

business insurance

World Airways, survivors win award for 1974 crash

SAN FRANCISCO—An alliance between insurers for World Airways Inc. and a plaintiffs' attorney has yielded an \$11.6 million jury verdict against a Times-Mirror Co. subsidiary.

A federal court jury last week awarded the damages in the Sept. 8, 1974, crash of a World DC-8 into a mountain on the Aleutian Islands, killing three crew members.

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Reporting weekly for corporate risk, employee benefit and financial executives/\$1.25 a copy; \$45 a year

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The Vatican Collections: The Papacy and Art

By DOUGLAS McLEOD

The Metropolitan Museum of Art in New York isn't relying on divine providence to see the colossal Vatican Art exhibit safely through its three-city U.S. tour.

Instead, the Met—organizer of the priceless show of paintings, statuary and artifacts from the Holy See in Rome—has insured the treasures for \$90 million with a combination of a U.S. government indemnity agreement and man-
scripted Lloyd's of London policies.

The indemnity agreement, obtained through a relatively new federal program, has significantly reduced insurance costs for the show by providing the first \$50 million of coverage at no premium charge.

Four years in preparation, "The Vatican Collections: The Papacy and Art" opened at the Met in February and closed June 12. It is now being installed at the Art Institute of Chicago, where it will open July 21 for a three-month run. Its

third and final stop before returning to the museums and libraries of Vatican City will be at the M.H. DeYoung Memorial Museum in San Francisco, where it will be on display from Nov. 19 to Feb. 19, 1984.

The exhibit of 237 works includes art spanning 25 centuries, from a Corinthian vase dated 560 B.C. to 19th-century marble busts, and from 13th- and 14th-century oil paintings on wood panels to a water-color on paper dated 1955.

Insuring these objects on their journey from and to the Vatican—in museum parlance, arranging "wall-to-wall" coverage—required devotional effort from the Met and its broker, Alexander & Alexander Inc.

First, The Met applied to the National Endowment for the Arts for a \$50 million indemnity under the federal Arts and Artifacts Indemnity Act.

The act, passed in 1975, was intended to open the doors of U.S. museums to foreign exhibits by providing at no cost insurance that otherwise might be prohibi-

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Photo courtesy of The Art Institute of Chicago

Federal judge issues new coverage theory

By STEPHEN TARNOFF

NEW YORK—The latest court decision interpreting insurance coverage for companies defending long-latent disease claims says coverage depends on the facts of each individual claim.

In doing so, the court rejects previous opinions that the general theories of exposure, manifestation and triple-trigger can be used to determine coverage.

In American Home Products Corp. vs. Liberty Mutual Insurance Co., U.S. District Court Judge Abraham D. Sofaer relies on a new "injury-in-fact" theory that says the insurer on a risk when an injury is *diagnosable* is liable.

American Home, a diversified manufacturer of drugs, foods and household products, is currently defending about 54 product liability lawsuits arising from the manufacture and sale of six pharmaceuticals including DES, a synthetic estrogen taken by many pregnant women in the 1950s to prevent miscarriages.

The suit against Liberty Mutual involves interpretation of the coverage it provided American Home from 1944 until 1976. American Home and Liberty Mutual disagreed over which policies apply to the claims.

In similar disputes, courts have come up with at least three distinct theories. Most favor the exposure theory, which says that the insurers on a risk at the time the victim inhales or ingests the toxic substance are liable.

Other courts, holding to the manifestation

theory, have said that insurers at the time the victim shows symptoms of the disease or it is diagnosed are liable.

And one court, in Keene Corp. vs. INA, has said that all insurers on a risk from the time of exposure through manifestation—including the latency period—are liable. This "triple-trigger" theory would provide the broadest coverage.

American Home sought either an exposure or triple-trigger theory ruling in its case against Liberty Mutual. The insurer favored manifestation.

In his decision, Judge Sofaer rejected all three theories.

"Neither the exposure nor the manifestation theory can be wholly justified by the policy language," he said. He treated triple trigger as an extension of the exposure theory.

Judge Sofaer says what triggers coverage is medical proof that the injury occurred. When injury occurred will depend on the toxic substance involved, the individual exposed to it and the period and intensity of exposure.

The judge's ruling appears to differentiate between when the disease or injury is diagnosable and when it is actually diagnosed to determine coverage. He believes coverage is triggered when an injury is diagnosable, even if that is many years before it is diagnosed.

"Thus, an occurrence of personal injury, sickness or disease under the policies means any point in time at which a finder of fact determines that the effects of exposure to a drug actually resulted in a diagnosable and compensable injury," the court said.

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N.Y. allows life insurers to trade futures

By RHONDA L. RUNDLE

NEW YORK—Gov. Mario Cuomo is expected to sign a law passed by the state Legislature June 24 that substantially liberalizes investment rules for domestic life insurance companies.

The legislation is a victory for the state's powerful life insurance industry, which sought the changes to make it more competitive with independent pension fund managers and with other non-bank financial institutions.

"The bill is the most comprehensive passed in the last 20 to 30 years in the area of investments," says James P. Corcoran, superintendent of the New York Insurance Department.

Mr. Corcoran is convinced that the omnibus investment reform law is a plus for individual and commercial insurance buyers.

The changes allow the life insurers to take advantage of new hedging instruments—such as financial futures—to reduce their investment risk and to improve their investment income, he explained.

"Higher investment income helps consumers because

it means premiums can be lower," he added.

Both pricing and availability may be enhanced through use of financial futures on interest-rate-sensitive insurance products like guaranteed-interest contracts for corporate pension plans, universal life insurance and qualified corporate savings plans with fixed-rate features.

Besides loosening investment rules, the legislation allows New York-based life insurers to acquire subsidiaries engaged in any lawful business activity except banking.

Previous restrictions on such acquisitions have slowed New York life insurance companies' entry into the financial services arena already populated with insurers like New Jersey-based Prudential Insurance Co. of America and Transamerica Corp. in California.

Although New York-based life insurers were the strongest proponents of the law, other insurers also will benefit from more liberal regulation. That's because New York's strict investment rules have traditionally set the standard for non-New York companies and other state insurance regulators.

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Some already in the market

By RHONDA L. RUNDLE

Many major U.S. life insurance companies are gearing up to plunge into the financial futures markets as soon as New York's legislation to permit hedging transactions takes effect.

Insurers view futures as a tool to protect the value of their investment portfolios, to boost their investment income, to compete more aggressively with other financial institutions and to develop new interest rate-sensitive products for both commercial and personal insurance buyers.

Up until now, New York state's former prohibition on the use of financial futures and some of the newer investment vehicles, like index futures and options on futures and indexes, has kept most major U.S. insurers out of those markets, even though other states permit insurance company participation.

But, some of these same companies have been quietly running pilot programs through non-insurance company subsidiaries to get

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\$11.6 million awarded in crash

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Defendants in the case are Jeppesen Sanderson Inc., a Denver-based unit of Times-Mirror that prints aeronautical route and approach maps, and the Federal Aviation Administration, which supplies the information to Jeppesen.

So far, only Jeppesen would be required to pay the \$11.6 million because the judge hasn't decided if the FAA bears any liability. The plaintiffs include World and the widows of three World crew members killed in the crash.

Plaintiffs' lawyer Albert R. Abramson of Abramson & Smith in San Francisco argued that Jeppesen's map for the Cold Bay, Alaska, airfield where the plane was to refuel was missing any notation of a key "feeder route" to the only runway approach the plane could have used. As a result, he says, the crew was relying upon a faulty radio navigation transmission from the FAA-operated airfield.

Mr. Abramson says World's lead insurer, Association Aviation Underwriters Inc., decided to retain him to try the case against Jeppesen and the FAA. He already represented the widows.

Times-Mirror's first \$5 million of liability coverage was written by Mission Insurance Co. through Sayre & Toso Inc. The first excess layer of at least \$20 million is through Lloyd's of London, lawyers said. Ralph Gentry, risk manager for Times-Mirror, says the primary policy includes "no significant deductible" for Jeppesen's activities. The \$11.6 million award includes \$9.3 million to World Airways for the loss of the DC-8 hull and the balance in compensatory damages to the families of the dead crew members.

Longshore bill in House

WASHINGTON—The House Labor Standards subcommittee will begin hearings next week on legislation, S. 38, to overhaul the federal Longshoremen's and Harbor Workers' Compensation Act.

The legislation, introduced by Sen. Don Nickles and passed June 16 on a voice vote by the Senate, would cap annual benefit increases at 5%. Currently, benefits are increased every October to match the annual increase in the national average weekly wage.

FAA drafting fire safety rules

WASHINGTON—The Federal Aviation Administration says it is working on draft rules aimed at reducing the spread of fire in aircraft interiors. The announcement comes weeks after an in-flight fire aboard an Air Canada DC-9 killed 23 passengers (BI, June 13).

The FAA says one rule will probably require seats to include a "fire-blocking" layer of material between fabric and urethane foam cushions to delay the combustion of the urethane.

One suit has been filed in the Air Canada fire by the family of a Vietnamese refugee who died on the plane. It names Air Canada and DC-9 manufacturer McDonnell-Douglas Corp. as defendants.

Alton's libel coverage settled

ALTON, Ill.—The debate over which insurance policy applies to a libel judgment against the Alton Telegraph continues to drag through Illinois courts, but a judgment handed down last week brings the case one step closer to completion.

Illinois Circuit Court Judge Jonathan Isbell ruled that a 1969 Commercial Union Insurance Cos. policy providing \$1 million in libel coverage, in effect when Justice Department investigators first read an allegedly libelous memorandum from Alton Telegraph reporters, is the policy that should apply to the loss.

Commercial Union had argued that Zurich-American Insurance Cos., the Telegraph's insurer from mid-1969 to the present, was liable for the coverage since it was the insurer of record when contractor James Green, the subject of the memorandum, discovered that the memo falsely linked him to organized crime.

However, the judgment does not mean that CU will pay out its limits immediately, attorneys say.

After the Telegraph declared bankruptcy in 1981, it negotiated a \$1.4 million settlement with Mr. Green (BI, April 19, 1982). Z-A and CU each agreed to advance \$500,000, pending the settlement of the coverage issue. The original judgment against the newspaper had been \$9.2 million.

CU also retained the right to argue that Z-A was too slow in denial of its coverage and that Z-A's policy, which followed the CU form, should have taken over coverage for claims filed after March 1969.

Trading of Baldwin stock halted

CINCINNATI—Baldwin-United Corp. says the Securities and Exchange Commission has halted trading of its stock through July 9 to protect shareholders and provide an orderly dissemination of information about the negotiations with creditor banks.

Baldwin, the parent company of several insurers, is attempting to persuade the banks to delay its repayment of as much as \$1 billion in loans, used primarily to purchase MGIC Investment Corp.

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Bridge accident losses may exceed insurance

By DONNA GORDON

GREENWICH, Conn.—The bridge accident last week on the Connecticut Turnpike is the second this year that may produce losses exceeding the state's \$1 million road liability insurance policy.

Three people were killed and three others were critically injured June 28 when a 100-foot-long, three-lane-wide section of the Mianus River Bridge on Interstate 95 collapsed.

In January, seven people were killed when a tractor-trailer rammied into cars lined up at a toll booth on the Connecticut Turnpike. The accident is still under investigation to determine if highway defects were the cause, but about 20 claims have been filed already.

Two of the persons killed when two cars and two tractor-trailers fell from a section of the bridge 65 feet to the riverbed at about 1:30 a.m. last Tuesday were "relatively young men," said Arnold K. Shimelman, a Connecticut assistant attorney general. One was 21, another 31.

"We may be looking at substantial claims. It doesn't take much these days for a jury to return a verdict of \$1 million damages on one claim," he added.

If losses in either accident exceed the \$1 million limit, the state must pay the excess because it does not purchase excess liability insurance, Mr. Shimelman said.

The state's highway defect or road liability insurance policy is underwritten by Aetna Life & Casualty Co. There is no annual aggregate on the limits of \$1 million per occurrence for bodily injury and \$100,000 per occurrence for property damage, said Mr. Shimelman.

The state paid an annual premium of \$662,615 for the road liability policy, which expires Dec. 1.

Property damage to the turnpike, including the

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Photo: Wide World

The collapse caused tractor-trailer trucks to plummet to the riverbed below.

Honeywell will appeal jury award

By LEN STRAZEWski

MIAMI—Honeywell Inc. and its primary liability insurer say they will appeal a \$12.2 million jury award resulting from the mishandling of a burglar alarm signal three years ago.

The jury award, handed down in Dade County Circuit Court on June 23, granted Trend Coin Co. and its owners, Albert, Bertie and Jay Weinberg, \$8 million in damages resulting from the theft of gold and silver from their Miami business.

They also were awarded \$3.17 million in interest and \$1 million in punitive damages from defendants, which include Honeywell, six of its employees and Aetna Casualty & Surety Co.

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USF&G turns bad-faith suit into \$1.02 million victory

By DOUGLAS McLEOD

LOS ANGELES—United States Fidelity & Guaranty Co. turned the tables in a bad-faith lawsuit alleging it wrongly refused to pay a policyholder's claim and won \$1.02 million in damages.

The award by a Los Angeles Superior Court jury includes \$995,984 in punitive damages based on its finding that Orient Handel, a Los Angeles-based rug merchant, and its two owners fraudulently inflated a theft claim filed with USF&G.

Attorneys familiar with bad-faith actions say this may be the first time that punitive damages have been awarded to an insurer claiming fraud on the part of a policyholder after being sued for refusing to pay a claim.

USF&G had written a commercial multiperil policy with an annual aggregate \$500,000 limit covering two Orient Handel locations, a Los Angeles showroom and a warehouse, according to Richard B. Wolf of the Los Angeles law firm of Parkinson & Wolf, which represented the insurer. The policy was in effect from March 1975 until March 1978, when USF&G refused to renew it, he said.

In February 1978, Orient Handel reported a burglary at its showroom in which it claimed 109 oriental rugs worth \$471,519 were stolen.

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IRS ruling favors 401(k) plans

By DOUGLAS McLEOD

WASHINGTON—A recent Internal Revenue Service ruling on 401(k) salary reduction plans resolves one ambiguity that has kept some companies from offering a plan, benefit experts say.

But while the ruling may spur new interest in the plans, other unanswered questions remain that may keep many employers temporarily on the sidelines in the 401(k) action, the experts add.

The IRS ruled June 20 that an employee's pretax contributions to a 401(k) plan may be included as part of the employee's salary in determining pension benefits.

This was one of several issues left untouched by the IRS' preliminary regulations that have governed the use of 401(k) plans since 1981 (BI, Dec. 13, 1982). Final regulations on the plans have been expected since last year and may come by the end of the summer, the IRS says.

For the time being, however, the latest revenue ruling has solved one problem.

"This is good news and confirms what most of us have been expecting for some time," said Henry von Wodtke, a benefit consultant with Buck Consultants Inc. in New

York.

"It's cleared up a very definite problem," said Harry Gross, a partner with Kwasha Lipton, a benefit consulting firm in Fort Lee, N.J. "It was a cloud hanging over everyone's head."

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errors & omissions

- Settlement negotiations are continuing between The Mayo Clinic and a former patient who has won a \$2.1 million jury award for malpractice. The law firm representing the plaintiff has retracted information it provided *Business Insurance* that the case had been settled for \$1.95 million (BI, June 20). The Minneapolis law firm of Kurzman, Shapiro, Manahan & Partridge also says The Mayo Clinic has stated that it will not settle the case of Hutton vs. Mayo Clinic et al for \$1.95 million and that the clinic's self-insured reserves were inaccurately stated.

- Due to an editing error, a comment by another attorney regarding the risk of asbestos in the air was incorrectly attributed to attorney Lawrence T. Hoyle Jr. of Philadelphia (BI, June 20). See letters column, page 6.

Wrongful death suit could alter policies on hiring ex-convicts

By STEVE TARAVELLA

ST. LOUIS—A highly unusual employer negligence case could cause personnel directors to refuse to hire convicted felons or at least screen job applicants' past histories more carefully.

A Missouri Court of Appeals in St. Louis recently ruled that the parents of a Monsanto Co. secretary, who was raped and killed by a co-worker in 1979, have the right to sue the company for negligence in its hiring policies.

A St. Louis Circuit Court had earlier dismissed the suit. The co-worker, former mail clerk Burton D. Woods III, had served three years in a Missouri prison on a rape and robbery conviction before he was hired by Monsanto.

The victim's parents, James L. Gaines and Margaret M. Frazier, allege that Monsanto was not careful in examining the background of Mr. Woods before hiring him. They assert that Monsanto "knew or should have known by ordinary care that (Mr. Woods) was likely to cause harm to others if not controlled."

The case is unique compared with similar suits brought against employers because the incident did not occur during working hours or at the worksite. The victim, Kasandra Gaines, was killed at 2 a.m. in her apartment.

Mr. Woods was convicted of capital murder in the slaying. Monsanto claimed at both the lower and appellate courts that "the death was so non-work-related that Monsanto could have no liability," says P. Terrance Crebs, a Monsanto attorney with the St. Louis firm of Peper, Martin, Jensen, Maichel & Hetlage.

In addition, Monsanto claimed that, should the court determine the the slaying was work-related, Monsanto's responsibility should be limited to benefits payable under the state's workers compensation statute.

The appellate court subsequently ruled that the murder "was not an accident in the course of employment and thus not within the exclusive realm of the Workers Compensation Law." The case was remanded to
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Tort reform vote postponed until administration speaks

By JERRY GEISEL

WASHINGTON—A vote on federal product liability legislation could be delayed by as much as two more months while the Senate Commerce Committee waits for a response from the Reagan administration.

The Commerce Committee had been expected to vote either last week or this week on the measure, S. 44, which would pre-empt state product liability laws with one uniform federal law.

But the committee's chairman, Sen. Robert Packwood, R-Ore., isn't scheduling a vote until the administration comments on the bill, sponsored by Sen. Robert Kasten, R-Wis.

In a June 24 letter to the secretaries of labor, transportation and commerce, the attorney general, the director of the Office of Management and Budget and the chairman of the Council of Economic Advisers, Sen. Packwood and two other senators asked for the administration's views "on the need for federal legislation in this area, the wisdom of federal pre-emption of state product liability laws and the approach taken by S. 44."

The letter was written at the request of Sen. Ernest Hollings, D-S.C., the committee's ranking minority member, who wants clarification of the administration's views on the Kasten legislation.

Indeed, the administration's position on federal product liability legislation is cloudy.

Despite widely publicized statements that the administration supports
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It takes teamwork

That's the philosophy behind a new program CIBA-Geigy is launching to control health costs

By SALLIE J. DRURY

ARDSLEY, N.Y.—CIBA-Geigy Corp. is using more than a few benefit plan design changes in its new battle against health care costs.

This manufacturer and marketer of pharmaceuticals is attacking rising health care costs from three fronts and stressing the importance of employer-employee teamwork.

Its strategy:

First, the employer provides the resources to make cost-efficient health care possible.

Second, the employee learns to be a responsible consumer of health services.

And third, employer and employee work together to influence those external factors that cause costs to rise despite a consumer's best efforts.

This three-part approach is the basis of Takin' Care, the new benefits program covering 13,000 CIBA-Geigy's salaried and union employees. Although the program just began July 1, an ambitious communications effort has prepared employees for the change (see story below).

"What's changed is our whole philosophy toward benefits," said Denise Maleska, director of human resources for the corporation's agricultural division and chairman of the committee that made Takin' Care possible.

"We saw that health costs were going up, and felt that CIBA-Geigy could do something about it. The question we had to face is: Should a corporation be involved in the personal health of employees?"

The decision for CIBA-Geigy was an emphatic "yes."



"We had always done a good job on occupational health," said Ms. Maleska, "but we were seeing more and more that occupational health and personal health are one and the same."

CIBA-Geigy self-insures health benefits for more than 10,000 of its employees while the company's union workers are covered by a Blue Cross/Blue Shield plan.

Also, because of labor contracts, unionized employees do not yet participate in some parts of Takin' Care, such as the increased cost sharing.

"But, in general, our union employees have been very sympathetic to the need to contain health care costs," Ms.

Maleska said. "When the contracts are up, we will go to the negotiating table so our union employees can participate in the full (Takin' Care) program."

The central idea behind CIBA-Geigy's efforts, and the key to the success of Takin' Care, is that employer and employee must work together.

"Takin' Care reflects a partnership—a responsibility on the part of CIBA-Geigy to provide a more cost-effective medical benefit plan and expanded health services... and a responsibility on your part to take full advantage of these plans and services," said Chairman and Chief Executive Officer Otto Sturzenegger in a letter to employees.

First, the company controlled rising costs by modifying benefits coverage.

For example, CIBA-Geigy urges employees to use alternative health care providers, such as health maintenance organizations, because they are often more cost-effective and more convenient for employees.

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Three characters and a new logo tell the story

By SALLIE J. DRURY

ARDSLEY, N.Y.—Henry, Marsha and Andy were not strangers to CIBA-Geigy employees. When the three animated characters described Takin' Care, the corporation's new benefits program, employees already connected them with benefits.

"We had used the characters in an audiovisual program for our 401(k) salary reduction plan a year ago," said Denise Maleska, chairman of the company's committee to implement Takin' Care. "Using them again was intentional. We want our employees to relate to these characters and identify them with benefits information."

CIBA-Geigy and its benefits consultants Kwasha Lipton of Fort Lee, N.J., both believed the use of familiar characters in the audiovisual program

would make it easier for employees to learn to use the new program.

However, the audiovisual show was but a fraction of the enormous communications effort that prepared employees for the July 1 installation of Takin' Care.

The company also:

- Held small group meetings to explain the program to employees and to field questions.
- Presented each employee at these meetings with a glossy file folder, designed to provide a permanent place to file benefit news handouts, claims forms and bills.

• Plastered the Takin' Care logo all around the company, so employees will continually "think cost containment." This effort included posters on bulle-

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State regulators focus on work comp

Panel of outside experts will examine cost of occupational disease benefits

By CAROL CAIN

ST. LOUIS—State insurance regulators will be working with a panel of outside experts to evaluate the impact that occupational diseases will have on the workers compensation system.

"It appears that occupational disease will be the single most volatile issue affecting workers compensation in the next decade," said J. Michael Low, Arizona's insurance director. He also heads a workers compensation task force that met last month at the annual summer meeting of the National Assn. of Insurance Commissioners.

To reach its goal, the task force appointed a 25-member committee to examine how occupational disease claims could affect the solvency of workers compensation insurers and whether benefits will be available for the injured worker.

Committee members include representa-

tives from industrial accident boards, organized labor, employers and the insurance industry.

James W. Newman Jr., senior vp of the American Insurance Assn., and James C. Pullen, president of the International Assn. of Industrial Accident Boards and Commissions will co-chair the study.

Two subcommittees have been formed. One will review state laws regarding occupational disease compensation and various federal, state or private proposals on the issue and the other will deal with rating and reserving practices to fund occupational disease
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Model bill to regulate self-funded pools is expected at NAIC's winter meeting

ST. LOUIS—The National Assn. of Insurance Commissioners expects to have a model bill on the regulation of self-insured workers compensation pools ready by its winter meeting.

A study committee of an NAIC workers compensation task force presented a final report on group self-insurance at the NAIC annual summer meeting last month. A draft copy of the report, complete with recommendations, was given to the task force at its March meeting (BI, April 11).

Information in the 143-page report will be used to draft a model bill that would attempt to standardize regulation of self-

insured work comp pools.

The model bill will be an "alternative model"—one that does not endorse the concept of workers compensation pools, but rather offers guidelines for states dealing with work comp pools, said J. Michael Low, task force chairman and director of the Arizona Insurance Department.

"The likelihood of this coming up in state legislatures is inevitable. A guideline would be helpful," said Howard Bunn, vp of workers compensation for the National Assn. of Independent Insurers.

"Hawaii would appreciate any efforts... we have had this type of legislation arise and would like guidelines," Susan Kee-Young Park, Hawaii's insurance commissioner, told the task force.

Now, each state has its own set of rules for dealing with self-insured work comp pools.

The report doesn't deal directly with this
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Hiring practices challenged

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circuit-court level for rehearing.

Monsanto has asked the appellate court for a rehearing. If denied, Mr. Crebs says he will petition the state Supreme Court to hear the case.

If the case does go back to circuit court for trial, the plaintiffs seek \$500,000 in damages through Missouri's Wrongful Death Act. The act allows the next-of-kin to sue in cases in which the dead person would have been entitled to damages had death not occurred.

"If I were an insurance company, I'd be just off-the-wall in this case," says Mr. Crebs. "It presents a new risk that no underwriter has ever considered setting premiums for."

The notion that the employer could be held responsible for the activities of its employees outside of the workplace is "ridiculous," Mr. Crebs says. He predicts the case could produce "a chilling effect on

getting people employed who've been convicted of crimes and paid their debt to society."

