Michael J. Taxter promoted to vp of National Reinsurance Corp. of Stamford, Conn.

Keith J. Sari promoted to vp-property claims of American Re-Insurance Co.'s claims division in Princeton, N.J.

Insurers

A. Peter Quinn Jr. appointed president of Sargasso Mutual Insurance Co. Ltd. of Hamilton, Bermuda. Also, named vps were **Peter W. Bruce**, **Kernan F. King**, and **Jerome M. Sperber**.

Peter E. Fallon named president and chief executive officer of American Universal Insurance Group Inc. of Providence, R.I. Mr. Fallon succeeds **Earl C. Ostroff**, who is returning to private consulting practice.

Donna Ferrara named vp-claims litigation of Crum & Forster Corp., a unit of Crum & Forster Inc. of Morristown, N.J. Also, **Richard E. Kafaf** appointed vp-environmental claims for the company. Mr. Kafaf is in the Basking Ridge, N.J., office.

Donald A. Emeigh Jr. promoted to senior vp and secretary of Christiana General Insurance Corp. of New York in Tarrytown, N.Y.

Arthur R. Petzel Jr. promoted to senior vp and **John J. DiBiasi** promoted to vp-underwriting and marketing at Penn-America Insurance Co. of Hatboro, Pa.

At Transamerica Insurance Co. of Los Angeles, a subsidiary of Transamerica Corp., the following appointments were announced: **Bill Ehlers** to the newly created position of vp and senior executive for California field operations in the San Francisco office; **Michael Scott** to resident vp and manager of the Northern California region in San Francisco; and **Richard Bak** to resident vp and manager of the Southern California region in Costa Mesa.

Richard J. Liburdi promoted to vp and product manager-group pensions at Penn Mutual Life Insurance Co. of Philadelphia.

William J. Mudge named vp-workers compensation for Industrial Indemnity Co. of San Francisco, a subsidiary of Crum & Forster Inc.

Charles H. Sharpe appointed vp and director-claims for Selective Insurance Co. of the Southeast in Charlotte, N.C.

Edward A. Morris named vp-professional liability of Farmers Group Inc. of Los Angeles.

James Cavitt and **Robert Hogan** were promoted to executive vps for Superior National Insurance Co. of Woodland Hills, Calif.

Salvatore G. Buccolo promoted to regional vp-Southeastern region of Maryland Casualty Co. of Baltimore.

Agents/brokers

Bill Gunter, former Florida insurance commissioner and treasurer, named senior vp of Rogers-Atkins Insurance Inc. in Tallahassee, Fla.

John W. Gussenhoven, **Brian R. Hall**, **Robert F. Powell Jr.** and **William C. Remington** named to the board of directors of Johnson & Higgins of New York. Appointment to the board of Johnson & Higgins confers ownership status in the company.

William P. Stouffer named president of Frank B. Hall & Co. of Pennsylvania Inc. in Pittsburgh.

Roger S. Sweeney joined Frank B. Hall & Co. of Massachusetts Inc. in Boston as vp/producer. Mr. Sweeney was previously assistant vp and senior account executive with Allendale Insurance Co.

Continued on next page

Comings & goings: industry

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Continued from previous page

Norman A. Spargo named executive vp and Eastern group director of Fred S. James & Co. Inc. of New York. Mr. Spargo will be based in Atlanta.

J. Christopher Bulger named profit center manager of Fred S. James & Co.'s San Francisco office.

Clifford A. Metcalfe Jr. promoted to president and chief executive officer of Corroon & Black of Texas Inc. in the Houston office.

Roger W. Clark named managing vp of the Denver office of Alexander & Alexander Inc.

John D. Howard named managing vp of A&A's Houston office.

Michael L. Betlinski joined the Los Angeles office of A&A of California Inc. as senior vp and director of marketing-Pacific region. Previously, Mr. Betlinski was a senior vp at Marsh & McLennan Inc. in Los Angeles.

C. Don Smith named executive vp of Bayly, Martin & Fay International Inc. of Fort Worth, Texas. **Michael B. McAllister** succeeds Mr. Smith as president of Bayly, Martin & Fay Inc. of Los Angeles.

Bert H. Swails named president of Bayly, Martin & Fay Inc. of Houston. Mr. Swails succeeds **Larmon R. Salmon**, who retired.

Also, **Aggi Pharo** joined the New York office of BMF Inc. as executive vp-entertainment division. Ms. Pharo previously was assistant vp-entertainment division at Johnson & Higgins in Los Angeles.

Thomas W. Proctor named senior vp-special risks division of Proctor Homer Warren Inc. of Troy, Mich.

T.O. Dawson named chairman of Penta Corp. of Champaign, Ill. Also, **Steven L. Tyler** named president and chief executive officer. Mr. Dawson and Mr. Tyler succeed former Chairman and President **Arthur L. Tyler**, who retired.

Leonard P. Lawrence named chairman of Jardine Emett & Chandler Inc.'s Los Angeles office. **Steven P. Tiberg** succeeds Mr. Lawrence as president and chief operating officer of the office. Also, **Jim Bussio** named vice chairman of the office.

HMOs/PPOs

Stephen R. Tiwald joined PATH Co. in Park Ridge as president. PATH is a preferred provider organization subsidiary of Parkside Health Management Corp.

Excess/surplus

Hassan Ali named vp-casualty underwriting of Crum & Forster Managers Corp. (Ill.).

William E. Thomas named president of USA Insurance Services Inc. of Dallas, a managing general agency.

Other suppliers

Harry J. Conaway joined the Washington, D.C., office of William M. Mercer Meidinger Hansen Inc. of New York. He will coordinate communication between government officials and employers on tax and labor rules affecting employee benefit plans. Most recently, Mr. Conaway was associate tax legislative counsel for the Office of Tax Policy of the U.S. Department of the Treasury.

Also, **Robert M. O'Keefe** named head of Mercer's Detroit office.

Donald K. Heim promoted to president of Advanced Risk Management Services in New York, a loss financing division of Corroon & Black Corp.

Corbette S. Doyle promoted to president and chief executive officer of National Accounts Services in New York, a loss financing division of Corroon & Black Corp.

Kenneth H. Wells named chairman of Kenneth H. Wells & Associates Inc. of Aurora, Colo., a structured settlement consultant. Also, **Joseph M. Costello** named president.

Clifford W. Ritt joined the Washington, D.C., office of Buck Consultants Inc. as benefit consultant. Mr. Ritt previously was a principal with William M. Mercer Meidinger Hansen Inc. in Baltimore.

Paul M. Brown named regional vp-Pacific Northwest offices of August International Corp. of Bellevue, Wash., a health care cost management company. Most recently, Mr. Brown was the Spokane district manager for Blue Cross of Washington and Alaska.

Stanley B. Tulin and **Stephen G. Hildenbrand** joined Coopers & Lybrand of New York as partners and directors-life insurance services. Mr. Tulin will work out of both the New York and Philadelphia offices, while Mr. Hildenbrand is based in the Philadelphia office. Previously, both men were consulting actuaries with Milliman & Robertson Inc. ■

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OVERVIEW AT WORK

There was a Great Rumbling Noise, followed by a loud explosion in the dust collection system of a facility owned and operated by a major division of a multinational chemical manufacturer. Within a few seconds, a fireball shot to the top of the process rack. An employee, using the emergency telephone number, alerted the plant fire brigade. Responding were 21 brigade members, two fire trucks, the spill truck and an ambulance.

All explosion relief systems opened simultaneously including one on the second stage dryer, nine panels in the bag house and 14 panels on the cyclones. In addition, the roof sprinklers over the oven process rack operated, as well as the internal water spray in the bag house. Within minutes, the fire was under control. Then, the internal water spray protection system was checked for damage and restored to automatic service. Since protection and prevention measures worked as planned, property damage was minor, production was disrupted minimally and employees were able to stay on the job.

In a Different Incident, Fire Started in the Heat Treat Department of a light metal worker. Two employees were cleaning up a pit with a steam jenny and detergent. The pit was next to a furnace and quench tank, which were in the start-up mode. The oil in the tank was being heated to 350 degrees Fahrenheit. A third employee, on safety watch at floor level, noticed that the tank started to overflow. Almost immediately an open flame pilot burner ignited the oil, creating great billows of smoke and fire. Seventy-five sprinklers operated. So did a 4 x 12 foot smoke and heat vent which was right over the area. The smoke cleared away quickly, permitting the plant fire brigade, which had responded to the waterflow alarms, to get close enough for rescue operations and firefighting.

