

Business Insurance®

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Hull, liability insurers reserve \$60 million for Air France crash

LONDON—Hull and liability underwriters will pay an estimated \$60 million in claims stemming from the crash of an Air France Airbus A-320 jetliner last week during a demonstration flight in Mulhouse, France, sources in London say.

But, the underwriters could turn to the jet manufacturer's product liability insurers if the investigation into the crash, which killed three people and injured 50, finds the cause was system

Continued on next page

July renewals

Falling rates begin to stir bad memories

Competition reigns in the commercial property/casualty insurance market, as rates continue to float—and occasionally plunge—downward.

Many are beginning to suggest the softening market resembles the competition of the early 1980s, which caused insurers' profits to plummet.

"The market has gotten softer and softer as the year progressed," points out James E. Goulard, president of the Hall Services Division of broker Frank B. Hall & Co. Inc. in Briarcliff Manor, N.Y. "We're very close to where things were in '82-'83."

In fact, the two questions now on market observers' minds are:

- How low will rates eventually go?
- When will the competition end?

Few are ready to answer the former, while many predict the market will not harden until the next decade.

And, even though risk managers can look forward to more bargains in the years to come, observers point out that buyers will pay the piper when the market finally tightens.

"I know it is great for the general public to get good insurance rates, but it would be better in the long run to eliminate the peaks and valleys," pointed out Charles E. Keller, president and chief executive officer of broker Republic Hogg Robinson Inc. in Boston.

"I'm getting scared that here we go again. I feel we could be headed for problems in another 18 months," observed George Mills, risk manager for the New Jer-

sey Highway Authority in Woodbridge, N.J.

For the present, risk managers are nonetheless enjoying the bargains.

The biggest bargains are being extracted from property insurers. Risk managers and brokers both report that rate reductions of up to 50% are commonplace, and even larger savings are not impossible. Capacity is plentiful, even for earthquake risks.

However, the commercial liability insurance market also is rapidly softening. Rate cuts of 10% to 25% are most commonly reported, though some brokers say that prices are being slashed up to 50% for some types of excess liability coverage.

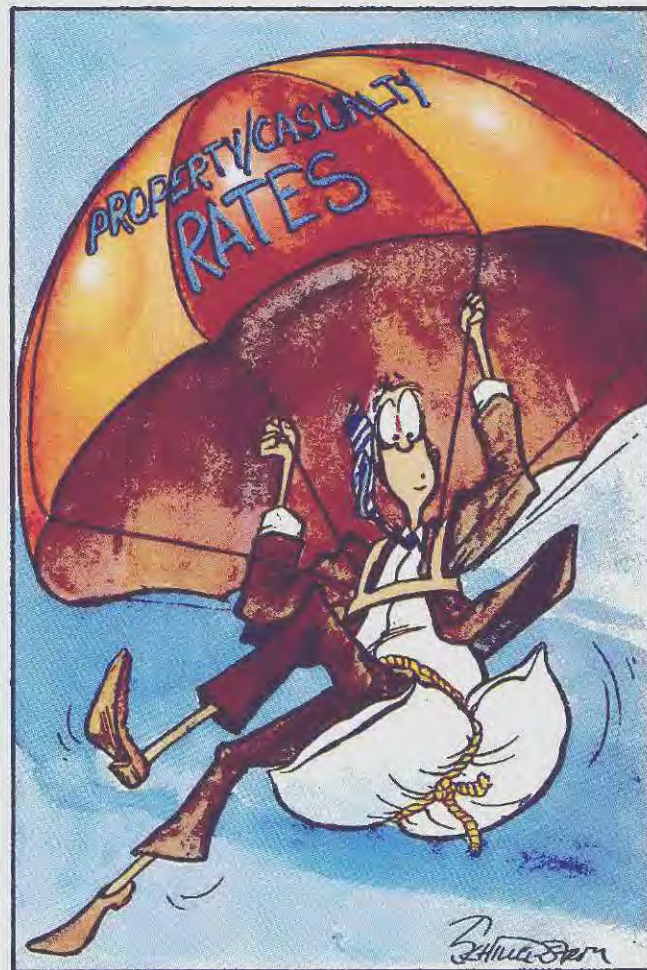
In fact, rates are being cut for lines of liability insurance that were very hard to place a year ago, including directors and officers liability and professional liability insurance.

Liability capacity also is not a problem, with risk managers reporting that insurers are again happy to fill out their high-limit programs.

While the softening market is a boon for corporate risk managers, it is a nightmare for the surplus lines market, which is seeing much of its business gobbled up by competition-happy admitted insurers.

Meanwhile, reinsurers and intermediaries report that reinsurance pricing is steadier than among primary insurers, though they do concede that competition is increasing for facultative business and for all types of property contracts.

Brokers, insurers assess market...	22
Risk managers report savings.....	24
Risks flee non-admitted market....	25
Reinsurers hold the line.....	26
London lowers rates to compete..	27



High court expands federal contractors' liability protection

By STACY ADLER

WASHINGTON—Last week's sweeping U.S. Supreme Court ruling that limits the liability of government contractors can be applied to non-military as well as military products, many legal experts say.

And, the defense is available in suits brought by civilian as well as military personnel.

While the decision will block new claims against seven manufacturers of Agent Orange, the decision probably won't aid defendants in asbestos personal injury suits, attorneys say.

In addition, the decision is unlikely to affect liability insurance rates for government contractors, experts say.

The high court on June 27 ruled 5-4 that private contractors that design products for the federal government cannot be held liable under state tort laws for accidents caused by defects in the product if it meets government specifications and the company warns the

Continued on page 30

Section 89 changes would ease burdens

By JERRY GEISEL

WASHINGTON—Legislation that could be passed this week by a congressional committee would substantially ease the administrative burdens of complying with complex non-discrimination rules for welfare plans.

The legislation also would make it easier for some employers to pass the Section 89 non-discrimination tests, which are used to determine if a sufficient percentage of an employer's non-highly compensated employees are covered by its welfare plans.

If an employer does not pass the tests, its highly compensated employees would be taxed on all or a portion of their benefits.

These proposed changes, welcomed by employers that have mounted an intensive lobbying campaign to convince Congress to overhaul Section 89, are included in a technical corrections bill pending before the House Ways and Means Committee. The bill is mainly intended to fix drafting glitches in the Tax Reform Act of 1986.

Section 89, which is scheduled to go into effect on Jan. 1, 1989, is a key part of the 1986 law (BI, June 6; April 18).

The technical corrections bill also provides new, more reasonable penalties for violations of the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (see story,

page 29).

Section 89 changes in the technical corrections bill include:

- Allowing employers to run non-discrimination tests for their welfare plans once a year on a date of their choice.

Currently, Section 89 says welfare plans must be in "continuous" compliance with the section's non-discrimination tests to be considered non-discriminatory.

Some experts have interpreted "continuous" to mean that employers would have to run non-discrimination tests daily to be in compliance with the law.

- Allowing employers to run the non-discrimination tests using a statistically valid random sample of employees.

- Modifying the so-called 80% alternative coverage test to make it easier for companies with multiple but similarly valued health care plans to comply with Section 89.

If an employer passes the alternative coverage test, it does not have to go through the time and expense of attempting to pass several other far more complicated Section 89 non-discrimination tests.

- Making it easier for employers to determine which part-time employees have to be included for testing purposes.

These proposed changes are being welcomed by benefit experts who have warned congressional staffers

Continued on page 29

Employers may destroy HMO industry: Analyst
Page 3

Update

Air France insured for crash

Continued from previous page
failure rather than pilot error, they say.
Air France and British Airways grounded their A-320 jets, manufactured by Airbus Industrie of Blagnac in Toulouse, France, for 24 hours following the crash.

The Air France jetliner is insured for \$45 million, London underwriters say. In addition, Air France has \$1 billion in liability coverage.

Underwriters estimate liability losses to total \$15 million, although no liability claims fund has been set up yet.

Air France's hull and liability insurance, which renews on Dec. 1, is led in France by Cie d'Assurances Maritimes Aeriennes et Terrestres S.A. and is reinsured around the world.

About 25% of the reinsurance is placed in the London market, led by Lloyd's of London underwriter Barry Coleman. The reinsurance was placed in London by Lloyd's broker Nicholson Chamberlain & Colls Ltd.

Airbus Industrie purchased its product liability insurance in France and reinsured the risk in the London market through Lloyd's of London broker Willis Faber P.L.C.

Airbus could have as much as \$1 billion in product liability insurance, the amount commonly purchased by other aircraft manufacturers. However, a Willis Faber spokesman would not give details.

Employer lie test use limited

WASHINGTON—Employers generally may not require current or prospective employees to take lie detector tests under a law signed by President Reagan last week.

Employers also may not discriminate against current or prospective workers who refuse to take polygraph tests.

However, an employer may require a worker to take a lie detector test if the employee is suspected of being involved in a theft or other situation that resulted in economic loss to the employer.

Federal, state and local governments, those under contract to the Departments of Defense and Energy as well as security services are exempt from the new law, which takes effect Dec. 27.

Keystone pension fund suit

DALLAS—Keystone Consolidated Industries Inc. expects its fiduciary liability insurance to cover a \$5.2 million settlement offer that would end a 6-year-old lawsuit filed by a labor union that charged company officials mismanaged an employee pension plan.

The settlement offer, which still is subject to court approval, stems from a suit originally filed by Rockford, Ill.-based United Auto Workers Local 449 in 1982 against Harold Simmons, who controls the Dallas-based hardware and wire manufacturer, and other company officials.

Keystone is covered by a fiduciary liability policy written by Warren, N.J.-based Federal Insurance Co., a unit of Chubb Corp., according to Ralph End, Keystone's corporate counsel. Mr. End said he did not know the policy limits but that they are "in excess of what's involved in this settlement."

The UAW suit charged that the defendants breached their fiduciary duty when they used funds from the Keystone Master Retirement Trust to invest in the stock of Amalgamated Sugar Co. of Ogden, Utah, shortly before the suit was filed. Keystone pulled out of the investment 12 to 18 months after the suit was filed, according to Mr. End.

In 1985, a federal judge in Peoria, Ill., ruled that Mr. Simmons and the other defendants breached their fiduciary duty by investing plan assets in Amalgamated stock, but he also noted that the defendants acted in good faith.

The judge also pointed out "the plan made substantially more money in that investment than it would have in any other type of investment," Mr. End said. However, Mr. End could not say how much the fund, which is managed in-house, made from the investment in Amalgamated stock.

Mr. End confirmed the settlement offer calls for a \$3.9 million payment to the retirement trust in 39 monthly installments of \$100,000 and \$1.3 million payable in 13 monthly installments of \$100,000 to reimburse the plaintiffs for attorneys fees and expenses.

Florida forming stand-by JUA

TALLAHASSEE, Fla.—Legislation calling for the formation of a stand-by joint underwriting association is awaiting Gov. Bob Martinez' signature.

The legislation automatically becomes law if Gov. Martinez does not sign it by Wednesday.

The stand-by JUA would be triggered after a certain number of applications are received by the state's market assistance plan, said Dan Sumner, assistant general counsel at the Florida Department of Insurance. "There will be no active, ongoing JUA."

The Florida Supreme Court late last month refused to review an appellate court ruling that derailed the JUA authorized by the Florida Tort Reform and Insurance Act of 1986.

Illinois requires auto insurance

SPRINGFIELD, Ill.—All Illinois automobile owners and operators will be required to purchase auto liability insurance beginning July 1, 1989, under a bill passed late last month by the Illinois Legislature.

Under the bill, which Gov. James Thompson is expected to sign, owners and drivers would be required to maintain minimum auto insurance limits of \$20,000 per person/\$40,000 aggregate for bodily injury and \$15,000 for property damage. Drivers without insurance identification cards would face a minimum \$500 fine if they cannot

Continued on page 29

Illinois regulator sues Pine Top execs, auditor

By STACY ADLER

CHICAGO—Illinois Insurance Director John E. Washburn is suing the directors and officers of insolvent Pine Top Insurance Co. and auditor Touche Ross & Co., charging they are responsible for the insurer's collapse.