The legal and ethical boundaries of an employer's responsibilities that this case touches are complicated, one workers compensation expert says.

"This puts the employer in a real spot," notes Dr. Arthur Larson, a leading expert on workers compensation and professor emeritus at the Duke University School of Law in Durham, N.C. "Is it the duty of the employer to protect all his employees against all his other employees?"

"I won't even speculate about that," he says. "That's a whole new ball game."

But, he observes, the appellate court decision does not mean that Monsanto is necessarily liable.

"This (the appellate ruling) isn't the end of the story," Dr. Larson says. "The plaintiff still has a very

heavy burden of proof."

Monsanto, one of the 10-largest employers in the St. Louis area, does not routinely check past histories of job applicants, says T.W. Jones, the company's personnel manager.

Monsanto asks on its employment forms if the applicant has ever been convicted, he explains. His staff examines the personal history of someone who responds "yes," but only "if we (see) a relationship between the nature of the offense and the kind of work for which he applied."

"We have absolutely no way of checking all applicants—there is no national clearinghouse," he says. "The average ex-offender probably does not give an honest answer (on the application)," he concedes, but adds that researching every possibility is simply not practical.

"The cost alone is prohibitive, and the benefits probably minimal. It's a mind-boggling task."

However, Mr. Jones says, before

hiring for a sensitive position like a security guard, Monsanto usually checks with authorities to verify that the applicant has no criminal record. Such checking is not done on mail clerks, he adds.

Monsanto was not aware that Mr. Woods had a prior criminal record, Mr. Jones says.

"If that argument holds (that Monsanto showed negligence) then the parents are arguing that no employer should ever hire a felon convicted of a crime that involved violence to another person," says Dallas L. Salisbury, executive director of the Employee Benefit Research Institute in Washington. "That seems to fly directly in the face of a huge number of government programs."

If Miss Gaines' murder had never occurred, Mr. Salisbury suggests, Monsanto might even be hailed as "a socially responsible corporation, helping those who have gone astray at one point or another in their lives to get back in

the workforce."

"If the lawsuit is successful, I certainly think it would tend to discourage" the hiring of former convicts, predicts Art Baebler, vp of the St. Louis Regional Commerce and Growth Assn.

"This could have some impact on a number of programs that encourage employers to employ non-traditional workers in the workplace," he observes. "Certainly it will impact employee relations people who have responsibilities for hiring."

Harry H. Lipsig, a well-known plaintiffs' attorney with the New York firm of Lipsig, Sullivan & Liapakis, does not expect to see too much of a withdrawal of big business from programs aimed at employing ex-convicts.

"The convicts that are rehired are presumably rehabilitated individuals and the program, as designed, does not contemplate hiring those individuals of dangerous proclivities," he notes. "If it did, it would be the height of stupidity."

Monsanto should have foreseen that Mr. Woods "would commit violent acts against other employees, and in particular, Kasandra Denise Gaines," the lawsuit filed by her parents allege.

It also asserts that Monsanto knew or should have known that Mr. Woods was likely to commit intentional misconduct because his job duties "would provide a temptation and an opportunity for misconduct similar to conduct which resulted in his conviction for rape and robbery."

The case rests on the test of foreseeability, says David G. Lupo, the St. Louis attorney for the victim's parents. "Looking back retrospectively, is it so unusual to have seen the things that happened, based on what we have alleged?"

Attorneys disagree on whether the case will spur similar suits against other employers.

If the plaintiffs are successful, "Companies are going to be subject to these kind of lawsuits, which may be cheaper to settle than to defend," notes Monsanto's attorney Mr. Crebs, citing the high cost of litigation today.

Dr. Larson isn't worried that this case will spur a rash of similar suits. "This is a rare combination of facts," he says. "It only pops up once in a blue moon."

The appellate court may have been wrong in declaring workers compensation inapplicable to the case, several observers in the legal community suggest.

"Even though it happened after hours, and was an assault of the type that would normally be non-compensable, it could have been caused by the distinctly dangerous behavior of the employer in bringing the employee into the workplace," says Gary T. Schwartz, a professor of tort law at the University of California at Los Angeles Law School.

Normally, he says, "If A and B meet at work and get into a fight outside of work, the employer is not liable under comp. But here, the comp analysis could be changed because the employer might knowingly have brought in someone dangerous."

If the incident is compensable, Professor Schwartz is quick to point out, "then no negligence needs to be shown."

Mr. Lipsig, the negligence lawyer, says, "It would seem to me that ordinary compensation would cover such a situation, but the common-law principle (says) that ordinarily if the employees of a corporation are careless or villainous and perpetrate a crime, there is no reason why the company shouldn't be held liable."

He says this is especially true when an employer "should have had knowledge of the dangers of negligent propensities of the employee." In these cases, "the company is responsible for any injuries it causes to anyone else."

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NAIC to study occupational diseases

Continued from page 3
claims, the development of necessary statistical reporting systems and the analysis of insurer solvency.

John Baulis, director of government and industry relations for CIGNA Corp., will chair the first subcommittee and John Purkis, vp with Liberty Mutual Insurance Co., will chair the subcommittee on rating and reserving.

"We anticipate a minimum of a year on this project. . . It will take at least that long to get this project to completion," Mr. Newman said.

The scope of occupational disease goes beyond workers compensation to all lines of insurance, including accident and health and product liability coverage, and also affects non-insurance programs, like Social Security, said Michael Camil-

leri, director of national affairs for the National Council on Compensation Insurance.

And the future will bring more occupational disease claims, he predicts.

Asbestos-related occupational diseases have received a lot of publicity lately, he said, but diseases associated with exposure to products like benzene and dioxin will receive increasing attention.

"The proposed study of occupational disease issues by the NAIC would have the funding for long-latent occupational diseases as its principal focus and would explore how funding needs for long-latent occupational disease claims may be affected by benefit levels and other substantive elements of a state's workers compensation law," said Warren P. Cooper, chief actuary of

the New Jersey Insurance Department.

"The study should not delve into all issues associated with occupational disease compensation, but should concentrate on relevant issues of particular concern to insurance regulators," he said.

The advisory committee will study:

- The appropriate definition of a "compensable occupational disease."

- Employer responsibility for occupational disease benefits, including questions of policy coverage.

- Coordination of benefits, including providing occupational disease benefits to retirees.

"This is really a unique effort on the part of the NAIC. This is not your standard advisory committee.

We've reached out and gathered on board key players," Mr. Low said.

Arthur Larson, professor emeritus at Duke University School of Law in North Carolina, is adviser to the group. He is a recognized scholar in the workers compensation field and has written a 10-volume treatise on the subject.

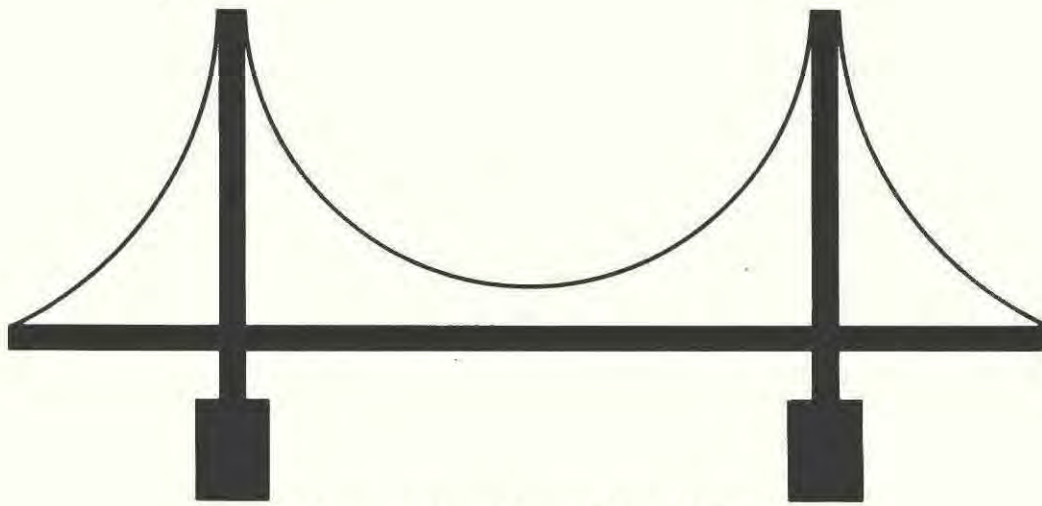
Others on the committee include William C. Aldrich of Hartford Insurance Group; Edward Bader of Arthur Andersen & Co.; Reginald Beane of the Independent Insurance Agents of America; Patricia Borowski of the National Assn. of Professional Insurance Agents; and Howard Bunn of the National Assn. of Independent Insurers.

Also, Donald DeCarlo of the National Council on Compensation Insurance; Bruce M. Eckert of the Pennsylvania Foundrymen's Assn.;

John J. Fitzpatrick of Gulf Oil Corp.; Ross Hodgkinson of Fireman's Fund Insurance Cos.; James J. Holland of Travelers Corp.; and C. Clarke Imbler of the Alliance of American Insurers.

Also, J.T. Noblin of the International Assn. of Industrial Accident Boards & Commissions; Eric Oxfeld of the U.S. Chamber of Commerce; Ruth Salzmann of Sentry Insurance Co.; Jerry Scheibl of Employers Insurance of Wausau; Leo Souza of the Workers' Compensation Insurance Rating Bureau of California; and Lee Steeneck of General Reinsurance Corp.

Also, Robert Sturgis of Tillinghast, Nelson & Warren Inc.; Robert J. Sullivan of Crum & Forster Inc.; Spencer Traver of The BFGoodrich Co.; and a representative from the AFL-CIO. ■



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Coordination of benefits subject of poll

ST. LOUIS—State insurance regulators will be surveyed this summer on how to coordinate health care benefits when more than one family member is working.

"It has often been said that health care cost-containment efforts are thwarted since individuals are sometimes able to secure duplicate insurance recovery resulting from a single medical expense," according to the survey prepared by a task force of the National Assn. of Insurance Commissioners.

"The purpose of the questionnaire is to ascertain from the various states their perception of the problem. . . if there is a problem," said Richard G. Shaw, West Virginia's insurance commissioner and chairman of a special task force of the NAIC that studies coordination of benefits on an ongoing basis.

The survey follows the adoption of a coordination-of-benefits model bill by the NAIC in December. That bill states that an employee's current employer should provide his or her primary medical coverage; any coverage an employee might have through retirement or layoff benefits is secondary (BI, March 14).

Regulators will be asked to answer 30 questions, including the following:

- Do you think that coordination-of-benefits provisions in group health insurance contracts should be worded in such a manner as to completely prevent duplicative reimbursement for services rendered?

- Should group health insurance and individual health insurance policies be coordinated to prevent duplicate benefits recovery?

- In cases where the employer pays all or a portion of the group policy and the employee purchases an individual health policy, should duplicate recovery be permitted?

- Do court orders in divorce cases whereby one of the parents is required to maintain health insurance coverage for the children create difficulties with the NAIC model regulations?

Although some said the surveys should be sent to employers as well as insurance regulators, only representatives of state insurance departments will be polled. Completed surveys are due Sept. 1.

The coordination-of-benefits panel was not the only NAIC health care committee to meet at the group's summer meeting last month in St. Louis.

Another group, the State and Federal Health Insurance Legislative Policy Task Force, approved a

Continued on page 9

Benefit issues discussed

Continued from page 8

model bill concerning state health insurance pools and heard from a panel about alternative health care delivery systems and cost-containment measures.

The model bill would establish a mechanism through which adequate levels of health insurance coverages can be made available to residents of a state who are otherwise considered uninsurable.

The bill would establish a state "association" or pool in which all health care financing mechanisms—insurers, non-profit service plan corporations, health maintenance organizations and self-insurers—would be members.

"Uninsurable pools may not be needed in every state, nor present the most effective answer to questions of availability of health insurance in every state," comments attached to the bill explain. It adds that although it adopted the model bill, the panel does not endorse the formation of such pools.

Besides taking action on the model bill, regulators also heard from providers and buyers of health insurance on cost-control efforts.

George Strumpf, associate director of the Group Health Assn. of America, pointed out the health maintenance organizations are proving to be a cost-effective way to deliver medical care.

"HMOs have succeeded because they offer an effective alternative to the predominant fee-for-service system," he said.

Mr. Strumpf noted there were only 26 HMOs in the country in 1970, serving about 3 million members. Today, there are 269 HMOs serving in excess of 11 million members, he said.

That growth is changing the players in the HMO market, he added. "While non-profit HMOs continue to predominate, in the past couple of years we have begun to see an increasing number of national HMO development efforts by for-profit firms."

Another reason for the success of HMOs is the awareness of employers, which now realize the role they can play in reducing health costs.

"Some employers are moving toward benefit packages with higher co-payments and deductibles in an effort to hold down premium increases among traditional carriers. At the same time, HMOs are growing in their attractiveness because they have been able to maintain their comprehensive benefits, while achieving significantly lower premium increases than their competitors," he said.

Regulation of health care, including the mandatory setting of hospital rates by state-established commissions, also was discussed by panelists.

Although the Health Insurance Assn. of America supports legislation that would establish prospective review of hospital budgets, the problem of high health care costs cannot be solved by regulation of the delivery system alone, explained John R. Hurley, the HIAA's assistant general counsel.

He said both the delivery system and the way health

care is financed must be altered to cut costs. The employer and consumer must be a part of any solution, not just providers, he said, referring to other health care cost-containment devices like higher deductibles and coinsurance levels, preferred provider organizations and mandatory coordination of benefits.

Other members on the advisory panel included Glenn Hackbarth, principal deputy to the Department of Health and Human Services' deputy assistant secretary for health planning and evaluation; Jan Ozgo, staff director for the committee on health care cost containment for the U.S. Chamber of Commerce; Shirley Rivers, director of the American Medical Assn.'s department of state legislation; and Joel E. Gimpel, associate counsel for Blue Cross/Blue Shield Assn. ■

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States' comp pooling rules contain vast differences

Continued from page 3

lack of uniformity among states, but in reading it, the diversity is obvious, said James W. Newman Jr., chairman of the study group that put together the report and senior vp of the American Insurance Assn.

For instance, most of the 30 states that allow workers compensation groups permit both public and private employers to join the pools, but public and private employers cannot be in the same group.

However, seven states—Alabama, California, Connecticut, Maryland, New Mexico, Tennessee and Texas—permit only public employers or some types of public employers to form groups (see chart). They prohibit private employers to do so.

On the other hand, Kansas allows only private employers to form work comp pools and New Jersey and Washington allow only school boards to join self-insured pools. Colorado permits public employer groups and groups made up

of physicians and health care institutions to form pools.

The study committee report also points out that different agencies are in charge of work comp pools in different states. The report concludes that states must decide whether their workers compensation board or insurance department will have regulatory authority.

Almost all of the states that enacted workers compensation pooling laws before 1979 gave regulatory authority to the states' workers compensation agency. But in states that have allowed self-insurance pools since 1979, regulatory authority has been given to the insurance department.

Overall, 15 states have given authority over pools to the workers compensation agency and 11 have given it to the insurance department. Colorado has split the responsibility: the insurance department controls public groups and the workers compensation agency regulates physician and health care

Continued on facing page

States that allow self-insured work comp pools

State	Year permitted	Type of employers allowed to form groups	Regulatory agency
Alabama	1981	Public	Workers comp agency
	1965	Private	Workers comp agency
Arkansas	1979	Public & private	Workers comp agency
California	1975	Public	Workers comp agency
Colorado	1981	Public	Insurance dept.
	1977	Physician or health care institutions	Workers comp agency
Connecticut	1979	Public	Workers comp agency & insurance dept.
	1949	Private	Workers comp agency & insurance dept.
Florida	1937	Public & private	Workers comp agency
Georgia	1981	Public & private	Insurance dept.
Illinois	1980	Public & private	Insurance dept.
Iowa	1913	Public & private	Insurance dept.
Kansas	1983	Private	Insurance dept.
Kentucky	1977	Public & private	Workers comp agency
Louisiana	1979	Public & private	Insurance dept.
Maine	1973	Public	Insurance dept.
	1979	Private	Insurance dept.
Maryland	1982	Public	Workers comp agency
Michigan	1974	Public & private	Workers comp agency
Minnesota	1980	Public	Insurance dept.
	1979	Private	Insurance dept.
Missouri	1982	Public & private	Workers comp agency
New Hampshire	1975	Public & private	Workers comp agency
New Jersey	1983	School boards	Insurance dept.
New Mexico	1977	Public	Insurance dept.
New York	1966	Private	Workers comp agency
	1955	Counties	Workers comp agency
North Carolina	1929	Public & private	Workers comp agency
Oklahoma	1978	Public	Workers comp agency
	1981	Private	Workers comp agency
Oregon	1981	Public & private	Workers comp agency
Rhode Island	1982	Public & private	Insurance dept.
South Carolina	1972	Public & private	Workers comp agency
Tennessee	1967	Public	None
Texas	1974	Public	None
Virginia	1979	Public & private	Insurance dept.
Washington	1982	School districts	Workers comp agency

Source: Regulating Workers' Compensation Groups, A study committee report to the National Assn. of Insurance Commissioners.

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NAIC's structure comes under fire

ST. LOUIS—The more than 1,150 people who attended the National Assn. of Insurance Commissioners' annual summer meeting last month often resembled a colony of hard-working ants.

More than 70 meetings were scheduled almost non-stop from June 12 through June 18 for state insurance regulators, their staffs and others interested in the regulation of insurance.

The opening session—a panel discussion on two federal bills call-

ing for the elimination of sex as an insurance rating factor (BI, June 27)—drew the largest crowd, with several hundred in attendance. But other meetings—including sessions on workers compensation, health care, risk retention and reinsurance—also drew big audiences. In fact, it was standing-room-only at several of the sessions.

Some of those at the conference say the 112-year-old NAIC, which holds four meetings each year, meets too much and accomplishes too little, too late. Others, though, support the association and stress the need for its cumulative actions.

"It's a group with lots of potential, but it doesn't seem to move fast enough," said a young staffer from a state insurance department who admitted: "But that may be a common complaint of youth."

Others, though, agree, noting that some of the NAIC's model bills are approved long after they are needed. Still others note that it takes the group too long, usually a year or more, to study issues.

Supporters of the group, like NAIC President Roger C. Day, the Utah insurance commissioner, say the diversity of state regulations is responsible for the lengthy process.

He notes that states that enact legislation before a model bill is adopted serve as a sort of laboratory. "And it's possible that states would follow a trend anyway, without a model, but not as quickly."

Smaller states say they look to the NAIC to provide guidelines and model bills. "It's good for smaller states like us, which don't have the staff," said Susan Kee-Young Park, Hawaii commissioner.

"The primary purpose of the

NAIC is to serve as a mechanism to improve state regulations and its objective is to (help) meet solvency regulations and protect consumers and to preserve the integrity of insurance," Mr. Day said.

He believes that the quarterly forums are not only educational, but serve as an exchange between and among members and the public. "And it clearly strengthens the capacity of state regulations."

The NAIC works through a committee structure, with final action on proposals taken at a plenary session attended by all the commissioners.

Some say this structure, including 10 committees, is bulky and hinders action, while others believe the committees, task forces and subcommittees are what make the association organized and manageable.

A move to hold only two full NAIC meetings annually, with regional meetings to be held in between, was deferred to the next meeting, to be held Sept. 18-21 in Tampa, Fla.

Although the NAIC's membership is composed of the chief insurance regulatory officials of the 50 states, the District of Columbia and the four U.S. territories, many others attend its meetings. One such visitor at last month's gathering was Steve W. Butterworth, deputy superintendent of insurance for the Cayman Islands.

"Cayman is now a regulated insurance environment," he reported to NAIC members, noting that authorities on the islands are cooperating with U.S. regulators, which had been a sore spot with some of the insurance commissioners.

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NAIC expected to draft model pooling legislation

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In Connecticut, both the workers comp agency and the insurance department share regulatory authority.

In Texas and Tennessee, on the other hand, pools are not regulated at all.

The study committee report also recommends:

- Regulators should decide how similar the activities and risks of pool members must be.
- The principal focus of regulatory efforts should be the performance and financial condition of workers compensation groups, not the approval or disapproval of individual employers' membership in a pool.
- State law should explicitly clarify the extent of joint and several liability for pool members if one member suffers financial difficulty. Each member of the pool should be responsible for the losses incurred by all work comp pool members.
- States should require that pools have a minimum combined net worth of \$1 million and minimum annual premium volume of \$250,000. However, the report notes, these requirements may have to be modified depending on the type of risks involved, the pool's retention level and state work comp benefit levels.
- Minimum limits for excess insurance and surety bonds should be established and adjusted periodically. Regulators should have the flexibility to establish higher requirements for some groups based on size, types of employment and other relevant factors.
- Groups should be required to establish reserves for bad debts and should specify the methods by which the bad debts are determined.
- Each state should decide if it

needs a guaranty fund to cover workers compensation claims if a pool cannot meet obligations, but such a fund should not take the place of any financial security requirement, relieve the members of an insolvent group of their joint and several liability or be pre-funded excepted for minimum administrative expenses.

● Regulators should have the authority to approve how much a group may distribute in dividends and how soon after the end of the accounting year the dividends may be distributed.

Copies of the report are available from James W. Newman Jr., Senior Vp-Policy Development and Research, American Insurance Assn., 85 John St., New York, N.Y. 10038.

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Task force hears reinsurance proposals

By CAROL CAIN

ST. LOUIS—The Reinsurance and Anti-Fraud Task Force of the National Assn. of Insurance Commissioners may examine increased regulation of alien and non-authorized reinsurers.

The task force heard a request for the examination at the NAIC annual summer meeting last month, in addition to a report from one of its members that contained several other proposals for the group to study, including the licensing of intermediaries.

Task Force Chairman Lyndon L. Olson Jr., chairman of the Texas Insurance Board, and Vice Chairman Kenneth C. Moore, director of the Alaska Insurance Department, will review the proposals and requests and then draft a game plan for the group. That plan is expected to be ready at the NAIC's fall meeting in September.

Meanwhile, some states, like Florida, Texas and North Dakota, have already worked with the reinsurance industry to pass legislation that begins to take a closer look at reinsurance practices within the United States, particularly how ceding companies are allowed to take credit for reinsurance on their financial statements.

Despite these actions, the demand for more information about reinsurers continues. For example, Albert E. Lewis, the former New York insurance superintendent and now a partner at the New York law firm of Cole & Dietz, asked the task force to ask for more information in particular about Lloyd's of London underwriters.

"I think we ought to ask and get a clearer picture of how Lloyd's operates," Mr. Lewis said. He said he was concerned with the heavy loss ratios in property/casualty insurance lines and the ability of Lloyd's to meet its U.S. commitments in view of the weakness of the British pound.

"I would like to know how much is owed and what is available to cover it by each of the respective (Lloyd's) syndicates," Mr. Lewis said.

But one of Lloyd's U.S. attorneys, Donald J. Greene, told the insur-

Informers should get immunity: Proposal

ST. LOUIS—People, including insurance regulators, who supply information in investigations of fraudulent insurance activities should be immune from civil liability, according to a model bill adopted last month by the National Assn. of Insurance Commissioners.

New York and Texas have already adopted such laws.

The model bill, which also has the support of the Conference of Insurance Legislators, would grant immunity to people who, without malice, supply information relating to fraudulent insurance transactions to a state insurance department.

A fraudulent insurance act is defined as giving information or concealing information with an intent to defraud.

The model bill would especially aid in the investigation of reinsurance fraud, said Lyndon Olson Jr., chairman of the NAIC task force that worked on the model bill and chairman of the Texas Insurance Board.

The Texas law, which was recently adopted by the Legislature and takes effect Aug. 29, includes immunity for people cooperating with investigations of both insurance and reinsurance fraud. The New York law deals only with fraudulent reinsurance transactions.

ance regulators that Lloyd's can meet its U.S. obligations without any trouble.

"Lloyd's is the only insurer that I know that writes business in the United States and maintains dollars in the U.S., and has since the 1930s," said Mr. Greene, an attorney with the New York firm of LeBoeuf, Lamb, Leiby & MacRae.

He added that the Lloyd's U.S. trust fund now contains some \$4.5 billion.

Because Lloyd's maintains "dollar" accounts, it has taken a giant

step to avoid currency fluctuation problems, said Mr. Greene, who volunteered to arrange meetings between Lloyd's representatives and the task force to clarify questions.

He also suggested that should the task force decide to formally examine Lloyd's that it also probe reinsurers in other nations.

Both Mr. Greene and Mr. Lewis are members of the advisory committee.

Besides questions about Lloyd's, the task force's advisory committee

also is examining other reinsurance issues, including the licensing of intermediaries, the role of managing general agents in the placement of reinsurance and the credit ceding companies receive for non-admitted reinsurance.

