

# business insurance

## Court approves settlement in Woodson class-action suit

SAN FRANCISCO—A U.S. District Court approved Fireman's Fund Insurance Cos.' \$55 million settlement of a class-action lawsuit brought by 2,000 people who had participated in a trust deed investment program sold by Woodson Co. in San Rafael, Calif.

The approval came June 20, despite charges by an attorney for some investors that the settlement was inadequate and the two \$6 million financial

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Reporting weekly for corporate risk, employee benefit and financial executives/\$1.50 a copy; \$52 a year

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## Best's are worse Many insurers' ratings lowered, omitted

By STEVE TARAVELLA

Many commercial insurers and reinsurers finish poorly in the A.M. Best Co.'s 1985 property and casualty company evaluations.

Best's ratings resulting from these evaluations of insurers' 1984 financials and operations are widely used by both brokers and insurance buyers to gauge insurers' financial stability.

But an insurer's rating—or lack of one—may not carry as much weight in today's shrinking commercial insurance market as it did in the competitive marketplace.

Most insurers don't expect their lower or missing ratings to hurt their business. Some say capacity is so difficult to find, a lower or missing Best's rating won't matter to insurance buyers.

Ratings are omitted this year for several major commercial insurance companies, like the risk-bearing units of Mission Insurance Group in Los Angeles, Midland Insurance Co. and Transit Casualty Co.

Best assigns an omit rating, the worst rating a company can receive, when the company's performance does not qualify for a rating of at least C, Best's lowest alphabetical rating.

Best has deferred its rating for others, like Wausau Insurance Cos., Northwestern National Insurance Co., Bituminous Casualty Corp. and Pine Top Insurance Co.

A deferral of a rating means a significant but non-recurring event affected the evaluation of the company or a significant event occurred after year-end 1984.

The event almost always has an adverse effect on the company's financial position, said Best's Vp Paul Wish.

And, the Oldwick, N.J., rating bureau didn't assign a rating at all to other companies, including prominent surplus lines insurers like International Surplus Lines Insurance Co., a Crum & Forster unit; and Mutual Fire, Marine & Inland Insurance Co.

A company's rating is not assigned if the company so requests, if its business is 100% reinsured, if the com-

### Major companies lacking Best's ratings

Company	1985	1984
Bituminous Casualty Corp.	DEFR	B+
Constellation Reinsurance Co.	NASN	B+
Design Professionals Ins. Co.	Omit	DEFR
Employers Insurance of Wausau	DEFR	B+
International Surplus Lines Insurance Co.	NASN	A+
Midland Insurance Co.	Omit	B+
Mission Insurance Co.	Omit	A
Mutual Fire, Marine & Inland Insurance Co.	NASN	B+
Northwestern National Insurance Co.	DEFR	B+
Pine Top Insurance Co.	DEFR	B

DEFR: Deferred NASN: Not assigned Chart: Amy Palmer

pany is inactive or if life insurance predominates.

Best released last week to certain subscribers the last of its ratings of 1,775 U.S. property and casualty insurers and reinsurers. It began releasing the ratings in April, as they were assigned.

Of the ratings, 25% were reduced, 8% were increased and 67% were not changed according to early figures.

The ratings, which have become the industry's most widely used indicator of an underwriter's financial viability, are on the desks of more Best's subscribers earlier this year than in previous years.

Last year, all of the ratings weren't released to all subscribers until September. Throughout the summer, Best heard a flurry of complaints from brokers groping for ways to assess insurers whose financial strength appeared to be dropping rapidly.

As one broker put it: "It takes more time to get out a Best's report nowadays than it does to give birth to a

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## P&G seeks ruling on excess cover for Rely losses

By DOUGLAS McLEOD

CINCINNATI—In the latest maneuver in the insurance coverage litigation over Rely tampon claims, Procter & Gamble Co. is asking an Ohio state court to decide how five former excess liability insurers should respond to toxic shock syndrome-related losses.

P&G's lawsuit, filed June 17 in the Court of Common Pleas for Hamilton County, Ohio, names Northbrook Excess & Surplus Insurance Co., Commercial Union Insurance Co., American Employers Insurance Co., Pine Top Insurance Co. and First State Insurance Co.

The five insurers provided various amounts of excess liability coverage over P&G's self-insured retentions between 1972 and 1981. Under several of the policies, P&G's retention was \$1 million per occurrence with a \$10 million annual aggregate.

The lawsuit asks for a judgment that all claims against P&G filed by victims of toxic shock syndrome constitute a single occurrence in each policy year for purposes of applying its per-occurrence retention.

The suit also asks for a court ruling allocating to the policies Rely-related expenses that aren't attributable to particular claims.

P&G withdrew its Rely tampons from the market in September 1980 after being hit with hundreds of lawsuits and claims by victims of toxic shock syndrome, which several studies linked to the use of high-absorbency tampons, including Rely.

The tampon was first test-marketed in August 1977.

P&G's lawsuit comes more than two years after Northbrook filed a declaratory judgment action in U.S. District Court in Chicago arguing that each toxic shock claim constitutes a separate occurrence under its policies and that certain expenses claimed by P&G are not covered under the policies (BI, April 23, 1984).

Applying the retention to each claim would increase P&G's self-insured losses and not attach Northbrook's coverage until one claim

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## Wellington settles few coverage suits

By STEPHEN TARNOFF

Despite the imminent resolution of asbestos insurance coverage disputes involving 34 producers and 16 insurers under the recently signed Wellington agreement, almost all the major asbestos litigation will rage on.

The agreement calls for coverage disputes between signers to be dismissed, but it is possible that the agreement will result in dismissal of only one of the more than about 40 pending coverage cases.

In the other cases, producers that have signed Wellington will continue to press their suits against insurers that have not signed the agreement. In many cases, these insurers are the majority of insurer defendants (see chart).

And, some producers that have signed Wellington will continue to litigate against all their insurers, including those that also have signed the agreement, over whether

### What producers gain by signing Wellington

Asbestos producer	Settling insurers	Non-settling insurers	Property damage claims disputes?
Armstrong World Industries Inc.	Nine	Nine	Yes
Fibreboard Corp.	Six	Four	No
Keene Corp. (pre-1977 insurers)	One	Three	Yes
Eagle-Picher Industries Inc.	One	Four	No
Pittsburgh-Corning Corp.	None	One	Yes
Owens-Illinois Inc.	None	One	Yes

Chart: Amy Palmer

there is coverage for the cost of removing asbestos from public and private buildings. The Wellington agreement does not address these property damage claims.

Nonetheless, asbestos producers and insur-

ers signing the Wellington agreement rejoiced last week. After 2½ years of negotiations, the agreement had finally been signed on June 19.

"The closing of Wellington is truly a land-

mark event which allows policyholders and insurers to bury the hatchet to go forward together in the future to address social problems and litigation problems of asbestos suits," said James Restivo, an attorney for Pittsburgh-Corning Corp., which has signed the agreement.

"Obviously, we're very pleased," said Robin A.G. Jackson, a director of Merrett Syndicates of Lloyd's of London, and a major supporter of the agreement.

Mr. Jackson signed the Wellington agreement on behalf of more than 100 syndicates at Lloyd's of London for which he had written authority. He also delivered signed agreements from other London companies.

While acknowledging that most asbestos cases will continue, the Wellington signers said they believe their coverage litigation costs will drop because the number of insurer

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## update

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guarantee policies Fireman's Fund sold to Woodson were actually mortgage guarantee insurance. Fireman's Fund is not licensed to sell mortgage guarantee insurance in California.

The coverage enabled Woodson to obtain Real Properties Securities permits from the state of California and promote its trust deed program as uniquely guaranteed and insured (BI, May 27).

Woodson filed for bankruptcy after Fireman's Fund refused to renew the coverage in 1984 and many of the firm's borrowers defaulted on loans. Woodson investors then sued Fireman's Fund, arguing the insurer was liable for the entire amount of the insured investments at the time of the bankruptcy.

The California Insurance Department is conducting an inquiry into the charge that the coverage Fireman's Fund provided for Woodson was mortgage guarantee insurance.

**Execs agree to buy Howden unit**

NEW YORK—Two groups of executives of Alexander Howden Underwriting Ltd. have agreed to purchase the firm's Lloyd's of London underwriting management operations from parent Alexander & Alexander Services Inc.

A spokeswoman for A&A said the agreement is subject to approval by Lloyd's.

The amount of the transaction was not disclosed, but the spokeswoman indicated the sale would be effective Jan. 1 if approved.

**Union Indemnity gets extension**

NEW YORK—Union Indemnity Insurance Co. of New York has been given a two-week extension for answering the New York Insurance Department's petition to liquidate the company, a spokesman for the department said (BI, June 17).

Union Indemnity now has until July 12 to answer the petition. A New York department examination found Union Indemnity insolvent by \$138.5 million at the end of 1984.

**Parachute maker to self-insure**

MANCHESTER, Conn.—Pioneer Systems Inc., a military and aerospace product manufacturer, is bailing out of the commercial product liability insurance market and self-insuring its parachute business.

The company's decision was prompted by the "exceedingly high costs of premiums," said Chairman Alan H. Greenstadt.

The company, which had \$46 million in sales last year, will self-insure all layers of product liability coverage for its parachute and discontinued line of ultralite aircraft, he said.

He would not release any information about the company's prior coverage, but he said that if premiums decrease, the company again would consider buying commercial coverage.

**Limits to include defense costs**

NEW YORK—Defense costs will be included within policy limits under a revision of the proposed Insurance Services Office's commercial general liability insurance forms.

At press time last week, ISO announced that it will file the policy amendment with state insurance departments beginning in the fourth quarter of 1985 for an effective date of July 1, 1986.

ISO announced in April that it was considering the revision of coverage for defense costs in its proposed claims-made and occurrence forms. The advisory organization said insurers need the change to control their defense cost expenses.

Currently, ISO's standard CGL form does not include defense costs within policy limits, although some manuscript forms do. (See earlier story, page 3.)

**Beckett names say they'll sue**

LONDON—A member of Lloyd's of London syndicates managed by Richard Beckett Underwriting Agencies Ltd. says "litigation is inevitable" and is expected both in the United States and in Britain.

And, Keith Whitten, a spokesman for the PCW 1985 Committee of syndicate members, says at least 300 of the 1,500 names will refuse to pay their share of the 62 million pounds (\$80 million) in losses to meet the July 31 solvency deadline at Lloyd's of London.

Any claims not covered by syndicate members will be paid from the Lloyd's Central Fund. The Beckett syndicates may have lost a total of 130 million pounds (\$167.7 million) since 1979 (BI, June 3).

In another development, Lloyd's Chairman Peter Miller announced last week Lloyd's is beginning a fact-finding inquiry into Beckett's management of the syndicates since it took over from PCW Underwriting Agencies Ltd. in 1983. He said the inquiry is not disciplinary, because "there is no evidence of malfeasance."

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**Interruption claim not offset by affiliate's gain, court says**

By DOUGLAS McLEOD

NEW YORK—A mining company is entitled to full recovery for a business interruption loss even though one of its affiliates earned extra income because of the mining company's loss, a federal judge has ruled.

The ruling is a blow to American Home Assurance Co., which had argued that a \$10.9 million claim filed by Beatrice Pocahontas Co. for a shutdown of its Buchanan County, Va., mine should be offset by the added revenue of an affiliated company that supplied coal on Beatrice's behalf during the shutdown.

Beatrice is a 50/50 joint venture between Republic Steel Corp. and Island Creek Coal Co., a subsidiary of Occidental Petroleum Corp.

During the four-month shutdown of Beatrice's mine following a fire in 1981, some coal that would have been provided by Beatrice was provided by other Island Creek mines.

Beatrice's insurance for its sole coal mine, which was managed by Island Creek, was provided under Occidental's master property insurance program.

American Home must treat Beatrice as an independent entity for purposes of adjusting the claim, U.S. District Judge Charles L. Brieant ruled in the case that was heard last month in the U.S. District Court for the Southern District of New York.

How much Beatrice now will recover under the claim is not known but the claim has already been adjusted below \$10 million, according to T. Michael Shelton, manager-treasurer operations for Island Creek.

The court's decision could also affect the adjustment of another business interruption claim—possibly amounting to as much as \$40 million—to be filed against American Home by another joint-venture mining company owned in part by Island Creek.

American Home, a unit of American International Group Inc., was the primary insurer on the Occidental program from October 1981 until October 1983, providing limits of \$4 million per occurrence for property damage and \$10 million per occurrence for business interruption, subject to a \$40 million annual aggregate limit.

*Continued on page 22***Fireman's Fund stock offering to benefit Amex**

By ROBERT A. FINLAYSON

NEW YORK—American Express Co.'s divestment of a portion of Fireman's Fund Insurance Cos.' property/casualty business is expected to benefit the huge financial conglomerate in two ways.

With only an equity interest in Fireman's Fund, American Express' earnings will be somewhat insulated against the swings in the commercial property/casualty insurance business.

And, by retaining the insurer's highly profitable life insurance operations, which fit nicely with American Express' other consumer-oriented units, American Express will be able to target individuals for its financial-supermarket services.

American Express decided that Fireman's Fund's property/casualty business did not dovetail with its other operations, according to Walter Montgomery, head of investor relations at American Express.

The company announced its decision to make a public offering of shares in the property/casualty operations of Fireman's Fund June 25.

American Express has not disclosed how many shares will be offered or when the offering will be

*Continued on page 24***New law squeezing comp market in Maine**

By CAROL CAIN

AUGUSTA, Maine—The leading workers compensation insurers in Maine say they will reduce the amount of business they write in the state because a new workers compensation law won't allow them to charge adequate rates.

The law, which is effective today, mandates an 8% rate reduction this year, freezes rates for the next 18 months and caps rate increases at 10% annually in 1987 and 1988.

So far, employers in the state are enthused about the rate cut and other cost-saving measures in the law, which was signed June 18 by Gov. Joseph E. Brennan. Maximum weekly benefits for permanent total disability in Maine are among the highest in the nation.

Some observers suggest, however, that enthusiasm may dim if employers are unable to find workers compensation insurance.

And, insurers say the new rate restrictions are intolerable. The last time workers compensation rates in Maine were increased was in March 1981, when rates rose an average 25%. Since then, actuarial analyses conducted by the National Council on Compensation Insurance, a New York-based ratemaking and research organization, have shown an average 130% rate increase is necessary (BI, July 18, 1983; Feb. 21, 1984; May 21, 1984).

Insurers lobbied the Legislature this session and expected some relief (BI, March 25), but the final compromise measure—L.D. 1634—included the minimum 8% reduction, which will take effect Aug. 1, as well as caps on future increases.

The new law also immediately calls for a competitive rating system, under which insurers would file rates individually rather than file rates en masse through a rating organization like the NCCI.

However, insurers say the competitive rating provision will have little effect in Maine, pointing out that rates are too low to encourage competition.

In fact, insurers already have decided to cut the amount of business they will write in Maine because of the low rates allowed.

Boston-based Liberty Mutual Insurance Co., the state's largest workers compensation insurer, last week placed a moratorium on

*Continued on page 22***Airlines' war risk rates likely to rise in light of losses linked to terrorism**

By STACY SHAPIRO

LONDON—Airlines probably will pay more for their hull and liability war risk insurance in the wake of three aviation losses last month that have been linked to terrorism.

One of the losses—the crash of an Air India Boeing 747 jetliner off the Irish coast—is the largest hull loss in aviation insurance history, with the total claim estimated at \$100 million.

It had not been determined last week whether the explosion aboard the jetliner, which killed 303 passengers and 23 crew members, was caused by a terrorist bomb, as speculated.

If the crash were an act of terrorism, the loss would be covered by Air India's hull war risk coverage rather than its so-called "all-risk" hull coverage, which excludes war risks and related perils.

In addition, two other terrorist-related aviation incidents could increase aviation war risk rates:

• The June 13 hijacking of a Trans World Airlines Inc. Boeing 727 on a flight from Athens to Rome. About 40 U.S. passengers and crew were still held hostage late last week, after terrorists killed one passenger. The aircraft, valued at less than \$15 million, was also still being

held by terrorists in Beirut last week.

• The June 12 hijacking and subsequent destruction in Beirut of a \$15 million Boeing 727 owned by Alia—The Royal Jordanian Airline Corp. There were no injuries.

Air India has \$100 million in hull insurance and approximately \$460 million in liability insurance, according to a London underwriter. A spokesman for Air

*Continued on page 6***errors & omissions**

• Caja de Reaseguradora de Chile gave Kroll, Pomerantz & Cameron authority to bring it into the litigation filed March 15 against Mission Insurance Group and two MIG subsidiaries, contrary to allegations that the firm did not have authority to represent the insurer, according to the New York law firm. The reinsurer later withdrew from the lawsuit, the firm says. The law firm's statement regarding this issue was omitted in the editing of a June 24 article.

# States act to block midterm cancellations

By CAROL CAIN  
and STEVE TARAVELLA

State insurance regulators are acting to prevent commercial property/casualty insurers from canceling policies midterm or giving policyholders inadequate notices of non-renewal.

- Recent actions taken include:
  - A temporary order by the Oregon Insurance Division restricts midterm coverage cancellations and requires timely notice of non-renewals, as well as reaffirms the division's existing prohibition on midterm premium increases.
  - A memorandum issued by the Arizona Insurance Department warns insurers that if they cancel large blocks of commercial poli-

cies before expiration, they "will be held accountable for their actions."

- A resolution adopted by the National Assn. of Insurance Commissioners cites the NAIC's opposition to midterm coverage cancellation and short notices of non-renewal.
  - A resolution adopted by the Western Zone NAIC commissioners warns insurers that their member commissioners will take appropriate action regarding insurer rate increases, withdrawals and writing limitations.
- These actions follow massive midterm coverage cancellations by some insurers and reflect insurance regulators' concerns that more such cancellations could occur.
- Transport Indemnity Co. in Los Angeles, for example, canceled in mid-April as many as 2,500 property/casualty policies (BI, June

3; May 6). But, California regulators say the cancellations did not violate state laws.

The temporary order in Oregon, which went into effect June 15, applies to all lines of insurance except reinsurance, marine, transportation, health and life coverages.

Under the order, "no insurance policy may be canceled by the insurer prior to the expiration of the agreed term or one year from the effective date of the policy or renewal, whichever is less."

However, midterm cancellations will be allowed if the policyholder fails to pay the premium promptly or if the cancellation is based on certain grounds related to the policy conditions, such as misrepresentation, substantial changes in the risk assumed or substantial breaches of contractual duties, conditions

or warranties.

In addition, the order does not apply to policies that have been in effect less than 60 days from the time a notice of cancellation is mailed or delivered.

The Oregon order also requires insurers to give a policyholder at least 30 days' notice if the insurer intends not to renew a policy.

Finally, the order reaffirms the division's rules prohibiting midterm premium increases.

A public hearing to consider permanent adoption of the rules is slated for Aug. 15.

Notice of the temporary order was signed May 30 after policyholders, insurance agents and legislators complained about midterm cancellations to Insurance Commissioner Jo

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# N.Y. attorney general's office issues objections to ISO forms

By MICHAEL BRADFORD

NEW YORK—The New York attorney general's office says the Insurance Services Offices' proposed commercial general liability forms would not reduce "wasteful" coverage litigation, as ISO claims.

The attorney general's office also expresses concern that the proposed elimination of virtually all pollution coverage, the retroactive dates on the claims-made form and the new aggregate limits also will prompt litigation and may leave policyholders and the general public without adequate protection.

State Insurance Superintendent James P. Corcoran is expected to decide this month whether the state will allow the new ISO forms to be used in New York (BI, June 10). At least 27 states have approved the forms.

The comments drafted by Attorney General Robert Abram's office were submitted as testimony to be added to the record of a May 16 public hearing held by the state Insurance Department to discuss the proposed forms.

At that hearing, brokers and representatives of buyers, including the Risk & Insurance Management Society, strongly opposed the new forms.

The attorney general's office decided to add testimony to the record of the May hearing because it felt "it was important for the consumer to be heard," said Peter Bienstock, chief of the Consumer Frauds & Protection Bureau, the division of the attorney general's office that drafted the comments.

The statement is not the first time the attorney general's office has spoken out on insurance matters, Mr. Bienstock says.

"We've commented from time to time," he said, on matters like claims-settlement practices and life insurance cost disclosure regulations.

The attorney general's office's nine-page statement attacks ISO's claim that the new forms—particularly the claims-made policy—would reduce costly litigation associated with liability claims.

According to the statement, the attorney general's office takes a "jaundiced view of proposed changes which do not reduce unnecessary litigation, but merely make optional, at added cost, various coverages which should be standard."

The attorney general's office is especially concerned about ISO proposals that would eliminate virtually all pollution coverage from the CGL forms, Mr. Bienstock says. The office believes that pollution coverage should be standard, he said, and the statement calls the ISO proposal to eliminate the coverage "overkill."

"The coverage, it is claimed, will be available on an optional basis at an additional cost," the statement reads. "This proposal has, in part, the valid purpose of eliminating wasteful litigation concerning whether 'gradual' pollution can be deemed 'sudden and accidental,' and therefore covered under the present form policy."

"However, the proposed solution constitutes overkill, and more importantly, it is contrary to our national and state efforts to protect the public from environmental hazards."

Wasteful litigation would more effectively be eliminated and the public welfare would be better protected if the CGL forms made comprehensive pollution coverage standard, the statement notes.

"Insurers would then be performing their intended function of assuming risk, the public would be adequately protected, and all insureds would be contributing, thus spreading the risk as broadly as possible."

The statement warns that pollution coverage is "simply too important for the public's protection to allow businesses to make the decision of whether or not to make additional expenditures in order to purchase adequate pollution insurance."

Another aspect of the proposed claims-made forms that could lead to increased litigation, Mr. Bienstock says, is the unclear use of the word "occurrence."