The suit, which seeks an unspecified amount of damages, alleges Pine Top's insolvency "was directly and proximately caused by the negligence and mismanagement of its directors and officers."

The suit also charges Touche Ross, the Chicago auditor of Pine Top from 1973 to 1985, with breach of contract, negligence and malpractice for improperly auditing the insurer's financial statements.

In addition, the suit accuses Pine Top's former parent, Whitney Financial Group of Phoenix, Ariz., of misappropriating funds during its brief ownership of the insurer in 1985.

Pine Top, the Schaumburg, Ill.-based insurance and reinsurance subsidiary of Phoenix, Ariz.-based Greyhound Corp., was placed in liquidation in January 1987 after company officials failed to present a satisfactory rehabilitation plan to the Illinois Insurance Department (BI, Dec. 29, 1986).

The insurer, believed to be insolvent by more than \$100 million, had been placed in voluntary rehabilitation in June 1986 (BI, June 30, 1986). Pine Top wrote gross premiums of \$10.3 million in 1985, mostly on a surplus lines basis.

A Greyhound spokesman said the company would not comment on the suit. Greyhound took a \$12 million aftertax charge against its second-quarter 1986 earn-

ings to "provide for all of its anticipated losses" resulting from the rehabilitation.

Leon Gold, general counsel for Touche Ross said: "A hindsight review performed by current Pine Top attorneys has resulted in concluding that reserves should have been higher as should have been reinsurance receivables. I believe that what may be apparent years after an insolvency is not capable of detection by the application of general accepted auditing standards years before an insolvency."

"We have studied all our auditing files relating to Pine Top and are confident that we applied all GAAS procedures."

Mr. Gold also said, "The experience of Pine Top—realizing they did not have enough reserves—is typical of the entire insurance industry."

The suit, filed June 20 in Cook County Circuit Court in Chicago, contends the directors, officers and auditors of Pine Top should have realized and reported that the insurer was insolvent as early as 1981.

"Each annual statement filed by Pine Top for the years 1981 through 1984, however, materially and erroneously overstated Pine Top's policyholder surplus," the suit states.

"The primary errors in the annual statement included misstatement as to the adequacy of loss reserves and misstatement as to the collectibility of reinsurance recoverables."

In addition to the allegations of mismanagement and misrepresentation of Pine Top's financial condition, the suit also accuses the insurer's directors and officers of:

Continued on page 16

Stark unveils new proposal mandating health benefits

By DEBORAH SHALOWITZ

WASHINGTON—A new proposal to require employers to provide health insurance to workers and their dependents is under consideration on Capitol Hill.

The proposal, introduced Thursday by House Ways and Means Health subcommittee Chairman Fortney "Pete" Stark, D-Calif., also would require employers to contribute to state risk pools for the uninsured.

Employers are expected to oppose Rep. Stark's bill for many of the same reasons they blasted a similar proposal passed earlier this year by the Senate Labor and Human Resources Committee, according to Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington.

Employers have objected to the cost of the Labor Committee-passed proposal, which is estimated at \$15 billion annually, and to the possibility that a bill mandating employer-provided health insurance would become a vehicle for other federally mandated benefits (BI, Feb. 22). The committee-passed proposal, S. 1265, originally was introduced by Senate Labor Committee Chairman Edward Kennedy, D-Mass.

Rep. Stark's proposal, H.R. 4951, generally is similar to Sen. Kennedy's proposal, but staffers estimate that the Stark proposal would cost employers \$20.5 billion annually.

Both bills would require employers to provide health insurance to all employees who work at least 17.5 hours per week and their dependents.

Maternity, prenatal and well-baby coverage would

have to be offered without deductibles or coinsurance requirements, and exclusions for pre-existing conditions would be prohibited.

Also, both bills would raise the tax deduction for health insurance purchased by the self-employed to 100% from 25%.

Both bills specifically permit employers to limit the employee's choice in selecting health care providers but do not permit any cap on total health care coverage.

However, the Stark proposal differs from the Kennedy bill in some significant ways.

First, the Stark proposal would require states to establish employer-funded health insurance pools to provide coverage to high-risk uninsured individuals.

Rep. Stark attempted to attach similar risk pool proposals to two bills in the past (BI, May 30, Dec. 28, 1987).

Individual premiums for coverage in the state health insurance pool could not exceed 150% of the average cost for similar coverage. Any state pool costs not covered by premiums would be funded by employers in the state. Employers would be assessed in proportion to their payrolls.

Second, Rep. Stark's mandated benefits bill would limit an employee's out-of-pocket expenses to \$1,000 annually for individual coverage and \$1,500 annually for family coverage, including all deductibles and coinsurance payments. Hospital charges and physician services would have to be covered.

Continued on page 4

Inside

✓ This week's editorial applauds the National Assn. of Insurance Commissioners' decision to release Insurance Regulatory Information System data. **PAGE 8**

✓ Much of the financial data sought by regulators does not accurately reflect insurers' financial condition, Continental Corp. Chairman John P. Mascotte said during the Assn. of Insurance & Financial Analysts' 13th annual conference. Coverage begins on **PAGE 12**

✓ Canada is setting hazardous material exposure standards to reduce workplace illnesses and injuries, says Jerome Karter of Johnson & Higgins. **PAGE 19**

✓ Richard E. Sherman of Coopers & Lybrand explains how to select a casualty actuarial consultant. **PAGE 20**

✓ In Speaking Out, Arthur E. Parry of The Wyatt Co. gives 10 examples of how changes in policy terms and conditions can be made when necessary. **PAGE 21.**

✓ Many insurance analysts believe insurer executives

are not in touch with marketplace reality, says analyst Myron M. Picoult of Oppenheimer & Co. **PAGE 31**

Departments

Around the states.....	28
Ask a casualty actuary.....	20
Benefit beat.....	6
Bermuda briefs.....	14
Classifieds.....	26
Insurance services guide.....	30
International issues.....	19
Legal briefs.....	21
Letters.....	8
Opinions.....	8
Perspectives.....	19
Speaking out.....	21
Ticker.....	31

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Dependent health coverage shrinks

By DEBORAH SHALOWITZ

WASHINGTON—The number of Americans without health insurance has risen during the 1980s largely because of a decline in the percentage of people with coverage from employer-sponsored health care plans, says a new federal government study.

The proportion of the population covered by employer-sponsored group health care plans fell to 64.8% in 1986 from 67.4% in 1979, according to the study.

While the proportion of the population that had health insurance because of their own employment remained stable during this period at approximately 33%, the proportion of the population covered by dependent coverage declined to 31.4% in 1986 from 34.3% in 1979.

The study, "Health Insurance and the Uninsured," is based in large part on information gathered in the U.S. Census Bureau's

March 1987 Current Population Survey and was prepared by the Library of Congress' Congressional Research Service.

In 1986 an estimated 36.8 million people, or 17.5% of the total population younger than 65, did not have health insurance, the study says.

In 1979, there were approximately 28.4 million uninsured Americans younger than 65, representing 14.6% of that population.

According to the Employee Benefit Research Institute, a Washington-based benefits think tank, about 10.6 million—or 19% of all children under 18—were not covered by health insurance in 1986. And, 87% of the uninsured children were member of families in which one or both parents worked, EBRI found.

The study does not explain why a smaller percentage of people have dependent coverage, but it does point out that as employers face rising health care costs, many are re-

quiring employees to pay greater amounts toward dependent coverage.

From 1977 through 1983, two-thirds of all U.S. employers paid the full cost of health care coverage for employees and 40% of employers paid the full cost of health care coverage for dependents, the study stated.

By 1987, however, substantially fewer employers—57%—were paying the full cost of health care coverage for employees, and only about one-third of employers were paying the full cost of coverage for dependents, according to the study.

In 1980, "it was the exception" for employers to require employees to share in the premium for employer-sponsored group health care plans, noted Deborah Chollet, a senior research associate at EBRI.

But in 1986, more than half of all employers that offered group health care plans required employees to pay for at least part of the premium for themselves and about two-

thirds of all employers required employees to contribute to the cost of dependent coverage, she said.

However, Scott Ziemba, a consultant in the Woodlands, Texas, office of Hewitt Associates, said employers are seeing "very little in the way of (employees) actually dropping coverage completely."

Mr. Ziemba said he thinks most employees are just "biting the bullet" and paying a larger chunk of the cost of dependent coverage.

The CRS study also said that demographic changes have contributed to a decline in the percentage of Americans covered by employer-sponsored group health care plans.

For example, children younger than 18 made up a smaller part of the population in 1986 than in 1979, and older children may not be eligible for dependent health care coverage under their parents' policies.

Continued on page 10

Liability cover major concern for small firms

By BRIGITTE MAXEY

CHICAGO—Just more than half of Chicago-area small businesses rank liability insurance costs among their top three problems, according to a recent survey.

Despite a general softening in the commercial liability insurance market, 14.2% of the respondents said the affordability of liability insurance looms as their biggest problem, 17.9% ranked it second and 18.7% ranked it as their third biggest problem—bringing to 50.8% the total number of respondents selecting liability insurance affordability among their top three concerns.

In addition, employee benefit costs were ranked among the top three business problems by 41% of the respondents. Of those, 8.2% called it the most pressing problem, 16.2% ranked it second and 16.6% ranked it third.

Those were among the findings in the sixth annual Survey of Small Business Sentiment, a poll of 803 Chicago-area small businesses conducted by the accounting firm of Touche Ross & Co. in Chicago and *Crain's Chicago Business*, which like *Business Insurance* is published by Crain Communications Inc.

For survey purposes, small businesses were defined as companies with sales of less than \$50 million. Nearly nine out of 10 responding companies were members of the manufacturing, service, wholesale, retail and construction industries.

"Small businesses are having trouble finding affordable liability insurance. Our members believe that Congress has not dealt with the underlying problem of out-of-control court system," remarked Don Hughes, legislative manager of the Illinois State Chamber of Commerce.

One survey respondent pointed out: "The insurance industry is trying to drive me out of the business with high workers comp rates and liability insurance costs—in short the insurance industry does not want union construction companies as accounts."

Government regulation—including taxes and reporting requirements—also is a top concern of small businesses, with 50.4% of the survey respondents ranking government regulation among their top three concerns.

In addition, government regulation was the most pressing concern of 21.9% of the respondents, compared with the 14.2% that ranked affordability of liability insurance as their major worry. Another

Continued on page 17

Most public employees receive free health plan

By ALISON KITTRELL

Virtually all state and local government employees have employer-sponsored health insurance, and a majority of the employees pay nothing for the coverage, according to a recent survey by the U.S. Labor Department's Bureau of Labor Statistics.

In its first poll of public employees, the BLS surveyed 141 state governments and 852 local entities, including health, education and administrative employers.

The 993 employers had about 4.3 million full-time employees.

The survey, similar to the annual BLS surveys on private-sector employees, looked at the type and makeup of several benefits, including health, pension and a variety of others (see stories, page 61).

Some 94% of the surveyed employees were covered by group health insurance plans, according to the study, "Employee Benefits in State and Local Governments, 1987."

And, 65% of the public employees made no contribution to the cost of individual coverage, although only 29% made no contribution to family coverage, according to the survey.

Of the employees with group health coverage, 99% were covered for hospital room and board and miscellaneous hospital services; inpatient surgery; outpatient surgery; physician visits while hospitalized; and diagnostic tests.

