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update

IEA syndicates stop writing new reinsurance treaties

MIAMI—The Insurance Exchange of the Americas has ordered three syndicates into rehabilitation and has declared a moratorium on new treaty reinsurance underwriting by all 23 IEA syndicates.

A fourth syndicate has been placed in rehabilitation by a Florida state judge, according to Bill Godwin, assistant director of com-

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Year of living dangerously

Request for liquidation ends struggle to rehabilitate Mission Insurance Co.

By STEVE TARAVELLA

LOS ANGELES—The California Insurance Department's attempt to liquidate Mission Insurance Co. ends more than a year of often frenzied attempts to save the insolvent insurer, once one of the California's largest workers compensation underwriters.

If MIC is ordered liquidated at a Feb. 24 court hearing as expected, the parties that have attempted to rescue MIC over the past year will face a new set of problems.

Besides asking Los Angeles Superior Court to liquidate MIC, which was placed in conservation in October 1985, the Insurance Department also requested the liquidation of four MIC subsidiaries under state control.

Taken together, the liquidation proceedings could be the largest in history.

In addition, the department requested and was granted permission Feb. 2 to place Mission American Insurance Co. in conservation. Mission American is MIC's immediate parent and the insurer that MIC's ultimate parent, Mission Insurance Group Inc., hoped would put the financially beleaguered company back in the black.

The department could not say whether Mission American could be rehabilitated.

MIG officials did not return phone calls.

The California department said it sought conservation of Mission American without advance notice to shield the insurer's assets in case MIG was placed in bankruptcy.

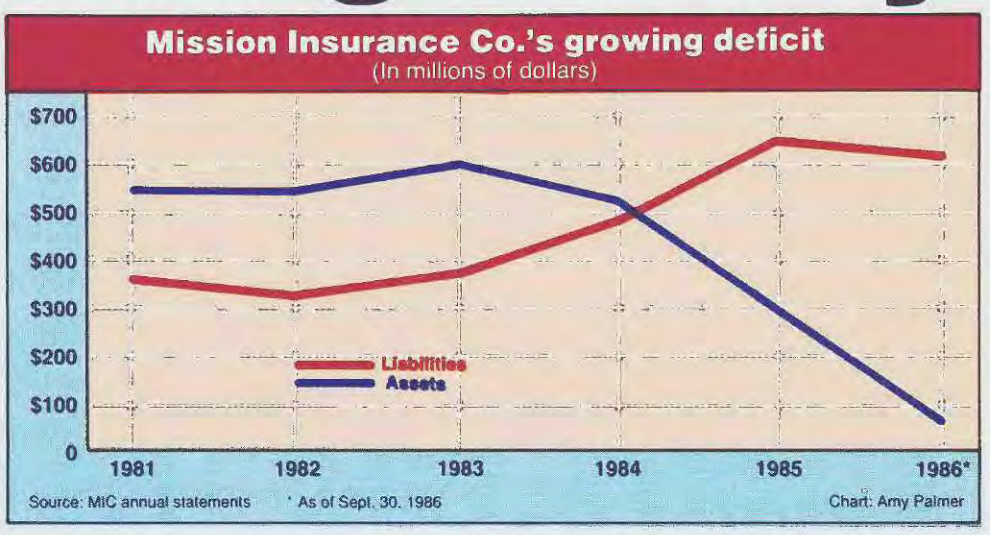
The following day, MIG consented to a Chapter 11 bankruptcy petition filed early in 1986 by MIG bondholders. The petition, which was filed after MIG defaulted on interest payments to bondholders, had been put on hold as various parties had negotiated rescue plans.

Last week's actions create a new set of problems for policyholders that bought direct insurance from MIC, insurers that ceded business to MIC and the insurance industry in general.

MIC's direct policyholders would have to seek claims payments from state guaranty funds if MIC is liquidated. All direct MIC policyholders are entitled to guaranty fund coverage since MIC wrote on an admitted basis in all states. However, the amount that policyholders can recover is capped by the funds.

"Every claimant will be taken care of," said California Insurance Commissioner Roxani M. Gillespie.

Ms. Gillespie noted that the department has received "tremendous" cooperation from the California Insurance Guarantee Assn. The majority of MIC's business was written in California.



However, insurers that ceded reinsurance to MIC could face large losses if MIC is liquidated because state guaranty funds to not cover reinsurance contracts. These ceding companies had been actively involved in negotiations to finalize a rehabilitation plan for MIC.

And, insurers are fearing the liquidation of MIC would cause state guaranty funds to boost the amount they assess admitted insurers.

MIC and the four subsidiary insurers the California department wants to liquidate are insolvent by a total of about $520 million, according to the most recent statements available.

MIC contributed the lion's share of the deficit. The California department reported that MIC had $612.8 million in liabilities and only $164.7 million in assets as of Sept. 30, 1986, creating a $448.1 million insolvency.

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CGL policies cover cleanup costs: Court

By STEPHEN TARNOFF

ST. LOUIS—Cleanup costs sought from defendants in Superfund litigation can be considered "property damage" and can be recovered from insurers under comprehensive general liability policies, a federal appellate court said.

In a ruling favorable to policyholders, the 8th U.S. Circuit Court of Appeals also held that property damage occurs at the time hazardous wastes are improperly released into the environment, not when the cleanup costs are incurred.

The Jan. 22 decision by the three-judge appellate panel reverses a decision by the U.S. District Court for the Western District of Missouri in a dispute involving Continental Insurance Cos., which wrote CGL coverage for the now-defunct Northeastern Pharmaceutical & Chemical Co. Inc. between 1970 and 1972.

The state of Missouri and the federal government sought to recover from NEPACCO's insurers the cost of cleaning up several well-publicized toxic waste sites in Missouri, including Times Beach.

Last week, an attorney for Continental said the insurer was filing a petition for a rehearing with the entire 8th Circuit.

According to attorneys representing policyholders, the 8th Circuit's decision is very important because it states that pollution cleanup costs are covered by CGL policies and also gives policyholders a favorable interpretation of coverage in hazardous waste

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Union sues Kaiser Steel over retiree health benefit cuts
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Insurers restricting use of claims-made CGL form

By ROBERT A. FINLAYSON

The Insurance Services Office's new occurrence-based commercial general liability policy form—not its controversial claims-made form—will dominate the primary liability insurance market for the foreseeable future, insurer executives predict.

Insurers say they will force only those businesses with high-hazard or long-tail exposures to use the claims-made form because:

- Regulators, buyers and brokers have steadfastly opposed the claims-made form.
- Most buyers can readily find markets to write their coverage on an occurrence basis, and insurers want to maintain their market share.
- Reinsurers have softened their stance on the necessity that direct coverage be written on a claims-made basis.



"Insofar as the claims-made policy is concerned, there has been a backing off within the industry in general and also on the reinsurers' side relative to the broad-brush application of the claims-made policy form," noted William Flint, assistant vp with United States Fidelity & Guaranty Co. in Baltimore.

"When it was originally filed, I think the assumption was that everything would move to claims-made—the reinsurers were insisting on it," explained John W. Purkis, a vp with Boston-based Liberty Mutual Insurance Co.

"But the opposition to the claims-made policy has led to a re-examination, and to some extent the reinsurers themselves have backed down a little," he added. "Whether that will change, I don't know. But there certainly has been a change away from the feeling that everything will go claims-made."

Insurers and reinsurers still value the ISO claims-made CGL form because it forces policyholders to pay an additional premium to obtain coverage beyond the initial policy period.

Generally, insurers describe ISO's new occurrence policy form as less valuable than the claims-made form for containing underwriting losses on general liability lines. However, they say the new occurrence policy has several definite advantages over the older occurrence form.

The most important advantage to insurers is that the new occurrence policy—like the claims-made form—has an aggregate policy limit. The existing occurrence CGL policy has a separate limit for products/completed operations liability, but it does not have an aggregate limit.

"The main thing we are looking to is the new occurrence policy with its aggregate-limit provision," said John Bowdish, commercial lines underwriting officer for Kemper Corp. in Long Grove, Ill.

In addition, the new occurrence form, again like the new claims-made policy, also excludes all coverage for pollution liability. The existing CGL policy includes coverage for sudden and accidental pollution liability but excludes coverage for non-sudden and gradual pollution.

The new form's total pollution exclusion is considered important by insurers, because many U.S. courts have ruled that the existing CGL pollution exclusion is ambiguous and have ordered insurers to defend and indemnify policyholders for losses stemming from gradual pollution incidents.

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update

IEA syndicates in rehabilitation

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pany regulation for the Florida Insurance Department.

Meanwhile, the Florida department has urged the IEA to cease all reinsurance and direct insurance underwriting.

However, the IEA only has discontinued writing assumed treaty business, saying that a broader moratorium would be unfair to brokers and syndicates. "We feel that it would be detrimental to other syndicates that are being properly managed," said IEA President Nicholas Cross.

The three syndicates ordered into rehabilitation in a Feb. 4 meeting of the IEA board of governors are Syndicate One Inc., Syndicate Two Inc. and Syndicate Three Inc., all managed by Daum Management Inc. Syndicate Two and Syndicate One were the exchange's eighth- and ninth-largest syndicates in 1985, based on gross premiums of $6.7 million and $6.4 million, respectively.

Syndicate One is owned by RLI Corp., which also owns 80% of Daum Management. Syndicate Two and Syndicate Three are owned by private investors.

Earlier, the IEA board had ordered Hispano American Insurance Syndicate Ltd.—the exchange's fourth-largest with 1985 gross premiums of $11.5 million—to show cause why it should not be placed in rehabilitation. However, Hispano American petitioned the Insurance Department for court-supervised voluntary rehabilitation, and a Leon County Circuit Court judge issued the rehabilitation order last week, Mr. Godwin said. He added that the Insurance Department will decide this week whether to seek court-supervised rehabilitation for the other three syndicates.

The IEA board is scheduled to meet on Tuesday to review a rehabilitation plan for the syndicates.

The four IEA underwriting members participated on six or seven "problem" reinsurance treaties, Mr. Goodwin said, adding that IEA and Insurance Department officials are examining other syndicates that may have participated on the same treaties.

"Undoubtedly, there are one or two other syndicates that have participated on those treaties," noted Nicholas Cross, IEA president. "We do not know if they participated to an extent that would cause their impairment."

The treaties in question do not include treaties between Omaha Indemnity Co. and two other IEA members, RAM Syndicate Inc. and Administrative Management Services Syndicate Ltd. Inc., Mr. Godwin said. Omaha Indemnity currently is arbitrating disputes with Royal American Managers, which owns RAM Syndicate and managed the business ceded to the two syndicates (*BI*, Sept. 1, 1986; April 28, 1986).

Lloyd's restructuring begins

LONDON—Four working members of the Council of Lloyd's of London's resigned last week as the restructuring of the 28-member ruling council began.

The four members, whose terms of office would have expired between 1987 and 1990, resigned "to avoid the otherwise necessary lengthy transitional arrangements" needed to meet recommendations by a government panel calling for an end to the working members' majority on the council (see earlier story, page 17).

The resignations of Patrick Bird, Richard Ballantyne, John Greig and Frank Barber will be effective July 1, by which time Lloyd's hopes that four non-Lloyd's members will be nominated to the council, Mr. Miller said.

Investors purchase Galaxy Re

NEW YORK—The two investors that have purchased Galaxy Reinsurance Co. plan to convert the reinsurer into a primary insurer that will write commercial property coverages.

Alvin B. Moss, a broker and reinsurance intermediary, said a group led by himself and investor David T. Chase spent $600,000 to acquire Galaxy's licenses from Swiss Union General Insurance Co. and Santa Fe Southern Pacific Corp.

The group also paid $800,000 in cash for the same amount in Treasury bills, which were subsequently contributed as Galaxy's policyholder surplus. With additional contribution, the insurer's surplus is almost $6 million.

Mr. Moss noted that as part of the purchase agreement, Galaxy's liabilities were assumed by Swiss Union, which owned 80% of the insurer. Liabilities totaled about $6 million as of September 1986, when it stopped writing business, said Mr. Moss. The company reported net written premiums of $3.1 million in 1985.

Galaxy had been managed by a unit of Constellation Reinsurance Co., which is now awaiting a decision by a New York court on whether it should be liquidated (*BI*, Jan. 26).

Galaxy, whose name is being changed to Galaxy Insurance Co., is expected to write $4 million to $5 million in net premiums this year, Mr. Moss said.

Robins considers buyout offer

NEW YORK—American Home Products Corp. would pay all Dalkon Shield claims against A.H. Robins Co. Inc. and bring the company out of reorganization if American Home's bid to acquire Robins succeeds.

American Home submitted a proposal to Robins' board of directors that called for the acquisition of Robins on a tax-free basis to Robins shareholders and the creation of a "substantial trust fund" for the benefit of Dalkon Shield claimants.

Under the proposal, the trust fund would assume responsibility for resolving all Dalkon Shield and related claims. It also contemplates that certain other creditors of Robins will receive full payment of their claims.

An American Home official and a Robins spokesman declined to provide financial details of the plan. The Robins spokesman said

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Texas legislators consider tort, insurance reform bills

By MICHAEL BRADFORD

AUSTIN, Texas—Texas lawmakers are considering sweeping tort reform and insurance reform proposals based on more than 50 recommendations by a legislative committee.

However, the insurance reform proposals—developed by the House-Senate Joint Committee on Liability and Tort Law and Procedure—do not call for such drastic measures as the rate rollbacks or premium refunds required under Florida's controversial 1986 Tort Reform and Insurance Act.

But the tort reforms do include major changes like the elimination of joint and several liability and caps on non-economic damage awards.

The joint committee submitted its report to the Legislature last month after being charged by the state's lieutenant governor and House speaker in 1986 with "studying the availability and cost of commercial, professional and governmental liability insurance and the impact of the tort recovery process on the insurance industry."

The vast reform package includes 30 recommendations for tort reform measures and 22 suggested changes in insurance regulation. The recommendations also include four proposals for more closely monitoring the competency of physicians in the state.

Under the proposals, the state's authority over commercial property/casualty insurance rates is left virtually unchanged except for the recommendation that rates be reviewed annually.

Florida's controversial tort reform legislation, which is being challenged in the state Supreme Court, gave broader rating authority to the state Insurance Department. In addition, the legislation froze commercial property/casualty insurance rates, forced a refund of liability insurance premiums and authorized a rollback of 1987 rates to 1984 levels.

Last week, at least seven tort reform and insurance bills encompassing most of the committee's recommendations had been drafted and introduced in the Legislature. However, proponents of the joint committee's package don't see an easy road to passage.

"It's a tough fight," says George Christian, secretary/treasurer of the Texas Civil Justice League. "It's a controversial issue in the Legislature. There's a lot of heat involved."

Frank Aaron, risk management coordinator at Velaro Energy Corp. in San Antonio, said he is "a little less than optimistic" about approval of the package by a "plaintiff-lawyer Legislature."

"I don't think the chances are too favorable at this time," echoed Jan A. Wilhelm, corporate risk manager at National Convenience Stores Inc. in Houston and president of the Houston Chapter of the Risk & Insurance Management Society. However, the changes are "necessary and long overdue," he said.

In its report, the committee says its tort reform recommendations, "which fully preserve the rights of the injured persons to seek relief through the courts, are intended to bring long-term stability to the liability insurance market through the restoration of underwriting predictability."

The committee recommends joint and several liability be abolished, so that a defendant would be liable

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Thiokol has $500 million in coverage

By LINDA J. COLLINS

CHICAGO—Morton Thiokol Inc. has $500 million of product liability insurance to respond to a $1.1 billion claim filed by an engineer in connection with last year's explosion of the space shuttle Challenger, says an attorney with the National Aeronautics and Space Administration.

A majority of the product liability coverage was placed with various syndicates at Lloyd's of London, confirmed Susan Smith, chief counsel for NASA's Marshall Space Flight Center in Huntsville, Ala.

The London broker for Thiokol's product liability coverage was Fenchurch Group Brokers International Ltd., according to an underwriter at the David Willis syndicate at Lloyd's.

The underwriter confirmed that the syndicate participated on the risk, but referred further questions to Fenchurch. Fenchurch officials could not be reached for comment.

In the lawsuit that was filed in U.S. District Court in Washington, D.C.,

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Mutual Fire panel to hold first meeting

By MICHAEL BRADFORD

PHILADELPHIA—The committee of policyholders formed to provide input regarding the rehabilitation of Mutual Fire, Marine & Inland Insurance Co. is holding its first meeting today to discuss its objectives.

The group, which now consists of at least seven policyholders, is gathering in Philadelphia this evening and Tuesday morning and will be on hand for a Tuesday afternoon hearing ordered by Judge James Crumlish Jr. to "consider the status of any outstanding motions and/or objections" concerning the rehabilitation plan.

The judge recently ordered the formation of the committee to represent several thousand policyholders of Mutual Fire, Marine in the rehabilitation proceedings (*BI*, Feb. 2).

Since Judge Crumlish issued the order to form the committee, the membership has expanded, as of late last week, to include representatives from Wal-Mart Stores Inc. in Bentonville, Ark., and Florida Farm Bureau Federation in Gainesville, Fla.

The other policyholders represented on the committee are Rite Aid Corp. in Harrisburg, Pa.; Sun Coast Hospital Inc. of Largo, Fla.; Federal Realty Trust Inc. of Bethesda, Md.; Healthdyne Inc. of Marietta, Ga.; and Calder Race Course Inc. in Miami. Those five policyholders originally requested formation of the committee.

Court filings made on behalf of Pennsylvania Insurance Commissioner George F. Grode says the insurer was insolvent by $5.8 million at year-end 1985. Mutual Fire, Marine's assets totaled $115.9 million and its liabilities were $121.7 million at the end of 1985, according to the court filings.

However, policyholders have questioned the validity of those

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inside

- This week's editorial notes that the rehabilitation in Pennsylvania of Mutual Fire, Marine & Inland Insurance Co. won't be compromised by the formation of a policyholder committee to represent the interests of the insurer's policyholders. **PAGE 8**
- Sen. Edward Kennedy, D-Mass., says all employers should be required to offer group health insurance benefits to their employees. He likened the minimum benefit proposal to the concept of a minimum wage. **PAGE 14**
- In Speaking Out, John Garner, a principal in the Los Angeles office of Towers, Perrin, Forster & Crosby, recommends medical case management to effectively lower employers' medical costs and ensure appropriate care for employees. **PAGE 23**
- In light of a new Delaware law that shields corporate directors and officers from some liability, the American Society of Corporate Secretaries says many Delaware corporations plan to amend their certificates of incorporation to limit or eliminate directors' liability for breach of fiduciary duty. **PAGE 26**

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Union sues Kaiser over cancellation of retiree benefits

By JUDY GREENWALD

FONTANA, Calif.—Kaiser Steel Corp.'s move to cancel retiree medical benefits may be a tactic to force retirees either to renegotiate their health care coverage now, or to stand in line with Kaiser Steel's other creditors in bankruptcy court later, some observers say.

The financially troubled company has said it must eliminate health care benefits for about 5,300 retirees because it no longer can afford to pay for the coverage (*BI*, Feb. 2).

But, in a lawsuit filed in U.S. District Court in Los Angeles seeking to restore the benefits, the United Steelworkers union notes that Kaiser Steel, in a 1984 agreement between the union and the company, said it would provide the retirees with lifetime health benefits.

A Kaiser Steel spokesman had no comment on the suit, stating he had read neither the suit nor the 1984 agreement.

But, Henry Bright, vp at The Wyatt Co. in New York, said, "It sounds as if they're just turning their pockets inside out and saying, 'I owe you, but I can't pay you. Go take me to court or file suit with the other creditors.' "

"Bankruptcy is a possibility that the company has recognized for some time and is doing all it can to avoid," said the Kaiser Steel spokesman, adding the steel maker is "hopeful" it can be avoided.

"We feel the company has better options as a going concern," he said, adding, "We just have to see how things go."

The spokesman also noted the company is discussing with the Pension Benefit Guaranty Corp. the possibility of terminating its underfunded defined benefit pension plan. The plan is underfunded by $241 million (see story, page 39).

About 4,000 of the approximately 5,300 retirees are unionized, said the Kaiser Steel spokesman. Many of them worked at a steel mill in Fontana, which was closed in 1983.

Health care benefits for about 1,000 current employees also were cut, but the company has promised to reimburse the employees for their medical expenses, said the spokesman.

About 4,300 of the retirees received health care benefits through the Kaiser Permanente Medical Program, a health maintenance organization not related to Kaiser Steel. Coverage for the remainder of the retirees is written by New York Life Insurance Co.

Kaiser Permanente canceled coverage after the company failed to make a $255,000 premium payment, a Kaiser Steel spokesman said.

A spokesman for Kaiser Permanente said the HMO has given the retirees 30 days in which to switch to self-paid coverage at a monthly cost of $76.40 for a single person.

A New York Life spokesman said the insurer has not officially canceled coverage, but it has stopped paying claims while it continues to negotiate with Kaiser Steel. The Kaiser Steel coverage was provided under a minimum premium plan. "We're not looking for any immediate fix to the problem," he added.

The Kaiser Steel spokesman said the company had missed making a $250,000 payment to New York Life.

Dave Platt, a retiree and a member of the board of

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No relief

Health costs rise 7.7% despite plan changes

By ALISON KITTRELL

The average cost of employee health care rose 7.7% during 1986 to $1,857 per employee, despite an increased emphasis on cost containment, according to a recent survey.

In fact, the responses of more than 1,500 corporations in 36 states nationwide revealed that at least one much-touted cost-containment option, health maintenance organizations, is being viewed with more skepticism than enthusiasm by employers.

However, employers are more positive about preferred provider organizations, according to "The Corporate Health Care Benefits Survey for 1986," conducted by Johnson & Higgins.

Employer's views on health care and its costs are important since they pay much of the nation's health care bill, J&H notes.

"As the source of health insurance for nine out of 10 working Americans, employers play a key role in the financing of our nation's health care system," said David Rahill, vp and manager of J&H's HealthGroup.

"Because of the continued rising in costs, managing these expenditures will be the leading health care issue for the rest of the decade," Mr. Rahill said.

Specifically, the survey found that:

- Although health care costs nationwide average $1,857 per employer, the cost varied significantly among regions and between unionized and non-unionized employers.
- Employers are asking their employees to contribute significantly to the cost of their health care coverage, through both deductibles and co-payments.
- Employers are lukewarm at best about the success of HMOs in controlling costs. However, there is more enthusiasm about PPOs—at least among the relatively small number of employers that offer them.
- Employers are offering an increasingly diverse menu of coverages, including coverage for alcohol and drug rehabilitation, dental care and vision care. In addition, more employers are incorporating plan elements designed to control costs, such as coverage for outpatient surgery and second surgical opinions.

The survey showed that the Pacific region—Washington, Oregon and California—had the highest per employee health care cost during 1986, with an average of $2,147. The lowest cost—$1,692—was reported by employers in the South Atlantic region, comprised of West Virginia, Virginia, Maryland, the Carolinas, Georgia and Florida.

However, the biggest percentage increase in average health care costs in 1986 compared with 1985 was 9.9%, reported by employers in New England. And, the smallest percentage increase was 6.2%, reported by companies in the Mountain states—Montana, Idaho, Nevada, Utah, Colorado, Arizona

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Availability of cost-containment services
(By percent of employers responding)

Service	Provide coverage	Offer incentives for use
Drug, alcohol rehabilitation counseling	87%	21%
Freestanding ambulatory surgery centers	86	66
Freestanding emergency clinics	82	32
Home health care	79	45
Extended care facilities	76	28
Hospice programs	64	35
Birthing centers	56	26
Midwives	25	6

Source: J&H survey — Chart: Amy Palmer

Per-employee medical costs in 1986

Region	Total medical cost per employee	Increase over 1985
Pacific	$2,147	7.5%
Mountain	1,815	6.2
North Central	2,046	7.4
South Central	1,784	8.1
New England	1,828	9.9
Mid-Atlantic	1,898	8.1
South Atlantic	1,692	7.7
National Average	$1,857	7.7%

Source: J&H survey — Chart: Amy Palmer

Canada court OKs captive write-off

By STEPHEN TARNOFF

OTTAWA—Taking an opposite position from U.S. courts, a Canadian appeals court says a Canadian company can deduct from it income taxes premiums paid to its captive insurer.

Rejecting the reasoning of numerous U.S. court decisions, the Federal Court of Appeal held that Montreal-based Consolidated-Bathurst Ltd. shifted risk to its Bermuda captive, Overseas Insurance Ltd., when Consolidated made premium payments to the captive during the 1975 tax year.

As a result, Consolidated's deduction of payments as a business expense was permissible under Canada's Income Tax Act, the court said.

However, the appeals court also ruled that there was no shifting of risk and that Consolidated could not take deductions for premiums paid to the captive from 1971 through 1974.

The decision runs counter to virtually every ruling by U.S. courts in similar cases where companies have attempted to deduct payments to their captive insurance company subsidiaries.

"It is a landmark decision in that it vindicates the use of captive insurance companies, and secondly, it is significant that Canadian courts are not prepared to follow American decisions in every case," said Consolidated attorney Donald G.H. Bowman with the the Toronto firm of Stikeman, Elliott.

John R. Power, senior general counsel for the federal Department of Justice, said he was pleased with the court's decision regarding the non-deductibility of payments from 1971-1974.

While the Canadian decision is not binding on U.S. courts, it likely will be cited by lawyers for companies seeking deductions in their cases before American courts, observed Sidney Pine, a partner with the New York firm of LeBoeuf, Lamb, Leiby & MacRae.

"It has some value," said Mr. Pine, an expert in captive insurance law.

At issue in the case was the deductibility of payments totaling approximately $5 million Canadian, including interest earned, that Consolidated made to its captive from 1971-1975.

Continued on next page

Engineer denies liability for bridge design

By CAROLYN ALDRED

LONDON—British consulting engineer Freeman Fox Ltd. contends it is not liable for any losses during the construction of the world's fifth-largest bridge because it no longer is working on the project.

The designer also asserts that it is not responsible for any design changes affecting the safety of the span across the Bosporus Strait in Turkey that were made since the Turkish highway authority dismissed two Freeman Fox senior staff engineers.

Reports from Turkey say several design changes have been made during construction in order to move up the bridge's completion by several months.

"Freeman Fox is no longer involved in decisions on construction of the bridge. And we have no responsibility now for changes on the bridge," said a company spokesman.

"The question of liability in the event of failure before or after completion of the bridge has become a complicated and contentious issue," the spokesman added.

Freeman Fox also charges that changes were made without its approval while its engineers were still on the site.

But, so far no claims have been filed against Freeman Fox's professional liability insurance, confirmed the Freeman Fox spokesman. The policy would cover any losses due to design faults of the bridge. The spokesman would not comment on the limits of the coverage.

Freeman Fox's brokers, Griffiths & Armour Insurance Brokers in Liverpool, also would not comment on the limits.

The Turkish General Directorate of Highways commissioned Freeman Fox to design the Bosporus Bridge, which has been under construction since January 1986.

The new, 3,597-foot, eight-lane suspension bridge will be part of the 17-mile second peripheral highway around Istanbul, which also is designed by Freeman Fox jointly with Botek of Istanbul. The cost of the bridge and the motorway totals $270 million, including Freeman Fox's design fee of between $2 million and $3 million, sources say.

The bridge construction now is being supervised by William Brown, a former partner of Freeman Fox and an acknowledged authority on bridge designs, the Freeman Fox spokesman confirmed.

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British firm Freeman Fox is involved in a dispute over the bridge across Turkey's Bosporus Strait shown in this artist's drawing.

Captive deduction

Continued from previous page

Consolidated originally formed a captive under the name Overseas Insurance Corp. in 1970. OI was managed by Insurance Managers Ltd., a Bermuda-based wholly owned unit of Reed, Shaw, Osler Ltd., a Canadian broker instrumental in advising Consolidated to establish an offshore captive.

The insurer was incorporated under Panamanian law and capitalized at $120,000. It secured a license to engage in the insurance business in Bermuda.

The assets of this corporation subsequently were transferred in 1974 to a second corporation, Overseas Insurance Ltd., which was incorporated in Bermuda.

All of the shares in both corporations were held by St. Maurice Holding Ltd., a Consolidated unit.

Under the insurance program, from 1971 to 1975, Consolidated insured certain risks of its own and of its subsidiaries with Canadian domestic insurers, which reinsured a large percentage of those risks with OI. The domestic insurers included Victoria Insurance Co. in 1970, Scottish & York Insurance Co. Ltd. from 1971 to 1974 and Elite Insurance Co. in 1975.

Consolidated and its subsidiaries insured two kinds of risks under the program. It insured with domestic insurers the aggregate of deductibles for it and its subsidiaries under primary property/casualty policies. Virtually all of these policies were reinsured by OI, which then bought stop-loss coverage to cap its own liability.

Consolidated and its subsidiaries also purchased insurance for a group of miscellaneous risks that were covered under "composite" policies. Initially, OI insured 20% of the composite risks on a direct basis. The remaining 80% was insured by other insurers. OI later retained a larger percentage of the risk. Furthermore, between 1971 and 1974, St. Maurice guaranteed insurers in both programs that it would indemnify them for losses they would have to pay if OI were unable to meet its obligations.

For years 1971-1975, Consolidated deducted as business expenses all of the premiums paid for the deductible and composite policies. The Minister of National Revenue, however, disallowed a substantial portion of the deductions. The premiums the minister did permit Consolidated to deduct included those paid to the domestic insurers for deductible coverage that was not reinsured with OI and premiums paid directly by Consolidated to domestic insurers for composite coverage.

Because domestic insurers retained only 7.5% of the deductible polices from 1971-1974 and 2.5% in 1975, the payments disallowed were "rather substantial," the appeals court said, though it is not clear from the ruling the amount involved.

At the trial court level, the judge found that because the payments Consolidated made were disbursements that artificially reduced Consolidated's income and actually were amounts transferred to a reserve fund, the payments were not deductible under the provisions of the Income Tax Act.

But, in its decision, the appeals court made a distinction between the 1971-1974 period, during which Consolidated issued guarantees to the domestic insurers, and the 1975 period, during which these guarantees were not in place.