Because the claims-made form would respond only to claims that were made during the policy period for "occurrences" after a specified retroactive date, litigation will arise to contest the term "occurrence," the statement argues.

"While leaving the definition of 'occurrence' as ambiguous as in the current CGL policy, the ISO claims-made proposal undoubtedly would continue the profusion of wasteful litigation, but now the litigation would be over the question of whether the occurrence was before or after the specified date,"

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**'Certainly insurers need not be required to play Russian roulette, (but) they should not shirk from their basic function—assuming risk,' the statement says.**

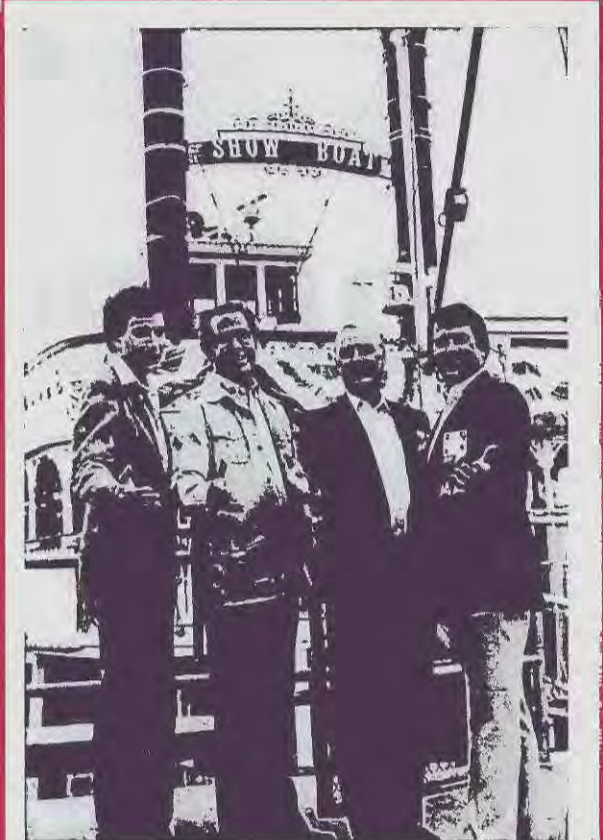


Photo: Meg Fletcher

## Risk management harmony

Warming up for their impromptu debut during a paddlewheel boat cruise of San Diego Bay are the Risky Business Four—all risk managers for public entities. The barbershop quartet entertained many of the 530 attendees of the Public Risk & Insurance Management Assn. conference last month in San Diego. From left, Don Herrold of Laramie, Wyo.; Allen Hyman of Corpus Christi, Texas; Milan Rice of El Paso, Texas; and Ron Dial of Visalia, Calif. Coverage of the PRIMA conference begins on page 10.

# Capacity, rate hikes worry top brokers

Rising rates, shrinking capacity and the introduction of a new commercial general liability claims-made form—all the troublesome market factors for risk managers—are serious concerns to the largest property/casualty insurance brokerages, too.

Insurance brokers benefit from only the first of these three tightening market conditions, since rising prices increase their commission income. But, even that is not making brokerage executives rub their hands in glee, because increased prices are a reflection of reduced capacity.

And together, that means brokers have to work harder, not only at finding markets but also at explaining to clients why they are paying higher premiums for lower limits of coverage, which also is often more limited in scope.

"Our workload has increased tremendously in this market. Our people have never worked harder," says Richard A. Archer, president of Los Angeles-based Emett & Chandler Cos. Inc., the 13th-largest U.S.-based broker.

"With diminishing capacity, we are working hard to satisfy the requirements of our clients," says Robert F. Corroon, chairman and chief executive officer of Corroon & Black Corp. in New York, the sixth-largest broker in the United States.

"The tight market," is the most difficult problem facing Boston-based Republic Hogg Robinson, said Charles E. Keller, president and CEO of the 14th-largest U.S.-based brokerage.

How some of the leaders of the 20 largest insurance brokerages in the country view current market capacity, prices and the proposed claims-made commercial general liability form emerged during recent interviews with *Business Insurance* reporters for

reports on their companies, ranked in the Agent/Broker Profiles issue (BI, June 24).

The problem of not finding enough insurance to fill clients' needs is on the minds of all the brokerage executives.

"We have grave concerns about capacity, our ability to fulfill our clients' requirements, which in the present environment we are not able to do," says Frank J. Tasco, president of Marsh & McLennan Cos. Inc., the largest broker in the world.

"I am concerned about capacity," says Patrick G. Ryan, chairman and chief executive officer of Rollins Burdick Hunter Co. in Chicago, the seventh-largest broker.

"I think there will be a capital shortage,"

he said, creating the risk that clients will not be able to purchase enough insurance.

"We're seeing a lot of companies that say they can't take on new business because they don't have the surplus," observed Sidney A. Stewart, chairman and chief executive officer of The Crump Cos. Inc. in Memphis, Tenn., the ninth-largest broker.

"If you start getting above \$200 million, you've really got to scrape," says Emett & Chandler's Mr. Archer.

Limits are far less for some lines of coverage that are particularly difficult to place, brokers agree.

By type of insurance, capacity is a problem for professional liability, product liability and general liability involving a pollution risk, said Horace Holcomb, senior vp of Alexander & Alexander Inc., the second-largest insurance broker.

"There is a significant contraction in the number of people who will write this business," Mr. Holcomb said.

For property risks, he noted, capacity

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**'We have grave concerns about capacity,' says Marsh & McLennan's Frank J. Tasco.**

# COMING SOON

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## N.Y. statement

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 the comments say.

The statement suggests it would be "far more effective to select one of the various interpretations of the term 'occurrence,' and specifically exclude all other interpretations."

Also, it continues, insurers may seek to move forward in time the retroactive date at renewals, "particularly when they are aware of an occurrence for which a claim has not yet been filed."

"Or, insurers might seek an additional premium to keep the same retroactive date in a renewal policy. When a CGL claims-made policyholder wants to change insurers, the new insurer might be unwilling to retain the previous retroactive date, or may impose a stiff surcharge to do so."

As a result, the attorney general's office claims that policyholders wanting to avoid gaps in coverage could find themselves locked into

one insurer.

"Further," the comments note, "unless they are very careful, policyholders who do change insurers may inadvertently leave gaps in their coverage."

The proposed claims-made form would allow buyers to purchase a "tail" endorsement that is designed to prevent gaps in coverage caused by cancellation or non-renewal. It would cover claims that occurred between the retroactive date of the policy and its expiration date, even if the claims are not reported during the policy period. The premium for such coverage could not exceed 200% of the premium for the final period of the claims-made policy.

The attorney general's office finds "equally vexing problems" concerning the tail endorsement.

Because purchase of the tail is at the policyholder's discretion, consumers who ultimately sue could be left without compensation if the policyholder is no longer in business and has not purchased tail coverage, the statement says.

"The decision (whether) to purchase a tail has too many implications for society generally to be left to the discretion of each purchaser of a CGL policy."

The statement says that ISO has argued that certain companies may not need long tails because there is little chance of suits being filed against them for past occurrences.

"If that is so," the statement contends, "then for those companies, the portion of the rates for long-tail coverage should be very low and their savings from declining such coverage should be minimal."

If the premium for the tail is not low, the statement argues, "then the insurance industry is conceding that for those companies, there is in fact significant risk of future suits being filed for occurrences today. A company going out of business will undoubtedly choose not to pay double their last insurance premium to compensate future consumers who may sue them."

The optional tail coverage "merely transfers the risk from the insurer to the policyholder, to the detriment of consumers who sue in the future," the statement says.

The new forms also feature two aggregate limits. One would apply to products/completed operations and another to all other risks.

The statement says the aggregate limits also are "intended to shift risk back onto policyholders."

The aggregate limits reduce the risk insurers assume by establishing limits of liability, the comments note, saying, "While certainly insurers need not be required to play Russian roulette, they should not shirk from their basic function—assuming risk."

The use of the aggregate limits increases the risk for policyholders, according to the statement.

"Policyholders will therefore be getting less coverage than they now do. To even approach the same coverage, by buying a very high general aggregate limit, the policyholder would undoubtedly have to pay substantially more than at present," the statement says.

The statement also says a letter from ISO President Daniel J. McNamara to member companies and published articles indicate ISO "is considering for quick adoption yet another shrinkage of coverage—an aggregate limit on defense costs plus indemnity payments. Contrary to ISO assertions, this change would likely do little to eliminate wasteful litigation."

"Instead, it merely means that to obtain the same protection, more coverage would have to be purchased. If it is advanced, this proposal for reduced coverage should be rejected."

Officials at ISO's office in New York would not comment on the statement.

Officials at the New York Insurance Department could not be reached for comment.

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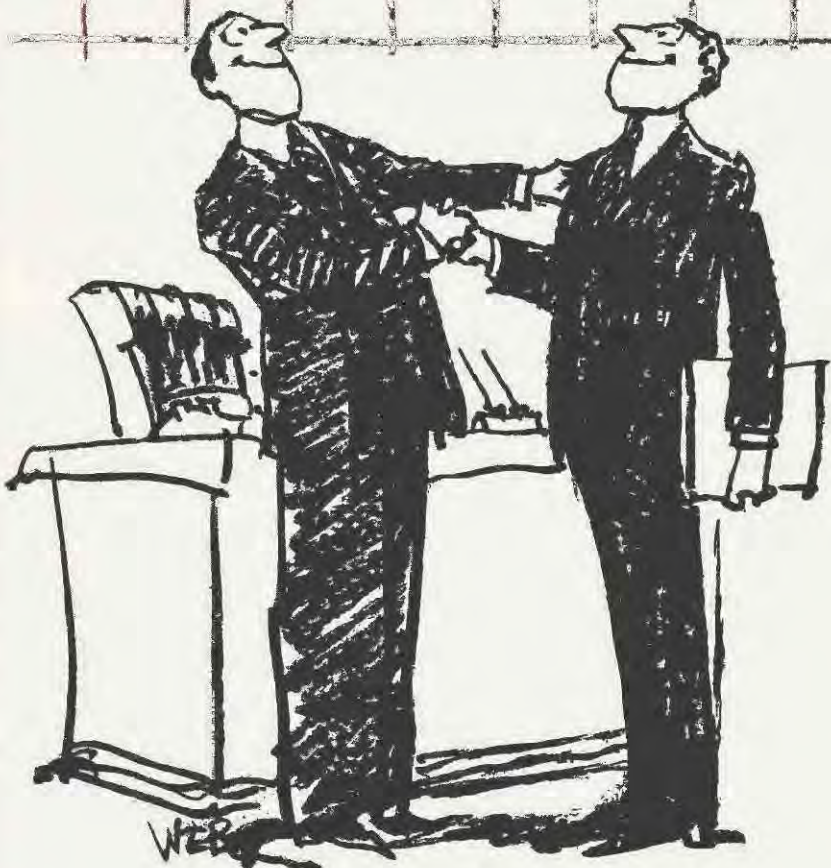
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## War risk rates

Continued from page 2

India says the airline has only \$100 million in liability coverage.

Air India's "all-risk" coverage is written by General Insurance Corp. of India and reinsured in the world aviation insurance market, particularly with Lloyd's of London and other London underwriters and French insurers.

Its hull war risk reinsurance is led at Lloyd's, according to the Air India spokesman, but the syndicate is not known. It's common for the hull war risk limit to be the same as the all-risk hull limit.

The Air India jet, bound for Bombay on a flight originating in Toronto, is insured for the replacement value of \$95 million, sources said. Also, a \$5 million spare engine also insured under Air India's coverage, was on the plane.

TWA has \$75 million in hull coverage for each of its aircraft and \$500 million liability coverage, ac-

ording to a London underwriter. Both its all-risk and war risk coverage are led by Associated Aviation Underwriters Inc. in New York, an underwriting facility owned by a number of U.S. insurers.

Fifty-five percent of TWA's coverage is placed in the U.S. market, 30% is in the London market and 15% is in the French market.

The details of the Jordanian airline's coverage for the jetliner destroyed by terrorists in Beirut last month was not available.

Hull underwriters had said last month—after the TWA and Alia incidents but before the crash of the Air India jet—that they would increase aviation hull war risk rates effective July 1 to a minimum of 10 cents per \$100 of insured value from 4 cents per \$100.

But underwriters said last week, after the Air India crash, that hull war risk rates may rise further if it's found a bomb caused the crash.

"Hull war risk rates will go up again if it is proven that Air India's disaster was a war and allied perils loss," said Barry Coleman, a leading Lloyd's aviation war risk underwriter who participated on both the TWA and Air India risks.

"There is not enough in the kitty to cover a 747 loss," he said. "But we don't know if it is a war loss yet, so we cannot speculate. . . ."

In addition to an increase in rates for hull war risk insurance, which is purchased separately from other aviation coverages, sources say underwriters may consider increasing liability war risk rates. Instead of being a separate policy, liability war risk coverage is included with "all-risk" aviation liability policies for an additional premium, currently averaging about 5% of the all-risk liability premium.

"The additional liability premium could also go up. It wouldn't surprise me," Mr. Coleman said.

However, sources say any increases in hull or liability war risk rates probably will not affect the U.S. airlines that renew their aviation coverage on July 1, including Delta Air Lines Inc., Northwest Orient Airlines Inc. and Pan American World Airways Inc. Most of these renewals are in place.

"It's too late for July 1 renewals," said one Lloyd's broker.

The potential liability faced by Air India and TWA from last month's incidents is capped by international agreements limiting the liability of airlines with international operations.

The 1929 Warsaw Convention dictates that airlines face a maximum liability of \$10,000 per passenger on international flights.

The 1966 Montreal Agreement, which applies to airlines that operate from U.S. airports or carry U.S. passengers, raises the maximum liability to \$75,000 per passenger, including legal costs. Under the agreement, plaintiffs cannot collect more than this unless willful misconduct by the airline is proven.

Thus, Air India's maximum liability would be capped at \$10,000 per passenger for non-U.S. citizens, since the flight did not depart from and was not bound for the United States. Its liability for the handful of U.S. citizens reportedly aboard would be capped at \$75,000 per passenger under the Montreal Agreement, as would TWA's liability.

Of course, survivors of air disaster victims and hijacked passengers could challenge these limits in court or attempt to prove willful misconduct by the airlines.

"There are some settlements higher than \$75,000, but the plaintiff must prove that there was willful misconduct, which is difficult and takes protracted litigations," said James Landry, senior vp and general counsel of the Air Transport Assn. of America, an industry group. "You'd have to show that there was willful misconduct on the part of TWA and, without being a jury or a judge, I think it would be difficult to establish." ■

# WAREHOUSE FIRES

**Several Major Fire Losses of the Last Decade** have involved warehouses, which were fully sprinklered and yet completely destroyed. In some cases, the sprinkler system was designed to minimum specifications. In others, the occupancy was changed to a more hazardous storage than originally anticipated. And in still others, temporary storage clogged aisles. A few of these conditions existed in two of the world's largest losses, which are reviewed here:

**Automotive Supplies.** Fire started in the temporary storage of plastic parts and spread to nearby cans of motor oil in cartons, which were palletized and stored in the aisles. Two employees attempted unsuccessfully to put out the fire with a hose stream from a nearby hose station within the building. A few minutes later, the plant fire brigade arrived and tried to fight the fire but was hampered by storage piled in the aisles. Although sprinklers were operating, the available water densities could not penetrate the intense fire plume generated by the burning plastics and oil. A total of 250 firemen fought the blaze, which continued to rage, overwhelming the sprinkler system and destroying about 18 acres of building. Estimated loss: \$145 million.

**Retail Products.** A carton of aerosol cans, containing carburetor and choke cleaner, was dislodged from its storage rack, fell to the floor, and split open. One or more cans discharged their contents which became ignited by a nearby electrically powered lift truck. Fire spread quickly over the 15-foot high palletized storage of aerosols, overpowering the existing sprinkler protection. Flaming, rocketing aerosol cans started fires in adjacent storage that included foamed plastic plates, plastic toys, additional aerosols and motor oil.

Within six minutes, the fire alarm had sounded, four sprinkler risers were flowing, the electric fire pump had started, and the fire department was on its way. In the meantime, the warehouse fire brigade entered the building but in less than two minutes was forced out by thick, black smoke. Within 20 minutes, flames broke through the roof and aerosol cans could be seen rocketing through the air. Some 300 firefighters got the blaze under control nine hours later. Estimated loss: \$125 million.

**IRI Recently Concluded a Review of Its Major Warehouse Exposures**, evaluating the adequacy of existing protection, specifying additional protection as necessary, and isolating exposures that are ticking "time bombs." Here are some of the "time bombs" most commonly encountered:

1. **Aerosol storage** is mixed with otherwise ordinary hazard storage.
2. **Hazard levels** have increased as the result of a change in commodities and their packaging.
3. **Storage height** is greater than planned by protection designers.

Specific suggestions for isolating aerosol storage are available from Mrs. P.A. Sasso, IRI, 85 Woodland Street, Hartford, Connecticut 06102 or telephone (203) 525-2601. Ask for a complimentary copy of **The Sentinel**, 2nd Quarter 1985, which features "The Hazards of Aerosols".

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## opinions

# Only a beginning

THE SIGNING of the Wellington agreement following 2½ years of negotiation is indeed a historic event.

This is the first time that defendants in massive tort litigation have drawn together to form a facility for handling and paying claims outside of the court system.

And, this is the first time that insurers and their policyholders have settled en masse disputes over the interpretation of insurance policies.

Those who negotiated the Wellington agreement deserve congratulations and are entitled to celebrate their considerable accomplishment.

However, the celebration over the signing of the Wellington agreement should be brief because much more needs to be accomplished before the Wellington agreement can achieve its goal of significantly reducing litigation costs and relieving the court system of massive litigation.

More producers and insurers need to be brought into the agreement in order to resolve the asbestos coverage litigation and for the claims-handling facility ultimately to succeed.

So far, most of the asbestos coverage litigation will continue because so many participants in each of the cases have not signed the Wellington agreement. While we appreciate that the pact should create savings because some of the participants will be dismissed from the actions, we'd like to see all this coverage litigation resolved by the Wellington agreement.

Full employment for asbestos defense attorneys—whether defending insurers against policyholders' suits or defending policyholders against insurers' declara-



tory judgment actions—should be abolished.

And, equally if not more important, signers of the Wellington agreement must now start building bridges with plaintiffs' attorneys. Plaintiffs' attorneys must be convinced that they should bring their clients' claims to the facility when it opens next year.

Only with plaintiffs' cooperation can the Wellington facility achieve its most important goal of conserving insurance coverage assets for payment of damage claims to victims of asbestos, instead of squandering the money on litigation. ■

## letters

### Logic shows FSAs foster overuse of health care

To the editor: Let's hear a round of applause for *BI's* May 27 article entitled "Federal Report Urges Restrictions on FSAs." I was pleased to see someone finally calling a spade a spade.

Proponents of flexible spending accounts need a course in basic logic. Any program that...

1. Tells employees they must "use it or lose it,"

2. Takes tax income away from our federal government, and

3. Allows employees to pick the level of benefits they will receive, (in the cafeteria-style FSA... is destined for failure or a large rate increase.

Items 1 and 3 listed above encourage employees to utilize a plan to its fullest

extent. How can someone call that a cost-containment plan?

Granted, the specific benefits included may be designed to contain costs, but the plan itself encourages overutilization, regardless of the tax savings gained.

If an employer gives a 21-year-old employee and a 64-year-old employee the choice of several medical and dental plans, do you think that the 21-year-old will pick a low-deductible medical plan with no dental benefit? Do you think the 64-year-old will pick the low-deductible dental plan with a high-deductible medical plan?

No way! And, what effect do you think this has on the level of claims?

I was amazed to see that health care ex-

penditures increased only 4% to 6% with the introduction of a flexible spending account, based upon a study performed by the U.S. Department of Health and Human Services. (This could be due to the low level of employee contribution assumed.)

The primary advantage of an FSA is the tax savings derived. How long do you think the Internal Revenue Service will allow this benefit to continue?

In any event, thanks for printing some of the negative aspects of an FSA benefit program.

**Richard C. Mattingley II**  
Regional Manager  
Ruland & Mattingley  
Solana Beach, Calif.

### Insurers' 'insane' price increases will lead to federal intervention

To the editor: A young boy stood on a street corner shouting, "Oranges for sale, oranges for sale!" A passing business executive said, "OK Sonny, I'll buy an orange. How much?" The child replied, "\$1 million." The stunned businessman said, "\$1 million for an orange? That's a lot of money!" The kid replied, "Yes, but I only have to sell one!"

Does this have any relevance to the insurance industry? You bet. On a daily basis, we see oranges/insurance offered for as much as 10 times last year's price.

The kid probably didn't have a "capacity" problem with oranges, but if the industry as a whole had a commercial multiperil combined loss and expense ratio of 134.52% (after dividends) for 1984 (according to A.M. Best Co.), it is obvious that

premium increases of 300% to 1,000% for this line are not warranted.

Yes, we desperately need to make an underwriting profit and to replace lost surplus. But at what price? Is the price to be the most severe market dislocation the buyer has ever seen?

As an example, we offer the condominium complex that last year paid \$49,000 in multiperil package premiums. With a 111% eight-year verifiable loss ratio, the best renewal offer this year is more than \$425,000. It is, in fact, the *only* offer.

This type of insane pricing and class underwriting can *only* lead to a clamor for more effective regulation of our industry. This callous "take it or leave it"

attitude invites federal regulation of pricing and forms.

The businessman didn't *need* an orange—at least not for \$1 million. Consumers and businesses *need* insurance and, more importantly, they need stable, solvent, responsible and responsive providers of this commodity or service.

Yes I know. It will work itself out in the usual insurance cycle, but this time we may have gone too far.

In the meantime, does anyone have a sensibly priced orange for sale? I'd sure like to speak with him!