Damage was minimal. Some wiring, piping and a few struts on the steel roof trusses had to be replaced. About 15,000 gallons of quench oil were contaminated and a 40 x 100 foot section of roof deck had to be cleaned. Impaired fire protection was restored following RSVP procedures, which are found in Section 1 of IRI's OVERVIEW Manual. Production resumed within hours.

In Both Cases, Good Planning, Good Training and Good People, applying the principles and philosophy of OVERVIEW,* helped preserve property, profits and jobs. You can do the same by reading IRI's OVERVIEW Manual and Forms Packet. For details and prices, contact Mrs. P. A. Sasso, IRI, 85 Woodland Street, Hartford, CT 06102 (203) 520-7412.

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Government, Unions and Educational Institutions 979
Commercial Consumers
Sub-total 26,175

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Insurance Companies 7,380
Actuaries, Consultants, Attorneys, Adjusters, Appraisers and Third Party Administrators 3,843
Others Allied to the Field . . . 2,991
TOTAL 50,946

* Source Business/Occupational breakdown of qualified circulation, May 30, 1988 issue, as submitted to BPA for June 1988 BPA Publisher's Statement.

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NOTICES

IN THE SUPREME COURT OF BERMUDA CIVIL JURISDICTION 1985 : NO. 228

IN THE MATTER OF MENTOR INSURANCE LIMITED, AND IN THE MATTER OF SECTIONS 33 AND 35 OF THE INSURANCE ACT 1978, AND IN THE MATTER OF THE COMPANIES ACT 1981.NOTICE IS HEREBY GIVEN that Charles W. Kempe, Jr. and Michael J. Arnold, the Joint Liquidators of the above-named Company, have obtained directions from The Supreme Court of Bermuda ("the Court") that the creditors of the above-named Company, which is being wound up by Order of the Court, are required to lodge with the Joint Liquidators on or before May 31, 1989 one or more completed claim forms in the form prescribed by Order of the Court, dated December 15, 1988. If the Joint Liquidators do not receive such a completed claim form or forms from a creditor on or before the said date, that creditor will not be admitted to rank for, or be entitled to receive, any dividend, declared or paid on or before December 31, 1992 (or such later date as the Court may direct). Circular letters dated January 19, 1989 enclosing the appropriate claim form or claim forms together with a copy of the Order of the Court dated December 15, 1988 have been dispatched to all known creditors. If a creditor has not received such a circular, claim forms and Order then they should contact the Joint Liquidators immediately in writing at the following address: **Mentor Insurance Limited (in Liquidation)P.O. Box HM 1563 Hamilton Bermuda HMFX**Charles W. Kempe, Jr. and Michael J. Arnold, Joint Liquidators of Mentor Insurance Limited (in Liquidation)

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RBH restructures aviation operation

Markets

Rollins Burdick Hunter Co., a unit of Chicago-based Aon Corp., has completed a major restructuring of its National Aviation Division, including establishing six regional aviation offices and hiring several seasoned U.S aviation insurance veterans.

The division will specialize in providing risk management services to airlines, aircraft product manufacturers, fixed base operators and other industries with aviation-related exposures.

While RBH has been a leading aviation broker for more than 50 years, representing such clients as Chicago-based United Airlines, the restructuring will strengthen its aviation capabilities, according to George E. Corde, RBH executive vp and chairman and chief executive officer of the National Aviation Division.

Mr. Corde, who came to RBH last April after 25 years with Briarcliff Manor, N.Y.-based Frank B. Hall & Co. Inc., has an extensive background in aviation brokerage.

The restructuring "will allow RBH to expand upon the services we already make available to our aviation clients—to concentrate our services to relate to their very special needs," Mr. Corde noted.

The division, which now employs more than 50 people, has set up three operating centers in Chicago, Los Angeles and Hearndon, Va. Howard Payne is senior vp and central regional manager in Chicago; Charles Engel is senior vp and eastern regional manager in Hearndon; and Leslie DeWald is senior vp and western regional manager in Los Angeles.

Mr. Engel, who was formerly principal of his own aviation brokerage—Hearndon, Va.-based American Southwest Intermediaries Corp.—joined RBH last February.

The division also has regional offices in: Portland, Ore., which reports to Los Angeles; and Houston, which reports to Chicago. Stewart Butler is senior vp of the National Aviation Division-Oregon and Ralph Harp is senior vp of the National Aviation Division-Texas.

And, the division will open a sixth office in Short Hills, N.J., in late February, which will be headed by senior vp John Eshbaugh, who joined RBH last spring. Mr. Eshbaugh was formerly a workers compensation aviation expert with United States Aircraft Insurance Group in New York.

Other significant staff additions include:

- O. Wayne Link, senior vp-national account development, who joined RBH last March. Mr. Link, formerly chief underwriting officer of USAIG in New York, will be based in Short Hills.
- James Strang, senior vp-administration, who will be based in Los Angeles. Mr. Strang came to RBH last January from Los Angeles-based Northrup Corp., where he had served as risk manager/assistant treasurer.
- Senior Vp James Matthews, who joined RBH last spring. Mr. Matthews was formerly a chief aviation products underwriting officer for Associated Aviation Underwriters in Short Hills, N.J., and most recently was an aviation broker for Hall in New York.

Other key officers of the division are RBH aviation veterans Gil White, senior vp-aviation in RBH's Philadelphia office; and Don Wilson, the founder of RBH's aviation operations, who will continue as a consultant to RBH's aviation operations in Chicago.

RBH is already the leading general aviation broker in the world, Mr. Corde said. Those accounts, ranging from individual owner/operators to corporate aircraft fleets, are serviced through RBH's Wichita, Kan., office.

The National Accounts Division will closely coordinate its activities with the Wichita office because of the latter's historic role in the aviation industry, Mr. Corde added.

According to Mr. Corde, the division also intends to enhance its relationship with London-based broker Nicholson, Chamberlain & Colls, in which RBH holds a minority ownership position. NCC is a leading retail and reinsurance aviation broker.

Mr. Corde said he hopes the relationship between the two brokers "will grow and expand as RBH grows in prominence within the aviation industry."

Reinsurance adviser

Pingel, Maltby & Associates is a new Dearborn, Mich.-based consultant that will help self-insured clients purchase reinsurance.

The consultant also helps insurers and reinsurers that want to leave the reinsurance business run off their existing business.

Among the services provided by Pingel, Maltby are claims reviews and commutations, contract wordings and reinsurance arbitration.

The company is owned by Carl R. Pingel and Jeffrey Maltby. Previously, Mr. Pingel was president of Summit Fidelity & Surety Co. in Dearborn, Mich. Mr. Maltby previously was vp-underwriting for Summit.

Pingel, Maltby & Associates is located at 1 Parklane Blvd., Suite 729 W. Dearborn, Mich. 48126; 313-271-4520.

Travelers PPO grows

Travelers Corp. of Hartford, Conn., has expanded its preferred provider organization to include two new operations in New York and Detroit.

Eighteen hospitals and more than 2,000 physicians are in the Travelers Preferred—Greater Metropolitan New York provider network. Nineteen hospitals and a growing number of physicians are in the Travelers Preferred-Detroit provider network.

All of the Travelers PPOs include the Patient Advocate utilization review program and the Taking Care wellness program.

For more information about Travelers Preferred-Metropolitan New York contact David M. Friedman, Executive Director, 650 Fifth Ave., New York, N.Y. 10019; 212-757-1067.

For more information about Travelers Preferred-Detroit contact Peter Strauss, Executive Director, 231 S. Bemiston, Suite 715, St. Louis, Mo. 63105; 314-727-0930.

Mergers/acquisitions

Berwanger Overmyer Associates, a Columbus, Ohio, insurance agency, has acquired **Jaeger Insurance Agency** of Columbus, Ohio.

ABI Management Inc. of San Francisco has acquired **Reeves Co. Inc. Insurance Brokers** of Lodi, Calif.

Tyler, Texas-based **Lindsey & Newsom Claims Services Inc.** has acquired **Bradford Adjustment Service**, which has offices in Cincinnati, Columbus, Dayton, Mansfield and Piqua, Ohio.