The effect of the guarantees was to protect both Victoria and Scottish & York from exposure to loss for any coverage ceded by either insurer to OI if the captive could not pay the losses, the court noted.

Concerning the years 1971-1974, the court said: "The effect of the guarantee arrangements was that in the event something unforeseen had occurred such as would have prevented OI from meeting claims presented by the domestic insurers. . .the appellant itself would have had to absorb any resulting loss otherwise covered by the terms of its insurance contracts.

"In respect of risks retained by OI, I do not see how the arrangement which operated throughout the 1971 to 1974 taxation years can be viewed as providing bona fide insurance protection under which risk shifted and was distributed," the court said.

However, concerning Consolidated's deductions for premiums paid to the captive in 1975, the court found that there was a transfer of risk because there was neither an indemnity nor guarantee agreement required under its arrangements with insurers.

"I am unable to say that in the 1975 taxation year, risk did not shift and was not distributed," the court said. "Unlike in the four preceding years the domestic insurer as the fronting company could not look to the insured to absorb losses covered by the scheme in the event OI defaulted."

Further, the court noted, there was a shifting of risk because:

- The coverage arranged in 1975 was very large—in the case of the "deductibles" policies alone the limit of coverage was $750,000 per loss, accident or disaster.
- The risks were numerous and of a similar kind.
- There is nothing suggesting that OI would likely have to pay similar losses incurred by more than one of the insured entities because the risks were not interdependent.

The court also rejected the view of some U.S. courts that payments to captives are not deductible because the captive and parent are part of the same "economic family."

Neither the Canadian government nor Consolidated will seek review of the appeals court ruling with the Canadian Supreme Court.

The latest decision by a U.S. court in such a case was the Jan. 26 ruling by the U.S. Tax Court that Louisville, Ky.-based Humana Inc. and its subsidiaries could not deduct the $21 million they paid to Humana's captive from 1977-1979 because there was no shifting of risk (*BI*, Aug. 26, 1985).

The decision came after the court granted Humana's motion for reconsideration of a 1985 decision by the Tax Court. ■

BI adds editor in Chicago office

CHICAGO-Stacy Adler has joined the *Business Insurance* Chicago staff as an assistant copy editor, announced Editor Kathryn J. McIntyre.

Ms. Adler, 22, is a recent graduate of the Medill School of Journalism at Northwestern University in Evanston, Ill., where she received a master of science degree in journalism. In addition, she holds a bachelor's degree in journalism from the University of Florida in Gainesville.



Ms. Adler

Prior to joining *BI*, Ms. Adler worked as a reporter for Security and Security Distributing & Marketing magazines in Des Plaines, Ill. She also was a researcher for *Crain's Chicago Business*, which is published by Crain Communications Inc., publisher of *Business Insurance*.

In her new position, she will be responsible for editing stories and writing headlines. She will also compile the Comings & Goings: Industry column.

Ms. Adler can be reached at 312-649-5262. ■



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"We've always had the philosophy that it takes quality people to make quality products. To do that, we need quality insurance programs so we can hire — and keep — quality people.

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opinions



Policyholder input a good idea

THE REHABILITATION of Mutual Fire, Marine & Inland Insurance Co. in Pennsylvania will be better planned and executed with the analysis and advice provided by a court-approved policyholder committee.

As we reported last week, Commonwealth Court of Pennsylvania Judge James Crumlish ordered the formation of a policyholder committee to represent the interests of thousands of Mutual Fire, Marine policyholders—at the request of policyholders and over the objection of the Pennsylvania Insurance Department.

We appreciate that rehabilitations are arduous and the last complication an insurance commissioner wants is a group of policyholders who think they know something about running an insurance company telling him what to do. And, we appreciate that the insurance commissioner wants to preserve the assets of the insurance company and not see them squandered away by a committee of policyholders who do not know anything about running an insurer.

Nonetheless, we applaud Judge Crumlish's ruling appointing the committee on behalf of all policyholders and authorizing the committee to submit its expenses to the court for approval.

We are sure the committee will not be permitted by the court to run amok of its charge to "consult" and "advise." In addition, the court hardly is going to approve unreasonable expenses.

At the same time, these policyholders are the owners of the mutual insurance company and either have pending claims or will file claims. These policyholders' interests will be served only by successfully rehabilitating the insurer. We expect the policyholders' committee will act responsibly.

letters

Scrutinize insurance law during soft markets, too

To the editor: In reading various articles and letters regarding "flex" rating, healthy competition, etc. (*BI*, Jan. 19), I think one should consider the problem facing the industry. Competition is never criticized no matter what runaway losses result, which has been evident among insurers over the past several years.

Insurers in almost every state are regulated—by filings—as to the maximum debit or credit that they can apply to established rates. The credit side is violated freely without fear of repercussions from regulatory bodies. That inures to the benefit of the voter and no one complains except the company that "lost" the business.

When rates revert to the sanity level (and, of course, there are always players who take advantage of this), the howls and accusing fingers are directed at our industry—no matter that it becomes a matter of survival. Then we do it all over again!

Perhaps it is time for regulatory bodies to begin to investigate all aspects of insurance law and enforce all of them instead of the more common ones that create no controversy.

George Knight Jr.
President
George Knight & Associates Inc.
Tulsa, Okla.

Few work comp claims do not an expert make

To the editor: Thank you for listing our company in the special self-insurance issue (*BI*, Jan. 26). I was disappointed, however, to find our description placed under the section of administrators who specialize in both property/casualty and employee benefits claims.

Despite our small involvement in workers compensation claims, we believe we should have been categorized under "benefit claims specialists."

Diane M. Rodgers
National Marketing Manager
Control Data
Benefit Services
Richardson, Texas

Company explains reinsurance confusion

To the editor: This letter is in reply to your mention of our company in the Update section of your Jan. 19 edition in which we are alleged to have falsely represented that we had some sort of reinsurance agreement with North American Reinsurance.

In the course of preparing an informational packet on our company, we inserted a sheet that listed several reinsurers and stated that these were the type and kind of reinsurers we hoped to have as reinsurers. It was not our intent to mislead or misrepresent that we had reinsurance agreements with these companies.

When we received several phone calls regarding this, we realized that people were misinterpreting what we were saying and immediately pulled that sheet from our information packet. We did this in the second week of December last year.

J.P. Saunders
Chairman and Chief Executive Officer
North American Fire & Casualty Co. Ltd.
Atlanta

Wholesaler not related to Caribbean reinsurer

To the editor: In your article "Offshore Reinsurer Figures in Indictment," you reported an alleged fraud involving an offshore insurer known as Cambridge General Insurance Co. of the Turks and Caicos Islands (*BI*, Jan. 19).

In various parts of the article, you referred to the above insurer as "Cambridge General."

Although I am certain that you used the term "Cambridge General" solely for the sake of brevity, we would like to share with your readers the fact that there is no relationship between Cambridge General Insurance Co. of the Turks and Caicos Islands, and Cambridge General Agency, an excess and surplus lines broker in San Francisco.

Wesley H. Luekens
Executive Vp
Cambridge General Agency
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.

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Health costs

Continued from page 3

and New Mexico.

There also was a significant difference in costs between employers with workforces that were mostly unionize and those with primarily non-union employees.

Among employers with 50% or more of their workforce covered under a collective bargaining agreement, the average annual cost was $2,255 per employee. Among employers with fewer than 50% of their workforce covered by a collective bargaining agreement, the average cost was $1,764, or 21.8% than those with a primarily unionized workforce.

Some 91% of all the employers surveyed said that their health insurance plan includes a deductible, and for 90% of those, the deductible was $100 or more. The deductible was $100 to $149 for 50%; $150 to $199 for 15%; $200 to $299 for 22%; $300 to $399 for 2%; and $400 or more for 1%.

More than half—59%—of the employers require no employee contribution for individual coverage. However, half of the employers that do require a contribution require employees contribute 20% or more of the cost of the premium for individual coverage.

Contributions are more likely to be required for dependent coverage: Only 30% of the employers surveyed paid the total cost of coverage for their employees' dependents. Contributions required for dependent coverage ranged from 1% to 9% of the premium for 11% of the respondents; 10% to 19% of premium for 13% of the respondents; 20% to 29% of premium for 14% of the respondents; 30% to 49% of premium for 10% of the respondents; and 50% to 100% of premium for 23% of the respondents.

In addition, the survey found that among employers whose workforce is 60% or more female, the average contribution for dependent coverage was 47% of premiums, compared with only 31% of premium for those employers whose workforces were predominantly male.

The survey also found that employers were less than enthusiastic about the success of HMOs in controlling health care costs.

Only 42% of the employers surveyed agreed with the statement, "HMOs are effective in controlling costs."

However, 44% of the respondents neither agreed nor disagreed with the statement, and only 14% disagreed.

Similarly, 49% of the respondents neither agreed nor disagreed with the statement, "HMOs attract only the good risks from your employee group." Twenty-five percent agreed with the statement, and 26% disagreed.

More than half—54%—of the respondents offered at least one HMO option to their employees during 1986. At these companies an average of 19% of employee enrolled in an HMO.

But, most of those employers that offered HMOs did not find the rates charged by the HMO to be less than the rates for their traditional indemnity plan. Twenty-four percent said the HMO rates were about the same, and 44% said the HMO rates were higher. Only 24% said the rates for their indemnity plans were higher, and 8% said they did not know.

There appears to be less uneasiness about the cost-containment success of PPOs, although they are offered by significantly fewer employers.

Only 15% of the employers nationwide said they offered a PPO arrangement during 1986, although an additional 12% said they plan to offer a PPO during 1987. And, the number of employers in the Pacific region offering a PPO was more than twice the national average—37%.

Those employers that did offer PPOs found that they saved money. Nationwide, they reported the PPO use generated a savings equal to 11.4% of total plan hospital costs and 9.5% of total plan physician costs.

And, 85% of the respondents whose companies had PPOs offered their employees some type of financial incentive to use the PPO.

"Though PPOs are utilized by a smaller percentage of employers than HMOs, they are generating significant cost reductions to employers' health benefit plans," the survey's authors note.

"These savings revert back to the company directly and not to the service provider, as with HMOs."

Employers' have adopted a wide variety of cost-containment measures other than cost sharing, HMOs and PPOs, the survey notes.

For example, 83% of the respondents nationwide offer coverage for second surgical opinions. In addition, 40% offer incentives to seek a second opinion, 59% impose a penalty if the employee does not get a second surgical opinion and 32% impose a penalty if the employee has surgery after a second opinion deems that surgery was unnecessary.

Of the employers that offer coverage for second surgical opinions, 74% could not say whether the program resulted in any cost savings, and 52% of those that were able to estimate savings said no savings had been realized.

In addition, 87% of the respondents offer coverage for drug and alcohol rehabilitation counseling, and 21% provide incentives to use the benefit.

Some 86% cover procedures conducted at freestanding ambulatory surgery centers and 66% provide incentives for such surgery. Eighty-two percent cover freestanding emergency clinics, and 32% provide incentives.

Other coverages offered by employers include: home health care, covered by 79% and incentives for use provided by 45%; extended care facilities, covered by 76% and incentives provided by 28%; hospice programs, covered by 64% and incentives provided by 35%; birthing centers, covered by 56% and incentives provided by 26%; and midwives, covered by 25% and incentives provided by 6%.

In general, 35% of the respondents said their plans provide a higher level of reimbursement for outpatient care than for inpatient care.

"In response to the increasing cost of in-hospital care, employers are finding it is cost effective to cover a greater number of preventive and outpatient services as a means for reducing total health benefit expenditures," the survey authors said.

Employers also offer several supplemental programs, in addition to their basic medical coverage. For example, dental care is offered by 70% of the employers, wellness programs and physical exams each are offered by 40%, employee assistance programs are offered by 39%, discount drug programs are offered by 27% and vision care is offered by 16%.

More than three-fourths—79%—of the respondents have plans in place to monitor payment of large claims to hospitals.

And, although more than 55% of the respondents could not say whether there were any savings realized from coordination of benefits provisions in their plans, the average among those that could quantify their savings was 5.5% of total claims paid.

●

Copies of the survey, "The Corporate Health Care Benefits Survey for 1986," are available free from Johnss2on & Higgins, 212 Carnegie Center, CN5323, Princeton, N.J. 08543. Attention: Vicki Dixon, HealthGroup.

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- **1985** Port Angeles, WA, tanker oil spill (2nd most expensive clean-up in U.S. history).
- **1986** St. Thomas, U.S. Virgin Islands, oil spill (class action).



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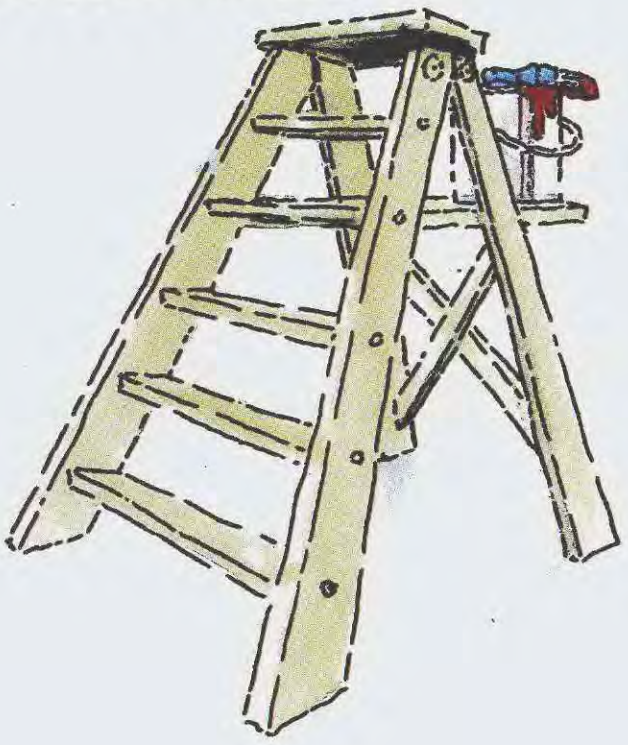
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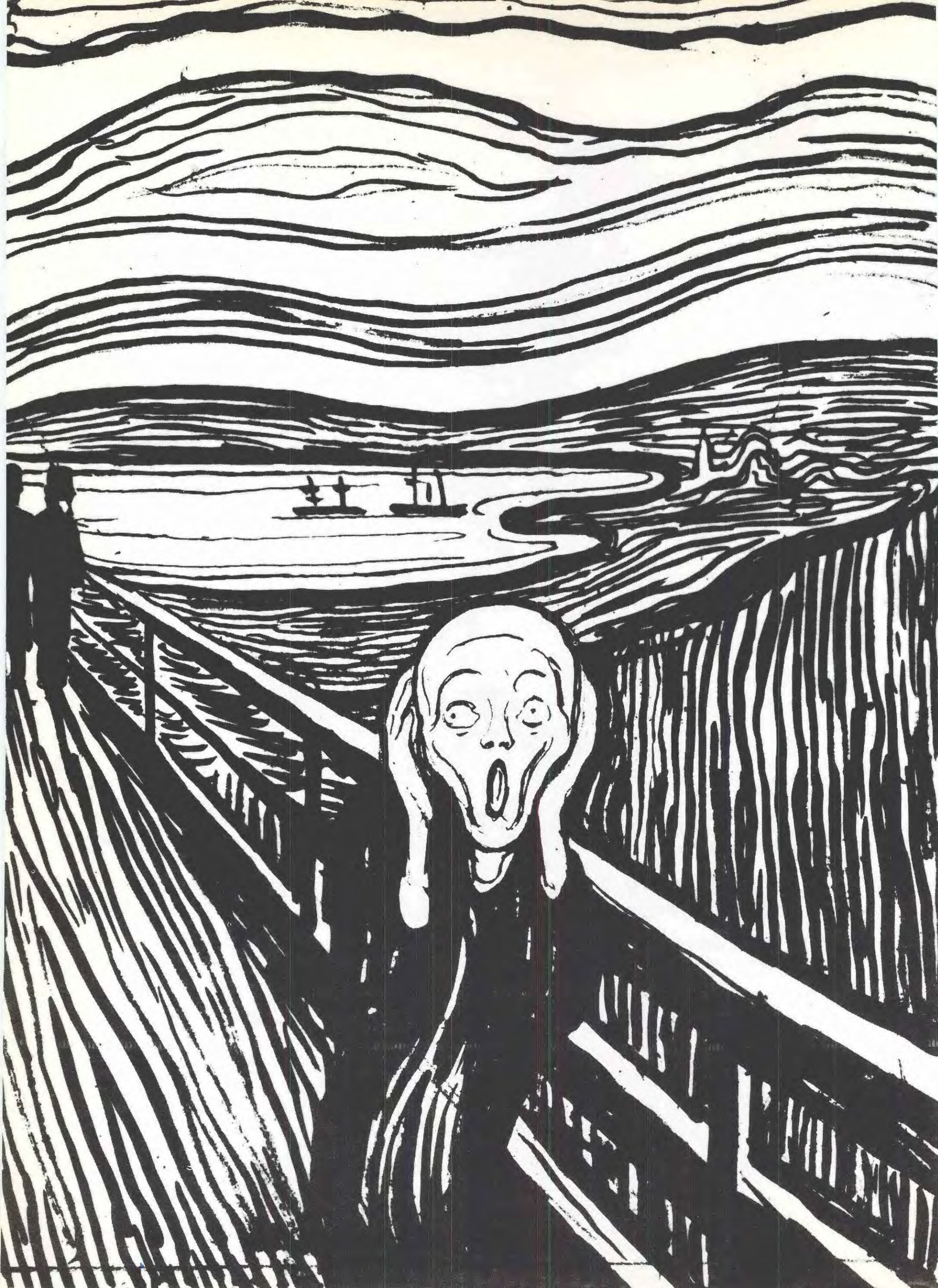
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With potential catastrophic loss, injury and risk all around us, no one would question the need to control financial uncertainty and make accidental losses manageable. In other words, the need for insurance. The problem arises when insurance is used as an entitlement mechanism to redress any loss, any injury, minor or major, imagined or real, no matter how ambiguous or arbitrary.

In recent years, the historic relationship between tort law and liability insurance has been radically distorted. This has resulted in a tidal wave of litigation that has clogged our courts, sent legal costs skyrocketing, and forced insurers to curtail their coverages and/or radically raise their premiums. At the same time, reinsurers are reluctant to share in the risks in such a volatile, unpredictable legal climate.

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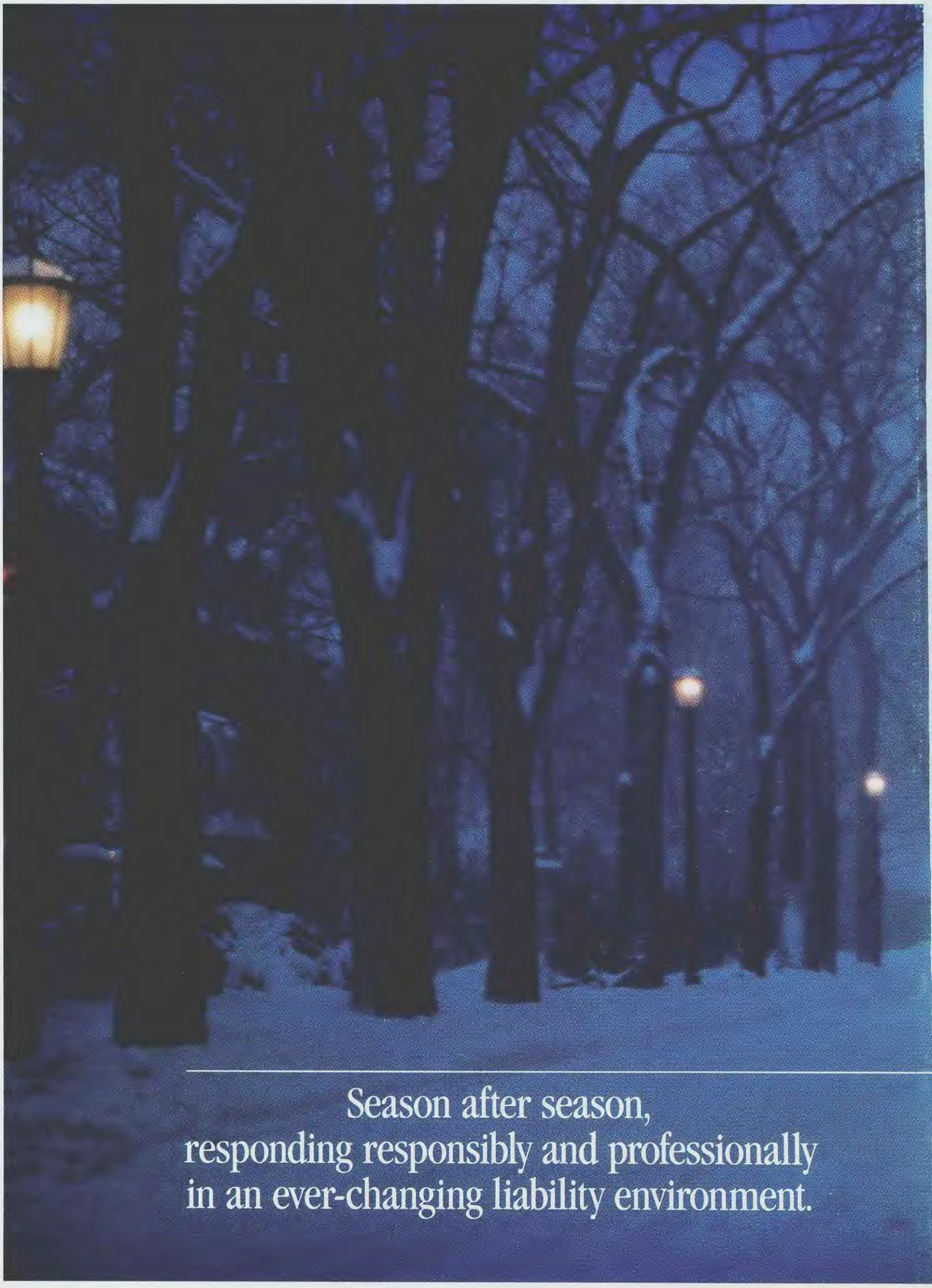
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The Hospital policy covers hospitals (150 beds or less), nursing homes, and their non-physician employees. Comprehensive general liability is also available for hospitals.



MEDIQ names risk management chief

comings & goings: buyers

William M. Boone, 38, has been appointed director-risk management at MEDIQ Inc. in Pennsauken, N.J. In this newly created position, Mr. Boone will be responsible for insurance administration for the health care product and services company and its subsidiaries. Mr. Boone reports to Lionel Felzer, senior vp-finance and chief financial officer. Prior to joining MEDIQ, Mr. Boone served 17 years with the Southeastern Pennsylvania Transit Authority, most recently as director of risk management with responsibility for SEPTA's insurance and self-funding programs as well as the implementation of a risk management information system. Mr. Boone also participated in the formation and was a director of Railroad Assn. Insurance Ltd., an offshore captive insurer that provides liability insurance to the U.S. and Canadian freight and passenger rail industry. Mr. Boone holds a bachelor of arts degree in biochemistry from the University of Pennsylvania in Philadelphia and a master of business administration degree from the Wharton School of Business of the University of Pennsylvania. In addition, he is a deputy member of the Risk & Insurance Management Society.

* * *

Jay W. Kretzler, 38, has been named manager of risk management at Columbia Gas System Service Corp. in Wilmington, Del. In this newly created position, Mr. Kretzler will be responsible for handling property and marine risks for the natural gas utility. Mr. Kretzler reports to Joseph V. Yandoli, assistant treasurer. Mr. Kretzler previously served as assistant manager of insurance with Consolidated Natural Gas Service Inc. in Pittsburgh. Prior to that, Mr. Kretzler was a senior adjuster with the National Grange Mutual Insurance Co. in Monaca, Pa. Mr. Kretzler received a bachelor of arts degree in psychology from Edinboro University of Pennsylvania. In addition, Mr. Kretzler is immediate past president of the Pittsburgh Chapter of the Risk & Insurance Management Society and a member of the Society of Chartered Property & Casualty Underwriters.

* * *

Larry Sutton, 36, has been appointed risk manager at Crown American Corp. in Johnstown, Pa. In this position, he will oversee property/casualty insurance, safety and loss control programs and employee benefits for Crown, which is a holding company involved in the operation and construction of shopping malls, hotels and department stores. Mr. Sutton reports to John Washko, vp and controller. Mr. Sutton most recently was employed as manager-equipment administration at Kidde Credit Corp. in Hagerstown, Md. Prior to that he served as risk manager at Grove Manufacturing Co. in Shady Grove, Pa. Mr. Sutton is a graduate of St. Francis College of Pennsylvania in Loretto, and holds the Associate in Risk Management designation.

* * *

Mary E. Kazan, 26, has been promoted to corporate manager of employee benefits for General Cinema Corp. in Chestnut Hill, Mass. In this position, her responsibilities include all employee benefits plans as well as employment recruiting. In addition, she serves as secretary of GCC's Employee Benefits Committee, which consists of General Cinema Corp.'s president, chief counsel and corporate director of employee benefits. Ms. Kazan reports to Michael Falivena, corporate director of employee benefits. Previously, she was corporate benefits administrator. Prior to joining GCC, a soft drink bottler and motion picture exhibitor, she was a benefits specialist with the Bank of New England in Boston. Ms. Kazan is a member of the New England Employee Benefits Council.

* * *

Alvin D. Howze, 38, has been promoted to vp, human resources and risk management at Riss International Corp. in Kansas City, Mo. In this position, he will oversee all employee benefits, insurance and safety programs, as well as all personnel-related activities for the interstate motor freight carrier. He reports to E.S. Riss, president. Mr. Howze previously served as director of human resources and risk management. Prior to joining Riss in 1983, Mr. Howze was manager of insurance for Time-DC Inc. in Lubbock, Texas. He holds a bachelor of science degree in personnel management from Louisiana State University in Baton Rouge. In addition, Mr. Howze is a deputy member of the Risk & Insurance Management Society and a member of the Personnel Management Assn.

Also at Riss International, **J. Barry Korns,** 39, was promoted to director of safety and fleet operations. In this position, he will oversee fleet safety and Occupational Safety and Health Administration compliance. Previously, Mr. Korns served as director of safety. He will report to Mr. Howze. Mr. Korns received a bachelor of science degree in business administration from Missouri Southern State College in Joplin. He is a former vp of the Safety Council of the Interstate Carriers Conference and a member of the Missouri Motor Carriers Assn. In addition, he is a deputy member of the Risk & Insurance Management Society.

* * *

Robert J. Gas, 31, has been promoted to casualty and property insurance manager at Walgreen Co. in Deerfield, Ill. In this position, he will be responsible for safety management, as well as the administration of insurance programs for the national drugstore chain. From his previous position as casualty claims manager he will continue to manage liability, workers compensation and property damage claims adjusting. Mr. Gas reports to Craig L. Ames, director of insurance and risk management. Prior to joining Walgreen in 1983, he served as an insurance claims supervisor for the Travelers Insurance Co. Mr. Gas holds a bachelor of business administration degree from Lewis University in Romeoville, Ill.

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We'd like to report on staff changes in your company's risk management, safety or employee benefits department. Just drop a note to Paul Winston, assistant copy editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5442. Please send a photograph, too.



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E. W. BLANCH CO.

london

Continued from previous page
pany's director of pensions.

He is particularly concerned that Mrs. Thatcher's opponents will alter the regulation that allows employees to leave—or "contract out"—of employer-sponsored pension plans, which in Britain are called occupation pension plans, and set up individual retirement savings plans, known as personal pension plans (*BI*, March 3, 1986).

"The new personal pensions are a simple, attractive and practical way to extend pensions coverage to many not in occupational pension plans," Mr. Hatry said. "It would be tragic if these were scrapped, particularly since they are the result of two years of intensive consultation with experts," he said.

Legal & General has written to party leaders opposing Mrs. Thatcher in the next general election, asking them to accept the framework of the 1986 pension legislation.

The Social Security Act, passed last year, has three main objectives:

- To cut the cost of Britain's state-run pension system, known as the State Earning-Related Pension Scheme, by the year 2010. Britain will reduce SERPS payments to retirees by the year 2000.
- To promote the growth of occupational pension plans and personal pension plans by providing incentives for employers and employees to contract out of SERPS. Employee contributions to personal and occupational pension plans are expected to be tax-deductible under the new regulations.

In addition, for the first time, employers contracting out of SERPS would be allowed to set up defined contribution plans to provide legally mandated pension benefits.

- To provide other changes in Britain's welfare system to direct more cash to very poor families with children.

A third draft of the regulations accompanying the act was introduced in Parliament last month by Social Security Minister John Major.

Dewey Warren stock

The president of an Oklahoma managing general agency has become the single largest shareholder of Lloyd's of London broker Dewey Warren & Co. Ltd.

William E. Thompson, president of Landmark National Corporation of Oklahoma City, increased his interest in Dewey Warren to 14.6% from 4.9% late last month.

Although Mr. Thompson is now the largest single shareholder of Dewey Warren, which is listed on London's Unlisted Securities Market, he will not be entitled to any special voting powers other than those proportional with the number of shares he holds, said Dewey Warren Financial Director Ian Crighton.

"We have no knowledge of Mr. Thompson or his company, other than as a shareholder, and know nothing of his intentions. We await with interest to meet him," Mr. Crighton said.

Mr. Thompson told *Business Insurance* he acquired the shares for two reasons: "Firstly, it is to average my share price out, and secondly, because I am keen to place more accidental death and health reinsurance in the London market."

Landmark is a privately owned managing general agency with a 1986 premium volume of slightly less than $20 million. It writes accidental death and health coverage and some U.S. casualty, including long-haul truck business.

Dewey Warren, which was involved in acquisition talks with broker C.E. Heath P.L.C. last year, specializes in marine insurance and reinsurance (*BI*, July 7, 1986).

New Jardine division

Jardine Glanvill Ltd., a subsidiary of Jardine Insurance Brokers Group, has set up a North American division in London to deal with large risks.