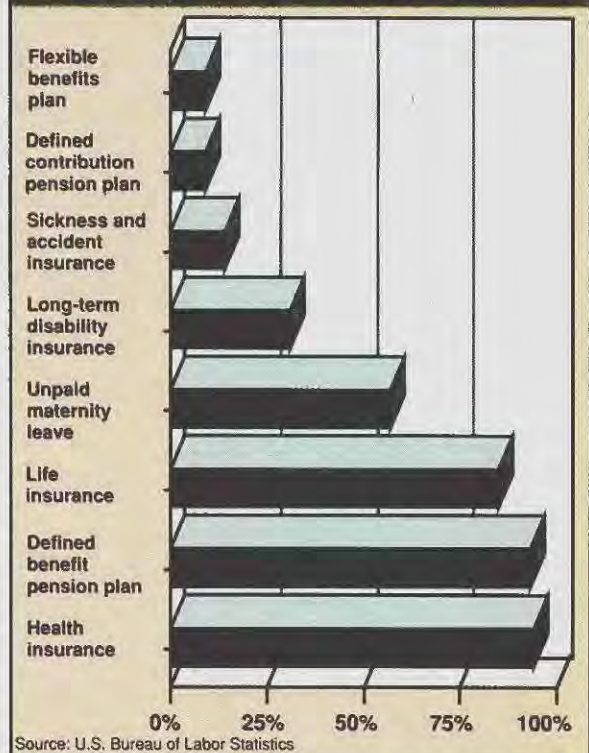
In addition, 98% had coverage for visits to a doctor's office, and 98% had coverage for mental health care, including 96% with coverage for inpatient mental health care and 94% with coverage for outpatient mental health care.

Two other widely available benefits were non-hospital prescription drugs, 93%; and private duty nursing, 97%.

Coverage was less universal in some other areas, including extended care facilities, for which 78% had coverage; home health care, 76%; dental care, 62%; and vision care, 37%.

The plans generally included deductibles and copayments, and limited coverage for some specific services, such as mental health hospitalization.

State and local government employee benefit packages (Percentage of full-time employees covered)



Most of the participants whose coverage was not subject to cost-sharing or specific limits were enrolled in health maintenance organizations: Some 24% of the total plan participants belonged to an HMO.

Some 96% of the employees were subject to set annual deductibles; however, hospitalization costs were not subject to deductibles for 27% of respondents.

Continued on page 15

Employers too hard on HMOs: Analyst

By DONNA DIBLASE

CHICAGO—Employers are unsuccessful at containing health care costs because they are not willing to restrict employees' health care utilization, charges one health care industry observer.

In addition, employers may end up destroying the health maintenance organization industry if they continue to force HMOs to compete against each other, said Kenneth S. Abramowitz, a senior research analyst with the New York-based stockbroker Sanford C. Bernstein & Co. Inc.

Mr. Bernstein made his remarks during the Group Health Assn. of America's "Group Health Institute" last week in Chicago. Some 2,000 HMO industry officials attended the meeting.

Benefit managers "give good speeches on health care cost containment, but when it comes to really making their employees suffer, they act like politicians. Instead of telling the truth about costs, they throw more benefits at their crying baby employees who want more health care but want to

Benefit managers 'give good speeches on health care cost containment, but when it comes to really making their employees suffer, they act like politicians,' says Mr. Abramowitz.

pay less for it," Mr. Abramowitz said during his keynote address, "The Future of Health Care Delivery in America."

"The question is: How long will corporate America be willing to pay for 20% inflation in health care costs? I have a theory that they'll choke on it by 1992," he said.

Successful health care cost containment "only comes about through pain and agony," Mr. Abramowitz asserted.

"Eventually, corporate America will have no choice but to move all employees into HMOs," he predicted.

However, benefit managers have a lot of "gripes" about HMOs, he observed.

Benefit managers "complain that HMOs skim off healthy risks, a perception that is aided by misinformation from health insurers." This phenomenon, known as adverse selection, occurs when an employer's better risks—or younger, healthy employees—enroll in HMOs and the poor risks—or older, more frequent utilizers of health care—remain in the employer's indemnity plan. As a result, the employer's indemnity plan costs increase.

However, Mr. Abramowitz said, adverse selection can occur in HMOs, since employees who are high utilizers of health care services can be attracted by the minimal or non-existent out-of-pocket costs required under an HMO.

Benefit managers also dislike the community-rating practices of federally qualified HMOs, he said.

Under the federal HMO Act of 1973, federally qualified HMOs must set their premiums based on the health care cost and utilization experience of their entire population.

Continued on page 17

Group unveils health care plan blueprint

By MARK A. HOFMANN

CHICAGO—Average monthly group health insurance premiums of \$110 for individual coverage and \$270 for family coverage would finance a recommended "basic benefits package," according to a group assembled by the American Medical Assn.

The Health Policy Agenda for the American People, an umbrella organization of 172 business, labor, medical and insurance groups, released the plan at the AMA's annual convention last week in Chicago. The plan reflects coverages and services its drafters think should be included in all health care plans.

They stress, however, that the document is only a blueprint for health insurance plans, not a formula for national health insurance.

Diane B. McCarthy, a former Arizona state representative who helped form the package and who serves as chairman for the HPA's implementation committee, said that the package should be considered a yardstick against which people should measure their own coverage.

The package contains three general components:

- Prevention and health promotion, consisting of prenatal

and child care; immunizations; and periodic examinations for adults to detect early signs of illness.

- Acute care, consisting of hospital room and board; inpatient and ambulatory physician services; services of other health-care personnel; up to 30 days of mental health treatment annually, including alcohol and substance abuse; up to 30 visits by nurses for short-term home care or up to 45 days of room and board and nursing services for nursing home care; and homebound hospice care for the terminally ill.

- Chronic care, consisting of home care and nursing home care. Under the home care provision, the plan covers up to 90 visits by nurses; an unspecified number of home visits by physicians, which would be subject to utilization review; medical equipment and supplies. Under the nursing home provision, the plan covers up to 90 days of room and board; nursing services and physician visits, subject to utilization review; and medical equipment and supplies when home care is not feasible.

The costs of setting up the HPA benchmark program are based on a number of assumptions. In their report to the AMA, the group emphasized that costs would vary considerably by region and specific terms of the contract between the insurer and the group.

Also, the projected costs assume that in any calendar year, the first hospital admission would be subject to a \$200 deductible. All other covered services would be subject to a \$100 deductible for individuals and a \$250 deductible for family coverages.

The plan also assumes a 20% copayment after the deductible is met. However, the plan sets out-of-pocket limits of \$1,500 per individual and \$2,500 per family.

The HPA did not suggest any maximum coverage limits. Also, the group did not specify how the cost of such plans should be shared between employers and employees.

The HPA was formed in 1982 to study health care issues and develop a framework for suggesting health-care policy. The recommended health insurance package was put together by the HPA's ad hoc committee on basic benefits, a group representing 10 associations and several independent consultants. It was chaired by former Utah Gov. Scott M. Matheson.

Synopses of the plan and a limited number of the HPA's full report to the AMA are available from The Health Policy Agenda for the American People, Director Linda J. Diamond, 535 N. Dearborn St., Chicago, Ill. 60610.



WHAT HAS REINSURANCE IN COMMON WITH GOTTFRIED W. LEIBNIZ?



Gottfried W. Leibniz – the famous philosopher and mathematical genius (1646 – 1716) lived most of his life in Hannover.

Many epoch-making ideas, like the world's first viable calculator, are connected with his name. This calculator was the first to incorporate the four basic modes of mathematics.

He also pioneered the binary system, reducing calculations to 0 and 1. His logic is an indispensable part of today's computer technology. We are dedicated to this legacy of innovation and excellence. In the spirit of Leibniz, we aspire to be in the forefront of advancing computer application, thus responding effectively and expeditiously to the increasing complexities of Reinsurance.



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Stark proposal

Continued from page 2

The Kennedy proposal would limit annual out-of-pocket expenses to \$3,000 for individual or family coverage.

Under Sen. Kennedy's plan, annual deductibles for hospital and physician services generally could not exceed \$250 per person or \$500 for family coverage. Copayments generally could not exceed 20% for covered services, up to the maximum cap of \$3,000 annually.

And, under Rep. Stark's proposal, employers could be fined \$100 per employee per day if they do not comply with the bill's mandates. Sen. Kennedy's proposal calls for undetermined civil penalties for non-compliance.

Several other differences between the two proposals include:

- The Stark proposal requires employers to extend health insurance coverage to employees and their dependents for 60 days after involuntary termination, which the Kennedy proposal does not.

- The Kennedy proposal limits the waiting period for coverage to 30 days. The Stark proposal does not contain this provision.

- Under Stark's proposal, employers must pay 80% of the premium for individual and family coverage. Kennedy's plan calls for the same general employer contribution, but requires larger payments toward low-paid workers' coverage.

Rep. Stark pointed out that critics might say the bill hinders U.S. competitiveness.

However, "all of the industrialized democracies which are our major trading partners—including Japan, Canada and West Germany—already provide a higher level of health benefits to their citizens than do we," he said.

Furthermore, "for the most part, the sectors of our economy which lag behind in providing health benefits are not those deeply involved in international trade," he added, referring to lower rates of health insurance coverage among some industries (see story, page 3).

Rep. Stark also said: "We cannot continue to allow some employers to have a free ride at the expense of everyone else. Employers who provide health insurance presently pay five times for health care: first, for their own employees; second, through the payroll tax for Medicare; third, through state and federal income tax for Medicaid; fourth, through local property taxes for the public hospitals and the medically indigent; and fifth, through hidden cross subsidies built into hospital charges in order to pay for uncompensated care."

Some larger employers, like Chrysler Corp. and Baxter Travenol Laboratories Inc., have endorsed the Kennedy plan for this very reason (BI, June 29, 1987). ■

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Club buys life plan for county police

A men's club in the southwest Chicago suburbs is paying for \$1 million in life insurance coverage for local sheriff's deputies.

The deaths of a sheriff's deputy and an auxiliary officer in a 1983 shooting spree that left five people dead prompted the Homer Men for Responsible Government, located in an unincorporated area protected by Will County sheriff's police, to buy more life insurance for the deputies.

The maximum death benefit paid to survivors of officers killed in the line of duty is \$25,000.

All Will County employees are covered under a \$10,000 term life and accidental death and dismemberment plan underwritten by The Hartford Insurance Co. Under the program, employees contribute 30%, or \$1.04 per month, of the

Benefit beat

premium, while the county pays 70%, or \$2.42 per month.

An additional \$10,000 in coverage is available for an additional premium, which also is split 30%/70% by the employee and county.

"The deputies had very little insurance coverage and the club felt it appropriate to insure the men that risk their lives to protect this community everyday," said James Clarage, the men's club president.

For a \$3,000 premium per year, the new policy provides a maximum coverage of \$200,000 per officer, up to a \$1 million annual aggregate, to survivors of officers killed in the line of duty.

Placing this particular type of

insurance was not an easy task. "We shopped for insurance carriers for one year before finding one that was willing to undertake the responsibility," said Mr. Clarage.

Samuel Maranto, owner of S.A. Maverick Annuity & Insurance Brokerage in Lockport, Ill., said that he contacted at least 10 insurers before finding one willing to underwrite the risk.

The policy, which took effect in March, is written by Lloyd's of London underwriters, said a spokeswoman in the sheriff's office.

"One major problem was that the men's club wanted to insure each individual up to \$1 million. This

was too much for one person unless this person was worth \$1 million on paper," Mr. Maranto said.

The Stand Alone Accidental Death Plan stipulates that an officer be a full-time employee and be on duty at the time of death.

"Some life insurance coverages are in effect 24 hours; under this coverage if the accidental death occurs while the officer is off duty, the beneficiaries are not awarded," Mr. Maranto said.

The policy is unusual because of the on-duty clause and the lack of a dismemberment benefit, according to Mr. Maranto.

"We had a certain amount of money to work with to get the best coverage at the given premium rate," Mr. Maranto said.

The men's club formally presented the policy to the sheriff last

month and plans to make the premium payment an annual gift.

The 36-square-mile township currently has one sergeant and seven deputies protecting its 13,441 residents.

The 1983 deaths of the two Homer deputies marked the second and third officers to be killed in Homer Township in 100 years.

—By Brigitte Maxey

Alaska state benefits

The state of Alaska opted to renew its employee health benefit plan with Aetna Life & Casualty Co. for seven months after state legislators strongly criticized a self-insurance proposal.

"It was looking better and better as we moved toward self-insurance, and then it just went right down the tubes," he said. The greatest opposition came from the judicial and legislative officials, who have a large number of non-union workers, he said. "The unions weren't too happy, either."