Richmond, Va.-based **Hilb, Rogal & Hamilton Co.** has merged its Grand Rapids, Mich., office with **Evans & Drums Inc.** of Grand Rapids, Mich. The acquisition will be accounted for as a pooling of interests.

New offices

Hewitt Associates has opened a new office at 2121 K St. N.W., Suite 620, Washington, D.C. 20037; 202-331-1155.

Corroon & Black Corp. has opened a new office for its **C&B Consulting Group** at 1615 Murray Canyon Road, Suite 800, San Diego, Calif. 92108; 619-297-7111.

McGriff, Seibels & Williams Inc. has opened a new office at LL&E Tower, 900 Poydras St., New Orleans, La. 70112; 504-595-6440. ■

California considers health care mandate

Around the states

SACRAMENTO, Calif.—A bill that would require employers with five or more employees to provide minimum health care benefits to full-time and many part-time employees is before the California Assembly.

Under A.B. 350, introduced late last month by Assembly Speaker Willie L. Brown Jr., D-San Francisco, employers' benefit plans would have to cover:

- Hospital outpatient services.
- Emergency health care.
- Surgical services, including follow-up care and anesthesiologist services.
- Necessary home, office and hospital visits by physicians and surgeons for both surgical and non-surgical care.
- Hospital inpatient care including intensive care.
- Medical or surgical consultation.
- Maternity care.
- Mental health care, including up to 20 days per year of inpatient care and at least 25 outpatient visits per calendar year.

Employers would have to pay the full employee premium and could not impose employee copayments or deductibles for hospital inpatient services for medical or psychiatric care; physician and surgeon services provided in the hospital; laboratory services; or ambulatory surgical benefits.

However, employers may require a copayment on other services, but that copayment must not exceed 25% of the charges.

To be eligible for employer-sponsored plans, part-time employees would have to work approximately 21 hours a week for a single employer and have monthly earnings equal to or exceeding 86.67 times the minimum wage of $4.25 per hour.

And, all employees must have worked four consecutive weeks for the employer to qualify for the employer-provided coverage, the bill says.

Assemblyman Brown estimates the monthly cost of providing the coverage will be about $75 to $85 per employee, said a spokeswoman for the legislator.

Employers would not receive any special tax incentive to provide a health care benefits plan.

However, if an employer did not provide coverage, the employer would be responsible for health care costs incurred by an eligible employee during the period in which the employer failed to provide coverage, according to the bill.

Because A.B. 350 would apply to self-insured plans as well as insured plans, California is seeking an exemption from the federal Employee Retirement Income Security Act of 1974, which pre-empts state regulation of self-insured benefit plans, said the spokeswoman for Assemblyman Brown.

If enacted, A.B. 350 would become effective when the ERISA exemption became effective. And, the regulation would be named the Tucker Health Insurance Act of 1989, after the late Assemblyman Curtis Tucker, D-Inglewood. He chaired the Assembly Health Committee until his death in 1988.

—By Donna DiBlase

Prop. 103 study

DES MOINES, Iowa—The Iowa Insurance Division is seeking comment at a Feb. 14 public hearing about the potential impact of California's Proposition 103 on property/casualty premiums in Iowa.

Insurers operating in California "are faced with either increasing their premiums in other states or placing their financial solvency in jeopardy" because of Proposition 103, "and either option could adversely impact on Iowans," who pay the lowest average auto premiums in the United States,

Continued on next page

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Around the states

Continued from previous page
said Iowa Insurance Commissioner William D. Hager.

If Proposition 103 is upheld by the courts, most property/casualty insurance "charges"—including those for personal auto insurance—will be rolled back to 20% below November 1987 levels, which "basically forces insurers to incur underwriting losses," Mr. Hager said.

"On top of that, they (insurers) are being threatened with antitrust litigation should they withdraw from the state," he added.

"It is in everyone's best interest that we study this matter in depth and be prepared to implement protective measures so that Iowans don't suffer the consequences of California legislation," he said.

In December, Mr. Hager announced a plan to use his authority as Iowa's insurance regulator to prohibit Iowa-domiciled insurers from selling property/casualty insurance in any state where the insurers expect to lose money consistently (*BI*, Dec. 19, 1988).

While automobile insurance rates are the most pressing concern, the Iowa Insurance Division's proposed approach could apply in the future to any similarly troubled line of insurance, according to Kevin Howe, Mr. Hager's executive assistant.

The hearing will be 10 a.m. Tuesday, Feb. 14, at the Hilton Inn, 6111 Fluer Drive in Des Moines.

People wishing to make presentations should contact Mr. Howe at the Insurance Division, Lucas State Office Building, Des Moines, Iowa, 50319; 515-281-5705.

—By Meg Fletcher

Maryland insurer reform

ANNAPOLIS, Md.—Insurers in Maryland would not be able to set rates based on advisory rates from the Insurance Services Office Inc. and would lose their exemption from state antitrust laws under a state Senate bill.

S.B. 187, introduced last month by Sen. George Della Jr., D-Baltimore City, and based in part on California's Proposition 103, also would forbid the 650 insurers licensed in the state from exchanging any information regarding rates.

However, the bill still would allow insurers to use ISO data on pooled loss experiences and trending information to set their rates.

Sen. Della said he drafted the bill because of the public's outcry over skyrocketing personal auto liability insurance rates.

The bill, if enacted, would lead to a more competitive insurance marketplace according to Sen. Della. Without the use of ISO advisory rates, which industry critics say encourage price fixing, insurers would be forced to establish their own rates and, theoretically, insurance prices would fall.

And, "if they (insurers) truly want to be competitive, they should have no objection to repealing the antitrust laws," Sen. Della said.

But small and medium-sized insurers say the bill would especially hurt them because they would have to rely more on costly actuarial analysis of ISO data to set rates rather than rely on ISO advisory rates or shared rating information.

Other insurance industry opponents of the bill feel ISO rates are, for the most part, ignored by the majority of insurers.

"You can look at the 150 companies actively writing insurance in Maryland and their rates are all over the place," said Minor Carter, senior vp-government affairs for United States Fidelity & Guaranty Co. in Baltimore. "How come prices vary so much if we're fixing rates?" "If you look at the commercial marketplace, nobody has used ISO rates in the '80s," said John Washburn, past president of the National Assn. of Insurance Commissioners and director of the Illinois Insurance Department.

And, eliminating insurers' antitrust exemptions "will eliminate the means in which medium and small companies can compete," said an ISO spokeswoman.

The Legislature's session, which began Jan. 11, adjourns April 11.

—By Michael Schachner

Eubanks joins law firm

LITTLE ROCK, Ark.—Former Arkansas Insurance Commissioner Robert M. Eubanks III entered private law practice last month as counsel to the Little Rock-based firm of Mitchell, Williams, Selig & Tucker.

Mr. Eubanks resigned as Arkansas' insurance commissioner in December, shortly before his first term was to end Jan. 14.

Gov. Bill Clinton appointed Deputy Commissioner Ron Taylor to serve the remainder of Mr. Eubanks' four-year term and to serve his own four-year term (*BI*, Dec. 26, 1988).

—By Meg Fletcher

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Health care commission

Continued from page 2
ployer package should contain but said employers would have to pay at least 75% of the premium.

In addition to the tax on employers, the proposal suggests a tax on uninsured workers with incomes exceeding 150% of the federal poverty. This tax could be set at 2% of the first $45,000 of wages. In 1988, the federal poverty level for a family of four was $11,170.

An unspecified portion of premiums payable to the health care pools would be subsidized for those earning less than 150% of the federal poverty level —or $16,755 based on 1988 poverty level figures.

While the commission did not recommend the scope of services the state pools should offer, it proposed a maximum annual out-of-pocket expense of $1,000 per person and $3,000 per family for pool beneficiaries with incomes greater than 150% of the federal poverty level.

The maximum annual out-of-pocket expense for those earning less than 150% of the poverty would be $1,000.

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California

Continued from page 2

After a public hearing, the insurers were ordered to cease the practice or face fines of $10,000 per company per day, up to a maximum of $100,000 per company.

Also, Novato, Calif.-based Fireman's Fund Insurance Co. earlier this month agreed to renew auto policies after the department issued a notice of non-compliance against seven of the insurer's affiliates that only were issuing six-month extensions (*BI*, Jan. 30).