The new division also hopes to develop strong links with the group's U.S. operation, Jardine Emett & Chandler Inc. in San Francisco, said Michael Gribben, managing director of Jardine Glanvill, which specializes in major insurance placements in the London and international markets.

"The Jardine Insurance Brokers Group has expanded twice over the past five years in America. The most recent acquisition, in 1986, of Emett & Chandler has doubled Jardine's direct insurance broking presence in the States.

"With the creation of a North American division here at Jardine Glanvill, we are providing our U.S.-domiciled operations with major risk wholesale support," Mr. Gribben said.

Marcus Brown has been appointed managing director of the North American division and a director of the main company. Mr. Brown formerly was an executive director at Willis Faber & Dumas P.L.C., where he was responsible for North American casualty business.

Risk management

The first professional institute in the United Kingdom to promote excellence in British risk management is inviting risk managers with at least 15 years of experience to apply to be elected fellows.

Applicants to the new Institute of Risk Managers must meet the experience requirement and pass a series of qualifying exams. However, the test requirement will be waived for those applicants with at least 15 years of experience who apply within the next 12 months under a "grandfather" procedure.

The first set of examinations are expected to be held in 1988, according to Roger Miller, chairman of the board of governors and general secretary of the Assn. of Insurance & Risk Managers in Industry & Commerce.

The Institute of Risk Managers has been set up by leading British risk management professionals in the United Kingdom with encouragement from AIRMIC. Its aims, as set out in the institute's prospectus, are:

- To identify and establish a base of professional knowledge relevant to risk management theory and practice.
- To compile and issue syllabi, textbooks and study guides and to promote the teaching of risk management.
- To hold examinations to test the qualifications of candidates for admission to the institute.
- To provide an organization for risk managers and to promote and protect the interest of the profession of risk management.
- To promote technical and ethical practices by its members.

Comings & goings

John Buchanan, senior vp of Jardine Emett & Chandler Inc. in San Francisco, has moved to Jardine's international markets specialist Jardine Glanvill Ltd. in London.

Peter Robinson, also from Jardine Emett & Chandler, has been appointed managing director of Jardine's wholesale insurance brokerage subsidiary Glanvill Enthoven North America Ltd. in London. ■



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Council of Lloyd's preparing to yield control to outsiders

By CAROLYN ALDRED

london

LONDON—Lloyd's of London is adopting a timetable for making the changes recommended in the Neill report, Lloyd's Chairman Peter Miller told Lloyd's members last week.

Details of the timetable were to be approved by Lloyd's Council late last week.

"We are already in discussion with the Department of Trade and Industry to seek a meeting with the secretary of state immediately thereafter to discuss our proposed methods of working out the timetable," Mr. Miller told Lloyd's members in a letter.

Meanwhile, Lloyd's is seeking four non-Lloyd's members to increase the number of non-members on the 28-member Lloyd's Council to eight.

The Lloyd's Council then will consist of 12 working members, eight nominated non-members of Lloyd's and eight non-working members of Lloyd's, who are elected by Lloyd's members who do not work in the market.

Each person nominated to the council must be approved by the governor of the Bank of England.

"We are already seeking four more nominated members of the caliber and with the resources of time available to join the council and discharge the important duties expected of them," Mr. Miller said in the letter.

The restructuring of Lloyd's ruling council to eliminate the working members' majority and to provide more independent supervision of the market was a key recommendation of 70 changes proposed by the committee report (*BI*, Jan. 26).

Until January 1983, Lloyd's was governed solely by working members. The first non-members and external members took places on a newly created council that year.

The restructuring will, for the first time, give majority control to people who do not work in the Lloyd's market. And, in five to 10 years, the Lloyd's chairman could be a non-member of Lloyd's, according to Sir Patrick Neill, who headed the special government inquiry into the quality of Lloyd's self-regulation.

But, Mr. Miller said that altering the council's makeup is unlikely to change the way the council operates.

"I cannot remember an occasion when a decision was not arrived at by an overwhelming consensus," Mr. Miller said.

"Nevertheless, the point made by Neill of insufficiency of outside representation is, in today's regulatory climate in the City (the financial district of London), a point well made and a point accepted by Lloyd's."

Lloyd's does not allow enough independent supervision of the market, the Neill report said.

"The checks and balances of Lloyd's are not, in our view, so firmly in place. The balance of initiative rests too much with the working members," said the report.

Pension changes

Legal & General Group P.L.C., one of Britain's largest insurance holding companies, is concerned that sweeping changes in Britain's pension system will be delayed if Prime Minister Margaret Thatcher is not re-elected.

The changes are spelled out in detailed regulations that must be approved by Parliament for the Social Security Act of 1986 to become effective in April 1988.

Legal & General fears that some of the changes may be scrapped if Mrs. Thatcher fails to win the next election, which she can call between now and June 1988, according to Chris Hatry, the com-

Continued on next page

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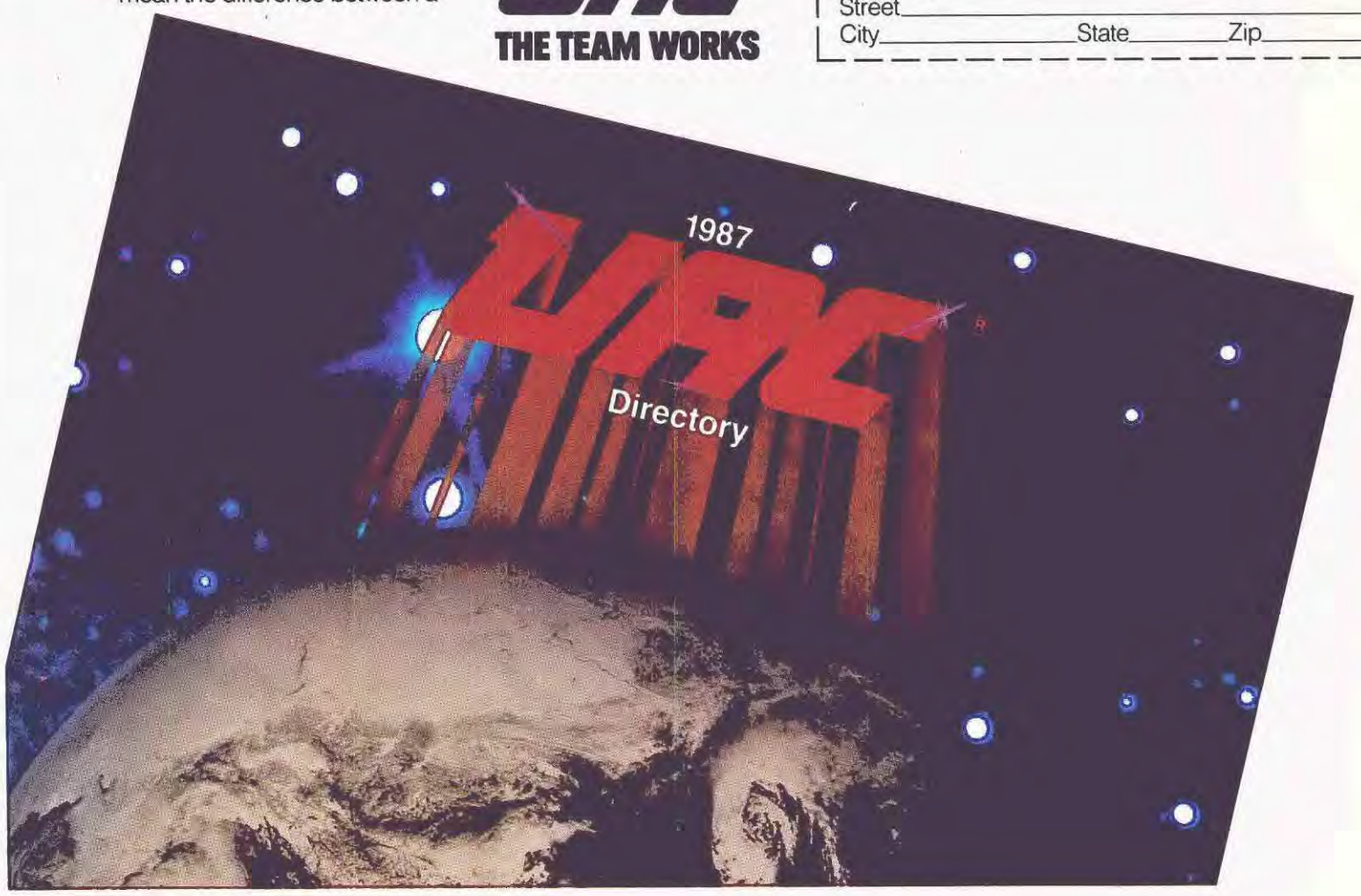
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European Commission seeks accounting rules

worldwide

BRUSSELS, Belgium—The European Commission wants to set up standard accounting practices for insurance companies in the European Community.

Late last year, the commission adopted a proposal for a directive on the annual accounts of insurance companies.

The new proposed directive is intended to complement the fourth directive on the annual accounts of limited companies adopted by the EC Council of Ministers in 1978. The fourth directive specifically allowed member states to exclude both banks and insurance companies from applying the new accounting rules.

The proposed directive will standardize accounting procedures in EC insurance companies, except for Lloyd's, along the lines of the fourth directive, although it will be designed specifically for the financial quirks of the insurance industry, said a commission spokesman. For example, the new directive will establish a new category of investment assets and the value of investments.

The new proposal is "extremely detailed," said a commission spokesman. Sources expect that it will be one to two years before the proposal is approved by the Council of Ministers and harmonizes the accounting practices of all insurance companies in the EC.

Skandia profits

STOCKHOLM, Sweden—Skandia Insurance Co. Ltd., the largest Swedish insurance company, predicts that increased rates will boost its 1986 pretax profits to 840 million Swedish kronor ($124.4 million at year-end 1985 exchange rates) from a 1985 pretax loss of 208 million kronor ($27.5 million).

According to a preliminary report for 1986, premium income for the group increased 13.9% to 4.1 billion kronor ($607.2 million) from 3.6 billion kronor ($475.9 million). The total cost of claims declined to slightly less than 3.1 billion kronor ($459.1 million) from more than 3.2 billion kronor ($423 million) in 1985.

Skandia also reported its surplus soared 71.9% to 9.8 billion kronor ($1.5 billion) from 5.7 billion kronor ($753.5 million), primarily due to the increasing market value of its 45% stake in Skandia International Holding A.B.

Skandia restructured in late 1985, selling 55% of Skandia International to the public. Skandia included Skandia International's results in its 1985 report but not in its preliminary 1986 report.

Skandia International's results will be published April 3, the spokesman said.

The largest single unit of Skandia International is its U.S. operation, Skandia America Group.

Another of Skandia International's subsidiaries, Skandia (U.K.) Insurance Co. Ltd., and British insurer Westgate Insurance Co. Ltd. are appealing a landmark court decision that awards a group of banks as much as $33 million because an employee of the insurers failed to disclose important information about credit insurance policies written for the banks (*BI*, Oct. 13, 1986).

Insurer advertising

HAMBURG, West Germany—West Germany's insurance industry spent a record 150 million deutsche marks ($78 million at year-end 1986 exchange rates) for advertising in 1986, according to the Central Assn. of the German Advertising Industry.

The amount spent includes 48% for magazine ads, 17% for daily newspaper ads and 16% for television commercials, said the association.

There are 750 insurance companies in the West German insurance market, including more than 330 property/casualty insurers, 100 life insurers, and 32 reinsurers.

●

Contributors to this week's column are International Editor Stacy Shapiro in London and correspondents Denise Claveloux in Brussels, Belgium, and Edelgard Simon in Hamburg, West Germany.



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MetLife HealthCare buys St. Louis HMO

MetLife HealthCare Management Corp., the health maintenance organization subsidiary of New York-based Metropolitan Life Insurance Co., has acquired St. Louis-based HealthCare Network.

Prior to the acquisition, HealthCare Network was equally owned by Metropolitan Life and St. Louis-based Washington University Medical Center.

Washington University Medical Center institutions will remain as major providers of HealthCare Network's medical services, according to the HMO.

HealthCare Network, with 62,000 enrollees, services 30% of the St. Louis-area HMO market.

"Our management views the acquisition as a very positive move, allowing more flexibility in contracting with hospitals, which will provide our members with a wider choice of physicians and hospitals to choose from, while still giving the members quality medical care," said Terry Barber, senior vp for HealthCare Network.

In addition to the St. Louis area, MetLife HealthCare Management has HMO operations in Chicago, Denver, Los Angeles, Miami, and Phoenix.

Mergers/acquisitions

Hasbrouck Heights, N.J.-based broker, **Alpha Aviation Insurance**, has acquired the **Edward L. Salmon Inc.** agency of Wall Township, N.J., and renamed it Alpha Insurance Agency.

Atlanta-based health care cost containment specialist **Beech Street Inc.** has acquired a Dallas-based third-party employee benefits claims administrator. **National Benefit Administrators Inc.** will operate as a subsidiary of Beech Street, which also has offices in Irvine, Calif., and Houston.

Modesto, Calif.-based **Giddings, Corby, Hynes Inc.** has acquired two insurance agencies: **Den Dulk Insurance Agency** of Ripon, Calif., and **C.C. Simminger Agency** of Manteca, Calif.

New York-based marine insurer **Marine Office of America Corp.** has acquired **CRB Management Inc.** CRB Management is a marine insurance firm that manages American Marine Insurance Group, a pool of insurers and reinsurers. AMIG companies underwrite both property and casualty marine coverages on hulls originating from American producers.

Benefit consultant **William M. Mercer-Meidinger Inc.** has acquired the Detroit-based human resources consulting firm of **The Sullivan Group Inc.** The Sullivan Group offers consulting services to clients from both its Detroit office and an office in Chicago. Mercer-Meidinger is the largest employee benefit consulting firm in the nation.

Insurance broker **Fred S. James & Co. Inc.** has acquired the Dallas agency of **Arthur L. Owen Co. Inc.** and **Owen Life Agency Inc.** Arthur L. Owen Co. specializes in oil and gas accounts and real estate accounts. Owen Life Agency handles health and life accounts.

James also acquired the Salem, Ore.-based agency of **Phillippay & Co.**, which handles property/casualty, employee benefits and personal lines.

New offices

Aneco Reinsurance Underwriting Ltd. and **Aneco Reinsurance Co. Ltd.** have moved to the Emporium Building, Fourth Floor, 69 Front St., Hamilton, HM12, Bermuda; 809-295-4239. However, the firm's postal address remains P.O. Box HM 1254, Hamilton, HM FX, Bermuda.

The Manglesdorf Cos. of Dallas, which specializes in structured settlements, has opened an office in Chicago at at 35 E. Wacker Drive, Suite 1310, Chicago, Ill. 60601; 312-372-0111 and 800-237-6991.

Self Insurance Exchange Inc., a national clearinghouse of experts and services specializing in self-insurance programs, has relocated to 4141 MacArthur Blvd., Suite 200, Newport Beach, Calif. 92660; 714-476-8812. ■

markets

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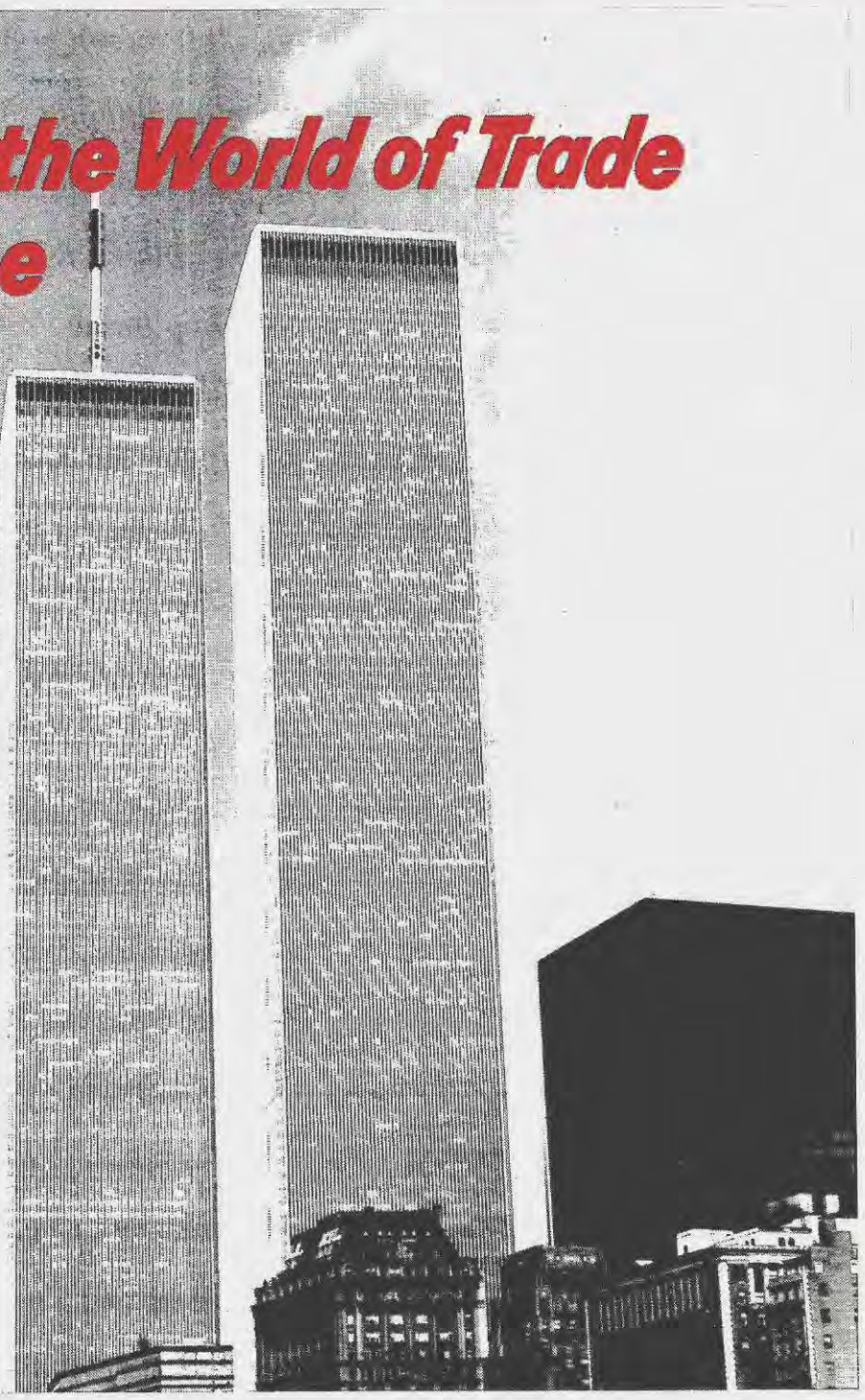
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Our Centennial Year

Kennedy calls for health insurance mandate

By JERRY GEISEL

washington

WASHINGTON—All employers should be required to offer group health insurance programs, says Sen. Edward Kennedy, D-Mass.

"The time has come to require all businesses in America to offer health insurance to all their workers—and all their dependents, too—as a condition of doing business," Sen. Kennedy said.

"It is time these costs be put where they belong—on the shoulders of the relatively small numbers of firms that refuse to protect their workers," he added.

Sen. Kennedy, speaking last week before a meeting in Washington sponsored by the American Hospital Assn., the nation's largest hospital trade group, said that just as employers are required by federal law to pay a minimum wage, they also should be forced to provide health care coverage.

Forcing all employers to offer health care coverage will help assure that hospitals will not be stuck with unpaid bills, he said.

"Thousands of community hospitals will no longer have to fear that the patient at the door cannot pay for the bed the hospital will provide," Sen. Kennedy said.

While employers would not be forced to offer "Cadillac-type" benefits, employer plans would have to protect participants against catastrophic health care bills, he said.

Sen. Kennedy, who has crusaded for greater health insurance coverage since the early 1970s, acknowledges such a federal benefit mandate would place a burden on very small employers since about half of the workers lacking group health care coverage are employed by companies with fewer than 25 employees.

But Sen. Kennedy, who now chairs the Senate Labor and Human Resources Committee, which influences health legislation, claimed that the cost of health insurance could be slashed for smaller companies through greater use of pooling methods.

"By pooling insurance costs in appropriate geographic areas, we can bring the burden on individual businesses down," he said.

"A minimum health care law creates no burdensome regulations for health providers. It requires no massive bureaucracy. It simply extends the current system of employment-based private health insurance to millions of workers denied it now," Sen. Kennedy noted.

It is up to the federal government to ensure that workers have health insurance coverage, he said.

"It violates no legitimate notion of the proper role of government—and it does not breach any proper wall of the separation between the public and private sector—for Congress to fulfill the constitutional concept of promoting the general welfare by providing health insurance to those who work," Sen. Kennedy observed.

ERISA council

Five new members of the Labor Department's ERISA Advisory Council have been appointed for three-year terms.

Kermit J. Berylson, a consultant to the accounting firm of KMG Main Hurdman in New York City, will represent the accounting profession; John Erlenborn, a former Illinois Republican congressman and now a partner in the Washington office of the law firm Seyfarth, Shaw, Fairweather & Geraldson, will represent employers; and John M. Naughton, executive vp with Massachusetts Mutual Life Insurance Co. in Springfield, Mass., will represent the insurers.

In addition, John Rother, director of federal legislation, policy and research for the American Assn. of Retired Persons in Washington, will represent the general public, while Bert Seidman, director of the AFL-CIO's Department of Occupational Safety, Health and Social Security in Washington, will represent employee organizations.

The 15-member Advisory Council on Employee Welfare and Pension Benefit Plans was established by the Employee Retirement Income Security Act of 1974 to advise the secretary of labor on various ERISA and retirement issues.

The council meets at least four times a year in Washington with all member expenses paid by the federal government.

Liability limits

Sen. Larry Pressler, R-S.D., has introduced legislation, S. 217, to eliminate the doctrine of joint and several liability in all tort actions except where defendants acted in concert.

Under the legislation, a defendant's liability for both economic and non-economic damages would be limited to the extent that it was responsible for an accident.

By contrast, under joint and several liability, a defendant only slightly at fault can be forced to pay 100% of the damages in a suit with multiple parties if other defendants are financially unable to pay damages.

Sen. Pressler concedes that plaintiffs could lose compensation if his bill were enacted into law.

"But to use the present joint and several liability doctrine in an attempt to compensate the plaintiff makes little more sense than to send the witness of a robbery to jail because we cannot find the robber," he said.

Meanwhile, in the House, Rep. John Porter, R-Ill., has introduced legislation to exempt unpaid volunteers from civil liability except for acts of willful and wanton misconduct.

OSHA field chief

Leo Carey, a veteran federal industrial hygienist, is the Occupational Safety and Health Administration's new director of field operations.

Mr. Carey will oversee OSHA compliance officers and health and safety inspectors. OSHA's field staff includes 1,700 employees in 10 regional and 72 area offices.

Mr. Carey, 38, had been OSHA's deputy director of field operations. He also served as area director of the OSHA Wilkes-Barre, Pa.-area office for nine years.

Mr. Carey, a certified industrial hygienist, holds a bachelor of science degree in chemistry from Allentown College and a master of science degree in occupational health from Temple University. ■



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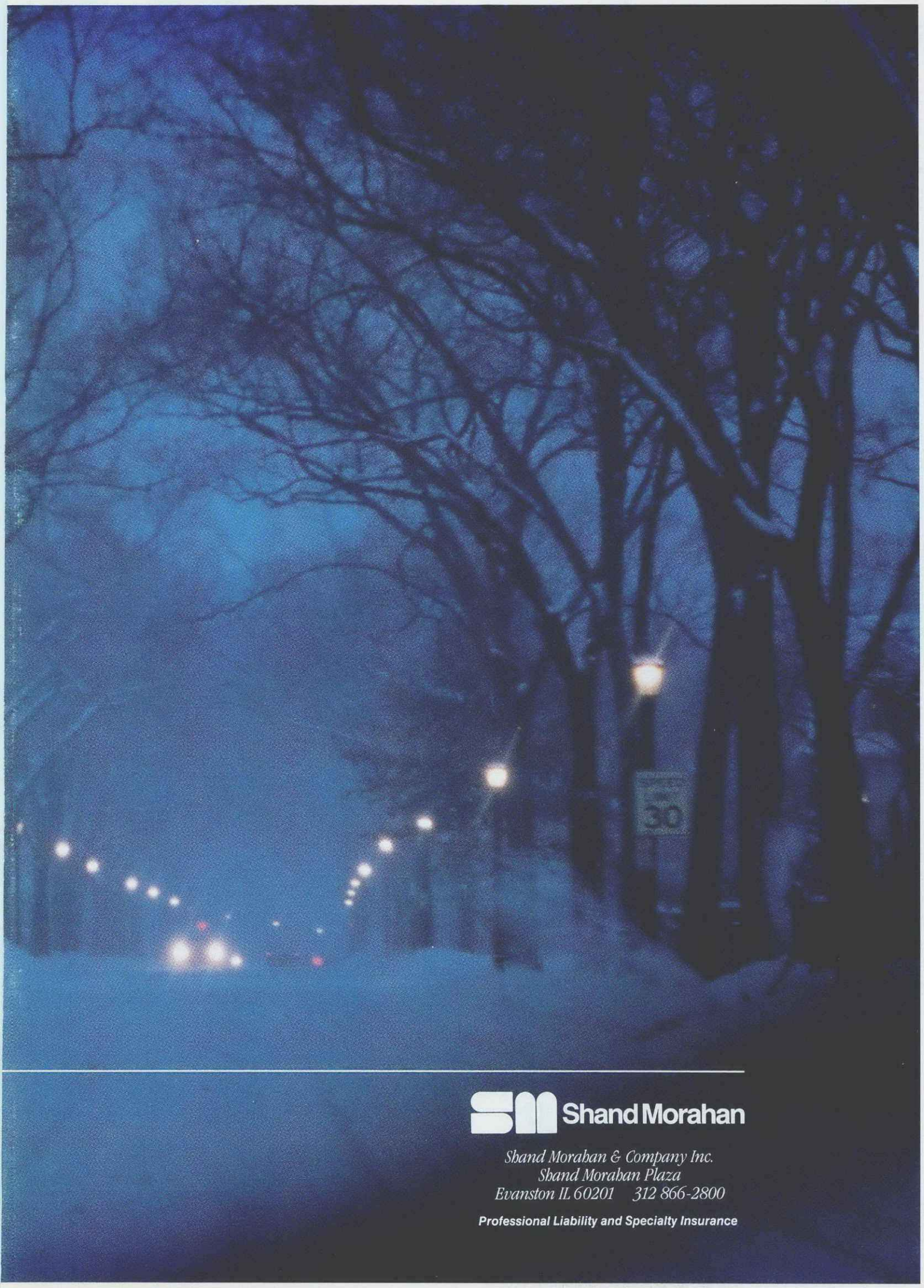
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Shand Morahan & Company will continue to discuss and attempt to clarify the issues most in need of reform. We ask you to join us in seeking solutions. Individually and collectively, we have the potential to change things. We are most interested in your thoughts and in sharing ours with you. For more information, write to: Joseph J. Prochaska, Jr., Chairman and Chief Executive Officer, Shand Morahan & Company, Inc., Shand Morahan Plaza, Evanston, IL 60201.

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Tailored savings

Case management can trim companies' health care costs

By John Garner

JANE DOE, an office manager, became permanently paralyzed following a bad fall during a hiking expedition. By the time she recovered from the acute phase of her treatment, she had a bad case of cabin fever. Her doctors, however, wouldn't hear of her going home.

At about this time, Jane's employer asked that her case be reviewed. Given the enormous costs of prolonged hospitalization, as well as Jane's strong desire to leave the hospital, it seemed sensible to get a second opinion and see if continued hospitalization was, in fact, the best way to handle the case.

Accordingly, the insurance company sent in a rehabilitation nurse/specialist who recommended that Jane enter a rehabilitation program on an outpatient basis.

To manage at home, Jane needed some ramps on the outside of her house, a lift to take her to and from the second floor and modifications to the bathroom. Although her policy did not cover these items, the insurance company—an enlightened one—was willing to make exceptions and pay for the alterations.

This example illustrates the value of medical case management and the part it can play in an overall health care utilization review program.

My experience indicates that case management is an extremely effective way for companies to lower medical costs and ensure appropriate care for their employees.

Certainly case management paid off—literally—for Jane's employer. Just as important, Jane benefited, too. She got what she really needed from her medical plan—not weeks or months of subsidized hospitalization but, rather, coverage for alterations that allowed her to return home.

This example also highlights the importance of *flexibility* in benefit plan design. Employers and insurers are often reluctant to make policy exceptions—such as those permitted in Jane's case—despite the fact that they frequently decrease health care costs. If flexibility is built into the design of a benefit plan, there will be less need to make exceptions—and more opportunities to take advantage of innovative alternative treatments.

speaking out

Jane's situation was one case in point. Here's another:

Most companies pay 50% of the cost of outpatient psychiatric treatment, up to a maximum of $1,000 or $1,500. But this type of benefit design actually forces people to use fully covered inpatient services—by far the most expensive treatment! Rather than boxing themselves in this fashion, companies should provide a range of alternatives: home health care, hospices, psychiatric residential treatment facilities and extended care facilities.

If a plan offers such benefits, a medical case manager has something to work with. He or she can then say, "Look, your plan covers these treatments. Let's talk to your doctor and select the one that everyone is comfortable with."

This approach not only eliminates the need to get an exception approved—with the delays inherent in that process—but also enables companies to give employees good news (e.g., "we have the following new benefits. . . .").

Of course, in structuring a plan to include alternatives that support more effective case management, companies must ensure that the alternatives are not used in addition to the usual hospitalization. Paying for both a regular hospital stay and home health care clearly will raise a company's costs. But because most of the benefits discussed in this article are new and only beginning to be included in company plans, controls can be built in from the start.

Another case I worked on shows the importance of involving a case manager early in the treatment process. Here, the company was self-insured. Bill, the unemployed husband of one of its employees, had a serious hunting accident. But because the case did not involve an employee or a family member of someone at corporate headquarters, the company did not learn of the situation until the claim was submitted—by which time Bill had been hospitalized for one month.