For example, the task force is looking at a list of proposals submitted at the meeting by James W. Schacht, acting director of the Illinois Insurance Department and a member of the task force.

The Illinois department is concerned about reinsurance fraud,

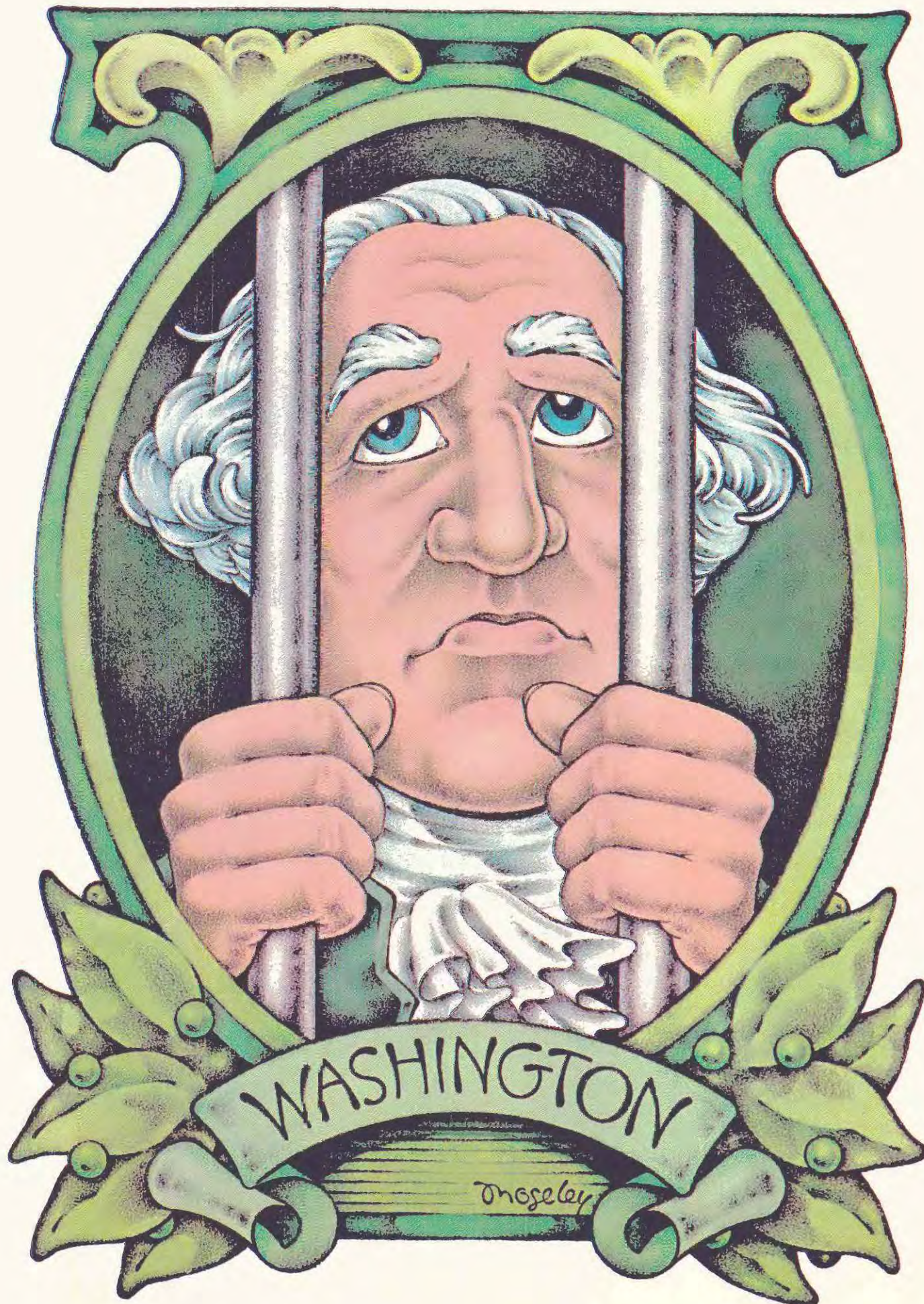
which played a role in the insolvency of several Illinois insurers, said the report, which was written by Illinois Deputy Director of Insurance Kenneth W. Smith (BI, Dec. 6, 1982).

The report attempts to identify regulatory weaknesses and describe possible solutions in four general areas:

- The inclusion of financially suspect reinsurers as reinsurance participants.

- Questionable intermediaries.

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- An increasing willingness to litigate reinsurance disputes.
 - The intentional abuse of reinsurance.
- Some of Mr. Schacht's specific recommendations to the NAIC task force include:
- Intermediaries placing business with non-U.S. reinsurers must supply the reinsurers' full name, address and U.S. manager, if any. This would permit the NAIC to compile a roster of alien reinsurers that could be consulted if problems arise. Such documentation, although often required by regulators, is not always given, the Illinois report says.
 - Change the rules governing

- reinsurance pools to aid the participation of financially strong, regional insurers in the reinsurance market.
- States should be encouraged to license reinsurance intermediaries, as New York does. The report notes, however, that most state insurance departments do not have the experience or staff to conduct in-depth examinations of intermediaries. So, it suggests that intermediaries be licensed in at least one state in order to do business in the remainder of the states.
 - The so-called "blank," the annual financial report insurers file with state regulators, should be amended so that reinsurance recoveries in dispute can be easily dis-

- closed.
- Insurers domiciled in a state should receive approval from regulators before entering into a managing general agency agreement with another company. The report notes that MGAs, which often have the authority to cede reinsurance on their insurers' behalf, are largely unregulated and some have contributed to the financial ruin of many insurers.
 - States need model regulations, similar to legislation proposed in Illinois, that would prohibit—except in special circumstances—domestic insurers with less than \$5 million in policyholders surplus from assuming treaty reinsurance. Illinois does not believe small domestic com-

- panies have either the expertise or the financial wherewithal to be in the reinsurance business, the report says.
- At a minimum, the report adds, states should require that the reinsurers of domestic insurers maintain a minimum amount of policyholder surplus before granting credit for reinsurance purchased by the domestic insurers.
- The Illinois report notes that "every state permits its domestic insurers to take annual statement credit for reinsurance cessions made to 'admitted' or 'authorized' reinsurers. However, state insurance laws and regulations appear to be quite diverse in defining the term."

Three states recently passed legislation governing reinsurance transactions. The Florida Legislature recently passed a bill that authorizes reinsurers to do business in the state if they meet certain requirements.

S.B. 812, which is on the governor's desk, authorizes the use of reinsurers that are licensed in Florida or licensed in another state but meet Florida's capital and surplus requirements. Reinsurers that are a member of an insurance exchange are also allowed to freely do business in the state.

Reinsurers that do not meet these requirements may still do business as "unauthorized" reinsurers if they can meet certain security requirements.

In Texas, a law that took effect in May formally allows a ceding company to take credit for reinsurance on its financial statement by recording it as an asset or a reduction of liability.

This practice was permitted in the past, but was not specifically covered by law.

The Texas legislation is similar to a model bill drafted by the Reinsurance Assn. of America in 1981. Several states including Utah, Indiana, Delaware and Virginia are looking at similar proposals, including the RAA's model bill.

The RAA drafted the model bill after discovering that state statutes vary considerably in their treatment of reinsurance and reinsurance transactions, said Frank Nutter, president of the Washington-based trade association.

One provision of that model legislation underscores the continuing obligations of a reinsurer if the ceding company becomes insolvent.

Aside from the RAA model bill, the NAIC reinsurance task force is also working on model legislation affecting reinsurance transactions, which could be introduced in draft form at the fall meeting.

One proposal that could be included in the NAIC model bill would be to allow a ceding company to take credit for reinsurance even if the reinsurer is an alien or offshore company. Or, alternatively, credit could only be given for reinsurance assumed by an alien underwriter if it maintains a U.S. trust fund.

In North Dakota, the Insurance Department will hold rule-making hearings later this summer following enactment of a law expanding the types of reinsurers that can do business in the state.

Prior to the law's enactment, only reinsurers domiciled in North Dakota or in another state or authorized to do business in a state were permitted.

The new law will allow the state to regulate the affairs of offshore reinsurers, which had been operating in the state without statutory backing, said Gregory Morris, counsel for the Insurance Department.

Two June storms cost \$57.5 million

NEW YORK—Two heavy storms early last month caused an estimated \$57.5 million in insured property damage, according to C.E. Hermanson, vp of property claim services for the American Insurance Assn.

Wind, hail and tornadoes that struck north and central Texas June 3-5 caused insured losses of \$21.5 million. This storm was assigned Catastrophe No. 6 by the Insurance Services Office.

A combination of wind, tornadoes and hail in parts of Colorado, Kansas and southern Texas June 4-6 caused insured losses of \$36 million: \$15.5 million in Colorado, \$12 million in Texas and \$8.5 million in Kansas.

This storm was assigned Catastrophe No. 97 by the Insurance Services Office.

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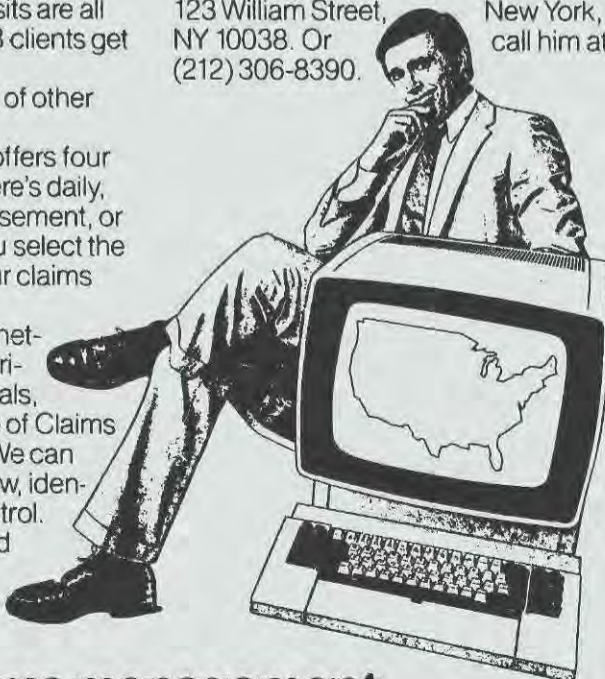
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In fact, even if a roof doesn't fall in, architects and engineers can still be involved in a suit.

After a crime in a suburban mall, for example, an architectural firm was actually sued for designing a shopping center that was "conducive to kidnapping."

And if that seems absurd, consider this: an engineer was called in as a consultant on a problem limited to the roof at the Hyatt Hotel in Kansas City. He was later sued for failing to notice structural weakness in the skywalk that collapsed there.

The point of all this is that the threat of professional liability is not only real, but growing.

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If you're interested in this subject and would like more information, please write to Insurance Company of North America at 1600 Arch Street, Dept. RC, Philadelphia, Pa. 19101.

Or if you're an architect or engineer and would like to discuss your specific situation, please call your agent or broker.

After all, you never know when something might go wrong.

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The cost of unisex legislation is too great

Continued from previous page
insurance as a 70-year-old.

Individuals cannot control their susceptibility to certain diseases, so under the logic of S. 372/H.R. 100, a terminally ill leukemia victim should pay no more for life or health insurance than a healthy person.

As absurd as these examples appear, they are no more absurd today than the elimination of sex as a rating factor would have appeared several years ago. Yet they are exactly what will occur if insurers have to abandon the use of group statistics.

Discrimination—differentiating among groups—is the very essence of insurance underwriting, ratemaking, coverage and benefits. Fair discrimination in these aspects of insurance, based on demonstrable evidence, is not only unobjectionable, it is desirable and necessary. Without it, private insurance could not exist. Accordingly, insurance laws use the phrase “unfair discrimination” to distinguish prohibited activities. This distinction between discrimination and unfair discrimination is essential to an understanding of insurance, but it is missing in S. 372/H.R. 100.

Proponents of the legislation try to play down its impact on state regulation of insurance, but it is difficult to disguise a bill that rewrites the nature of insurance and substitutes a federal definition and regulatory standard in every state.

Not only is the legislation wrong in principle, but it will actually take money out of women's pockets. Today, a typical woman pays more than \$8,000 less during her lifetime for automobile, life, health, disability and pension coverage than does a similarly situated man. This advantage to women, based on actual experience, would end if S. 372/H.R. 100 were enacted.

Under the legislation, women will pay \$360 million more a year for life insurance and \$700 million a year more for auto insurance; even in health and disability insurance, any reduction in insurance costs to women of child-bearing years will be more than offset by the increase in their costs because full pregnancy benefits are required. In pensions and annuities, as well, only 2% of women workers will gain at all, while the rest will receive no added benefits or will actually lose money.

But S. 372/H.R. 100 goes even further in imposing new insurance costs on individuals, businesses and state and local governments. Not only does the bill prospectively shift costs between men and women, but it also retroactively imposes billions of dollars in costs on corporate and public pension plans and on employers and insurance companies by lowering premiums of the higher-paying sex and raising benefits of the lower-paid sex on contracts already in effect—the so-called topping up cost.

The annual cost of S. 372/H.R. 100-type legislation to private and public pension plans has been estimated by the U.S. Department of Labor at up to \$1.7 billion, and this figure does not appear to include the full cost of public plans. If the history of cost projections involving government and insurance is a guide, all current estimates will prove low.

In the area of private pensions, the unfunded liabilities imposed by the legislation will bankrupt many of these plans. In Washington, the lower estimates of “only” \$1 to \$2 billion annually may be treated as “peanuts,” but that much a year in added pension costs is an extraordinary amount for American industry to absorb without severe financial hardship.

This will especially be felt since many pension plans are now underfunded, the Internal Revenue Service is increasingly forced to grant requirement waivers under the Employee Retirement Income Security Act and the Financial Standards Accounting Board (BI, May 30) is proposing that pension plan liabilities be carried on a parent company's balance sheet.

Significantly, most of the cost will fall on smaller employers that utilize defined contribution plans, which will be hardest-hit by the bills' retroactive impact.

The retroactive impact will also cause large losses to the investment portfolios of most of these pension plans, which included the stock of other companies also likely to be hurt by the legislation. Smaller companies will be the hardest-hit since they will not have the financial wherewithal to make up the lost value in their pension portfolios.

With respect to public pension systems, currently hard-pressed states and localities will be unable to afford the liabilities imposed by the bill. All of these liabilities would have to be paid by increased taxes or by reductions in services in state and localities obligated to fund the retirement system. The cost to California teachers' retirement systems will be \$2.6 billion. In New York, the added unfunded liabilities would be \$2 billion for the New York state and city teachers' and employees' retirement systems. The effect on New York City's financial condition has nationwide implications.

The impact on life insurance companies could be equally devastating. Large and small insurers—forced to absorb billions of dollars in retroactively mandated costs of reduced men's premiums and increased women's cash surrender values on life insurance policies in force added with concomitant obligations on existing annuity contracts—will suffer enormous reductions in surplus. Estimates of the retroactive cost of S. 372/H.R. 100 on some 150 life insurers surveyed show a loss of more than \$14 billion in surplus. More than 20 of these insurers admitted that they would be impaired or insolvent.

Ironically, the bulk of these retroactive costs to both pension plans and insurers will go to reduce men's premiums and increase men's benefits, with only a fraction going to women—a costly way to implement equal rights for women.

Even if retroactivity were eliminated from the bill, the remaining provisions are inimical to smaller insurers. Without the proven pricing tool of sex-based experience on which to predict costs, smaller insurers, with less surplus, will be more easily impaired. If the legislation's purpose was to eliminate competition and concentrate markets in the hands of a few large insurers, it could not have been more effectively drafted.

Similarly, an increasing number of employers, unable to either predict their pension costs with any degree of accuracy or to purchase sex-based annuities from insurers, will reluctantly restrict their retirement benefits to lump-sum payments. Is there any doubt that Congress, faced with such a response, will further intrude into pensions mandating lifetime annuities, regardless of cost? In addition to the conceptual defects of the bills, the expectation of increasing congressional involvement in the business community was one of the reasons that the U.S. Chamber of Commerce has strongly opposed S. 372/H.R. 100.

There also will be a direct loss in revenue to the federal government. Even if the

majority of employers survives the legislation, the added multibillion-dollar employer costs under the bill will be tax-deductible, and, together with any federal obligation incurred by the Pension Benefit Guaranty Corp., will produce a measurable drain on federal revenues. Loss of tax revenue will extend beyond pensions and life insurance to other lines where insurers restrict the sale of their products in the face of artificial legislative constraints.

Neither the costs of the legislation nor its rejection of sound insurance principles seems to concern backers who justify its economic havoc by calling it civil rights legislation. S. 372/H.R. 100 cannot properly be dignified by such a title. That legislation rewrites the insurance mechanism, imposes federal regulation of insurance and, at great economic cost, gives excessive benefits to men and takes money out of women's pockets. It should not be enacted.

Gender-rating based on money, not fairness

Continued from previous page

pending ratification of the Equal Rights Amendment, is constitutionally permissible. Insurers profit from it, as examples show.

In the 1950s, insurers won approval from regulators to grade life insurance prices by policy size and began offering nominal discounts for insurance on women.

Life insurance policies sold in 1981 averaged \$17,000 of coverage on women and \$38,000 of coverage on men. Companies typically charge 25% more per \$1,000 coverage for the smaller policies than for the larger ones. Consequently, women in aggregate may be paying more than \$500 million more each year for life insurance than they would if they were charged the rates men pay. Is fairness the purpose of the discounts?

In a lobbying mailing in May, GEICO Corp. told its policyholders in selected congressional districts that women pay less than men for life insurance. The same month, GEICO sent sales prospects a price list for term insurance showing women paying up to 9% more than men for the same coverage through age 37.

Auto insurance illustrates insurers' inconsistent use of sex classifications.

Sex-based pricing is actually applied to only 20% of the driving population—drivers under age 25. Young women as well as young men are surcharged, relative to adult rates, which are the same for both sexes. Although territorial rating and price variations among insurers make lower prices for young women a matter of chance, insurers claim young men pay more. Yet the reason given for the higher surcharge—men's higher accident rate—holds for male drivers at all ages.

According to insurance industry testimony, the average accident rate for men over age 25 is 38% higher than for women. Industry testimony is silent on the fact that women thus subsidize men for most of their driving lifetime.

Retirement provisions for American women are ruled by a double standard: Sex discrimination is illegal for employers under Title VII, but legal for insurers.

This double standard is exploited to the mutual advantage of employers and insurers, permitting employers to cut costs by underfunding women's pensions and creating a market for insurers who supply the sex-discriminatory annuities that employers are enjoined from handling directly.

When a retired employee chooses to assure retirement income for a spouse, the couple's retirement income is reduced from what would be paid to an individual. The decrease is larger for a retired man and his wife than it is for a retired woman and her presumably shorter-lived husband.

Eliminating this difference will benefit wives and widows supported by the pensions of retired men—a benefit that New York Mayor Edward Koch misinterprets as a “windfall for men.”

Opposition to state and federal legislation to prohibit sex discrimination in insurance and pensions because of the “burden” to public and private retirement systems is an arrogant demand by politicians and businessmen that some employees contribute 10% to 15% of their retirement income to help keep taxes down and business afloat.

Actuarial consultant Paul Barnhart is one of several industry apologists who threaten that, if sex discrimination is eliminated, “age will be the next factor to be attacked.” Although no risk factor should be exempt from evaluation of its effect on consumers, there is an important distinction between age and sex. Age ultimately impacts everybody equally, while sex is an immutable characteristic.

The insurance industry's lavish direct-mail and media campaign may not convince anyone but Ronald Reagan that sex discrimination is good for women, but it definitely gets the message across that insurers will pay a lot of money to keep sex discrimination legal, whatever the cost to women.

In response, the National Organization for Women is cooperating with other national organizations concerned with civil rights, women's rights and consumer protection on an intensive public information project supporting legislation to ban sex discrimination in insurance.

Recent enactment of non-discrimination laws in Montana and Nebraska is spurring legislative campaigns in other states. Increasing public attention should focus on the insurance industry's influence on legislation and regulation, applied through the Council of Insurance Legislators and the National Assn. of Insurance Commissioners. Litigation, particularly in the area of disability income insurance, will build on last year's successful settlement in Pennsylvania.

In that case, *Starer vs. Massachusetts Indemnity & Life Insurance Co.*, Ms. Starer brought suit against MILICO because she was charged 25% more for a disability policy than a man was charged. Under an agreement approved by Insurance Commissioner Michael Browne, the company said it would equalize disability policy rates in the state if the plaintiff, Ellen Starer, would drop her suit.

NOW agrees with *BI's* editorial that sex discrimination in insurance is a serious issue meriting far more study and debate than Congress has thus far given it. For too long, the protected status of the insurance industry has fostered consumer abuse, particularly where women are concerned.

What will fix the situation? Eliminating sex discrimination—not just discriminating better. Men and women should intend to test the prediction made recently by an insurance expert that “increased consumer sophistication” will prove “a force to buffet the industry.”

Michael Scheinblum promoted at R.J. Reynolds Industries

Michael S. Scheinblum, 40, is the new director of asset and risk management in the treasury department of R.J. Reynolds Industries Inc. in Winston-Salem, N.C. His responsibilities include real estate, insurance and risk-control functions. Mr. Scheinblum has been with the company since 1972, most recently as director of risk management for the Heublein Inc. division. Prior to that he was secretary at Benjamin, Connor & Walker Inc., an insurance agency in Hartford, Conn. He received a bachelor of science degree in insurance administration from the University of Connecticut in Storrs and has earned the Chartered Property & Casualty Underwriter and Associate in Risk Management designations. He is also a deputy member of the Connecticut Chapter of the Risk & Insurance Management Society and a past president of the Society of CPCU. Mr. Scheinblum reports to John Dowdle, vp and treasurer.



Mr. Scheinblum

comings & goings: buyers

degree in personnel management from Fairleigh-Dickenson University in Rutherford, N.J., and a doctorate in organizational psychology from Pace University in New York. Mr. Hancox reports to John E. Tait, president and chief operating officer.

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R. Jay Palmer, 40, has been promoted to vp and director of risk management at Old Kent Bank & Trust in Grand Rapids, Mich. The new position is the result of a merger with Pacesetter Financial Corp. Mr. Palmer is responsible for risk management activities at 23 of the corporation's banks and for internal audit activity at 10 banks. He joined the company in 1980 and has served as corporate audit and risk manager. Prior to that Mr. Palmer held various internal audit and risk management positions at Gerber Products Co. in Fremont, Mich. Mr. Palmer received a bachelor of science degree in management from Indiana University in Bloomington. He was also one of the founding members of the Western Michigan Chapter of the Risk & Insurance Management Society and is a past president of the chapter; he is now a RIMS national director. Mr. Palmer reports to Senior Vp William L. Wanniers.

Also Sharon K. Wilson, 25, was promoted to insurance administrator for the merged companies. Ms. Wilson will assist Mr. Palmer, to whom she reports, in risk management, administration of insurance programs and in negotiating and financing employee benefits. She joined the company in 1982. Before that, she was an underwriter at Farm Bureau Mutual Insurance Co. in Lansing, Mich., and at Citizens Insurance Co. of America in Howell, Mich. She received a bachelor of science degree in management and an associate degree in insurance from Ferris State College in Big Rapids, Mich. Ms. Wilson is a deputy member of the Risk & Insurance Management Society and a member of the Insurance Women of Grand Rapids.