**Richard D. Gund, CPCU**  
Professionally Planned Protection  
Hollywood, Calif.

### Consider state laws on auto coverage

To the editor: A Perspective section article on fleet loss control (*BI*, May 6) contained the suggestion that employers might restrict operation of company vehicles, with only employees and their spouses permitted to drive. It then said, "Employers should inform employees of this restriction, and of the uninsured status of any (other) driver."

In states with compulsory auto insurance, insurance and self-insurance filings

must meet statutory standards as coverage for the protection of injured parties. Then the most that the employer can do is provide for recoupment from unauthorized drivers. This point should not be overlooked.

**Bob A. Hedges**  
Professor of Risk Management  
and Insurance  
Temple University  
Philadelphia

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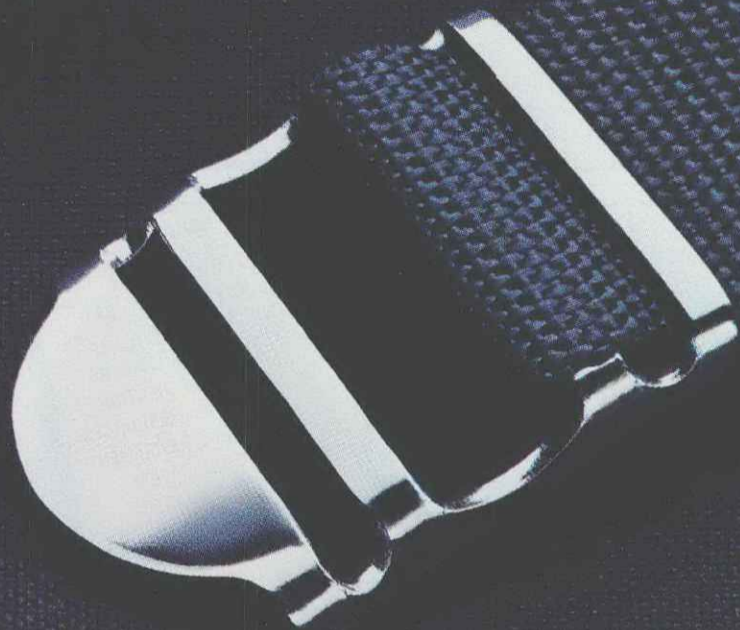
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## Programs win PRIMA awards

SAN DIEGO—Three innovative and money-saving programs won risk management achievement awards at the Public Risk & Insurance Management Assn.'s annual conference last month in San Diego.

Rockland County, N.Y., received the risk-financing award for saving \$5.8 million since 1977 under a program that included raising the county's deductible for general liability claims to \$100,000, self-funding workers compensation risks and convincing employee unions to accept a self-insured health plan.

Public schools in Jefferson County, Ky., received the safety and loss prevention award for a school bus driver training program. The \$80,000 program, which features annual in-service training and an obstacle course driving competition, netted a 39.3% average yearly reduction in insurance premiums, a 36.3% average yearly reduction in workers

compensation loss costs and a 32.3% reduction in total accidents.

The Virginia Housing Development Authority received the employee benefits award for developing a 401(k) savings plan.

The awards were presented on behalf of the more than 900 members of the PRIMA organization, who represent more than 6,000 public entities either directly or as pools.

Officers also were installed.

Succeeding Allen F. Hyman as president of PRIMA is Mary Lou Emmert, risk and benefits manager for Monterey County, Calif.

Joining Ms. Emmert on the board of directors as new vps are: Mary DeCampi, risk manager for Alexandria, Va.; Terry Bone of Colorado Counties Inc. in Denver; and Gary Kuckel, city manager of Coldwater, Mich.

Continuing on the board as vps are Mark Ferraro, risk manager for Dallas; Gary Martin, risk manager for Manhattan Beach, Calif.; and Howard Taylor, risk manager for Lakeland, Fla.



Ms. Emmert

## Governments should use 'streetwise strategies' in fighting liability claims

By MEG FLETCHER

SAN DIEGO—Local governments that adopt streetwise strategies to fight liability claims can improve the odds that they won't be the subject of another liability horror story.

Adopting policies governing the operations of jails and police departments to prevent claims, and promptly investigating and defending against claims that are filed, are especially important maneuvers.

This advice came from three attorneys and an insurance expert who spoke at seminars sponsored by the Public Risk & Insurance

Management Assn. during its sixth annual conference last month.

"Juries are notoriously generous with government money," warned John W. Witt, city attorney for San Diego.

Mr. Witt described as the "most shocking" case the \$9.5 million verdict trebled to \$28.5 million that Grayslake, Ill., was ordered to pay in an antitrust case because it denied a sewer tie-in to a developer (BI, Aug. 13, 1984).

That verdict prompted federal legislation to protect local governments from similar suits, and Grayslake has filed post-trial motions asking that the new protection be extended to it (BI, Oct. 1, 1984; Oct. 22, 1984).

The worst police horror story involved South Tucson, Ariz., which was ordered to pay more than \$3 million to a police officer who was paralyzed after being shot (BI, May 17, 1982).

The city responded to the judgment by filing for bankruptcy, but ultimately agreed to fund a settlement package by selling bonds and some city property, Mr. Witt said.

And now, every coastal city in California is "scared witless" about a \$6 million judgment in 1984 against Newport Beach, Cal., in connection with a swimmer's paralysis, Mr. Witt said.

Cited as precedent in that case was San Diego's \$25,000 settlement with survivors of a woman who drowned in a rip tide off a public beach. The plaintiff's attorney argued that San Diego had a duty to inform swimmers of the natural hazard because it provided lifeguards during the swimming season, although the accident occurred before the season began, he said.

Many of a public entity's most serious claims concern police, the speakers observed.

Jails and lockups generate the greatest number of claims against police, said James W. Chapman, resident vp of Markel Service Inc. in Richmond, Va., a managing general agent and broker that specializes in coverages for police and public officials.

For instance, at least one suicide has been committed in about 50% of the 4,000 jails in the United States, according to statistics cited by attorney James R. Schirott of Itasca, Ill.

Streetwise governments will prevent suicides in their jails by training jailers to detect warning signs and to take precautions, Mr. Schirott advised.

All prisoners should be within the jailers' sight or earshot. And, those who threaten suicide should be put into a cell and constantly monitored by camera.

Liability claims also can be spurred when prisoners harm one another. Protecting prisoners from one another can be difficult because commonplace items can be made into weapons. A tightly rolled magazine can become a club; a stick deodorant melted into a cup can become a Molotov cocktail.

A "surprising" number of jails do not separate prisoners by age or the seriousness of their charge, Mr. Schirott said. "You must segregate," he emphasized.

While jails create the most claims, the costliest claims come from police activities on the street,



Mr. Chapman

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Continued on page 12

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**Municipal liability**

*Continued from page 10*  
including pursuit cases, Mr. Chapman observed.

And, problems also surface for police in regard to the hiring, training and supervising of subordinates, Mr. Schirott said.

Only 2% of U.S. counties require psychological testing of jailers, according to a survey by a national sheriffs association. Meanwhile, the other 98% of U.S. counties are exposing themselves to unnecessary liability, he said.

A job applicant can be screened with the help of psychological tests and lie detectors for about \$100. "It's just crazy not to do it," Mr. Schirott said.

Prospective employers should also thoroughly check the background of police applicants, he said.

Once hired, police personnel can generally be fired at will as long as the reason is other than political, Mr. Schirott noted.

Streetwise municipalities will adopt reasonable and workable policies—especially in regard to pursuing suspects, using force and weapons and training jail personnel—as the best risk control.

Documenting training of jailers and their receipt of a policy manual may help reduce the size of a judgment in a liability case, Mr. Chapman said.

A recent U.S. Supreme Court decision made municipalities optimistic that courts would be reasonable in assessing training programs. The court ruled that an employee's misconduct in an isolated incident could not be considered proof that a training program was inadequate.



Mr. Witt

Police reports can create problems for municipalities, warned Jay S. Judge of the Park Ridge, Ill., law firm of Judge & Knight Ltd.

Police officers tend to include opinions and draw conclusions, rather than merely present facts, he said. As a result, "every accident report done by police may be your next lawsuit," Mr. Judge warned.

Once a claim is filed, streetwise municipalities can control the liability cost with early investigation of the claim and a well-controlled defense.

And, the claims should be reported promptly to insurers to ensure coverage.

Mr. Chapman cited the approach used by Ken Edens, risk manager of Topeka, Kan., who said he begins prompt in-house review of cases that could become potential

claims upon reading the reports.

The city attorney immediately sends him a letter asking him to do the investigation, so the information is protected by attorney-client privilege and cannot be used against the city later.

Municipalities should employ an aggressive defense attorney who argues for reason in interpreting statutes, Mr. Judge advised.

He also urged public officials to negotiate with defense counsel so it can defend nuisance suits without overspending.

In most police cases, defense costs are the main liability, with \$3 out of every \$4 going to defense attorneys, Mr. Chapman said.

When an insurance company wants to settle a case and the city does not, the city should accept the insurance company's settlement, release the insurer from additional responsibility and fight the case tooth and nail, Mr. Judge suggested.

Whether the subject of the suit is the police or another public official, a "substantial" exposure is to punitive damages, said Mr. Schirott.

A public official acting in his official capacity who is successfully sued for punitive damages must be indemnified by his employer, according to a recent decision by the 7th U.S. Circuit Court of Appeals, which has jurisdiction over Illinois, Indiana and Wisconsin, he added. ■

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**Finding coverage tougher  
for public entities: Panel**

By MEG FLETCHER

SAN DIEGO—Public entities' special handicaps can put liability insurance out of their reach when commercial insurance is difficult to buy.

Consequently, public entities must work harder to grab the insurance that is available.

That was the assessment offered by three panelists who spoke last month at the sixth annual Public Risk & Insurance Management Assn. conference.

The conference was called "The Turning Tide," a reference to changing conditions in the commercial marketplace.

Public entities are handicapped by two characteristics, according to Michael P. Vaughan-Fowler, a London-based director of the North American Division of broker J.H. Minet Co. Ltd.:

- They have high visibility, which results in an attitude of entitlement by plaintiffs and high claims frequency.
- Public entities often seek competitive bids from insurers, even in a sellers' market. This makes them unattractive to insurers, especially those in London that attach a great deal of importance to loyalty.

The bidding problem is compounded further when public entities send out several brokers seeking the same coverages.

Then, a single insurer may receive duplicate submissions from different brokers.

It is better to choose one broker that has access to all markets, Mr. Vaughan-Fowler explained.

"It is incongruous to have insurance purchased on the same basis as paper clips," he quipped.

Municipalities should not be surprised by big premium increases, advised a consultant.

"Frankly, a 100% increase should be considered a major coup by a risk manager," according to H. Felix Kloman, principal and associate director of the consulting firm Tillinghast Nelson & Warren. Mr. Kloman is based in Darien, Conn.

One town that Mr. Kloman declined to name was quoted a premium 1,069% higher than last year's—\$695,000 compared with \$65,000—for \$1 million in liability insurance in excess of a \$150,000 self-insured retention, he said.

Following the discussion, Mr. Kloman said he is still continuing to work to find coverage for that town, which had a problem with inadequate loss information.

"Dramatically" higher premiums is only one of several characteristics of what Mr. Kloman termed the "anti-market" of 1985.

Other characteristics include: fewer insurers, dwindling underwriting capacity, increased underwriting selectivity, higher retentions by policyholders and policy restrictions and modifications.

A major factor in the tighter market conditions is the reduction of reinsurance available to primary insurers, noted James G. Smith, vp of broker Johnson & Higgins in its Houston office.

He said he expects "constant" and "steep" price increases for the next two years.

He also predicts that, as of Jan. 1, there will not be any sudden and accidental pollution coverage available. Coverage for police will be available primarily on a claims-made basis, unless there are major tort changes, and there will be almost no coverage for prior acts under a claims-made form.

In this marketplace, public entity risk managers must work harder, the panelists advised.

The panelists recommended short-term strategies of: improving risk assessment and data collection, developing better contacts with underwriters by personalizing submissions, educating governing boards and finance committees, considering collective purchasing, funding higher retention levels and revising agent/broker remuneration to a fee rather than commission basis. ■

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# Comp cost control requires broad program: Panel

By MEG FLETCHER

SAN DIEGO—Controlling public entities' workers compensation costs requires a broad-based program that begins even before a worker is hired, experts say.

Critical steps in a work comp cost-management program—which can be used by both public and private employers—were outlined during two seminars at the annual conference of the Public Risk & Insurance Management Assn. last month in San Diego.

These steps include:

- Pre-employment physicals.
- Proper job training.
- Prompt reporting and investigation of accidents.
- Worker rehabilitation.
- Claims and litigation management.

A workers compensation cost-control program for public entities starts with pre-employment physicals, especially for employees in public works and utility departments, said Mary Lou Emmert, president of PRIMA and risk and employee benefits manager for Monterey County, Calif.

The physicals will be most useful, she suggested, if the doctor has a comprehensive checklist detailing the physical requirements of individual jobs and marks off those physical tasks the employee is able to perform.

Once a physically capable employee is hired, it is important that the employee and his or her supervisor receive proper training in specific job duties and that the training be periodically repeated.

"If you don't, you are just fishing for a compensation claim and probably a liability claim" from a third party triggered by the employee's poor training, Ms. Emmert said.

Prompt reporting of an injury is the most important aspect of a work comp management program, she said. An injured employee should fill out a standardized report, which should be signed by the supervisor and promptly sent to the risk manager for review and possible investigation.

The panelists pointed out, however, that a risk manager's dealings with the injured worker may be limited by statutes that vary from state to state.

An injured employee should be sent, when possible, to a clinic or doctor who has the employer's welfare in mind and who is familiar with the kinds of reports required by the employer, said Edward Fleming, president of Fleming & Associates, a third-party administrator in La Canada, Calif.

"If we don't care where he goes, we are throwing money away," he said.

The condition of an employee who is not on the job and is receiving comp benefits should be tracked closely through frequent phone calls from a supervisor or another official, panelists agreed.

If an employee with a soft-tissue injury—like a muscle strain—is out of work for six weeks, it is time to have a medical specialist review the injury, Mr. Fleming said.

Ideally, good medical care and personal follow-up by the employer will aid an injured employee's recovery and make him or her feel needed so he or she will return to work as soon as possible, Ms. Emmert said. Achieving that goal reduces direct and indirect costs of any injury, she added.

But, many workers compensation cases do not follow that ideal pattern, panelists noted.

Rehabilitation specialists should be called in as early as possible in cases in which an employee is severely injured or suffers from chronic pain or in which the employer's exposures are great, said Dr. Phillip Bussey, vp of Bussey,

Davis & Associates Inc., a rehabilitation counseling firm in Lanham, Md.

"So often, people in our field are called in to clean up a mess," added Estelle L. Davis, president of Bussey, Davis & Associates. Early intervention by rehabilitation specialists can reduce costs by keeping an employee from getting locked into a rigid psychological reaction to the injury, Dr. Bussey and Ms. Davis agreed.

Good rehabilitation not only helps workers deal with their immediate medical problems, but it also helps them plan for the future.



Rehabilitating an injured worker involves many physiological and psychological aspects, including a worker's perception of pain and willingness to tolerate it, Ms. Davis said. She favors outpatient treatment rather than care in a "pain clinic" for chronic pain sufferers.

Returning an injured employee to work requires a doctor's certification that he or she can perform the physical demands of the former job, even on a part-time basis, or modifying the job so he or she can return to work, the panelists said.

But, that's easier said than done.

In a typical case cited by Ms. Davis, the worker is trained only in manual labor. He is released for "light duty," but it is not adequately defined. He worries not only about reinjuring himself, but also about losing his job. He responds with be-

havior that marks him as a malingerer and that causes him emotional problems, she said.

A solution lies in the proper definition not only of a job's physical requirements but also of an injured employee's physical condition.

Defining an injured worker's condition can be done with the help of rules and regulations governing Social Security disability payments, Dr. Bussey suggested.

Yet, even proper definition of both the job requirements and the employee's capabilities will not solve all problems, according to comments at the seminars.

For instance, Mary L. DeCampli, risk manager for the city of Alexandria, Va., asked panelists to what extent the city should have been expected to meet the needs of a tourist council employee who could

no longer climb steps in a historic building in which she led tours.

Ms. Davis said it should be enough if the city made "reasonable" accommodations, like installing a ramp, grab rails, etc.

Ms. DeCampli said the worker's problem was resolved by moving her into a position that required less walking. But, the city's handling of this case caused other workers to seek help for their special needs, creating a morale problem, she said after the session.

A worker who would rather stay off the job and collect comp benefits than return to work poses different problems for public employers, panelists agreed.

Employers should respond by carefully scrutinizing these employees' claims and protesting un-

*Continued on next page*

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Continued from previous page  
reasonable ones, said claims administrator Mr. Fleming.

A malingering worker usually hires an attorney who sends him to a doctor to get a medical report that supports a finding of disability, he said. Since it can cost an employer at least \$3,000 to \$5,000 to contest such a claim—that he may lose anyway—it might be best to try to negotiate a settlement, he said.

If the employer decides to fight, it must hire competent counsel, said William L. Reagan, an attorney with Gassett, Perry & Frank in Santa Cruz, Calif.

He told public risk managers who want to get the most from attorneys in work comp cases to:

- Deal with only two or three law firms. This lets the firms develop expertise in the municipality's operations and increases their accountability to the municipality.

- Consider timing when calling in attorneys so cases are neither too stale nor so fresh that the attorney

does preliminary work that others could have done less expensively.

- Insist the attorney evaluate the probable outcome of the case at its start and periodically during the its development.

- Have attorney-support services, like investigators and court reporters, used during depositions, and if possible have them bill the risk manager directly and negotiate a discount for prompt payment.

- Use a medical examiner that both sides can accept.

Danger signs include an inflexible determination on the attorneys' part either to fight or to settle all cases, unreturned telephone calls, failure to provide updated status reports and multiple attorneys' names on the case file, which means continuity has been lost because many attorneys have been working on the case, he said.

Ms. Emmert said an attorney once took her to lunch and later billed her for it. "Get rid of those people," she said. ■

# Public employers lag behind in health cost control: Study

By MEG FLETCHER

SAN DIEGO—Public-sector employers generally lag behind private-sector counterparts in introducing health care cost containment measures, a survey reports.

The only exception is that public-sector employers are more likely to offer preferred provider organizations, though nearly all public employers with access to health maintenance organizations offer that health care option.

"(Private) employers are developing a wide variety of techniques to manage health care costs, and aggressive use of these techniques can deliver impressive bottom-line results. The public sector seems to

be lagging in taking advantage of this knowledge," according to the survey of 256 public employers conducted by consultant William M. Mercer-Meidinger Inc.

The Public Risk & Insurance Management Assn. cooperated in the preparation of the survey, presented last month in San Diego at PRIMA's annual conference.

Public employers still provide "relatively generous" medical plans that insulate employees from the cost consequences of their health care decisions, the survey says.

Respondents' health care costs have increased an average of 25% over the last three years, although one agency reported a 250% increase, the study says.

About 52% of the public sector employers—compared with 38% of those in the private sector—offer medical/surgical plus major medical coverage to salaried employees. Such plans tend to be the most generous with the least employee cost-sharing, the survey says.

Deductibles are \$150 or less in 65% of the salaried plans offered by public employers.

Fewer than half the public employers surveyed have adopted comprehensive plans in which an employee copayment is required for all or almost all medical services. But, 15% of the agencies said they are considering a change.

The survey says health care plan changes public employers have considered include increasing maximum out-of-pocket limits, increasing or adding employee contributions to premiums and using a flexible spending account.

"Very few of the agencies have even considered other cost-control changes such as increasing or adding contributions for short-service employees or extending the waiting period before new employees are eligible for medical coverage," according to the report.

However, public employers have adopted some features that encourage employees to become more health care cost-conscious.

The most popular features are pre-admission testing incentives, used by 34% of the plans; voluntary second surgical opinions, used by 32%; and concurrent review and alternative health care incentives, each used by 30%.

Public employers "do not take full advantage of sophisticated data analysis techniques which can identify problem areas and thus lead to corrective measures," the study said. Only 27% of the respondents are using state-of-the-art data bases with five-digit diagnosis coding. About 65% said their claims reports are not compared with national, regional, local or industrial norms.

"Not only do public-sector employers seem slow to ask their carriers for sophisticated statistical data, 34% of the survey respondents said they were unfamiliar with such reports," the study says.

However, public employers are more likely to offer PPOs than private employers. The survey found that 13% of the respondents, compared with about 3% in private-sector surveys, offer PPOs.

Respondents said they would feel best about a PPO sponsored by an employer or a coalition of employers or by doctors. "The respondents generally were negative about Blue Cross/Blue Shield organizations and insurance companies as PPO sponsors," the survey says.

Nearly all the respondents with access to an HMO offer that option, and 30% offer more than one HMO.

The survey found that public employers are on a par with private employers in underestimating the health effects of lifestyle. "But public-sector employers are not taking the initiative in trying to improve lifestyles as much as their private-sector counterparts," it says.

Although public employers say employer coalitions and health care providers are the groups that can best control health care costs, only one-third of the agencies belong to a local employer coalition.

The survey breakdown was: city agencies, 62%; county agencies, 19%; school boards or districts, 4%; state agencies, 3%; and other, 12%. About 40% were urban, 40% were suburban and 20% were rural.