Remembering my previous experience with Jane Doe's case, I suggested the company call in a case manager. In this instance, the company sent a nurse (who happened to have a background in rehabilitation) from its own medical department to talk to Bill. She discovered that he was a veteran and therefore entitled to Veteran's Administration benefits.

None of the people at the hospital had considered this possibility, so medical case management actually provided a fresh, useful perspective. And, once again, it led to a course of action that saved the company money. It also enabled Bill to receive treatment from doctors experienced in dealing with gunshot wounds. (Today, of course, this solution would not be as attractive for the company because under the provisions of the Consolidated Omnibus Budget Reconciliation Act, the plan would have to pay for the patient's V.A. hospitalization.)

Generally, the first opportunity to involve a medical case manager is during the preadmission certification process.

Hospital utilization review companies are set up to handle this. If they do preadmission certification, they will identify certain types of intractable cases such as Acquired Immune Deficiency Syndrome, certain psychiatric disorders, spinal cord and head injuries, burns and strokes. Before calling in a medical case manager, they will seek approval for alternative care from the employer or the insurance company.

Continued on next page

John Garner is a principal in the Los Angeles office of Towers, Perrin, Forster & Crosby.



ASK A RISK MANAGER

Measure performance of others as yourself

Q **Measuring job performance is an everyday task for risk managers with several employees in their department, but the task of job performance review is reduced to writing once a year. How do you measure the performance of employees on your staff and how is this performance communicated to the "boss" and personnel?**

A For those who have never had to reduce job performance to the written word using a performance appraisal system, it seems like too much paperwork. For those who have lived through the exercise at least once, you begin to see some merit in the formal exercise.

While it may be too early to digress from the subject of measuring others, it is never too early to think about using the same measurement tools you use in this system to measure yourself.

The system you use may differ to some degree in the format used to analyze exempt and non-exempt employees. While this may be true in the majority of performance appraisal systems the focus is still the same: You are measuring performance using a rating scale from "distinguished" at the upper end to "marginal" at the lower.

Rather than mix the discussion up into both exempt and non-exempt employee performance analyses, I will limit my answers to the exempt employees only.

The following exercise takes place early in the calendar year. You start, obviously, with the employee name and job title. It is important to have an accurately descriptive job title.

The next step is to set forth job performance by describing job accountabilities. Look at your job description and use the principal accountabilities shown on that document. We try to limit this list to five to seven brief and separate statements.

You follow this with a performance indicator that identifies the degree of competency of the job performance of each statement.

As an example, our claims manager, as one primary job, must "select and contract with outside claims administrators, then monitor, analyze and authorize certain claim payments made by insurance adjusters on behalf of our company in order to minimize costly settlements and litigation." The key indicator of this performance is comparison to our forecast of a report from the claims administrators' offices that handled claims of more than $10,000, measured every six months.

One other principal accountability for our claims manager is "the analysis of claims on behalf of groups and profit center divisions, and presenting to them the best possible solution to mitigate this exposure in the future, and thereby avoid large-claim dollar expense." The key indicator here is a quarterly claim report that also measures the opening and closing value of these large claims.

At year's end we move into the performance evaluation section of the analysis, describing the extent to which the objective was met, and identify the level of performance. In addition to the basic scales previously mentioned, we use "adequate," "competent" and "commendable."

Our insurance manager agreed to five job accountabilities during the past year and one of them, as an example, was to "analyze, with on-site inspections of major locations, our operations to evaluate the exposures to loss and provide adequate protection under our master purchased insurance and self-insurance programs and to recommend other protective measures to limit exposure to loss." The key indicator here is the annual review of some 18 profit centers relating their operations and exposures to loss to the insurance coverages, as well as the preparation of trip reports.

Another example of a job accountability for our insurance manager was to "assist the broker in drafting insurance contracts to meet the needs of our operations; and to represent the company's interest, when needed, at insurance marketing negotiations." The key indicator here involves confirming the accuracy of detailed annual insurance specifications used to market 20 major insurance contracts.

At year's end we again evaluate the performance, stating the extent to which the objective was met, and then selected one of the five ratings.

Our financial and systems manager outlined seven major job responsibilities with key indicators, and some of these may be of interest.

His first involved an "accurate and timely budget and expense allocation." The key indicator was to complete the budget within a time frame so we could allow for distribution and revised allocation by August.

A second involved a "statistical analysis of data to solve future and possible year-end budget allocations." This is in the workers compensation and liability areas. The key indicator involved performing two actuarial analyses of incurred loss data in such a manner as to allow an independent review, rather than complete analysis.

A third job was to "implement IBM-PC automation." The key indicator here was to establish a workable actuarial model; catalog and index all automated worksheets; and develop graphic presentations of data, as needed.

Again, at year's end we evaluated performance and rated each job as it was performed during the year.

When the performance rating is complete, a summary is required that gives an overall rating of one of the five rating categories with a brief explanation of your rationale.

The last step is to look at the overall appraisal and attempt to suggest areas of improvement in job performance and skill development.

The appraisal process began with the employee and with meaningful job accountabilities established in the beginning of the year. In addition, you agreed to key indicators to measure performance. Furthermore, at year's end, the performance evaluation serves as a basis for salary review.

It is a good system, I believe, and is perhaps better than most. Everyone knows the beginning and the end, and it's up to you to guide the employee performance to a successful conclusion during the year.

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



Mr. Perry

This month's column, on risk management issues, is written by Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco. Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

Mr. Duva's and Mr. Perry's columns appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Perry'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.

Case management

Continued from previous page

Because this can lead to unnecessary—and possibly costly—delays, it's a good idea to work out an automatic approval procedure. In one large company for example, a utilization review package was implemented that provides preadmission review, continued stay review (by telephone), concurrent review (on-site at the hospital when appropriate), discharge planning, medical case management and automatic audits on larger hospital bills, all of which ensured that approvals were built in.

Another company plagued by delays in getting approvals found that its review organization habitually had trouble reaching the human resource vp responsible for granting approvals. The solution here was simple. The vp authorized the benefit administrator to approve most cases directly and to involve him only when the circumstances were unusual.

Whatever method a company uses, alternative treatments should be reviewed and approved as quickly as possible. Early action is not only critical in terms of saving money, but from a treatment standpoint as well. After a certain period, it may no longer be possible to carry out alternative treatments.

In reviewing the options for a particular case, companies shouldn't automatically dismiss any that seem unusually expensive.

If, for example, the hospital utilization review company says, "We want to send Joe Jones to the best unit in the world for such-and-such," a company's first reaction may be to deny approval because of the expense involved. But sometimes the most expensive alternative is the best in the long run, especially in the case of rehabilitation institutions that specialize in a particular condition and may speed a patient's recovery.

Medical case management coupled with a flexible plan design offers companies a chance to consider innovative treatments that not only better serve employers' needs but may also save money. But to reap the advantages of case management, companies must:

- Be willing to make policy exceptions when a case warrants them.
- Intervene early to enable patients with chronic or terminal illnesses to get alternative care sooner.
- Work out an automatic approval system to eliminate administrative delays that run up bills and impair the quality of patient care.
- Keep an open mind about seemingly expensive treatments.

Unquestionably, case management benefits some organizations more than others in the short run. In particular, insurance companies with a block of pooled business on small cases will find it to their advantage. Companies with self-funded plans also stand to gain from case management. But so, too, do companies that are neither self-funded nor experience rated. For although they will not realize any immediate financial advantages, their hospitalized employees and dependents will definitely benefit. From a long-term perspective, therefore, case management offers something of value to everyone.

info

• The Menninger Foundation has published a report titled, **"Predicting Which Disabled Employees Will Return To Work: The Menninger RTW Scale."** Of interest to claims benefits managers and rehabilitation coordinators, this scale not only indicates who is likely to return to work, but also identifies those who should benefit from rehabilitation. The report—TMF-P008-18—is available for $10 from the Menninger Foundation, Research and Training Center, Jayhawk Tower, 9th Floor, 700 Jackson, Topeka, Kan. 66603; 913-223-2051.

• For every $3 employees receive in wages, their employers provide an additional dollar in various benefits, according to Fax Communications Inc. In a new publication, **"Understanding Your Employee Benefits: What's In It For You,"** Fax informs and motivates employees to understand and appreciate the value of their employee benefits. The basics of employee benefits are conveyed in an easy-to-read style with illustrations. Employer contributions to Social Security and disability coverage also are covered. Designed and priced to be included in take-home handouts, a free sample copy of the booklet is available from Fax Communications Inc. Dept. BI, 3279 20th St., San Francisco, Calif., 94110; 415-641-7422.

• According to a new publication issued by the Society of Chartered Property & Casualty Underwriters, insurance buyers can take a variety of actions that will help control the price they pay for business, auto and home insurance. **"How Consumers Can Affect Insurance Cost"** is the title of the 16-page illustrated booklet designed to increase the level of knowledge of insurance buyers. The booklet covers the basic insurance coverages that are available and necessary, the factors that affect the cost of these coverages, and safety considerations. Specific sections include actions businesses can take, actions motorists can take and actions homeowners can take. Single copies are available free from the Communications Department, Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355.

• **"Cocaine In The Workplace"** is the title of a new booklet designed to dispel more than a dozen myths surrounding the drug and highlight its dangerous side effects. The 16-page illustrated booklet from Krames Communications encourages supervisors to focus on performance issues and shows them how to draw up a contract with affected employees to require increased performance by a fixed date. Co-workers are urged to not enable drug use by covering for abusers and are informed of the warning signs of cocaine abuse. Company managers or supervisors can obtain a sample copy of the booklet by sending a request on company stationery, or by attaching their business card to their request, from Krames Communications, 312 90th St., Daly City, Calif. 94015-1898.

• A new videotape explaining the hows and whys of the **Texas Workers' Compensation Assigned Risk Pool** is now available to agents and their clients. "A Workable Solution: An Introduction to the Texas Workers' Compensation Assigned Risk Pool" describes how the pool is organized and funded, why some businesses are rejected in the voluntary market and what services the pool offers to prevent losses. The assigned risk pool was created in 1953 by the Texas Legislature to provide a source of work comp coverage for employers that cannot obtain it in the voluntary market. The videotape is available for loan in VHS and ¾-inch video formats from the Insurance Information Institute, 800 Brazos, Suite 4220, Austin, Texas 78701; 512-476-7025.

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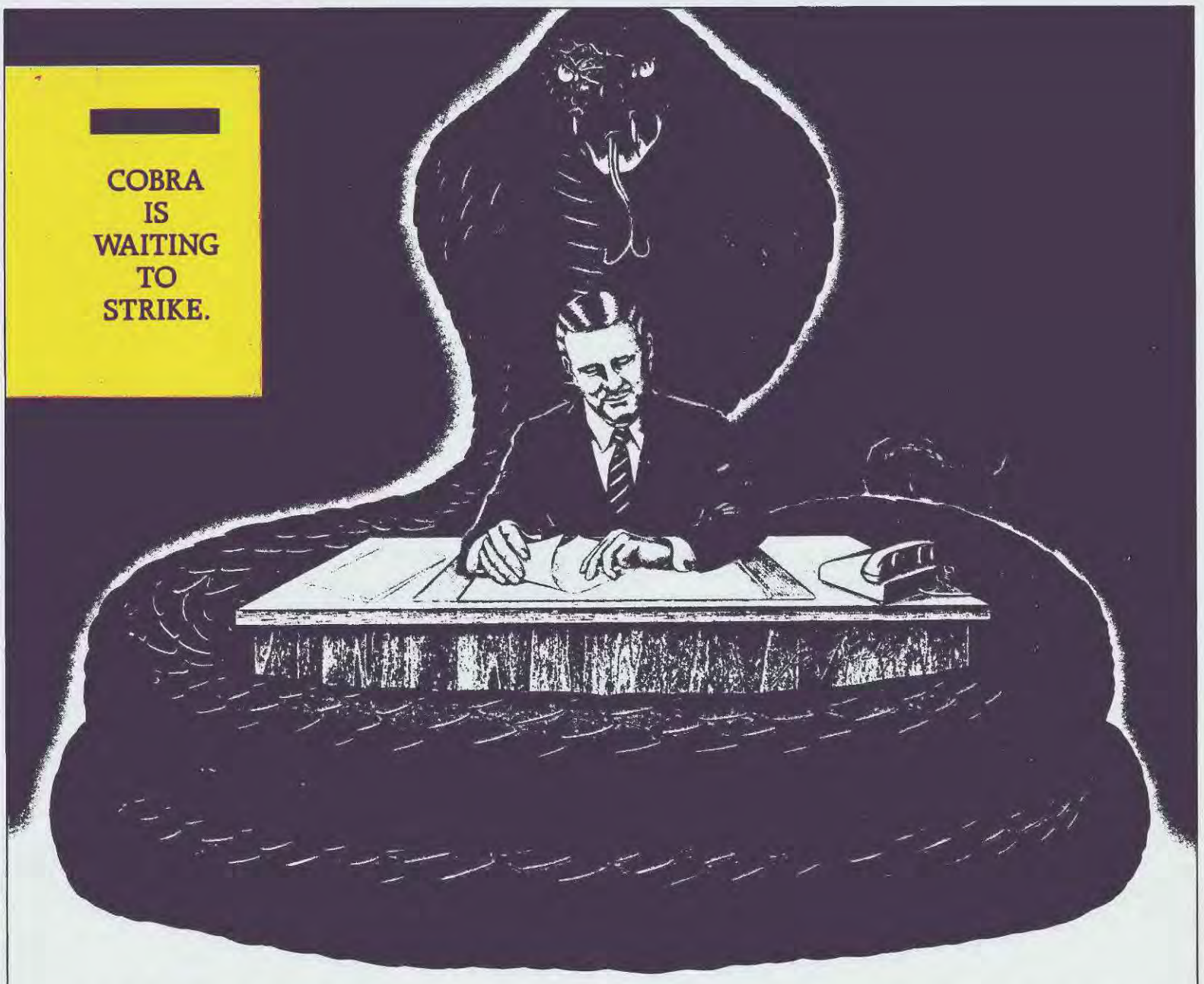
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update

RIMS PREVIEW
Issue Date: March 23
Ad Closing: March 10

The editors of *Business Insurance* are preparing a pre-conference report on the upcoming RIMS Conference in Las Vegas, Nevada. We'll provide last minute updates on the Conference agenda, exhibits and events, including info on the host city.

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Most Delaware firms to limit directors' liability: Survey

By PAUL D. WINSTON

An overwhelming majority of Delaware-incorporated companies plan to amend their certificates of incorporation to limit or eliminate the liability of their directors for breach of fiduciary duty, a survey shows.

Amendments to Delaware's General Corporation Law signed last summer by Gov. Michael N. Castle shield directors from some liability by allowing shareholders of Delaware corporations to approve provisions to limit or eliminate directors' liability for duty of care violations (*BI*, June 23, 1986).

And, under certain conditions, one of the amendments permits indemnifying directors and advancing them funds to cover the cost of litigation against them.

Under previous Delaware law, directors found grossly negligent in performing their duties could be held personally liable for monetary damages and could not be indemnified by their corporations.

A synopsis of the law explains that it "represents a legislative response to recent changes in the market for directors liability insurance."

The unavailability of directors and officers liability insurance "threatened the quality and stability of the governance of Delaware corporations because directors have become unwilling, in many instances, to serve without the protection such insurance provides and, in other instances, may be deterred. . .from making entrepreneurial decisions," the study notes.

The survey, conducted by New York-based American Society of Corporate Secretaries Inc., included 310 corporations in Delaware, where nearly one-third of ASCS' member companies are incorporated. About half of the Fortune 500 companies and 40% of New York Stock Exchange-listed companies are incorporated in Delaware.

Some 75% of the respondents plan to ask shareholders to approve amendments to their corporations' certificates of incorporation to limit or eliminate directors' personal liability for breach of fiduciary duty of care, as Delaware law now permits.

Twenty-one percent were undecided whether they will take such action, while 4% did not plan to take any action. Shareholder approval to limit directors' liability may be obtained at an annual meeting or special meeting or through written consent.

Of those corporations planning to seek shareholder approval for the amendments, 85% intend to do so at their next annual meeting; 6% plan to call a special meeting before their next annual meeting to request the amendments; 5% intend to seek approval through written consent of shareholders; and 3% will wait for a future annual meeting. One percent were undecided.

At 85% of the corporations planning to seek amendments, shareholders will be asked to eliminate directors' personal liability, while 10% will ask to limit personal liability. Five percent were undecided.

When asked whether they will cancel directors and officers liability or let their coverage lapse as a result of the reduced liability of their directors, only 5% said they would and 6% said they probably would, while 51% said they would not cancel or let their D&O coverage lapse. Some 38% were undecided.

According to the ASCS, one amendment to the Delaware law "permits general authorization of advancement of litigation expenses to an officer or director before disposition of an action, under certain conditions." However, the law does not allow any indemnification or limitation of directors' liability for:

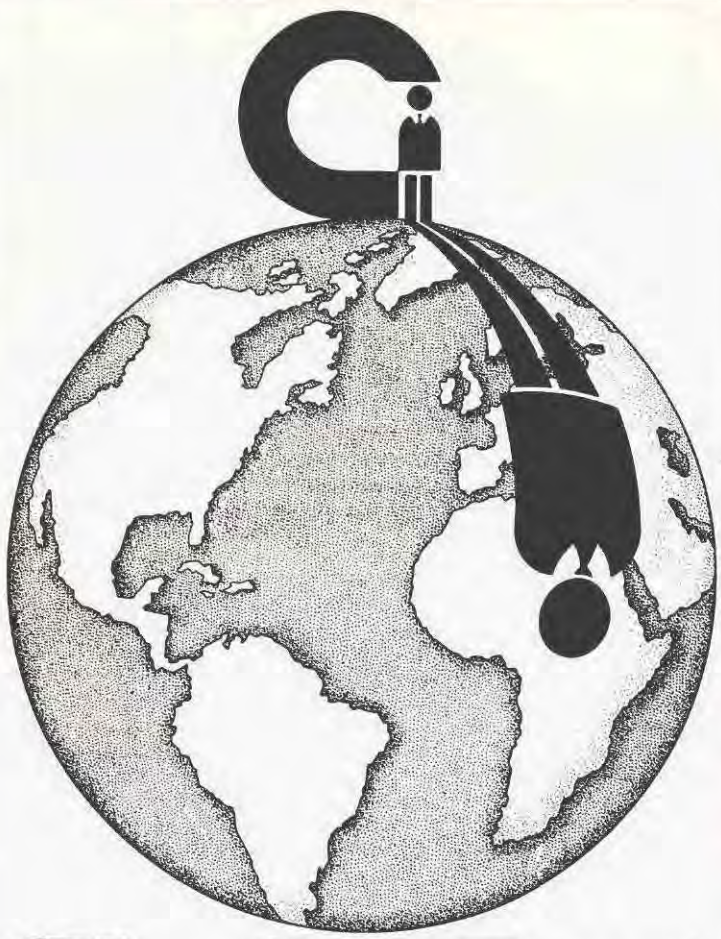
- Any breach of directors' "duty of loyalty to the corporation or its shareholders."
- "Acts or omissions not in good faith or that involve intentional misconduct or a knowing violation of law."
- Transactions in which directors derive "an improper personal benefit."

Asked whether their corporations plan to amend their charters and/or bylaw provisions on indemnification to permit general authorization of advancement of expenses, two-thirds of the respondents—66%—said yes, while only 7% said no and 27% were undecided.

Seventy-eight percent said they had not entered into indemnification agreements with any of their directors, while 22% said they had.

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For a free copy of the survey, contact Diana Wienckoski, American Society of Corporate Secretaries Inc., 1270 Ave. of the Americas, New York, N.Y. 10020.



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comings & goings: industry

Wentz is new chairman at Crum & Forster Inc.

Sidney F. Wentz has been named chairman and chief executive officer of Crum & Forster Inc. as part of a reorganization of the top management of the Morristown, N.J.-based insurer.

Mr. Wentz will succeed **Melvin Howard**, who becomes chairman of Crum & Forster's executive committee while remaining vice chairman of Xerox Corp., Crum & Forster's parent company. He is also chief executive of Xerox Financial Services Inc.

Succeeding Mr. Wentz as president and chief operating officer will be **Robert J. Vairo**, who had headed Crum & Forster Underwriters Group, which has been combined with U.S. Insurance Group as part of the company reorganization.

John J. McGinty, vice chairman and chief financial officer of Crum & Forster Inc. and a vp at Xerox, will be returning to the parent company in a senior management position, which hasn't been specified yet.

William E. Buckley was named chairman and chief executive officer of Crum & Forster Commercial Insurance, a newly created unit that includes all commercial and specialty, excess and surplus insurance operations in 40 states and all ocean marine and Canadian insurance operations.

Previously, Mr. Buckley was chairman of U.S. Insurance Group.

George L. Yeager named senior vp-insurance operations at Crum & Forster Inc. Previously, Mr. Yeager was senior vp and chief underwriting officer at Crum & Forster Underwriters Group.

Charles T. Gerry promoted to senior vp-operations planning of Crum & Forster Inc. Mr. Gerry had been senior vp-human resources planning at Crum & Forster Underwriters Group.

Leslie R. Cheek III named senior vp-federal affairs and **Robert J. Sullivan** named senior vp-governmental affairs at Crum & Forster Inc.

In other insurer changes:

Fred G. Marziano named executive vp of New York-based Continental Corp. and president of its agency group. He succeeds **Walter Hallowell**, who became executive vp of the agency group. Previously, Mr. Marziano had been executive vp and chief underwriting officer at Fireman's Fund Insurance Cos.

At the recently merged Blue Cross & Blue Shield of Missouri, **Clifford S. Graham** promoted to senior vp/client satisfaction. Formerly, Mr. Graham was vp/provider relations.



Mr. Talbert

Hamilton B. Talbert Jr. joins Blue Cross & Blue Shield of Illinois as vp of municipal accounts. For the past 20 years, Mr. Talbert worked at The First National Bank of Chicago providing banking services to governmental units.

A. Robert Johnson appointed senior vp of claims at Transport Insurance Co. in Dallas.

Richard C. Higgins named corporate vp of the research and coordination divisions at Tokio Marine Management Inc. in New York, the U.S. manager for Tokio Marine & Fire Insurance Co. Ltd.

Also at Tokio Marine Management, **Arthur W. Brooks** joined as vp and general manager of the re-

Continued on next page



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ANSUL

comings & goings: industry

Continued from previous page

David E. McPherson promoted to executive vp from senior vp.

Other management changes at Allstate Life include: **Merwin E. Soper** promoted to senior vp-group operations from vp; **Janette A. Raffino** promoted to vp-group insurance services from vp-Northbrook operations; **Sherman A. Wolff** promoted to vp-group brokerage operations from vp-group financial; and **C. Nelson Strom** promoted to vp-corporate accounts from vp-group administration.



Mr. Rolfes

Gary Rolfes joined IBA Health & Life Assurance Co. of Kalamazoo, Mich., as vp-insurance operations. Previously, he was manager of underwriting services for American Chambers Life Insurance Co. in Tampa, Fla.

C. Brian Schmalz elected executive vp and chief operating officer of Philadelphia-based Reliance United Pacific Surety Managers Inc. Previously senior vp in charge of West Coast operations, he now is responsible for day-to-day bonding operations worldwide. Also elected was **Vincent G. Fasano** to senior vp and chief claims officer. He previously was assistant vp for Western bond claims operations.

Also at Reliance United, **Lawrence W. Carlstrom** elected senior vp. Mr. Carlstrom assumes underwriting, marketing and administrative responsibility for bonding operations of the company's United Pacific Division in Federal Way, Wash., which covers the Western United States, including Alaska and Hawaii.

Agents/brokers

Following the merger of New York-based broker Fred S. James & Co. with Memphis, Tenn.-based The Crump Cos. Inc., several Crump executives have been appointed to new positions with James. **Sidney A. Stewart Jr.** named vice chairman of James and chairman of its executive committee. Mr. Stewart, previously chairman and chief executive officer of Crump, will direct James' wholesale, reinsurance, underwriting and underwriting management operations. He will be based in Memphis, with an office in New York.

James M. Power, former president and chief operation officer at Crump, named senior executive vp at James. He will now oversee James' administrative operations from Memphis. **Edward B. Morrow Jr.**, a former Crump executive vp, named executive vp at James and will continue to be based in Memphis, responsible for the Southern region.

Donald A. Thomas named senior vp, and **Gordon E. Noble** named executive vp at James. Mr. Thomas, based in Memphis, previously was executive vp and chief insurance officer with Crump, and Mr. Noble, located in San Francisco, was a Crump executive vp.

In addition, James has promoted **Donald K. Morford, Quill O. Healey and C. Richard Peterson** to executive vps. Based in San Francisco, Mr. Morford previously was a senior vp of James. Mr. Healey is based in Atlanta and was previously was a senior vp. Mr. Peterson, also a former senior vp, is based in Philadelphia.

Kenneth R. Sandy named president of Corroon & Black Corp.'s Fairbanks, Alaska, subsidiary. Most recently a vp/branch manager, Mr. Sandy joined C&B's Fairbanks operation in 1981 as assistant branch manager.

Also at C&B in Alaska, **Wayne W. Brown** promoted to president of Corroon & Black Inc. (Anchorage) and **Gerald E. Borstad** promoted to chief operating officer. Mr. Brown, who was named chief executive officer of the Anchorage operation in 1985, joined C&B in 1974. Mr. Borstad joined C&B in 1976.

In other changes at Corroon & Black, **James H. Levine** promoted to senior vp and a director of the Brokerage Services Group. Mr. Levine, who joined C&B in 1974, named vp of BSG's sales and marketing division in 1984.

Excess/surplus

Robert A. Scott named senior vp and chief financial officer at Swett & Crawford Group in Los Angeles. Previously, Mr. Scott was senior vp and CFO for Whittaker Health Services Inc., in Los Angeles. Also, **Nancy L. Oblinger** named senior vp-corporate communications and **Vivien I. Sainz** named senior vp-administration. Previously, Ms. Obliger and Ms. Sainz were vps at Swett & Crawford. ■

Three claims specialists profiled

The directory of claims specialists in the Jan. 26 issue of *Business Insurance* should have contained information as printed below on the following three companies. Responses from Jardine Emett & Chandler Inc. and Executive & Employee Benefit Plans Inc. were not received by *Business Insurance*, and the response submitted by American SelfCare Corp. contained incorrect information.

Executive & Employee Benefit Plans Inc.

2025 Riverside Drive, Columbus, Ohio 43221; 614-481-8391

Parent company: Community Mutual Insurance Co.
Year founded: 1959.
Services provided: 82% claims administration, 18% other services.
Region served: Nationwide.
Specialty: Health insurance, disability.
Self-insured clients/claims: Administration: 130 clients.
Client mix: Administration: 120 corporations, 10 union-sponsored plans.
Staff: 80 total staff members.
Charges: Administration: per employee per month.
1986 gross revenues: $3.6 million total.
Branch offices: Administrative and sales offices in Cleveland and Cincinnati, Ohio; Vienna, Va.; Houston.
Subsidiaries: Claims Center Inc. (claims software leasing).
Principal officers: Diana L. Hilmer, senior vp; C. Jeffrey Wintersteller, vp-marketing; Karen E. Cobe, vp-operations.

Jardine Emett & Chandler Inc.-Employee Benefits Service Division

433 State St., Schenectady, N.Y. 12305; 518-381-1600

Parent company: Jardine Matheson & Co. Ltd.
Services provided: 100% claims administration.
Region served: Nationwide.
Specialty: 75% health insurance, 25% disability.
Self-insured clients/claims: Administration: 23 clients, $44.3 million claims paid.
Client mix: Administration: two corporations, 10 Taft-Hartley plans, one union-sponsored plan, nine association plans. Health insurance: 280,000 employees covered.
Staff: 63 total staff members, 53 of whom serve self-insured clients only.
Charges: Administration: per capita.
1986 gross revenues: $3.6 million from claims services.
Branch offices: Sales offices in New York, Cedarhurst, Syracuse and Albany, N.Y.; Boston, Mass.; Parsippany, N.J.; San Francisco; Chicago; Houston; Los Angeles; Phoenix, Ariz.; Spokane, Wash.; Portland, Maine.
Principal officers: Richard Archer, chairman; Timothy Reath, executive vp; Harold Talbot Jr., president/chief executive officer; E. Paul Hansen, chief financial officer; Thomas P. McDonough, president-Employee Benefit Services Division.
Membership: SPBA, SIIA.

American SelfCare Corp.

690 E. North Ave., Carol Stream, Ill. 60188; 312-653-6120

Year founded: 1953.
Parent company: American Family Corp.
Services provided: 98% claims administration; 2% other services, including actuarial and consulting services.
Region served: Nationwide.
Specialty: 90% health insurance, 10% disability.
Self-insured clients/claims: Administration: 58 clients, $77 million claims paid.
Client mix: Administration: 49 corporations, nine public/government entities. Health plans: 55,000 employees covered, 80,000 dependents covered.
Staff: 70 total staff members, all of whom serve self-insured clients only.
Charges: Administration: per employee per month.
1986 gross revenues: $2.1 million total.
Branch offices: Administrative and sales office located in Columbus, Ga.
Principal officers: Salvador Diaz-Verson, president; Leonard Jagoda, treasurer; Louis Hazouri, secretary; Daniel Amos, director; David Hudson, manager.
Membership: SPBA, SIIA, Self-Insurance Assn. of Illinois. ■

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Attracting talent

Financial inroads pit insurers vs. Wall St. for high-caliber workers

By AVRA WING

Insurance companies—both property/casualty and life/health—are making a concerted effort to attract and develop better talented people.

"Financial services is a people industry," comments William Potvin, a partner with Touche, Ross & Co. in New York. Over the long term, "the competitive edge is to have the smartest people who can move the fastest. Investment banking has found this out."

"More executive searches are being launched today than in the past," reports Donald DeWard, director of personnel administration at Hartford, Conn.-based Travelers Corp.

If a scale from one to 10 were established, with one representing no need for talent and 10 a "dire" need, the insurance industry would probably fall at around seven or eight, says Rich Pescatore, superintendent of staffing and placement at USF&G Corp. in Baltimore.