Robert E. Hancox, 40, is the new vp of human resources at The Penn Mutual Life Insurance Co. in Philadelphia. Mr. Hancox replaces Joseph J. Horvath, now vp and general counsel for the company. Mr. Hancox oversees the company's employee benefit and compensation activities, as well as other human resources functions. He was formerly vp of human resources at Insurance Co. of North America in Philadelphia; prior to that he was regional personnel director for State Farm Insurance Cos. in Wayne, N.J. Mr. Hancox received a bachelor's degree from Lycoming College in Williamsport, Pa., a master of business administration

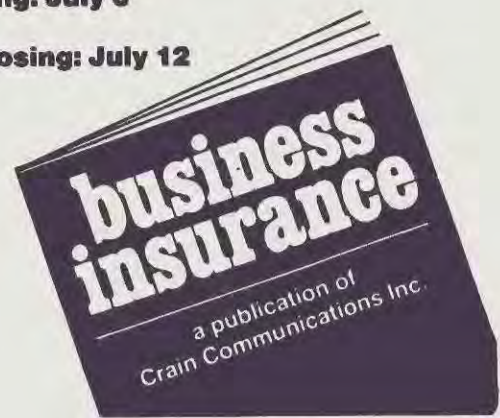
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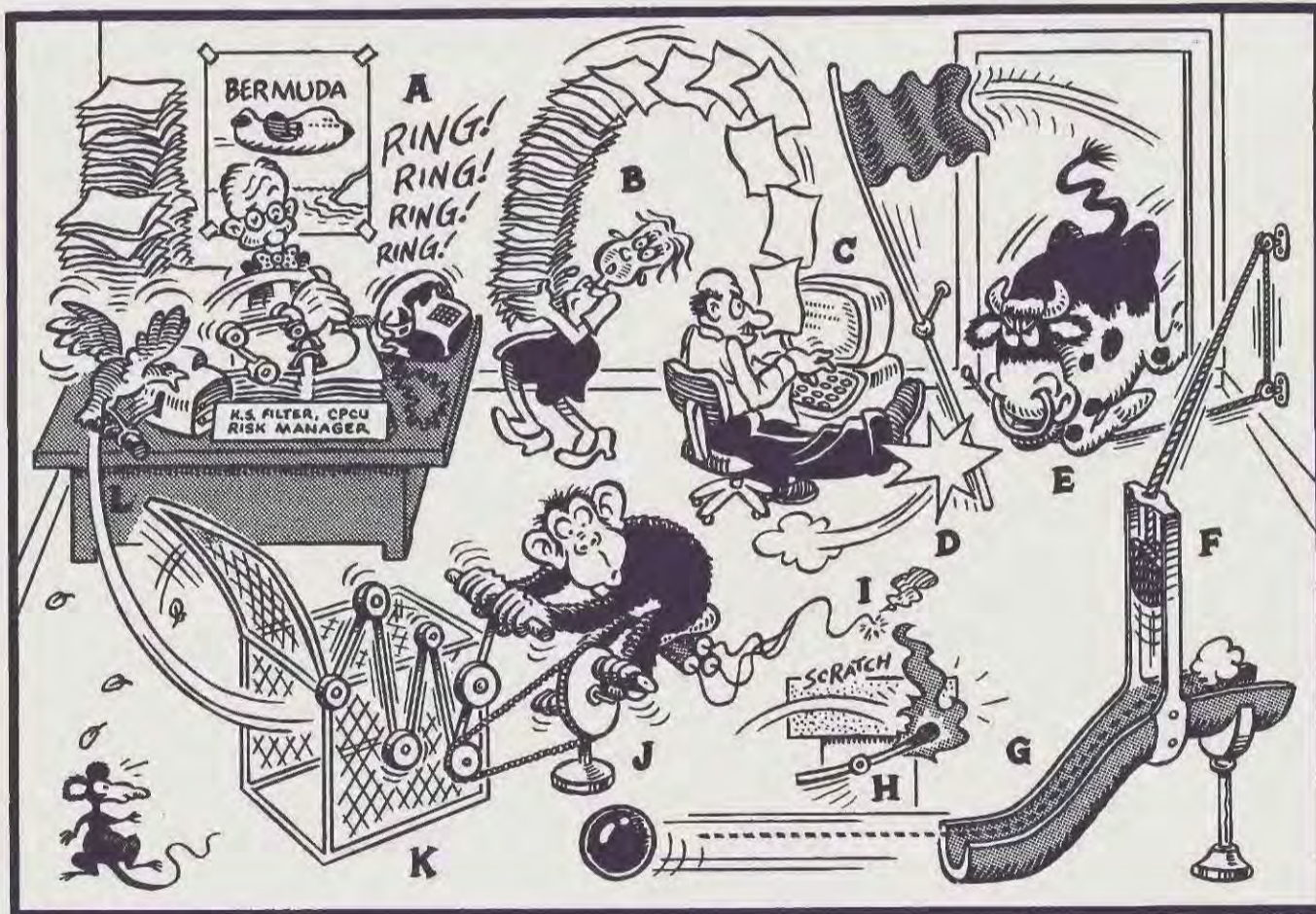
Protecting Property Issue Date: July 25; Ad Closing: July 12

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PBGC urgently needs premium hike: Jones

By JERRY GEISEL

WASHINGTON—The Pension Benefit Guaranty Corp. is now headed down the road to bankruptcy, its executive director says.

Congress must raise the pension termination insurance premium the PBGC annually charges employers with pension plans to \$6 per plan participant from the current \$2.60 to prevent the agency from going broke, warns Executive Director Edwin Jones.

Speaking at a Senate Labor and Human Resources subcommittee hearing last month, Mr. Jones said a \$6 premium is needed to put the PBGC's insurance program on a sound financial footing.

The insurance program, funded by the premiums, guarantees work-

washington

ers and retirees vested benefits when companies fold insufficiently funded pension plans.

Mr. Jones said that if the implementation of a \$6 premium is delayed for just one year, the agency's deficit would rise to \$440 million from \$333 million by the end of 1983.

By then, the deficit would be so large that it could not be retired with a \$6 premium.

The PBGC's financial health deteriorated sharply last year. In 1982, the agency incurred \$220 million in new claims from employers that folded their pension plans, usually after going out of business. That's about three times the

amount of claims incurred by the PBGC in 1981 or 1980.

In fact, the \$49.2 million claim the PBGC incurred last year when Braniff International Corp. collapsed is larger than all the claims the PBGC absorbed during any of the agency's first three years, 1974-1976.

Aside from a premium hike, Mr. Jones said Congress should approve legislation, S. 1227, proposed by Sen. Don Nickles, R-Okla., to curb abuses "which have become such a drain on the system."

The Nickles legislation would make it much tougher for employers to dump their underfunded plans onto the PBGC. For instance,

a company would be allowed to terminate an underfunded plan only if the PBGC determined that the continued operation of the plan would force the company out of business.

Currently, any employer can dump an insufficiently funded plan onto the PBGC. If it does, the PBGC then has the right to take up to 30% of the company's net worth to pay for unfunded vested benefits. However, companies with little or no net worth may find it cheaper to terminate their plans and shift the liabilities onto the PBGC rather than continue to fund the plan.

Sen. Nickles' legislation also would generally make employers that sell subsidiaries contingently liable for their units' pension benefits for up to 10 years after the sale. Employers would no longer be al-

lowed to transfer their pension liabilities to a weak company, which then terminates the plan and leaves the PBGC stuck with the unfunded vested benefits.

Older-worker rule

Employers will have until Aug. 8 to file comments with the Equal Employment Opportunity Commission on the agency's interim rules that require firms to offer their older workers a choice of enrolling in corporate group health insurance plans or sticking with Medicare as their primary insurer.

Those interim rules also require firms that offer benefits like dental or vision care that supplement basic health care packages to provide those supplemental plans to all employees up through age 69 (BI, April 18).

A company could not, for example, require older workers to pay higher deductibles for vision care coverage than younger employees.

The interim rules implement a provision in the Tax Equity and Fiscal Responsibility Act that said employers had to offer workers ages 65 through 69 the same health insurance benefits as their younger employees.

Comments on the interim rules, which were published in the June 7 issue of the Federal Register, should be sent in quadruplicate to Treva McCall, Executive Secretariat, Equal Employment Opportunity Commission, 2401 E St. N.W., Room 5215, Washington, D.C. 20506.

Reinsurance OK'd

The Labor Department has approved J.C. Penney Co.'s proposal to use its Vermont-based insurance subsidiary to reinsure group life insurance policies for Penney employees issued by Prudential Insurance Co. of America.

Under the proposed reinsurance contract, Prudential will pay J.C. Penney Life Insurance Co. 50% of the premiums and payments received and Penney Life will reinsure Prudential for 50% of the risk.

Reinsurance arrangements in which a company's domestic insurance subsidiary reinsures employee benefit plans through a licensed reinsurer are individually reviewed by the Labor Department (BI, Aug. 20, 1979).

Providing life insurance benefits to 136,000 Penney participants in the company's life insurance plan will account for about 2% of Penney Life's business this year.

Social Security

The Internal Revenue Service is reminding non-profit employers that they no longer can drop out of the Social Security program.

The IRS noted that the Social Security Amendments of 1983 enacted this spring (BI, April 4) prohibited non-profit employers, known as 501(c)(3) organizations, from withdrawing from Social Security after March 31.

In addition, the new law also requires non-profit employers that withdrew from Social Security prior to March 31 to re-join the federal program by Jan. 1.

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WEEK OF JULY 27, 1981

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WEEK OF AUGUST 10, 1981

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Disaster raises questions on architect's insurance needs

WEEK OF FEBRUARY 1, 1982

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WEEK OF MAY 3, 1982

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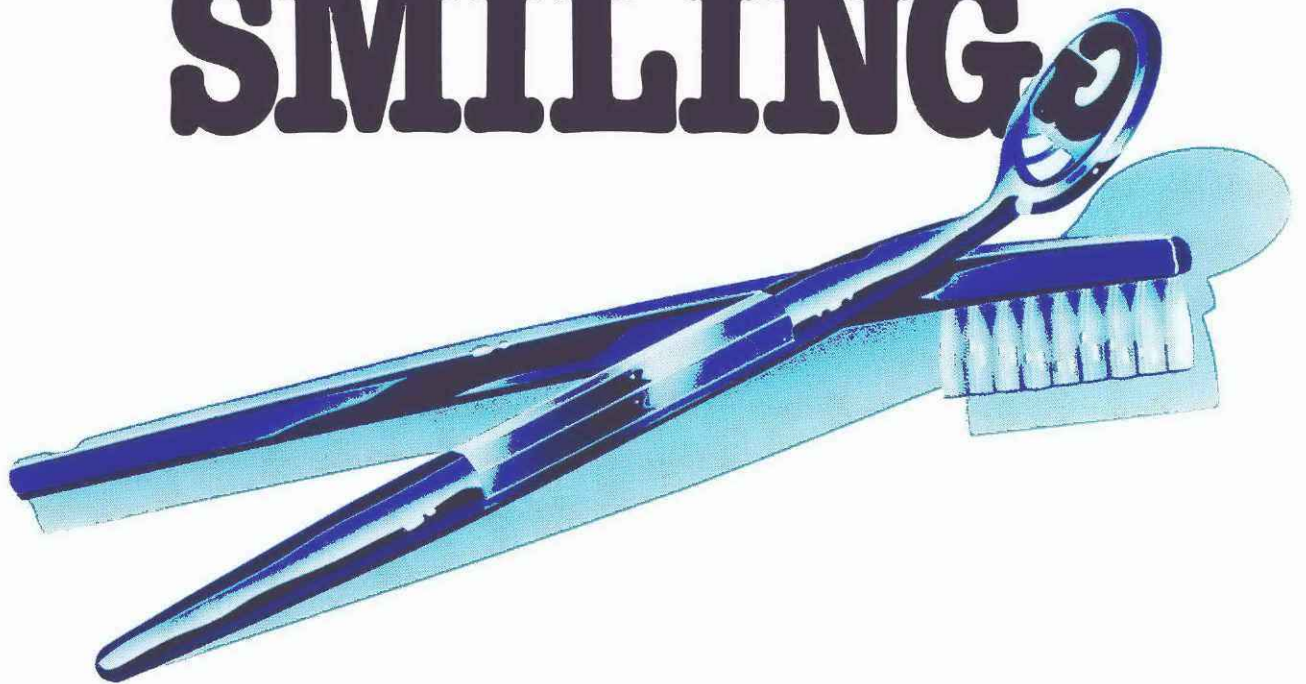
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Education for agents

Cost concerns cut demand for training

By DONNA LEIGH YANISH

Is continuing education vital to cash-strapped agents and brokers?

It's important, many concede, but it's not absolutely necessary.

Seminars, especially those held away from home offices, are usually among the first expenses to go when cost cutting, industry observers say, noting that many agents are trimming their expenses by reducing the number of people they send to educational programs.

For example, agencies that once sent three or four employees are now only sending one or two, notes Timothy Cunningham, president of James H. Cunningham Insurance Agency Inc. in Oak Park, Ill., and a member of the Independent Insurance Agents of America's education committee.

Most sponsors of training programs—including national, state and local producer associations—have felt the effects of the cutbacks, Mr. Cunningham says. The seminar business, except for those organizations offering programs on hot topics in the agency business like automation and agency perpetuation, has fallen off for everyone.

Agents and brokers are scrutinizing whatever doesn't directly put revenue back into the business, he adds, noting that not only does education not bring revenue directly into an agency or brokerage, it also can directly or indirectly drain valuable resources.

The direct costs of seminars and education programs include tuition, travel expenses and hotel accommodations, but there are hidden costs of which agencies are now more aware than ever. Producers and support staff attending educational seminars aren't producing or servicing accounts, so the cost of education also includes the revenue the student could have brought into the agency or brokerage if he or she were not in training.

There's another reason many agencies aren't sending people to seminars: There are not as many inexperienced people currently in the agency workforce. Agencies are expanding more slowly today than two or three years ago and are not hiring as many people who need training.

"There are plenty of qualified people out there

because agents and brokers aren't hiring as much. When agencies are hiring, they can choose people who are already trained. They're not hiring the neophyte, so they don't need training programs," Mr. Cunningham notes.

Yet many agents and brokers say educational programs are important to their businesses, despite their costs.

Mr. Cunningham's Oak Park, Ill., agency continues to send producers and support staff to association-sponsored programs, he notes.

"Education through seminars is essential, particularly for a shop like mine. If I'm looking for special training of any sort, I have to look to seminars. The large national brokers have more resources internally and, therefore, more people with specialties."

But Mr. Cunningham says he thinks even principals and staff members at large national brokers need continuing education, too.

"For any size agency or brokerage, education increases the capability of the staff. There's a definite advantage to having people in the learning mode. It's a real, although intangible, benefit."

The learning mode includes two different types of courses for agents and brokers: programs that bestow a professional designation—like the Chartered Property & Casualty Underwriter designation—and association-sponsored seminars on particular topics.

"I view the association-sponsored programs as vocational training. They're task-oriented. Work toward the professional designations is academic training. You learn to understand the broad insurance picture. There's a real difference between the two—and both are important."

Although some agencies and brokerages have cut back or stopped funding employees' participation in programs to attain professional designations, the programs haven't felt the same crunch suffered by the association-sponsored programs.

Agents and brokers participating in programs like the CPCU courses, for example, must complete 10 courses that can take about five years to complete.

CPCU candidates who have taken several courses paid for by their employers are likely to

continue the program, even if they have to pay for the training themselves, because of the hours already invested in the school, one agency principal says.

The same is not true for association-sponsored programs, particularly those sponsored by the national organizations that require participants to travel long distances.

About three years ago, the IIAA sponsored seminars at various resort areas in the country. They usually lasted a few days and participants were allowed to combine the learning experience with recreational activities, explains Kevin O'Brien, marketing manager for the association's education division. The seminars usually drew from 60 to 80 participants.

But agents' and brokers' budgets began to feel the pinch from falling commissions and mounting expenses. Participation in the programs fell by almost half, he says.

The IIAA responded by changing the types and locations of the seminars, Mr. O'Brien notes.

Today, IIAA-sponsored seminars are a lot more work than play, he explains. They're held in city hotels rather than at resorts, and consist of concentrated programs focusing on a central topic.

"We try to choose hot topics, such as automation. Three years ago we didn't even have a program on automation. Last year we had 300 participants in a conference on the subject in Chicago. This year, we had 400 in Dallas."

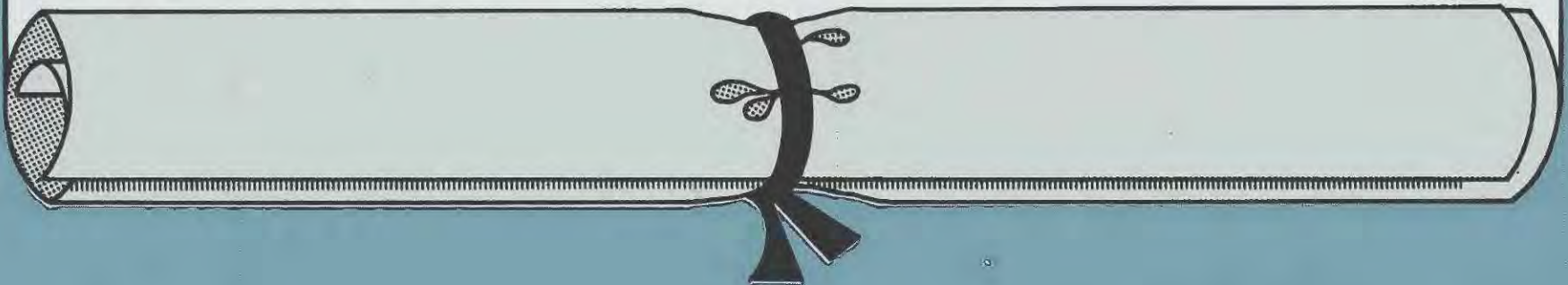
Both of these programs on automation lasted two days. The morning sessions dealt with general topics, like the kinds of automation programs insurers offer to independent agents.

The afternoons were divided into programs to accommodate participants with varying degrees of computer expertise. Speakers at one session, for example, would address issues for participants who are considering installing their first computer system.

Speakers at another session would address ways to improve the systems participants currently utilize.

The automation programs also include a trade show where vendors can present their systems to

Continued on next page



IIAA focuses on specific topics for seminars

Continued from previous page participants.

However, the automation conferences don't leave time for recreation that was allowed at former IIAA programs.

Like the automation seminars, other programs sponsored by the national IIAA are intended for agency principals.

General agency management seminars sponsored by the IIAA are designed to round out principals' management backgrounds, according to Mr. O'Brien. But since attendance is decreasing at general-topic seminars, the IIAA selected specific topics for these programs that can be of immediate help to agency principals, he says.

Seminars on agency perpetuation, for example, are well-at-

tended, he notes.

Perpetuation is also one of the issues discussed at the National Assn. of Professional Insurance Agents' five-day program on agency management, according to Susan M. Cochran, the PIA's manager of educational programs. The PIA sponsors the same program two times each year, she says, but she notes that it changes the topics discussed at each program.

The seminars focus on topics like financial management, staff training and automation. They are usually held on college campuses and feature experts from around the country as speakers.

During the past three years, attendance at the conferences has declined a few percentage points, Ms.

General agency management seminars sponsored by the IIAA are designed to round out principals' management backgrounds, according to Kevin O'Brien, marketing manager for the IIAA education division.

Cochran says, noting that attendance at last year's meetings ranged between 75 to 100 participants.

The PIA also offers its multiweek basic insurance school twice a year.

Attendance of about 95 students at the first of this year's presentations, she said, was not much smaller than the number at the

first basic insurance school in 1982.

This program is far more intensive than PIA's other major seminar.

Students attend about 130 hours of class over three weeks. Classes include basic instruction on both commercial and personal lines taught by insurance professors from major universities and guest speakers.

The course also includes some sales training.

The course costs \$875 for PIA-member agencies. Students are usually new producers or staff personnel about to become producers and are frequently relatives of agency owners, Ms. Cochran says.

These two major programs—the management course and the basic course—are the only continuing education seminars sponsored by the national PIA, she adds. Over the past few years, the organization has eliminated all smaller seminars due to lack of participation, leaving them to the state and local associations.

Agents and brokers are more likely to attend shorter seminars sponsored by state and local groups, one agent reasons. One big advantage, he notes, is that if a state organization sponsors a meeting, it probably is a relatively short distance away, thus trimming travel expenditures.

Yet state and local associations are also feeling the effect of agents' drive for cost control.

The Independent Insurance Agents of Wisconsin, for example, has seen a steady decrease in participation in their education programs, notes Vp Edward Cantwell. The association is currently surveying its members to determine what format and subject matter should be offered at its seminars in an attempt to bolster attendance.

The survey's preliminary results indicate that Wisconsin agents desire a wide range of seminar topics, but they prefer half-day meetings to longer programs.

The association is also exploring broadcasting educational programs for its members by radio. Such a system is sponsored by the University of Wisconsin's extension program and is currently used by the state real estate industry association. Programs are broadcast from the university to county courthouses where students can receive their instruction without having to travel long distances.

In short, it brings the classroom to the student, Mr. Cantwell says.

A similar idea—but one that doesn't use the airwaves—is currently being developed by the Independent Insurance Agents of California, notes Roberta M. McCreary, director of research and education.

In response to a distinct decline in attendance at its seminars, the state association is setting up 20 joint-venture programs with local agents' associations around the state. The state group will supply materials and teachers for both half-day and full-day seminars on a variety of topics, Ms. McCreary says.

The joint ventures will not only cut down on travel time for member agents, making it easier for them to attend seminars, but also will strengthen the local associations, she adds.

IIAA of California is also exploring cooperative education programs with local chapters of the National Assn. of Insurance Women and the Society of CPCU, she adds.

Though California, Wisconsin and other states are trying to respond to a decrease in attendance at educational seminars, not every state has felt the crunch.

For instance, Robert Ross, director of education for the Florida Assn. of Independent Agents, notes that attendance fell off about a year ago, but has rebounded to its former levels.

The association, like the California agents' group, offers programs in a variety of areas in the state to cut agents' travel expenditures. ■



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Is getting designation worth the effort?

Agents and brokers disagree on whether it is worth the time and money to attain one of the many professional designations offered by industry education groups.

Some contend that clients sit up and take notice of an agent that has an industry designation.

"Most clients give an individual instant credentials if he or she has a CPCU (Chartered Property/Casualty Underwriter designation), and so does the (insurer) marketplace. They know what's required to get the designation," says Richard M. Coffey, managing vp for Alexander & Alexander Inc. in Omaha, Neb., who has earned two designations: a CPCU and an ARM (Associate in Risk Management).

"We encourage all our employees to get their designations. We pay for the entire courses and for textbooks. We also help in continuing education instruction in the greater Omaha area."

Alexander & Alexander of California also encourages its employees to continue their education, says Senior Vp Jerry Aparton, who has a CPCU designation, but he wonders if clients really know what the designations mean.

"You always need to explain what they mean to clients, but once they know, it does lend a certain amount of credibility," he says.

Women in insurance agencies and brokerages say the designations lend them credibility not only with clients who recognize what the initials mean, but with their colleagues. A designation shows that an agent has been around for a while, says Linda Eckland, assistant vp and producer for the Minneapolis office of Corroon & Black Corp.

Achieving the CPCU designation, for example, takes up to five years, so someone who has earned a CPCU has clearly been in the insurance business and has studied the industry for more than a brief time, she explains.

The CPCU, perhaps the granddaddy of insurance designations, may require the broadest educational background. The Society of Chartered Property/Casualty Underwriters, the group that administers the program, claimed more than 14,000 members in 1981, the last time the organization completed a census.

CPCU doesn't break down membership by segment of the insurance industry, according to a spokeswoman, because of shifts from one segment of the industry, like agencies and brokerages, to another. However, she says the largest contingent in the organization is from insurance companies.

The American Institute for Property & Liability Underwriters, which offers the courses to attain the CPCU designation, notes that personnel from agencies and brokerages accounted for about 23% of the approximately 15,000 people who took at least one of the examinations required for the designation in 1982.

Insurance company employees accounted for about 70% and other segments of the industry—including risk managers, consultants and claims personnel—accounted for the other 7%.

Before beginning the CPCU program, students must have at least three years' experience in the field of property/casualty insurance. The American Institute also recommends that prospective students have completed at least one of the Insurance Institute of America's specialty programs, which waives at least one of the CPCU courses.

The CPCU sequence of 10 courses takes about five years to complete. All courses have been

designated by the American Council on Education as being equivalent to upper-division undergraduate or graduate-level courses.

Topics included in the 10 courses include risk management; commercial lines property/casualty insurance (although personal lines are covered); insurer operations; accounting and finance; management; and the legal aspects of insurance.

Besides the CPCU designation, agents and brokers can earn a professional designation from the IIA. The three IIA specialty programs geared to agents and brokers are:

- The Accredited Advisor in Insurance (AAI), the IIA's newest designation, initiated about two years ago and designed specifically for agents and brokers.

Recommended for those just entering the industry, the program requires the least amount of study—about nine months. Course work deals with sales, product knowledge and agency management.

- The Associate in Risk Management (ARM), which is being sought by an increasing number of agents and brokers who want to offer risk management services to their clients.

The three parts of the program instruct the student in four areas of risk management: identifying and analyzing potential loss exposures; finding the best type of insurance for treating those exposures; implementing those methods; and monitoring the results.

The last of the three courses also focuses on risk retention.

- The Associate in Management Program designation (MGT), which is recommended for those in middle- and upper-insurance industry management who have planning, organizing, decision-making or administrative responsibilities.

Most of the subject matter contained in the four required courses could apply to management in any industry, because they concentrate on human rather than technical resources. The final course examines strategies for managing people in a changing environment.

The Society of Certified Insurance Counselors' (CIC) program, founded in 1969, is the only professional program in the industry that requires continuing education for members to retain their designation. Candidates must be either li-

censed agents with two years' experience or insurance instructors.