The department also expects to challenge the average 9.6% premium increase that State Farm Insurance Cos. of Bloomington, Ill., imposed on all of its auto insurance policies statewide last week.

And, the department has set March hearings on a State Farm plan under which a subsidiary that charges higher rates would issue all new auto policies in the state (*BI*, Jan. 30; Nov. 28, 1988).

"We're taking on industry leaders. . . .And what do we hear from you? Charges that we're footdragging," Ms. Gillespie said.

"If you, the legislators, aren't happy with the fact that it takes a 30-day notice period before a company can be brought to hearing, don't call your capital correspondent and tell him I'm dragging my feet. If you don't agree with the law, change it," she scolded.

And, if legislators believe the fines assessed against insurers are inadequate, "don't ring the media and say I let insurers off cheap. Change the law," she said.

As far as serving consumers, the department handles about 950 calls daily and has recovered more than $51 million for consumers since Ms. Gillespie became commissioner in 1986, she pointed out.

In addition, legislators should have been trying to correct insurance market problems in the state long before Proposition 103 was enacted, Ms. Gillespie charged.

"If we want to discuss footwork, let's examine the 'Legislative Shuffle': the Legislature's record in dealing with insurance reform. For years, policyholders were treated like wallflowers at the prom, while the trial lawyers and insurers dominated the dance card," she quipped.

"Consumers were finally driven to the initiative process in desperation," she said. "The Department of Insurance will not be your whipping person on this one."

Ms. Gillespie ended her remarks on a conciliatory note, however, requesting that the Legislature and the department work together on insurance reform.

In other Proposition 103-related activity, a coalition of insurance agents and brokers filed suit on Jan. 31 against Ms. Gillespie in Sacramento County Superior Court seeking to block banks from selling insurance.

The state Banking Department ruled this month that state-licensed banks can act as insurance agents and brokers. A Proposition 103 provision deleted an insurance code provision prohibiting those sales but did not delete a comparable state financial code provision (*BI*, Jan. 16).

The agents are seeking an emergency stay to stop the commissioner from issuing insurance licenses to banks and to suspend current licenses.

The agents also asked the court to enjoin the state superintendent of banks from accepting or approving proposals from banks intending to sell insurance.

The plaintiffs in the case are independent insurance agents David L. Welfare of Santa Ana and Robert E. Sanford of Sacramento, president of the Independent Insurance Agents & Brokers of California; the Professional Insurance Agents & Brokers of California; the California Assn. of Life Underwriters; and the Independent Insurance Agents of America.

Ms. Gillespie has not responded to the suit, a spokeswoman said. ■

Excess insurers

Continued from page 1

1985, Gelman purchased $1 million in primary comprehensive general liability insurance from Fireman's Fund Insurance Co. of Novato, Calif.

The company also purchased $1 million of primary product liability insurance from Central National Insurance Co. of Omaha, Neb.

The $20 million first-layer excess policy written by Los Angeles-based Mission National attached to both of the primary coverages. The Hudson policy was written in excess of the Mission National policy.

As a result of the ruling, Gelman faces tens of millions of dollars in pollution claims stemming from four lawsuits filed between Aug. 1, 1984, and Aug. 1, 1985, without coverage for pollution claims exceeding $1 million but less than $21 million.

Judge Duff ruled in a memorandum opinion that will not be published. However, the decision still can be cited to other courts hearing similar litigation.

"The value of the case is that it is a precedent for the proposition that excess language similar to that in this case is not ambiguous and does not require an excess insurer to drop down and replace an insolvent primary insurer," said Hudson attorney John Morrison of Altheimer & Gray in Chicago.

"The effect of the case is to bring certainty to both insurers and insureds as to the legal consequences of policy language and its effect when an underlying insurer become insolvent," he said.

Gelman Sciences has not decided whether it will appeal the decision, said Gelman environmental attorney David Fink of Cooper, Fink & Zausmer in Farmington Hills, Mich.

"We are going to review the decision in the context of pending environmental litigation against Gelman and in the context of other available insurance coverage and make a decision," Mr. Fink said.

Courts are split on the issue of whether an excess insurer has to drop down when a policyholder cannot recover claims from an insolvent underlying insurer.

Last year, a California state judge ruled that an excess insurer does not have to drop down and pay claims in a long-latent injury case until all of the policyholder's primary insurers that wrote coverage during other policy periods have exhausted their limits (*BI*, May 16, 1988).

And, a New York state appellate judge in 1987 ruled that when a policyholder cannot recover claims against an insolvent primary insurer, an umbrella insurer is not required to drop down (*BI*, May 11, 1987).

However, a Massachusetts state court judge that same year ruled that when a policyholder cannot recover claims against an insolvent primary insurer, the umbrella insurer must drop down (*BI*, June 1, 1987).

Judge Duff's ruling is one of the first rulings of its kind in Illinois.

"It is a case of first impression in Illinois," said Mr. Morrison, Hudson's attorney.

"It is the first decision of its kind in Illinois," agreed Mr. Fink, Gelman's attorney.

However, the law in Illinois is not settled.

In a 1985 Illinois appellate court case, *McNeal vs. International Fire & Casualty*, the umbrella policy that Fireman's Fund subsidiary International Fire & Casualty Co. wrote stipulated the insurer would pay in excess of amounts "recoverable" from underlying insurers. The court found the word "recoverable" was ambiguous and therefore ruled that the umbrella insurer had to drop down.

However, Mr. Morrison points out that the word "recoverable" has been eliminated from most of today's excess insurance policies.

For example, the Hudson insurance policy stipulates it will "not attach unless and until the insured or the insured's underlying insurance has paid or has been held liable to pay the total underlying insurance limit. . . ."

Judge Duff said Hudson's policy "plainly states that Hudson is not liable to Gelman until the underlying insurers have paid or are held liable."

"Since Mission has not paid or been held liable to pay its limit of liability, Hudson's liability under its own policy does not attach," Judge Duff ruled.

Gelman argued that Hudson's policy was ambiguous because of a separate clause that stipulated the policyholder must maintain its underlying coverage.

However, Judge Duff said this maintenance clause did not make Hudson's policy ambiguous.

The judge also rejected Gelman's argument that there is a presumption under Illinois law that secondary excess umbrella liability insurers will drop down when underlying insurers go bankrupt.

•

Hudson Insurance Co. vs. Gelman Sciences Inc.; U.S. District Court for the Northern District of Illinois Eastern Division, No. 88 C 4369.

Property/casualty claims administrator listed

The following company was not included in the directory of property/casualty claims administrators that appeared in the Jan. 30 issue of *Business Insurance*.

Corroon & Black Management Inc.
Suite 200, BNA Center, Nashville, Tenn. 37217; 615-360-2290

Year founded: 1978.
Parent company: Corroon & Black Corp.
Services provided: 90% claims administration, adjusting and auditing, 10% other services.
Region served: Nationwide.
Specialty: 55% workers compensation, 40% general liability, automobile and property, 5% professional liability and product liability.
Self-insured clients/claims: Administration: 150 clients, $180 million claims paid.
Client mix: Administration, adjusting and auditing: 60 public/government entities, 16 association plans, 70 corporations, three risk retention groups, one reciprocal company.
Staff: 137 total staff members.
Charges: Administration and adjusting: flat fee, percent of claims, per claim. Auditing: time and expense.
1988 gross revenues: Not reported.
Branch offices: Atlanta; Bethesda, Md.; Bettendorf, Iowa; Boise, Idaho; Carmel, Ind.; Denver; Fairfax, Va.; Harrisburg, Pa.; Helena, Mont.; Jackson, Miss.; Louisville and Pikeville, Ky.; Madison, Wis.; Minneapolis; Oklahoma City; Parsippany, N.J.; Raleigh, N.C.; Richlands, Va.; St. Louis; San Diego, San Jose, North Hollywood and Stockton, Calif.; Worthington, Ohio; Springfield, Ill.; Mobile, Ala.
Principal officers: Kenneth H. Pinkston, chairman; Robert J. Jennings, president/chief executive officer; James R. McMasters, executive vp; Randall Cook and Louis Midden, senior vps.

Update

Intermediaries reduce staff

Continued from page 2

to a reinsurance services unit handling runoffs and commutations, he added. Aon Re also plans to establish a Manhattan office.