"There is a lot of competition out there for good people," Mr. Pescatore added.

"Most companies have realized the need for more skilled people, but the industry hasn't produced them," said Bert Morton, vp of human resources at The Home Group Inc. in New York.

"We are seeing too few totally competent people" in the industry, concurred Daniel Borbas, vp of human resources at Zurich-American Insurance Group in Schaumburg, Ill. And, the competent personnel that can be found "are commanding premium prices," he said.

Many property/casualty insurers now are actively seeking top-notch professionals—including underwriters, actuaries, claims personnel and financial wizards—following the prolonged soft property/casualty insurance market in which many companies curtailed training programs and recruiting activities.

Property/casualty insurers also are making frantic efforts to train in-house personnel as quickly as possible.

At the same time, among multi-line and life/health insurers where diversification into financial services is occurring, a battle is heating up for specialists from outside the industry.

In addition to looking for more talented people, insurance companies are looking for more entrepreneurial people.

This search is resulting in both better compensation packages in insurance companies and some corporate raiding among insurers for the best executives and professionals.

But, attracting top talent and entrepreneurs to the insurance industry is not easy. The insurance business suffers from a reputation of being boring and underpaying its employees, industry officials point out.

The property/casualty insurance business, in particular, faces a recruiting challenge not only to prepare for the future, but also to recover from its past mistakes.

During the recent competitive property/casualty insurance pricing cycle, "the industry cut new hires, training and development and wound up with a lot fewer people. Now we're all looking for people—but we haven't trained them for the last four or five years," remarked William Bolinder, president and chief operating officer of Zurich-American.

Casualty actuaries, technical underwriting specialists, senior claims adjusters and loss control specialists are "really scarce," Mr. Bolinder explained.

"There just isn't enough (actuarial) talent to go around," commented Mr. DeWard of Travelers.

"The demand for skilled professionals is enormous, and there are not enough people to go around in certain areas" said Carolyn Davis of Carolyn Davis Associates, a recruiting firm in White Plains, N.Y.

"I think it's probably the result of what the property/casualty industry has gone through over the last few years. When the crunch came, the training people were probably the first to go, so there's a shortage of well-trained people," she said.

Technically proficient people are needed across the board, Ms. Davis said. "In the soft market, people did not need to know very much, but now in the hard market, people have got to be wise."

To improve the level of talent and performance of their personnel, many property/casualty insurers are beefing up their human resources programs and in-house training programs.

Travelers, for example, is looking "at people in-place doing in-depth analysis of performance and potential and what we're going to do to help them," said Thomas Helfrich, Travelers' vp for organization and management development. "We don't have depth and breadth in-house or that which will be ready quickly enough."

Continued on next page

Students yawn at insurance jobs

By AVRA WING

NEW YORK—"Boring."

That's how college students characterized the insurance industry in Continental Corp.'s 1986 recruitment survey, according to Kenneth Zeigler, vp for employee relations of the New York-based insurer.

It's a perception that will not die easily, pronounced Linda Lomell, president of The College of Insurance in New York. The college finds in its recruiting efforts that many high school students are uninterested in seeking a career in insurance, she said.

Of several hundred New York City-area high school seniors indicating an interest in a business career, only 2% said they would want a job in the insurance industry, she noted, citing a recent survey by the college.

"We see a real obstacle to attracting a top-notch (insurance) workforce," Ms. Lomell said, because of low interest and negative perceptions about financial rewards and opportunities for advancement.

Furthermore, despite the insurance industry's avowal to hire better qualified, better educated people at all levels, insurers still are not looking to graduate business schools for employees (see related story).

In its study, the College of Insurance found that students perceive an insurance professional as being "dull or negative—a salesman or claims adjuster who won't pay a claim," Ms. Lomell explained.

The insurance industry has not done a good job of self-promotion, observers agree, and little information—especially positive information—about the characteristics and workings of insurance has filtered to the public. Worse still, insurers have received a lot of negative publicity because of the liability insurance crisis, Mr. Zeigler noted.

"It's too early to say how the latest wave of negative publicity will impact new recruits," commented William Bolinder, president and chief operating officer of Zurich-American Insurance Group in Schaumburg, Ill.

Some, however, are more optimistic about young people's perception of the industry.

Zurich-American's vp of human resources, Daniel Borbas, said he notices an "increased awareness" with "more young people beginning to see insurance as a viable career."

And Mr. Zeigler agrees that, as insurance companies become more visible, the image they have of being dull is changing.

Projected 1987 salary increases

	Executives	Salaried exempt	Salaried non-exempt
Insurance	6.6%	6.0%	5.9%
Banking/finance	6.3%	5.8%	5.5%
All service companies	5.9%	5.4%	5.3%
All manufacturing companies	5.3%	5.1%	4.8%

Source: Hewitt Associates, September 1986

Chart: Amy Palmer

The evolution to becoming financial service organizations occurring at many insurance companies is credited by observers as the primary reason the perception of insurers is changing. Companies' activities in the securities, investment, and real estate markets are casting a more glamorous glow over the insurance industry, and helping potential employees perceive insurers as "the major money distributors they are," in Ms. Lomell's words.

One way companies are trying to strengthen any positive stirrings toward insurance as a career—and a direct result of their move into broader financial services activities—is through higher starting salaries.

"We're willing to pay more for high-potential college graduates," noted Doron "Bud" Antrim, director of domestic property and casualty personnel operations at Hartford, Conn-based Hartford Insurance Group, while declining to be specific.

For non-management salaries, insurance companies report being competitive with other industries. A September 1986 Hewitt Associates survey of 564 businesses from a cross-section of industries shows that the insurance industry paid larger base salary increases for lower-level employees than other industries in 1986 and intends to pay larger increases again this year (see chart).

The 21 insurers responding to the Hewitt survey showed an average 5.8% increase in pay for salaried, non-exempt workers last year, while the average for all non-manufacturing companies (214 reporting) was 5.4%, and the average for manufacturing companies (297 reporting) was 4.9%.

Projected 1987 average increases were given as 5.9% for the insurers reporting, 5.3% for the 194 non-manufacturing companies reporting and 4.8% for the 279 manufacturing companies reporting.

Yet, young people still perceive insurance as a low-paying career, The College of Insurance survey revealed. Students ranked it as low as the publishing industry, which is generally regarded as a low-paying industry, Ms. Lomell said.

The insurance industry's college recruitment activity has definitely increased after four or five years of the soft cycle, companies and consultants report.

Insurers are looking for people at starting levels for its traditional, mainline functions —underwriting, claims, actuarial—as well as for those with strengths in financial specialties, marketing and data processing, the companies report (see related stories).

Among those companies beefing up their presence on campuses is The Home Insurance Group. "We will be going back to college campuses," said Bert Morton, vp of human resources for the New York-based insurer.

Another company placing heavy emphasis on college recruiting is Continental Corp., Mr. Zeigler reported. Continental had not done on-campus placement before 1986, he said, but had depended on "first bouncers" —people who had worked a year or two at another company.

Now Continental has instituted an aggressive, high-level recruitment program generated from the office of Chairman John Mascotte and conducted through senior executives who act as liaisons with colleges they have links to, such as their alma mater. These senior staff members will visit 35 campuses—including Yale University in New Haven, Conn.; Cornell University in Ithaca, N.Y.; Brown University in Providence, R.I.; and Dartmouth College in Hanover, N.H.— and recruit for the entire corporation, Mr. Zeigler said.

Continental is looking primarily for talented people for its claims adjustment and underwriting departments, he said, but also is trying to place actuarial, systems, human resource and loss control personnel.

The executives' recruiting duties "won't be easy," Mr. Zeigler admitted, referring to the negative impression college students seem to have about the insurance industry.

In fact, after surveying undergraduates, Continental discovered that "boring" was the first word that popped into their heads when asked for their impression of the insurance industry. The company decided to incorporate its recognition of the negative response in its recruiting efforts, Mr. Zeigler said, and has just prepared a brochure with a cover picture of a young man yawning.

CIGNA Corp. in Philadelphia recruits at 120 campuses, according to Patrick Hasson, assistant vp on the executive staff. And Hartford, Conn.-based Travelers Corp. has continued to be an "aggressive" hiring presence at the undergraduate level, said Donald DeWard, director, personnel-administration.

Prudential Insurance Co. of America is "paying more attention" to college recruitment, reported Donald Mann, vp of human resources. The company is trying to develop long-term, multilevel relationships that will help the company identify and attract high quality graduates.

Newark, N.J.-based Prudential is seeking students with "smarts," of course, he said, but, equally important, those with "leadership skills."

The companies are still looking for business majors, but there also seems to be a trend toward hiring liberal arts students. Donald Blake, assistant director of education at The Hartford, said that the "masses of (our) employees have business backgrounds, not liberal arts (backgrounds)," while Continental seeks both humanities and business students, according to Mr. Zeigler.

And Mr. Bolinder at Zurich-American said he prefers to hire liberal arts students—to whom the company can impart its own "culture," which might be "in conflict with what's in the textbooks." Humanities majors "know how to learn fresh business concepts," he added.

Ms. Lomell sees CEOs as wanting "broad-based liberal arts people" and questions whether the message has been made clear to recruiters at some companies. ■

MBAs snub insurance industry: Survey

Leading business school graduates are overlooking the insurance industry as a viable career option, according to an informal survey.

There appear to be several reasons for this:

Insurance companies traditionally have not needed—or have not perceived that they needed—many of the disciplines taught to students pursuing a master of business administration degree, and were primarily growing their own talent in-house, observers say.

The business schools, for their part, did not offer strong curriculums in the mainline insurance function, some contend. And, insurers had not been paying salaries that could compete with the more lucrative offers made to MBAs by other industries, such as investment banking.

But, as some insurance companies evolve into diversified financial services organizations, the demand for employees with master of business administration degrees will increase, observers contend.

Fred Way, dean of placement at Columbia University's business school in New York, said he's seen insurers beef up MBA recruitment efforts "a little bit" now that they are "moving into capital markets." And, he predicted the industry will seek more MBAs as this trend continues.

However, there is still doubt among insurers if the higher price tag for a business school graduate is justified. And where MBAs have been hired they are being brought into the financial services or investment side of the business, rather than underwriting, actuarial or claims areas.

Business school is not necessary to prepare employees for the mainstream insurance functions, according to Donald Mann, vp of human resources for Newark, N.J.-based Prudential Insurance Co. of America.

"I'm not sure there is a correlation between an MBA and effectiveness on the job," added Kenneth Zeigler, vp of employee relations for Continental Corp. in New York.

He noted that business school curriculums have not been particularly geared toward insurance functions and that often companies prefer to train new people in their own philosophies and techniques.

Dwight Foster, head of Peat, Marwick, Mitchell & Co.'s executive search practice in New York, commented that the "insurance industry just hires night school MBAs." But he questioned if MBAs "are worth it to the industry."

Bert Morton, vp of human resources for The Home Insurance Group in New York, noted that the company is "not going to go out for a lot of MBAs."

However, The Travelers Corp. stepped up its MBA recruitment program in 1986 and will be even more aggressive this year, said Donald DeWard, director of personnel-administration for the Hartford, Conn.-based insurer.

The company is looking for MBAs to fill slots in its Business Diversification Group, investment and finance areas and marketing activities, he said. There is "no lack of competition" for business school graduates from other financial service institutions, he noted.

CIGNA Corp. in Philadelphia recruits at 10 business schools and five law schools, according to Patrick Hasson, assistant vp on the executive staff. Of the 10 MBAs hired last year, all went either into the investment or strategic planning areas of the company—not into claims or underwriting, he noted.

Prudential hires several MBAs each year, noted Mr. Mann, and they go "almost exclusively" into the investment areas of the company.

Reports from the graduate schools confirm that insurers recruiting at graduate business schools are seeking personnel for financial functions other than traditional insurance underwriting, and that the insurers are paying competitive salaries.

At the business schools asked, the percentage of graduates going into insurance was extremely low. At the Harvard University Graduate School of Business in Cambridge, Mass., out of 498 people reporting on their employment from the 1986 class of 780, only two went into insurance. (Out of classes of roughly the same size, two entered insurance in 1985; one in 1984; two in 1983.)

In contrast, 185 graduates went into investment banking last year; 91 in 1985; 110 in 1984; and 84 in 1983.

At Columbia, with 500 of the business school class of 585 reporting, 14 went into insurance. Among the companies hiring Columbia MBAs were Prudential Insurance Co. of America; Aetna Life & Casualty Group, in Hartford, Conn.; Travelers Corp.; and CIGNA Corp., Mr. Way said.

From classes of roughly the same size, 16 from Columbia took insurance jobs in 1985; 12 in 1984; and 10 in 1983.

On the other hand, last year 107 MBAs from Columbia's class went into commercial banking.

While the numbers differ substantially between those choosing insurance and those choosing banking, the salaries were closer, according to Mr. Way. The range reported for the graduates entering insurance careers was $32,500 to $50,000. The new bankers reported a salary range of $30,000 to $65,000.

The 1986 class of Stanford University's business school in Stanford, Calif., had one graduate out of 318 going into insurance, the first in several years.

Approximately 11 graduates from a 1986 class of 482 at Northwestern University's Kellogg Graduate School of Management in Chicago took insurance jobs (375 reported placement). Among the employers were Travelers, Prudential and Northbrook, Ill.-based Allstate Insurance Co. Salaries ranged from $40,000 to $55,000.

About 56 Northwestern MBAs took investment banking positions at salaries of $40,000 to $72,750.

From the Wharton School of Business of the University of Pennsylvania's 1986 class of approximately 750, 596 of whom reported the jobs they had accepted, 16 people entered insurance company positions. However, all 16 had been hired in either the real estate or investment areas of their employers. The salary range was $20,000 to $48,000.

At the same time, about 120 graduates of the Wharton School in Philadelphia chose jobs with investment banking or brokerage houses with salaries ranging from $20,000 to $70,000.

In 1985, approximately nine Wharton graduates from a class of about 700 took insurance jobs and 100 took investment banking or brokerage positions.

Outside opportunities attract industry execs

By AVRA WING

Although new opportunities for top management are opening up as insurers diversify their product offerings, some insurance industry executives say greater challenges can be found outside established companies.

And, a simple desire to seek independence has led other executives to break away from the pack and start businesses on their own.

Economics has had a substantial influence on some of these decisions. For example, some executives have opted to take advantage of early retirement programs. And, improving industry conditions have spurred several to launch or sign on with new ventures.

But personal reasons seem to prevail.

Bruce Esselborn, formerly with American International Group Inc., resigned in April 1986 after 18 years with AIG to join start-up surplus lines insurer United Capitol Insurance Co. in Atlanta as president (*BI*, Aug. 11, 1986).

"At age 43," he commented, "you get antsy."

Mr. Esselborn had held various positions at AIG, including executive vp responsible for several property/casualty companies, executive vp of domestic life and health companies and vp in charge of branch and field operations in the United States and Canada.

He said he liked working at AIG "when it was small. I prefer a small company—things move a lot faster. I want to be attached to a small, elite, 'Green Beret' unit."

Now, with a brand new company, Mr. Esselborn said he has "a chance to build from scratch. I've been asked before to fix something (within AIG), but there was a support system" in place. Now, he added, there's "nothing—not even a paper clip."

Mr. Esselborn noted that the potential to make more money on his own was not the reason he left AIG to join a fledgling company.

"Money doesn't move people. When people leave (it means) something has been festering," he said.

As he hires additional management personnel at United Capital, he said is "looking for original thought."

The surplus lines insurance business "has always been creative," he noted, but added that, at large companies, that creativity "can be stifled. An idea has to go to research and development to see if it is a good one. The timing can be gone."

Daniel Gross, 44, has been on his own as a consultant since resigning as president of Philadelphia-based Colonial Penn Insurance Co. seven years ago. Before joining Colonial Penn, Mr. Gross had been with the Equitable Life Assurance Co. of America.

He is now president and chief operating officer of Enhance Reinsurance Co. in New York, a newly formed financial guarantee insurer (*BI*, Nov. 10, 1986).

"Starting your own company is the American dream," Mr. Gross noted, referring to the establishment of his consulting business. "I preferred going the way I did."

Now, he said he is again living out that "dream" by helping establish Enhance Re. "Once you've had a taste of being on your own," it would be hard to go back to an established company.

Mr. Gross acknowledged, however, that the new, aggressive, entrepreneurial stance adopted by some insurers has made the industry seem more exciting than it did several years ago.

"If Equitable had been the way it is now 18 years ago, maybe I wouldn't have left," he said.

Although Mr. Gross noted that his decision to go it alone once might have seemed a grave career risk, today breaking away from an established company is not that unusual. "No one feels very secure in the corporate world anymore," he said.

Because of the huge number of mergers and acquisitions over the last several years, for example, a lot of senior executives are "looking around," Mr. Gross noted. "You don't feel loyalty (to a company) anymore." ■

Brokers hunt insurer talent

Insurance companies could find that hiring and training more talented employees will only make insurers a better hunting ground for insurance brokers seeking employees.

Brokers' primary source of new employees is insurers.

And, the quality of the employees hired by brokers will increase as the quality of insurers' personnel increases, said Peter Pruitt, president and chief operating officer at broker Frank B. Hall & Co. Inc. in Briarcliff Manor, N.Y.

"The quality of people in the insurance industry is going up. The industry will be better managed," Mr. Pruitt observed.

But at least one brokerage is developing more in-house training programs because insurers aren't providing the talent it wants.

Alexander & Alexander Services Inc. has started "an aggressive personnel program" that will train managing vps for the New York-based broker's 100 profit centers, said Senior Vp Robert Moore.

The 18-month program covers such areas as financial management, organizational dynamics and leadership skills, he said.

A&A also is adding training and personnel directors at each of its seven regional offices, and the brokerage is rotating selected employees among its different operations, including its London office.

"We wouldn't go to this expense if there were a group of people we could draw on (to hire)" at the insurers, Mr. Moore said.

"We have to develop them. We can't go anymore to an insurance company and hire people of the caliber we need."

Brokers' need to employ top people is increasing as industry conditions improve. "In a hard market, there's more revenue but more pressure to meet client needs," he remarked.

In addition, insurers are becoming more sophisticated, Mr. Moore noted. "To remain competitive we've got to be more on top of their problems than they are."

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Insurers summoning 'financial wizards'

By JUDY GREENWALD and AVRA WING

Insurance companies now are looking for more sophisticated financial managers from outside the industry.

The insurance industry's increased complexity is fueling the demand for these so-called "financial wizards," observers say.

Insurers are recruiting financial managers in an effort to:

- Manage various interest-sensitive products recently introduced by life insurers.
- Generate the highest possible investment return from funds raised as a result of increased premium growth in the property/casualty insurance industry.
- Help cope with burdens created by tax reform.

"This is a financial business. It is becoming more and more competitive and more and more complex, and so it seems the need for more highly-trained professionals would follow from that," said Dan Beaton, director of recruiting and staffing at the Metropolitan Life Insurance Co. in New York.

Insurers today need financial executives who can supply "broader depth" than their actuarial staffs, said Ed Bader, partner in charge of Arthur Andersen & Co.'s insurance practice in Hartford, Conn.

Michael Klarner, president of MIK Recruiting Associates in White Plains, N.Y., observed that only a few years ago personnel recruitment was generally confined to within the industry.

Today, however, insurers are looking for a different type of individual—primarily financial managers—and won't hesitate to go outside the industry to seek these types of recruits.

"They'll take people from a lot of different places" as long as they bring the needed financial expertise with them, he said.

Insurance companies' financial management is becoming more sophisticated, agreed Stephen Forbes, senior vp-financial planning and control for the Life Office Management Assn., an industry support group based in Atlanta.

He termed the changes in financial management a "revolution," noting that some insurance companies did not have a chief financial officer as recently as several years ago.

"The management of scarce capacity is becoming a key issue," one that didn't exist several years ago, Mr. Forbes noted as an example of the new issues facing financial professionals at insurance companies. Insurers' financial officers must now deal with questions such as, "How much capacity is required to meet solvency objectives?" he added.

Dwight Foster, principal and national practice director for executive search at Peat Marwick Mitchell & Co. in New York, said insurers today require a "far more sophisticated business information flow." This requirement, in turn, means the companies must have "much stronger" financial planning, he said, noting that financial executives are claiming a bigger role in plotting strategy.

Many insurers, particularly life companies, are converting from mutual to stock ownership, which requires "strengthened financial organizations," he added.

The chief financial officer today "has got to assume the role of a general manager," said Victor Caleo, president of Michael Scott Consulting, a New York-based recruiting firm. "He's got to know how to generate creative financing. He's not the 'treasurer' anymore," he said, adding that an insurer CFO must "be global in his thinking."

LOMA's Mr. Forbes cited another major factor demanding a higher level of expertise: the decline in interest rates, which affects the companies' investment yields as well as the success of interest-sensitive insurance products.

Today, individual life insurance products are "more investment-oriented," noted Treacy Holmes, a consultant with Omnisearch, an executive recruiting firm in Fort Worth, Texas. Gone are the days when most life insurance beneficiaries simply received a set lump sum when someone died, she said.

As a result, insurers are looking for a wide range of financially oriented personnel, including people who worked for investment and accounting firms and those with master of business administration degrees, Ms. Holmes said.

Property/casualty insurers are placing a big effort on how to invest their funds to get the best return, added Rich Pescatore, superintendent of staffing and placement at USF&G Corp. in Baltimore, who agreed there is a "big push" for financially oriented personnel at most insurers.

Tonia Flightner, senior corporate recruiter at Lincoln National Corp. in Fort Wayne, Ind., said, "There is an increasing emphasis on the way this corporation invests its money, and there's an effort to beef up our investment staffing."

Particular emphasis, she said, is being given to recruiting for Lincoln National Investment Management Co., which manages the parent's investment operations.

USF&G's Mr. Pescatore noted another insurer concern is the new tax law. More emphasis is being placed today on recruiting people who understand how the tax laws operate and who can develop "innovative ways to meet the challenges they offer," he said.

Financial managers from outside the insurance industry bring new ideas and easily make the transition to working at an insurance company, say financial executives who have made such a move.

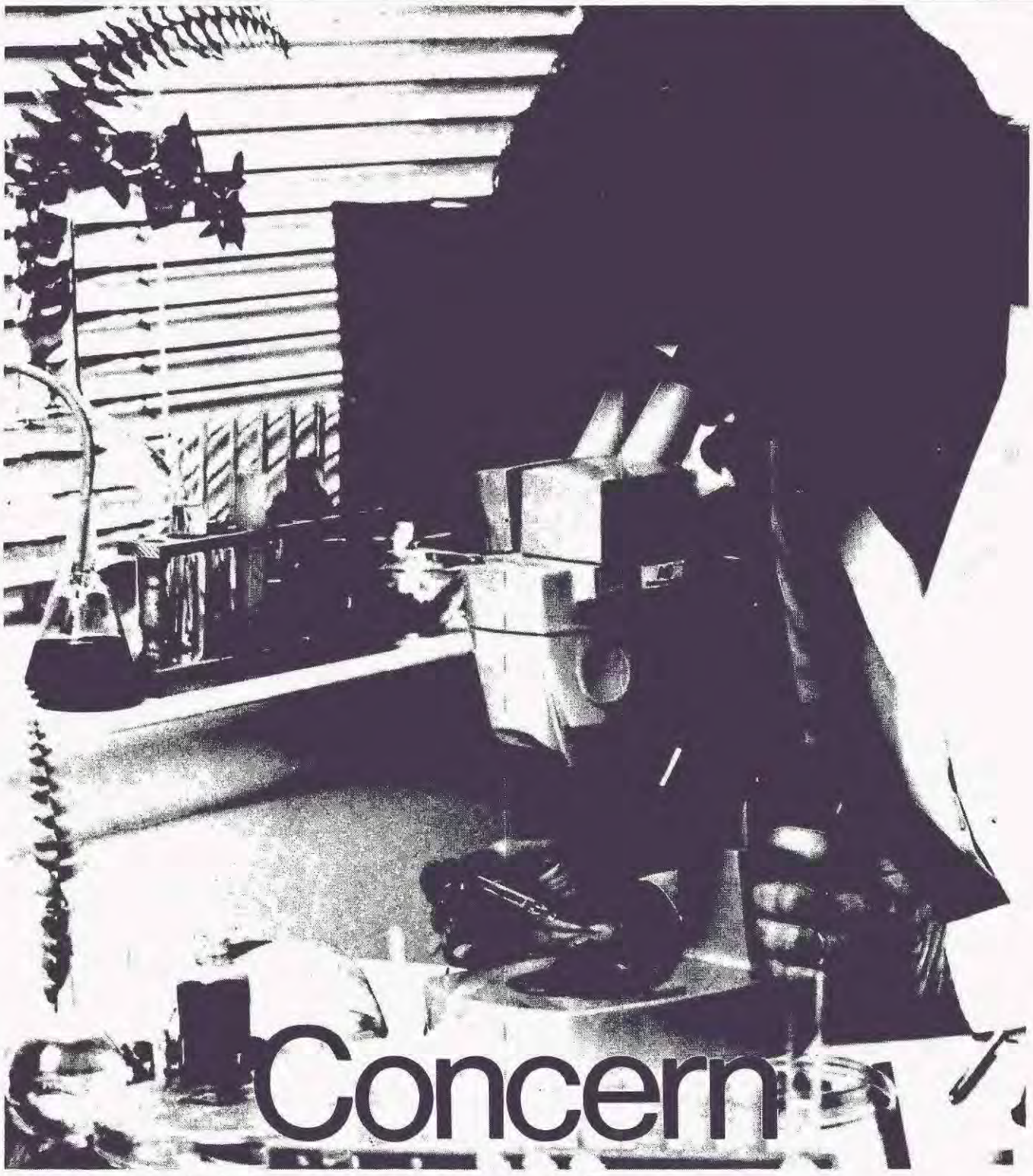
Frank Noonan, chief financial officer at UNUM Corp. in Portland, Maine, and former financial manager for General Electric Co.'s air conditioning unit, noted that when he joined UNUM, he brought with him experience in strict financial controls and how to integrate financial management with business operations.

One way in which this has manifested itself, he said, is in UNUM's adoption of "totally fresh ways of allocating capital to lines of business."

It was not difficult to make the change from a manufacturer to an insurance company, Mr. Noonan maintained. While the technical aspects of the accounting are different, "the business principles are basically the same."

Rather than shop for financial management only on the outside, Travelers Corp. is also training its own financial executives.

Continued on page 28H



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Financial talent search

Continued from page 28F

Travelers' Financial Management Development Program, which was begun last year, is designed to train executives with "the experience to be able to look at problems from a multiple perspective, both from the finance side and the business side," said Director Linda Garneau.

About half of the program's first group of 20 trainees were already Travelers employees, with the remainder recruited from elsewhere. The company is now recruiting its second group of 20.

All members of the program have a minimum of a bachelor's degree and already have successfully completed courses in financial accounting, managerial accounting and corporate finance, Ms. Garneau said. Many also have work experience.

The rigorous three-year program calls for completing four nine-month rotations in various Travelers departments, such as corporate finance, investments and systems. While they are working, they also must complete 39 weeks of academic work that consists of two hours classes and six to eight hours of homework per week.

Applicants are warned, Ms. Garneau said, that the program is "not for the faint-of-heart." ■

Insurers tap outside human resource help

Hiring people from outside the insurance industry for key business positions is forcing insurance companies to improve their human resource programs, insurers say.

And, often the companies are going outside the insurance business to find the human resource professionals they need.

Recruits from outside the industry often come from corporate cultures strikingly different from that of the traditional, conservative insurance business to help insurers deal with new, more complex, human resource programs and to integrate the different types of employees insurers are trying to attract.

Such is the case at Travelers Corp., where Hal Johnson, senior vp of personnel/administration, joined the company in June 1985 from Federated Department Stores Inc. In addition, Thomas Helfrich, vp of organization and management development, joined Travelers in May from General Electric Co., and Lynn Schenck, another former Federated official, joined the insurer as vp for executive compensation about three months ago.

At Continental Corp., Robert Cassidy, senior vp of human resources, came over from General Foods Corp. And, Kenneth Zeigler, vp for employee relations, joined the New York-based insurer from NL Industries Inc.

UNUM Corp., formerly Union Mutual Life Insurance Co., hired Sheila Hofmann, a private consultant, in October 1985 as second vp for compensation and benefits to develop stock option plans for executives.

Following the acquisition of securities brokerage Donaldson, Lufkin & Jenrette, Equitable Life Assurance Co. of the United States named Joseph Ratigan, the broker's chief personnel officer, senior vp of human resources.

In March, the Life Office Management Assn., an industry support group, will offer for the first time a seminar on incentive compensation for investment professionals, a sign both of the growing importance of financial specialties at insurers and the lack of experience in dealing with such employees.

Travelers is re-examining its job succession planning system, as well as taking a "broader approach" to the entire human resources function, Mr. Helfrich said. The personnel staff will examine not only such questions as "What is the shape of the pipeline?" and "Who are successors to X, Y and Z jobs?" but also will ponder such questions as "What are the human resource issues over the next few years?" and "Are we positioned to deliver our strategy?" he explained.



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business insurance

Good clerical help scarce, insurers find

Finding top talent isn't the only recruiting problem insurers have.

The growing shortage of competent clerical workers also is a top concern of insurers.

The Bureau of Labor Statistics predicted in November 1985 that a decrease in the size of the 16-to-24-year-old population over the next several years may mean increasing competition for a dwindling entry-level workforce, noted Thomas Helfrich, vp of personnel-administration for organization and management development at Travelers Corp. in Hartford, Conn.

The Bureau of Labor Statistics' study shows the size of the male labor force—including those working and those seeking employment—for the 16-to-24 age group will shrink 17.5% to 10.5 million in 1995 from 12.7 million in 1984.

The female 16-to-24 labor force will shrink 15% to 9.6 million in 1995 from 11.3 million, the BLS predicts.

UNUM Life Insurance Co. in Portland, Maine, "can't get enough people" at the clerical level, said Terry Cohen, vp of human resources. To rectify this problem, UNUM is looking at such means as forging better links to high schools and offering an educational reimbursement program.