The five courses in the program, each requiring a three-day workshop followed by an essay test, focus on types of personal, commercial, life and health insurance as well as agency management. Programs vary by state, with instruction dealing with state regulations and insurance products important to buyers in the area.

The Chartered Life Underwriter designation (CLU), offered by the American College of Life Underwriters, deals almost exclusively with life insurance, although one of the 10 courses focuses on other types of group insurance. Students in the CLU program are also instructed in estate planning, investments and income tax. ■



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Multistate licensing eases expansion

PRINCETON, N.J.—The multistate licensing movement is slowly taking the time and expense out of expanding your geographic base.

Agents and brokers in 19 states and Bermuda now participate in the multistate insurance licensing program, designed by the National Assn. of Insurance Commissioners to help bring uniformity to the agent qualification process.

Proposed more than a decade ago, the multistate plan was devised by the Educational Testing Service's Center for Occupational & Professional Assessment in Princeton. ETS was asked by the state regulators to establish a national standard for evaluating the professional qualifications of prospective insurance agents.

The goals of the program are:

- To raise the overall quality of state insurance licensing examinations.

- To eliminate the high cost of recurring test development and validation.

- To protect consumers.

- To enhance the professional status of agents and facilitate reciprocity among participating states.

The result is a two-part examination in each of four major insurance coverage areas: life, accident and health, property and casualty.

Part I, which consists of 50 multiple-choice questions, tests candidates for licensing on basic knowledge of insurance practices and products common to all states. Its content is based on a national job analysis conducted by ETS to ver-

ify the core responsibilities of entry-level insurance agents, says Daphne Philos, ETS' director of the multistate insurance licensing program.

Some of the 19 states that now use the multistate test have reciprocity agreements, so agents in those states with the multistate license aren't required to take Part I again to become licensed in other states, Ms. Philos notes.

Questions for Part I are drafted and approved by a national committee of insurers, agents and brokers and academicians.

Part II covers the unique laws, rules and regulations specific to each state in 25 to 40 multiple-choice questions. Questions for Part II are written by examinations committees appointed by the insur-

ance commissioner of each participating state.

Testing specialists from ETS instruct the committees on test-writing techniques, Ms. Philos notes.

Those who write the tests also receive input from personnel in the various branches of the insurance industry to eliminate any possible bias toward one segment of the industry, she says.

There are multiple versions of all the tests to reduce the chance of cheating, Ms. Philos says. The versions meet uniform content specifications so that one version is not tougher than another and does not unduly stress one particular area, she adds.

ETS doesn't publish study guides to help prepare candidates for the

examination, although it does provide sample questions. State agents' associations and various commercial publishing companies, however, do offer study aids for the multistate exam, Ms. Philos notes.

The 3¼-hour testing sessions are offered twice every month at facilities managed by ETS personnel in the participating states.

Licensing candidates may take both Parts I and II in two of the four licensing categories at one session. For example, a candidate may take the test to be licensed for both property and life insurance sales at one testing session.

Almost all participating states allow candidates to take the test without pre-registration. Some states, however, charge a walk-in fee for the service.

The cost for each examination ranges from \$20 to \$40 depending on the state, Ms. Philos notes.

ETS sends test results directly to licensing candidates. It also provides candidates who fail a Part I examination with diagnostic information that assists in identifying areas that need further study.

In addition to notifying candidates of their results, the program provides state agencies with test results for each candidate and summary statistics about the number of candidates registered and tested, as well as the number passing or failing the individual parts.

States that use the multistate insurance licensing program are Arizona, Colorado, Delaware, Hawaii, Illinois, Indiana, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, North Dakota, Pennsylvania, Rhode Island, Vermont, Washington, West Virginia and Wisconsin. ■

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Illinois refines licensing code

SPRINGFIELD, Ill.—Agents and brokers in Illinois could soon have a streamlined licensing code.

Late last month, the state Senate was considering legislation, H.B. 1134, that would significantly change the way agents are licensed.

The bill, sponsored by Rep. Richard Mautino, D-Spring Valley, would eliminate the current dual agents and brokers licensing system. It would be replaced with a producers license covering both.

The bill also would eliminate corporate and partnership licenses currently required in addition to individual licenses. However, agencies and brokerages would still have to register with the Illinois Insurance Department.

The corporate and partnership licenses currently require that sellers of insurance be either an officer or partner in the firm, explained Jay Shattuck, director of government affairs for Independent Insurance Agents of Illinois, which strongly supports Rep. Mautino's proposal.

Many agencies and brokerages want to add producers without making them corporate officers, Mr. Shattuck says, explaining the proposal would allow just that.

If the bill passes, Illinois will also join a growing number of states requiring continuing education for agents and brokers, although Mr. Shattuck notes that the requirement in the proposal is rather limited.

Unlike most states that require a certain number of hours of course work every year to maintain a license, the Illinois legislation would require agents and brokers to take only 25 hours of continuing education courses during the four years after receiving their license. ■

Insurance of the future will keep some past trends

The insurance industry of 1990 will include something from the past, the continuation of current trends and more emphasis on new technology, according to a recent study.

From the past will be the return to the managing general agency system. Continuing will be an increase in mass-marketed package policies. And in the future, insurers will increasingly rely on developing computer interfaces with agents and brokers.

That's the picture of the industry painted by the Long Range Planning Committee of the Professional Insurance Agents Assns. of New York, New Jersey and Connecticut in a study released last month.

Commercial lines rates won't return to the levels of the late 1970s nor to current manual rate levels, the report indicates. But there will be more package policies, making it easier for producers to quote a rate to the consumer, the study says.

Independent agents and brokers will face new competition from direct-writing insurers and the property/casualty affiliates of life insurers who will try to penetrate the market with package products. In addition, there will be a growth in the mass-marketing of commercial line insurance through associations, particularly on a state or regional basis, according to PIA's report.

Despite the new competition from direct writers and life insurers, large national insurers will maintain their strength in the marketplace by purchasing large urban and suburban property/casualty agencies, according to the study. The insurers will buy the agencies initially as investments, but with long-range plans to use them as managing general agencies or even branch offices, the report predicts.

While the larger insurers are building their empires, small and medium-sized regional insurers will change their focus to bolster

their position in the marketplace.

Their top priority probably will be specialty product marketing, according to Robert A. Nicosia, president of PIA of New Jersey who served on the committee compiling the report.

Insurers interviewed by the committee said that 80% of their business is produced by 20% of their agency force, causing many insurers to look at committing to that 20% as many support services as necessary to tighten relationships and continue growth, Mr. Nicosia says.

"The net effect of this assessment will be an economic decision by all companies as to the size of agencies with which they can profitably do business," he explains.

Smaller agencies probably will

join forces with managing general agencies, Mr. Nicosia continues. The MGA will, in essence, be the insurer's branch office, while the smaller agency will be the sales arm of the insurer, acting much like a broker for the MGA.

The report did not, however, suggest that most agencies will lose their identities as independent agencies and become arms of insurers, though it does state that the nation's agency force could shrink from 25% to 35% over the next seven years. This shrinkage will be caused not only by insurers' decisions to reduce their agency force, but by agency mergers and combinations as well as agency mismanagement.

Another current trend that will continue is the shift from general

insurance activity as a base of agencies' operations. Smaller agencies will turn to specialization, while larger agents and brokers will departmentalize, the study says.

Specialization in small agencies could be confined to personal insurance products including Individual Retirement Accounts, life and health products and some limited financial services, the report notes.

In larger agencies, the report continues, principals will develop specific, departmentalized profit centers that are professionally managed and staffed by technical and sales personnel, borrowing the structure of many of the large national brokerage houses (A/BT, June 6).

The report indicates that in both small and large agencies, the computer and its application will play a major role in cost containment, productivity and operations management.

"Instead of waiting for their (insurers) to subsidize them, many agencies will move aggressively into computerization either on their own or in partnership with one or more other agencies," says Daniel J. Kraft, president of the PIA of New York State.

The report was based on interviews over the past several months with executives from 24 insurance companies and 12 representatives of national brokerages, agency franchises, the New York Insurance Exchange and the Insurance Institute for Research. ■

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Claims firm uses microcomputers to get job done

By DAVE GALANTI

EAST ORANGE, N.J.—Using computers to speed claims administration services is nothing new, but not many claims administration firms take the plunge using microcomputers.

Eastern Benefits Systems, a subsidiary of the W.S. Vogel Agency in East Orange, has.

EBS administers both insured and self-insured group health claims. The firm's clients, which include companies like Reader's Digest, Jones New York and Resorts International, employ a total of 15,000 to 20,000 workers.

William E. Vogel, president of EBS, wanted to bring the automated part of his firm's medical, dental and disability claims ser-

vices in-house, but was blocked by the high cost of developing a system using mini- and mainframe computers, which are larger and more expensive than microcomputers.

EBS was using an on-line, time-sharing system leased from an outside vendor, but Mr. Vogel desired more control over the system. However, he discovered that a change to in-house automation using minicomputers would cost the firm between \$330,000 and \$380,000 in hardware alone.

"That cost was prohibitive for our firm," Mr. Vogel says. "At that price, it just wasn't cost-effective to install an in-house system."

Mr. Vogel says he found the answer to his problem in the use of microcomputers, which are similar

to so-called "personal" computers sold for use in homes or small businesses. By combining several microcomputers into a network, the firm could obtain the required speed, response and storage and spend only about \$80,000 for hardware.

The system uses a daisy-chain network of the Intertec Data Systems' CompuStar—a microcomputer—and a 96-megabyte Control Data Corp. cartridge module drive. Plans call for the eventual use of 20 to 25 CompuStars and three disk drives.

EBS worked with Toucher & Spreen Associates of Oakland, N.J., in developing the system.

The cost so far for the software and other services has totaled about \$200,000.

"Paul Spreen and I have been working together for the past 13 years, the last three in our own business," says Toucher & Spreen's Tom Toucher. "We had expertise in working with minicomputers and mainframe systems but we fell in love with the micros, especially for use in the EBS system. We felt micros gave the firm more control over the system and would use a (computer) program that would be very easy to translate from one hardware system to another."

"When we decided to go into the third-party administration business a few years ago, we felt that our competition was the insurance companies, not other third-party administration firms," says Mr. Vogel.

"As such, when we decided to

automate we wanted more than a check-writing system. We wanted a system that made evaluating and auditing of insurance claims an integral task in every claim processing.

"We literally started from scratch," he adds. "We also didn't want to develop the system piecemeal. So we took one person in our office who had a strong background in claims administration and health care and put him to work with Toucher & Spreen in developing our program."

"Everyone said micros were not big enough; they didn't have enough memory," he says. "And they are right to a point, because individually they don't have enough memory. To succeed, our business relies on a lot of information such as employee information, claims histories, prevailing health care costs and diagnostic codes, and this all must be stored."

"In addition, the system must be reliable," he adds. "No customer wants to hear that your central processing unit is down and that no work can be processed. I don't want employees to be unproductive by an inoperative machine. We're in the business of processing claims. If we can't do that, we're out of business."

Use of a network of microcomputers eliminated both potential problems, Mr. Vogel asserts.

"With this system, the micros operate together in a true network," he says. "In other systems involving more than one microcomputer, the micro operates basically as a terminal only. In this system, each micro contains a duplicate set of operating programs and shares a common data base originating from a sophisticated disk drive."

"This gives us the memory capacity we need. It also gives us the flexibility and reliability we need. There is very little down time. If a micro goes down, that will only cost us five minutes. Since each micro stands alone, all we do is replace the defective machine."

"Since the micros are relatively inexpensive, it's not impractical to have a couple in storage," Mr. Vogel says.

Mr. Vogel also claims his network of microcomputers reduces EBS' maintenance expenses.

"This system cuts down on our service contract costs, among other things. With larger systems, service contracts can average about 1% of the cost of the hardware. In this system, the only fixed maintenance cost comes from the service contract on the disk drive and because this is a relatively simple machine, the contract on this is not costly."

The claims administration system is now complete and approximately half of EBS' clients are currently on the system, with the rest to be added soon. The system is designed so that eventually clients and consultants may be able to tie into the system via terminals in their own offices.

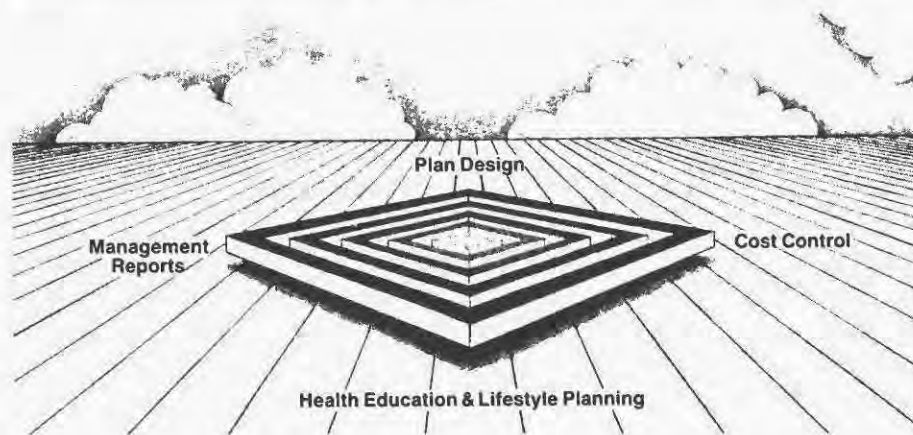
EBS plans to sell the system to other third-party claims administration firms or to current clients that may later decide to administer their own claims in-house.

EBS owns the software system. Toucher & Spreen will install the system and do any programming needed to adapt the system to unique situations, says Mr. Toucher.

"Before we started with our system, a claims examiner could do about 40 to 45 claims per day," Mr. Vogel says. "A day after we started using this system, it was up to 55 per day. It has gotten better since. We estimate that the system has increased our productivity from between 15% to 20%."

PILOT ANNOUNCES FOUR-POINT PLAN TO CUT MEDICAL INSURANCE COSTS.

RISING COSTS COULD VERY WELL UNDERMINE THE HEALTH CARE STRUCTURE OF AMERICA. HERE'S WHAT PILOT IS DOING TO HELP REVERSE THE TREND.



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Pilot was a pioneer in providing such plans with its Control-Med program specifically designed to encourage less costly outpatient treatment, second opinions

for surgery and the like. Other innovative plans are in the works and will be announced soon.

MANAGEMENT REPORTS

Pilot's state-of-the-art, on-line claims system, P.A.C.E., not only provides fast handling of claims, it also generates a wide range of reports which enable employers to audit their insurance programs. To compare charges of the various providers of medical services, for example, to see which are most efficient. Or to see which kind of illnesses or accidents are most common among their employees. Armed with this information, employers are better equipped to negotiate for more efficient care and to counsel employees seeking medical help.

COST CONTROL

A special Cost Control unit has been set up at Pilot which concentrates on reviewing unusually large claims, auditing charges of hospitals where services seem inconsistent with treatment, or where costs seem out of line. They are in constant contact with Professional Standards Review Organizations, and other auditing organizations across the country, seeking more effective means of cost control.

HEALTH EDUCATION & LIFESTYLE PLANNING

The best way to cut medical costs is not to get sick in the first place. That's why Pilot has inaugurated Health Education & Lifestyle Planning, a program designed to assist employers in developing health maintenance programs for their employees. It addresses such problems as overindulgence in eating, drinking and smoking, drug use, hypertension detection, stress management, and the general problem of staying physically fit. It involves everything from pamphlets and payroll stuffers to worksite classes and exercise facilities to nutrition programs and blood pressure testing.

Pilot management has also taken an active leadership role in the campaign for health cost containment promoted by industry groups such as the American Council of Life Insurance and the H.I.A.A.

Just as there is no single cause for the inflation of medical insurance costs, there is no single solution. But we feel our Four-Point Plan is an important first step in controlling those costs for our policyowners. If you'd like to know more about our group plans and our cost control program, please contact Pilot Regional Group Office, or the Group Division, Pilot Life Insurance Company, P.O. Box 20727, Greensboro, NC 27420. Or call (919) 299-4720.

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VEBAs benefit agencies and employees

By Robert Feinschreiber

AN INSURANCE broker or Agency establishing a voluntary employees' beneficiary association can reap substantial tax savings and benefit its key employees.

A VEBA is especially advantageous now that the 1982 Tax Equity and Fiscal Responsibility Act has imposed severe restrictions on pension and profit-sharing plans. A wide variety of employee benefits, including severance pay, is available through a VEBA.

Employer contributions to a VEBA are tax-deductible. These contributions and their earnings are tax-exempt to the employees until contributions are paid. All taxes are deferred until payments from the fund are made.

The unique quality of a VEBA is the choice of benefits. It can provide many benefits like vacation payments, severance pay and sickness, disability or death payments.

A company that establishes a VEBA can choose the benefits it desires to offer. It should consider various factors including salary data, the business' history and shareholders' philosophy.

As long as benefits are paid out more slowly than contributions are received, the VEBA assets can accumulate tax-free. However, it is advisable to select at least one benefit that employees can use now, like vacation payments, to demonstrate that the VEBA is not solely for future benefits.

A VEBA can pay severance benefits when employment terminates for any reason, including retirement or death. Usually, severance payments do not have to be made for many years after funds are paid, enabling income to accumulate tax-free.

Severance pay may be as much as twice the employee's anticipated annual salary during the last employment year. There are no maximum or minimum limits on severance. But, under TEFRA, severance pay must be fully paid to the participant or beneficiary within two years after employment ends.

Severance pay benefits are independent of, and in addition to, any retirement benefits. Thus, a VEBA is very valuable to a company that is subjected to the new TEFRA maximum annual pension limits. For defined contribution plans the maximum contribution has been lowered to \$30,000 from \$45,475 and the maximum benefit from a defined benefit plan has been lowered to \$90,000 from \$136,425.

A VEBA can provide for weighted severance pay benefits. A formula developed by VEBA expert Fred E. Glickman provides benefits expressed in terms of number of severance pay days as the square of the number of years of service (see chart).

This method provides greater benefits for key employees.

Another advantage is that life insurance may be purchased through a VEBA. Life insurance premiums usually are not tax-deductible, but the VEBA contribution for these premiums is deductible and provides a benefit.

Benefits are generally limited to term insurance, but participants may be given the right to convert to whole life coverage on termina-

tion of VEBA participation.

Long-term or short-term disability benefits also may be provided by a VEBA. These benefits may equal all or a portion of the participant's salary before disability.

A common practice is to fund disability payments for a brief initial period, say, 60 days. This provides income during the waiting period for disability insurance payments. The disability benefit from a VEBA may be offset by the Social

Security disability benefit. This offset increases benefits for higher-paid management compared with those for lower-paid workers.

A VEBA may provide many other benefits. Any benefit qualifies to be incorporated in a VEBA if it safeguards or improves the health of an employee or the employee's family, or protects against the interruption or loss of an employee's earnings. Permissible benefits include reimbursed vacation

expenses, subsidized recreational activities and child-care facilities.

A VEBA also may be used to pay the cost of employee legal services. An employee may even be given a choice of benefits.

Various features can favor key employees but a VEBA cannot exclude low-paid workers. If a business has two locations, it can be selective by limiting VEBA participation to one location.

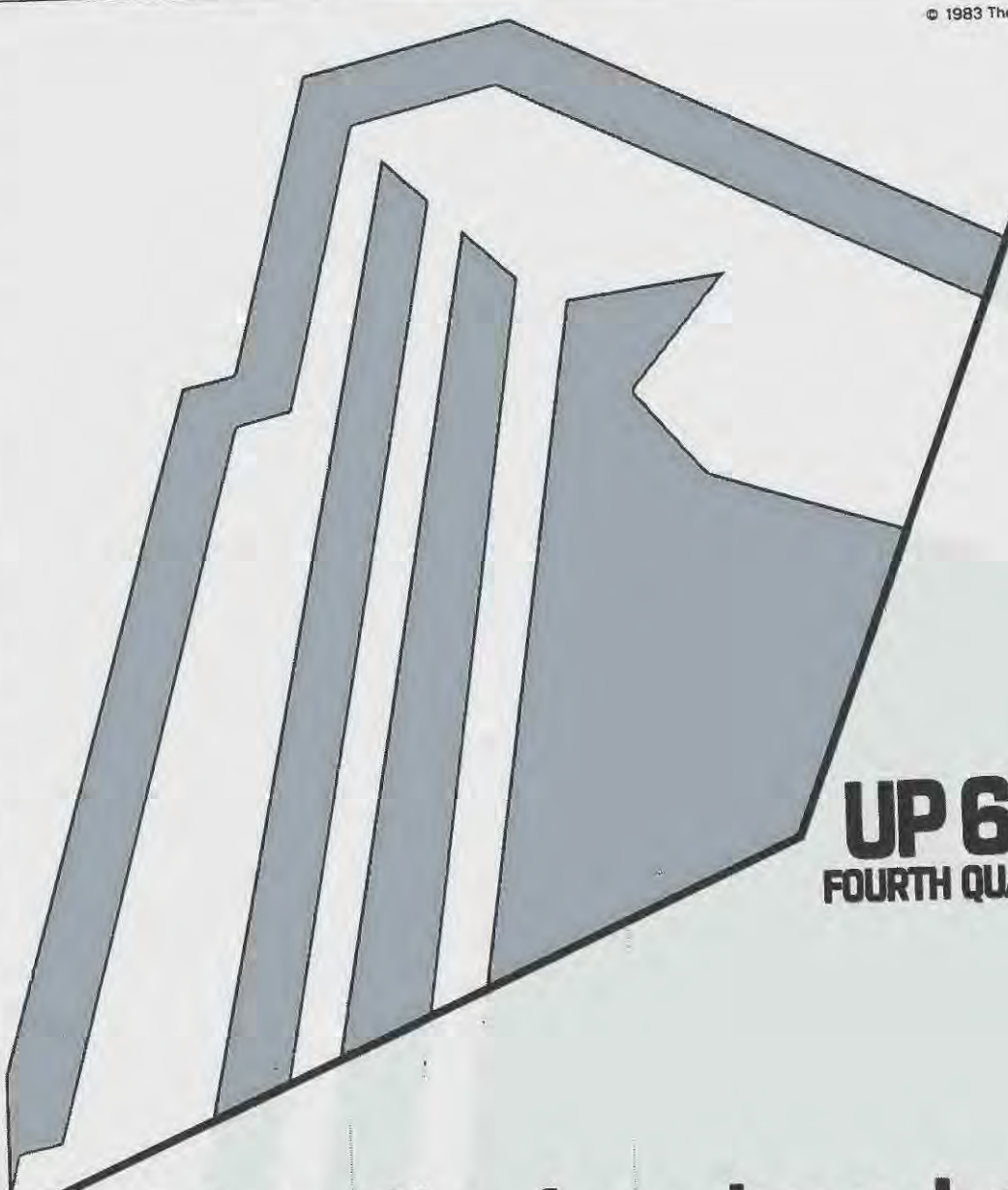
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Severance pay benefits

Years of service	Months of severance pay
5½	1
8	2
10	3
14	6
19	12
27	24

Credit: Fred E. Glickman

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Robert Feinschreiber is a partner in the Key Biscayne, Fla., office of the law firm Feinschreiber & Associates.

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How VEBA's benefit agencies

Continued from previous page

A company can limit VEBA participation to full-time employees. And since it is not a pension plan, older workers can participate, even if they are not eligible for a pension.

An employer that is no longer able or willing to fund a VEBA can reduce or eliminate contributions. This is a major advantage compared with pension plans, which are usually permanent. Even if contributions cease, its assets need not be immediately disbursed to the participants and, therefore, are not

taxed to them.

If the VEBA provides severance benefits they are still disbursed only in employee severance cases. But, if the employer totally ceases operations, all severance benefits are payable. A VEBA is beyond the reach of a company's creditors.

Establishing a VEBA requires more know-how than starting a pension plan, since many potential benefits are available but easily overlooked. A small company with 10 employees will find a VEBA worth the effort only if it plans to

set aside about \$10,000 per year, because maintenance costs are about that high.

Larger companies incur higher actuarial and administrative costs, so greater amounts are necessary for a VEBA to be worthwhile. Yet larger companies will reach the maintenance level readily.

A VEBA proposal should be submitted to the Internal Revenue Service for approval. The tax attorney responsible for the VEBA must be familiar with every facet of VEBA operation.

To take advantage of a voluntary employees' beneficiary association for this year, companies must act before the end of 1983. ■

Employee spirit is key in buy-out's success

By DAVE GALANTI

TAMPA, Fla.—There's more to a change of ownership at a major brokerage than cash or stock exchanges. There are people.

And in some cases, people can pose a problem. If new owners ignore the morale of branch managers and support staff, they run the risk of ruining the productivity of the network they have purchased.

For example, when Hilb, Rogal & Hamilton Co. was formed to buy broker Insurance Management Corp. from Continental Financial Services Corp., the new owners knew they needed more than money to make the deal work. They needed the support and enthusiasm of the staff.