State officials considered self-insuring after Hartford, Conn.-based Aetna, the only bidder on the new contract, said it would increase rates 40% at the July 1 renewal.

The renewed plan, effective July 1 through Feb. 1, 1989, increased health insurance premiums for the state's 12,000 active employees to an average of \$435 a month per employee from \$307—or an average of \$63 million in fiscal 1989 from \$45 million in the fiscal year ended June 30, Mr. Coughlin said.

Aside from the 40% premium hike, terms of the Aetna plan, which provides varying benefits under contracts with each of the state's nine unions, were unchanged at renewal.

For example, the largest benefit plan, for the General Government Unit of the Alaska Public Employees Assn., affects about 7,500 employees and covers major medical, dental, vision and hearing insurance. Single coverage requires a 10% employee copayment up to a \$1,950 annual maximum and a \$100 deductible. Copayments and out-of-pocket maximums are the same for family coverage, but the deductible is \$300 per individual. The state pays the full premium.

The self-insured proposal would have cut benefits for an estimated 3,700 state employees, including those in two unions—the Supervisory Unit of the Alaska Public Employees and the Confidential Employees Assn.—as well as all non-union government appointees.

Employees in those unions would have been required to pay 25% of their first \$10,000 in medical bills each year, because their labor contracts limited the state's monthly contribution to the benefit plan to \$307 per employee.

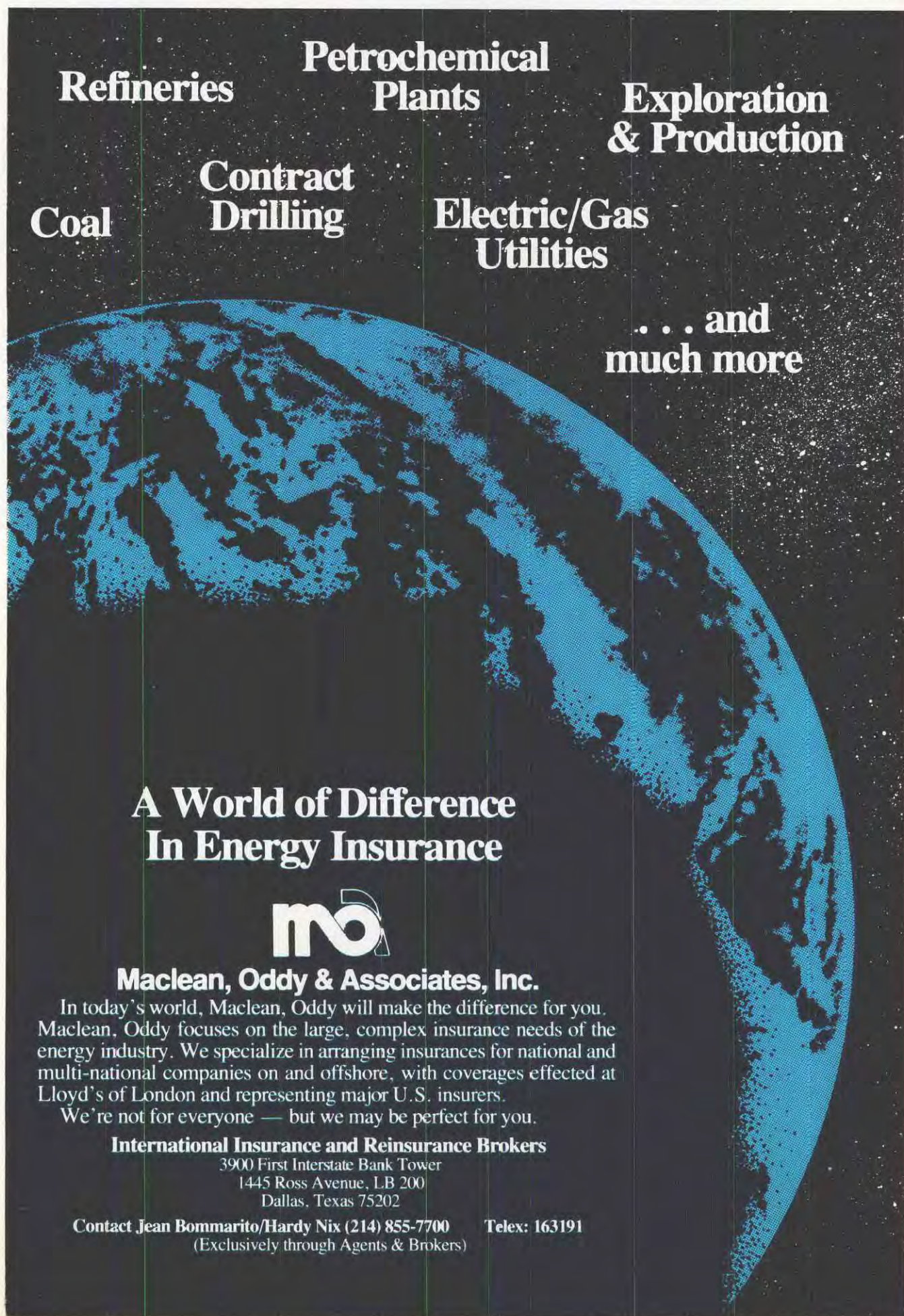
However, those employees would have had the option of retaining the 10% copayments if they made a contribution to the plan.

But, "in the spirit of equity" the governor extended the units' coverage for the next seven months without charge, Mr. Coughlin said.

While the Aetna plan is the core benefit plan, the state also offers a supplemental flexible benefits plan completely paid by employees that includes additional health insurance and an annuity plan.

The state is considering changing the core plan to the flex plan and making some contribution to that plan, Mr. Coughlin said. Legislative approval would be required to make the change, he added.

—By Jacqueline LaSota



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Opinions

Put IRIS data to good use

INSURANCE BUYERS, agents and brokers have won public access to important financial information about the more than 5,000 property/casualty and life/health insurers operating in the United States.

We are glad the National Assn. of Insurance Commissioners finally agreed last month to make public the results of its Insurance Regulatory Information System tests (BI, June 27).

The IRIS tests are applied to an insurer's financial results to produce ratios. These ratios are compared with the norms for the overall property/casualty insurance industry or life/health insurance industry. Results outside the norm are not a definitive statement that an insurer is going down the tubes, but unusual ratios do raise red flags calling for closer examination of the insurer.

In releasing the IRIS results, the NAIC also will release the industry averages and basic information on how the ratios are calculated.

The NAIC will not release, however, any information on what range of deviation from the average regulators will use to determine whether to target an insurer for further investigation.

While the NAIC's definition of acceptable devia-

tions from the norm would be helpful, it won't take long for agents, brokers and insurance buyers to come up with their own ranges and to share this basis for analysis.

Therefore, we do not believe that NAIC analytical guidance is necessary for agents, brokers and buyers to use the data to better evaluate an insurer's financial stability.

Although the rash of property/casualty insurance company insolvencies has slowed, there are certainly financially shaky property/casualty insurers still in business, as well as life/health insurers with a less-than-certain future.

Agents, brokers and insurance buyers should carefully analyze the IRIS ratios of the companies they do business with when the ratios for 1987 financial statements are released later this year.

Many people have lobbied the NAIC for years to publish the IRIS ratios, but if one person can be singled out for forcing this important regulatory change it is Joseph Belth, a professor at Indiana University who convinced a District of Columbia Superior Court judge to order the release of some NAIC statistical and analytical data.

Thanks, Professor Belth.

Letters

Cost sharing is key to Allied-Signal plan

To the editor: Joseph Duva, corporate director of employee benefits at Allied-Signal Inc., appears to believe that the reason Allied-Signal may get employee medical benefit costs under control has more to do with "bargaining power" with providers or insurers (in this case, CIGNA Corp.) than the apparent fact that it will be limiting its employees' options as to choice of providers if those employees do not choose to pay substantial amounts in deductibles and coinsurance (BI, June 6).

Based upon the background information provided in that article and in the original story (BI, Feb. 22), it seems that Allied-Signal is introducing rather significant cost sharing to the employees from what it had in place before. My experience in health benefits cost analysis suggests that therein lies the largest potential for making the program work, not because Allied-Signal shifted the risk to CIGNA. I submit that what appears to be a tremendous disincentive to the employees to receive care outside the CIGNA provider network is the real hero (or martyr) here. Obtaining savings in a medical benefits program is not all that difficult if the employees carry the brunt of the burden (a philosophy with which I at least partially agree if costs are going to be brought under control).

By effectively "forcing" the employee into the managed care system and then using the public relations value of a major employer account to negotiate an insurer into providing guarantees, Allied-Signal should successfully control the cost of its medical benefit plan. I wonder how many other employers with union contracts or a tradition of little or no employee cost sharing could make such a change without extreme difficulty?

Allied-Signal is to be congratulated in dealing directly with the real issue in cost containment, that of cost sharing by the

employees, either in cash or in lost freedom of choice and utilization. But we in the industry should recognize that therein lies the secret to what might make this particular program work and not in the many other highly publicized features of this supposedly innovative plan.

Hobson D. Carroll
Employee Benefit Specialists Inc.
Minneapolis

Directory listings corrected, amended

To the editor: The premium volume and revenue figures for Morency, Weible & Sapa Inc. were inadvertently reversed on the questionnaire we returned (BI, June 27). In 1987 our volume was \$25 million and our gross revenues were \$3.9 million.

G.A. Morency Jr.
Morency, Weible & Sapa Inc.
Hinsdale, Ill.

To the editor: Amalgamated Programs Corp.'s profile as submitted was incorrect (BI, June 27).

Light & Rubin Inc. and Amalgamated Programs merged in October 1987. There was no acquisition.

Also, two of the officers of Light & Rubin were not listed: Herbert Rubin, chairman, and Sheldon B. Siskin, president. Both also are officers of Amalgamated Programs.

Jay Levy
Secretary/Treasurer
Amalgamated Programs Corp.
New York

To the editor: When we provided information for Buck Consultants Inc. for your directory of employee benefits information system vendors, we omitted Houston and Los Angeles from our list of offices (BI, May 30).

Edward Gadowski
Senior Writer
Marketing Department
Buck Consultants Inc.
Harmon Meadow, N.J.

Many possible answers for A.R.M. Exercises

To the editor: As one who has taken and passed 15 Chartered Property & Casualty Underwriter and Insurance Institute of America examinations, I found Nikola Drobac's diatribe (BI, June 20) against an A.R.M. Exercises question (BI,

May 23) quite amusing.

It seems he has missed the purpose of these A.R.M. Exercises. I also wonder whether he knows what is in the ARM 54 course.

As noted in each introduction to these exercises, the answers given are "possible" answers. The institute admonishes: "Give reasons (for your answers). Since many examination questions have more than one acceptable solution, your grade may depend on the soundness of your reasoning."

In fact, I hope George L. Head will grade Mr. Drobac's alternate answer (sans the sour grapes) and let us know whether his reasoning would have earned a passing grade!

As to multiple-choice vs. essay questions, let me paraphrase Darwin ("Heaven forbid us from Lamarck's nonsense"): May the institute forbid us from multiple-choice tomfoolery!

S.J. Davidson
Hallmark Insurance Associates Inc.
Fresno, Calif.

Product liability study overlooks some suits

To the editor: I would like to comment on the article, "GAO Disputes Product Liability Crisis," published in your March 14 edition.

First of all, not all suits are filed in a federal court and the notion that there is no crisis is absolutely not true. Also, the General Accounting Office does not say how many insurance companies have been declared bankrupt, leaving many companies exposed and going bare.

In our own case, after our insurance company, Union Indemnity Insurance Co. of New York, went broke, we received quotes of a \$300,000 premium and \$100,000 deductible for \$500,000 in primary coverage—plus we pay for all attorneys' fees. Our second quote for the same coverage was \$200,000 premium and \$50,000 deductible plus attorneys' fees.