G.L. Hodson & Son Inc., a Corroon & Black Corp. unit, is cutting 17 people, closing its Manhattan facultative reinsurance unit and moving its New Hyde Park, N.Y.-based property facultative unit to its Atlanta office, said Executive Vp Michael E. Rothpletz.

TPF&C Reinsurance, a division of Towers, Perrin, Forster & Crosby Inc., has laid off 12 support staff, said Senior Vp Philip W. Mitchell. Meanwhile, the firm is in the process of hiring 12 production and support staffers for a new Chicago office, he said.

$10 million property claim OK'd

DETROIT—Lloyd's of London underwriters must pay a $10.2 million property damage and business interruption claim by McLouth Steel Product Corp. of Trenton, Mich., stemming from a 1985 furnace blast, a U.S. District Court jury in Detroit has ruled.

Underwriters refused to pay the claim, citing a policy exclusion denying coverage for a loss resulting from a furnace design defect, said Frank Sove, McLouth's executive vp of finance.

The insurance was placed by Alexander & Alexander Services Inc. and Lloyd's of London broker Price Forbes Ltd., a Sedgwick Group P.L.C. unit, Mr. Sove said.

Bain Clarkson settles EIL case

LONDON—Lloyd's of London broker Bain Clarkson P.L.C. will pay more than $6 million to three members of a now-defunct environmental impairment liability reinsurance facility that paid claims on an EIL policy written for Dallas-based RSR Corp.

Under a settlement reached last month during a London High Court trial, Bain Clarkson agreed to pay Bavarian Reinsurance Co. Ltd. of Munich; Zurich Reinsurance Co. of Zurich, Switzerland; and Zurich Re subsidiary Alpina Reinsurance Co. a total of $6.13 million plus legal costs to cover the reinsurance claims.

The companies were members of Environmental Risk Assessment Service (International) Ltd., an EIL reinsurance facility that former London broker Clarkson Puckle Ltd., now part of Bain Clarkson, set up in 1976 to reinsure EIL insurance policies for U.S. manufacturers from 1977 through 1983.

ERAS collected less than $40 million of premiums and faces more than $100 million of claims to date. Dozens of pool members are suing Bain Clarkson, charging misrepresentation and breach of duty in the broker's role in setting up ERAS.

Facility members also are suing Paris-based Societe Commerciale de Reassurance, which was the facility's lead reinsurer (*BI*, Dec. 7, 1987).

Despite the settlement, litigation brought by Bavarian, Alpina and Zurich relating to other ERAS policies and litigation filed by dozens of other Lloyd's syndicates and reinsurance companies will continue, lawyers say.

However, the settlement is encouraging news for the other facility members suing Bain Clarkson and SCOR, lawyers say.

Conviction voids robbery cover

LONDON—A 3.15 million pound ($5.5 million) safety deposit box insurance policy that would have covered part of the loss suffered in Britain's largest robbery on record was voided after the owner of the safety deposit box center was jailed for participating in the robbery.

Parvez Latif, owner and general manager of the Knightsbridge Safety Deposit Center, was sentenced last week to 18 years in prison for conspiring with five others to rob the center and steal an estimated 30 million pounds ($52.7 million) in cash and jewels.

The mastermind of the robbery, Valerio Viccie, was jailed for 22 years, while the others received varying sentences.

Only 10.5 million pounds ($18.4 million) in goods has been recovered, the Central Criminal Court revealed during the trial.

Just prior to the robbery, Mr. Latif—who was on the verge of bankruptcy—had increased his company's safety deposit box insurance to 3.15 million pounds from 1 million pounds ($1.8 million). The policy was placed with Lloyd's of London syndicates through Lloyd's broker GHC Financial Institutions Insurance Services Ltd., confirmed Keith Jones, GHC managing director (*BI*, July 27, 1987).

However, the center did not purchase an endorsement to the policy that would have covered employee dishonesty, Mr. Jones said. "No claims were paid because Latif was part of the conspiracy."

Knightsbridge, which went into liquidation shortly after the robbery, was "grossly underinsured," Mr. Jones observed. Safety deposit box centers can purchase up to 110 million pounds ($193.3 million) in coverage through GHC, he said.

Briefly noted

Larry Fitzpatrick, president and chief executive officer of the Center for Claims Resolution, has resigned his post as acting CEO of the defunct **Asbestos Claims Facility**. . . .House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., said last week he would be willing to consider proposals to simplify **Section 89 non-discrimination rules** for welfare plans. But, Rep. Rostenkowski said he would oppose efforts to repeal or delay the highly complex law. . . .The board of directors of **Marsh & McLennan Cos. Inc.** has authorized the repurchase of an additional 2.5 million shares of M&M common stock. M&M has already bought back 5 million of its own shares under two previous repurchase programs since October 1987. . . .TMCare, a unit of Tucson Medical Center, has signed a letter of intent with Maxicare Health Plans Inc. to purchase the assets of **Maxicare/HealthAmerica Health Plan of Arizona Inc.**, a 50,000-member health maintenance organization. Terms of the deal were not disclosed.

Combined ratios don't tell true story

By MYRON M. PICOULT
Special to Business Insurance

Ticker

OVER THE PAST 18 MONTHS we have made numerous comments regarding the negative impact that the Tax Reform Act of 1986 was likely to have on the property/casualty insurance industry in terms of earnings and the industry's ability to accumulate incremental statutory capital.

Mr. Picoult

The measures incorporated into the tax law are material for an industry that has basically not paid any taxes. In essence, the tax law redefined taxable income for the industry by increasing its revenue base through the inclusion of some preference items and a small portion of tax-exempt income. The expense side of the equation also was reduced through the use of discounting on loss reserve increases. Hence, a larger pretax earnings figure was generated.

In order to further curtail the industry's tax flexibility, an alternative minimum tax calculation also was included. It should also be noted that "Uncle Sam" is no longer a 50/50 partner with respect to underwriting losses: insurers now absorb 66% of the losses and the government 34%.

Our research indicates that for the average company the tax bill will equal 5% to 20% of operating cash flow. For an industry that virtually has not paid taxes, that is a substantial chunk of cash.

Given the aforementioned information, we naively believed several months ago that various insurers would recognize the negative implications and react accordingly. Most of the major insurers appear to have a good understanding of the implications of the tax bill, while about 50% of the medium-sized companies appear to understand how the world has changed. Most small companies are lost somewhere in the woods.

In any event, few, if any, insurers appear to have adjusted their premium rates for the impact of tax payments. The rationale seems to be that the market pricing environment simply does not permit recognition of the tax burden at this time and, in some cases, the rationale probably extends to a misreading of the impact of the tax law.

We surveyed primary, multiline and reinsurance companies. We gathered paid tax data for both the 1988 third-quarter and nine-month periods. We realize that the data are not perfect. For example, some of the nine-month figures include tax payments made in 1988 for 1987. In addition, some of the data include tax payments that related to operations overseas or in Canada.

For example, our estimate for American International Group Inc. recognizes taxes on foreign property/casualty operations, but the premium figure does not include foreign premiums since this information is not available on a quarterly basis.

In other instances, allocation of taxes may or may not have been made. For example, the General Re Corp. figure is a consolidated corporate number that includes both foreign and miscellaneous operations. We have no way of figuring out the portion of taxes that relates to miscellaneous operations.

Finally, some figures include a small portion of state taxes for those jurisdictions that impose a state income tax as opposed to a premium tax.

We again stress that we recognize that some of the tax numbers we are using can be considered "box car" numbers because various tax estimates and allocations have not yet been made. We also recognize that full-year data are more useful than the quarterly and nine-month data we are using.

Hence, it could be argued that tax payments for 1989 as a whole would be more useful than 1988 because most insurers will have used up their carryforwards. However, the purpose of this exercise is to get some numerical framework for the impact of tax payments on specific insurers. Insurers must and should provide better tax details. In essence, we hope to use this study as a springboard for future reviews that will permit a more insightful perspective on the impact of the 1986 tax law.

We calculated the impact of the *paid* tax figure on reported combined ratios by dividing the tax payment for the third quarter and the nine-month period by the appropriate written premium figure (nine-month figures only are shown in the chart). The resulting ratio was added to the reported statutory combined ratio. The "adjusted" combined ratio provides some insight into the tax bill's impact on underwriting results. We have used written premiums as the denominator since we consider taxes an expense item.