The new principals had to work to convince the employees that the change from corporate to local ownership would be beneficial.

Insurance Management started its efforts at the top—the corporate level—by deciding to maintain as much autonomy as possible within local offices and share ownership with local managers through stock participation.

But that still left the company half a problem. How do we positively publicize the new ownership to other levels of employees?

Hilb, Rogal President Robert Hilb says that process started right after the change in ownership and continues today with the help of branch managers. And, for one office, the transition wasn't difficult at all, he says.

Stewart Davis, president of Insurance Management Corp. of Tampa Bay, says there was never a real morale problem on the lower levels.

"You might be surprised about this, but the change really didn't affect many people below the management level," Mr. Davis says. "Because the corporation is organized to emphasize local management, employees on the lower level did not see that great a degree of change."

Insurance Management of Tampa Bay actually consists of two offices, a 15-employee office in St. Petersburg Beach that handles marine, small commercial and personal lines risks, and a 20-employee Tampa office handling medium- and small-sized industrial risks and wholesale business.

Employees were completely apprised of events as movement toward the sale and finally the change of ownership progressed, Mr. Davis says. He says he believes there was no staff anxiety about the change.

"I felt personally that it was a positive step for us and that's what I tried to portray," he adds. "However, the people here work for this office and profit center, and the Richmond (Va.) head office presence is not pervasive as it might be with other brokers."

"In other words, they know that Richmond is the head office and that there are common goals for our offices, but since they see themselves as working for this office, their feeling about their jobs didn't change much just because the ownership in Richmond changed."

Today, he says, the challenge for him is the same as for any agency or brokerage manager: To keep his staff fired up in a time of increasing competition and rate cutting.

However, the change in ownership meant a much bigger change within the ranks of the Hilb, Rogal local managers, Mr. Davis says.

"It's brought the people near the top of the local offices much closer together," he says. "For one thing, there have been more group meetings. From a personal standpoint, I feel that I am now a part of something. I'm closer to the top, and that's a good feeling."

Mr. Davis believes that Hilb, Rogal's upcoming stock offering, which will bring stock ownership to the lower employee ranks, will further staff identification with the new corporation. That, he adds, is important to future success. ■



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Senators delay vote on tort reform bill

Continued from page 3

enactment of a federal product liability bill, internal Commerce Department memorandums earlier obtained by *Business Insurance* reveal that high-ranking administration officials harbor serious reservations about the legislation (BI, May 23).

"The administration is divided at this time regarding the specific provisions on a federal product liability bill. OMB and the Domestic Policy Staff retain serious reservations about the general concept and merits of the Kasten bill," according to one of the memos.

Despite growing support for the Kasten legislation in Congress, support by the administration is absolutely necessary for the bill to win congressional approval, observers say.

"The prospects for passage without substantial support from the administration are nil," says an opponent of the Kasten bill. "If the White House says no, the bill won't make it across the street."

Administration support is vital

because many legislators, especially Republicans, tend to follow the administration on complex issues on which they lack a strong background. Product liability reform is one of those issues.

Some backers of the Kasten bill are optimistic that the administration will quickly respond to the Packwood letter, which was co-signed by Sens. Hollings and Kasten, so that a committee vote can be scheduled.

"The administration realizes the importance of this issue and will not slow down the process," predicts Victor Schwartz, counsel for The Product Liability Alliance, a broad-based group that is trying to develop a business consensus on federal product liability issues.

Aside from clarifying once and for all the administration's general position on the need for federal product liability legislation, the senators' letter also requests comments on specific provisions in the Kasten bill. Those provisions include:

- The elimination of subroga-

tion and indemnification rights and its potential cost to the federal government. Under that provision, which would apply in product liability suits involving workplace accidents, subrogated actions by employers and insurers against manufacturers to recover workers compensation benefits paid to the employee would be barred.

- Requiring judges, rather than juries, to determine punitive damages in product liability cases.

- The statute of repose that would prohibit product liability suits in cases where a capital goods product, like a printing press, is more than 25 years old.

- The elimination of collateral estoppel in product liability actions. The doctrine of collateral estoppel allows facts to be established in a case by showing that a previous court accepted the fact. That saves a party in a lawsuit the cost of re-litigating an issue.

- The standard of responsibility for wholesalers and retailers. Under the bill, suits against product sellers that are not manufacturers are sharply restricted unless the

manufacturer cannot pay or cannot otherwise be served with a suit.

In addition, the senators want administration comments on sections of the Kasten bill involving defenses if a product is altered or misused and manufacturers' responsibilities to warn of product hazards.

Manufacturers, insurers, consumers and trial attorneys are all keenly interested in the fate of Sen. Kasten's tort reform legislation.

Many manufacturers and insurers say a federal product liability bill is needed to restore balance to a legal system that they believe has become tilted in favor of the consumer.

While employers initially supported product liability bills at the state level, more companies eventually realized that passage of different state bills did little to reduce the uncertainty they and their in-

surers face in defending product liability suits.

Only a uniform federal law, which would pre-empt state product liability statutes, would give that certainty, more and more manufacturers now argue.

But consumers and plaintiffs' attorneys view the Kasten legislation as an unwarranted attack on the common law that has protected people injured by defective products.

"A federal bill takes every state legislature and every state court out of business," says one trial attorney lobbyist.

The Kasten bill now has 21 cosponsors, mainly Republicans. However, one lobbyist opposed to the bill contends that many cosponsors lack a high level of enthusiasm for the bill.

But an aide to Sen. Kasten disagrees. "There is substantial support for this bill," she says.

Pension credits can include 401(k) plan contributions

Continued from page 2

Under a 401(k) plan, employees can defer a percentage of their gross salary to a company profit-sharing or savings plan, where it accumulates interest tax-free until it is withdrawn, which in most cases cannot occur until the employee reaches age 59½. When withdrawn, the money is subject to 10-year forward averaging for tax purposes.

During their working lifetimes, employees pay income taxes only on their salaries after the 401(k) contribution is deducted.

The IRS preliminary regulations, though, were silent on whether 401(k) deferrals could be included in calculating pension benefits under career-average or final-pay plans. Excluding the deferrals would have reduced pension benefits.

Some also feared that companies that included 401(k) deferrals for pension purposes could run afoul of IRS pension regulations that prohibit discrimination in favor of highly compensated employees. The 401(k) rules permit highly paid employees to contribute a larger percentage of their salaries than lower paid employees.

While many companies put off a decision on setting up a 401(k) until this point was clarified, many others went ahead on the strength of IRS opinion letters—issued in response to individual requests for an IRS review of a company's plan—which said that gross salaries

could be used for pension purposes, according to Kevin T. O'Brien, counsel to the Employers' Council on Flexible Compensation in Washington.

The revenue ruling is thus in line with previous opinions issued by the IRS, Mr. O'Brien noted.

"(The ruling) would have been a real showstopper had it not come out this way," he said.

The revenue ruling reads: "The inclusion of elective contributions under the qualified cash or deferred arrangement as compensation in the defined benefit pension plan does not cause the pension plan to be discriminatory within the meaning of section 401(a)(4) of the (Internal Revenue) Code," which prohibits discrimination in favor of highly paid employees.

While the ruling may prompt some of those who had held back on setting up a salary reduction plan to take a new look at establishing 401(k)s, benefit consultants are not expecting a stampede.

"If (companies) are really nervous, this doesn't settle all their doubts," Mr. von Wodtke said.

Other ambiguities in the preliminary rules remain, including the absence of clear criteria governing early withdrawal of 401(k) funds, he pointed out. Currently, the funds can be withdrawn only when the employee reaches age 59½, when he or she leaves a company or dies or upon proof of hardship.

Hardships approved by the IRS to date include "purchase of a primary residence" and payment of

educational expenses or extraordinary medical expenses. No further definition of "hardship" exists, and many companies are holding off on 401(k) plans until this, too, is resolved, Mr. von Wodtke said.

The revenue ruling "is one shoe that's dropped and a lot of people are going to wait for the other shoe," he said.

Other problems yet to be addressed, Mr. Gross added, include whether states can tax 401(k) deferrals and the so-called "recharacterization" of contributions from highly paid employees—contributions that exceed what is allowed under the discrimination tests applied to 401(k) plans, Mr. Gross added.

Since final IRS regulations are expected by the end of the summer, many companies may simply decide they can afford to wait, Mr. O'Brien said.

"They may say, 'We've waited this long, we can wait a few more months,'" he explained.

Still, the consultants see the ruling as a significant step for the growth of salary reduction plans.

"For some companies that have held off, this is the first step," Mr. Gross said.

College of Insurance issuing reinsurance market guide

NEW YORK—A comprehensive directory of property/casualty reinsurance markets in Bermuda, Canada and the United States is being prepared by Dr. Robert W. Strain, dean of the College of Insurance.

The directory will include most of the 9,000 reinsurance individuals and nearly all of the 600 reinsurance organizations in Bermuda, Canada and the United States.

Individual entries in the directory will list names, titles, spe-

cialties and number of years in the industry. Entries will include information on type of organization, business and distribution system.

The directory will be available in September for \$25 from the College of Insurance, 123 William St., New York, N.Y. 10038.

Dr. Strain is the editor of two previous volumes on this topic: "Reinsurance," a 700-page textbook, and "Reinsurance Practices, a Workbook With Cases," designed to be used along with the text.

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Teamwork is focus of CIBA-Geigy program

Continued from page 3

At present, the company provides no financial incentive for employees to use HMOs, although an incentive is being considered, Ms. Maleska said.

Employees are being offered an incentive to get a second surgical opinion for non-emergency, elective surgery. CIBA-Geigy will pay the full cost for this second opinion and, in some cases, a third opinion. Even if the added opinions do not agree, the company will still reimburse the employee for the full cost of surgery, if the employee elects to have the surgery.

If the employee does not request a second opinion, the company will reimburse at 50%.

"But it is always the employee's choice if he or she has the surgery," Ms. Maleska stressed.

"If one physician recommends surgery and another discourages it, the company does not say, 'Go with the opinion that you shouldn't have the surgery.' We just want our employees to be aware that surgery should be carefully considered, and to be aware of the risks and alternative measures."

The company also is trying to encourage employees to use ambulatory surgical facilities. It reimburses 100% of ambulatory charges across the board, including anesthesiologist fees.

However, because CIBA-Geigy's inpatient coverage is quite generous (all charges are reimbursed at 100%, based on reasonable and customary fees, except the anesthesiologist's fees, which are reimbursed at 20% of the surgeon's bill), it is questionable whether CIBA-Geigy is providing incentive to use ambulatory care.

But the company believes it is.

"We also stress that it is more convenient for an employee to recover at home, and that it saves his own personal expenses," Ms. Maleska said.

The company also increased the employees' share of health insurance premiums. Formerly, a single employee with no dependents paid \$2.50 per month toward the health insurance premium; an employee with dependents paid \$10.

"This amounts to about a 5% contribution, whereas it used to be

about 10% (in 1971)," Ms. Maleska said. "We are returning to a 10% contribution level over a period of two years. Right now we are at 8%."

This 8% increase means \$6 per month for a single employee with no dependents. An employee with one dependent pays \$12 a month and an employee with two or more dependents pays \$17 a month.

However, Ms. Maleska says the actual out-of-pocket cost for the employer could be smaller next year even though the percentage of contribution will increase.

"If our premiums are reduced as a result of cost-containment measures or if we see some other significant savings, we will, of course, pass that on to the employees," she said.

After redesigning these benefit plan portions, CIBA-Geigy set the gears in motion for worker involvement through a wellness program.

"What we heard most from employees is that they wanted a preventive approach to health care," Ms. Maleska said.

In response, CIBA-Geigy instituted a six-step program.

The first step—health promotion and awareness—teaches employees to be responsible for their own health. For example, employees are taught that "common sense" rules—eating balanced meals, maintaining appropriate weight, breaking the smoking habit and exercising—are commonly overlooked and can lead to health problems.

The second step—risk assessment/risk reduction—helps employees identify and reduce health risks. For example, the company sponsors blood pressure testing.

Third is fitness and exercise. The company encourages employee fitness by sponsoring YMCA membership or membership in an approved, alternative fitness facility in areas where employees do not have access to a Y.

Fourth is disability management. When an employee is disabled, the company encourages and sponsors rehabilitation.

Fifth is the employee assistance program, a confidential counseling program that previously had been available only at select company lo-

cations. Now every employee can take advantage of the program, which is designed to treat psychological problems before more severe, physical manifestations occur. Special programs are conducted for stress, alcohol and drug abuse, family problems and financial strain.

Sixth is the Employee Health Management program, a pilot program at three company locations. This program offers employees health care counseling, referral services and limited treatment at the company's offices.

"Not only is this convenient for the employee," Ms. Maleska said, "but it reduces absenteeism. Now an employee doesn't have to take half a day off to travel to a doctor's office when he or she has a health question."

Despite these efforts by both company and employees, external forces can still cause health care costs to rise. To counter this, CIBA-Geigy is working in legislative and community health care endeavors and encouraging employees to do the same.

CIBA-Geigy is a member of the Fairfield-Westchester Business Group on Health and other business coalitions. And, it financially supports the development of quality, cost-efficient health services.

CIBA-Geigy also encourages employees to participate on the boards of hospitals and health agencies whenever possible, "both to make it known how we feel and to understand the hospital's point of view," Ms. Maleska said.

While CIBA-Geigy believes it is on the road to controlling rising health care costs, two years of work preceded this year's activities.

In April 1981, a nine-member health care task force was formed at CIBA-Geigy to study the problem of rising health care costs. Ms. Maleska was chairman of this task force, which included employees in

the company's health services unit and corporate benefits and human resources people.

To determine CIBA-Geigy's specific needs, the task force brought managers from various departments to committee meetings to speak on behalf of various employee sectors, such as production line workers.

Presentations also were made to the executive committee, the decision-making body at CIBA-Geigy, to gain its support.

"We got management approval before implementation, because that is the only way to have smooth implementation. The planning we did paved the road," Ms. Maleska said.

About a year after planning began, an implementation committee was formed to determine how cost control needs could be met. This committee involved more than 100 people, Ms. Maleska estimates. "We had input from specialists from all over the company," she said. "And we had input from employees to see how they would react."

The employee input came in the form of focus groups. Small groups of employees from different areas of the corporation met with members of the implementation committee to describe their health care needs and react to benefit plan proposals.

"When we went to our executive committee and when we went to our focus groups, we had thoughts in mind for benefits changes, but we also were looking for new ideas," Ms. Maleska said. "All the feedback we got confirmed ideas that we had: That the company and its employees would be willing to work toward better health and lower costs."

"We also found that some employees know a great deal about the rising cost of health care, but many see only their coverage and don't understand the problem," she added. "And if they don't under-

stand, they can't do their share (toward lowering costs)."

Although Ms. Maleska reports that the executive committee at CIBA-Geigy was very receptive to the plans for an aggressive, ongoing cost-containment program, she admits her committee had to be "very up front about the issue of a possible conflict of interest."

Because of the nature of CIBA-Geigy's business as a supplier of health care products, lower health costs could adversely affect the company's bottom line.

However, the company spent about \$18 million on medical costs in 1982 and had projected to spend about \$22 million in 1983. These figures, together with a concern for better health, overrode the conflict of interest concerns, Ms. Maleska said.

"As a health care corporation, we want our employees to be healthy. We don't see health care suppliers and consumers as adversaries," she said.

"Some people blame doctors, hospitals and health product manufacturers for the high cost of health care, some blame employees for overutilization and some blame employers for not supporting lower-costing alternatives or not educating employees," she said.

"We at CIBA-Geigy don't believe any one group is to blame; everyone has a hand in it and we all have a part in making health care cost-effective."

"Our three-part solution is a beginning," Ms. Maleska continued. "It's a start. These next few months and maybe this year will be a learning time. We'll want to measure our success and fine tune the plan."

"But will we be able to finally reduce health care costs?"

"Absolutely," she said with conviction.

"There is a solution out there. We just need to find the right one." ■

Characters and logo tell the story

Continued from page 3

tin boards as well as bumper stickers and note pads for each employee.

- Printed Health Care Notes and Fact Sheets, which provide spot benefit information on a particular aspect of the program. These Health Care Notes and Fact Sheets also will be issued throughout the year to educate employees about benefit trends and company benefit changes.

- Printed a Report to Employees to communicate "corporate commitments to health, safety and environmental protection."

- Printed an overview brochure of the new program.

- Printed an Implementers Guide, a four-inch ring binder full of benefits information that was sent to the benefits specialist at each corporate location. This allows the program to be run independently at each location.

- Sent letters from CIBA-Geigy's chairman of the board to the employees' homes, alerting them to the new program and endorsing it.

"The care that CIBA-Geigy took in presenting the program to its employees, so that the employees would really know the plan and take action, is what's really unique to CIBA-Geigy," said Alan Turetz, consultant with Kwasha Lipton. "The company put a heck of a lot of benefits options together and had to take extreme care not to overwhelm people."

"It's by far one of the best programs I have seen," he continued.

Perhaps most amazing of all is

that CIBA-Geigy produced this communications project in four months. "The company worked incredibly hard," Mr. Turetz said, "and we matched its effort."

Also, Mr. Turetz pointed out, CIBA-Geigy's health care task force and implementation committee streamlined the process.

But much of the work was accomplished so quickly because of CIBA-Geigy's in-house printing facilities. All of the printing was done at CIBA-Geigy except for that on the glossy folder.

"And we do our own design and typesetting in-house," Mr. Turetz said, "so we were able to turn around copy to mechanicals in 24 hours."

Furthermore, some of the programs had to be communicated in more than one way. For example, union employees were presented a different audiovisual program than salaried employees. Also, in some cases information had to be tailored to fit employees in a specific location.

"For salespeople in the field, we sent the cassette portion of our audiovisual presentation," Ms. Maleska said. "We reached everyone."

And in reaching everyone, Ms. Maleska is finding a warm reception.

"The employee feedback we're getting indicates that most of the employees liked the slide show and the whole communications program, although a few people have a personal preference against cartoon characters," she said. "But the important thing is that it gets the mes-

sage across, and it did that.

"Employees recognize the cost issue of health care," she continued, "and there is very strong support for the wellness issue and preventive care."

"And believe it or not, there already has been evidence of savings, even though the program hasn't officially begun."

"Employees are beginning to use our own medical facilities more," Ms. Maleska said. "Rather than taking a half a day off to go to an outside doctor with a health care question, they'll make an appointment with one of our physicians. Is this a result of the communications program? Absolutely."

Although Ms. Maleska said the program will not be officially reviewed until the beginning of 1984, she believes significant savings will be accomplished.

"The investment in continued communications is worthwhile," she said. "This is not a one-shot deal. We will continue to commit benefits dollars to communications and plan to have some form of communication—whether a Fact Sheet or items in the employee newsletter—in front of employees at least once a month."

CIBA-Geigy's expense for the introduction of Takin' Care will be \$160,000 to \$200,000 for 1983, Ms. Maleska estimates. This represents less than 1% of the company's \$22 million benefits budget for its 13,000 employees.

"We believe publicity is an important part of the success of this program," Ms. Maleska said. "And, we want this program to succeed." ■



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Honeywell, insurer to appeal award

Continued from page 2

Honeywell manufactured and installed the system at Trend Coin as well as monitored the alarm.

According to testimony offered since the Weinbergs filed suit in 1980, the theft and resulting losses were the result of negligence on the part of Honeywell and its security alarm operators, who failed to respond to a warning signal triggered by the break-in.

Honeywell did not deny at the trial the allegation that it had mishandled the alarm and testified that the company's employees had interpreted the signal as a flaw in the telephone lines that transmitted the alarm.

However, the company countered that its 1976 contract with Trend Coin absolved it from most of the liability due to a failure of

the system.

The contract, the company said, limited Honeywell's potential losses to \$390, half of the annual service charge Trend Coin paid to Honeywell.

Honeywell's attorney Kenneth Kavanaugh also challenged the Weinbergs' testimony and claimed that Trend Coin's losses could be no more than \$600,000.

The six-person jury in the court of Circuit Court Judge Joseph Gersten did not agree and found for the plaintiffs, noting that the widespread use of such hold-harmless agreements by Honeywell and its competitors, which limit their liability for failures and errors in alarm systems, prevented Trend Coin from freely entering into a contract.

Neither Mr. Kavanaugh nor the

Weinbergs' attorney would return calls to comment on the decision, but a spokesman for Aetna Casualty & Surety confirmed that it is Honeywell's primary liability insurer and that an appeal of the judgment is planned.

Aetna would not reveal the limits of coverage under its policy or whether it would cover the punitive damages assessed, but industry sources say it is unlikely that Aetna's portion of the coverage exceeds \$1 million.

The remainder of the award may be covered by Honeywell's excess liability insurer, Northbrook Excess & Surplus Insurance Co. Northbrook confirmed that its coverage followed the Aetna policy, but would not disclose coverage terms or comment on the case, pending an appeal.

Bridge collapse loss may exceed cover

Continued from page 2

bridge, is covered by the Aetna Insurance Co. affiliate of CIGNA Corp. under a policy with limits up to \$331.6 million. The state's last annual premium was \$366,474 for the policy, which expires Jan. 1, 1985. The bridge is insured for a replacement cost of \$17.6 million to 80% of value. The state has not yet estimated the loss.

CIGNA's Aetna affiliate also covers the Connecticut Turnpike under a separate policy for loss of business up to an annual aggregate of \$54.7 million. The policy, which costs \$16,950 annually and expires Jan. 1, 1985, may not be tapped if the bridge is repaired before the 14-day deductible is satisfied.

The Greenwich toll plaza, which provides access to the bridge, collected \$903,427 in revenues in March, said a state official.

The bridge is the major commuter link between Connecticut and New York City, carrying 90,000 cars and trucks a day. The state is spending \$500,000 to build a temporary two-lane span.

The state purchases its insurance through the State Insurance Purchasing Board. The Department of Transportation's Bureau of Highway's insurance coverage is brokered by Francis M. Jackson Associates Inc. of Hartford.

The National Transportation and Safety Board last week was investigating the collapse. Early speculation focused on the possible failure of a steel pin linking two spans.

"There is no talk in the attorney general's office of going after anyone involved with the design, manufacture or inspection of the structure," Mr. Shimelman said.

The 24-year-old bridge was last inspected in September by the bridge safety unit in the state Department of Transportation. A spokesman said the inspection did not reveal structural problems.

The collapse provoked a new wave of concern for the quality of the nation's bridges, which many officials say are in need of repair.

"One of things this is going to do is to make municipalities all over the country take a look at the conditions of our bridges," said Tom Wander, a vp in charge of government practice at consultant Risk Planning Group in Darien, Conn.

Insurers may not react.

Marshall A. Ames Jr., a vp of Victor O. Schinnerer & Co., a Washington, D.C.,-based underwriting manager that underwrites architects and engineers liability insurance, said, "Obviously it concerns everyone when something like this occurs, but you have to keep it in perspective. This one particular tragedy would not change our view of exposures of bridges," he added.

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N.Y. allows life insurers to trade futures

Continued from page 1

"We look on the bill as a major landmark piece of legislation that goes a long way toward deregulation of the life insurance business," says Peter J. Flanagan, president of the Life Insurance Council of New York, an industry group with 57 member companies.

He stressed that the bill is significant for all U.S. life insurers because of New York's extra-territorial reach. "All licensed foreign insurers—such as Prudential, Travelers and John Hancock—must substantially comply with New York law to do business here," he points out.

The new law does not change investment regulations for the state's property/casualty insurers, which had more flexibility than the life companies, says Mr. Corcoran. However, in the wake of the just-passed law, life companies will enjoy some opportunities—such as use of financial futures—that remain off-limits to property/casualty insurers.

"I'm sure the property/casualty companies will be asking, 'What about us?' We'll take a look at them next year," he says.

One of Mr. Corcoran's next assignments will be to promulgate regulations that more specifically define and outline aspects of the new investment law. Although the legislation goes into effect 60 days after the governor signs it, certain provisions may be delayed until the regulations are ready.

'We are interested in making sure that insurance companies are solvent rather than creating a lot of new business for (securities) brokers,' explains New York Insurance Superintendent James Corcoran.

"We will move quickly, but it could take 90 days to six months," Mr. Corcoran says.

Among the areas that need clarification are the types of futures transactions that will be permitted and how they can be used. For example, the bill is silent on the use of stock index futures and options.

The law provides for use of bona fide hedging transactions entered into for the purpose of offsetting changes in foreign currency exchange rates or the market value of an obligation proposed to be acquired or sold by the insurer within one year.

But insurance company investment officers, securities brokers and state regulators are waiting to see how the superintendent defines a "bona fide hedging transaction."