Hundreds of small companies do not expose their plight for fear of competition learning of their problems in defending themselves. Hundreds of suits are brought about on products made 20, 30 and 50 years ago. Plaintiffs' attorneys use current technology on products built years ago when the Occupational Safety and Health Administration and many other governing agencies did not exist. In other words, we should have known what

Continued on page 10

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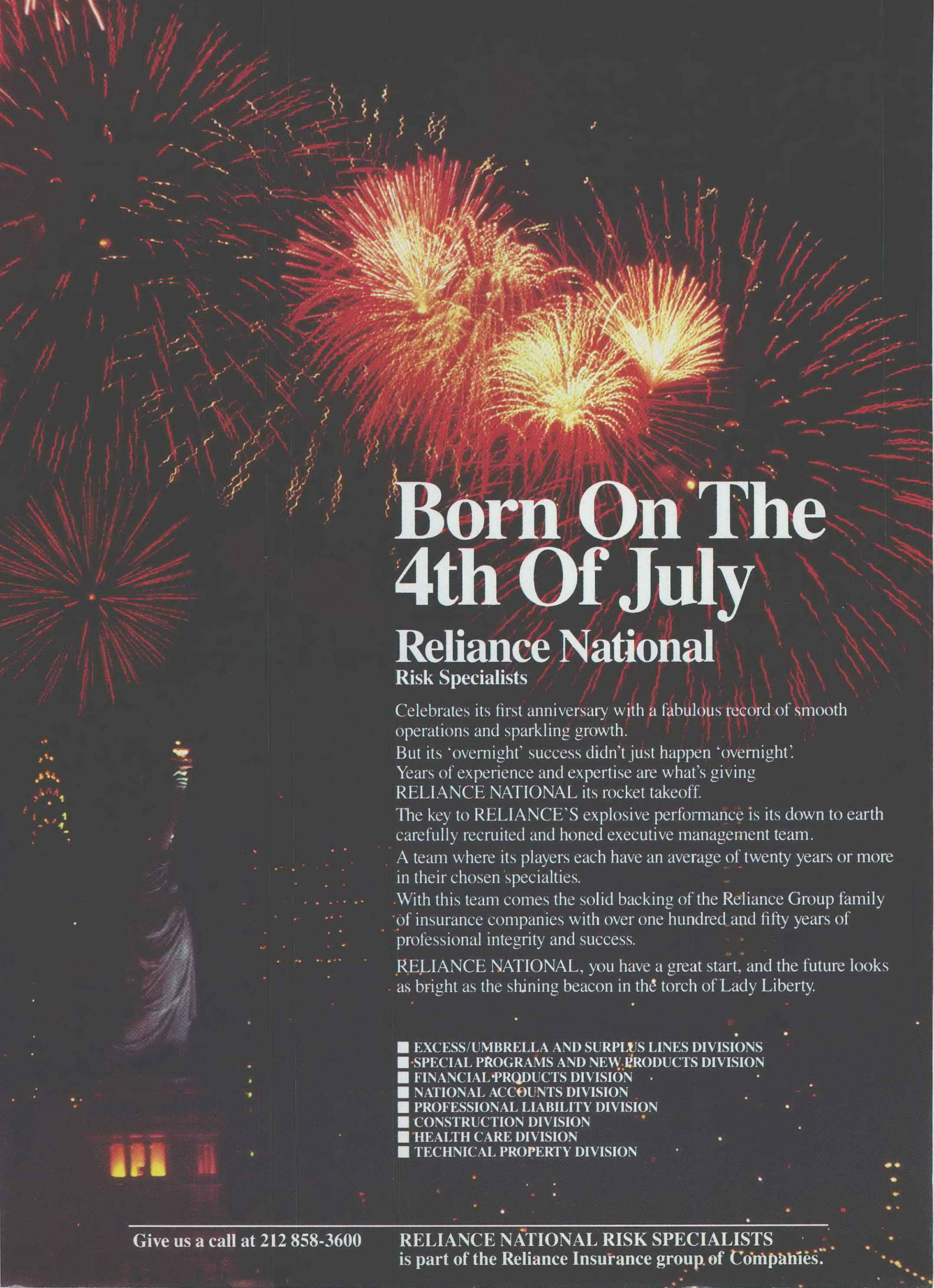
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Uninsured Americans

Continued from page 3

Typically, employer-sponsored group health care plans offer coverage for dependents up to either 18 years old or 25 years old.

Changes in the workplace also contribute to the decline in the proportion of the population covered by employer-sponsored group health care plans, the study said.

According to the CRS study, the shift from a manufacturing economy to more of a service economy has contributed in part to the increase in the number of uninsured people because not as many service providers offer health care plans compared with manufacturers.

High proportions of workers not obtaining health care coverage from their employers were reported in industries like agriculture, entertainment services, personal services, retail and construction.

However, a great majority of employees in industries such as manufacturing, mining, professional services and financial services were covered by employer provided health care plans (see chart), according to the survey.

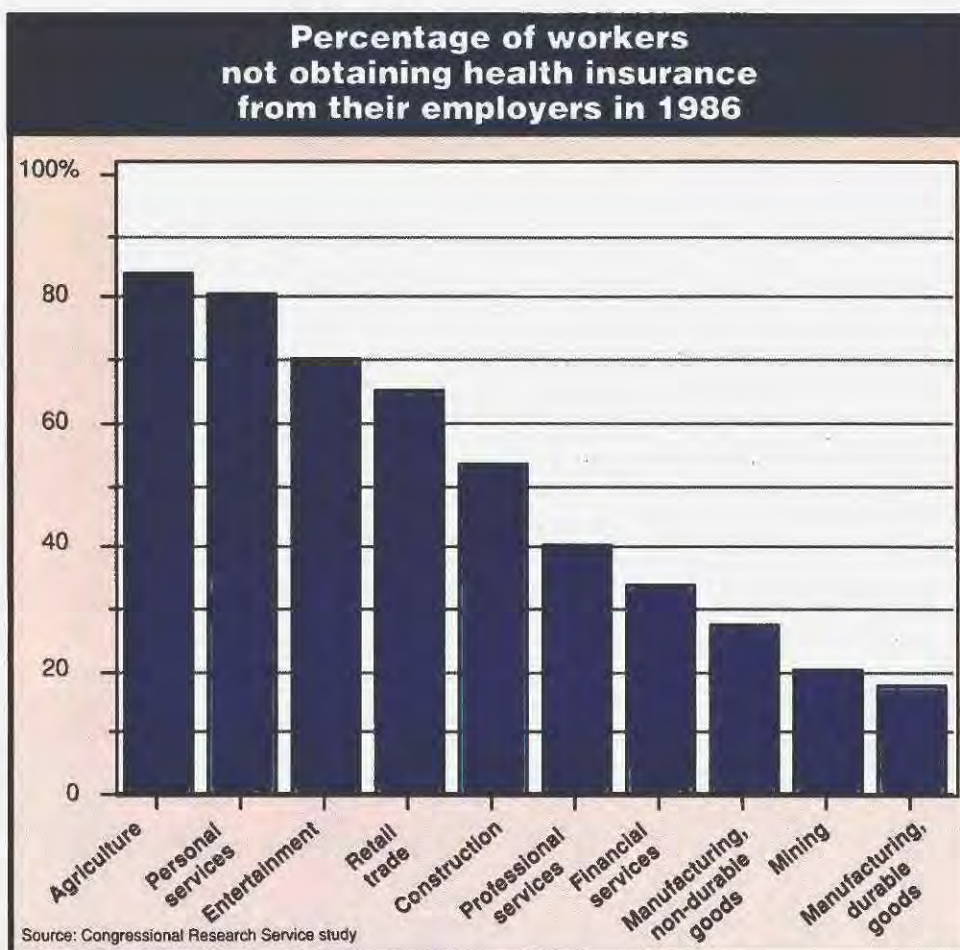
The CRS study also noted that employer-sponsored health insurance is much more prevalent among large companies than among small firms.

Drawing on data compiled by EBRI, the CRS study noted that in 1986, 62.7% of workers in businesses with fewer than 25 employees did not obtain health insurance from their employers.

Workers who did not receive employer-sponsored health care insurance also included:

- 34% of workers in firms with 25 to 99 employees.
- 25.2% of workers in firms with 100 to 499 employees.
- 20.5% in firms with 500 to 999 employees.
- 14.6% in firms with 1,000 or more employees.

Mr. Ziemba said the growth of employment in small and medium-sized firms during the 1980s could be a factor contributing



to the decline in employer-sponsored health care plans.

Some people who do not obtain health insurance either from their employers or by buying private health insurance policies do receive coverage from government programs like Medicare and Medicaid, the study pointed out.

Medicare provides health insurance for virtually all of the elderly.

However, health insurance coverage from Medicaid, which are state-run programs, is

contingent upon the applicant meeting certain eligibility requirements.

Eligibility for Medicaid is generally restricted to those meeting a test of financial need and having a certain physical status—such as being disabled—or being a member of a single-parent family.

The CRS study was prepared for the House Education and Labor and Energy and Commerce committees and is not available to the public.

Letters

Continued from page 8

we know today, 40 and 50 years ago, when offering products to the public.

We are not a fly-by-night company. In fact, we are 67 years old and have contributed to our community with steady work and taxes and have supported education and many other worthy community products. But, in the meantime, our Congress and representatives have ignored our pleas and have done nothing but lent a deaf ear to the real product liability problems. If Congress would only consider one item, and that is a statute of repose of 15 or 20 years, this would cut off many frivolous suits involving old products that were made in good faith according to the state of the art at the time of manufacture.

Vincent G. Biro
Vp

The Biro Manufacturing Co.
Marblehead, Ohio

Broker affiliation act a boon or burden?

To the editor: The purpose of the National Assn. of Insurance Commissioners' Broker-Controlled Company Act, as communicated, is to protect the interests of policyholders.

We find three things important to a policyholder in the placement of its risks with an insurance company:

- Payment by the insurer of all claims that should be covered under the policy.
- Coverage that is not only available but also right for the risk(s).
- Cost that is affordable.

If this act is addressing these issues for the benefit of current and future policyholders, it will be a good thing. However, if it works to the ultimate disadvantage of the insured consumer, like so many believe the divestiture of AT&T did, it will be a bad thing.

Barbara Garro

Director-Risk Management Service
UK&W Technical Resources Ltd.
Albany, N.Y.

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Insurance analysts conference

Financial data, reality not the same: Mascotte

By JUDY GREENWALD

SOUTHAMPTON, Bermuda—Insurers are now "engaged in the longest-running production of the Mad Hatter's tea party ever," with several federal, state and financial regulatory bodies seeking financial data that does not accurately reflect the industry's financial condition, says an insurance company executive.

Guests at the tea party want to be entertained "each according to his or her quirks and foibles. Like any good host, my industry's Mad Hatter counterparts and I try to play our roles," said John P. Mascotte, chairman and chief executive officer of Continental Corp., alluding to Lewis Carroll's "Alice's Adventures in Wonderland."

Those guests include the Internal Revenue Service, state regulators, analysts, the Financial Accounting Standards Board and the Securities and Exchange Commission, said Mr. Mascotte in a sometimes-scathing speech at the 13th annual insurance conference sponsored by the Assn. of Insurance & Financial Analysts in Bermuda last month.

The IRS, for instance, wants the industry to show its income to collect taxes but "isn't very interested in financial accuracy or insights," Mr. Mascotte said. For example, under the Tax Reform Act of 1986, insurers must pay income tax "whether you actually have income or not."

The SEC and FASB, meanwhile, want conformity with generally accepted accounting principles but call for "assertions of unproven and unprovable concepts," he said.

For instance, insurers must release financial reports that reflect cost rather than market value of some assets.

"When you think about this legerdemain for just a moment, you will infer, as I do, that CPAs have a passion for being precisely wrong rather than approximately right," he said.

Regulators demand a demonstration of "unassailable financial strength." But they do this by telling the industry to "pretend some assets don't exist when they really do."

For instance, he said, Continental has produced about \$400 million in salvage and subrogation recoveries over the past 10 years, "But the state regulators insist that we pretend these assets don't exist until they're converted into cash."

Regulatory accounting also calls for the industry to pretend some assets do exist when they really do not. For instance, he said, because bonds are carried at book rather than market value, at the end of 1981 Continental's bonds were reported to be about \$800 million more than they were actually worth.