The agencies' median budget was \$30 million in 1984, and the median number of employees was 600. ■

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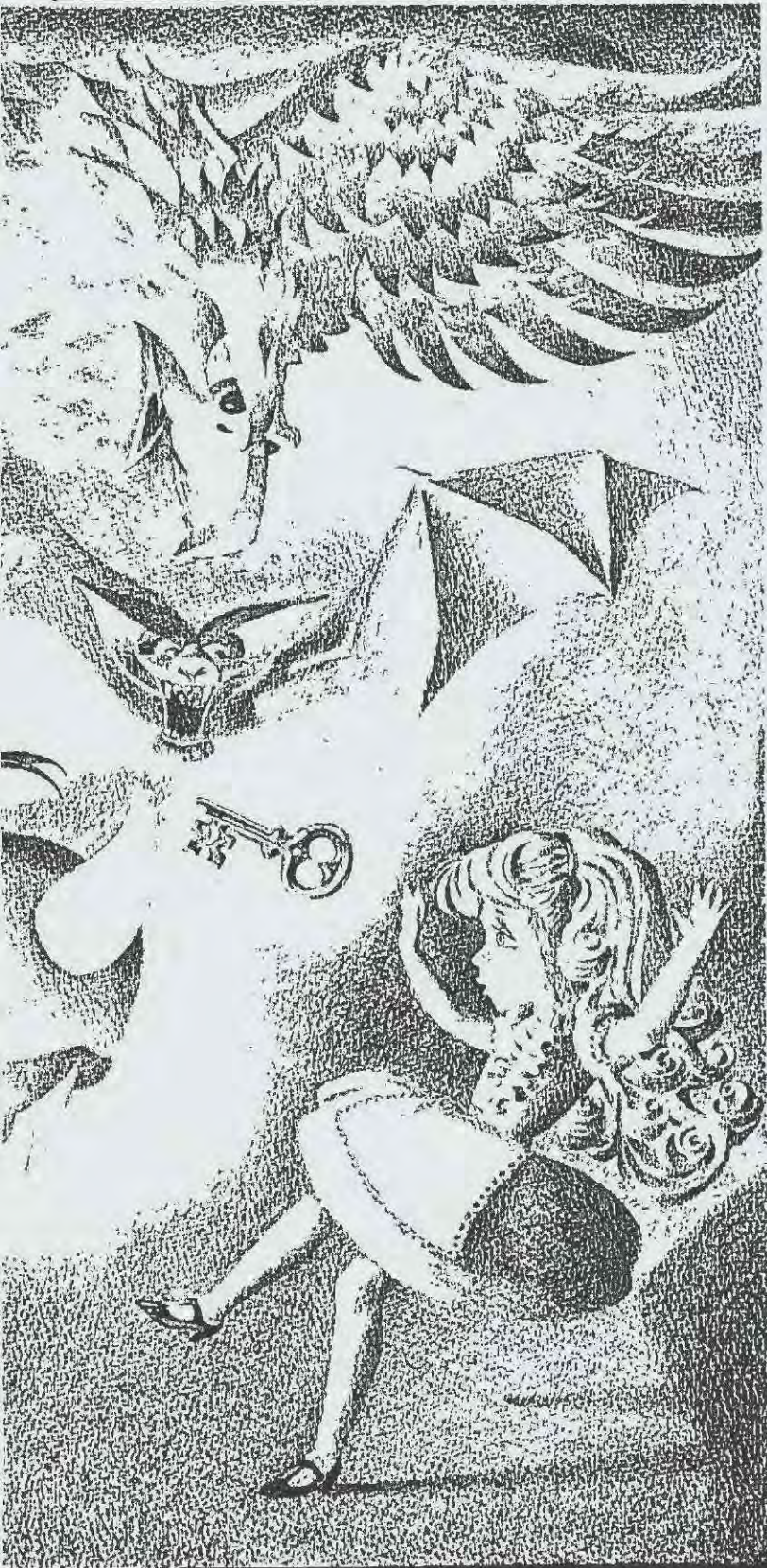
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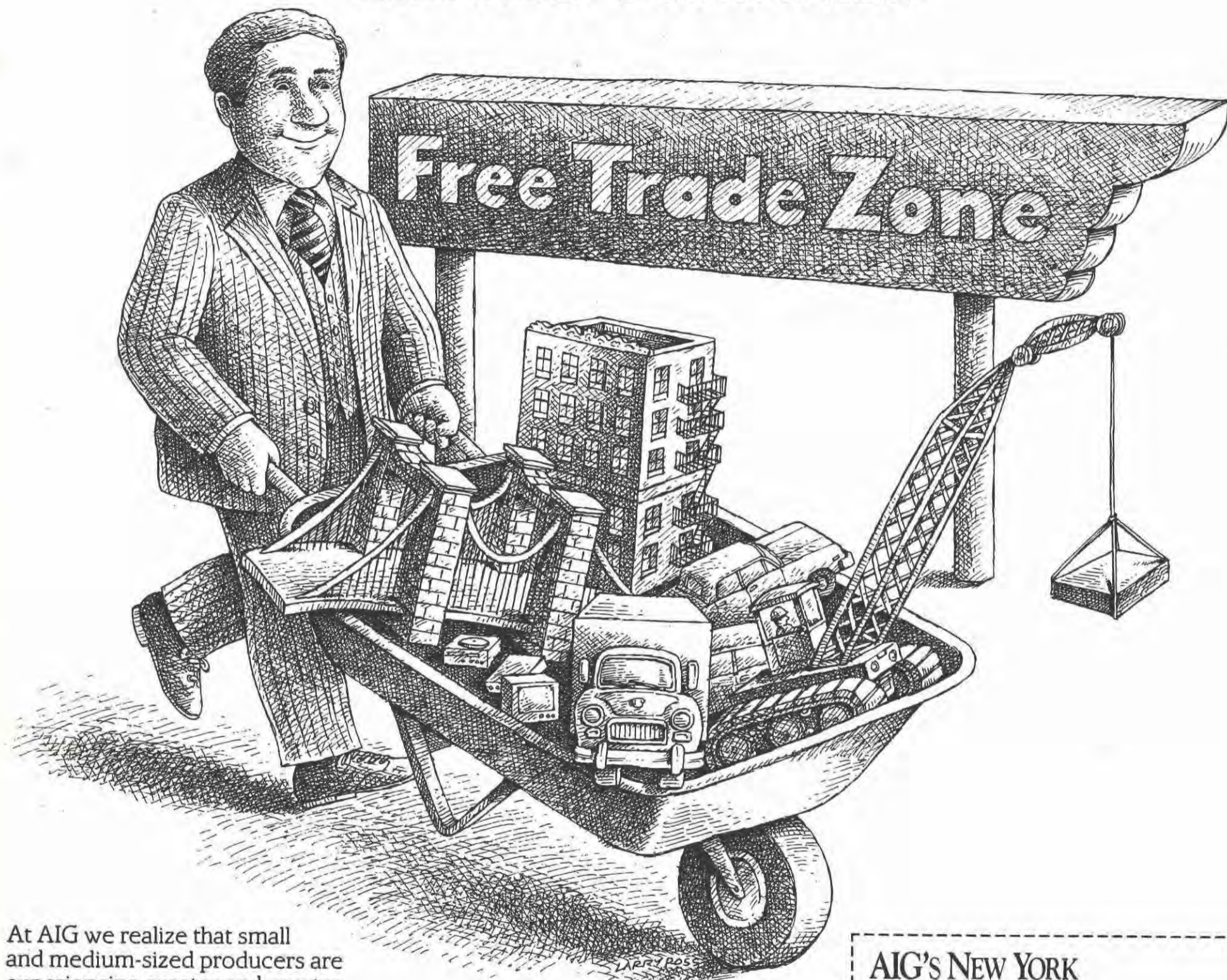


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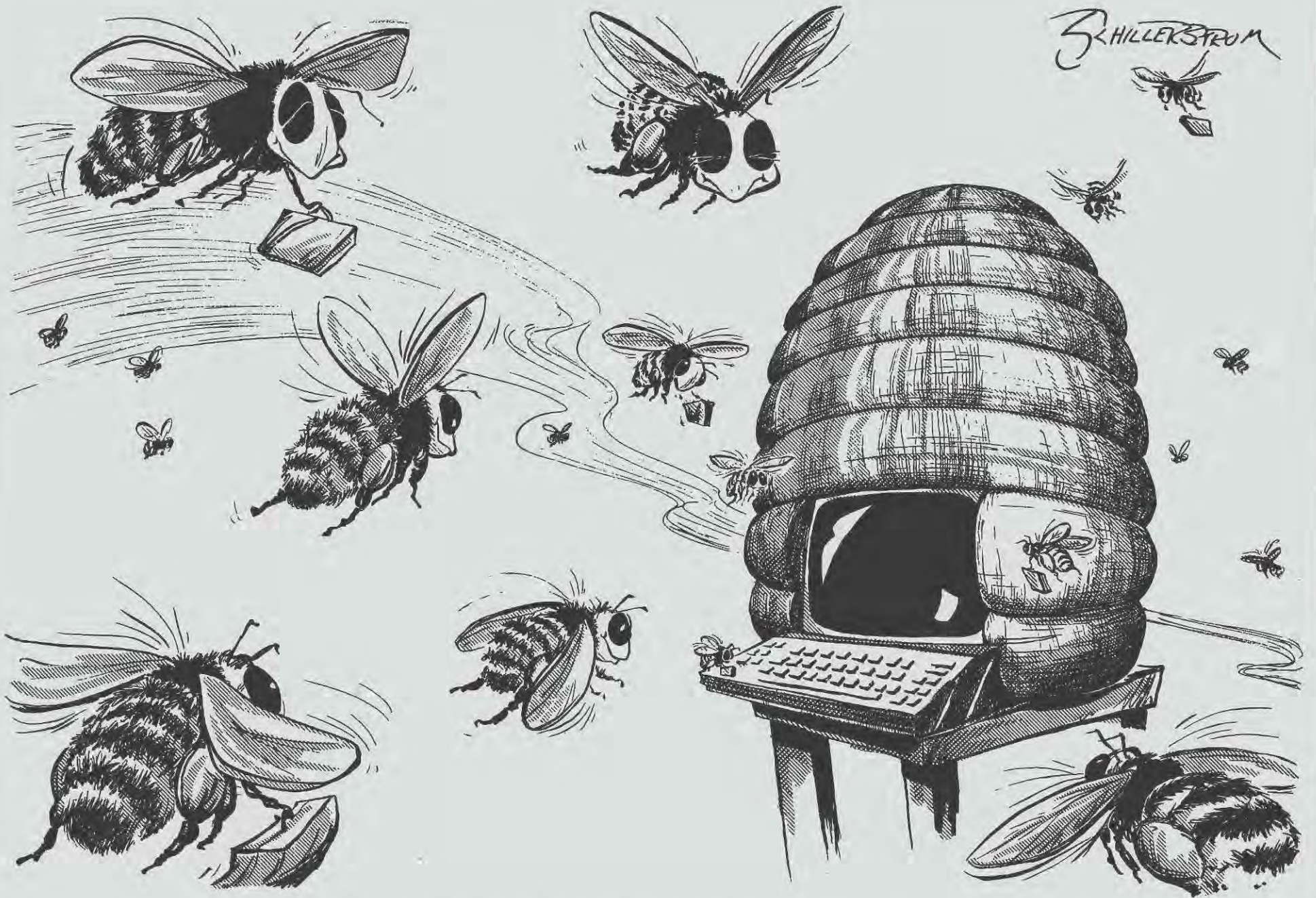
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# SHARING THE LOAD

## Time sharing is the best way to automate claims processing

By David F. Walter

**T**HERE IS A GROWING movement toward companies taking more direct control of their health benefit plans through self-administration. But, in most cases, this administration is a manual process, which offsets the advantage of control with the disadvantages of inefficiency. I believe that time sharing on a computer system owned by a claims administration service company offers a way to alleviate the inefficiency through automation, retain the desired internal control and avoid the problems of owning and operating a computer system.

The decision to automate the claims processing function is a significant step for an organization. In making that decision effectively, it is important to ask "What problems are we trying to solve," rather than skipping many steps and jumping to a later question, such as "What system should we buy?" An organization often can meet its operational needs faster, better and at a lower cost through sharing an existing service rather than buying or creating its own.

In considering buying vs. time sharing, we will examine nine areas: hardware, facilities, maintenance, software, personnel, installation, ongoing support services, organizational changes and cost.

- **Hardware.** The hardware needed by the claims administration staff consists of a terminal for each examiner and one or more printers, depending on volume. The terminals can be inexpensive—typically about \$1,000 each. Printers vary in cost upward from \$3,000 for a commercial-grade letter-quality printer

with accessories. These items are all the hardware needed directly by your claims people to print checks, explanation of benefits, letters and reports.

Of course, additional equipment is needed to drive these devices and do data processing. In time sharing, the only additional equipment needed are high-speed modem pairs. Current technology using multiplexing modems can support medical and dental claims processing for more than 10,000 employees on a single phone line.

For a self-insurer that purchases its own computer system for claims administration, the central computer is a major expense. Including the processor, disk units, tape units and communications controllers, you can expect to spend nearly \$75,000 for the smaller systems and more than \$250,000 for the larger ones.

In all system purchases, you will be advised by the vendor to "buy for the future." What this means is you buy more than you need right now. This means more dollars out of your budget right now.

Obviously, in time sharing there also must be a central computer somewhere, but you are not paying for all of it, or for more than you need at any time. The monthly cost for communications and modems is typically less than the maintenance costs of a dedicated computer and software system.

It is possible that your company's data processing manager has said you can put your applications in his big system—in essence an internal time sharing. But, with the high volume of transactions and many large data files required by claims processing, it is rare that a claims processing function can be added to an existing

system without new system hardware additions as well. If your corporate system can support a complete claims processing system, then your company already has overbought in at least one area.

The computer industry gives more for your money as you buy larger machines. This is reflected in the "price/performance ratio." What this means is that you can use part of a medium-sized machine for less than it costs you to purchase a small one. If you grow, you can use part of a large machine for less than you can buy a medium-sized one.

If you really need a large machine dedicated to your claims processing, time sharing can still be competitive, but that brings us to our second area—facilities.

But remember, your claims people most likely said, "I need a better way to administer the benefit plans." They almost certainly did not begin their request with, "I need to buy a computer."

- **Facilities.** The facilities needed for time sharing are minimal: a shelf for the modem and floor space for the printer. Lockable cabinets for the printing stocks are needed with either a time-sharing or an installed system. All these requirements can be met in a normal office environment.

Despite the recent advances in technology, computers and their peripherals are still relatively fragile devices. Also, with the significance of the financial activities performed in claims processing, you will not want to have your computer open to the general population. If you buy a system, a computer room is a definite requirement for security alone.

*Continued on next page*

# Time sharing eases problems of automation

Continued from previous page

Also, small rooms with computers and disc drives tend to get hot, often hotter than the equipment manufacturer recommends. Once you have a computer room, you will need special air conditioning and humidity control, special electrical and wiring requirements. Cooling water lines may be needed for the air conditioner.

You will need a terminal or printer as the system console in the computer room. Furthermore, since you will be doing your own system operations, you will need tapes, possibly disc packs and racks to store them.

Designing a computer room takes experience. You should either hire a consultant or pay an internal expert. Either way, as you build or expand your computer room, you are getting far away from the original goal: faster and better claims processing.

- **Maintenance.** The principle here is simple: The more you buy, the more you will spend year after year to maintain it. This is true for the hardware and facilities, and for software.

Typical maintenance charges range from 10% to 15% of the purchase price each year, forever. And, as equipment ages, vendors can stop supporting it.

The same is true for software. Over time, you can expect your maintenance costs to rise with inflation and salaries of support personnel. It is typical to spend 50% of the original price of a large software system each year to maintain and enhance it.

In the case of time sharing, your fee would have a component of the system maintenance costs, but you only pay a prorated share. Furthermore, regarding enhancements, the time sharing vendors typically include these in the basic fee.

- **Software.** When you buy a computer system to process claims, you buy more than just claims software. There are different layers of programs, and you would pay for all of them.

First, there is the operating system. This may come with the hardware, but you are going to pay for updates, and you are going to pay to have them installed. And, if they do not work, you will pay while you wait to get them fixed, too.

Then, there are software tools: languages, file and data base managers, etc. You probably will need these also, especially if one of your true needs is better reporting capability.

The operating system and software tools all may be bought from your computer vendor.

Finally, there is the claims system itself. The claims system is the set of programs that will control how your claims are paid. People who are willing to buy just object code from vendors can find prices as low as \$60,000 initially. But, buying object code means you also have tied yourself forever to the vendor, because only the vendor can make changes you might want, over and above

ongoing maintenance.

With a purchase of source code, you gain independence—and probably add at least \$80,000 or so to your bill.

If you are among those who said, "I'll just use available time on my corporate computer," this is where you now get caught. The computers in your corporate data processing center are probably large machines. Software for larger machines costs more than similar software for smaller machines. In order to avoid spending \$100,000 or so for new hardware, you will now spend an additional \$100,000 to \$200,000 for mainframe-based software. Prices ranging from \$150,000 to more than \$250,000 are typical in the marketplace for object code for mainframe computers.

A separate question about the software is, "Are the vendors themselves in the business of paying claims?" Claims software most often is sold by software companies. They may have people on their staff who once paid claims, but they typically do not have to live daily with the performance of their product.

**'It is important to focus on the original problems and questions without jumping to the assumption that automation requires buying a (computer) system. . . . It pays to consider alternative delivery mechanisms rather than just alternative system vendors,' Mr. Walter says.**

If your company decides to purchase a claims system, particular attention should be paid to this item. If the vendor uses the product every day, too, you are likely to receive better support.

Time-sharing services provided by companies that are themselves in the claims administration business provide this added assurance of quality.

- **Personnel.** When you buy a computer and software system, you need trained personnel to run it. If your company buys a system, you will have to "buy" new people, too. These new people are in addition to those who pay the claims and print the reports and checks.

One of these new people, needed during the day, is called "system manager." This person knows the computer, the operating system and other software packages. He or she also may be a programmer, performing extra work.

Either way, the system manager's salary will range upward from \$25,000 for the smallest system. Most companies assign a "burden" factor of at least 50% to account for other costs, like benefits, office space, phones, furniture etc.

This person represents an ongoing expense that is not needed at all for claims processing and is not needed by a time-sharing client.

Organizations big enough for their own claims processing may do the data entry on-line during the day and do the printing in batch at night. With time sharing, the person doing this operation must know how to run the printer. With an installed system, this operator must know how to run the computer, too.

Nightly backups must be run for security and safety purposes. Expect an additional salary increment to pay for the higher level of training and responsibility for this operator. Again, add at least 50% to figure for burden. There are no added personnel costs in

time sharing.

- **Installation.** First, two facts: The more you have to install, the more it will cost and the longer it will take. And, when your people are working on installation, they are not being productive in their normal jobs.

These two facts provide the basis for comparing the cost of system and time-sharing installation and may be the most important aspect in your deciding how to process your claims.

The hardware installation for time sharing is very simple. Once the communication line has been installed, the terminals and printer are easy to connect and place into service. In most cases, time-sharing customers are installed and running in far less time than is needed to bring in a new computer system. Time is money.

Both system and time-sharing vendors will provide training. You may also be able to get help in the installation of your particular benefit plan structures.

In the best situation, the vendor can even provide temporary help in

disruption during installation, there will be long-term changes. New reporting and referral links will be needed in the organization to handle the new system, its daily operations, and its problems. All these will be a distraction from the original function—paying claims.

With time-sharing, there are no new non-claims people to be added. The changes that do occur typically are reductions in complexity as people's jobs become easier. You are free to concentrate on solving the direct problems without creating new ones.

- **Cost—the bottom line.** The particular set of problem areas discussed above all have an impact on the cost of deciding whether to buy a system or share one. Treated conservatively, these areas would represent the same total cost to your organization as the basic selection of software and hardware. As such, they should be carefully considered as you make your decisions.

Even the decision-making process for choosing the type of automated support is changed when the initial decision is to consider time-sharing before buying. The cost of time-sharing is significantly lower up front, allowing decisions to be made at lower management levels.

Further, since no new hardware or software is needed, the data-processing involvement is minimal. The corporate facilities department need not be involved, since no new facilities are required. Since no new people would be hired, the corporate personnel department need not have the expense of hiring anyone. And, with less to learn how to operate, the training costs are lower.

Finally, and most important, the time and cost to implement is much less with time sharing.

The larger the organization, the greater the costs will be in the selection and implementation phases. Larger organizations have more complicated, multilevel decision processes, and they generally have more options to consider.

On the implementation side, larger groups buy more equipment, which is also likely to be more complex. The size and complexity both contribute to longer installation.

Also, the training time and cost would be greater as the organization grows. As a rough estimate, I would allocate the cost equivalent of a full-time manager for a month for the decision-making for any system purchase, and add an additional equivalent month for every 5,000 employees in the organization.

Many factors are involved in deciding how best to automate the claims processing function.

No attempt has been made here to compare particular features of various vendor offerings. I am assuming that essentially-equivalent levels of capabilities can be found from either system or time-sharing vendors.

As stated at the outset of this discussion, it is important to focus on the original problems and questions without jumping to the assumption that automation requires buying a system.

When hundreds of thousands of dollars are being committed and when many individuals' jobs are about to be changed, it pays to consider alternative delivery mechanisms rather than just alternative system vendors.



David F. Walter is vp-information services for CC Systems Corp., a cost-containment administration company in Minneapolis.



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# PIA, IIAA offer variety of support services

By LINDA J. COLLINS

The Independent Insurance Agents of America and the National Assn. of Professional Insurance Agents offer many support and educational services to their members.

In many cases, the services involve an additional charge to members. However, group or quantity discounts make these services less expensive to members than if the agents tried to duplicate the services on their own.

Services provided to agents by the IIAA and/or the PIA in addition to their lobbying and providing of information on industry and regulatory issues include:

- Advertising support.

The IIAA has a national Joint Agency/Company Marketing (JAM) program, with actor Raymond Burr as its spokesman. The JAM program was designed to make the association's logo easily recognizable to the public, and to describe to the public the role of the independent insurance agent.