The definition will limit use of futures to strict hedging transactions that protect a company's existing assets against changes in interest rates, says Mr. Corcoran. "We probably will not permit anticipatory hedging," he added.

This means that life insurance companies will not be able to trade

futures contracts in anticipation of changing interest rates unless they are holding an asset in their investment portfolio that could drop in value if interest rates rise.

A typical hedge would involve protecting a fixed-interest rate bid on a guaranteed-interest contract for a corporate pension plan by buying a Treasury bill futures contract to lock in the commitment rate. The futures position protects the insurer during the interim period between the time the bid is made and the time that the funds are received for investment.

If interest rates drop before the insurer receives the client's funds, the gain in the futures contracts would help to offset the loss on the yield from investments purchased after funds are actually in hand.

Securities brokers and non-New York insurance company investment officers agree that the new law is a step in the right direction, but express disappointment that it does not go further in permitting insurers investment flexibility.

They also point out that the law's restriction on use of futures to 2%

of admitted assets will hamstring small insurance companies that specialize in interest rate-sensitive products from expanding their New York business.

Up until now, the most aggressive insurance company futures traders have been non-New York insurers that write a substantial volume of universal life insurance and annuities products (see related story, page 1).

"Futures are sophisticated products and I want to make sure that companies get a track record before we leap into this," Mr. Corcoran explains. "We are interested in making sure that insurance companies are solvent rather than creating a lot of new business for (securities) brokers."

Insurance companies and regulators have been reluctant to permit the use of futures because of a prejudice that futures are speculative rather than being a risk management tool, explains George P. Newman Jr., managing director of Virginia Trading Corp., a Chicago-based think tank that advises clients on use of interest rate futures.

Virginia Trading Corp. is currently advising two major East Coast life insurers with serious futures pilot programs under way.

"The overall message of the legislation is that New York wants to make insurance companies more competitive without sacrificing consumer protection," Mr. Corcoran sums up. It signals New York's intention to be in the fore-

front of permitting industry to compete internationally, he adds.

The legislation was unopposed once it was explained to consumer groups that higher premiums were the consequences of inhibiting more investment flexibility to insurers, Mr. Corcoran says.

However, an earlier version of the legislation that would have permitted insurance companies to engage in banking activities was opposed by the banking industry. The bill that passed continues to bar insurance companies from banking operations.

Instead, the bill provides for establishment of a Temporary Commission on Banking, Insurance and Financial Services to study the structure and dynamics of the financial services business and to make recommendations to Gov. Cuomo concerning changes in New York laws and regulations affecting these industries.

The report is due Feb. 15, 1984.

The bill also requires at least one-third of the directors of stock life insurance companies to be from outside the industry and requires licensed New York life insurance companies to file audited financial statements each year with the state Insurance Department.

Life insurers writing direct premiums in New York of less than \$250,000 annually and fewer than 500 New York policyholders would not have to file the statements, which would be open to public inspection.

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Insurance Management: vps, directors, managers of insurance, risk, benefits, compensation, safety, security, etc.	5,299
Government, Associations, Unions, Educational Institutions	1,034
Commercial Consumers Sub-total	22,954
Insurance Agents & Brokers	9,771
Insurance Cos.	5,217
Financial Institutions	352
Actuaries, Attorneys, Adjusters, Appraisers & Consultants	2,603
Others allied to the field	937
TOTAL	41,834

*Source Business/Occupational breakdown of qualified circulation, November 1, 1982 issue, as submitted to BPA for December 1982, BPA Publisher's Statement.

Using futures

Continued from page 1

their feet wet in the futures markets before plunging in on a larger scale after the New York legislation is signed into law (see related story).

Aetna Life & Casualty Co., Prudential Insurance Co. of America and Travelers Insurance Co. have been modestly trading futures through non-insurance company subsidiaries. CIGNA Corp. and The Equitable Life Assurance Society of the United States are preparing to start trading.

"We're working with half a dozen insurance companies that are using options and futures in non-insurance company subsidiaries," says Larry Larkin, vp-options and futures at Goldman Sachs & Co., a New York securities trading firm.

Use of futures by insurance companies falls into three major categories:

- Management of separate accounts, mostly for pension plan clients.

- Management of general accounts, which are the insurance company's commingled assets backing up the insurance policies it has written.

- New design and enhancement of specific interest rate-sensitive insurance products.

"We haven't even begun to think of all the applications," points out William Igleheart, vp-common stock for Aetna Life & Casualty Co. "Most of the big insurance companies will be using them within the next six months," he adds.

For example, if an insurance

company is offering interest-rate guarantees to prospective policyholders before the deposits are received, then the insurer can use futures to lock in the agreed-upon rate, explains Mr. Igleheart. This situation most frequently arises with guaranteed interest contracts—GICs—for pension plans.

Once the insurer obtains the deposits, it can buy securities to lock in the agreed-upon rate. However, it may be several months between when the rate is offered to the client and when the dollars start to flow in. Many of these plans tend to be bid out in September and October with a Jan. 1 effective date.

While the giant East Coast life insurance companies are learning the ropes in the fast-paced financial futures marketplace, a handful of medium-sized insurers outside of New York have been actively trading futures for three years or more. Securities brokers and insurance company investment officers who are using futures estimate that there are six to 10 insurers that are—or have—played the futures markets.

Some of these companies are among the most aggressive and successful marketers of annuity policies and universal life insurance, which compete with investment or savings products available through other financial institutions.

Universal life insurance has been one of the industry's hottest new product entries in recent years because it promises two things: permanent life insurance and competitive interest paid on the cash value that builds up in the policy.

Two years ago, The Life Insurance Co. of Virginia in Richmond

obtained permission from the state Insurance Department to use hedging transactions on a limited scale and has since become one of the most active insurance company futures traders in the country.

Life of Virginia also is a large market for universal life insurance, which represents more than half of its new premium this year.

"One thing that puzzles me is why more companies don't use them (futures) since hedging is a conservative procedure that protects us from risk that can jeopardize profits," observes James L. Londrey, vp-asset management for Continental Financial Services, which manages investments for Life of Virginia.

Mr. Londrey—like other investment managers using futures—is reluctant to describe how the contracts are used to support the company's universal life policies because "many people have been asking us for that information and we consider it a sort of competitive edge."

In general, however, futures can be used to protect insurance companies against increasing interest rates, which decrease the value of their investment portfolios. In lieu of selling a \$100 bond worth only \$80 to meet claims payments or other cash needs, an insurer can sell short futures contracts and use gains in that market to offset unrealized losses in the bond portfolio.

When a company has investments on both long and short sides of the market, it can reduce losses caused by movements in interest rates.

Bankers Life & Casualty Co. in Chicago has actively traded a com-

bination of futures and options to achieve a better maturity match of its assets and liabilities.

"Within the next one to three years, insurance companies will be among the biggest players in the futures markets," predicts Mitchell Harper, vp-investments for Bankers Life.

American United Life Insurance Co. in Indianapolis is one—if not the only—insurance company to have bought futures to bolster its forward-commitment position because of predictions for lower interest rates in early 1980.

The strategy worked like a charm until interest rates started to edge up, causing substantial unrealized losses in the futures position. The company closed out its position in November 1982 following the August bull market and essentially broke even on the investment, says a company investment executive.

But, there were some uncomfortable moments when margin calls had to be met during 1981 and most of 1982, and the company has not used futures since last fall.

State insurance laws around the country have been changing rapidly to permit insurers to engage in futures trading for hedging purposes only. Only Minnesota, Arkansas, Nebraska, North Dakota, Virginia and now New York permit insurer activity in financial futures by statute, and the New York law limits that activity to life insurers.

However, many other states permit such activity through informal policy or through investment "basket or leeway clauses," according to a survey conducted by Arthur An-

dersen & Co., the first public accounting firm to become involved in insurance company use and accounting for futures.

Several states, including California, Texas, and Colorado, have bills pending in their legislatures that would change current insurance law to permit use of futures for hedging purposes only.

State insurance commissioners have been reluctant to permit broad use of financial futures because many examiners don't understand how they work and therefore prefer not to deal with them. Also, there is considerable potential for abuse that could get an insurer into deep financial trouble because the contracts are highly leveraged.

A small investment of several hundred thousand dollars controls many millions of dollars of futures contracts, for example. Futures traders tend to downplay this risk because they point out that players are required to meet daily clearing requirements, so that a company can bail out of a position before its losses become too severe.

Although the New York law limits insurance company participation in hedging transactions to 2% of admitted assets, this translates into \$600 million for a \$30 billion company like Equitable, points out Vp Bruce Marquand.

"It might take us at least a couple of years to get to that limit," he notes.

One of Mr. Marquand's responsibilities this year is to coordinate Equitable's legal, accounting and other systems to prepare for participation in the futures markets. It takes at least four to six months to get started, he says.

Coverage ruling

Continued from page 1

This can be at the time of exposure, manifestation or in between.

"Depending upon the facts of each case, the drug involved, the period and intensity of exposure and the person affected, an injury may occur in this sense upon exposure, at some point in time after exposure but before manifestation of the injury, and at manifestation," the court added.

Judge Sofaer also said that Liberty Mutual must defend any claims that could be covered by policies issued between 1944-1976 when it provided coverage.

Attorneys differ on how the "injury-in-fact" approach will be implemented.

"Despite the fact that the court pretends to reject exposure and manifestation and uses injury-in-fact, it sounds a lot like manifestation," says Christopher Mansfield, assistant vp and attorney for Liberty Mutual. "On the facts of this case, we consider it a victory."

"One of the significant parts" of the decision is that it rejects the Keene triple-trigger approach, Mr. Mansfield adds.

"Keene, which was supposed to be the great omnibus theory for insureds, has never been adopted. The court is really saying that 'you can't rely on the Keene decision in the case of drugs.'"

An attorney close to the litigation, who asked not to be identified, added that "this case could be the most restrictive of all."

The attorney acknowledged that the decision could provide more coverage than the manifestation theory, however, since coverage under that theory is usually restricted to the period when the injury actually is diagnosed or manifests itself. However, the "injury-in-fact" theory is narrower than exposure or the Keene triple-trigger theories, he said.

But the attorney added that the court very clearly outlines the insurers' duty to defend if it appears that the case will fall under their policy. "It is as broad or broader than any other case that has faced

the issue," he said.

Other attorneys—including Sheila L. Birnbaum, an attorney for the New York firm of Skadden Arps, Slate, Meagher & Flom, which represents The Home Insurance Co. in another coverage case—agree that the decision is not as broad as the triple-trigger theory handed down in Keene vs. INA.

But an attorney for Keene Corp. said that the American Home decision still favors policyholders.

"In all instances, he (Judge Sofaer) makes it clear it (injury) is something before manifestation," says Eugene R. Anderson, a partner in the New York firm of Anderson, Russell, Kill & Olick. "He makes it clear that whatever he's saying, it's not manifestation."

"In the end, Judge Sofaer says that the burden of disproving coverage is on the insurance industry," Mr. Anderson adds. "That's a decision that benefits the policyholders."

An attorney for a major insurer said that in some cases the "injury-in-fact" theory could be as broad as the triple-trigger theory.

In the case of an asbestos injury, "theoretically, each policy (under the 'injury-in-fact' theory) could be triggered until manifestation is complete."

For example, in the case of a worker exposed to asbestos over a number of years, there could be numerous "injuries-in-fact" and the insurers on the risk throughout the time of the injuries would be liable.

However, if there were not a continuous exposure to a toxic substance that results in continuing injury, then coverage available to the manufacturer could be restricted.

For example, if a person ingests a drug that does not injure upon ingestion, coverage is limited to when the subsequent injury is diagnosable.

Judge Sofaer indicates that the "injury-in-fact" theory could provide less coverage than the exposure theory but that overall the impact is uncertain.

"No doubt the exposure theory will potentially extend coverage to greater numbers of claimants' recoveries than requiring proof of in-

jury-in-fact, especially if all periods after exposure are treated as 'exposures in residence,'" the court said.

"But the practical effects of these rules cannot readily be known and may prove unjust. Insurance contracts have absolute monetary limits, and the decision to expand coverage to a greater number of claims than the policy language indicates will impose a redistribution of the limited proceeds available."

"Some claims that would have been entirely covered by a narrower construction of policy will be covered only in part; others will be entirely deprived of coverage when a policy limit is exhausted in satisfying claims based on a broader construction of the insurance contract."

"Thus, a policy obtained by a manufacturer to cover workers or consumers actually injured during coverage may have its purpose undermined significantly if it is expanded to cover the claims of workers or consumers who are injured before or after that period," the court added.

The biggest problem the "injury-in-fact" theory may cause policyholders is that coverage is determined based on the facts of each individual claim. This could force a court case on coverage for each claim to determine when the injury would have been diagnosable.

In contrast, the previous three theories define injury as occurring when the claimant is exposed to the harmful substances, when the injury manifests itself, or both.

The "injury-in-fact" decision could "multiply litigation horrendously," said the attorney for an insured involved in coverage litigation.

Insurers may make policyholders litigate every case over coverage, another attorney said. "It's a potentially expensive proposition."

But Mr. Mansfield of Liberty Mutual does not think the judge's approach would cause a great many problems in practice. He predicts a few test cases for each drug would determine when injury-in-fact took place.

"I would hate to think you would

have to have minitrials on each and every underlying case," he said.

Judge Sofaer rejects the argument that the "injury-in-fact" approach would create thousands of minitrials in individual cases, that these hearings would lead to unreliable findings and that the approach fails to consider recent developments that expand manufacturer liability.

Judge Sofaer said the "injury-in-fact" approach is supported by the policy's language and background, intentions and expectations of the parties and considerations of practicability and fairness.

"It provides liberal protection to the insured, without doing violence to the principle—long a part of the law of New York—that insurance policies are contracts under which insureds obtain all the protection for which they may reasonably be said to have paid, but no more," he said.

In terms of applying the "injury-in-fact" approach, Judge Sofaer said that under the language of the Liberty Mutual policies, American Home must prove the cause of the occurrence (accident or exposure), the result of the occurrence, (injury, sickness or disease) and that the result occurred in the policy period.

The language is broad enough to permit findings that a single exposure injured a person to a compensable extent or that injury occurred at the time of manifestation, depending on the particular case, the court said.

"So long as the insured is held liable for an identifiable and compensable injury, sickness or disease that is shown to have existed during coverage, that liability will be insured against," no matter if the injury coincides with exposure or manifestation.

Judge Sofaer said he rejected the exposure theory because it is inconsistent with the policies' plain meaning. Nor has American Home Products offered evidence to explain or demonstrate how an "occurrence" could logically include every exposure to the substance it manufactures, the court said.

"The policies require that the re-

sulting injury and not the exposure occur "during the policy period," the court added. The policies were designed to protect against liability for injuries and thus cover occurrences where both exposure and injury take place.

The manifestation theory is also inconsistent with the policy language, the court added. "The comprehensive general liability policy language covers all injuries, sickness or diseases that occur during coverage, not merely those that become manifest."

The ruling distinguishes between the drugs in this case and asbestos, for which the exposure, manifestation and the triple-trigger theories were developed.

"American Home Products cannot rely on the rationale of cases that have found immediate injury from the ingestion of asbestos fibers because the drugs at issue in this case differ markedly from asbestos in the manner in which they are alleged to injure humans," the court said.

American Home Products has not submitted proof that any of their drugs cause injury upon exposure and at least two (Ovral and DES) specifically do not. Ovral is an oral contraceptive.

Also in the 54-page opinion, Judge Sofaer said that the insurance companies which changed their comprehensive general liability policy in 1966 to cover an "occurrence," not an "accident," rejected both the manifestation and exposure theories.

The court said that the "injury-in-fact" standard is how insurers have interpreted their policies.

Judge Sofaer called for the U.S. Supreme Court to review the various coverage decisions, something it has declined to do on at least three occasions.

"The only judicial solution to the problem of obtaining an authoritative construction of the CGL language is review by the Supreme Court," he added.

Attorneys for American Home and Liberty Mutual said the companies are studying the decision and have not yet decided if they will appeal.

Vatican exhibit insured for \$90 million

Continued from page 1

tively expensive in the commercial marketplace, according to Alice Martin, indemnity administrator for the Museum Program of the National Endowment.

Foreign shows traveling in the United States are eligible for the federal indemnity, as are U.S. shows traveling abroad if they are part of an exchange with the foreign country.

Passage of the act followed special legislation in 1974 granting indemnity for an exchange of exhibits between the Met and the Soviet Union's Ministry of Culture. That exchange would not have been possible if the parties had been forced to buy commercial insurance, Ms. Martin said.

The indemnity under the 1975 Act provides broad coverage, agreeing to pay for any item that is "lost, destroyed, stolen or suffers damage from any external cause except wear and tear." Nuclear and war risks, excluded under most fine arts policies, are included under the federal indemnity.

Deductibles under the program are based on a sliding scale. For exhibits indemnified for up to \$2 million, the law provides a \$15,000 deductible; exhibits valued at between \$2 million and \$10 million carry a \$25,000 deductible; and those valued at between \$10 million and \$50 million carry a \$50,000 deductible.

A \$50 million aggregate limit is the highest available under the law, and a separate limit of \$10 million is applied to art objects shipped

in a single vehicle.

The indemnities are backed by the full faith and credit of the U.S. government, but the government maintains no loss reserve to cover claims, according to Ms. Martin. If a loss pierced an indemnity's deductible, Congress would have to pass a special appropriation to pay the claim. She added that while dozens of exhibits have been indemnified since 1975, no loss has ever exceeded the deductible.

The value of indemnity agreements in effect at any one time cannot exceed \$400 million.

In deciding whether to grant an indemnity, an advisory panel of eight museum directors and the Federal Council on the Arts and the Humanities examines a number of factors, including packing, shipping and security arrangements for each exhibit; each participating museum's control of temperature, humidity and lighting, all of which could damage the art works if not properly regulated; and previous losses among participating museums.

These reviews tend to be tougher than those conducted by commercial insurers because the National Endowment doesn't have the luxury of boosting premiums to cover losses, according to Ms. Martin.

"With commercial insurance, if there's a problem, they can just raise their rates," she said.

Security arrangements to protect the Vatican Collections are closely guarded secrets. Pan American World Airways is the official carrier for the exhibit, but not all of

the shipments will be made by air, according to a Met spokeswoman.

The federal indemnity also requires that each item in an exhibit carry an agreed value in U.S. dollars, a value which is often subject to negotiation among the lending museum, the borrowing museum and the National Endowment.

In the case of the Vatican exhibit, which apparently had no trouble acquiring its \$50 million indemnity, those values added up to about \$90 million, according to Peter DeVito, an assistant vp with A&A in New York.

The Met, therefore, next went to the commercial marketplace for insurance to wrap around the federal indemnity.

About \$40 million in added coverage was placed with Lloyd's, Mr. DeVito said. Most of the \$40 million comprises first-dollar coverage for works the federal program will not insure, including paintings on wood panels, which the National Endowment considers too fragile to indemnify. A smaller part of the Lloyd's placement is excess insurance for items that are covered by the federal indemnity.

The Met has also insured the indemnity's \$50,000 deductible with Lloyd's, and has arranged excess insurance for single shipments of Vatican works that exceed \$10 million in value, Mr. DeVito said.

Neither Mr. DeVito nor the Met would comment on the total cost of insurance for the exhibit, but the savings attributable to the federal indemnity are significant.

The federal indemnity program

has saved U.S. museums about \$11 million in insurance premiums on imported exhibits over the last seven years, Ms. Martin says.

She adds that insurance costs for a "blockbuster" exhibit like the Vatican collections can amount to one-third of a show's entire cost if insurance is arranged entirely through commercial markets.

The Vatican exhibit costs \$3 million to pack and transport from Vatican City to its U.S. destinations and back home, which is being underwritten by Philip Morris Inc.

Each museum also is responsible for raising funds to show the exhibit, exclusive of insurance but including security costs.

The Met spent about \$1.2 million, half of which was raised by ticket sales and the other half donated by Manufacturers Hanover Corp., Merrill Lynch Pierce Fenner & Smith Inc. and The Robert Wood Johnson Jr. Charitable Trust.

The Art Institute is spending \$3.1 million on the show, including improvements to its facilities and \$750,000 in security hardware and personnel. Those underwriting the Chicago showing are Continental Illinois National Bank, which donated \$500,000, and the city of Chicago, which donated \$250,000.

The exhibit will cost the De Young Museum in San Francisco \$2 million, \$600,000 of which has been donated by Standard Oil Co. of California and Chevron Cos.

Another very valuable exhibit, the \$300 million exhibit of van Gogh paintings brought from Amsterdam in 1980 to the Art Gallery

of Ontario, cost \$300,000 to insure through commercial markets, according to Maar T. Haack, a product manager with St. Paul Fire & Marine Insurance Co., which participated on the risk. Those insurance costs reportedly ate up about a third of the exhibit's budget.

A state-sponsored indemnity program in Florida also has produced substantial savings for museums.

The Florida Arts and Artifacts Indemnity Act, passed in 1981, provides a maximum \$1 million indemnity with a \$25,000 deductible for exhibits brought to the state from other U.S. museums and valued at at least \$1 million, according to Brenda Williamson, a spokeswoman for the Center for Fine Arts in Miami.

Funding for the indemnity program comes from a state working capital reserve fund. Up to \$3 million can be committed to indemnities at any given time, she said.

The Center for Fine Arts is now putting together a show of 200 paintings from 60 U.S. museums to open next January and will participate in the Florida indemnity program, Ms. Williamson said.

A study of projected insurance costs for the show conducted by Huntington T. Block Insurance of Washington, D.C., found that if the exhibit's total value is \$100 million, commercial insurance premiums will be reduced from about \$200,000 to about \$56,000 through participation in the Florida program, she said.

USF&G wins damages from policyholder

Continued from page 2

According to court papers, USF&G requested itemized invoices to support the claim, but was told that no invoices existed for the imported rugs representing the bulk of the loss.

USF&G then undertook an investigation in which inventories at Orient Handel's two Los Angeles locations and a St. Louis store were taken. USF&G also requested Orient Handel's property tax affidavits, income tax returns, receipts for shipments handled by its customs broker and other documents, all of which the rug company refused to provide, according to court papers.

USF&G also says it asked to do a "time and motion" study at the Orient Handel showroom to determine if 109 rugs could have been removed in the 10 minutes that the store's burglar alarm records indicated thieves were on the premises. Orient Handel also refused this re-

quest.

In July 1979, after 17 months of investigating, USF&G "tentatively" denied the claim, saying that if invoices were produced, the claim would be paid, according to Mr. Wolf.

In August 1979, Orient Handel produced records of its customs broker and filed a complaint in Los Angeles Superior Court accusing USF&G of breach of contract for failing to pay the claim and bad faith in failing to accept or deny the claim in a reasonable period of time, according to Nicholas A. Weimer, the Los Angeles attorney representing Orient Handel and its owners, Nassir Shokrian and Lotfollah Shokrian.

The suit sought payment of the \$471,519 claim, plus \$10 million in punitive damages.

USF&G then filed a cross-complaint alleging that the burglary had been staged and that Orient Handel and the Shokrians had con-

cealed material facts about the alleged loss, misrepresented the values and descriptions of the rugs and "edited" the custom broker's records.

After subpoenaing the original records of the customs broker, USF&G found that the broker had indeed kept invoices for the imported rugs, contrary to the rug company's assertions. However, because of the passage of time, most of the invoices could not be found.

USF&G also accused Orient Handel of concealing the existence of a San Francisco branch store to which it had shipped a number of rugs prior to the burglary, rendering the earlier inventory of the company's stock useless.

Mr. Weimer says the San Francisco store, though it did business under the name Orient Handel and received shipments from Orient Handel in Los Angeles, was not owned by the Shokrians at the time of the burglary. The San Francisco store has since been bought by the Shokrians, he said.

In the trial that began March 7, USF&G argued that it should be able to collect compensatory damages to cover the expense of its investigation of the claim—expense that was for naught because of the alleged fraud by Orient Handel. It also argued that the fraud entitled it to punitive damages.

In a motion for a directed verdict in its favor, Orient Handel countered that USF&G was not entitled to any money damages because it would normally have investigated the claim and incurred expenses regardless of whether or not it suspected fraud.

On May 25, after deliberating for 13 days, the jury found in USF&G's favor. While concluding that there had been a burglary at the Orient Handel store, the jury found that the Shokrians had fraudulently inflated the amount of the loss.

The jury awarded the insurer \$30,536 in compensatory damages,

compared with the approximately \$70,000 it had requested, Mr. Wolf said. The jury also assessed punitive damages of \$52,946 against Orient Handel and \$471,519 against each of the Shokrians.

Mr. Weiner said he will file a motion for a new trial, and if denied, will appeal the jury's verdict to the state 2nd Circuit Court of Appeals.

Attorneys for both sides say they're aware of no other cases in which an insurer collected damages from a policyholder over a claim it didn't pay.