"Will there be enough skilled clerical workers to fill the company's needs?" asks Patrick Hasson, a CIGNA Corp. assistant vp in charge of all recruitment for the insurer's Bloomfield, Conn., and Philadelphia offices. He said the shortage of clerical help is the personnel issue he is "most worried" about.

To compensate for the shortage of trained clerical recruits, CIGNA has increased its entry-level hiring in the last few years, he said. "Our policy is try to hire at the lowest level and promote."

However, Mr. Hasson says the caliber of available entry-level recruits coming out of high schools has fallen in the last few years, so CIGNA last year instituted a basic training program in which typing and computer skills are taught.

CIGNA also is hiring retirees, part-time workers and temporary help to fill in gaps in its clerical staff. It also offers flex time and job sharing to its employees to open more work options for clerical workers.

Travelers also has instituted a program in which it hires retirees on a temporary basis to supplement its insufficient clerical workforce, according to Donald DeWard, director of personnel administration. ■

Claims-made

Continued from page 1

To date, only a few of the nation's largest property/casualty insurers have implemented either the new ISO claims-made or occurrence CGL policy forms, even though most had expected to do so during 1986.

A *Business Insurance* survey of the largest property/casualty insurers reveals that most expect to have both new CGL policy forms in place by the end of this year, and many insurers plan to begin implementing the forms by midyear.

The insurers' latest projections are based in large measure on the fact that insurance regulators in 46 of the 52 U.S. jurisdictions have approved ISO's new claims-made CGL policy form, while 50 have approved the occurrence form (see story, page 30).

Many insurers delayed implementation of the new ISO general liability forms because state insurance regulators initially opposed the forms.

But that opposition now has largely subsided, mainly because of the numerous revisions that ISO made in the policy forms in an effort to appease regulators (*BI*, July 21, 1986; Jan. 20, 1986; Jan. 13, 1986).

Another delay in implementation was due to ISO's new rating rules, which change the way in which rates are calculated for various businesses. Under the new rules, rates for some types of businesses, such as manufacturers and contractors, may jump.

Many insurers waited to implement the CGL forms until October 1986, when ISO published transition rules it developed at the request of several insurers to phase in the new rating system.

And, insurers still are facing delays in implementing the forms because some states are moving slower than others in approving the forms.

For example, New Jersey, which has not approved either the new occurrence nor the claims-made form, is a particularly important state for insurers because many multistate corporations have home offices there, explained James A. Metz, vp-underwriting and production for Ohio Casualty Corp., based in Hamilton, Ohio.

"So that may delay us in states like Pennsylvania and Delaware, where there's a substantial amount of business in all three states written on the same policy," Mr. Metz said.

Still, insurers say they now must implement the new CGL policy forms because ISO's board of directors decided last year to withdraw support for the old occurrence CGL policy form beginning in July 1987.

'In the short term, we don't see as widespread a use of this form as we envisioned a year ago or we would like to see,' says Carl W. Meier, vp of commercial lines for New York-based Continental Corp., referring to the claims-made form.

"If a carrier wants to use ISO, they have to adopt the new format," observed Ed Mankowski, a vp with Alexander & Alexander Services Inc. of New York.

"I don't see how any company could function" without ISO support, Mr. Mankowski added.

While most primary liability insurers expect to begin using the new ISO CGL policy forms by the end of the year, they will put only the occurrence form into widespread use.

"In the short term, we don't see as widespread a use of this form as we envisioned a year ago or we would like to see," said Carl W. Meier, vp of commercial lines for New York-based Continental Corp., referring to the claims-made form.

"It's now a question of whether or not we are able to put some of the business on claims-made," he added.

Insurers' current intentions concerning the ISO forms are a complete turnaround from 1984, when ISO first filed the claims-made CGL policy form with state regulators.

At that time, risk managers and brokers feared the more restrictive claims-made form would virtually supplant the older occurrence CGL policy.

That fear appeared justified as many major property/casualty insurers said that large losses from coverage written on occurrence CGL forms and pressure from reinsurers would force them to use the new claims-made CGL form. They said that the claims-made form probably would become the policy of choice for most insurers (*BI*, Oct. 29, 1984).

Now, however, the situation is radically different.

Insurers that switched to wholesale use of the claims-made form early last year found that other insurers were not following suit, and many policyholders forced to accept claims-made coverage by their current insurers found occurrence-based coverage with new markets (*BI*, Aug. 11, 1986).

Meanwhile, reinsurers decided they could insulate themselves from long-tail exposures on general liability business by inserting sunset clauses in treaties with ceding insurers.

Such clauses, which insurers say are now in widespread use, cut off reinsurance coverage for occurrence-based liability policies five years after the policy expires (*BI*, Jan. 5).

As a result, many reinsurers have backed away from their insistence that insurers write only claims-made CGL policies, according to insurers.

Of the 19 property/casualty insurers contacted by *Business Insurance*, six said they already have begun implementing the new ISO policy forms. Those insurance companies are CIGNA Corp.; Continental; Fireman's Fund Insurance Cos.; Ohio Casualty; SAFECO Corp.; and St. Paul Fire & Marine Insurance Co.

In addition, USF&G plans to begin using the new policy forms in April.

And, eight insurers—Aetna Life & Casualty Co.; CNA Financial Corp.; Hartford Insurance Group; Kemper; Liberty Mutual; Reliance Group; Royal Group and Sentry

Continued on next page

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Claims-made

Continued from previous page

Insurance Group—said they will have the new policies in place by midyear.

Chubb Corp. implemented ISO's claims-made form on a limited basis about a year ago, but it has not determined when it will implement the new occurrence form, according to a spokeswoman.

Three insurers—American International Group Inc., Crum & Forster and Travelers Corp.—did not respond to questions from *Business Insurance* regarding their timetable for implementing the new ISO commercial general liability policy forms, but brokers say they expect most insurers, including AIG, Crum & Forster and Travelers, to begin using the new forms by July.

Following are synopses of individual insurers' plans concerning the ISO—and in some cases the insurer's own—claims-made and occurrence forms:

Aetna Life & Casualty

Hartford, Conn.-based Aetna Life & Casualty Co. plans to begin fully implementing the ISO CGL policy form in July, a year later than its original target date.

Aetna has used the claims-made policy form for selected risks on a limited basis, but the insurer plans to write most of its business on the new occurrence form, according to a spokesman. The insurer began using the claims-made CGL form primarily in early 1986 for risks with long-tail exposures, such as drug and chemical manufacturers.

"Aetna is a conservative underwriter and tends to do business with insureds that can be written successfully on an occurrence form, and for most of our book of business this remains the form of choice," the spokesman explained.

Chubb

Chubb Corp. attempted to implement the new ISO claims-made CGL policy form in early 1986, but "the market did not respond," according to a spokeswoman.

Currently, the Short Hills, N.J.-based insurer is using the new claims-made form on a selective basis, the spokeswoman says.

"We don't write much of the kind of business that would require" claims-made coverage, she noted.

The spokeswoman did not know when the insurer plans to begin using the new ISO occurrence policy form.

CIGNA

CIGNA Corp., one of the first insurers to begin using the new CGL policy forms, began implementing the new forms on a manual basis in January 1986 for selected risks with long-tail exposures. The Philadelphia-based company expects to fully implement both new CGL policy forms using its computerized rating system by September, according to a CIGNA spokesman.

However, CIGNA expects only a slight increase in the number of claims-made policies when it moves from the manual to computerized system. A CIGNA spokesman says claims-made policies will likely account for only 1% to 2% of the insurer's premium volume.

"At this point, the plan is not to substantially change the percentage of claims made vs. occurrence policies," the spokesman explained.

CIGNA has identified a number of classes of business that it will write on only a claims-made basis. These include aircraft and aircraft parts manufacturers; oil and gas extraction companies; chemical manufacturers; power plants; and manufacturers of engines and turbines, construction and mining machinery, and metal working machinery. The spokesman said CIGNA will write such risks only on a claims-made basis, even if it means losing the business.

CGL timetable

Insurer	Implementation date
Aetna	July 1987
AIG	July 1987[3]
CIGNA	January 1986[1]
CNA	July 1986[2]
Chubb	January 1986[4]
Continental	October 1986[1]
Crum & Forster	July 1987[3]
Fireman's Fund	February 1986[1]
Hartford	July 1987
Kemper	July 1987
Liberty Mutual	July 1987[2]
Ohio Casualty	September 1986[1]
Reliance	June 1987[2]
Royal	July 1987
SAFECO	January 1987
Sentry	July 1986
St. Paul	January 1987[5]
Travelers	July 1987[3]
USF&G	April 1987

[1] Limited use initially, scheduled for full implementation later this year.
[2] Using own policy forms.
[3] According to brokers.
[4] Implementation of occurrence form undetermined.
[5] Began limited use in early 1986.

Source: *BI* survey. Chart: Amy Palmer

CNA

CNA Financial Corp. in Chicago plans to fully implement its own new claims-made and occurrence CGL policy forms by July, according to a company spokeswoman. The insurer began using these new forms in January.

While the insurer will make both the claims-made and occurrence policy forms available, CNA expects to use the claims-made form only occasionally.

"CNA favors occurrence coverage and sells very little claims-made coverage," because most of the business CNA writes is "suitable to occurrence" coverage, the spokeswoman noted.

Unlike most insurers, CNA has not established a list of business classes that it prefers to write on a claims-made basis. Instead, it evaluates each risk on an individual basis, the spokeswoman explained.

Despite implementing its own policy forms, CNA supports the new ISO CGL policy forms, the spokeswoman noted. "We believe it is important for us and the other carriers to use the ISO forms as the industry standard," she said.

However, CNA expects considerable litigation over the claims-made policy form because of the tendency of U.S. courts to "reinterpret policy language and insurer intent," she noted.

Continental

Continental Corp. began phasing in the new ISO policy forms in October and is continuing this process in to 1987, Mr. Meier explained.

Mr. Meier said the insurer is currently in a transition phase. While most of its business is still on the old occurrence form, "we don't envision that we'll stay with the old occurrence form for very long," he explained.

Mr. Meier noted that Continental last year did switch some of its larger policyholders over to claims-made coverage on manuscript policies, which must be approved by regulators in the state in which policyholder has its home office.

But, like most insurers, Continental plans only very restricted use of the claims-made CGL policy form, Mr. Meier said.

"We are putting some business on claims-made, but not an awful lot of it," he said.

Fireman's Fund

Fireman's Fund Insurance Cos. in Novato, Calif., was one of the first insurers to begin using both the new ISO occurrence and claims-made CGL forms on a broad basis.

Fireman's Fund began using the new forms in February 1986 and expanded its use of the forms as states approved them.

'In the states where we've implemented the new forms, we're not hurting,' says Ms. Wheeler of Fireman's Fund.

The insurer now is using the new forms in 26 states, according to Mary Beth Wheeler, assistant vp-commercial insurance.

Ms. Wheeler said Fireman's Fund expects by July to be using the new forms in all states in which they are approved.

The insurer finished its formal training program for underwriting, marketing and claims staff last year, according to Ms. Wheeler.

Initially, Fireman's Fund had planned to use the claims-made form on a wider basis, but continuing objections from buyers and agents and brokers—as well as the lack of support from other insurers—forced Fireman's Fund to reverse that decision. The insurer now plans to use the claims-made form only for a limited number of classes of business.

"We have a revised authorities guide in our field offices that specifies the classes for which we will use claims-made, but it gives the underwriter a significant amount of leeway on an individual risk basis to make a choice as to whether the claims-made or occurrence contract will be used," Ms. Wheeler explained.

"We're telling the underwriter to look for risks that have inherent cumulative trauma and late claim development characteristics. Those are the kinds of risks that we would like to have on claims-made," she pointed out.

Ms. Wheeler noted that Fireman's Fund was one of the largest, if not the largest, insurer to attempt a broad implementation of the claims-made policy form.

"We sort of stuck our nose out there, and we've learned our lesson through the school of hard knocks."

Fireman's Fund slowed its implementation of the new forms last year, hoping other insurers would join in and begin using the new policy forms, she explained.

Ms. Wheeler said that because Fireman's Fund was one of only two or three insurers that began using the new forms in early 1986, the insurer lost some business, although Fireman's Fund suffered no significant damage to its business.

"In the states where we've implemented the new forms, we're not hurting," Ms. Wheeler said.

"We can point to specific accounts that we have lost because of a resistance on the part of the insured or the agent to go with a new CGL policy, but we're not seeing a reduction in our business flow because of the fact that we have implemented the new CGL."

Ms. Wheeler said Fireman's Fund is particularly proud of its new automated aggregate tracking system, which aids the insurer by keeping tabs on a policyholder's paid losses, loss reserves and policy aggregate balance.

Hartford

Hartford Insurance Group in Hartford, Conn., attempted to implement its own claims-made CGL policy form in early 1986 but "couldn't find any buyers," noted John F. Donahue, vp of commercial lines.

Mr. Donahue explained that concerns about claims-made coverage voiced by brokers and buyer groups and the fact the occurrence form was readily available in the market made it impossible to place all but the most obvious high-hazard risks on the claims-made form.

Because the insurance industry is so competitive, no one company has the ability to force a large percentage of policyholders to buy coverage on a claims-made basis, according to Mr. Donahue.

Hartford will begin implementing ISO's new CGL policy forms in July. However, the occurrence-based form will be used for most of the insurer's business, Mr. Donahue pointed out.

Only a limited number of very large companies with long-tail exposures, such as product liability, will be written on a claims-made basis, he said.

Hartford is now testing new computer programs designed to automate the rating processing of policies written on the new ISO forms. The insurer also is finishing training its employees to use the new forms.

Kemper

Kemper Corp. expects to begin broad implementation of the new ISO policy forms about mid-1987, according to Mr. Bowdish.

Kemper is awaiting the completion of modifications to its computer system before switching over to the new CGL policy forms, he said.

Kemper had hoped to begin using the new policy forms in July 1986, but changes to its computer system were not completed in time.

Mr. Bowdish noted that Kemper executives are in the process of developing underwriters' guidelines for use of the claims-made form.

However, he pointed out that the claims-made policy will be used only for a limited number of business classes.

And, he added that Kemper expects to write only about 5% of its business on a claims-made basis.

Mr. Bowdish noted that Kemper does not normally write the kinds of long-tail risks

Continued on next page

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46 states OK claims-made

NEW YORK—The Insurance Services Office's claims-made commercial general liability policy form has been approved for use in 46 states and territories, while the new occurrence form has been approved in 50 states and territories, according to a spokeswoman for the insurer trade group.

Two states—New Jersey and Massachusetts—have yet to approve either form.

ISO currently has ongoing discussions with all the states that have not approved one or both of the forms, an ISO spokeswoman said.

The new claims-made CGL policy form has been approved in Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan and Minnesota.

Also, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

The occurrence policy form has been approved in all of the jurisdictions that have approved the claims-made form, plus Nebraska, New York, Texas and Vermont. ■

Continued from previous page
that he said should be written only on a claims-made basis. "When we do write that type of risk, it will likely be in order to provide a market to accommodate a producer," he added.

Liberty Mutual

Liberty Mutual Insurance Co. currently plans to begin using the new ISO occurrence CGL policy form in July. The insurer also has its own claims-made CGL policy form, but plans to use it only on a very limited basis, also beginning in July.

"In most instances, we will be using the new occurrence policy," Mr. Purkis said.

Mr. Purkis said the insurer has delayed implementation of the new occurrence form because of delays in regulatory approval of the ISO form.

"We're going to have a problem in those states that haven't approved the new occurrence policy, because we'll probably have to use the old form where you have a multistate structure, although we haven't completely faced up to that problem.

"That's part of the reason we keep putting (implementation of the new forms) off," Mr. Purkis explained.

Liberty Mutual has filed its claims-made policy with state regulators only on an individual risk basis, he noted.

'In most instances, we will be using the new occurrence policy,' says Mr. Purkis.

"It has come up in several instances where a large policyholder wanted (a claims-made policy) to fit into their own excess structure," Mr. Purkis said. "There is some uncertainty on everybody's part as to what the hell you've got if you write occurrence underlaying and claims-made above," he added.

Liberty Mutual does have a list of business classes that they will write only on a claims-made basis, such as drug and chemical manufacturers, Mr. Purkis said. But such businesses account for only a small part of the insurer's premium volume, he added.

Liberty Mutual had hoped to put the new forms in place March 1, 1986, but moved back the date because of slow regulatory approval of the new policy forms.

However, Mr. Purkis is more confident the insurer will meet its new implementation date of July, partly because ISO plans to withdraw support for the old CGL policy form and because Mr. Purkis does not expect many more states to approve the new forms, he explained.

"For those two reasons, my recommendation to my top management would be that we continue and take this data, where in the past I have tended to make the recommendations that have put it off."

Ohio Casualty

Ohio Casualty Corp. began implementing the new CGL policy forms Sept. 1 in Midwestern states that have approved the new forms. In January, the insurer also began implementation of the forms in California, Arizona, Washington and Oregon.

And, Ohio Casualty expects to implement the forms in the remainder of the states by the end of the year.

But, Mr. Metz said he does not expect the insurer to use the claims-made form to any great extent.

"We feel the type of risks that we write, which are the smaller- to medium-size mercantile, contractors and manufacturing-type risks, don't have the exposure that warrants a claims-made policy," Mr. Metz said.

"So we have basically gone with the new ISO occurrence form just about everywhere we've implemented it so far," he added.

The decision of whether to write a risk on a claims-made basis will be made by the insurer's home office, not by the branch offices, Mr. Metz noted.

Mr. Metz, like executives for many insurers, said the lack of approval of the new forms in several key states will continue to delay the insurer's implementation of ISO's new CGL forms.

He said it has taken "a great deal of work and a lot of time and money" to implement the new CGL policy forms.

"We hope to have it done by the end of '87," but we're not promising anything."

Ohio Casualty has modified its entire branch automation system to accommodate the new policy forms, Mr. Metz noted.

Reliance Group

Reliance Insurance Group in Philadelphia will begin implementing its own new claims-made and occurrence CGL policy forms in June, according to David F. Bell, vp-product management.

Mr. Bell said Reliance's forms contain policy language almost identical to ISO's, but the policy is organized in a package format. This package policy includes liability, property and some marine

Continued on next page

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Claims-made

Continued from previous page
coverages, he explained.

"It's something we hope will be a little more recognizable and a little less threatening" to agents and buyers," Mr. Bell added.

State approval of Reliance's forms generally has tracked that of the ISO forms, which in large measure is the reason the insurer has been delayed in implementing its own new policy forms, Mr. Bell said.

But, now that the approval process is nearly complete, the insurer will begin using its new forms, Mr. Bell noted.

"We're taking the approach that the approvals are coming through —maybe not as fast as we'd like— but there's no reason not to go ahead and plan on implementing," he concludes.

Reliance sees "very, very limited application" of the claims-made form, "which is the position we've had all along," according to Mr. Bell.

For the most part, Reliance does not even write the types of business that should be written on a claims-made basis, such as high-hazard or jumbo accounts, Mr. Bell explained.

"There are some people for which claims-made is appropriate —generally, it's the more sophisticated insured," Mr. Bell said.

Reliance has completed training its underwriters to use both new forms and modifying its computer system to process the forms.

Royal Group

Royal Insurance Group in New York plans to begin using the new ISO commercial general liability policy forms in July. The insurer pushed back its planned implementation date from January to July because of the changes ISO made to the new forms, according to Eugene V. Farrell, secretary and general liability product manager for Royal.

'We get very little, if any, need or call for the use of the claims-made form—although we're ready, willing and able to write business on a claims-made basis,' says Dale Lauer, home office casualty manager for SAFECO.

Because of market conditions, Royal will write most general liability business on the occurrence form, Mr. Farrell said.

"Our position is that we support claims-made but recognized that the market is not ready to accept it at this time," Mr. Farrell explained.

"We always expected we would continue to use the occurrence form, but we had hoped for a broader application of claims-made," he added.

Mr. Farrell noted that Royal will insist on using a claims-made policy form for high-hazard, long-tail risks, mainly manufacturing or heavy contractors.

"We would take a firm stand on these," he said.

SAFECO

Seattle-based SAFECO Corp. began on Jan. 1 full-scale use of the new CGL policy forms in the states in which they were approved, keeping to its original deadline for implementing the new forms, explained Dale Lauer, home office casualty manager.

"We're on-line using it, and this is our second month doing so," he said.

Most of SAFECO's general liability business will be written on the new ISO occurrence policy form, according to Mr. Lauer.

"We get very little, if any, need or call for the use of the claims-made form—although we're ready, willing and able to write business on a claims-made basis," Mr. Lauer noted.

"We do write a fair amount of industrial-type risks, but the type that we write we haven't seen the need to go claims-made," he explained.

He added that SAFECO's regional casualty managers determine whether a risk should be written on a claims-made basis.

"We really do it on an individual risk basis, and we look at what the long-tail liability exposure is and how well can you predict losses," Mr. Lauer explained.

Like most of the major property/casualty insurers implementing the new CGL policy forms, SAFECO has totally updated its computer systems in order to handle the new forms.

St. Paul Fire & Marine

St. Paul Fire & Marine Insurance Co. in St. Paul, Minn., attempted to implement its own new claims-made and occurrence policy forms in early 1986, but found that the new ISO rating structure, on which the forms are based, was causing significant price increases for many businesses.

The insurer "put the brakes" on implementation of its new forms until October 1986, when ISO filed the transition rules designed to phase in its new rating system, according to Fred P. Themmes, senior underwriting officer for St. Paul.

Mr. Themmes said St. Paul in January continued to implement its new CGL policy forms in the states where they were approved. He expects the new forms to be fully implemented in the states where they are approved by April or May.

St. Paul's occurrence form is approved in all but seven states, while the insurer's claims-made form has been given the nod in all but 12 states. The latter figure will likely drop to six to seven within the next two months, Mr. Themmes predicted.

St. Paul has backed off its original plan for widespread use of its claims-made CGL policy form, but the insurer still thinks this form is necessary for some risks, according to Mr. Themmes.

"We still think the claims-made form has a place, and where it can be sold we will sell it. But we are not going to chase business away to other companies because we will write it only on claims-made form," Mr. Themmes explained.

"We are going to do what I would call individual risk underwriting," he said.

"If we envision a latent injury exposure potential, then we would try to use the claims-made policy form."

However, there are some risks that St. Paul will write only on a claims-made basis—even if it means losing the business, Mr. Themmes noted. However, before the claims-made form was available, St. Paul was not a market for those risks, he pointed out.

As an example, he cited governmental entities that own or have owned sanitary landfill facilities and chemical manufacturing facilities.

Unlike ISO's claims-made policy form, which is triggered when a claim is reported—verbally or in writing—against the policyholder, the St. Paul form is triggered when an accident is reported.

With that exception, the two forms are very similar, Mr. Themmes said.

Sentry Insurance Group

Sentry Insurance Group in Stevens Point, Wis., began using the new ISO CGL policy forms in July 1986 and has continued to expand its use of the forms as states have approved them.

As one of the first insurers to implement the new forms, Sentry ran into several problems, including rating problems caused by ISO's new rating system, explained Ed Severson, casualty underwriting superintendent for Sentry.

"We realize we are ahead of the industry with it, but we are working out bugs as we roll along," he said.

Sentry plans to make only occasional use of the claims-made policy form, according to Mr. Severson.

"We prefer to market the occurrence form. We feel comfortable with it," he said.

Mr. Severson noted that the occurrence form is acceptable for 90% to 95% of the business Sentry writes. He also said Sentry never intended to use the claims-made form on a broad basis.

USF&G

United States Fidelity & Guaranty Co. plans to implement in April ISO's new CGL policy forms in states in which they have been approved in April, according to Mr. Flint.

Like several other insurers, USF&G delayed implementing the new CGL forms because of the long delay in gaining state regulatory approval, Mr. Flint said.

The insurer has backed off from its original plan to switch many existing occurrence policies over to the claims-made policy form, Mr. Flint noted.

He cited the change in the reinsurance market's position on the claims-made policy and general softening market conditions as the reasons for the company's new position.

Mr. Flint said USF&G will be using the claims-made policy form "on a definitive, rather than broad-brush, basis," meaning that only a small number of business classes will be offered solely claims-made coverage. Those classes include most contractors and manufacturers, he said.

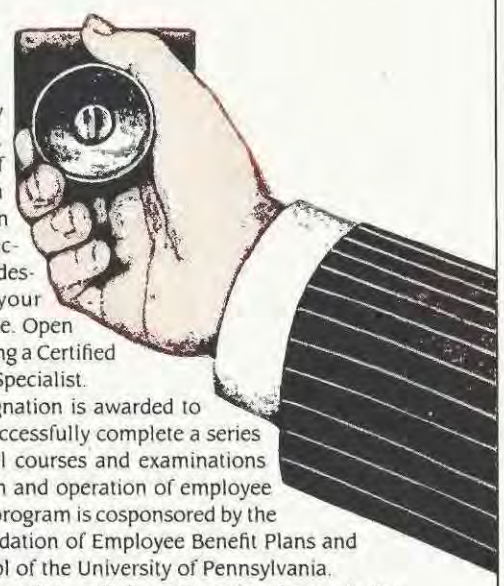
For businesses that have operations in any of these classes, USF&G will write coverage for the entire company on a claims-made basis, Mr. Flint noted.

"We have taken the position that while we have addressed it on an individual classification basis, if we have a multiclassification risk which performs operations described by what could be referred to as a claims-made classification, then the risk in its entirety has to be looked at as essentially a risk that we would prefer on a claims-made basis," he explained.

However, Mr. Flint pointed out that this is not an iron-clad rule.

"There may be a situation where we would reconsider the claims-made position on an individual risk," Mr. Flint noted. "Particularly on a multiclass risk—if it's a big account and we could negotiate some reasonable safety factors that are acceptable to both sides," he added. ■

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CEBS

Bridge design dispute

Continued from page 3

Mr. Brown initially worked on the bridge's design when the firm won the contract. However, he resigned from the company in October 1985 and was subsequently appointed by the Turkish highway authority, the bridge's owner, to be engineer-on-site, Freeman Fox confirmed.

Freeman Fox still has "a contractual relationship with (the Turkish highway authority) on the peripheral roadway and our staff are still on site, but Mr. Brown has assumed full responsibility for construction of the bridge," said the Freeman Fox spokesman.

The reason the engineers were taken off the project is unclear; the Turkish General Directorate of Highways did not return phone calls.

Since the Freeman Fox engineers' dismissal, reports in Turkey say minor design changes have been made to complete the bridge by the spring of 1988 instead of October that year as originally planned. Those changes include reducing the thickness of some steel plates in the towers, slimming down the towers of the suspension bridge, and changing the mixture of cement.

In December, the wall in the excavation hole—dug to house the bridge's supporting towers—collapsed, demolishing the external staircase of a house near the site, confirmed the Freeman Fox spokesman.

Insurers for the consortium of contractors constructing the bridge will not say whether claims have been filed on their construction insurance policy.

The bridge—being built by Japanese, Italian and Turkish contractors led by the Japanese contractor Ishikawajima-Harima Heavy Industries Co. Ltd.—is insured for $200 million. The coverage is led by Taisho Marine & Fire Insurance Co. of Tokyo, a Taisho spokesman in London confirmed.

The Japanese Engineering Pool also participates on the risk, which is partially reinsured by Munich Reinsurance Co. in Germany, a spokesman from Taisho confirmed. Part of the risk was retroceded to the local Turkish market, sources say.

Taisho also insures the construction of the rest of the new highway around Istanbul for another $100 million, the Taisho spokesman said.

One London broker who quoted for the risk said the consortium also has contractors all-risks third-party liability insurance with limits of about $10 million.

The new bridge is located about three miles north of the first Bosporus Bridge, also designed by Freeman Fox. "We won the contract for the design of the second bridge against considerable competition from leading U.S. firms, because of the success of the first Bosporus Bridge," said the Freeman Fox spokesman.

The first Bosporus Bridge, which when it opened in October 1973 had the fourth-largest span in the world, was designed to carry up to 80,000 vehicles a day. It is making a profit, having repaid its construction costs with tolls in less than four years. Its daily crossings exceed 115,000 cars, which is why a second bridge is needed, said the Freeman Fox spokesman.

The new Bosporus Bridge will be 53 feet longer than the first crossing, making it the fifth-longest span in the world, according to Freeman Fox.

The only longer spans now are the Humber Bridge in the United Kingdom, also designed by Freeman Fox, which has a span of 4,626 feet; the Verrazano-Narrows Bridge in New York, 4,260 feet; the Golden Gate Bridge in San Francisco, 4,200 feet; and the Mackinac Bridge in Michigan, 3,800 feet, according to The World Almanac and Book of Facts.

Freeman Fox & Partners, the parent company of Freeman Fox Ltd., was formed in the middle of the last century. Other projects the firm has handled include the construction of the Sydney Harbour Bridge in Australia in the 1920s and more recently the Forth Road Bridge in Scotland, the Severn Bridge in the Western England and the Hong Kong Metro rail system. ■

Texas proposals

Continued from page 2

only for a percentage of damages proportional to its fault in personal injury and property damage cases.

Abolishing joint and several liability is "absolutely necessary," says Wayne Harwell, president of the Greater San Antonio Builders Assn.

In addition, Mr. Harwell is hoping a proposal to impose penalties for filing frivolous lawsuits will become law.

The committee suggests allowing courts to order payment of the defendant's expenses if a suit is found to be frivolous.

"If we can get those two through, I think this (legislative) session would be a great victory and we should all rejoice," said Mr. Harwell.

The joint committee also is recommending a $250,000 cap on non-economic damage awards. Currently, there is no statutory limit on non-economic damage awards.

The panel recommends that punitive damages should be awarded only if there is "clear and convincing evidence of fraud, malice, or total absence of care. . . ." In addition, punitive damages should be distributed 25% to the plaintiff, 25% to the plaintiff's attorney and 50% to the state's general revenue fund, according to the committee.

This recommendation is in line with those recently proposed by an American Bar Assn. commission that said that a certain portion of punitive damage awards should go toward "public purposes" rather than solely to the plaintiff and his attorney (*BI*, Jan. 19).