JAM commercials are aired on network television, and radio and ads appear in major business and consumer publications.

IIAA members benefit from the JAM campaign at the local level because of the logo identification. Members can use the association's logo on all their agency materials and correspondence and in their local advertising efforts. Also, member agents can buy radio and television spots that feature Raymond Burr promoting their agency.

Other advertising materials are also available through the IIAA.

The PIA publishes a guidebook with tips for members on how they can promote their agencies.

PIA members can also purchase ads that can be customized for newspapers or magazines, and they can buy sales literature, agency brochures and radio spots through the association.

By fall, its advertising services will be expanded to include a PIA-endorsed ad agency through which agents can obtain customized advertising materials for all media at a reduced group rate.

- Marketing support.

Both associations conduct surveys and publish research data on a regular basis to show market trends and to identify key industry issues.

The IIAA has a computerized Market Access service through which agents with a personal computer and a modem can post requests for market information on an electronic bulletin board. The IIAA then responds with information gathered through surveys of its members.

This service is particularly useful to members seeking information on local markets for specific coverages.

Agents with computers also have access to the IIAA's Electronic Management Information Service, through which they can get daily insurance news and financial information on the industry; marketing data by ZIP Code and by state; tips on agency management; and information on surveys conducted by the IIAA.

Through EMIS, IIAA members can also order materials and register for seminars and conventions. About 400 agents are now using the service, and it is generally free to members.

The IIAA also publishes a marketing strategy manual to help agents target sales growth opportunities and manage selling efforts.

The PIA has a commercial lines survey/proposal kit containing 75 policy and proposal forms that can be customized with an agency's

name and logo, and materials designed to help the agent analyze and develop a risk management program for clients.

The PIA members also can subscribe to a risk management hot line service operated through the facilities of Tillinghast, Nelson & Warren in Dallas.

By fall, the PIA expects to have a microcomputer users' group up and running. The group will help agencies set up a computer system and help those that already are automated expand their computer capabilities.

Also in the fall, the PIA will offer users discounts on computer hardware and software.

Commercial and personal lines brochures also are available from both the PIA and IIAA to use in

explaining insurance topics to clients and prospects.

- Educational and personal services.

The PIA has designed an extensive personnel program called Salespower. The program, which is updated quarterly, walks an agent through selecting, hiring, training, compensating and managing a new producer.

The PIA and the IIAA also offer self-study cassette tapes and manuals to educate agency personnel on specific topics.

In addition, the associations both conduct seminars throughout the country every year on a broad range of topics.

The IIAA and the PIA offer several insurance and financial services products for members and

their agency personnel, including life and health insurance, group medical coverages, disability and hospital income coverages, and IRA and tax savings plans.

In addition both have located agent errors and omissions markets for their members.

The two associations provide group discounts on forms and supplies, office equipment and client premium gifts.

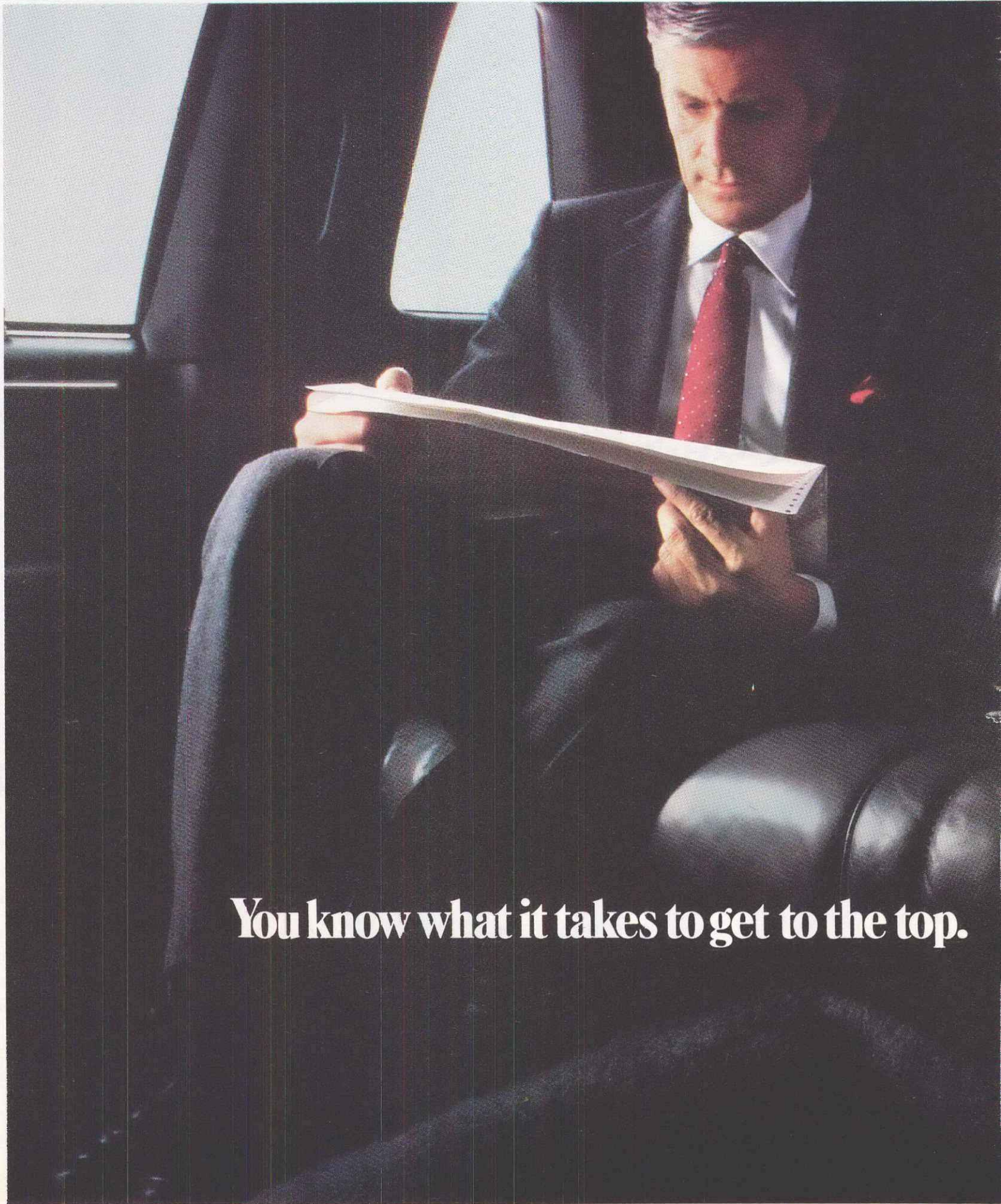
Project InVEST is a program sponsored by the IIAA to teach high school seniors the basics of insurance agency and company operations. In the two-semester class, which is taught as part of a school's regular curriculum, students simulate agency and company activities. IIAA members also participate as guest speakers for the classes. More

that 100 high schools throughout the country participate in Project InVEST.

The PIA sponsors two three-week insurance schools each summer for insurance agency personnel. The schools are held on university campuses and taught by professors of insurance from leading universities.

One of the PIA insurance schools is held at California State University at Chico, and the other is held at the University of North Carolina in Charlotte. Each school draws an average of 60 students, who can earn college credits for completing the program.

Both associations also have public relations programs to increase the visibility of agents on the local and national level. ■



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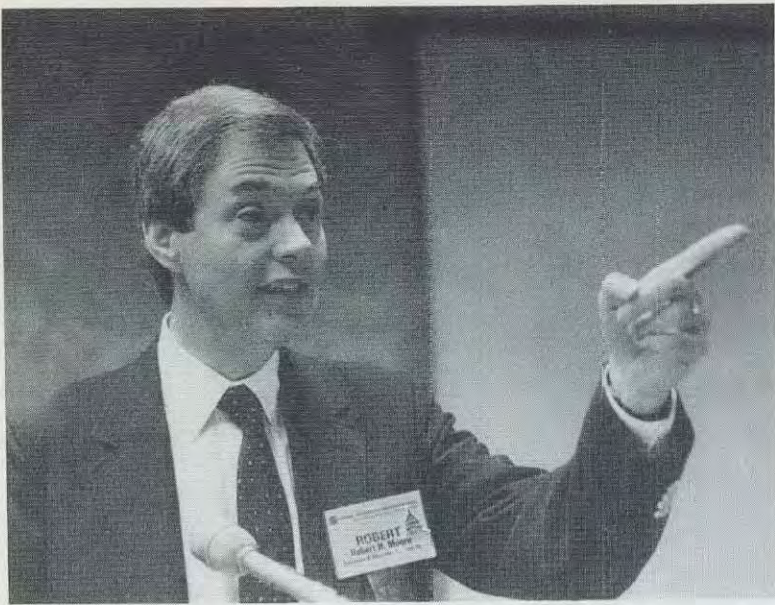


Photo: Linda J. Collins

Robert H. Moore, newly elected president of the NAIB, makes a point.

## Industry's image needs help, new NAIB president advises

By LINDA J. COLLINS

SEA ISLAND, Ga.—The insurance industry is getting a bad rap, and it is up to brokers to help set the record straight, says the newly elected president of the National Assn. of Insurance Brokers.

"Some Washington policymakers and the general business press see the insurance industry as a monolithic force...manipulating vast assets for its own ends and hiding behind actuarial tables and mountains of statistics," said Robert H. Moore, who also is vp-government and industry affairs for Alexander & Alexander Services Inc. in Washington.

Mr. Moore told brokers attending the NAIB's annual meeting that they can help remedy this situation by clarifying the insurance broker's role for the benefit of legislators and regulators, as well as the public and the media.

Brokers also need to heighten their professional image and reputation and use their influence, he said. "The time has come for visibility and broad public understanding of our special role in the U.S. and world economy," he said. "We must develop strategies for bringing our expertise and knowledge to bear on public policy issues."

Mr. Moore added that brokers need to make legislators, regulators

and the public more aware of the broker's role as risk manager for insurance buyers. "Our vested interest in helping the insurance-buying public solve its problems puts us in a unique position to be useful to policymakers," he explained.

Mr. Moore said that as NAIB president, he will maintain daily contact with the association and schedule weekly sessions with the NAIB staff to evaluate and refine association strategies and activities.

The NAIB's Laws and Legislation Committee "will meet in Washington later this summer to assess priority issues facing brokers and to develop an agenda for addressing them," Mr. Moore said. The committee is chaired by Hamilton M. Loeb Jr., senior vp and manager of Reed Stenhouse Inc. in Chicago.

To help them keep informed of legislative activities and serve clients more effectively, excerpts from the association's legislative updates now will be distributed to all members who receive the weekly "Friday Flash" newsletter.



The updates previously had been sent only to board members as part of their quarterly report.

The association also plans to conduct its own analysis of insurance industry issues, Mr. Moore said. Such analysis is "uniquely suited to the special role of the broker," because the broker is an intermediary between the insurance buyer and the insurance companies.

The NAIB intends to blend politics with sales skills and expertise to influence members of Congress on insurance-related issues, Mr. Moore said.

The association uses its political action committee (NAIBPAC) to contribute funds to political candidates who support its efforts.

Areas in which the NAIB will work to influence legislation include environmental impairment liability coverage and capacity and rating problems, Mr. Moore said.

Other issues of concern to brokers include potential major insurer insolvencies and civil justice reform.

"We need to demonstrate the brokers' analytical skills and business expertise to members of the House and Senate, as well as to regulators and members of the executive branch," Mr. Moore said.

He said the burden will be on the NAIB's committees and board to "identify and work with individuals within our firms who can come to Washington to be a resource to policymakers."

The civil justice system, which is saddling the industry with large losses through monumental liability awards, "poses a serious dilemma for the country at large, and brokers can bring a helpful perspective to this problem."

"Ours is a society where it seems perfectly rational to use litigation to resolve disputes, particularly when the plaintiff has no personal or communal ties to the individuals or organization being sued," he said.

"We are confronted by sociopolitical and cultural trends which cannot be turned around in the short term."

Mr. Moore warned brokers that if they do not expand their reach and respond to such policy issues, they forfeit their right to influence the outcome.

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## Hardening market poses new problems for brokers

By LINDA J. COLLINS

SEA ISLAND, Ga.—Insurance brokers have come a long way from their "lowly fellow" reputation in the 18th century, says Robert V. Hatcher Jr., chairman and chief executive officer of Johnson & Higgins in New York.

Mr. Hatcher quoted a definition of "broker" given in Samuel Johnson's 18th century dictionary: "A lowly fellow, one who lives off the efforts of others: a procurer. Brokers, having no stock of their own, set up a trade with that of another man and commonly abuse both sides to make a little paltry gain."

"It's useful to measure how far we've come," Mr. Hatcher said in a

keynote address to kick off the National Assn. of Insurance Brokers' annual meeting May 28-31, at the Cloister in Sea Island, Ga.

Despite these inroads, however, the current hardening of the insurance market is taking its toll on producers, he said.

"Now that the market has finally turned, the price of the product seems almost an afterthought; it is the very existence of the product that is at stake for many of our clients," Mr. Hatcher said.

"This kind of market taxes our professionalism and our capacity for hard work," Mr. Hatcher said.

Government intervention can be expected if the market tightens much further, he warned, adding that once the government gets into the insurance business, it won't leave, even if conditions improve.

He also charged that lack of capacity is more "psychological than it is financial. Effectively, insurance capacity is how much insurance underwriters want to write."

Mr. Hatcher said that, in general, underwriting cycles are driven by rational behavior in a "relentlessly competitive business. . . . Underwriters' expectations move capacity; capacity moves prices; prices move profits; profits change expectations again; and on it goes."

But, he said, what is neither rational nor easily understood is the explosion of court awards fueling the current hardening market. U.S. courts have been returning enormous awards, especially in product liability cases, and insurers are bearing the brunt.

Mr. Hatcher quoted a study by Jury Verdict Research Inc. that shows nearly a 600% increase in the number of million-dollar judgments in product liability settlements between 1977 and 1983.

The study also reveals an average of 43% of all million-dollar awards come in either product liability or medical malpractice suits.

In addition, the insurance industry is faced with the task of writing policies whose language won't be so ambiguous as to require judicial interpretation, Mr. Hatcher said.

For example, courts are interpreting "aggregate" to mean unlimited and "accidental pollution" to mean all pollution, he said.

The insurance industry's emphasis on tort reform to limit the recovery on liability policies may be misdirected, Mr. Hatcher said. Instead, the industry should work to change a legal system that allows judges to interpret ambiguous contract language in favor of the policyholder.

Commercial insurance contracts should be interpreted in "such a way as to carry out the reasonable intent of both parties" he said.

The commercial general liability policy proposed by the Insurance Services Office is a "quick fix" that does not attack the cause of industry losses: judicial misinterpretation of contracts, Mr. Hatcher said.

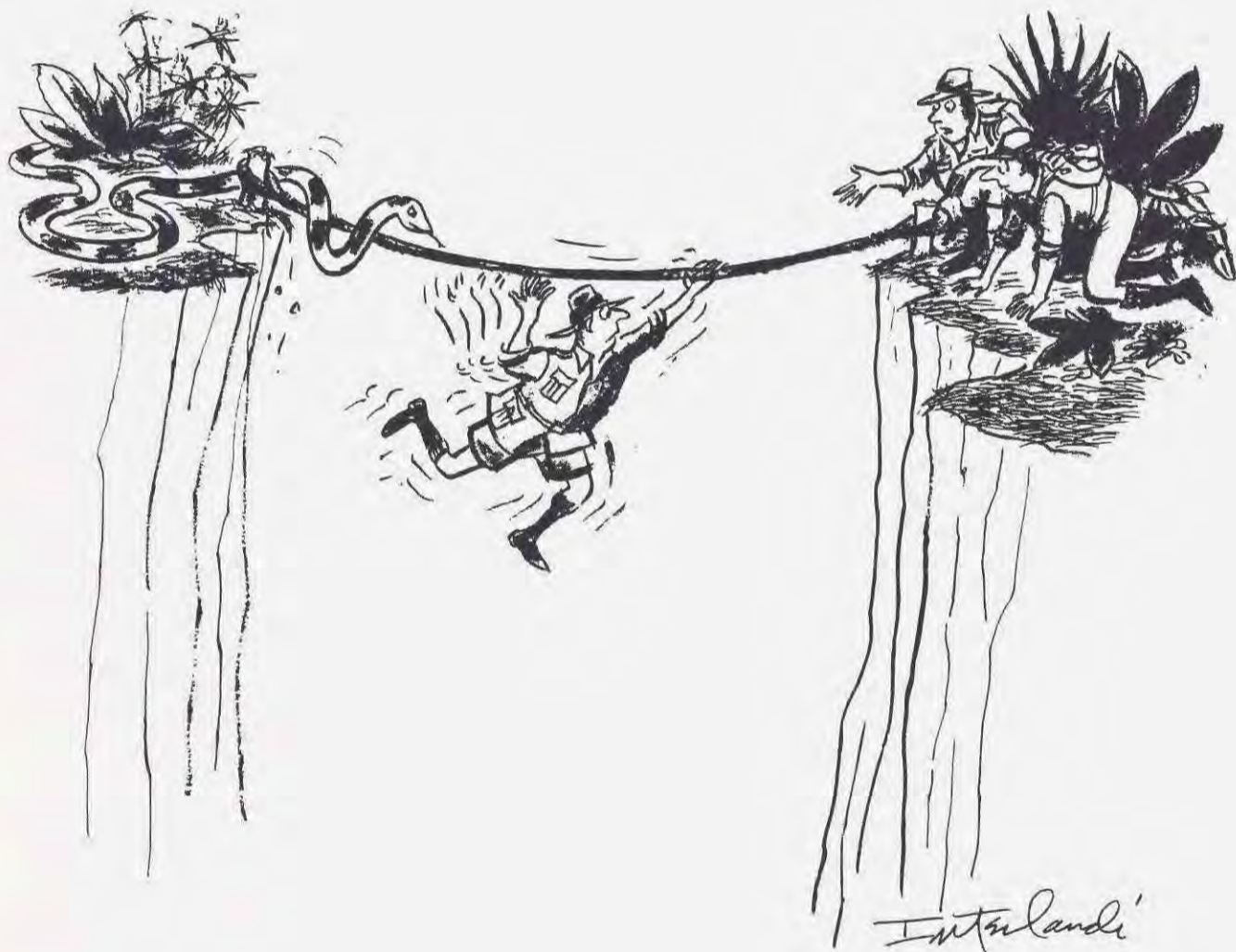
He said that although the new CGL language is intended to exclude certain risks, there may be certain ramifications, including:

- Judges still will have the right to interpret contract language and may extend coverage.

- Since fewer risks will be insured, there will be fewer premium dollars available to pay judicial awards that will be handed down.

- More claims may be triggered because the term "occurrence" is replaced by "claims-made," which does not tie claims down to a specific occurrence.

- Gaps in coverage may be caused by the application of a retroactive date in the new claims-made form.



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## Insurers should educate Washington: RAA head

By LINDA J. COLLINS

SEA ISLAND, Ga.—The insurance business is more misunderstood by the federal government than any other industry, according to Andre Maisonnier, president of the Reinsurance Assn. of America.

"People in Washington have an abysmal knowledge of the insurance industry, and particularly the property/casualty insurance industry. Their ears are closed," Mr. Maisonnier told members of the National Assn. of Insurance Brokers' at its annual meeting May 28-31 at the Cloister in Sea Island, Ga.

He said the government is spending hundreds of millions of dollars

each year in research on "the auto industry, the steel industry, and on rattlesnake propagation," but very little is spent to better understand "the role we of the insurance industry play in the economy."

The Justice Department, the Department of Transportation and the Federal Trade Commission are just some of the governmental bodies that make "occasional forays" into specific insurance industry issues and do not take the broader view, Mr. Maisonnier said.

For example, he said, federal officials need to consider "the number of people which the property/casualty industry employs, the role which we play in society and the many functions that we perform as major investors in this country."

The root of the problem, he said, is that the federal government misunderstands the function of insurance companies.

"It believes that we...sell insurance and that our function is to absorb the risk, when in fact our function is to spread the risk. As such, we are often identified with and compared to gamblers," Mr. Maisonnier said.



Mr. Maisonnier

The industry is misunderstood at the federal level, he continued, because it is regulated by state rather than federal authorities, and thus, no federal agency has a vested interest in "the continuation of the private insurance mechanism."

The insurance industry also differs from other industries in the way it prices its product. Mr. Maisonnier asked, "How many other industries have to wait years after they have sold their product to find out the cost of the raw materials?"

And, few people—either within or outside the industry—understand what underwriting is all about, he added.

Mr. Maisonnier pointed to the effect of Superfund legislation—which regulates the cleanup of waste sites—on the dwindling environmental impairment liability insurance market as an example of what can happen when the federal government tries to impose legislation without a clear understanding of these laws' implications for insurers.

And, Mr. Maisonnier said that unless something is done about what is, in effect, retroactive pollution liability imposed on the industry by Congress and the courts, he doubts whether insurers and reinsurers will "find it in their hearts" to underwrite any more EIL coverage.

But, he added that the insurance industry is partly responsible for the federal government's lack of knowledge about insurance. The insurance industry has historically veiled itself in a cloak of secrecy because it feared that government scrutiny would invite federal intervention and regulation, Mr. Maisonnier said.

But now, he said, "We have to rethink our position." Although he was not advocating federal regulation, Mr. Maisonnier said it would be to the industry's advantage for the federal government to understand "what we are and how we operate," because the insurance industry plays such a key role in the American economy.

"Without us, the economy breaks down, as has been witnessed already by the breakdown of many industries resulting from the lack of availability of our products." ■

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## Regulators act

Continued from page 3

sephine M. Driscoll, said Larry Kibbee, executive assistant to the commissioner.

Violation of the order would constitute an unfair trade practice, with penalties ranging from fines to revocation of an insurer's authority to write business.