"I don't think there's a case in the country that we have been able to find directly on that point," Mr. Wolf said.

Other attorneys experienced in bad-faith litigation agree that the case may be a first, and most expressed approval of the notion that insureds as well as insurers be held liable for not dealing in "utmost good faith."

Earl Nemser, a partner with the New York law firm of Cadwalader, Wickersham & Taft, said he has never heard of an insurance company seeking punitive damages in a case similar to Orient Handel. He expressed the fear that, if the verdict is upheld on appeal, insurers may step up the now uncommon practice of filing cross-complaints in bad-faith cases, possibly inhib-

iting other insureds from pursuing valid claims.

He added, though, that since insurance companies found to have acted in bad faith may be assessed punitive awards, the same should be reasonably expected of a policyholder acting in bad faith.

"What's good for the goose is good for the gander," he said.

William M. Shernoff, a Claremont, Calif., attorney who frequently represents policyholders in bad-faith cases against insurers, said he doesn't expect to see many insurers follow USF&G's example in the Orient Handel case. Such cross-complaints are rare because an insurer could be "digging its hole deeper" in a bad-faith case if it doesn't have strong evidence of fraud by the policyholder, he said.

"It's rare, and the reason it's rare is that (insurers) had better be right or they're playing with fire," he explained.

While saying this was the first case he'd seen in which punitive damages were awarded to the insurer, Mr. Shernoff said he was not surprised by the verdict.

"It's certainly not anything alarming, because that's the way the law should be. It should run both ways," he said.

"The penalty should be there as a warning to people that they should deal in good faith."

insurance services guide

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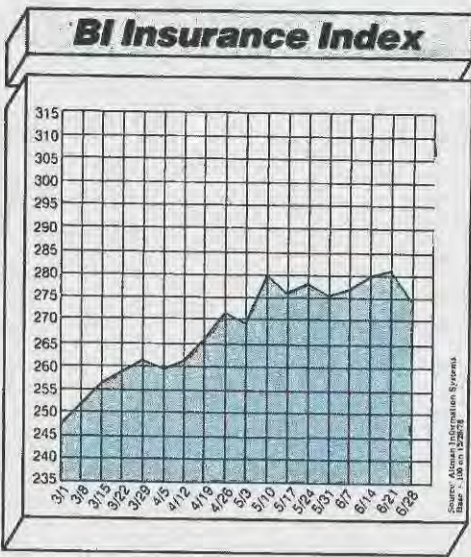
Health plans include retirees

NEW YORK—Most major companies continue to cover retired employees under their medical insurance plans, according to a survey by Towers, Perrin, Forster & Crosby.

Of 300 large companies studied by TPF&C, 287 offered employees medical coverage after retirement. Fewer than 20 of these companies continued the coverage only until the retiree became eligible for the federal Medicare program.

In most cases, employees enrolled in a company's health insurance plan remain eligible for medical coverage after retirement if they meet the pension plan's age and service requirements.

Almost all of the companies studied design their retiree health care plans to avoid duplication of benefits, the majority through the use of coordination-of-benefits features or integration with Medicare benefits.



The Business Insurance stock index plunged 7.3 points to 274.3, for the week ending June 28 from the record of 281.6 set June 21. Reflecting the drop, 41 issues closed down, 13 were reported gains and 10 issues closed unchanged. The largest gains were reported by American National Insurance Co., 6.5%; Carolina Casualty Insurance Co., 5.7%; Alexander & Alexander Services Inc., 3.3%; American Bankers Insurance Group, 3.2%; and Farmers Group Inc., 3.0%. The largest losses were reported by Bitco Corp., 18.9%; Statesman Group Inc., 17.4%; CNA Financial Corp., 10.3%; Integrated Resources Inc., 10.1%; and Orion Capital Corp., 8.8%. The BI index posted a 2.6% decline, which matches the percentage drop in the New York Stock Exchange composite over the same period.

Insurers look at where they've been while proceeding full speed ahead

By MYRON M. PICOULT
Special to Business Insurance

AS WE WERE COMPOSING this column, we thought of a story relayed to us a few years ago by a high-ranking officer of a sizable company, who has since retired.

The chairman, his chief marketing officer and the head actuary were all in a car headed for a crucial meeting. The chairman was behind the wheel but the marketing officer, who was in the passenger seat, had used his foot to depress the accelerator all the way to the floor.

In the back seat, looking out the rear window, was the head actuary who was navigating and telling his two companions where they had been, as opposed to where they were supposed to be going.

As we survey the present property/casualty insurance scene, we are reminded of this story and the fact that the business as a whole appears to be emulating Economics 101: a commodity product in an industry with excess capacity. Eventually the situation will self-correct and there will no doubt be some meaningful structural changes to the business, but that continues to look like a very drawn-out process.

From our perspective, we think it would be better to have a horrible ending than to have horrors without an end.

As the second quarter wound to its conclusion, it had all the earmarks of a no-win solution. Catastrophe losses through the middle of June approximated \$503 million, compared with \$993 million in the first six months of 1982. While this 49% decline is not quite as good as the 69% decline posted for the first quarter, it nonetheless provides a

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts. His column appears the fourth Monday of every month.



Mr. Picoult

comfortable cushion for the second quarter.

If underwriting results continue to show little or no deterioration in the second quarter, it seemingly belies the theory of a quick fix for commercial price levels. Conversely, if underwriting results and earnings prove to be disappointing despite the relatively favorable level of catastrophes, individual stocks and perhaps the group as a whole may reflect investor disenchantment.

As we have said in the past, the operating environment, particularly in the commercial lines segment of the business, is the pits. Attempts to rationalize what the participants are indulging in are most difficult. It seems to us that all insurance company managements have purchased the same Ouija boards that keep repeating "Hold on to market share... hold on to market share."

To most companies in the business, it is apparently anathema to even consider, no less actually effect, a reduction in market share despite the inability to secure a profit or meaningful return on the capital at risk. One wonders if, in fact, some of the major companies have been in a predatory pricing mode for the past few years and are inclined to continue to pursue this modus operandi and eliminate some gnatty competitors.

One further step in the process appears to be an attempt to develop "captive agency" forces, which are still "independent," along with the nurturing of various group- and mass-marketing approaches. To be sure, managements now recognize that distribution costs must be brought down if agency companies are to survive and prosper.

In a future column we will get into group- and mass-marketing approaches. Today we will take a quick look at the independent agent who is fighting for survival.

The "independence" of the traditional independent agent is not what it used to be. Casualty companies are seeking to do more business with fewer agents as one way to pare distribution costs.

It is virtually impossible not to pick up an industry trade magazine and find a multitude of advertisements from various companies extolling the benefits of interfacing, or tying in directly with a particular insurance company's computer system. These systems, once understood and effectively used by agents, can increase productivity. In general, these

systems can retrieve information to answer questions, provide quotes, issue certificates and binders, take loss reports and order policy changes. The concept is virtually useless if an agent's office is not automated. Consequently, we have seen a rise in the number of insurers that provide consultation services to guide agents toward the best support systems.

This does not come free. There are costs, either direct or indirect, which could make an agent more dependent upon a particular insurer. Conversely, it would appear that more demands could be made on agents in terms of amounts of business submitted and business mix.

The bottom line to this is that agency automation may not really make the independent agent more independent as the agency companies put the squeeze play on the U.S. agency system.

Financial briefs Commercial rates

Fierce insurer competition is helping commercial insurance buyers much more than individual auto owners, new Insurance Services Office figures show.

The figures show insurers have managed for more than three years to closely match their personal auto premium growth to the growth in underlying rates recommended by ISO, an advisory ratemaking body run by the industry. In three commercial lines, however, insurers are taking an underwriting bath, the figures confirm.

Buyers are getting the biggest break in the commercial auto line, followed by general liability and commercial multiperil.

General liability insurance premiums written by major companies have dropped 17.3% compounded over the last 40 months, while advisory rates recommended by ISO for the same coverage have risen by 15.7%.

Together the figures mean that general liability coverage buyers are paying premiums at least one-third below what ISO recommends its member insurers should be charging in order to make an underwriting profit.

The difference between prevailing premiums and recommended rates is even greater when it comes to commercial auto, a line that insurers complain is costing them dearly.

The ISO-released figures show that while ISO has recommended rate hikes totaling 50.6% over the 40 months ended March 31, the actual industry premium growth has been 2.3%, which means buyers of commercial auto coverage are paying about half what ISO says they should in order for insurers to achieve underwriting profits.

In the commercial multiperil line, ISO says it has recommended a 33.6% hike in rates since the beginning of 1980, yet premiums have grown just 5.2%, a 28.4% deficiency.

In private-passenger auto, ISO says it has recommended a 30.6% premium hike since Jan. 1, 1980, while premiums have grown 28.4%, a difference of only 2.2%.

ISO's ratemaking does not include the effect of investment income on insurer results. As a consequence, the fact that premium growth is far below ISO recommended-rate growth does not necessarily mean insurers are suffering financially.

Frank B. Hall

Frank B. Hall & Co. Inc. has declared a quarterly dividend of 42.5 cents per share of common stock, payable Aug. 8 to shareholders of record July 15.

Aneco Re

Net income at Aneco Reinsurance Co. Ltd. grew 181.5% in the first quarter to \$236,941, compared with \$84,172 in the first quarter of 1982. Premiums written by Aneco increased 33.2% to \$2.78 million from \$2.09 million in the first three months of 1982.

Aneco Chairman and President Francis J. Mulderig said the company's improved profitability resulted from a number of factors, including significant gains in the company's risk management operations as well as a decrease in general corporate expenses.

British Issues

28 June Companies	Price pence	P/E	Div. pence	Yield %	High—Low pence
Comml Union	168	50.9	16.86	10.0	169—165
Eagle Star	415	16.5	24.29	5.9	415—406
Genl Accident	411	13.1	24.29	5.9	411—406
Gdn Royal Exch	450	11.9	27.26	6.2	451—440
Phoenix	306	16.7	25.00	8.2	310—306
Royal	503	13.0	37.86	7.5	505—491
Sun Alliance	1231	16.9	68.57	5.6	1238—1200

Brokers	Price	P/E	Div.	Yield	High—Low
CE Heath	331	9.0	21.07	6.4	335—331
Hogg Robinson	109	8.4	8.57	8.5	109—106
JH Minet	126	12.0	6.50	5.2	126—124
Sedg Grp	231	13.2	10.00	4.3	232—226
Stenhous Hldg	108	10.1	7.86	7.3	111—108
Stew Wrightson	246	8.9	20.43	8.3	255—246
Willis Faber	558	14.7	25.00	4.5	558—548

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

JUNE 28, 1983 6/22/83 THRU 6/28/83

Insurance Cos.	Price	% Chg.	P/E	Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	38.13	-4.7	6.7	2.64	6.9	39.63	38.13	1,380.4
American Bankers Ins Group	16.25	3.2	12.8	0.50	3.1	16.25	16.13	52.0
American Gen Ins Co	21.75	-1.1	8.3	0.80	3.7	22.13	21.75	393.1
American Indty Finl Corp	20.50	-1.2	15.2	1.12	5.5	20.75	20.50	3.8
American Intl Group Inc	67.63	-3.4	11.7	0.44	0.7	70.25	67.63	981.4
American Natl Ins Co	20.63	6.5	8.6	0.84	4.1	21.50*	20.63	79.7
American Sts Life Ins Co	30.00	0.0	8.4	0.88	2.9	30.00	30.00	9.9
Aneco Reins Ltd	4.50	-5.3	150.0	0.00	0.0	5.25*	4.50	203.9
Avemco Corp	18.00	-4.0	10.8	0.58	3.2	18.75	18.00	6.1
Banks Iowa Inc	46.50	1.1	12.3	1.52	3.3	46.50	46.50	0.7
Bitco Corp	20.00	-18.9	6.3	1.33	6.7	24.67	20.00	11.6
Carolina Cas Ins Co	9.25	5.7	12.8	0.32	3.5	9.25*	9.25	2.3
Chubb Corp	62.50	0.2	9.7	3.12	5.0	62.88*	62.50	322.6
Combined Intl Corp	32.75	0.8	10.9	2.00	6.1	33.13	32.63	369.8
Continental Corp	30.25	-0.4	16.7	2.60	8.6	30.38	30.13	363.9
Crawford & Co	21.25	-5.6	15.4	0.60	2.8	22.00	21.25	14.8
Crown Life Ins Co	102.00	0.0	6.7	3.10	3.0	102.00	102.00	1.0
Employers Cas Co	39.50	-0.6	8.1	1.20	3.0	39.75	39.50	6.1
Equifax Inc	35.50	-3.4	16.2	1.40	3.9	36.88	35.50	15.7
Excelsior Ins Co	15.00	0.0	9.6	0.70	4.7	15.00	15.00	8.8
Farmers Group Inc	39.00	3.0	10.2	1.36	3.5	39.00	38.88	2,022.8
Foremost Corp Amer	52.25	-2.8	16.0	1.24	2.4	53.75	52.25	84.0
Fremont Gen Corp	27.38	-5.2	912.5	0.68	1.8	27.38	25.63	450.9
Great West Life Assurn Co	205.00	-0.5	9.9	10.00	4.9	206.00	205.00	2.0
Hanover Ins Co	56.50	-4.2	7.0	0.88	1.6	59.50	56.25	27.4
Hartford Steam Boiler Insptn	54.50	-0.9	12.0	3.00	5.5	55.00	54.50	7.3
Jefferson Natl Life Ins Co	46.50	-2.1	14.6	0.76	1.6	47.50	46.50	3.3
Kepper Corp	47.25	-5.3	8.9	1.80	3.8	49.88	47.25	173.1
Lincoln Natl Corp Ind	51.88	-1.7	9.5	3.00	5.8	54.13	51.88	131.7
Mission Ins Group Inc	36.25	-5.8	10.0	1.00	2.8	38.00	36.25	82.3
Nationwide Corp Ohio	41.75	0.0	15.3	0.70	1.7	0.00	DID NOT TRADE	
Northwestern Natl Life Ins	36.75	-5.5	24.3	1.50	4.1	39.13*	36.75	92.8
Ohio Cas Corp	52.00	-3.0	9.8	2.52	4.8	53.13	52.00	241.2
Old Rep Intl Corp	30.63	-2.4	7.5	0.90	2.9	31.38	30.63	28.9
Orion Cap Corp	26.00	-8.8	13.1	0.66	2.5	28.50	26.00	48.6
Preferred Risk Life Ins Co	33.25	0.8	9.2	1.00	3.0	33.50	33.25	10.5
Provident Life & Acc Ins Co	61.50	-1.6	8.7	2.60	4.2	62.50	61.50	39.4
St Paul Cos Inc	65.75	2.1	6.7	2.80	4.3	67.00	65.00	157.5
Safeco Corp	56.75	-2.6	11.8	2.40	4.2	58.13	56.75	61.0
Sri Corp	39.25	-8.2	7.3	1.12	2.9	42.75	39.25	312.1
Seibels Bruce Group Inc	31.00	-6.4	17.0	0.80	2.6	32.75	31.00	167.3
Statesman Group Inc	8.88	-17.4	6.5	0.15	1.7	10.38	8.88	43.0
Tokio Marine & Fire Ins Co	102.88	1.2	16.5	0.92	0.9	104.00	102.50	48.5

JUNE 28, 1983 6/22/83 THRU 6/28/83

	Price	% Chg.	P/E	Div.	% Yld.	High	Low	Vol. (000)
Travelers Corp	29.50	-8.2	7.8	1.80	6.1	31.75	29.50	633.9
United Fire & Cas Co	33.25	0.0	9.8	0.88	2.6	33.25	33.25	0.1
United States Fid & Gty Co	49.38	-3.9	11.6	3.84	7.8	51.25	49.38	92.9
United Svcs Life Ins Co	21.00	-7.2	6.3	1.00	4.8	22.63	21.00	31.0
USlife Corp	23.88	-8.2	6.6	0.88	3.7	25.88	23.88	243.1
Washington Natl Corp	31.25	-8.1	14.2	1.08	3.5	32.38	31.25	286.4
Zenith Natl Ins Corp	22.50	-4.3	10.9	0.80	3.6	23.50	22.50	10.3
INSURANCE COMPANIES	AVERAGE		10.1		3.8			
Agents/Brokers								
Alexander & Alexander Svcs	23.75	3.3	0.0	1.00	4.2	24.00	23.63	504.6
Baldwin & Lyons Inc	43.50	0.0	20.3	1.32	4.3	43.50	43.50	0.0
Corroon & Black Corp	24.00	-2.0	12.8	1.80	7.5	24.38	24.00	17.0
Crump E H Cos Inc	11.25	-2.2	16.3	0.40	3.6	11.50	11.25	3.7
Emett & Chandler Cos Inc	10.50	0.0	0.0	0.00	0.0	10.50	10.50	2.0
Hall Frank B & Co Inc	30.88	-3.1	17.5	1.70	5.5	31.63	30.50	100.8
Integrated Res Inc	37.75	-10.1	14.8	0.00	0.0	42.75	37.75	154.3
Marsh & McLennan Cos Inc	42.75	-1.7	12.4	2.20	5.1	43.00	42.00	395.6
Poe & Assoc Inc	7.25	0.0	0.0	0.40	5.5	7.50*	7.25	2.9
Reed Stenhouse Cos Ltd	14.50	0.9	14.5	0.60	4.1	16.63	14.00	42.2
AGENTS/BROKERS	AVERAGE		16.7		3.6			
Conglomerates Holding Cos.								
American Express(Fireman's Fd)	68.25	-5.5	14.2	1.92	2.8	71.75	68.25	1,128.5
Anderson Clayton(Ranger/PanAm)	30.50	0.0	20.3	1.32	4.3	30.75	30.50	40.3
Armco Inc	18.63	0.0	0.0	0.40	2.1	18.88	18.50	399.7
City Investing Co. (Home Ins.)	36.75	0.3	8.7	1.80	4.9	38.88*	36.75	1,531.6
CNA Finl Corp (CNA)	19.50	-10.3	7.7	0.00	0.0	21.63	19.50	33.8
Control Data (Comm. Credit)	56.13	-6.3	14.1	0.60	1.1	59.75	56.13	1,095.6
General Re Corp	61.00	-0.8	12.9	1.28	2.1	62.50	61.00	731.4
Gulf Utcl Corp	26.25	0.0	8.2	1.32	5.0	27.00	26.25	550.7
Cigna Corp	47.50	-0.5	6.8	2.48	5.2	48.25	47.50	460.6
ITT (Hartford Group)	40.50	3.8	8.7	2.76	6.8	41.75	40.50	2,148.5
Optimum Hldg Corp	7.75	0.0	12.7	0.00	0.0	7.75	7.75	

How The Hartford helps reduce insurance costs.

"Our Claims know-how kept a \$170,000 loss from turning into a million-dollar loss!"

Claude Glaser, Senior Vice President, Claims Department, explains how The Hartford's fast, expert Claims service can minimize the size of a loss and cut insurance costs.

Q. How can The Hartford's Claims capability help reduce a company's insurance costs?

A. The lower a company's losses, the lower its insurance premiums. And at The Hartford, we have an impressive track record for minimizing losses. One example involved an explosion at a California oil refinery. A corrosive substance spewed into the air and covered some 2,000 automobiles. If it wasn't removed quickly, all 2,000 cars would have needed repainting at a cost of \$500 each—a potential million-dollar loss.

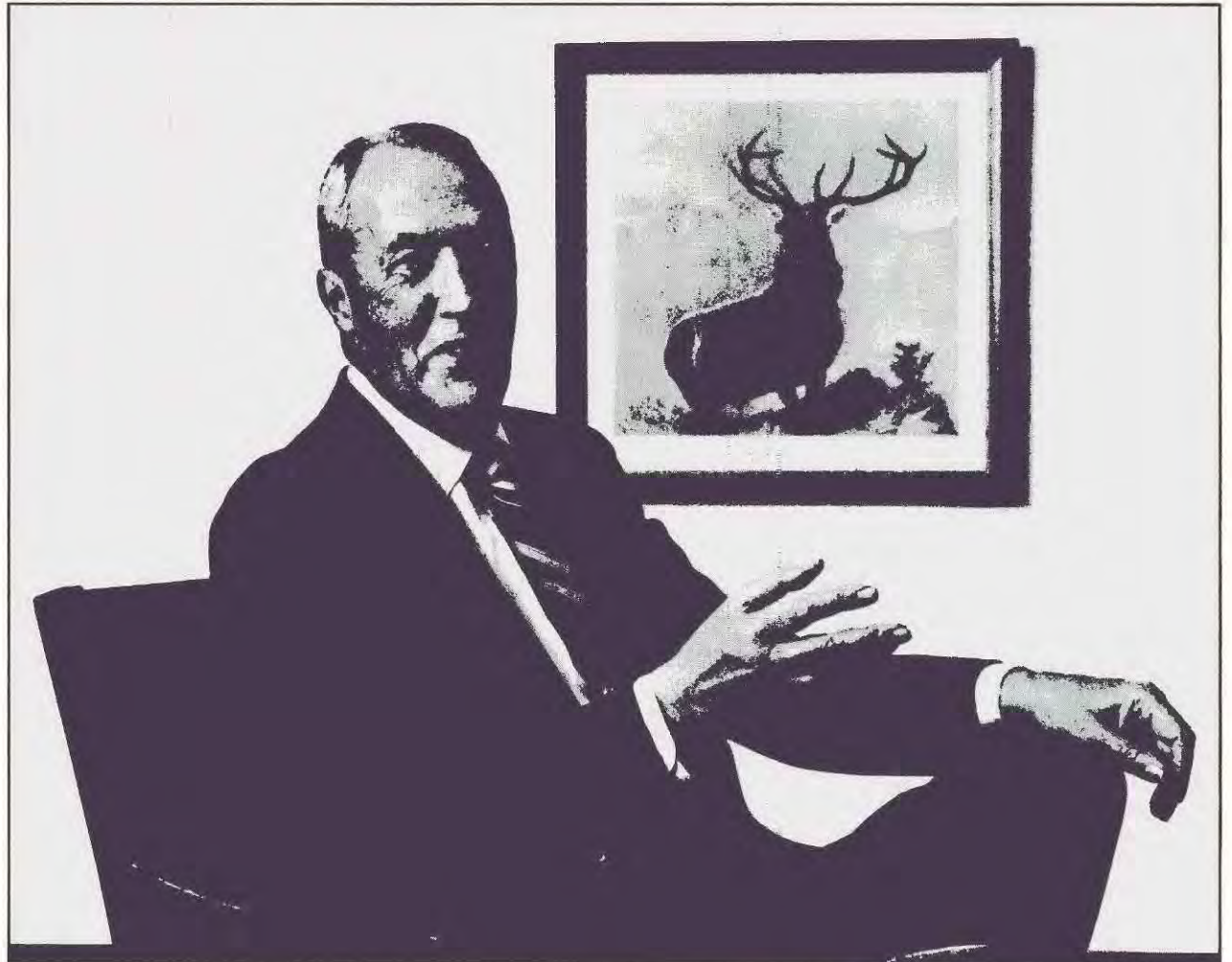
Our Claims people responded quickly and decisively. They had the substance analyzed and authorized its immediate removal with a special cleaning process. The cost? Just \$85 per car for a total of \$170,000—less than one-fifth the loss that would have resulted from routine claims handling. That minimized the impact of the loss on the refiner's premiums.

Q. Why is The Hartford able to respond to a claim more quickly and effectively than other insurers?

A. Unlike many insurance companies, we handle about 99% of our claims with our own staff. We have over 200 fully automated Claims offices and some 4,200 Claims personnel—including experts in a wide range of specialized loss areas, and a countrywide staff of registered nurses who work full-time for the medical, social, psychological and vocational rehabilitation of claimants. So we have the people in place, ready to respond. And there's no add-on charge for outside claims service.

Q. How can effective rehabilitation cut insurance costs?

A. It can speed up the return of injured employees to productive work. In a recent case, a heavy-equipment operator suffered a severe back injury which prevented him from returning to his job.



We arranged for his medical treatment and also coordinated and helped finance his retraining as a meatcutter. We even advanced him funds to open his own retail butcher shop. He became productive and self-sufficient once again. And our insured was spared the negative impact that some \$300,000 in anticipated disability payments would have had on its premiums.

Q. Can I use The Hartford's Claims expertise even if I self-insure?

A. Sure. Through our subsidiary, Hartford Specialty, we're currently providing "unbundled" claims service to some of the country's largest corporations. You can get any level of claims service you need, independently of insurance coverages. You can also get OSCARSM, the revolutionary up-to-the-day, on-line claim

reporting system that lets you break out claims on the spot using criteria you select on the spot.

Q. How can I put The Hartford's Claims capability to work for my company's benefit?

A. Just contact a broker or an independent agent who represents The Hartford.



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