"One of the big reasons why this industry suffered so badly in the early 1980s is that it believed in these screwy numbers it's required to report," Mr. Mascotte said.

The analysts, for their part, demand to be shown everything, and "then rely on the SEC and GAAP notions that because you can quantify, you can compare. Shoes aren't ships, aren't sealing wax, but you and your PC's are, by God, going to compare them anyway," said Mr. Mascotte in a reference to Lewis Carroll's "Through the Looking Glass."

Continental was required to post earnings per share of \$1.11 for the first quarter, said Mr. Mascotte, although he said he would have been more comfortable if he could have said real earnings were probably somewhere between 50 cents and \$2 and it is simply too early to quantify it any more precisely than that. But neither analysts, nor the accounting and reporting conventions, would permit that.

This forces the industry into two modes, he said. The first is a "variation of the shell game. What looks like a reasonable number today is the number we're going to show you."

Secondly, he said, "it tempts us to become members of a crazy cult, the cult of published numbers believers." After spending \$12 million in 1987 to build numbers to present to regulators, the SEC and the IRS, "we succumb to the temptation to believe that because the numbers exist they must mean something and, worse, that if they mean something, then we ought to use them to make decisions on how we

operate the company."

Analysts say the industry is overcapitalized, yet regulators clamor for more capital to shore up what they consider inadequately-balanced sheets based on their accounting rules, Mr. Mascotte said.

While the SEC sympathizes with the industry's problems in explaining its tax liabilities under new GAAP rules it does not do anything about it.

"The process has made me frustrated and more than a little cynical," especially about analysts, Mr. Mascotte said. "You give the impression that you can run through the pasture without stepping in all the cow pies that are part and parcel of this industry's financial reporting systems," he said. "Maybe it's time to slow down and check your shoes."

The only three things that matter in the insurance business are cash flow, real economic value and time, according to Mr. Mascotte.

Discussing time, he suggested developing a financial reporting system that more clearly distinguishes between the current impact of past business and the present value of future profits of business being written today.

He also suggested to the analysts in the audience that they stop focusing on making sense of current calendar year numbers and work harder to decide "which managements are doing the things that will pay off over the next five years."

Analysts also should forecast cash flows and market-adjusted book values for each of the companies they follow, he said.

In addition, they should focus on the "less tangible but more important issues," including whether business is being written at the right time, products are being priced correctly, and insurers are reserving properly.

Mr. Mascotte said beginning with the second quarter, Continental will begin publishing cash flows "so you can determine whether or not we're taking in more than we're spending or vice-versa."

Executives differ over severity of cycle

By JUDY GREENWALD

SOUTHAMPTON, Bermuda—The next turn in the property/casualty insurance cycle "clearly will not be a repeat of the last" in terms of severity, predicts William O. Bailey, vice chairman of Aetna Life & Casualty Co.

But that isn't necessarily clear at all, disagreed Jack Byrne, chair-

man and chief executive officer of Fireman's Fund Corp., who said that while he and Mr. Bailey are looking at the same facts, "we come out quite differently."

Both men spoke at a session at the 13th annual Assn. of Insurance & Financial Analysts' insurance conference last month in Bermuda.

Although disagreeing, the two executives played off one another

as in a well-oiled routine punctuated by mild ribbing that was later dubbed the "Byrne and Bailey Show" by attendees.

In addition, Mr. Byrne expanded on his remarks when he spoke alone at a later conference on insurer insolvencies in New York that was co-sponsored by Standard & Poor's Corp., the Risk & Insurance Management Society Inc. and the National Assn. of Insurance Brokers.

"The last cycle was clearly the deepest and the sharpest in the history of the business," said Mr. Bailey.

But one reason the next downturn in the cycle will not be as damaging is that the business today is not the same as it was five to six years ago, he said. He cited as an example Liberty Mutual Insurance Co.'s decision to stop writing workers compensation coverage in Maine after losing \$130 million since 1981 (BI, Sept. 28, 1987).

"Companies are, in fact, leaving both states and markets to a degree that I've not experienced in my long time in the business," said Mr. Bailey, who joined Aetna in 1954.

Another factor that will moderate the cycle's severity is that there has been little, if any, increase in reinsurance capacity, both in London and domestically.

Relatively low interest rates—unlikely to get much higher—also discourage a return to cash-flow underwriting, Mr. Bailey said.

The Tax Reform Act of 1986 also will slow competition, he observed.

"I think most insurance companies are rapidly understanding the implications of the tax act" and the amount of capital it will cost them, said Mr. Bailey.

Mr. Byrne, observing at one point that Mr. Bailey obviously is an optimist, said: "I don't know what the shape of the cycle is going to be." However, "I'm really quite depressed over what I see over the next four to five years," he said.

For the past 16 years, the property/casualty business has generated a 9.5% return on investments. Referring to earlier comments by Mr. Bailey that 15% is a desirable return, Mr. Byrne

questioned how likely it is for insurers to obtain such a high return in the future.

There is too much capital "sloshing around" the industry that is generating "totally inadequate returns," he said.

And, while "we think" it may be true some of the millstones of the past such as asbestosis "are no longer hanging around our necks," he asked: "What are the millstones that God has waiting for us?"

"Tort reform is, in fact, having a positive effect," said Mr. Bailey.

Although tort reform still has a long way to go, the accomplishments thus far mean "we're not as likely to get hit by the sins of the past this time around as we were the last," he added.

Mr. Bailey also indicated that he was not particularly concerned about the impact of the antitrust litigation filed by 19 state attorneys general against the insurance industry (BI, June 20; March 28). These suits, he said, have three clear objectives:

- To get the financial and political support of bar associations.

- To repeal the McCarran-Ferguson Act, which gives the insurance industry limited exemption from federal antitrust laws. Mr. Bailey added that he "could care less" if it is repealed.

- To "find another scapegoat" in yet another manifestation of the "deep pocket syndrome."

"We're ready to go on trial on this case yesterday," Mr. Bailey said, adding he wishes the situation was like the Korean War in that the insurance industry could "declare victory and walk away."

In referring to Fireman's Fund being named as a defendant in only the state antitrust action filed in Texas, Mr. Bailey quipped that obviously the state action was frivolous.

Mr. Byrne's retort: All the antitrust suits are frivolous.

Mr. Bailey also cited problems facing the industry, including inadequate return on capital. The industry did not make much money at the height of the hard market, yet prices are clearly softening today, he said.

Another problem, he said, is that it is easier for insurers "to give a little ground" and lower prices in a softening market than it is for them to either stand fast "or start fighting."

But, despite anecdotal evidence to the contrary, he added, "this does not mean to me prices are going to plummet down."

Analysts should stop focusing on the industry's problems and instead should examine how well these problems are being handled, said Mr. Bailey, adding it is a "given" that prices will increase in a hard market and decline in a soft one.

At the New York conference, Mr. Byrne reiterated his opinion that there is too much illusory capital in the insurance business.

In 1980, he said, the market softened because the industry thought it had \$4 billion to \$5 billion more in surplus than it needed. But in 1984, insurers were told they did not have enough surplus to conduct their business.

The industry has too much reported capital, he said, "and it did not come from the insurance business." Instead, it came from other factors, including the raising of new capital, which he called "dumb."

"Was the reported capital real?" he asked rhetorically.

A more realistic view of the balance sheet can be seen, said Mr. Byrne, if the industry were to get its reserves "right" and list assets like bonds at market, rather than book, value.

The hard market came about because the book value of bonds far exceeded their actual market value, which gave insurers an inflated conception of their net worth, Mr. Byrne said, allowing insurers to cut rates too much. Then, insurers had to increase loss reserves, depleting surplus, he explained.

"All this is accounting," said Mr. Byrne. "We should run our business around the real net worth we have, and not some phony net worth," he said, calling for insurers to "maintain a disciplined balance sheet."

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European insurers suited to invade U.S. successfully

By JUDY GREENWALD

SOUTHAMPTON, Bermuda—The chances of European insurers successfully "invading" the United States through acquisitions are greater than the likelihood of a reverse raid, says John R. Cox, chairman and chief executive officer of A.C.E. Insurance Co. Ltd.

"That's because Europeans are 'more able to adapt to the U.S. than Americans are to Europe,'" explained Mr. Cox during a session on international insurance at the 13th annual Assn. of Insurance & Financial Analysts' insurance conference held last month in Bermuda.

Americans who are going abroad to do business, explained Mr. Cox, have a tendency to be ineffective "because what they attempt to do is to export America, and it doesn't work."

And, Americans are less likely than Europeans to bring in capable management, he said.

"Americans also have a great deal of pressure" to show short-term gains because they must report their financial results every 90 days, said Mr. Cox.

Americans are less likely than Europeans to bring in capable management, says Mr. Cox.



Mr. Cox

Because European companies tend to report their results less frequently, they are more willing to invest substantially in a new operation and wait to see it pays off, he commented.

While Mr. Cox said he was not suggesting financial results be released "when you get around to it," he believes there should be more emphasis on the balance sheet and "a lot less" on the profit and loss statement "if you're going to properly run a company."

The Japanese, he said, at this point are interested in the United States essentially to help service Japanese clients with U.S. interests. But, in the "battle" for the global market, it is basically the United States vs. Europe, said Mr. Cox, adding that he is afraid the Americans will be "running a very distinct second."

"I think it's going to be very hard to position ourselves there (in Europe)," agreed Leandro S. Galban Jr., senior vp at DLJ Securities Inc. in New York, speaking at a later session during the conference.

On the other hand, Europeans will make more U.S. acquisitions, said Mr. Galban.

"They will continue to buy U.S. companies, and I think they will" prefer making those acquisitions on a friendly basis, he said.

Unfriendly acquisitions are unlikely, he said, "because they need to rely on managements here to be successful."

While the acquisition trend will continue, it will not necessarily accelerate, said Mr. Galban, because Europeans have a "sense of urgency" about taking advantage of 1992, when insurance trade barriers among Common Market countries will drop (BI, May 16).

"I think they have a sense they can have us (the United States) any

time they want, which may not be true," said Mr. Galban.

International expansion after the elimination of European trade barriers in 1992 will be accomplished through acquisitions, some joint ventures, alliances involving cross holdings and merger activity, predicted J.F.M. Peters, chairman of the executive board of Dutch in-

surer Aegon N.V.

But Mr. Peters doesn't believe North American companies will actively participate in the European market after 1992. "It will be mostly a European game," he said.

The party has started already, Mr. Peters commented, "and I can only tell you my company is not a wallflower."

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1984 — 97.0
1985 — 99.7
1986 — 84.1
1987 — 84.2

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COMBINED RATIO 20.8
(1983-1987)

ASSETS

(000 Omitted)

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1985 — \$105,993
1986 — \$159,568
1987 — \$168,859

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Benefit manager criticizes health insurers

By JUDY GREENWALD

SOUTHAMPTON, Bermuda—Major employers are fueling innovation in the health care industry because insurers have failed to respond to client needs, charges an employee benefits manager.

Concern about health care cost management "has been an ongoing dialogue for the past six to seven years" and has become the "No. 1 issue" in health care, said Kenneth J. Morrissey, manager of corporate employee benefits at Chicago-based FMC Corp., during a panel discussion at the 13th annual insurance conference of the Assn. of Insurance & Financial Analysts last month.

At FMC, he said, 70% of the 25,000 active employees are provided health care through managed care arrangements, which included health maintenance organizations and preferred provider networks.

The slightly more than 30% of its employees who participate in an HMO arrangement includes 50% of those who have access to such a program, he said.

FMC's overall strategy is "to manage health care costs while maintaining quality benefit programs," Mr. Morrissey said.

FMC is following a policy of seeking out multiple vendors because of "the inability of any one vendor to be responsive" to the needs of all of FMC's 35,000 employees and retirees, he noted.

Mr. Morrissey pointed out that the chemicals and manufacturing firm's total health care costs increased slightly more than 7% last year.

Rates for traditional indemnity plans jumped an average of 15% to 20% in 1987, while HMO rates increased 2% to 7% (*BI*, Dec. 28, 1987).