No penalties have been issued, but "there have been some serious conversations with a lot of companies," Mr. Kibbee said, without naming the insurers.

He noted that insurers say "they are concerned about capacity problems and reinsurance treaties that have, or are about to, dry up."

"If a company can show us they have extremely bad problems... that's an individual thing we'll consider. But we have real large companies without problems just canceling mass books of business," Mr. Kibbee said.

In Arizona, the Insurance Department has issued a memorandum warning that insurers canceling large blocks of policies during midterm "will be held accountable for acting without due regard to their obligations to policyholders."

The memo was prompted by complaints the department received, beginning in early March, from agents and brokers who said some insurers were sending them midterm cancellation notices, said Deloris Williamson, property and casualty department supervisor.

She would not name the insurers that have been the subject of the complaints.

However, Midland Insurance Co., which earlier this year intended to cancel about 200 truck liability and physical damage policies during midterm, says it will not since it was contacted by the Arizona department.

When the insurer began issuing cancellation notices in April, it offered two months' notice, even though most of the policies only required a 30-day notice of cancella-

tion, said Lawrence P. Johnsen, Midland's secretary and general counsel in New York.

Midland had sent notices to "a small percentage" of the 200 policyholders when the department asked that the policies be reinstated, Mr. Johnsen said. The company agreed in the second week of May to reinstate them, he says.

The cancellations were part of an attempt to improve premium-to-surplus ratio by reducing underwriting in certain lines, he said.

In the memo, Arizona Insurance Director S. David Childers says the department recognizes insurers' right to cancel or not renew individual policies according to coverage terms. But, he says the department questions midterm cancellations of blocks of business by insurers seeking a "quick fix."

The April memo reminds insurers of their obligation to provide "responsible and fair treatment of the public and policyholders."

In the memo, Mr. Childers tells insurers doing business in Arizona "that midterm cancellations, without a corresponding increase in hazard and without policy language setting forth the conditions upon which the policy may be canceled midterm, are injurious to the public interest and in violation of the trust owed by the insurer to its policyholder."

"While we understand the present difficulties facing the industry, we also recognize that many of these problems were self-inflicted as a result of pricing schemes, poor underwriting practices and irresponsible management," Mr. Childers wrote.

The memo addresses only commercial insurance because Arizona has stringent regulations on cancellation of homeowner's and personal auto insurance.

The memo says the department regards mass midterm cancellations as unfair trade practices and will take appropriate action.

That action could include calling a hearing and subsequently issuing

a cease-and-desist order, revoking the insurer's certificate of authority or imposing a fine.

On a national level, the resolution adopted by the NAIC at its annual summer meeting last month recognizes indiscriminate cancellation and non-renewals of property/casualty policies as a problem in a majority of states.

The resolution urges insurers to abide by guidelines, including:

- Cancellations of insurance contracts that have been in effect for 60 days should be prompted only by unfavorable underwriting factors pertinent to the individual risk that were not present at the inception of the coverage.

- Insurers desiring to withdraw from a product or line of insurance or stop doing business through an agency should arrange for another insurer to assume the business or retain all policyholders until the policies' expiration date.

- Insurers initiating non-renewals should provide policyholders 30 days' notice of their intention.

These guidelines are not intended to supersede individual state laws, the resolution notes.

A resolution adopted by the insurance commissioners from the NAIC's Western Zone takes a tougher stand.

In that resolution, commissioners said that poor operating results of insurers have resulted in an "unprecedented number of midterm cancellations, extraordinary rate increases and wholesale withdrawals from certain lines."

The resolution says every state "will cooperate and coordinate information on insurer rate increases, withdrawals and writing limitations, and each state will take the appropriate action under their Unfair Trade Practices Act in light of these actions."

The Western Zone is Alaska, American Samoa, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Texas, Utah, Washington and Wyoming. ■

## Interruption claim not offset by gain

Continued from page 2

The American Home policy included a \$1 million deductible for all claims except business interruption at certain coal mines, where a deductible period of 10 "waiting days" was imposed.

Lloyd's of London underwriters provided excess insurance above limits provided under the American Home policy, but Mr. Shelton would not disclose the limits.

Under the joint venture agreement between Republic and Island Creek, Republic was obligated to buy 50% of its yearly requirement of "low-volatile metallurgical" coal from Beatrice, up to a limit of 600,000 tons. Island Creek was obliged to buy an equal amount.

While the Beatrice mine was closed from November 1981 until March 1982, Island Creek and Republic bought coal from other sources, including other mines affiliated with Island Creek.

Beatrice filed its \$10.9 million business interruption claim against American Home in June 1983.

American Home conceded that Beatrice was an insured under the policy, which covered joint ventures and any other "associated or controlled entity" for which Occidental was responsible for placing insurance. The insurer also conceded the mine closure was a covered loss.

In adjusting the claim, though, American Home insisted that the loss be reduced by the increase in Island Creek revenues related to supplying substitute coal to Republic.

The insurer's adjuster, GAB Business Services Inc., had requested information about other Occidental mines operated by Island Creek, but Island Creek refused to provide this information, court papers say.

In May 1984, Beatrice filed a declaratory judgment action in U.S. District Court for the Southern District of New York, asking for a court ruling that American Home adjust the claim on a "stand-alone" basis with no consideration given to Island Creek income.

Beatrice argued that it is an independent corporation whose operations are separate from those of Republic and Island Creek, noting that the Occidental policy identified Beatrice as a separate entity in its schedule of covered locations. Beatrice also operates only one mine, and therefore did not supply or derive income from any of the substitute coal sold to Republic during the closure, the company claimed.

The American Home policy also contained no language stating that the various insured operations will be treated as a single entity for the purpose of adjusting losses.

American Home, however, argued that it was "inconsistent" for Beatrice to be considered part of "the collective assured" in claiming coverage but separate from other Occidental operations in adjusting the loss.

The insurer also argued that Island Creek's management agreement with Beatrice established the interdependence of the firms. Under that agreement, Island Creek received commissions for all Beatrice coal mined and shipped and additional commissions on the sale of coal not bought by Republic or Island Creek.

"The principle that business interruption insurance is intended to restore lost earnings should not be distorted to provide a windfall to the assured," American Home said in court filings.

In addition, American Home claimed that the policy required "the collective assured" to offset business interruption losses from within through "the use of substitute facilities and property."

Finally, the insurer argued that since the two parties to the insurance contract were in equally strong bargaining positions, any ambiguities in the policy should be interpreted against those who prepared the policy: Occidental and its broker, Frank B. Hall & Co. Inc.

American Home filed a counterclaim asking the court to rule in its favor.

Judge Brieant entered a summary judgment in Beatrice's favor, however, finding that Beatrice operated as a separate entity from Island Creek.

The policy's description of the insured contained nothing "which justifies piercing the corporate veil of Beatrice at the insistence of the insurance company simply because Island Creek had the responsibility, as a fiduciary under a management agreement, to place the insurance for Beatrice and did so as part of a blanket policy insuring many operations in several different industries," Judge Brieant's ruling said.

The ruling added the policy provision calling for use of substitute facilities applied to Occidental's oil wells and to Island Creek, but not to Beatrice, "which had no substitute facilities."

"In placing this insurance, Occidental's experienced brokers disclosed the properties covered and listed Beatrice separately on its schedule of locations and properties insured, as a company operating a single mine with no 'substitute' facility available," Judge Brieant wrote.

The judge—noting that Beatrice's two shareholders put up \$5 million in capital and took out \$10 million in bank loans to form the company—added that Beatrice could not survive a shutdown without business interruption insurance or a pledge from Island Creek to carry its debt service.

"If Beatrice is considered, as it should be, as a separate free-standing economic unit, then there is no economic 'windfall' as defendant argues," the ruling says.

Judge Brieant ordered the two sides to agree either on the amount of the loss or on the issues that remain unresolved, and to report on the status of the talks on July 9. Island Creek's Mr. Shelton said there is a "good" chance that the amount of the claim payment will be agreed on by July 9.

But Stuart Cotton, American Home's lawyer, said it is "inconceivable" that an amount could be agreed on by that date, adding that the two sides may agree on a method for arriving at a settlement.

Mr. Cotton, a partner with Rein, Mound & Cotton in New York, would not comment on whether American Home will eventually appeal Judge Brieant's ruling. He added that American Home hasn't established its own determination of the amount of the Beatrice claim.

Judith Roth, a lawyer with Phillips, Nizer, Benjamin, Krim & Ballon in New York representing Beatrice, said the company hasn't established the amount by which its claim would have been reduced if it had lost.

The other claim that may be affected by the decision involves another business interruption loss suffered by VP-5 Mining Co., a joint venture between Island Creek and Alabama By-Products Corp.

A fire shut down the VP-5 mine from April 1982 until the fall of 1984, when it resumed limited production, according to Mr. Shelton.

Mr. Shelton would not comment on the size of the VP-5 loss and said that a claim has not yet been filed with American Home, though he added that a claim is "imminent."

Mr. Cotton, however, said that a preliminary number—unadjusted by American Home—was in the neighborhood of \$40 million.

Mr. Cotton would not comment on the Beatrice decision's impact on the expected VP-5 claim, saying only that the two cases have "similarities and differences. They are not identical," he said. ■

## Maine workers comp law

Continued from page 2

soliciting new work comp business in the state.

And, Liberty Mutual will apply stricter underwriting guidelines to existing policies and plans to withdraw as a servicing insurer for the assigned risk pool.

"The Legislature has left us no alternative but to take these drastic steps," said Gary L. Countryman, Liberty Mutual's president.

"We have worked diligently for reform over the past (four) years, attempting to improve the system for our policyholders, for injured employees and for insurers. During that period we have remained committed to Maine despite the fact that Liberty Mutual has lost \$51 million (after investment income) in that period due to a combination of a costly benefits structure and grossly inadequate rates," Mr. Countryman said in a statement.

"While the law contains some modest benefit level reductions, it also mandates an insurance rate reduction of 8%, despite the fact that actual costs are not likely to decrease by that amount. This is patently unfair and will result in further underwriting losses if we continue to underwrite a large percentage of workers compensation insurance in Maine," he said.

He emphasized that Liberty Mutual is not pulling out of the Maine market. "Nor are we abandoning our long-term policyholders with good experience... However, we intend to cut future losses as much as possible, and the first step in that is to curtail any expansion in Maine for the foreseeable future."

Liberty Mutual, which wrote \$45.3 million in direct workers comp premiums in Maine last year, has about 30% of the state's work comp market. That includes premiums related to the assigned risk pool, a spokesman said, adding that Liberty Mutual is the servicing insurer for about 50% of the policyholders in the pool.

Other insurers that write a significant amount of workers compensation coverage in Maine include Aetna Life & Casualty Co. in Hartford, Conn.; United States Fidelity & Guaranty Co. in Baltimore; and St. Paul Fire & Marine Insurance Co. in St. Paul, Minn.

USF&G is also taking steps to reduce its workers compensation business in the state, according to Minor Carter, vp of government and industry affairs.

"We will not be able to write the risks we have in the past," he said.

St. Paul decided earlier this year to write less business in the state. Even if the Legislature had adopted some modest reform measures favoring insurers, St. Paul had determined months ago that they would not significantly help, a spokesman said.

St. Paul, which wrote about \$4.2 million in direct written premium in Maine in 1984, decided at the beginning of this year to limit its volume in Maine to \$2 million or less in 1985. In addition, it eliminated dividend plans for new and renewal business.

Aetna is studying the law, particularly the competitive rating filing requirements, a spokesman said.

The approximately 180 insurers that write workers compensation in the state are "pretty much outraged" by the law, said Joseph DiGiovanni, vp of the New England region for the New York-based American Insurance Assn. "We will have to see what will happen."

Besides being miffed at the Legislature, insurers also feel slighted by employers, Mr. DiGiovanni said.

"We met with the business community at length... and we did support them in calling for a reduction of benefit levels and expected their support to have rates increased," he said. "But they abandoned the insurance community."

In addition to the 8% rate reduction, the caps on future increases and competitive rating, the new law:

- Freezes for the next three years the maximum benefit at 166.66% of the average weekly wage, which is currently \$447.92.

- Caps benefit cost-of-living increases at 5% until July 1988.

- Provides for a pension or Social Security offset for workers compensation benefits.

- Requires employees to pay their own attorneys' fees when they lose a case. Previously, Maine was the only state that required employers to pay all attorneys' fees, even if the employee lost.

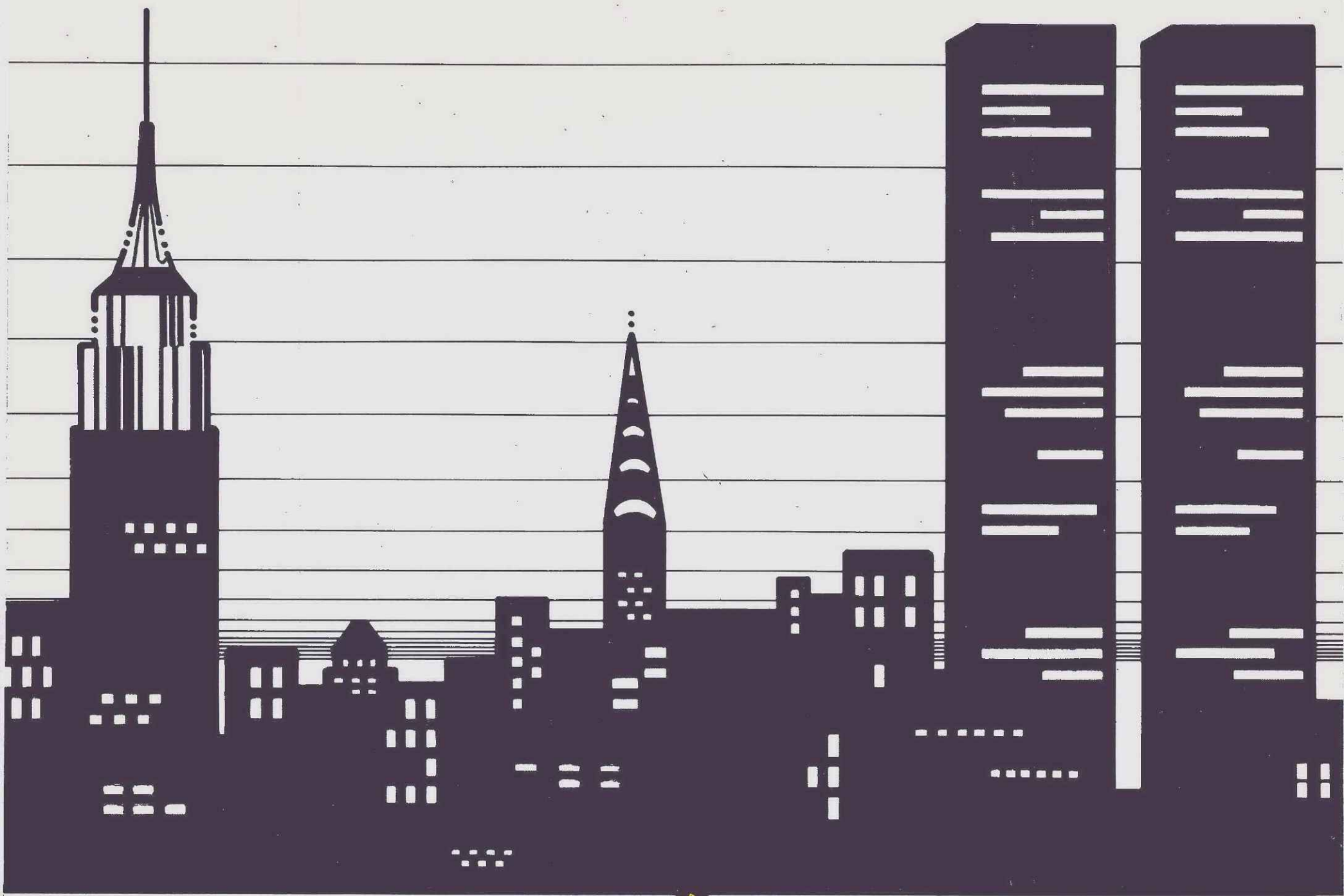
- Splits the assigned risk pool into two categories: one for employers with poor records and the other for smaller employers with good records.

Employers expressed joy over the cost-saving provisions of the new law, but admitted they had hoped for further benefit cuts.

"We view the law as very helpful. The workers compensation insurance system in Maine was in desperate need of a major overhaul. The new law doesn't do everything... but it's a step forward," said Robert Turner, manager of public affairs with Champion International Corp. in Bucksport, Maine.

Champion, based in Stamford, Conn., self-insures its workers compensation risks in Maine.

"We stopped the bleeding with this new law," noted Keith Ruff, regional governmental affairs manager for Atlanta-based Georgia-Pacific Corp., which also self-insures its workers comp program in Maine. ■



Graphics: Amy Palmer

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# Fireman's Fund

Continued from page 2 held.

Stock analysts say American Express will hold 25% to 60% of Fireman's Fund, depending on stock market conditions at the time of the offering.

The recent downward cycle of the property/casualty insurance industry has taken its toll on Fireman's Fund, which in turn has dragged down American Express' earnings.

June Hoffer, an analyst with Prudential-Bache Securities in New York, says that Fireman's Fund has "been a drag on Express' earnings for some time."

The insurer posted pretax losses of \$242 million in 1983 and \$114 million in 1984.

And traditionally American Express management style "has been to have steady and predictable earnings and not have any surprises, and I think the property/casualty business in the last three years has presented them with

many more surprises than they would like," explained David Seifer, an analyst for First Boston Corp. in New York.

Those surprises included a \$4 million first-quarter net operating loss this year reported by Fireman Fund's property/casualty unit, compared with a gain of \$5.5 million in the first quarter of 1984.

In 1984, Fireman's Fund recorded aftertax operating income of about \$42.8 million compared with \$63.4 million in 1983.

And, in 1984, American Express

was called upon by the California Insurance Department to inject \$130 million into the insurer's statutory reserves (BI, Nov. 19, 1984). American Express also added \$70 million to Fireman's Fund's surplus.

That action followed a similar injection of cash in 1983, when American Express boosted Fireman's Fund's reserves by \$230 million, causing a fourth-quarter net loss for the parent (BI, Dec. 10, 1983).

The announced resignation of

Sanford I. Weill as president of American Express was not unrelated to the stock offering.

Mr. Weill had been trying to arrange a leveraged buyout of Fireman's Fund, but an agreement over the terms of the buyout could not be reached with the 52-year-old executive, an American Express official confirmed.

Mr. Weill will be succeeded as president by Louis V. Gerstner Jr., who will continue as chairman and chief executive officer of the American Express travel unit. ■

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#### Business Insurance Circulation Breakdown\*

<b>Commercial Consumers</b>	
<b>Administrative:</b>	
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Vice-presidents, general managers and other administrative personnel	2,573
<b>Financial:</b>	
Chief financial officers and vice-presidents of finance	2,168
Secretaries, treasurers, controllers and other financial personnel	7,167
<b>Risk/employee benefits:</b>	
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	8,206
<b>Sub-total</b>	<b>22,627</b>
Associations	1,081
Government, unions and educational systems	944
<b>Commercial Consumers</b>	
<b>Sub-total</b>	<b>24,652</b>
Insurance agents and brokers	9,524
Insurance companies	5,867
Financial institutions	556
Actuaries, attorneys, adjusters, appraisers and consultants	3,265
Others allied to the field	1,143
<b>TOTAL</b>	<b>45,007</b>

\* Source: Business/Occupational breakdown of qualified circulation, Nov. 5, 1984 issue, as submitted to BPA for Dec. 1984, BPA Publisher's Statement.

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# Wellington

Continued from page 1  
defendants will be reduced, and the trials may be completed sooner.

"There will be a significant reduction in coverage litigation as far as asbestos goes," said Mr. Restivo of Pittsburgh-Corning, a principal negotiator of the agreement.

However, his own company remains locked in litigation in Philadelphia with Travelers Indemnity Co. because Travelers did not sign the agreement.

The settlements with Wellington signers "takes us out of many cases," said Mr. Jackson. "We believe it will reduce our legal costs."

The coverage litigation "should be sizeably reduced," said John F. Shea Jr., vp and claim counsel for Aetna Casualty & Surety Co. and spokesman for the Wellington group.

The Wellington agreement, named for Yale Law School Dean Harry Wellington who chaired the negotiations, provides the conditions for asbestos producers and their insurers to settle their coverage disputes.

The agreement also sets up an asbestos claims-handling facility to dispose of asbestos bodily injury claims out-of-court.

But, just as the continuing litigation in the coverage disputes raises questions about the ultimate savings to producers that have signed the agreement, opposition from plaintiffs' attorneys to the yet-to-be opened claims facility raises questions about its ultimate success in handling and disposing of claims (see related story).

Of all the asbestos coverage litigation, the trial in San Francisco involving five major asbestos producers and more than 75 insurers could realize the most benefits from the Wellington agreement.

Two of the five asbestos producers have signed the agreement: Fibreboard Corp. and Armstrong World Industries Inc., while GAF

Corp., Raymark Corp. and Manville Corp. remain embroiled in the suit. And, at least 11 of the major primary and excess insurers in the trial, the largest of all the asbestos coverage cases, have signed the agreement.

While these signers will continue in the San Francisco litigation to the extent their adversaries are not signers of Wellington, everyone agrees that the continuing litigation should be smaller, shorter and therefore less costly because actions involving coverage for bodily injury claims between the signers will be dismissed.

"It's got to simplify" the litigation, said William R. Irwin, an attorney for Fibreboard with the San Francisco firm of Brobeck Phleger & Harrison. "It's always easier to litigate against a lesser number of parties than a larger number."

With fewer parties, "we can try a simpler case," he explains.

Fibreboard had been litigating with 10 insurers prior to the agreement but now will be litigating with only four: The Chubb Corp., CNA Financial Corp., Home Insurance Co., and American International Group Inc., all of which did not sign Wellington.