Continued on next page

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Workplace safety

Continued from page 1

prevent wasted time and taxpayer money.

In the meantime, Mr. McCann said he is "elated with the decision," because it will promote workplace safety.

The decision stems from 1984 criminal charges that Magnet Wire and five of its managers had knowingly and recklessly caused the injury of 42 workers by failing to provide adequate safety precautions in the workplace against toxic substances.

The defendants had argued that Congress, in passing the federal Occupational Safety and Health Act of 1970, which regulates workplace safety, intended to pre-empt states from applying criminal statutes to workplace conditions that are specifically regulated by OSHA.

Two state lower courts agreed with the argument.

But in its decision last week in *People vs. Chicago Magnet Wire Corp.*, the Illinois Supreme Court overturned the lower court rulings upholding the defendants' contentions.

Instead, the Illinois court followed the reasoning of a 1988 Wisconsin Court of Appeals decision, which held that states have the right to pursue criminal charges against corporations and their officers even if the charges stemmed from safety violations covered under OSHA (*BI,* May 23, 1988).

The Illinois Supreme Court's Feb. 2 decision said: "To adopt the defendants' interpretation of OSHA would, in effect, convert the statute, which was enacted to create a safe work environment for the nation's workers, into a grant of immunity for employers responsible for serious injuries or deaths of employees. We are sure that would be a consequence unforeseen by Congress.

"There is nothing in the structure of OSHA or its legislative history which indicates that Congress intended to pre-empt the enforcement of state criminal law prohibiting conduct of employers that is also governed by OSHA safety standards," the Illinois high court added.

Prosecutors and safety advocates hailed the ruling.

"It's probable we will have a Supreme Court case in a couple of years. But as a practical matter, prosecutors will have all the green light they need now," said Joseph Kinney, executive director of Chicago-based National Safe Workplace Institute, which he described as a foundation-supported, independent occupational health and safety research organization.

The Illinois court's decision "will hasten the day we can go out of business," said Mr. Kinney, who last year released a report lambasting OSHA for failing to prosecute employers that operate unsafe workplaces (*BI,* July 25, 1988).

Cook County State's Attorney Daley hailed the decision as one of "national importance" that would protect the health of workers.

"We think this will send a message" that no employee should be deliberately exposed to hazardous conditions, Mr. Daley said at a news conference.

Mr. Daley said the ruling also would allow him to reopen a similar case against four officials of Elk Grove, Ill.-based Film Recovery Systems, Inc. for the 1983 death of a worker.

Mr. Daley's office won murder convictions against three Film Recovery officials in 1985, but failed to extradite the company's president from his home in Utah to stand trial (*BI,* June 24, 1985). Mr. Daley now says he will use the Magnet Wire decision in a fourth attempt to extradite the Film Recovery official.

Employer representatives slammed the decision, saying it will lead to more criminal prosecutions in workplace safety cases.

Stephen Bokat, vp and general counsel of the U.S. Chamber of Commerce in Washington, D.C., accused the Illinois court of making its own law rather than ruling on whether OSHA pre-empts state law.

"They didn't feel OSHA had enough teeth in it. They're going to put their own teeth in it," he said, calling the ruling "garbage."

The decision will lead to "criminal cases galore. It's an invitation for state prosecutors who want to make a name for themselves to bring safety charges," Mr. Bokat said, noting that Mr. Daley is running for mayor in Chicago.

Mr. Bokat said he also would like the U.S. Supreme Court to rule on the pre-emption question. Allowing state law to pre-empt federal safety regulations would lead to inconsistency of enforcement of workplace rules, he said.

Mr. Gottschalk of the Illinois Manufacturers' Assn. said the decision "sends some horrific signals."

He called the ruling "more anti-job than pro-job" and expressed concern that the ruling will allow the 102 state's attorneys in Illinois to set health and safety standards as they see fit.

"This decision puts at risk any person who has some management responsibility where risk is possible," Mr. Gottschalk said.

The NSWI's Mr. Kinney disagreed. "Most employers are reasonably conscientious about health and safety in the workplace. They have nothing to fear. For those who are marginal operators, this should be a wake-up call," he said.

Mr. Gottschalk also said the ruling—if not overturned by the U.S. Supreme Court—could hamper efforts to make U.S. businesses more competitive in the international marketplace. Employers facing the possibility of jail would be less likely to take economically justified risks, he said.

An OSHA spokesman in Washington, D.C., said that the agency had no comment on the decision and has never taken a position on the pre-emption question.

However, a letter sent by the U.S. Justice Department last fall to the U.S. House Committee on Government Operations noted: "As for the narrower issue as to whether the criminal penalty provisions of the OSH Act were intended to pre-empt criminal law enforcement in the workplace and preclude the states from enforcing against employers criminal law. . .it is our view that no such general pre-emption was intended by Congress."

The U.S. Supreme Court would be the last stop for a case that has wound its way through the Illinois court system for more than 3½ years.

A Cook County grand jury voted indictments in June 1985 against Magnet Wire and five of its officers, charging them with aggravated battery, reckless conduct and conspiracy against about 40 workers over a three-year period because they had knowingly allowed workers to be exposed to toxic substances.

Cook County Circuit Judge Earl Strayhorn in December 1985 agreed with the company that OSHA pre-empted the criminal charges and dismissed the case.

Mr. Daley appealed Judge Strayhorn's ruling to a three-judge Illinois Appellate Court, which in June 1987 upheld Judge Strayhorn's decision (*BI,* July 6, 1987).

The appellate ruling read in part: "The state has expressed valid and legitimate concerns about the consequences of pre-emption in its ability to to control the activities of employers. But Congress has evidenced an intent that criminal sanctions should not be imposed for activities involving workplace health and safety except in highly limited circumstances, and that health and safety requirements should be established through clear and detailed notice of their legal obligations.

"Illinois' view that employers may be held criminally liable for workplace injuries or illness, regardless of their compliance with OSHA standards, would lead to piecemeal and inconsistent prosecutions of regulatory violations throughout the states, a result that Congress sought to preclude in enacting OSHA," the appellate court said.

But last year, in a case cited by the Illinois Supreme Court, the Wisconsin Court of Appeals ruled that OSHA did not pre-empt state laws.

The Wisconsin court also blasted the 1987 Illinois appellate decision for allegedly ignoring "the rule that an act of Congress is presumed not to pre-empt state law or that the burden of showing pre-emption is upon the person claiming it. Indeed, the court appears to have proceeded on the assumption that the state had the burden to show lack of pre-emption."

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People of the State of Illinois vs. Chicago Magnet Wire Corp., et al; Illinois Supreme Court, Docket No. 65588—Agenda 12—March 1988.

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Nine-month combined ratios adjusted for tax payments*

	Paid taxes	Net premiums written	Paid taxes as % of net premiums	Combined ratio	Adjusted combined ratio
Property/casualty insurers					
AIG	$276.0'	$6,494.0	4.3%	99.4%	103.7%
Chubb	75.0	2,074.0	3.6	99.0	102.6
Fireman's Fund	41.8	2,147.3	1.9	110.4	112.3
GEICO	28.1	812.5	3.5	98.2	101.7
Home Group	18.4	1,617.5	1.1	108.0	109.1
Ohio Casualty	46.0	1,032.4	4.5	101.0	105.5
SAFECO	25.4	1,149.8	2.2	101.4	103.6
St. Paul	75.0'	1,955.8	3.8	103.8	107.6
USF&G	5.3	2,452.0	0.2	106.5	106.7
Property/casualty average	-	-	2.8	103.1	105.9
Multiline insurers					
Aetna Life & Casualty	0.0	5,114.8	0.0	110.4	110.4
American General	23.5	1,438.0	1.6	112.7	114.3
CIGNA	0.0	4,511.7	0.0	107.2	107.2
Lincoln National	35.0	1701.0	2.1	100.8	102.9
Travelers	17.1	4,012.3	0.4	105.5	105.9
Transamerica	4.5	1,173.5	0.4	107.1	107.5
Multiline average	-	-	0.8	107.3	108.0
Reinsurers					
General Re	22.5	1,479.4	1.5	99.2	100.7
NAC Re	5.1	120.2	4.2	106.9	111.1
Reinsurance average	-	-	2.9	103.1	105.9
Overall average	-	-	2.1	104.6	106.6
ISO average	-	-	2.1	105.3	107.4

*All amounts in millions of dollars
'Estimate

Source: Oppenheimer & Co.
Chart: Chris Woolsey

Continued from previous page

Initially, we estimated that taxes would raise combined ratios two to four percentage points. The overall average was 2.1 points for both the quarterly and, as shown in the chart, the nine-month periods. Based on the data published by the Insurance Services Office Inc., tax payments added 1.5 points to overall combined ratios for the quarter and 2.1 points for the nine-month period. On average, primary insurers' combined ratios jumped 3.1 points for the quarter and 2.8 points for the nine months. The comparable average numbers for the multiline group were 0.3 and 0.8 points, respectively. For the two reinsurers surveyed, third-quarter ratios were pushed up 3.1 points and the nine-month figure was increased 2.9 points.