Any damages awarded in a civil suit should be reduced by the amount that a plaintiff receives from payment of "collateral benefits," like health insurance, the proposal states.

Other tort reform proposals by the committee include:

- Restricting the venue for filing lawsuits to the county where a plaintiff claims to have suffered damages. The restriction would prevent those filing lawsuits to take "unfair advantage" of juries in counties that have historically awarded unusually large awards, the committee says.
- Establishing a system of "comparative responsibility" so that damages can only be awarded if the percentage of responsibility attributed to the claimant is less than or equal to the combined percentage of responsibility assigned to all other persons involved.
- Structuring contingent fees in cases other than those related workers compensation or the Crime Victims Compensation Act.

The committee suggests plaintiffs' attorneys' fees be limited to 40% of the first $100,000 of an award, 33.3% of the next $200,000, 25% of the next $200,000 and 10% of any amount exceeding $500,000.

- Mandating structured settlements for awards exceeding $100,000.
- Prohibiting prejudgment interest on all damage awards.
- Exempting public officials and directors of charitable institutions from job-related liability except in cases of "intentional acts."
- Extending governmental immunity to persons under contract with the state Health Department.
- Restoring charitable immunity to corporations exempt under Sections 501(c)(3) or 501(c)(4) of the Internal Revenue Code.

Lefty Morris, an Austin attorney and spokesman for the Texas Trial Lawyers Assn., said his group is opposed to the committee's recommendations because there is no evidence the proposed changes will result in reduced insurance costs.

He said tort reform measures passed in Florida showed such laws don't lower insurance rates. The Florida Insurance Department approved 1987 rate hike requests averaging 6.2% filed by commercial insurers (*BI*, Dec. 15, 1986).

"So why pass laws that take away people's rights?" Mr. Morris asked. "When you put unjustified caps on what juries can deliberate and decide is just, you've got impaired rights."

A minority committee report written by Sen. Kent Caperton, D-College Station, recommends no changes be made to the civil justice system except for allowing penalties against those who file frivolous suits or "otherwise use the courts in a frivolous way," said Geri Elliott, who provided special counsel to the committee.

Ms. Elliott said the minority report agrees with most of the insurance and medical profession reforms suggested in the joint committee's report.

The committee's insurance reform proposals are similar to reforms recently adopted by other states.

For example, under the proposals, insurers doing business in Texas would be subjected to increased disclosure of financial data, including information on claims and reserves.

The information would be filed at the time insurers submit annual reports with the State Board of Insurance, and the committee suggests all information except "raw data submitted. . .for closed-claims purposes" be made available to the public.

Rates charged for commercial, professional and governmental liability insurance would be reviewed annually by the state board, which would be able to make "any necessary adjustments in premiums," the committee recommends. Any information filed to the board to support rate filings for the coverages would be made public, according to the recommendations.

Board-approved rates should be based on "available and credible Texas data," the committee recommends, rather than on a combination of state and nationwide data as they are now.

Insurers that write liability insurance would be allowed to cancel the coverage for any reason during the first 60 days of a new policy, under the committee's proposals.

However, midterm cancellations would be allowed only in cases of fraud, non-payment of premium or a change in risk. And insurers would be required to provide written notice at least 60 days before cancellation or non-renewal on midterm cancellation.

The committee also suggests public hearings on any policy form changes considered by the board.

In addition, the committee says in its report that insurers writing liability coverage "should be required to provide on request to insureds and potential insureds accident prevention services."

The proposals also call for measures aimed increasing reinsurance capacity.

One recommendation suggests life insurers be authorized to write reinsurance for professional, commercial and governmental liability risks, and another proposes creation of an exchange-type facility to write reinsurance.

Rep. Mike Toomey, R-Houston, co-chairman of the committee and sponsor of seven bills introduced last week, said the framework of such an exchange is addressed in a "shell bill," but details on exactly what coverages the facility would write or how it would operate have not been worked out.

Other insurance reform proposals in the committee's report include:

- Increased regulation of surplus lines insurers (*BI*, Jan. 26). The committee suggests higher minimum surplus and capital requirements and other regulatory changes.
- Creation of self-insurance pools for public entity excess liability risks.
- Formation of a joint underwriting association for non-profit organizations formed under sections 501(c)(3) and 501(c)(4) of the Internal Revenue Code.

Rep. Toomey said feedback from insurers on the tort reform and insurance proposals has been quiet.

"They have been fairly quiet so far," said Mr. Toomey. "I think they realize they are the brunt of a lot of criticism."

Mr. Toomey said insurers also realize "there is going to be significant insurance reform. They realize it is going to happen and there is not a whole heck of a lot they can do about it. They're not fighting it, either."

A spokeswoman for the Alliance of American Insurers in Austin said the group hasn't had the opportunity to thoroughly review the committee's report and "we don't know yet which sections we will support and which we will not."

The proposals also would directly affect some risk management professionals in Texas.

The committee recommends that risk managers who provide loss control services as outside vendors be certified by the State Board of Insurance. A spokeswoman for the joint committee said the certification would be similar to the way insurance agents are licensed in the state. ■

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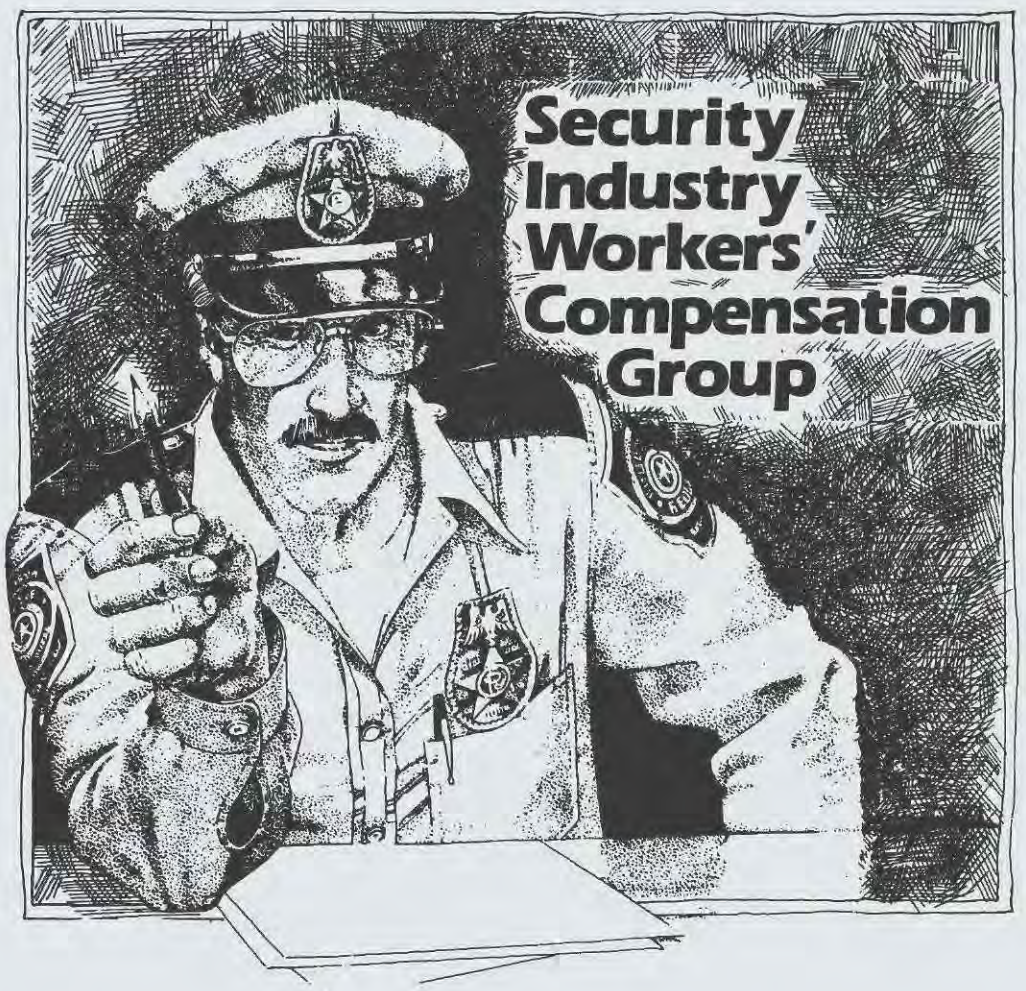
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Many events lead to MIC's demise

Nov. 17, 1983: After 20 years as Mission Insurance Group Inc. president and chief executive officer, E. Richard DeRosa, 59, officially retires, although he has not directed the company since August. He sells his Mission stock but continues as a director of MIG.

Executive Vp and Chief Operating Officer Louis F. Marioni, 55, formally steps in as MIG president and chief executive officer after a six-month search for candidates.

December 1983: MIG posts a $15.4 million net loss—its first in 19 years. Its year-end combined ratio hits 124.7%

March 1984: Moody's Investors Service Inc. lowers its rating to Baa-3 from A-3 on about $75 million of outstanding MIG senior debt.

June 14, 1984: Ray D. Johnson Jr. comes aboard as president of Mission Insurance Co. His most recent experience was at two affiliates of American Financial Corp., MIG's largest shareholder.

After eight years, Stanley Braun leaves his post as president of MIC to become executive vp at Fairmont Insurance Co. in Burbank, Calif.

July 1, 1984: MIC's policyholder surplus drops 34.8% in the first half of the year to $192.2 million from $249.9 million.

August 1984: A.M. Best Co. drops its rating to an A from A-plus on MIC and other MIG units.

Moody's again reduces its rating, this time to a single B-1 from Baa-3, on $75 million of MIG senior debt.

Nov. 16, 1984: Mr. Johnson is elected chief operating officer of MIG and continues to serve as MIC president.

Dec. 31, 1984: MIG adds $188 million to reserves in 1984, $70 million of which was added in the fourth quarter, and suffers a $198.1 million net loss for the year.

Jan. 1, 1985: Mission Reinsurance Corp., a New York-based MIC unit, stops writing new and renewal treaty and facultative business and begins canceling facultative business.

Feb. 1985: Mission retains Solomon Bros. Inc. to secure $75 million in additional capital.

Feb. 14, 1985: Mr. Marioni, a 23-year MIG veteran, resigns as president and CEO of MIG and is replaced by Mr. Johnson.

Feb. 21, 1985: Reinsurers sue MIC in U.S. District Court for the Southern District of New York, citing MIC's role in a reinsurance pool managed by an affiliate, Pacific Reinsurance Management Corp. Pacific and MIG are also named. Plaintiff reinsurers seek recision of contracts written by MIC that they reinsured.

March 8, 1985: To allay concern over financial and management turmoil at Mission, Mr. Johnson sends state insurance commissioners a three-page letter, assuring them that MIG will "take every action necessary" to put it back into "a solid financial operating position."

March 11, 1985: MIG announces that its principal shareholder, AFC, will boost MIG's surplus by $75 million from an estimated $43 million.

AFC is widely criticized for the complicated transaction, which called for the abrupt dissolution of another AFC subsidiary, Transport Indemnity Co. AFC is given the right to increase its stake in Mission to 91.3% from 49.9%.

Mr. DeRosa resigns as an MIG director.

March 25, 1985: The California Insurance Department begins its routine triennial examination of MIC several months early.

March 26, 1985: Accountants Coopers & Lybrand qualify MIG's 1984 financial statements pending the outcome of the Feb. 21 lawsuit and of a similar one filed Feb. 18 that names Pacific and MIG.

March 27, 1985: AFC and 10 MIG directors and officers are sued by a Mission shareholder in Los Angeles Superior Court over the handling of the previously announced capital infusion.

March 31, 1985: Michael A. Mulholland resigns as MIG's chief financial officer.

May 20, 1985: To dissuade other participants in Pacific's reinsurance pool from joining the Feb. 21 suit, which purports to be a class action, MIG temporarily relieves 18 non-U.S. companies of their responsibility to pay reinsurance claims pending the outcome of an independent audit of Pacific.

May 23, 1985: Policyholders sue AFC's Transport Indemnity Co. over sweeping coverage cancellations that result from AFC's attempts to bail out MIG.

June 17, 1985: MIC wins a round in its reinsurance battles when a U.S. District Court orders arbitration of the disputes stemming from Pacific's pool.

June 20, 1985: AFC's Carl H. Lindner, 65, is elected chairman of MIG at the group's annual shareholders meeting in Cincinnati, the first time the meeting is not held in Los Angeles. Four longtime directors resign.

William R. Story assumes the position of MIC president, replacing Mr. Johnson. The power shift is first revealed in MIC's second-quarter 1985 financial statement.

June 28, 1985: Best reduces the rating of MIC and all other MIG insurers to "omitted."

July 1, 1985: MIG reopens the doors of Transport Indemnity, christening the facility Mission American Insurance Co. Mission American is now the group's chief risk-bearer with $62.5 million in surplus.

Aug. 9, 1985: MIC steps up efforts to collect outstanding reinsurance and asks the U.S. District Court in Chicago to hold Borg-Warner Corp. liable for $50 million in current and projected obligations of its Centaur Insurance Co. subsidiary.

Aug. 14, 1985: AFC agrees to commit an additional $40 million to surplus of MIG before the end of the third quarter.

Sept. 11, 1985: MIC estimates it has paid out $28 million in claims since June on behalf of the 26 reinsurers now reviewing the books of Pacific's pool.

Oct. 7, 1985: Mission American writes its first policy, an umbrella policy for a California risk.

Oct. 31, 1985: Declaring MIC insolvent by $169 million as of Aug. 3, the California Insurance Department takes control of the insurer.

Nov. 1, 1985: Moody's further reduces its rating on MIC debt to Caa from single B-1.

Nov. 3, 1985: Walter Wally, an agent of the California Insurance Department, is dispatched to work at MIG during its conservation. He has served as on-site manager ever since, monitoring expenses, receiving money and trying to conserve the company's assets.

Nov. 4, 1985: MIG's stock drops to an all-time low of $1.25 on the New York Stock Exchange.

Nov. 6, 1985: A federal judge in Chicago dismisses MIC's suit against Borg-Warner.

Nov. 7, 1985: The 2nd District Court of Appeals in Los Angeles rules MIC cannot cancel or decline to renew the liability policies of about 6,200 home day-care providers pending a trial. MIC claimed that keeping the California policies in force could be financially devastating because it had lost some of the program's reinsurance.

Nov. 12, 1985: Alaska National Insurance Co., an MIC reinsurance policyholder, sues in Alaska Superior Court to pierce MIC's corporate veil, holding Mr. Lindner personally responsible for MIC's debts.

Nov. 13, 1985: The Alaska court issues a restraining order preventing MIG companies and two AFC affiliates—Great American Insurance Co. and Great American Insurance Co. of Alaska—from taking any assets out of the state.

Nov. 25, 1985: MIG announces plans to reinsure all of MIC's non-reinsurance business into Mission American, which is to receive a $125 million capital infusion by selling preferred stock to AFC. The department agrees to the transfer.

Nov. 27, 1985: MIG announces plans to restructure its outstanding public debentures.

Dec. 6, 1985: Mr. Johnson, as president of Mission American, circulates a six-page letter written to California Insurance Commissioner Bruce Bunner, setting forth the terms of the insurance company reorganization.

Dec. 13, 1985: The New York Stock Exchange suspends trading of MIG stock.

December 1985: Best assigns an omitted rating to Integrity Insurance Co. partly because of $6 million in reinsurance recoverables from MIC.

Jan. 7, 1986: Several MIG bondholders, led by the M.J. Whitman & Co. Pension Plan, sue to force MIG into involuntary Chapter 11 bankruptcy in California after the company defaults on several bond payments.

Jan. 17, 1986: The bondholders ask the court to prevent MIG from making payments to other creditors and from transferring money to affiliates or other equity holders.

Feb. 5, 1986: On MIC's behalf, the California Insurance Department sues to recover reinsurance proceeds that Delaware regulators seek for an insurer already in liquidation, Pacific American Insurance Co.

Feb. 10, 1986: MIG circulates a second letter written by Mr. Johnson to Mr. Bunner setting forth in detail the plan to spare MIC from liquidation.

Ceding insurers would receive surplus notes in exchange for foregoing certain rights of offset. Ceding insurers also would be given a voice in how Mission American is run.

Feb. 11, 1986: MIG submits the complicated plan—to which the California department has agreed in principle—to a Los Angeles Superior Court for approval.

March 6, 1986: The Superior Court in Los Angeles tentatively approves MIC's bailout plan as support for the proposal grows among ceding insurers, which stand to receive more of what they are owed under this plan than if the company were liquidated.

March 24, 1986: Because it no longer meets the NYSE's financial standards, MIG is delisted by the exchange.

Mid-May 1986: Bondholders who sued five months ago to force MIG into bankruptcy temporarily withdraw their petition in deference to a plan to restructure MIG's debt in which all MIG bondholders would be offered new stock options. The stay is conditioned upon completion of MIC's rehabilitation plan.

June 6, 1986: Chief Deputy Commissioner Roxani Gillespie, 45, is appointed California insurance commissioner, succeeding Mr. Bunner, who resigns to become a partner in Peat Marwick Mitchell & Co.'s insurance practice in New York.

July 31, 1986: Norris Hayes, a free-lance reinsurance auditor from Salisbury, Conn., is slain at his Los Angeles hotel just prior to completing an audit of MIC for a domestic reinsurer. No suspects have been arrested, and the circumstances surrounding his death remain a mystery.

Aug. 11, 1986: For the first time in years, Sayre & Toso Inc. is not ranked among the nation's top MGAs by *Business Insurance*. The MIG unit held the No. 1 position from 1979-1984 and dropped to No. 2 in 1985.

Aug. 29, 1986: MIG reports net losses of $6.4 million and $12.5 million for the second quarter and first half of 1986, respectively. For the same period, however, MIC and its subsidiaries—whose results are not pooled with those of MIG while under state control—report net losses of $44.5 million and $48 million, respectively.

Sept. 11, 1986: MIG publicly declares that its own corporate restructuring and MIC's reorganization "may not be feasible."

Mid-October 1986: A definitive version of the MIC bailout agreement, first unveiled almost a year earlier, is signed by representatives of MIG, MIC's ceding insurers and regulators in Texas and California. However, MIG again expresses doubt that the plan will work as conceived.

The California department meets with various reinsurance companies—collectively and individually—to seek payment of obligations to MIC that allegedly have not been paid.

Late October 1986: Karl Rubinstein, a Dallas insurance attorney, is appointed special deputy commissioner by the California department to help handle the MIC insolvency.

Oct. 31, 1986: Joseph A. Morton retires as the department's chief of conservation and liquidation—a post from which he has supervised MIC's reorganization attempts for a year—and is appointed "retired annuitant." Since this permits him, as a retired state employee, to work 90 days out of each year in his previous capacity, Mr. Morton finishes out 1986 and will work on the MIC case through March 31.

Nov. 10, 1986: MIC quietly stops paying all claims except workers compensation claims.

Nov. 20, 1986: Mr. Rubinstein invites representatives from several state guaranty funds to a clandestine meeting in San Francisco to discuss, along with Ms. Gillespie, what contingency plans could be put into effect if MIC must be liquidated.

Dec. 3, 1986: MIC and its subsidiaries report a net loss of $53.5 million for the third quarter, bringing their net loss for the first nine months of the year to $101.4 million.

Dec. 16, 1986: MIG reveals the California department has begun pursuing a new plan, one that would infuse additional capital into MIC and its subsidiaries from various parties that would benefit if liquidation were avoided.

At the same time, MIG says collection of MIC's outstanding reinsurance continues to be difficult, and re-echoes its doubts about the success of either of the pending plans.

Dec. 22, 1986: Frustrated at the trickle of reinsurance recoverables coming into MIC, Ms. Gillespie files a bad-faith suit in Los Angeles Superior Court against 144 reinsurers—most domiciled outside the United States—seeking $700 million in money allegedly owed for claims MIC has paid or will pay, an unspecified amount for incurred-but-not-reported losses and $500 million in punitive damages.

Jan. 1, 1987: Sayre & Toso closes its doors.

Jan. 26, 1987: MIC, which has already stopped paying all claims except workers compensation claims, now only has enough funds to pay work comp claims within California.

Feb. 2, 1987: Having tried all available options, the California department requests court permission to liquidate MIC. A hearing is scheduled for Feb. 24, at which MIC is not expected to protest issuance of a liquidation order.

At the same time, the department receives permission to take control of Mission American.

—Compiled by Steve Taravella

Mission liquidation

Continued from page 1

MIC's insolvency has grown from $361.5 million at year-end 1985, when MIC reported assets of $285.1 million and liabilities of $646.6 million, and has swelled from the $169.5 million insolvency reported by the department when MIC was placed in conservation (see chart).

At that time, MIC had almost 20,000 policyholders nationwide; it has not written business since then.

The other insurers that the department seeks to liquidate are:

- Mission National Insurance Co., which has assets of about $190 million and liabilities of about $246 million for a $56 million deficit.
- Holland-America Insurance Co., which has assets of about $75 million and liabilities of about $99 million for a $24 million deficit.
- Mission Reinsurance Corp., which has assets of about $65 million and liabilities of about $53 million, or a $12 million surplus.
- Enterprise Insurance Co. has assets of about $35 million and liabilities of about $39 million for a $4 million deficit.

These four companies were all placed in conservation just days after MIC was taken over in 1985. MIC, Mission National and Enterprise are domiciled in California. Mission Re and Holland America are domiciled in Missouri, but they have been supervised by the California department along with the other three companies.

Mission Insurance Co. of Texas Inc., a fifth MIC subsidiary, remains in conservation in Texas and is not affected by the California department's attempt to liquidate the other insurers, says Kenneth McDaniel, an examiner with the Texas State Board of Insurance in Austin.

The Texas company, which was placed in conservatorship in November 1985, is currently paying claims but is not writing business, Mr. McDaniel said. The company reported a surplus of $10.8 million as of Dec. 31, 1985, based on assets of $31 million and liabilities of more than $20 million, the latest figures available.

The Texas department's plan for Mission of Texas is not complete, Mr. McDaniel noted. But, he said the department hopes the insurer "could be in a position to write again."

The California department's request for the liquidation of MIC and the four subsidiaries comes after more than a year of efforts by regulators, other insurers and debtholders to save the companies.

Ms. Gillespie noted that "everyone was given an ample chance."

"No one should feel the state didn't give them an ample chance to rectify the situation; there should be no surprises. I feel at least I accomplished that, even if I failed at rehabilitating Mission," she said, reflecting on the project that has consumed much of her seven-month tenure as commissioner.

Shortly after MIC was placed in conservation, regulators, MIG, insurers that ceded business to MIC and MIC's reinsurers began negotiating a rehabilitation plan. And, for a time, it had appeared that the parties had worked out a proposal that would successfully restructure the insurer (*BI*, Feb. 17, 1986).

Under a plan tentatively approved by the Los Angeles Superior Court on March 6:

- Mission American, formed by MIG in March 1985 after it acquired the old Transport Indemnity Co., would have reinsured virtually all business written by MIC and its subsidiaries, except assumed reinsurance business.
- Mission American would have received virtually all the assets of MIC and its subsidiaries—including any reinsurance recoverables collected—to help support the assumption of this business.
- Ceding insurers that decided to participate in the plan would have received half the profits of Mission American over a 10-year period as well as a surplus note with interest of 2% on the principal, to be paid out of reinsurance recoveries, to cover their claims.

These ceding companies also would have been given a voice in Mission American's management but would have had to agree to waive any rights of offset. Otherwise, Mission American had feared, ceding companies that also reinsure MIC under other treaties would have offset claims payments owed MIC by the amount MIC owed them.

- Ceding insurers that elected not to take part in the plan would have received an amount commensurate with what they would receive under a liquidation.

As the various parties worked to finalize the plan, MIG last fall said the MIC reorganization and a proposed restructuring of MIG's corporate debt "may not be feasible," because of rising losses on business written by MIC and an inability to collect reinsurance proceeds (*BI*, Oct. 6, 1986).

For instance, a group of 50 to 60 primarily non-U.S. reinsurers did not pay MIC's reinsurance claims pending the results of an audit of Sayre & Toso, an MIG managing general agent.

In addition, other reinsurers that had sued to rescind management and reinsurance contracts with MIC and an affiliate, Pacific Reinsurance Management Corp., stopped paying MIC's reinsurance claims pending arbitration of the disputes.

In November, as Mission's financial problems mounted, the department retained Shearson Lehman Bros. to suggest alternate ways to keep MIC out of liquidation.

"Unfortunately nothing could be done. It would have taken substantial capital to bail out Mission," Ms. Gillespie said.

"The economics deteriorated more rapidly than anyone would expect," pointed out Jeff S. Liebmann, a partner at LeBoeuf, Lamb, Leiby & MacRae in New York, which represented more than 50 MIC ceding insurers during negotiations on various rehabilitation proposals.

One of several proposals considered during the past few months would have required a $250 million contribution from American Financial Corp., MIG's principal shareholder; a $200 million loan from the California Insurance Guarantee Assn.; and a $250 million infusion from the insurance industry in general, which was expected to view the proposal as an equity investment opportunity.

"This particular proposal went nowhere," said Ms. Gillespie. "There was no willingness on the part of the people involved to put in that kind of money in view of their positions."

While Ms. Gillespie noted last week that AFC failed to come through with a promised cash infusion for Mission American and that the refusal of MIC's reinsurers to pay claims stymied rehabilitation efforts, she is reluctant to blame any particular group for MIC's fate.

"That would be totally inappropriate in light of litigation," she observed, referring to numerous lawsuits filed in the wake of MIC's financial problems.

But all agree that unpaid reinsurance claims were one of the major obstacles to MIC's rehabilitation.

"What really caught a lot of people by surprise—including us—was the degree to which the reinsurers on the direct book were not paying. We didn't expect that to be as severe as it turned out to be," said LeBoeuf's Mr. Liebmann.

In December, Ms. Gillespie filed suit against more than 140 MIC reinsurers, seeking $200 million in claims payments for losses MIC had already paid and $500 million for case reserves established for anticipated claims payments.

Ms. Gillespie noted that the amount of reinsurance recovered by MIC picked up after the suit was filed. "We are doing a lot better now than we were before we filed our lawsuit," she said, though she said she was unable to cite the specific amount collected since then.

The California department announced last week it has retained William S. Price, former executive vp-field operations at Crum & Forster and once chairman of U.S. Insurance Group, a C&F unit, to serve as MIC's liquidator if the court issues a liquidation order.

Ms. Gillespie said Mr. Price will attempt to "come up with the best, lowest ultimate (operating) cost that we can" to maximize the assets to pay policyholder claims.

"MIC is going to be taken care of very well," Ms. Gillespie said.

For his services as MIC's liquidator, Mr. Price will receive an annualized salary of $200,000, a car and housing costs, all of which will come from the MIC companies' estates.

These arrangements—contained in a legal declaration by Joseph A. Morton, California deputy insurance commissioner in charge of liquidation and rehabilitation—were approved last week by Los Angeles Superior Court Judge Ricardo Torres.

In California alone, about 13,000 policyholder claims are pending against MIC, about 10,000 of which are workers compensation claims, CIGA says. Cash-flow problems forced MIC to stop paying all but workers compensation claims on Nov. 10, 1986, and, subsequently, all but California work comp claims on Jan. 26.

MIC, which has issued no new policies since Oct. 31, 1985, would be required under a liquidation order to cancel any remaining in-force policies within 45 days. Policyholders would be refunded any unearned premium.

State guaranty funds, which will pay claims to MIC's direct policyholders, were gathering information on MIC last week while awaiting a liquidation order.

Most state guaranty funds are triggered by a court order of liquidation and a finding of insolvency. Once triggered, the funds assess other insurers licensed in that state a certain percentage of the premiums they wrote the previous year for particular lines of coverage.

Some guaranty funds can begin making claims payments within a week of receiving claims files, guaranty fund directors say.

The California Insurance Guarantee Assn., for example, has sufficient money on hand to begin making payments to claimants before it must assess California-licensed insurers for the MIC insolvency, according to CIGA Executive Director John Gates in Los Angeles. CIGA likely will begin making payments as soon as it obtains the necessary claims files, he said.

"We'll see how it hits us when we get the claim files in," noted Paul Gulko, president of Guaranty Fund Management Services, the administrative arm of property/casualty guaranty funds in six New England states, Virginia and Washington, D.C.

The prospect of liquidating Mission could not come at a worse time for guaranty funds, many of which already are levying record assessments on insurers.

Connecticut's guaranty fund, for example, already has assessed insurers 2% of net written premiums—the maximum allowed—and expects to make a similar assessment again this year, even without the MIC liquidation, Mr. Gulko pointed out.

CIGA has never had to assess its maximum —1% of net written premiums—but Mr. Gates suspects such an assessment will be necessary for some lines of coverage to pay claims owed to MIC policyholders.

In 1986, CIGA collected $58 million in assessments to respond to claims against seven insolvent insurers.

CIGA claimants must satisfy a $100 per-claim deductible—on top of other applicable deductibles—and can then be reimbursed up to a maximum $500,000 for all but workers compensation claims, which are paid according to state benefit schedules.

Besides California, other states in which MIC wrote substantial amounts of premium include Texas, Georgia, Florida, Missouri, New York, Louisiana and Oklahoma.

Most states offer insurers a mechanism by which they can recoup what they are assessed, pointed out Richard J. Marcus, ex-

Continued on next page

Suit against MIG officers stayed

LOS ANGELES—Two suits brought last fall against 15 former Mission Insurance Group Inc. executives and accountant Coopers & Lybrand have been stayed for six months, pending arbitration of previous suits that address similar issues.

At the same time, the U.S. District Court in Los Angeles denied the former executives' request for monetary sanctions against the attorneys who filed the two actions.

The two suits stem from the operations of Pacific Reinsurance Management Corp., an MIG subsidiary that ceased doing business in mid-1984, and raise issues of negligence, common law fraud, breach of fiduciary duty, and violations of both federal securities laws and the Racketeer Influenced and Corrupt Organizations Act (*BI*, Oct. 6, 1986).

The suits—filed in September in the same court—were brought by Ohio Reinsurance Corp., which is in runoff, and five other reinsurers.