Armstrong World Industries Inc. will stop fighting over coverage for bodily injury claims with nine of its 18 insurers.

"We certainly will have to pursue our case with respect to property damage and all non-signatories of Wellington," said Robert Saylor, an attorney for Armstrong with the Washington, D.C., firm of Covington & Burling.

But, Mr. Saylor added, the Wellington agreement means that "a very significant portion of Armstrong's coverage is now resolved by negotiation."

This includes settlements with Aetna Casualty & Surety Co., Liberty Mutual Insurance Co., and Reliance Insurance Co., three of its four primary insurers. The only primary insurer of Armstrong that

did not join was Travelers.

"It will accomplish a substantial simplification of the trial no matter what," observed Mr. Saylor.

For example, fewer parties will be in a position to object to evidence at trial, and "that means a shortened trial," he says.

Not as fortunate in reducing its coverage litigation among the asbestos producers signing Wellington is Eagle Picher Industries Inc.

It will still be in litigation with Kemper Group, Prudential Re Insurance Co., AIG and American Employers Insurance Co., part of Commercial Union Insurance Co., because those insurers have not joined Wellington, said the company's general counsel, James Ralston.

Only one of its insurers in two suits it is pursuing, First State Insurance Co., joined Wellington.

"Unfortunately, it will not end our coverage litigation," Mr. Ralston said of the agreement.

"In terms of insurance litigation, it did not have the result we hoped for when we originally got into the negotiations," he admitted.

But, Mr. Ralston said his enthusiasm for the agreement and the claims facility is not diminished. "We're very pleased," he said. "We've supported this from the earliest day."

The one case expected to be settled by the Wellington agreement is an appeal by Keene Corp. of a court decision limiting the Insurance Co. of North America's duty to defend Keene.

The appeal will be superseded by the Wellington agreement since both Keene and INA have signed up, said Keene attorney Jerold Oshinsky with the Washington firm of Anderson Baker Kill & Olick.

However, three other suits filed by Keene will continue:

- A suit seeking coverage for bodily injury claims against three pre-1977 excess insurers that did not join Wellington. The defendants are CNA, Home and American Home.

- A suit demanding coverage for property damage claims filed against its pre-1977 excess insurers.

- A suit against its post-1977 excess insurers, filed June 21, seeking coverage for property damage claims and also coverage for bodily injury claims from those insurers that have not joined Wellington.

Even when all the parties to a lawsuit have signed the Wellington agreement, the litigation may continue.

Owens-Illinois Inc. and its insurer, Aetna, both signers of the agreement, will continue to litigate the definition of occurrence for purposes of applying deductibles.

The Wellington agreement provides that when per-occurrence deductibles exceed \$25,000, the parties

shall resolve disagreements by negotiation, followed by non-binding alternative dispute resolution and, if necessary, by litigation.

Owens-Illinois' deductibles were \$100,000 and \$250,000.

The Wellington agreement does not supersede the litigation and settlement talks because settlement negotiations preceded the signing of the agreement, Mr. Shea said.

Owens-Illinois also is suing Aetna for coverage of asbestos-related property damage claims.

In addition to failing to settle most coverage litigation cases, the Wellington agreement could increase litigation, some suggest.

Certain coverage disputes unresolved by the Wellington agreement—such as whether policies excluded asbestos diseases—must be resolved between the Wellington signers under the facility's alternative dispute resolution mechanism. This could mean that a policyholder that has signed Wellington will be litigating against non-Wellington signers in court and participating in alternative dispute resolution with Wellington signers.

"It will be two places instead of one," said Mr. Oshinsky, who represents various policyholders in the coverage litigation.

However, Mr. Shea counters that many coverage disputes between signers have been resolved, and that the alternative dispute resolution proceedings will not be that costly. "I don't perceive that the amount or expense of ADR are comparable to litigation," he said.

Those that have signed Wellington now hope that other companies will join the facility.

"It makes sense for those companies to do this, and we would hope the wisdom of what we are doing makes sense to those not subscribed," said Mr. Restivo, representing Pittsburgh-Corning.

Mr. Jackson of Merrett predicted that many companies that did not sign up probably will.

Some say that as more producers and insurers join Wellington, pressure to join will build on remaining policyholders and insurers in the underlying bodily injury litigation or the coverage litigation.

"It's apparent that if some parties have lesser involvement in the litigation... it means the burden shifts to other parties to carry the ball," one attorney said.

In the underlying litigation, for example, fewer defendants may mean that those that remain could face paying higher damage awards.

Last week, both GAF and Raymark, two major producers that have not signed the agreement, said that they had not closed the door on Wellington, but are not ready to join.

"We haven't changed our position, said Raymark general counsel Harry Day. "At this point in time,

we don't feel it is to our advantage to subscribe to it. But that's not to say we will never be part of it."

Mr. Day said that the defense coverage provided in the agreement is not as favorable as a coverage decision Raymark obtained against its insurers that is currently on appeal in Illinois state court.

Robert Poyourow, an attorney with GAF, said that it also has not closed the door on Wellington. "We have always been considering Wellington," Mr. Poyourow said.

But, he says the fact that GAF will not be joined in litigation by those that signed Wellington will have no effect on GAF's ability to win its cases.

To settle the insurance coverage disputes between asbestos producers and their insurers, the Wellington agreement calls for insurers to cover all bodily injury claims against producers if the insurer was on the risk anytime from the time a claimant was exposed to asbestos until the manifestation of an asbestos-related disease.

The coverage is similar to what is provided under the triple-trigger theory handed down in *Keene Corp. v. Insurance Co. of North America* in 1981.

Regarding defense costs, the agreement stops the duty to defend under pre-1966 policies upon exhaustion of policy limits. But, if a producer exhausts all of its coverage for defense, including excess coverage, defense costs will be covered by a defense fund established by all the Wellington insurers.

The agreement also caps coverage provided by policies that do not have aggregate limits and caps policyholders' deductibles under policies that do not have aggregate deductibles.

The 34 producers signing Wellington are: A C & S Inc.; Armstrong World Industries Inc.; Carey Canada Inc.; Celotex Corp.; Certain-Teed Corp.; Dana Corp.; Eagle-Picher Industries Inc.; Fibreboard Corp.; Flexitallic Gasket Co.; Flintkote Co.; Genstar Corp.; Hopenan Brothers Inc.; Keene Corp.; Maremont Corp.; National Gypsum Co.; Nosroc Corp.; and Nuclear & Environmental Protection Inc.

Also, Nuturn Corp.; Owens-Corning Fiberglas Corp.; Owens-Illinois Inc.; Pittsburgh Corning Corp.; H.K. Porter Co. Inc.; Rock Wool Manufacturing Co.; Shook & Fletcher Insulation Co.; Thorpe Insulations; C.E. Thurston & Sons Inc.; Turner & Newall P.L.C.; Unijax Inc.; and U.S. Gypsum Co.

In addition, the names of five producers who have signed have not been released.

The 16 insurers that signed the agreement are: Aetna Life & Casualty Co.; American Universal Insurance Group; Bituminous Casualty Corp.; CIGNA Corp.; Continental Corp.; Crum & Forster; Employers Insurance of Wausau; Fireman's Fund Insurance Cos.; First State Insurance Co.; Harbor Insurance Co.; Hartford Insurance Group; Liberty Mutual Insurance Co.; underwriters at Lloyd's of London; Reliance Insurance Co.; Royal Insurance Co.; and Zurich-American Insurance Co.

# Plaintiffs' lawyers criticize facility

Skepticism and even hostility to the Wellington agreement are emerging among plaintiffs' attorneys.

While the agreement was being negotiated, some plaintiffs' attorneys expressed reservations, but now that the facility is preparing to open, the criticism is louder and more forceful.

"The manner in which they are setting it up is totally unacceptable to my clients," says Ronald Motley of the Barnwell, S.C., firm of Blatt & Fales, who represents about 6,000 asbestos victims.

The claims-handling and claims-settling mechanism of the Wellington agreement depends upon the cooperation of plaintiffs' attorneys, who will be asked to present their cases to the Wellington facility sometime next year.

Currently, there are more than 30,000 claims demanding damages for bodily injury related to asbestos pending in the nation's courts.

Mr. Motley charges that the producers and insurers have adopted a strategy for denying plaintiffs adequate compensation and to continue litigating the damage claims.

Defendants that had previously been more inclined to settle claims are now united with those that fought claims, creating a monolith, he contends. Now, all defendants will settle or none will, he says.

Those espousing "millions for defense and nothing for tribute" won over the more-moderate defendants, he also charges.

"Initially we do not intend to participate," said Aaron Simon, a plaintiffs' attorney in Los Angeles with the firm of Greene, O'Reilly, Broillet, Simon, McMillan, Wheeler & Rosenberg.

Plaintiffs' attorneys remain "very skeptical" of whether plaintiffs will benefit by the agreement. The facility is more a "boon for the insurance industry" than beneficial to plaintiffs, he suggested.

Not all plaintiffs' attorneys, however, are dead-set against the facility. Stanley C. Levy of Levy, Phillips & Konigsberg in New York, who represents about 1,000 asbestos claimants, said he is unsure whether he will bring cases to the facility.

He expressed concern about whether the facility will compensate certain disease victims who may not be physically impaired but have evidence of an asbestos-related disease.

And, he criticized the manner in which insurers and producers negotiated the agreement.

Mr. Levy said plaintiffs' attorneys, who were originally to be included in negotiations to set up the facility, ended up being excluded.

Another plaintiffs' attorney said the facility would have to pay plaintiffs—as would the tort system—for plaintiffs to participate.

"Unless the facility competes with the marketplace, it isn't going to work," said Paul Gillenwater, a Knoxville, Tenn., plaintiffs' attorney.

"It's absolutely critical to the success of the entire undertaking," he said. "We're willing to give the Wellington group a shot. We have an open mind." But, "that can close very quickly," he added.

John F. Shea Jr., a spokesman for the facility and vp and claims counsel of Aetna Casualty & Surety Co., says "we intend to have further meetings with plaintiffs' attorneys." He said he is confident that the facility will win the support of plaintiffs' attorneys.

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## P&G asks ruling

Continued from page 1

exceeded \$1 million or all claims assigned to one policy year exceeded \$10 million.

P&G filed a motion to dismiss the action on jurisdictional grounds or have it moved to federal court in Cincinnati. That motion is still pending.

After filing its suit in Ohio state court, P&G also filed a new motion to dismiss the Northbrook declaratory action on the grounds that the coverage issues would be better resolved by the Ohio court. Alternatively, P&G is asking the Chicago federal court to stay its proceedings until the Ohio action is resolved.

A P&G spokeswoman said the company filed a separate lawsuit in Ohio to add insurance company defendants that were not involved in the earlier Northbrook action.

Meanwhile, Northbrook has paid P&G several million dollars to cover Rely judgments, settlements and certain defense costs. The payments have been made under a "non-waiver agreement," in which neither party waives its rights of recovery in the pending litigation, according to court papers.

P&G's excess insurance coverage between 1972 and 1981 included the following:

- Two policies written by American Employers, a unit of Commercial Union Insurance Cos. One was for the period July 1972 to July 1975 and the other from July 1975 to July 1978. The policies carried limits of \$50 million over a self-insured retention of \$250,000 per person, \$500,000 per occurrence and \$500,000 in the aggregate.

- One policy written by Commercial Union covering July 1978 to July 1979. The policy carried a limit of \$25 million over a self-insured retention of \$1 million per occurrence with a \$10 million annual aggregate.

- Two policies written by Northbrook covering July 1979 to July 1980 and July 1980 to July 1981. These two policies also carried limits of \$25 million over a retention of \$1 million per occurrence and \$10 million annual aggregate.

- An excess umbrella policy written by Pine Top through underwriting manager Baccala & Shoop for the 1979-80 policy year and providing limits of \$25 million over Northbrook's \$25 million layer.

- Another excess umbrella policy written by First State, providing limits of \$25 million over the Northbrook insurance for the 1980-81 policy year.

The American Employers and Commercial Union policies provided first-dollar defense cost coverage, though defense costs were included in the policy limits, according to P&G's complaint.

The Northbrook policies, how-

ever, covered defense costs and indemnity only after exhaustion of P&G's self-insured retention, and defense costs likewise were included in policy limits, the complaint indicates.

A P&G spokeswoman refused to comment on the number of toxic shock claims now pending against the company or the amount of damages sought.

In its 1983 lawsuit, Northbrook said that more than 422 lawsuits and 222 claims were filed after 1980.

P&G's complaint charges that American Employers and Commercial Union have refused to pay claims or defense costs attributable to their policy periods, and that P&G has been forced to fund these costs itself.

While conceding that it has received "partial and conditional reimbursement" of claims and expenses from Northbrook, P&G also charges that it has been forced to bear most of the settlement and defense costs on claims attributable to the Northbrook policy period.

P&G's suit seeks a ruling that American Employers is responsible for paying all defense costs on claims covered by its policies from 1972-78 and that it must indemnify P&G for judgments and settlements in excess of \$500,000 (or \$250,000 per person) up to its policy limit.

The suit also asks the court to rule that Commercial Union must pay all defense costs on claims covered by its policy along with judgments and settlements in excess of \$1 million; and that Northbrook must pay covered defense and indemnity claims exceeding \$1 million.

These demands suggest that P&G's losses in the 1972-1978 policy years have exceeded P&G's self-insured retention of \$250,000 per person, \$500,000 per occurrence and \$500,000 in the aggregate for the American Employers policies and the \$1 million per-occurrence deductibles in the 1978-79, 1979-80 and 1980-81 policy year.

In arguing for application of the per occurrence retention, P&G asserts in each case that "under the terms of the policy, all of the Rely (toxic shock syndrome) claims arise from the same occurrence."

The complaint does not define the occurrence to which the claims in each policy year are related under P&G's interpretation of the coverage.

However, since P&G is suing for coverage under policies predating its 1977 introduction of the Rely tampon, it appears P&G may be relating the definition of occurrence to product development.

As of April 1983, Northbrook had paid \$4.9 million in undisputed claims for the 1979-80 policy year and \$700,000 in undisputed claims for the 1980-81 policy year. These

amounts were apparently in excess of what Northbrook argues is P&G's \$10 million retention on the losses.

Northbrook is believed to have paid additional amounts since then, though the additional payments haven't exhausted Northbrook's policy limit for the 1979-80 policy year.

James Noren, Pine Top's general counsel, says that the Pine Top excess umbrella layer for the 1979-80 policy year has not yet been pierced by Rely claims.

P&G also charges that Northbrook breached its policy obligations by filing the 1983 declaratory judgment action against P&G in U.S. District Court for the Northern District of Illinois in Chicago.

The complaint also asks for a court ruling that Pine Top and First State must indemnify P&G for any ultimate net loss that exceeds the underlying Northbrook policies. This suggests that P&G believes that losses in the 1979-80 and 1980-81 policy years may exhaust the underlying \$25 million limit policies.

In addition to the issue of interpreting P&G's retention, the lawsuit asks the court to resolve a dispute over "general expenses" that aren't attributable to any particular claim.

Northbrook has argued that these expenses should be allocated

equally among each of the three policy years from 1978 to 1981, "despite the fact that a disproportionate number of such claims and suits relate to personal injuries in the policy years 1979-80 and 1980-81 covered by the Northbrook policies," according to P&G's complaint.

Commercial Union, which had the 1978-79 policy, disputes Northbrook's allocation plan, the complaint says.

Officials of Northbrook and Commercial Union either declined to comment on the suit or could not be reached for comment. Northbrook stopped underwriting insurance in January.

None of the insurers named in P&G's complaint has yet filed an answer.

In its 1983 declaratory judgment action, however, Northbrook had argued that each of the toxic shock claims against P&G was a separate occurrence and that the \$10 million aggregate retention should apply.

Northbrook's suit also said that P&G had claimed coverage for certain costs that Northbrook argued were not covered by its policies, including costs related to research on toxic shock; P&G's toxic shock task force; development of a computerized toxic shock information system; and salaries and fees of certain P&G employees and outside counsel.

## Best's ratings

Continued from page 1

baby—that information is already obsolete" (BI, Oct. 1, 1984).

In evaluating companies, Best considers underwriting, reserving and investment practices, management and whether a company's net resources could absorb an "unusual shock."

Best's six alphabetical ratings are: A-plus and A (both denote excellence), B-plus (very good), B (good), C-plus (fairly good) and C (fair).

"Without an adequate Best's rating, you're not really an accessible reinsurer—period," said James G. Smith, president and chief executive officer of Constellation Reinsurance Co. of New York, which chose to forgo a rating this year rather than accept a lower rating.

Constellation Re had a B-plus rating last year and an A rating the year before. As a result, Constellation will accept no new or renewal business beginning today, he said.

Mr. Smith says Best made certain changes in its evaluation process that Constellation wasn't aware of until about June 4, when it was informed of Best's decision.

Because Constellation lacks a rating, Galaxy Reinsurance Co., of which Mr. Smith is also president, also will not carry a Best's rating this year.

The company is now assessing its options, he says.

International Surplus Lines, whose rating also was not assigned in 1985, refused to comment. Other Crum & Forster units carry an A rating, which is down from an A-plus assigned to all Crum & Forster units last year.

Mutual Fire Marine, which carried a B-plus rating last year, did not respond to phone calls.

Mead Reinsurance Corp. of Dayton, Ohio, which had an A rating last year, also is not assigned a rating this year.

Mead Re was not assigned a rating for 1985 because a substantial portion of its business is reinsured with offshore companies not licensed in the United States that are themselves not rated by Best, says Mead Re Senior Vp John Webb.

Unlike past years, Best did not recognize letters of credit posted by such reinsurers in its evaluations, several underwriters say.

Most brokers prefer to use companies with at least an A rating. If a company has a rating below A, most brokers say they analyze the company and may request client permission to use the insurer.

"We look at those situations on a case-by-case basis," says Robert L. Peretti, managing director of Marsh & McLennan Inc.'s Los Angeles office.

"We're going to take the position companywide that we will not be able to keep business in those companies with omit ratings," said an official at another large brokerage. The broker's errors and omissions coverage does not respond to claims involving companies with an omit rating, he explained.

The Mission Insurance Group companies are among the more prominent insurers whose ratings were omitted this year.

Ratings for Mission Insurance Co., Mission Insurance Co. of Texas, Mission National Insurance Co., Mission Reinsurance Corp., Holland-America Insurance Co., Holland-America Lloyds and Enterprise Insurance Co. have all been omitted this year. All carried an A rating last year.

A Mission spokesman attributes the omitted rating to the company's losses in 1984. Mission Insurance Group (MIG) reported a \$198 million loss last year, compared with a \$15 million loss in 1983.

However, MIG is starting up a new property/casualty insurer, Mission American Insurance Co., capitalized at \$37.5 million.

Continued on next page

## update

### Beckett names say they'll sue

Continued from page 2

However, Mr. Miller told Beckett syndicate members that Lloyd's will not offer them any "financial lifeboat" to help them meet their losses.

The PCW 1985 Committee said Lloyd's actions "are unsatisfactory and provide no prospect of a solution to this affair."

Despite the Beckett problems, however, Mr. Miller said Lloyd's syndicates should show an overall profit of 50 million pounds (\$64.5 million) for 1982, the year just closing under Lloyd's three-year accounting system.

Mr. Miller released the results earlier than usual because of speculation that Lloyd's would show an overall loss of 70 million to 100 million pounds for the period (BI, May 20).

### Some midwives get coverage

TRENTON, N.J.—Princeton Insurance Co. has agreed to provide medical malpractice liability insurance to two birthing centers and 67 licensed nurse-midwives in New Jersey.

The midwives are among 1,300 midwives threatened with the loss of their malpractice coverage since Mutual Fire Marine & Inland Insurance Co. in Philadelphia announced it would not renew their policies, which will expire this year (BI, June 24).

According to Princeton Vp Don Smith, the new policies require no deductibles or co-payments and have per-occurrence and aggregate limits of \$1 million each.

The midwives' annual premiums are \$402 for midwives who do not assist in deliveries and \$1,609 for midwives who do. The birthing centers' annual premium will be between \$7,000 and \$10,000, although the exact amount has not been determined.

Previously, the centers paid \$2,500 a year to Mutual Fire Marine, while the midwives paid between \$300 and \$1,100 a year.

### Orient-Pacific names arbitrator

SANTA ANA, Calif.—Orient-Pacific Insurance Agency, a Laguna Hills, Calif., managing general agent, has named Bernard Hubsher, a New York attorney, as its arbitrator in contract disputes with Houston-based Ranger Insurance Co.

Ranger has selected William C. McIlwain Jr., a retired General Reinsurance Corp. official in Columbus, N.C., as its arbitrator.

At issue in the dispute is Ranger's right to restrict Orient's underwriting authority (BI, June 24).

### Illinois malpractice bill signed

SPRINGFIELD, Ill.—Illinois physicians and insurers expect to benefit when a medical malpractice reform law takes effect Aug. 15. H.B. 1604, which reforms the state's medical malpractice law, was signed by Gov. James Thompson on June 25.

The law:

- Expedites procedures for dismissing defendants who were not involved in the occurrence that led to the lawsuit.

- Calls for review panels—composed of a judge, attorney and medical provider—to screen malpractice cases before suits may be filed.

- Limits attorneys' contingency fees to one-third of the first \$150,000 of medical malpractice awards, 25% of the next \$850,000 and 20% of any amount exceeding \$1 million.

- Abolishes punitive damages in medical malpractice suits.

Although physicians see the law as a victory, a spokeswoman for the Illinois State Medical Assn. said its members still want the law amended to limit awards for pain and suffering.

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Continued from previous page

Mission American, which was expected to open for business today, will not be eligible for a rating until 1991, under Best's rating rules.