Mr. Morrissey said employees are becoming increasingly dissatisfied with major insurers because employees are tired of filling out insurance forms, having to call someone before being admitted to a hospital and paying co-payments. "As a

result, that part of the market has been lost forever," he commented.

Mr. Morrissey said he sees "an increased focus on the quality side of health care delivery" in the future.

Discussing the increasing cost of psychiatric care, Mr. Morrissey said: "I think what we are trying to figure out here" is getting the most value from expenditures. Eventually, FMC will reimburse employees for psychiatric costs only when employees see an FMC network provider, Mr. Morrissey predicted.

He also predicted a growing number of specialized care centers for performing organ transplants. "It's a tremendous way to manage your health care both from the quantitative and qualitative perspective," he said.

He also noted that the Financial Accounting Standards Board is preparing regulations that would require employers to recognize the expected cost of retiree health costs during employees' active careers, rather than expensing them as a cost when a claim comes in after retirement.

This would result in "substantial changes" in the health care provided to retirees, Mr. Morrissey predicted, with employers provided less retiree health coverage or maybe none at all.

Mr. Morrissey said he sees a continuation of a fragmented health care system in the United States.

However, "I don't think we can continue to have health care inflation three or more times the nation's inflation rate," he said. "I think there has to be a limit in terms of what this nation will pay."

Also during the panel discussion, Lawrence P. Leisure, a principal and national practice leader for group benefits for Towers, Perrin, Forster & Crosby Inc. in New York, said: "I think carriers are going to have to get their act together" in how they provide health care. He added that they "haven't necessarily demonstrated great aptitude" in managing HMOs to date. Many assume a "we are smarter than anyone else" attitude, he said.

Mr. Leisure noted that one of his concerns is that insurers tend to centralize their HMO operations, even though they must be managed at the local level to be effective.

In addition, because of consolidations, some good HMO people have left their firms, he said.

"I think there's going to be some enormous shifts in market share" among insurers, Mr. Leisure said.

Chief executive officers and chief financial officers, who are now more involved in their firms' health care, do not have the same loyalties to health care insurers that benefit and human resource managers used to have, he said. "I think there are going to be more and more major carrier changes."

In addition, many HMO operations are "severely undercapitalized," and their role in the market "could be severely diminished" unless they agree to participate in joint ventures with insurers.

"I think we'll have mandated health care in the next five years," Mr. Leisure said, referring to the proposal that employers be required to provide health insurance to employees.

But beyond mandated health care benefits, Pamela Bailey, director of the Washington-based National Committee for Quality Health Care, said she believes national health insurance is "unlikely in the near term."

"I think that's just a measure of the current frustration" with rising costs, she said.

The "most basic" issue for the future is how the federal government can continue to work in partnership with the private sector to find a system that delivers quality health care to those in need but is still consistent with providing individual freedom of choice at a reasonable cost, she said.

"I think a lot of the answers are still out there to be discussed," Ms. Bailey said.

Herbert E. Goodfriend, senior vp at Prudential/Bache Securities Inc. of New York, and Jeffrey Cone, vp and senior security analyst at Goldman, Sachs & Co. of New York, moderated the panel discussion.

Grayston to head Hall's Bermuda unit

By ROGER SCOTTON

HAMILTON, Bermuda—Stuart Grayston, president of Bermuda-based Skandia International Risk Management Ltd., is joining Frank B. Hall (Bermuda) Ltd. as president and chief executive officer.

Mr. Grayston succeeds Robin Spencer-Arscott, who left Hall this spring to become chairman and chief executive of Rollins Burdick Hunter (Bermuda) Ltd.

Skandia International has not yet named a successor to Mr. Grayston.

BF&M partner

London-based Sun Alliance & London Insurance P.L.C. is considering an equity stake in Bermuda Fire & Marine Insurance Co. Ltd., Bermuda's largest domestic insurer.

According to BF&M's 1987 annual report, Sun Alliance and BF&M have signed a "memorandum of intent" in which Sun Alliance has been given "an option to participate in the shareholding of (BF&M), representation on the board and an expansion of the present business relationship between the two companies."

The agreement was reached to

allow BF&M to purchase excess-of-loss reinsurance with Sun Alliance, the report says. The reinsurance, a \$50 million layer excess of \$32 million, will enable BF&M to handle any deterioration in the runoff of a discontinued book of business written for BF&M between 1968 and 1983 by H.S. Weavers (Underwriting) Agencies Ltd. in London, the report says (*BI*, July 6, 1987).

Although BF&M reported a 1987 underwriting profit of just more than \$4 million, the Weavers book produced losses last year of \$7.7 million, leaving BF&M with a net loss of more than \$3.6 million. That compares with net earnings of \$1.6 million in 1986.

"We hope the purchase of the increased protection will once and for all put this continuing drain on our earnings behind us," the report says.

BF&M also reported that net earned premium volume fell about 22% to \$31.4 million in 1987. However, the company says the decline was due to a large account that was written in 1986. Without this account, net premiums would have

grown about 5% last year.

Tighter regulation

Local partners of three Big Eight accounting firms are calling for tighter controls over insurers and reinsurers incorporated in Bermuda but managed from other jurisdictions.

The three accountants are insolvency specialists that have encountered difficulties liquidating insurers that maintained most if not all of their records outside Bermuda. Bermuda's 1978 Insurance Act requires all companies to prepare annual statutory financial statements and keep them five years at their principal office in Bermuda.

However, Charles Kempe of Arthur Young & Co., liquidator of Mentor Insurance Co. Ltd., and Christopher Whittle of Ernst & Whinney, liquidator of Bercanus Insurance Co. Ltd., believe a more stringent approach to enforcing the existing rules should be adopted to ensure that adequate financial information is maintained on the island.

And David Anfossi of Touche Ross & Co., liquidator of Oceanus Mutual Underwriting Association (Bermuda) Ltd., says he wants the current law changed, noting that his firm is turning away audit business in cases where a prospective insurance client's books are maintained overseas.

"The 1978 Insurance Act provides for the appointment of an insurance company's principal representative who is meant to notify authorities of changes affecting his company's solvency," he said. "But all too often, he doesn't have a clue what's going on when the company is not managed here and neither do its local directors."

Mr. Anfossi pointed out that Oceanus was "grossly in arrears" in filing statutory financial reports with the Bermuda registrar of companies but had been granted time to produce them on the basis of assurances that eventually proved worthless.

Mr. Whittle said he thinks current controls are being sacrificed to win or retain business.

"I believe we have to enforce our rules and ensure the spirit of our legislation is being observed," he said. "We don't need to change the rules, but we do need to have principal representatives who are going to ensure that their companies maintain records here at all times, not just at the end of the financial year."

"My own accounting practice is now seriously considering its policy on accepting audit appointments for companies which do not keep substantially all their accounting records in Bermuda, because the companies are so often the ones we have problems with," Mr. Whittle continued. "The difficulty is that the law does not spell out precisely what records should be kept here."

Mr. Kempe agreed that Bermuda needs a better working definition of what are "sufficient" records.

"This is the term used to describe records that have to be kept here at all times to enable companies' financial conditions to be determined. But, we need a better definition," he said.

The accountants point to Bercanus and River Plate Reinsurance Co. Ltd. as recent examples of insolvent companies found to be under direct foreign control or management and whose business records were not available to local liquidators.

CFM buys Polaris

Bermuda-based CFM Insurance Managers Ltd. is acquiring the offshore business of Polaris Insurance Managers Ltd., a management company set up in Bermuda five years ago by Laguna Hills, Calif.-based Phoenix International Insurance Managers Inc.

CFM Insurance owner and Chief Executive Peter Leighton says the acquisition covers the sale of eight Polaris management contracts worth about \$200,000 in annual fees, including the management of BF Goodrich Co. subsidiary Risktech Insurance Ltd.

According to Mr. Leighton, Po-

laris decided to sell the contracts in order to concentrate on new business onshore. He said that CFM was formed in February as a wholly owned subsidiary of Commodity & Futures Management Ltd., his 3-year-old trading and investment management firm.

"We decided to get into insurance and thought the acquisition route would be the best way to do it," he said.

Mr. Leighton added that CFM Insurance, which now has a staff of four, is looking for other possible acquisitions in order to expand.

X.L. redemption

Cayman-based Exel Ltd., parent company of Barbados-domiciled excess liability insurer X.L. Insurance Co. Ltd., last week announced that it was converting its Dutch auction offer to buy back its shares from 32 non-sponsor shareholders into a fixed-price redemption offer.

Chairman and Chief Executive Officer Ian Heap said Exel was now offering to pay \$220 a share for the approximately 260,000 eligible shares, which represents about 6% of the company's stock.

The new offer, which closes July 13, could cost the company \$57.2 million if all eligible shares are tendered.

Mr. Heap said that Exel's decision to fix a price was made last week at the close of the original Dutch auction offer launched May 25 (*BI*, June 13). The Dutch auction invited tenders at a unit price of between \$180 and \$230.

"Of the 260,000 eligible shares, about 21,000 were tendered under the Dutch auction offer at various prices by three shareholders," Mr. Heap said. "We have accepted these tenders. We will be redeeming at \$220 from the three shareholders and are now extending the same offer to the other 29 eligible shareholders on the basis of a fixed price."

Mr. Heap said that the 32 non-sponsor investors, a group that had to buy stock in Exel as a condition of purchasing insurance from X.L. Insurance, originally paid \$150 a share.

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Health plan survey

Continued from page 3

For almost half of the employees with deductibles—48%—the annual deductible was \$100. Other annual deductibles were \$200, reported by 13% of the employees with a deductible; \$50, reported by 12%; and \$150, reported by 11%.

Only 1% of these employees had an annual deductible of less than \$50, and only 2% had an annual deductible of more than \$300. The remainder were subject to deductibles of varying amounts.

The most common coinsurance level, reported by 76% of the employees with a coinsurance provision, was 80%. Eleven percent reported a coinsurance level of 90%, while the remainder had some other level.

The out-of-pocket expenditures of 79% of the employees with a coinsurance provision were capped at some level; however, limits varied greatly. The most common cap, reported by 15% of these employees, was \$400 per individual. However, 14% had a per-person limit of \$500; 12% had a limit of \$1,001-\$1,499; 11% had a limit of \$1,000; and the remainder of the respondents had varying out-of-pocket caps.

As with their private sector colleagues, cost containment is a major concern for public employers, the survey found. And, "To help contain costs of health care, a number of plans provided less expensive alternatives

to a hospital stay," the survey authors point out.

In addition to the plans that provided coverage for out-of-hospital care such as extended care facilities and home health care, many plans were designed to cut the cost of hospitalizations that do occur.

For example, slightly more than one-fourth of the participants were covered by plans that provided more generous benefits for pre-hospitalization testing than for tests performed in the hospital, and 22% of the participants had coverage for hospitalizations only when the hospital stays were certified.

Forty-seven percent of the participants were in plans with a second surgical opinion program; for 24% of the participants, the plan paid for, but did not provide a specific incentive for, employees to obtain the second opinions.

The remaining plans provided incentives for second opinions that ranged from not paying for a procedure obtained without a second opinion to reducing payment for such procedures.

The authors add: "Not all cost containment measures are directed toward hospital expenses. Thirty-five percent of the participants were required to have expensive dental procedures authorized in advance in order to be covered.

"Offering higher reimbursement rates for generic prescription drugs, discouraging

weekend hospital admissions for other than emergencies, higher rates of payment for delivery at a birthing center, and incentives for employees to audit hospital bills were less common than the other cost containment measures previously described," the survey authors wrote.

Another cost containment measure increases the amount that employees must pay toward their health care coverage. And, 35% of the public employees were required to contribute to individual coverage in 1987, while 71% were required to contribute to dependent coverage.

For 90% of these employees, the premium contribution was a set monthly amount averaging \$16 for individual coverage and \$72 for family coverage, according to the survey.

In other survey findings:

- The public employer plans show "a recurring pattern...to permit benefit plan participation immediately upon being hired."