Some of these same plaintiffs pursued similar charges in U.S. District Court for the Southern District of New York two years ago seeking rescission of management and reinsurance contracts with PRMC and Mission Insurance Co. One of the suits was settled in late 1985 (*BI*, Dec. 16, 1985), while the other was ordered into arbitration, which is still pending (*BI*, June 24, 1985).

"It is clear that the Los Angeles actions and the contract disputes in the other reinsurance actions involve many important common issues of fact and law; hence it is likely that the process of arbitration will prove helpful to the court's resolution of the instant actions," the opinion states.

Claims against MIG, which also is named as a defendant in the actions, were already stayed because MIG is now in Chapter 11 bankruptcy proceedings and, thus, did not need to be addressed by this ruling.

The Feb. 2 ruling enables Mission to proceed without having to fight the issues on two or three different fronts, according to MIG's law firm, Buchalter, Nemer, Fields, Chrystie & Younger in Los Angeles.

Mission American sues Zurich unit for bad faith

LOS ANGELES—Mission American Insurance Co. is charging Zurich-American Insurance Co. of Illinois with bad faith for allegedly refusing to settle a case that eventually cost Mission American $4.3 million.

The suit, filed in December, arises from a product liability suit against Peter Pirsch & Sons Co., a Kenosha, Wis., business that manufactures, designs and distributes fire trucks.

Zurich American wrote a $500,000 primary product liability policy for Pirsch, while Transport Indemnity Co., Mission American's predecessor, wrote $4.5 million in coverage excess of $500,000.

In November 1982, a Brookline, Mass., firefighter was permanently injured when thrown from a "Pumper" fire vehicle, according to court papers.

The man's wife, Jacqueline V. Tynan, sued Pirsch for negligence, breach of warranty and loss of consortium. In December 1985, a jury found the firm negligent.

Two months ago, the parties finally reached a $4.8 million settlement, to which Mission American contributed $4.3 million and Zurich's $500,000, Mission American says.

Mission American, which is now in conservation in California, alleges that at about the time of the trial, Ms. Tynan offered to settle the case for a structured settlement that would have cost $1 million to secure.

Mission American says it offered to contribute $600,000 to Zurich's $500,000 policy limits to pay for an annuity, but Zurich refused to agree to the settlement.

Mission claims Zurich exhibited bad faith by not accepting the settlement offer. Mission says the offer was "reasonable," considering that Ms. Tynan's attorneys offered evidence of more than $4.5 million in damages, not including pain and suffering.

Zurich owed Mission American the same duty to act in good faith as it did Pirsch, says Paul Alvarez, Mission's Los Angeles attorney with Breidenbach, Swainston, Crispo & Way.

For procedural and strategic purposes, Mission American sued in both the U.S. District Court for the Central District of California and in Los Angeles County Superior Court. It is pursuing the federal court claim, Mr. Alvarez reports.

Zurich declined to comment because the case is in litigation.

Mission liquidation

Continued from previous page
ecutive secretary of the National Committee on Insurance Guaranty Funds in Schaumburg, Ill.

Some states, like Texas, permit insurers to offset their premium tax by the amount they are assessed, he noted. Others, like California, require insurers to pass on their assessments to policyholders through a premium surcharge. And many states, like Iowa, permit insurers to take guaranty fund assessments into consideration when calculating rates.

While MIC's commercial policyholders will likely get most of what they are owed from guaranty funds, MIC's ceding insurers—which, according to MIG, are owed about $581 million—will not be so lucky.

It is unclear how much of that, if any, these companies will get if MIC is liquidated.

Meanwhile, Ms. Gillespie was unable to speculate on the fate of Mission American, which was placed in conservation in California last week.

"It's premature to say what we'll be able to do, if anything," she said. She added that the California department has no immediate plans to liquidate Mission American.

Mission American's assets are now under state control and not affected by the separate bankruptcy proceeding.

MIG's bankruptcy proceedings also will not affect MIC's anticipated liquidation, CIGA's Mr. Gates said. MIG's general creditors must press their claims with the U.S. Bankruptcy Court, while policyholders will be paid through liquidation or conservation proceedings.

Ms. Gillespie was scheduled to meet late last week with Mission American executives in Los Angeles, where they will discuss, among other issues, the status of the company's in-force policies and whether it will continue to write business.

A recent audit of Mission American declared the insurer is in considerably worse shape than its financial statements have indicated and concluded that it may be insolvent.

In its Sept. 30, 1986, filing with state regulators, Mission American reported assets of $147.4 million and liabilities of $116.2 million, or a $31.2 million surplus.

But, according to the audit conducted by John A. Massengale, a rehabilitation adviser with the Texas Board of Insurance, Mission American had assets of only $143.6 million as of Sept. 30, compared with liabilities of $136.6 million, or a $7 million surplus.

For example, Mr. Massengale disallowed credit for receivables from Mission American affiliates, like a $17 million receivable from Sayre & Toso Inc., MIG's once-prominent but now inactive underwriting management unit.

Sayre & Toso, which was the largest underwriting manager ranked by *Business Insurance* from 1979 to 1984, closed its doors Jan. 1.

Mr. Massengale noted, however, that even the audited results may be misleading, because Mission American misallocated certain business expenses. For example, numerous office, management and operating costs charged to Mission Insurance Co. of Texas should have been charged to Mission American, he said.

His report concludes that if Mission American properly reports money it owes to MIC and its subsidiaries as a liability, Mission American will show a surplus deficit.

"I believe Mission American Insurance Co.'s presentation of its financial information is optimistic at best," Mr. Massengale concludes in his report. "It is my opinion that Mission American Insurance Co. is insolvent."

Supervising Mission American during its conservation is Karl L. Rubinstein, a Dallas insurance attorney retained several months ago as special deputy commissioner to work on the MIC case.

To assist regulators and the California attorney general's office in handling Mission American's conservation, Mr. Rubinstein has been authorized to retain his partners or associates as he desires. A fee schedule for 30 attorneys who could be used for Mission American's conservation matters was approved last week by Los Angeles Superior Court.

The attorneys' fees average $119 hourly, to be paid out of Mission American's estate. Of the 30 attorneys, 19 bill more than $100 an hour; Mr. Rubinstein bills his work at $190 an hour, the highest rate charged by any of the attorneys.

Before the Mission American conservation order was issued last week, Mr. Rubinstein submitted a brief declaration to the court stating his objections to giving Mission American a 24-hour advance notice of the conservation action.

Doing so "would run the significant risk that assets would be transferred, disposed of or otherwise impaired," he wrote. "I have been involved in many similar solutions and have seen that management frequently interferes with smooth transmissions and sometimes attempts to remove assets."

Mr. Rubinstein did not return phone calls.

Ms. Gillespie said that while such a declaration may be uncommon in conservation applications, "a case like the Mission does not come everyday."

While the fate of Mission American is uncertain, at least one rehabilitation attempt is already in the works.

A majority of MIG bondholders are working to keep the insurer afloat, said their attorney, James P. Heffernan of Anderson, Russell, Kill & Olick in New York.

Mr. Heffernan said he now represents a group of more than 25 investors who—as of last Tuesday—held bonds with a face value of about $37 million.

Working with representatives of AFC and MIG, the investors hope to develop a reorganization plan "within a short period of time" that will pump enough money into Mission American to take it out of state control, he says.

These funds are expected to come from AFC and the bondholders, including New York investor Martin J. Whitman of the M.J. Whitman & Co. Pension Plan, the lead plaintiff in the January 1986 action that sought to place MIG into involuntary bankruptcy.

"We're ready, willing, able and anxious to put up our share of the money to rehabilitate MAIC," Mr. Heffernan said. "As far as we're concerned, MIC is dead and gone, but MAIC is a viable company."

The bondholders last year had put on hold their attempt to place MIG in Chapter 11 while they tried to restructure the company's corporate debt (*BI*, March 17, 1986). However, the debt restructuring was contingent on approval of the MIC bailout plan.

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Associate Editor Michael Bradford in Dallas also contributed to this story.

Kaiser retirees

Continued from page 3
directors of the Kaiser Steel Cares Foundation, a group attempting to arrange emergency aid for retirees, said the decision to cut medical benefits has already caused considerable hardship for some of the retirees.

"We have all kinds of really bad cases," he said. "If I tell you about some of them, you wouldn't believe it."

Calls have been coming into the foundation, which recently received $50,000 in funding from Kaiser Permanente, at the rate of "probably 400 a day," he estimated.

In a Jan. 23 letter to the retirees, Bruce E. Hendry, who was named Kaiser Steel chairman last month following a proxy fight, stated: "I know you have worked hard for those benefits and you have every reason to believe that you should receive them as promised. Tragically, the once mighty Kaiser Steel does not have the financial ability to continue funding your medical benefits."

Mr. Hendry continued: "I am saddened to find that we are unable to meet our financial obligations, especially the medical benefit payments to you. Although Kaiser Steel does not presently have sufficient funds, it does have assets, and while others also have claims on those assets, you have the right to your share of these assets and I am committed to seeing that you are treated fairly in that regard."

'I am saddened to find that we are unable to meet our financial obligations,' Mr. Hendry says.

The suit filed by the United Steelworkers notes that in a collective bargaining agreement between the union and Kaiser Steel effective August 1980, Kaiser Steel agreed to provide retirees with health benefits, including coverage for hospital, medical, outpatient, vision, dental and prescription drug costs.

In September 1984, the union and Kaiser Steel issued a "memorandum of understanding."

In that memo, Kaiser Steel contended the company's obligations in relation to its health insurance program ended when the collective bargaining agreement expired, while the union contended the agreement was valid throughout the lives of eligible individuals.

However, the memorandum also states, "Both the union and the company recognize that whatever the legal status of the rights at issue, the financial viability of the company is sufficiently doubtful so as to raise serious questions regarding its ability to provide the HIP (health insurance program) benefits throughout the lives of the eligible individuals."

The agreement then sets out a program of "continuing coverage" that states that except for changes in retirees' dental, vision care and major medical benefits, "the company will pay the full cost (including inflation) of the benefits described in the HIP for the respective lifetimes of all eligible individuals."

Karen Feldman, a Steelworkers union attorney, noted the cutback in major medical benefits, which only immediately affected retirees under age 65, had little impact because most retirees were covered under the Kaiser Permanente HMO plan, which does not separate major medical from other health benefits.

Continued on next page

update

Robins considers buyout offer

Continued from page 2
the company is considering the offer.

American Home said the proposal is consistent with its strategy to expand into the pharmaceutical and health care fields.

Handbooks may be contracts

SPRINGFIELD, Ill.—Employers, especially in Illinois, are expected to analyze their employee handbooks after the Illinois Supreme Court ruled late last month that handbooks may create binding contractual obligations.

The court said employee handbooks, or other policy statements, are binding contracts if they clearly state an offer has been made; are disseminated to the employee in such a manner that the employee is aware of the contents and reasonably believes it to be an offer; and the employee accepts the offer by commencing or continuing work after learning of the policy statement.

The case arose after a hospital worker sued her employer for not following dismissal procedures stated in an employee handbook.

The high court's decision "will open the door to a lot of lawsuits," said Tom Luetkemeyer, an attorney representing the hospital. "I think it will result in a lot of employers getting rid of their handbooks."

Briefly noted

The Securities and Exchange Commission will seek public comment at a hearing March 23 on the issue of whether **corporate debt securities** guaranteed by insurers should be exempt from registration requirements (*BI*, Oct. 20, 1986). The commission is scheduled to report its findings by April 28. . . .By almost a 5-1 vote, United Steelworkers union members ratified a four-year contract with **USX Corp.** that includes health care cost-containment measures and other benefit provisions (*BI*, Jan. 26). . . .The Georgia Insurance Department has agreed to drop litigation over **HOW Insurance Co.**'s status as a risk retention group as part of a settlement with HOW. The settlement removes the last state insurance department challenge to Delaware-chartered HOW, which provides product liability coverage to more than 11,000 home builders.

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Continued from previous page

The memorandum did provide that retirees could purchase at group rates any benefits no longer paid by the company.

The agreement also provided that from Jan. 1, 1985, through Dec. 31, 1994, retirees over age 65 had the choice of having the company pay either major medical or dental and vision benefits. The complicated agreement provided these benefits would be funded in part by royalties from a Kaiser Steel mine operation.

Referring to the memorandum, the lawsuit filed by the union notes that except for the cutback in these benefits, "there are no provisions. . .governing the termination of retiree benefits coverage.

"Therefore, the (memorandum) unequivocally provides that Kaiser must provide retired members of Kaiser, their surviving spouses and dependents with the enumerated health and welfare benefits for their lifetimes."

The suit also says that Kaiser Steel "made repeated and unequivocal representations to retirees and plaintiffs that retirees would continue to receive health and welfare benefits for the period covered in the (memorandum) once they retired."

The suit asks for unspecified damages as well as a temporary restraining order and preliminary and permanent injunctions requiring Kaiser Steel to maintain retirees' health care benefits.

"I would expect the company has committed a major act of insolvency" in refusing to pay its retiree health benefits, commented Robert M. Dohrmann, an attorney with Schwartz, Steinsapir, Dohrmann & Sommers in Los Angeles, who is representing the union.

Observers say that in light of the 1984 agreement between the union and Kaiser Steel, the company may have a hard time convincing a court that it can terminate the benefits.

"Theoretically, the only way you can set aside something like that is in a bankruptcy court," C. Richard Donovan, senior vp at Herget & Co. Inc., a benefit consultant in Baltimore, said, referring to the 1984 memorandum.

"It seems to me this is a legal issue, where the specific remedy is to provide the medical benefits," he said.

David L. Glueck, a Chicago-based vp at consultant Towers, Perrin, Forster & Crosby, said the "case law seems pretty clear" that "canceling these benefits is essentially impossible."

"I certainly wouldn't be real comfortable with their position if I were their attorney," Mr. Glueck said.

Henry T. Saveth, vp-technical analysis in Johnson & Higgins' National Benefits Office, said one factor clouding analysis of the whole situation is the "differences of opinion" between current and former management. "We just don't know how that comes into play," he said.

While cautioning it is "pure speculation," Dennis T. Blair, assistant vp of Alexander & Alexander's Research and Training Services Group, said Kaiser Steel may be, in effect, telling the retirees they have the choice of either negotiating a reduction in benefits now or joining Kaiser Steel's other creditors in bankruptcy court later.

Kaiser Steel's position could be, "Take your choice, but there's no way we're paying full lifetime coverage," Mr. Blair said.

"It's probably a bargaining tactic," agreed Dave Kempken, head of William M. Mercer-Meidinger Inc.'s Chicago office and formerly Bethlehem Steel Corp.'s employee benefits manager.

Mr. Kempken said by permitting the issue to be brought into court, Kaiser Steel "can't wind up worse than they did before they started," except for legal fees.

"It seems to be one of the few options they have available, depending on how serious their financial situation is," he said.

Mr. Kempken said that assuming Kaiser Steel remains an "ongoing entity," he expects that the company, either through an eventual agreement with the union or as a result of litigation, will wind up giving the retirees somewhat reduced health benefits. "What that would be, would be purely speculative," he said.

Another observer agreed it is possible Kaiser Steel hopes to negotiate a reduction in the retirees' health benefits.

"There's no way in the world they're going to win in court," the observer said. "They've got to be thinking they're getting something out of this."

"My indication is that we simply could not afford to make the payments," responded the Kaiser Steel spokesman. "There is something that had to give, and what had to give was making those medical payments. I just can't comment on the supposition of ulterior motives behind it."

Observers pointed out courts have tended to favor retirees in cases where the company explicitly promised retirees a continuation of benefits.

In a case involving Bethlehem Steel, for instance, a federal judge ruled that because of ambiguous plan language as well as extrinsic evidence—including promises made to its retirees—Bethlehem Steel did not have the right to reduce retirees' health benefits.

The steel company eventually reached a settlement with its retirees over the issue (*BI*, March 18, 1985).

TPF&C's Mr. Glueck observed, "Sooner or later, Congress will get so upset on this issue there will be another ERISA for health benefits. "I'm not sure what straw will break the camel's back."

Observers said the Kaiser Steel situation could become analogous to the plight of LTV Corp. Last summer, LTV filed for reorganization under Chapter 11 of the Federal Bankruptcy Act and stopped payment of health benefits for 78,000 retirees.

In August, a New York bankruptcy court granted LTV's request to continue to provide benefits to retirees for six months, retroactive to July 17 (*BI*, Aug. 4, 1986).

In October, with LTV in mind, Congress approved legislation stating a company in Chapter 11 that had been providing a health care plan for its retirees had to continue to pay benefits until May 15, 1987.

The legislation also provided that any company with a retiree health care plan in effect on Oct. 2, 1986, that subsequently went into Chapter 11 also had to continue benefits until May 15 (*BI*, Oct. 27, 1986).

Congress also approved, as part of the Omnibus Budget Reconciliation Act of 1986, a related provision that requires companies in Chapter 11 to give retirees the right to buy lifetime post-retirement health care coverage if the company had offered retiree health benefits before its bankruptcy filing.

The company can charge retirees a premium equal to 102% of the group rate. In addition, a surviving spouse can buy coverage for up to three years after a retiree dies (*BI*, Dec. 29, 1986). ■

Kaiser Steel, PBGC discuss termination

By JUDY GREENWALD

FONTANA, Calif.—Kaiser Steel Corp. is discussing with the Pension Benefit Guaranty Corp. the possibility of terminating its underfunded defined benefit pension plan.

A Kaiser Steel spokesman said, however, that while negotiations are ongoing, he "couldn't begin to put a time line" on when a final agreement would be reached. An "overall restructuring" of the company must be completed first, he said.

The company has about 5,300 current retirees.

Kaiser Steel also has applied to the Internal Revenue Service for a waiver of its 1985 pension plan contribution. The IRS is required to consult with the PBGC before deciding whether to approve the waiver request.

The Kaiser spokesman said he did not have available information on how much the company owed for its 1985 pension payment. He noted that the 1985, rather than the 1986, payment is at issue because the 1985 payment was not due until September 1986.

The company announced an "agreement in principle" with the PBGC in September that would reduce the corporation's cash outflow burden by $50 million over the next three years, and $80 million over the next six years, said a statement by Monty H. Rial, who at the time was Kaiser Steel's chairman and chief executive officer.

The agreement calls for PBGC to assume $205 million of the company's $241 million in unfunded pension liabilities in return for a secured subordinated promissory note of at least $50 million and a new issue of convertible preferred stock with a redemption value of no more than $104 million, according to the company.

The preferred stock would be convertible into 30% of Kaiser Steel's common stock at the end of five years and would be redeemable at any time at Kaiser Steel's option.

The company said in September that these amounts are subject to adjustment based upon an evaluation of Kaiser Steel's major assets. The company spokesman noted that two weeks ago the company put its coal operation up for sale, which will have an impact on any final agreement.

A PBGC spokeswoman also stressed the agreement in principle is not final but a "road map to the future."

Kaiser Steel said in its September release that the agreement in principle was contingent on the company retaining its current management. But in January, Mr. Rial was deposed as chairman by Bruce E. Hendry after a proxy fight. The company spokesman, said, however, the PBGC has said the agreement still can stand.

In a Jan. 23 letter sent to retirees whose medical benefits were cut by Kaiser Steel, Mr. Hendry assured the retirees that "most pension benefits are insured by an agency of the U.S. government, the Pension Benefit Guaranty Corp., and will be unaffected by this announcement" (see story, page 3).

Karen Feldman, an attorney with the United Steelworkers union, noted the maximum monthly benefit the PBGC would guarantee for a 65-year-old retiree if Kaiser Steel terminates its plan would be $1,850.95 in 1987.

A potential problem, she said, is so-called shutdown benefits promised under the plan. The Kaiser Steel retirees, many of whom worked at a mill in Fontana that was shut down in 1983, could lose at least part of a $400 monthly supplement if the plan is terminated, she said.

A termination of the Kaiser Steel plan would increase the PBGC's deficit, which currently totals about $4 billion.

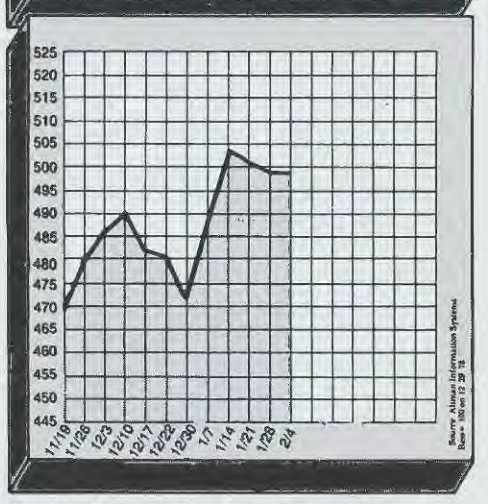
BI Industry Stock Report

February 4, 1987 1/29/87 thru 2/4/87

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	27.25	1.9	389.3	1.00	3.7	27.25	27.00	360.4
Baldwin & Lyons Inc	OTC	21.00	0.0	17.1	0.20	1.0	24.00	20.00	2.0
Corroon & Black Corp	NYSE	30.75	-9.6	13.9	0.65	2.1	34.13	30.75	1,117.3
Gallagher Arthur J & Co	OTC	25.25	-6.0	18.0	0.20	0.8	27.00	25.25	262.5
Hall Frank B & Co Inc	NYSE	16.00	5.8	0.0	0.00	0.0	16.00	15.38	168.3
Marsh & Mclennan Cos Inc	NYSE	62.88	-12.1	19.1	1.90	3.0	67.00	61.50	6,259.3
Poe & Assoc Inc	OTC	12.25	0.0	15.5	0.40	3.3	12.25	12.25	7.4
AGENTS/BROKERS	AVERAGE			19.9		2.4			
Conglomerates & Holding Cos.									
Anderson Clayton(Ranger/PanAm)	NYSE	65.63	0.0	18.8	0.00	0.0	0.00	0.00	0.0
Armco Inc	NYSE	8.13	27.5	0.0	0.00	0.0	8.13	6.88	3,289.2
Berkley W R Corp	OTC	27.50	-5.2	15.2	0.24	0.9	29.00	26.75	861.3
Berkshire Hathaway Inc Del	OTC	3090.00	2.1	179.2	0.00	0.0	3100.00	3060.00	1.2
CIGNA Corp	NYSE	60.00	-0.8	0.0	2.60	4.3	60.00	58.25	2,850.5
CNA Finl Corp (CNA)	NYSE	55.00	-0.5	13.9	0.00	0.0	55.38	54.50	276.8
General Re Corp	NYSE	57.63	-1.5	24.8	0.88	1.5	57.88	55.75	2,743.2
ITT (Hartford Group)	NYSE	59.50	-2.1	24.5	1.00	1.7	60.50	58.50	3,156.0
Sears Roebuck & Co. (Allstate)	NYSE	46.38	1.4	12.6	1.76	3.8	46.38	45.50	3,792.1
Transamerica Corp (Occidental)	NYSE	36.00	-2.7	10.1	1.76	4.9	36.75	35.50	835.9
CONGLOMERATES/HOLDING COS.	AVERAGE			89.3		0.2			
Insurers									
Aetna Life & Cas Co	NYSE	60.50	-1.4	10.5	2.64	4.4	61.00	59.25	2,043.6
American General Corp	NYSE	41.00	-1.8	11.3	1.12	2.7	41.50	40.75	1,227.9
Amern Heritage Life Invt Co	NYSE	42.00	3.1	14.5	1.32	3.1	42.00	41.00	2.9
American Indty Finl Corp	OTC	18.75	1.4	0.0	1.12	6.0	18.75	18.25	20.9
American Intl Group Inc	NYSE	66.75	-3.8	19.1	0.25	0.4	68.00	65.13	2,051.3
Aneco Reins Ltd	OTC	2.75	-4.3	0.0	0.00	0.0	2.75	2.75	24.2
Avemco Corp	NYSE	35.00	4.5	15.5	0.50	1.4	35.25e	33.00	32.9
Business Mens Assurn Co Amer	OTC	27.75	-0.9	0.0	1.10	4.0	28.25	27.75	8.4
Chubb Corp	NYSE	63.50	3.0	11.3	1.68	2.6	63.50	62.00	1,447.6
Combined Intl Corp	NYSE	58.25	-1.7	10.9	2.24	3.8	58.63	57.13	330.0
Continental Corp	NYSE	47.50	-3.1	226.2	2.60	5.5	48.50	47.50	552.5
Crown Life Ins Co	OTC	355.00	0.0	12.3	6.40	1.8	355.00	355.00	0.5
Durham Corp	OTC	42.50	-1.2	13.0	1.36	3.2	43.50	42.50	4.3
Farmers Group Inc	OTC	43.50	-0.6	14.5	1.00	2.3	44.75	43.50	1,344.7
Fairmont Finl Inc	AMEX	18.63	4.2	14.9	0.00	0.0	18.88	17.50	494.1
Fireman Fd Corp	NYSE	37.00	2.1	15.7	0.30	0.8	37.13	36.00	1,380.2
Fremont Gen Corp	OTC	19.38	9.9	0.0	0.48	2.5	19.38	18.25	325.5
Great West Life Assurn Co	OTC	700.00	0.0	14.4	18.00	2.6	700.00	700.00	0.0
Home Group Inc	AMEX	19.38	-3.7	31.3	0.00	0.0	19.88	18.63	341.7
Hanover Ins Co	OTC	69.75	2.2	14.8	0.56	0.8	69.75	68.25	42.4
Harleysville Group Inc	OTC	15.63	-5.3	10.0	0.32	2.0	16.00	15.63	51.8
Hartford Steam Boiler Inspctn	OTC	58.50	6.4	13.7	1.60	2.7	58.50e	55.25	149.0
Kans City Life Ins	OTC	26.50	-0.9	11.0	0.96	3.6	26.50	26.25	186.2
Kemper Corp	OTC	33.75	12.5	13.5	0.60	1.8	33.75	30.88	2,907.7
Liberty Corp S C	NYSE	37.75	-0.7	12.7	0.72	1.9	37.75	36.88	21.2
Lincoln Natl Corp Ind	NYSE	50.38	-0.2	11.6	2.16	4.3	50.88	50.38	251.2
Mission Ins Group Inc	PAC	0.75	0.0	0.0	0.00	0.0	4.38	0.75	112.5
Monumental Corp	OTC	55.63	0.0	18.8	0.00	0.0	55.63	55.63	1.1
Nac Re Corp	OTC	28.00	-2.6	0.0	0.00	0.0	28.75	28.00	116.6
Nobel Ins Ltd	OTC	17.50	-1.4	13.2	0.37	2.1	17.75	17.50	212.5
Northwestern Natl Life Ins	OTC	30.75	-0.8	10.3	0.86	2.8	31.00	30.75	264.3
Ohio Cas Corp	OTC	42.50	-1.2	14.1	1.50	3.5	42.50	42.00	203.7
Old Rep Intl Corp	OTC	33.25	7.7	12.9	0.78	2.3	33.25	30.88	135.0
Orion Cap Corp	NYSE	28.00	5.2	0.0	0.76	2.7	28.00	26.88	65.7
Protective Corp	OTC	20.50	-2.4	11.3	0.70	3.4	21.00	20.50	51.1
Provident Life & Acc Ins Co	OTC	26.00	5.6	9.8	0.84	3.2	26.00	25.00	391.7
St Paul Cos Inc	OTC	45.75	4.6	13.3	1.50	3.3	46.25	44.25	2,058.3
SAFECO Corp	OTC	56.00	-3.0	11.6	1.70	3.0	57.50	56.00	561.9
Scor U S Corp	OTC	13.00	0.0	26.0	0.00	0.0	13.00	13.00	344.0
Seibels Bruce Group Inc	OTC	16.00	-0.8	0.0	0.80	5.0	16.50	15.75	27.6
Selective Ins Group Inc	OTC	22.00	2.3	43.1	0.92	4.2	22.00	21.38	56.6
Statesman Group Inc	OTC	4.75	0.0	0.0	0.05	1.1	4.75	4.63	41.5
Tokio Marine & Fire Ins Co	OTC	70.50	0.9	79.2	0.17	0.2	70.63	70.00	125.2
Torchmark Corp	NYSE	27.13	-6.1	10.4	1.20	4.4	28.00	27.13	950.7
Travelers Corp	NYSE	48.63	-1.5	11.6	2.28	4.7	48.75	48.25	1,495.0
Trenwick Group Inc	OTC	18.00	-1.4	138.5	0.00	0.0	18.00	17.75	105.6
United Fire & Cas Co	OTC	29.50	-3.3	13.8	0.80	2.7	30.88	29.50	7.2
United States Fid & Gty Co	NYSE	42.38	-3.4	48.7	2.32	5.5	43.75	42.13	1,286.5
Unum Corp	NYSE	29.88	0.4	8.8	0.40	1.3	30.13	29.50	841.8
Uslife Corp	NYSE	46.75	0.5	12.1	1.20	2.6	47.00	45.25	154.6
Washington Natl Corp	NYSE	30.50	-1.2	13.9	1.08	3.5	30.88	30.38	47.2
Zenith Natl Ins Corp	OTC	24.50	8.3	29.5	0.80	3.3	24.50	22.75	144.8
INSURANCE COMPANIES	AVERAGE			14.1		2.5			

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BI Insurance Index



The *Business Insurance* index of insurance industry stocks closed at 498.5 points on Feb. 4, down 0.1 point from 498.6 on Jan. 28. In all, 21 stocks were up, 33 were down and nine were unchanged. The biggest gains were by Kemper Corp., up 12.5%; Fremont General Corp., up 9.9%; Zenith National Insurance Corp., up 8.3%; Old Republic International Corp., up 7.7%; and The Hartford Steam Boiler Inspection & Insurance Co., up 6.4%. The biggest losses were by Marsh & McLennan Cos. Inc., down 12.1%; Corroon & Black Corp., down 9.6%; Torchmark Corp., down 6.1%; Arthur J. Gallagher & Co., down 6%; and Harleysville Group Inc., down 5.3%. The *BI* index fell an average of 0.02%; the New York Stock Exchange rose 1.7% during the same period.

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