The company, headquartered in Los Angeles, is expected to pick up many of the policies now written by Mission Insurance Co. (MIC) as they come up for renewal. It will become the group's chief underwriting unit for new and renewal business, and gives MIG "a vehicle with which to go forth," the spokesman says.

Plans for the new company were under way before Mission officials were informed that their other companies would not be rated, according to the spokesman. MIC and other underwriting units will continue to operate, but "at a different level."

Mission American will initially write only workers compensation business in California. It will soon begin writing other commercial property and casualty risks and personal lines in other states, the spokesman explains.

The insurer will operate independently of other MIG subsidiaries, and none of its business will be pooled with that of other MIG subsidiaries, the spokesman says.

Mission American will share officers with Mission Insurance Co. Ray D. Johnson Jr., MIC president, will serve as Mission American president, chairman and chief executive officer. William R. Story, MIC executive vp, will also be executive vp at Mission American.

Other management changes at Mission include the election of Carl H. Lindner as chairman of MIG at the group's annual shareholders meeting June 20. The meeting was held in Cincinnati—home of Mr. Lindner's American Financial Corp.—instead of its traditional Los Angeles site.

American Financial now holds 49.9% of MIG's stock and a warrant to purchase up to 91.3% of the company.

Mr. Lindner replaces Edward A. Smith, a Kansas City attorney who had been chairman for the past 14 years. Mr. Smith declined to seek re-election and resigned as a director after 20 years.

New York-based Midland Insurance Co. also received an omit rating. The drop in the insurer's policyholder surplus was the biggest reason, said Lawrence P. Johnsen, secretary and general counsel.

Losses decreased Midland's surplus at year-end 1984 to \$23 million, compared with \$57 million in the prior year, Mr. Johnsen said. In 1984, Midland's rating was B-plus.

Midland continues to write new policies, Mr. Johnsen reports, but only for workers compensation, short-line railroad risks, maritime risks like stevedores and other specialty lines. It stopped writing association and excess liability insurance earlier this year, which had accounted for about half of its \$75 million in net premiums in 1984.

Mr. Johnsen acknowledges that the absence of a positive Best's rating will cost Midland some submissions, but he reports that because market conditions are tight, "We're still seeing a lot of business."

Best also deferred the 1985 rating of Bituminous Casualty Corp., which had a B-plus rating last year.

The Rock Island, Ill., insurer hopes to regain that rating—or receive a better one—by next year, said Robert L. Murphy, senior vp-insurance operations.

Mr. Murphy attributes the deferral to two factors: The merger of the insurer's parent, Bitco Corp., with Old Republic International Corp. earlier this year, and Bituminous' significant financial improvement since the beginning of this year. As a result, the 1984 figures are a poor reflection of its current financial condition, he says.

Largely because of a capital infusion from Old Republic, Bituminous has a policyholder surplus of about \$47 million today, up from year-end 1984's surplus of \$25 million, he says.

The company's surplus at year-end 1983 was \$61 million, according to Best.

Mr. Murphy says he is not worried that the rating deferral will discourage brokers from placing business with Bituminous. Brokers recognize the company's new improved position and its affiliation with Old Republic, which has an A rating.

Also deferred is the rating for Northwestern National Insurance Co., an Armco Inc. unit in Milwaukee. That company was rated B-plus last year.

The rating "recognizes the problems we've faced and the actions we're taking to strengthen the company, including the capital enhancement program," according to an Armco Insurance Group spokesman.

Armco is pursuing plans to inject more than \$133 million into Northwestern National and another Armco insurer (BI, April 8).

Best deferred a rating for Wausau Insurance Cos., whose affiliates were previously rated B-plus, partially because of "the severe losses we experienced in 1984 and other significant changes we are undergoing," according to a Wausau spokesman.

These changes include reducing or discontinuing some categories of business, establishing more stringent underwriting criteria, increasing rates in many lines of insurance, selling some subsidiaries and emphasizing categories of business with the most profit potential.

The Wausau spokesman declined to name what lines of business Wausau is reducing or discontinuing.

Also deferred was the rating for Pine Top Insurance Co. in Phoenix. Best deferred Pine Top's rating because of the insurer's recent change of ownership, according to Glenn G. Herbst, Pine Top's president.

Greyhound Corp. sold Pine Top, which had a B rating last year, to San Francisco-based Whitney Financial Group in March. Mr. Herbst hopes Best will rate the company next year.

He also does not think the company will lose much business because of the rating deferral.

Insurance brokers and buyers will "be looking at the underlying financial stability. In this hardening market, that will be more important than the rating," he says.

Pine Top's policyholder surplus at the end of March was \$13.2 million, up from \$12.7 at the end of 1984.

The alphabetical ratings of some major property/casualty commercial insurers also were changed by Best.

For example, all affiliates of American International Group Inc., like National Union Fire Insurance Co. of Pittsburgh, Pa., American Home Insurance Co. and Lexington Insurance Co., now carry a contingency attached to their A-plus ratings. The contingency indicates that certain factors reviewed by Best fall below industry norms for that rating classification, but not substantially enough to warrant a full-step downgrade.

Sentry Insurance Cos. in Stevens Point, Wis., sits with a C-plus rating, down from a B-plus last year. Commercial Union Insurance Cos. (U.S.) dropped to B from B-plus. Crum & Forster units, like Industrial Indemnity Co. in San Francisco, dropped to A from A-plus, as did Royal Indemnity Co., Royal Insurance Co. of America and affiliates of The St. Paul Cos. Inc. and American General Corp.

The ratings of Fairmont Insurance Co. in Burbank, Calif., and Fremont Indemnity Co. in Los Angeles—both prominent workers compensation insurers in California—dropped to B-plus from A.

The only leading commercial insurer for whom Best improved a 1985 rating is Boston-based Liberty Mutual Insurance Co., which now boasts an A-plus rating. It previously carried an A.

Ratings of some of the largest reinsurers have slipped, too. The ratings of North American Reinsurance Corp. in New York and Kemper Reinsurance Co. in Long Grove, Ill., dropped to A from A-plus.

Walter L. White, Kemper Group treasurer, says, "Our basic feeling is that because of the way Best did the test, we do not get credit for substantial investments in our foreign subsidiaries."

Mr. White explains that Kemper Re has more than \$33 million invested in foreign operations that might not have been acknowledged under Best's 1985 rating system.

Transatlantic Reinsurance Co. in New York, which is partly owned by AIG, was given an A-Contingent rating; it previously had an A rating.

Major reinsurers whose rating dropped to a B-plus from an A-plus in 1984 include: Prudential Reinsurance Co. in Newark, N.J.; Skandia America Reinsurance Corp. in New York; National Reinsurance Corp. in Stamford, Conn.; and Gerling Global Reinsurance Corp., the U.S. operation of Gerling Group of West Germany.

Gerling Global's rating slip is principally due to underwriting losses and a drop in policyholder surplus, to \$24.5 million at year-end 1984 from \$37 million at year-end 1983, according to Bernd Vogelsand, senior vp and corporate secretary. Gerling Global's combined ratio last year was 153.5%.

The rating for American Mutual Reinsurance Co. in Chicago, a C-plus company last year, was omitted this year. The reinsurer suspended underwriting operations in February and is running off its business, according to President Roy J. Hammond.

Its surplus sits at about \$5 million today, down from \$9.5 million at year-end 1983, according to Mr. Hammond.

The rating for Ohio Reinsurance Corp. in Celina, Ohio, was omitted for 1985; the company boasted an A rating in 1984. Ohio Re stopped writing new and renewal business almost a year ago. Don W. Montgomery, chairman and president, says the company has improved "dramatically" since year-end 1984, and if reviewed today, might be considered a B company.

An Ohio Re affiliate, Celina Mutual Insurance Co., which had a B-plus rating last year, also had its rating omitted this year.

Other companies to which Best assigned an omitted rating are:

- Transit Casualty Co. in Los Angeles, which temporarily ceased all new and renewal business about two months ago. Transit Casualty is assessing its financial situation and awaiting an audit to be conducted by Touche Ross & Co., according to President Gerald DeGennaro. It had a B-plus rating last year.

- Four Armco Inc. units that are running off their business: Dallas-based Compass Insurance Co., which was rated B last year; Universal Reinsurance Corp. in Milwaukee; American Druggists' Insurance Co. in Cincinnati, and Armco Reinsurance Co. Armco Re has stopped taking on new business and is being absorbed by American Druggists.

- Centaur Insurance Co. in Chicago, a Borg-Warner Corp. unit that has stopped writing new and renewal business. It was given an A rating last year.

- Union Indemnity Insurance Co. of New York, a Frank B. Hall & Co. unit facing a rehabilitation attempt in New York (BI, June 17).

- Delta America Reinsurance Co., which had an A rating last year but was ordered into rehabilitation in May after the Kentucky Insurance Department found the company insolvent by \$66.7 million at year-end 1984 (BI, June 24).

Associate Editor Carol Cain and Directory Editor Marilou Jones also contributed to this story.

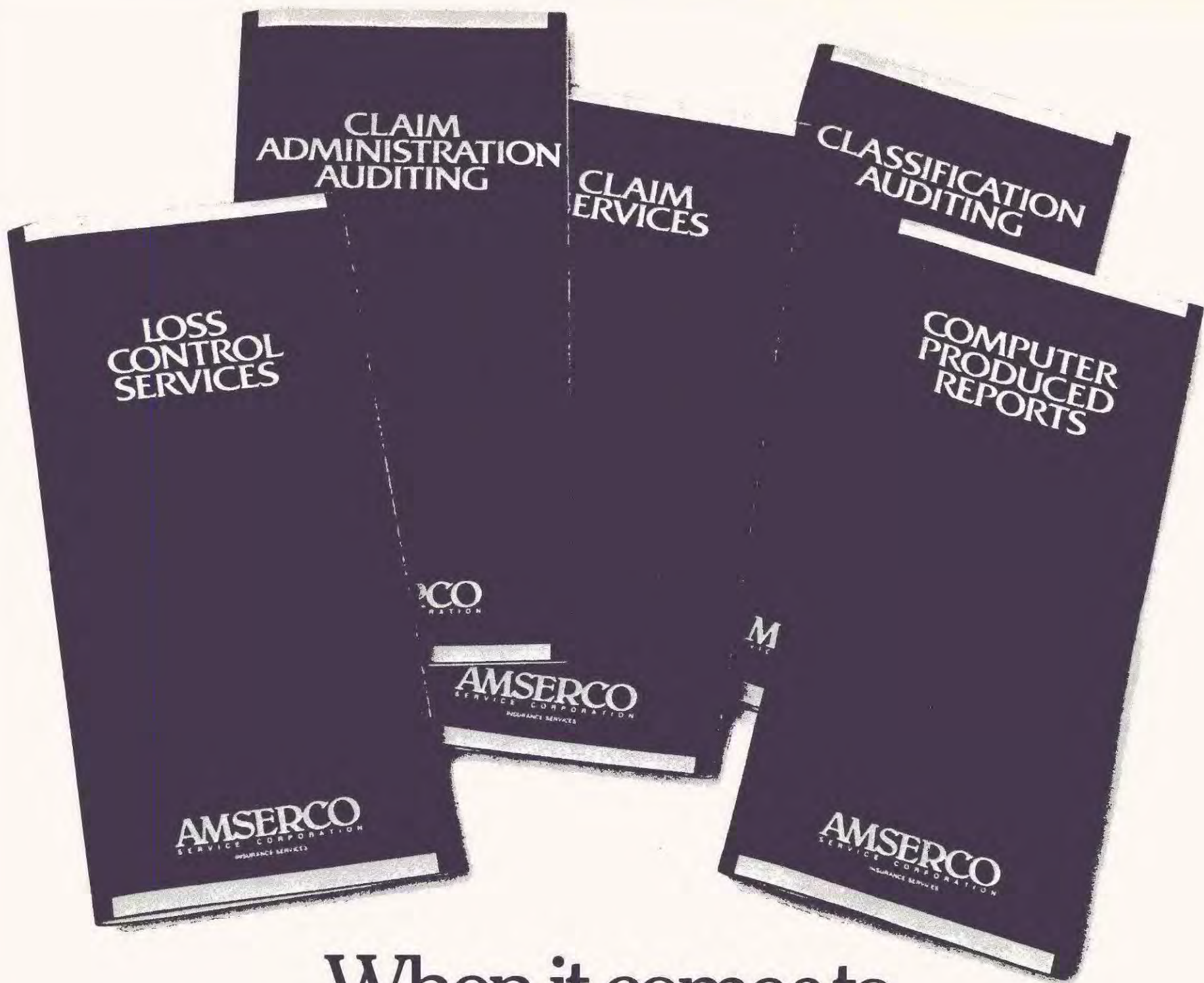
# BI Industry Stock Report

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Brokers	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE 30.00	1.3	0.0	1.00	3.3	30.25	29.38	545.8
Baldwin & Lyons Inc	OTC 63.00	-1.6	11.4	0.80	1.3	67.50	63.00	0.4
Corroon & Black Corp	NYSE 45.00	-3.7	0.0	1.00	2.2	46.38	45.00	42.8
Crum E H Cos Inc	OTC 32.88	1.2	24.7	0.44	1.3	33.00*	32.25	48.7
Emett & Chandler Cos Inc	OTC 24.25	2.1	115.5	0.00	0.0	24.25*	24.00	26.0
Gallagher Arthur J & Co	OTC 44.00	-0.8	26.3	0.23	0.6	44.75	44.00	25.3
Hall Frank B & Co Inc	NYSE 27.88	0.9	0.0	1.00	3.6	27.88	26.88	264.1
Marsh & McLennan Cos Inc	NYSE 71.00	-0.7	19.7	2.40	3.4	71.00	69.50	186.2
Poe & Assoc Inc	OTC 8.00	0.0	0.0	0.03	0.0	8.00	8.00	0.3
Reed Steinhilber Cos Ltd	OTC 21.75	3.6	28.2	0.60	2.8	21.88	21.25	117.5
AGENTS/BROKERS	AVERAGE		44.4		2.0			
<b>Conglomerates &amp; Holding Cos.</b>								
American Express(Fireman's Fd)	NYSE 46.50	-0.5	15.9	1.28	2.8	47.25	45.63	4,091.6
Anderson Clayton(Ranger/PanAm)	NYSE 37.25	-4.5	32.1	1.32	3.5	39.00	37.25	214.1
Arco Inc	NYSE 8.50	3.0	0.0	0.00	0.0	8.75	8.13	533.0
Berkley W R Corp	OTC 14.88	-4.0	0.0	0.32	2.2	15.50	14.88	71.7
CIGNA Corp	NYSE 56.75	2.0	810.7	2.60	4.6	57.00	55.00	702.4
CNA Investing Co (Home Ins.)	NYSE 35.25	0.4	5.5	0.00	0.0	35.25	35.25	300.8
CNA Fintl Corp (CNA)	NYSE 52.88	0.2	20.3	0.00	0.0	52.88	51.50	70.7
General Re Corp	NYSE 82.75	0.8	54.4	1.56	1.9	82.75	81.25	466.8
ITT (Hartford Group)	NYSE 30.75	-3.1	9.6	1.00	3.3	32.00	30.63	2,082.6
Optimum Hldg Corp	OTC 0.50	0.0	0.0	0.00	0.0	0.50	0.50	0.4
Sears Roebuck & Co. (Allstate)	NYSE 38.00	0.7	9.5	1.76	4.6	38.13	37.13	3,206.3
Teledyne Inc (Argonaut)	NYSE 256.13	1.2	5.5	0.00	0.0	256.13	247.88	139.1
Transamerica Corp	NYSE 31.75	2.4	15.6	1.64	5.2	31.75*	30.88	438.6
(Occidental & Fred S. James)	NYSE 31.75	2.4	15.6	1.64	5.2	31.75*	30.88	438.6
CONGLOMERATES/HOLDING COS.	AVERAGE		11.3		1.7			
<b>Insurers</b>								
Aetna Life & Cas Co	NYSE 45.88	1.7	23.3	2.64	5.8	45.88	44.63	1,067.7
American General Corp	NYSE 34.38	3.8	11.2	1.00	2.9	34.38	33.25	877.0
Amern Heritage Life Invt Co	NYSE 34.00	0.0	10.1	1.20	3.5	34.13	34.00	1.0
American Indty Fintl Corp	OTC 20.25	0.0	0.0	1.12	5.5	20.50	20.25	13.0
American Intl Group Inc	NYSE 83.63	1.7	24.7	0.44	0.5	83.63	81.75	514.4
Aneco Reins Ltd	OTC 1.50	0.0	0.0	0.30	0.0	1.50	1.50	19.0
Aveco Corp	NYSE 28.63	-0.4	13.3	0.60	2.1	28.88	28.63	3.1
Business Mens Assurn Co Amer	OTC 27.50	-0.9	7.6	1.04	3.8	27.88	27.50	83.3
Chubb Corp	NYSE 70.00	-3.8	17.6	2.20	3.1	71.75	70.00	90.7
Combined Intl Corp	NYSE 47.50	-3.6	9.3	2.16	4.5	48.00	47.38	321.2
Continental Corp	NYSE 43.00	-2.0	21.9	2.60	6.0	43.38	43.00	527.5
Crown Life Ins Co	OTC 146.00	0.7	8.8	5.00	3.4	146.00*	143.00	0.9
Durham Corp	OTC 38.25	-3.2	7.4	1.28	3.3	39.50	38.25	11.1
Farmers Group Inc	OTC 61.50	0.2	10.8	1.76	2.9	61.50	60.88	242.1
Freemont Gen Corp	OTC 25.38	-4.2	0.0	0.48	1.9	25.75	25.25	216.6
Great West Life Assurn Co	OTC 376.00	0.0	9.7	14.00	3.7	376.00	376.00	0.7
Hanover Ins Co	OTC 42.75	-0.6	72.5	0.56	1.3	43.25	42.75	192.8
Hartford Steam Boiler Insptn	OTC 46.50	-1.1	40.1	1.50	3.2	47.00	46.50	22.7
Kans City Life Ins	OTC 24.75	-1.6	25.6	0.32	1.3	25.00*	24.75*	12.4
Kemper Corp	OTC 57.13	1.1	24.6	1.80	3.2	57.13	56.00	114.4
Liberty Corp S C	NYSE 30.38	-2.8	14.2	0.72	2.4	31.25	30.38	13.3
Lincoln Natl Corp Ind	NYSE 42.88	-0.9	11.3	1.84	4.3	43.38	42.88	311.0
Mission Ins Group Inc	NYSE 7.13	-6.6	0.0	0.00	0.0	7.38	7.13	50.2
Monumental Corp	OTC 31.25	-1.6	23.0	1.30	4.2	31.50	31.25	21.4
Nobel Ins Ltd	OTC 10.50	5.0	13.8	0.33	3.1	10.50	10.00	63.8
Northwestern Natl Life Ins	OTC 28.38	-1.1	6.8	0.80	2.8	28.38	26.63*	472.0
Ohio Cas Corp	OTC 60.00	-0.6	22.2	2.80	4.7	60.00	59.75	76.8
Old Rep Intl Corp	NYSE 35.25	-0.7	8.5	0.74	2.1	35.25	34.50	295.2
Orion Cap Corp	NYSE 26.00	-0.5	0.0	0.76	2.9	26.13	25.38	143.2
Protective Corp	OTC 19.75	2.6	6.7	0.66	3.3	20.00	19.50	233.0
Provident Life & Acc Ins Co	OTC 23.00	-1.1	6.2	0.88	3.8	23.00	22.63	482.0
St Paul Cos Inc	OTC 70.63	0.9	0.0	3.00	4.2	70.63*	69.63	971.0
SAFECO Corp	OTC 41.25	-1.8	14.7	1.60	3.9	41.25	41.00	364.9
Sri Corp	OTC 18.50	-1.3	88.1	0.68	3.7	18.75	18.25	465.7
Seibels Bruce Group Inc	OTC 19.25	-9.4	0.0	0.80	4.2	20.25	19.25	19.3
Statesman Group Inc	OTC 4.88	0.0	0.0	0.15	3.1	4.88	4.75	33.0
Tokio Marine & Fire Ins Co	OTC 192.00	4.6	33.2	0.00	0.0	192.00*	181.50	7.4
Torchmark Corp	NYSE 45.50	-3.2	10.1	1.00	2.2	46.75	45.50	181.7
Travelers Corp	NYSE 45.63	-1.9	11.0	2.04	4.5	46.25	45.63	1,110.3
United Fire & Cas Co	OTC 22.00	0.0	0.0	0.80	3.6	22.00	22.00	0.0
United States Fid & Gty Co	NYSE 36.88	-0.3	39.7	2.20	6.0	37.88	36.50	410.0
UsLife Corp	NYSE 36.13	1.0	8.2	1.04	2.9	36.13	35.50	414.9
Washington Natl Corp	NYSE 23.50	-2.6	6.9	1.08	4.6	24.25	23.00	71.3
Zenth Natl Ins Corp	OTC 16.13	-0.8	0.0	0.68	4.2	16.25	15.75	54.0
INSURANCE COMPANIES	AVERAGE		17.1		3.2			



The Business Insurance index of insurance industry stocks closed at 362.9 points on June 26, up 2.6 points from 360.3 points on June 19. In all, 28 stocks were up, 18 closed down and 12 were unchanged. The biggest gains were by CNA Financial Corp., up 11.6%; Zenith National Insurance Corp., up 7%; American Indemnity Financial Corp., up 4.9%; Chubb Corp., up 4.6%; and Northwestern National Life Insurance, up 4.5%. The biggest losses were by Arthur J. Gallagher & Co., down 5.7%; Business Men's Assurance Co. of America, down 3.6%; Hartford Steam Boiler Inspection & Insurance Co., down 3.2%; Continental Corp. and The Crump Cos. Inc., both down 2.3%. The BI index rose 0.7% for the period; the New York Stock Exchange composite rose 1.5%.



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