It should be noted that in those instances where there appears to be a relatively large tax payment for a specific company, such as AIG, it should be recognized that the company is most likely in a profitable underwriting position. Another insight relates to the tax payments of the multiline insurers. It appears that some of those insurers might be purposefully writing business at a loss believing that they can offset it through a partial consolidation with their life insurance operations.

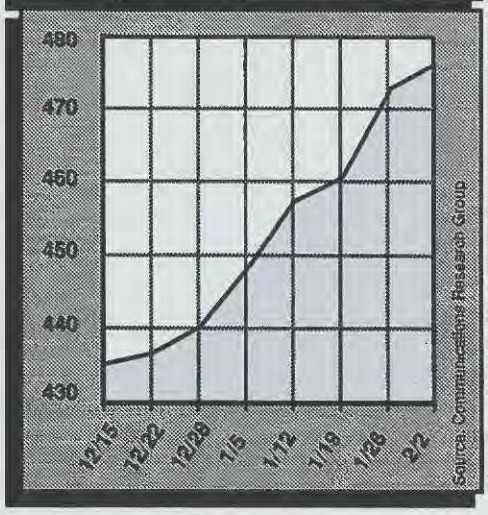
Last but not least, there is the Technical and Miscellaneous Revenue Act of 1988. In essence, this is an attempt to "end-run" proposed FASB No. 96, which deals with the recognition of deferred taxes. If this standard were implemented, it apparently would have to be checked against the alternative minimum tax rules for generally accepted accounting principles. If implemented, it would enable insurers to report effective tax rates in their GAAP statements that would basically emulate the federal tax levels.

Importantly, however, TAMRA does not alter the economics of real cash flows for the property/casualty insurance industry, except for a quick, one-time offset with remaining "Fresh Start" benefits.

Notwithstanding the caveats about the quality of the data we are using, the industry's third-quarter and nine-month combined ratios were "dirty"—the reported ratios were several points lower than what they really are. Expense ratios were favorably distorted by increased premium retentions and improper recognition of tax payments.

In the words of Lewis Carroll in "Alice's Adventures in Wonderland," this lack of decisive recognition of tax payments is "curiouser and curiouser." ■

BI Insurance Index



Insurance industry stocks rose last week, as the Business Insurance Index rose 3.8 points to 477.0 on Feb. 2, from 473.2 on Jan. 26. Advancing issues were led by United Medical Corp., up 11 points; U.S. Healthcare, up 10.5%; and FHP International Corp., up 10.2%. Declining issues followed Sierra Health Services, down 16.4%; Belvedere Corp., down 9.1%; and Western Health Plans, down 7.4%. The most active issue during the period was Sears, Roebuck & Co. (Allstate), 3.7 million shares traded. The *BI Index* gained 0.8% for the period; The Standard & Poor's 500 was up 2.1%; the Dow Jones 30 Industrials, up 1.9%; and the New York Stock Exchange Composite, up 1.7%.

British Issues

Feb. 2 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	386	12.5	25.3	6.6	387—384	
Genl Accident	960	9.5	58.0	6.0	962—942	
Gdn Royal Exch	212	11.4	13.1	6.1	213—208	
Royal	442	14.4	30.0	6.8	442—434	
Sun Alliance	1120	8.5	54.7	4.9	1128-1112	
Brokers						
Bradstock	223	12.6	9.0	4.0	224—223	
CE Heath	463	14.7	34.5	7.5	463—440	
Hogg Robinson	151	14.0	8.0	5.3	151—147	
Lloyd Thompson	211	16.6	8.0	3.8	211—209	
PWS Holdings	130	18.6	5.2	4.0	130—130	
Sedgwick Grp	262	21.8	16.0	6.1	263—260	
Steel Birl Jones	227	20.3	13.3	5.9	229—227	
Willis Faber	258	17.6	15.3	5.9	262—245	

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

FEBRUARY 2, 1988 **1/27/89 THRU 1/2/89**

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	23.13	0.6	-1.6	28.13	17.75	403	1.00	4.3	15.8	3.71	6.23
Corroon & Black Corp.	NYSE	32.00	0.8	2.8	34.75	28.00	199	1.08	3.4	4.8	12.40	2.58
Gallagher Arthur J. & Co.	NYSE	17.25	0.0	3.0	19.13	13.88	22	0.48	2.8	12.2	5.46	3.16
Hall Frank B. & Co.	NYSE	3.00	9.1	4.2	5.50	2.50	176	0.00	0.0	-1.6	0.00	N/A
Hilb, Rogal & Hamilton	OTC	15.75	0.8	3.3	15.75	9.75	7	0.00	0.0	12.4	4.60	3.42
Marsh & McLennan Cos. Inc.	NYSE	57.25	-0.4	1.8	59.63	45.25	455	2.50	4.4	14.0	6.74	8.49
Poe & Assoc. Inc.	OTC	8.25	0.0	0.0	9.25	6.75	11	0.40	4.8	9.3	0.27	30.56
BROKERS	AVERAGE		1.6	1.9					2.8	9.5		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	32.00	1.6	8.5	32.00	23.50	165	0.36	1.1	6.9	17.63	1.82
Berkshire Hathaway Inc. DEL	NYSE	5000.00	2.6	43.2	5050.00	3000.00	77	0.00	0.0	20.1	2492.68	2.01
ITT (Hartford Group)	NYSE	54.25	-0.2	8.2	55.00	43.25	1428	1.48	2.7	7.1	52.23	1.04
Sears Roebuck & Co. (Allstate)	NYSE	42.88	2.7	4.9	46.13	32.25	3733	2.00	4.7	11.2	34.74	1.23
CONGLOMERATES	AVERAGE		1.7	16.2					2.1	11.3		
INSURERS/REINSURERS												
Aetna Life & Cas Co.	NYSE	49.75	2.3	5.3	52.50	39.50	1008	2.76	5.5	8.2	53.56	0.93
American General Corp.	NYSE	33.50	0.4	12.1	36.38	27.50	1209	1.40	4.2	8.5	28.04	1.19
Amer Heritage Life Invt	NYSE	25.50	1.5	-1.0	27.00	24.00	130	1.08	4.2	10.8	20.98	1.22
Amer Indty Fin'l Corp.	OTC	10.88	1.2	3.6	12.00	8.25	7	0.56	5.1	7.1	17.06	0.64
American Int'l Group	NYSE	73.63	0.9	8.7	74.63	49.00	1503	0.40	0.5	10.9	33.55	2.19
Aon Corp.	NYSE	28.25	1.8	0.9	29.00	21.88	321	1.28	4.5	9.3	15.13	1.87
Argonaut Group	OTC	49.50	2.1	13.1	50.75	29.50	172	0.00	0.0	7.4	34.94	1.42
AVEMCO Corp.	NYSE	24.38	1.6	-5.8	28.75	17.88	51	0.40	1.6	11.3	7.74	3.15
Baldwin & Lyons Inc.	OTC	14.88	0.9	0.0	16.38	12.13	21	0.20	1.3	6.2	17.57	0.85
Belvedere Corp.	AMEX	5.00	-9.1	11.1	6.00	4.00	4	0.04	0.8	7.4	7.87	0.64
Chandler Insurance	OTC	11.00	1.1	18.9	11.25	4.25	73	0.00	0.0	5.3	4.81	2.29
Chubb Corp.	NYSE	62.00	1.4	6.9	63.38	51.25	703	2.16	3.5	7.1	46.13	1.34
CIGNA Corp.	NYSE	52.13	3.2	10.6	55.38	42.75	503	2.96	5.7	9.7	49.19	1.06
CNA Fin'l Corp.	NYSE	58.88	-1.3	-2.7	66.13	51.00	157	0.00	0.0	9.3	46.40	1.27
Continental Corp.	NYSE	34.63	3.4	6.9	41.63	31.50	754	2.60	7.5	11.1	42.10	0.82
Durham Corp.	OTC	32.25	0.8	-2.3	36.75	21.50	8	0.92	2.9	37.5	26.00	1.24
Fireman's Fund Corp.	NYSE	32.75	3.5	12.0	33.50	25.75	541	0.50	1.5	6.9	30.91	1.06
Forum Re (Bermuda)	OTC	1.63	8.7	0.0	4.00	1.13	2	0.00	0.0	4.5	2.58	0.63
Fremont Gen Corp.	OTC	14.00	1.8	4.6	14.13	8.75	71	0.60	4.3	9.5	16.24	0.86
Frontier Insurance Group	OTC	13.50	0.0	8.0	13.50	6.50	29	0.00	0.0	6.8	5.97	2.26
General Re Corp.	NYSE	58.88	1.1	6.1	60.25	45.50	852	1.20	2.0	12.0	26.21	2.25
Home Group Inc.	NYSE	12.50	2.0	13.6	14.38	10.50	228	0.20	1.6	1.5	17.75	0.70
Hanover Ins Co.	OTC	28.25	5.6	5.6	27.75	20.50	828	0.36	1.3	5.4	25.10	1.13
Harleysville Group Inc.	OTC	19.38	1.3	7.7	19.63	13.38	39	0.48	2.5	7.6	16.65	1.16
Hartford Steam Boiler	OTC	38.50	2.7	4.8	38.50	22.50	230	1.40	3.6	11.1	10.65	3.62
Kans City Life Ins	OTC	32.75	-0.8	-5.1	39.50	25.25	24	0.00	0.0	10.4	39.22	0.84
Kemper Corp.	OTC	29.75	10.2	24.0	29.75	20.75	1405	0.84	2.8	9.5	26.50	1.12
Lawrence Ins. Group	AMEX	7.75	-6.1	-1.6	11.63	4.50	129	0.24	3.1	17.2	2.90	2.67
Liberty Corp. S.C.	NYSE	37.00	-0.7	2.8	47.25	33.88	13	0.80	2.2	12.8	17.40	2.13
Lincoln Nat'l Corp.	NYSE	47.88	1.3	8.8	53.50	40.25	173	2.48	5.2	12.4	36.62	1.31
NAC Re Corp.	OTC	32.25	0.0	1.6	33.50	18.50	302	0.00	0.0	14.4	19.92	1.62
Navigators Group	OTC	21.00	-4.5	5.0	22.00	14.50	2	0.00	0.0	10.2	12.88	1.63
Nobel Ins Ltd.	OTC	4.75	-5.0	0.0	9.50	3.75	63	0.42	8.8	-18.3	7.76	0.61
Northwestern Nat'l Life	OTC	29.00	-2.5	-6.8	34.50	22.63	607	1.12	3.9	7.0	35.05	0.83
Ohio Cas Corp.	OTC	43.00	1.8	20.3	45.25	32.25	291	1.88	4.4	6.6	27.86	1.54
Old Rep Int'l Corp.	OTC	27.13	3.8	13.0	27.13	19.13	599	0.74	2.7	6.4	27.82	0.98
Orion Cap Corp.	NYSE	19.75	-0.7	28.4	20.75	13.13	75	0.76	3.8	6.7	9.34	2.11
Phoenix Re Corp.	OTC	10.25	0.0	7.9	11.00	6.75	82	0.00	0.0	5.6	11.08	0.93
Protective Life Corp.	OTC	14.00	-1.8	5.7	15.13	12.25	70	0.70	5.0	17.1	17.25	0.81
Re Capital Corp.	AMEX	10.00	1.2	9.5	11.75	7.88	15	0.00	0.0	22.2	11.49	0.87
Provident Life & Acc Ins Co.	OTC	22.00	2.9	14.3	25.00	15.63	626	0.68	3.1	18.5	21.96	1.00
St Paul Cos. Inc.	OTC	48.00	0.5	10.3	51.00	38.25	1536	2.00	4.2	6.7	35.83	1.34
SAFECO Corp.	OTC	27.25	0.9	15.3	30.00	22.75	1058	1.08	4.0	7.6	23.94	1.14
SCOR U.S. Corp.	NYSE	8.13	-7.1	-11.0	9.50	6.63	45	0.20	2.5	5.8	9.38	0.87
Seibels Bruce Group Inc.	OTC	12.50	0.0	9.8	14.25	11.00	55	0.80	6.4	8.4	12.51	1.00
Selective Ins Group Inc.	OTC	22.63	-4.7	-1.6	26.50	19.25	176	1.24	5.5	5.0	19.52	1.16
Statesman Group Inc.	OTC	3.44	5.8	9.9	5.56	2.75	138	0.05	1.5	-344.0	3.48	0.99
Tokio Marine & Fire Ins	OTC	85.25	-5.0	-6.7	98.00	63.25	29	0.22	0.3	51.7	0.00	N/A
Torchmark Corp.	NYSE	32.13	-0.4	5.3	33.50	24.50	186	1.20	3.7	10.4	12.24	2.63
Transamerica Corp.	NYSE	33.63	1.5	-0.7	36.75	29.75	363	1.88	5.6	7.7	24.94	1.35
Travelers Corp.	NYSE	37.00	4.2	6.5	40.00	33.00	915	2.40	6.5	13.6	45.28	0.82
Trenwick Group Inc.	OTC	14.50	-3.3	0.0	15.25	9.75	202	0.24	1.7	14.2	15.41	0.94
United Fire & Cas Co.	OTC	30.50	0.0	0.0	30.75	24.00	12	1.08	3.5	5.1	22.56	1.35
United States Fid & Gty	NYSE	29.88	-1.2	4.8	34.38	28.50	1517	2.64	8.8	8.4	19.52	1.53
UNUM Corp.	NYSE	28.25	4.6	4.6	28.25	17.88	308	0.48	1.7	11.8	28.53	0.99
USLIFE Corp.	NYSE	39.75	4.9	14.0	40.13	28.00	291	1.36	3.4	10.5	46.77	0.85
Washington Nat'l Corp.	NYSE	26.00	0.0	-3.7	28.75	24.00	13	1.08	4.2	-7.6	32.33	0.80
Zenith Nat'l Ins Corp.	NYSE	17.75	3.6	1.4	23.88	15.00	104	0.80	4.5	8.3	12.53	1.42
INSURERS/REINSURERS	AVERAGE		0.7	5.8					3.1	3.7		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International Corp.	OTC	16.25	10.2	34.0	15.25	6.00	836	0.00	0.0	8.9	3.54	4.59
HMO America Inc.	OTC	1.13	6.6	20.2	2.75	0.81	21	0.00	0.0	-1.8	1.12	1.01
Maxicare Health Plans	OTC	0.75	0.0	0.0	4.25	0.50	431	0.00	0.0	-0.1	0.00	N/A
Pacificare Health Systems	OTC	14.50	-3.3	18.4	15.00	5.75	7	0.00	0.0	12.7	6.35	2.28
Safeguard Health Ent.	OTC	5.38	-2.2	-2.2	8.25	4.00	16	0.00	0.0	10.8	2.75	1.96
Sierra Health Services	AMEX	1.88	-16.4	15.3	3.00	1.25	23	0.00	0.0	14.5	1.59	1.18
United Health Services	OTC	5.13	1.4	14.0	2.69	1.75	396	0.00	0.0	-2.0	2.59	1.98
United Medical Corp.	AMEX	6.25	11.0	19.0	6.50	2.50	65	0.00	0.0	-312.5	3.91	1.60
U.S. Healthcare	OTC	6.63	10.5	14.1	4.44	2.13	1118	0.16	2.4	-36.8	2.89	2.29
Western Health Plans Inc.	AMEX	0.75	-7.4	8.7	3.38	0.50	3	0.00	0.0	-0.4	0.82	0.91
HMOs	AVERAGE		1.0	14.2					0.2	-30.6		
ALL COMPANIES	AVERAGE		0.9	7.0					2.6	0.3		

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