- More than 80% of the participants were in plans that had no length-of-service requirement for coverage. And, even when length-of-service requirements existed, they seldom were longer than three months.

- In addition to the 24% of participants who belonged to HMO plans, 7% were in preferred provider organization plans. The remaining participants were in traditional indemnity plans.

About one-fourth of all the participants were in self-insured plans.

- The vast majority of the public employees had coverage for drug and alcohol abuse treatment: 94% of the medical plan participants had inpatient coverage for drug abuse treatment, and 81% had coverage for outpatient treatment.

However, in more than three-fourths of the cases, the coverage for drug abuse treatment was subject to more restrictions than other coverage.

Similarly, 95% of plan participants had coverage for inpatient alcohol abuse treatment, and 85% had coverage for outpatient treatment.

But again, more than three-fourths of the plans had less extensive coverage for alcohol abuse than for other treatments.

- Fewer than half of the plan participants had coverage for some less-common medical benefits. For example, about 40% had coverage for routine physical exams and for well-baby care; about 30% had coverage for immunizations and inoculations; and about 20% had coverage for organ transplants, according to the survey.

Copies of the study, "Employee Benefits in State and Local Governments, 1987," are available for \$4.50 each from the BLS Sales Office, P.O. Box 2145, Chicago, Ill. 60690; 312-353-1880. Request Bulletin No. 2309, Stock No. 029-001-02976-4.

Most public entity workers covered by group life plans

By ALISON KITTRELL

The nation's state and local government employees are provided with a wide variety of benefits in addition to health care and pension benefits, according to a survey by the Bureau of Labor Statistics.

The survey, "Employee Benefits in State and Local Governments, 1987," reveals that the vast majority of public employees on the state and local level receive employer-provided health insurance and defined benefit pension plans (see related stories).

But, public employers also provide several other benefits, and 9% of the employees surveyed can choose from more than two benefit options in a flexible benefit plan or reimbursement account.

The benefits available to state and local employees include:

- Life insurance. Some 85% of state and local government employees surveyed are covered by employer-sponsored life insurance. Of that group, 69% receive life insurance coverage paid totally by their employer and 16% are required to contribute to the cost of the coverage.

Group life insurance benefits are more common among police and firefighters, 91% of whom have coverage, compared with teachers, 82%; and other employees, 85%.

For 55% of employees with life insurance coverage, the benefit was a flat dollar amount. Teachers were most likely to have flat amounts of life insurance coverage: 59% of the teachers with life insurance were covered by these plans.

The amounts of coverage provided in the flat-amount plans ranged from \$15,000 to \$100,000, with an average of \$13,700 for teachers, \$10,900 for police and firefighters and \$10,100 for regular employees.

The remaining 45% of the employees with group life insurance were in plans that tied the benefit to a multiple of the employee's earnings. "This enabled the level of protection to keep pace with increases in the employee's pay," the BLS points out.

The average benefit provided under these multiple-of-earnings plans was 170% of earnings for teachers, 180% of earnings for police and firefighters and 140% of earnings for other employees.

Almost three-fourths of the participants were eligible for life insurance immediately upon employment. When there was a length of service requirement, it was usually three months or less.

In addition, two-thirds of the participants with life insurance had extra coverage—usually double—in the event of accidental death.

And, 55% of the participants had life insurance after retirement, although for most retirees, benefits were reduced at least once upon or after retirement.

- Long-term disability insurance. Thirty-one percent of the state and local government employees responding to the survey had long-term disability insurance. In addition, 81% were covered under pension plans that provided immediate benefits in case of disability.

Among those employees with LTD insurance benefits, only 10% had to contribute to the cost of the coverage. The most common contribution required was a set monthly amount per \$100 of covered earnings; that amount ranged from 20 cents to more than \$1.

Some 89% of the LTD participants were in plans that replaced a fixed percentage of earnings. The most common replacement levels were 60% of earnings, reported by 28% of the LTD participants; 50% replacement levels, reported by 22% of participants; and 67% replacement levels, reported by 19% of participants.

Sixty percent of the LTD participants are in plans with a maximum monthly payment, which generally ranged from \$2,000 to \$5,000.

In addition, one-fourth of the LTD participants were in plans that had special limits on disabilities due to mental illness. In most cases, benefits would be paid for only a limited period unless the person were institutionalized.

LTD plans also generally had longer length of service requirements than other benefits: Almost 30% had service requirements ranging from one to three years.

"Because of the long-term nature of this benefit, more employers restricted eligibility to employees who have demonstrated some attachment to the organization," the survey authors explained.

- Sickness and accident insurance. Some 14% of the employees surveyed were covered by sickness and accident insurance, and more than 80% of the covered employees did not contribute to the cost of their coverage.

The maximum duration of the disability payments was almost always fixed, and the limit averaged 26 weeks.

- Maternity and paternity benefits. Although only 1% of the employees surveyed were covered by a policy offering paid maternity leave, 57% were eligible for unpaid leave.

In most of these cases, the leave was for a fixed number of days, and the most common limit, reported by 31% of those with maternity leave, was 12 months.

Some 17% were limited to a six-month leave. And, 9% were limited to a three-month leave, while an equal number had a limit that was more than 24 months.

The rest had some other specified limit for maternity leave.

Virtually none of the employees were covered by a paid paternity leave benefit. However, 30% were eligible for unpaid paternity leave, and almost all of these plans provided a fixed number of days.

As with maternity coverage, the most-common unpaid paternity leave limit was 12 months, cited by 28% of survey respondents. Some 13% were eligible for a six-month leave, and 17% were eligible for leave longer than two years.

- Educational assistance benefits. Some 53% of the employees surveyed were eligible for employer-paid assistance for education that is job-related.

And, 15% of the respondents were eligible for non-job-related educational assistance.

State, local entities offer pension plans

By ALISON KITTRELL

Defined benefit pension plans are by far the predominant retirement benefit vehicle for state and local government employees, according to a survey by the U.S. Bureau of Labor Statistics.

Some 93% of state and local government employees are covered by defined benefit pension plans, according to the survey, "Employee Benefits in State and Local Governments, 1987." In comparison, only 9% are covered by defined contribution pension plans.

A total of 98% of the state and local government employees surveyed are covered by some type of pension plan, compared with 94% who have health insurance (see related story, page 3).

Only 22% of the employees covered by defined benefit plans that are financed completely by their employer. The remaining 78% are in plans that are financed by both employer and employees.

About half of defined contribution plan participants contribute to the plans.

Almost all—98%—of employees covered by defined benefit plans have retirement benefits tied somehow to their earnings at retirement time.

For the majority of these employees—65%—an average of three years of salary are used to determine the benefit. Usually, employees use the last three years of employment.

The terminal-earnings formula is used to determine a retiree's annual benefit. Under that formula, the employee's average pay for a three-year period is multiplied by a flat percent, and then multiplied by the employee's years of service. The survey respondents multiplied final earnings by an average of 1.89%.

Fewer than 1% of the employees were in defined benefit plans that determined the benefit according to one of two other methods: career average, which bases the benefit on an average of the employee's salary during his or her entire career; or dollar amount, which determines the benefit by a flat amount multiplied by years of service.

Defined benefit pension plans replaced an average of 51.6% of final-year earnings for retirees earning \$15,000 at retirement and having 30 years of service, according to the survey. The replacement level was 52% for 30-year veterans retiring with a final salary of \$25,000, and 52.2% for those with a final salary of \$35,000.

Continued on next page

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Pine Top litigation

Continued from page 2

- Failing to develop and implement adequate underwriting procedures and controls.
- Consistently underpricing insurance and reinsurance business underwritten by Pine Top.
- Failing to maintain adequate loss reserves.
- Paying excessive commissions to managing general agents and failing to monitor MGAs.
- Ceding reinsurance to financially unsound reinsurers and failing to implement an adequate collection procedure.

Several of the reinsurers to which Pine Top ceded business now are either under supervision, in rehabilitation or in liquidation, according to the Insurance Department.

Among the troubled reinsurers to which Pine Top ceded business are: Mutual Fire, Marine & Inland Insurance Co.; Mission Insurance Co.; Transit Casualty Co.; Union Indemnity Insurance Co.; Mentor Insurance Co. Ltd.; and Ee-con Insurance Co.

Directors and officers of Pine Top named in the suit include:

- Ralph E. Battastini, chairman of Pine Top from 1977 to October 1983 and a member of the board of directors from February 1973 until October 1983.
- Richard A. Bove, vp and controller of Pine Top from November 1983 to July 1986 and a member of the board of directors from July 1985 until December 1985.

- W. Carroll Bumpers, a member of the board of directors of Pine Top from September 1977 until April 1985 and the current chairman of Greyhound Financial Corp.

- Eckert M. Egner, president of Pine Top from May 1975 until March 1978. Mr. Egner also served as a member of the board of directors from February 1973 until March 1979 and as vp from February 1973 until May 1974.

- Kenneth H. Hanson, a member of the board of directors and president of Pine Top from March 1979 until February 1985.

- John W. Teets, a Pine Top director from October 1981 until April 1985 and from December 1985 until January 1987, and the current chairman, president and chief executive officer of Greyhound Corp.

The suit names an additional 16 directors and officers of Pine Top, as well as Glenn G. Herbst, a board member and president of the insurer from April 1985 until January 1987 and senior vp from February 1982 until April 1985.

The suit, which seeks unspecified punitive damages from Mr. Herbst, accuses the former Pine Top president of fraudulent mismanagement for making "false statements of material facts regarding the financial condition of Pine Top."

The suit says Mr. Herbst misrepresented by approximately \$3.3 million reinsurance recoverables on Schedule F of the insurer's 1984 annual statement submitted to the Illinois Insurance Department.

Mr. Herbst "intended to deceive and to convey a false impression to the Department and Pine Top's policyholders,

claimants and other creditors regarding the financial condition of Pine Top," the suit alleges.

Mr. Herbst said he could not comment on the suit.

The Insurance Department lawsuit also charges auditors Touche Ross with, among other things, failing to:

- Disclose that Pine Top's reserves were continuously and significantly inadequate.
- Evaluate Pine Top's underwriting practices.
- Evaluate the collectibility of Pine Top's reinsurance recoverables.

In addition, the suit alleges that Whitney, which owned Pine Top from March 1985 until December 1985, misappropriated \$253,000 of the insurer's assets.

The suit says Whitney has refused to pay Pine Top the \$253,000 it allegedly misappropriated and asks the court to order reimbursement plus any additional damages the court deems fair.

The suit also accuses three officers of Whitney—Robert A. Brown, Terrence S. Cassidy and H. Loren Hawley—of negligence for "improperly withdrawing" the \$253,000 from Pine Top and asks the court to order them to pay the \$253,000 plus any additional damages the court deems fair.

Greyhound, which sold Pine Top and Pine Top Life Insurance Co. to Whitney for \$28 million in March 1985, reassumed control of the insurers a few months later because of internal problems at Whitney resulting in litigation among its owners, directors and officers (BI, Dec. 23, 1985; April 8, 1985).

Pension benefits

Continued from previous page

When Social Security benefits are included, the replacement levels are much higher for retirees with 30 years of service: 82.6% for those earning \$15,000 at their retirement, 77.4% for those earning \$25,000, and 71.4% for those earning \$35,000 or more.

The age at which employees could retire with unreduced benefits was much younger than 65 for many of the participants.

For example, 38% of the participants could retire at any age after having reached a set number of years of service. Some 22% could retire at age 55 with unreduced benefits, although they also usually had to have worked a certain number of years.

"Other age and service requirements differed considerably among occupations. One-third of the regular participants and one-quarter of the teachers were in plans with minimum age requirements of 60 to 65, with widely varying service requirements. In contrast, one-quarter of the police and firefighters were eligible to retire at a specified age before 55, generally with 20 to 25 years of service," the survey authors noted.

In addition, the authors continued: "Ninety-one percent of regular participants and 94% of teachers could retire before normal retirement age and receive an immediate, reduced pension; however, only 56% of police and firefighters were in such plans."

Seventy-five percent of the retired governmental workers received a post-retirement benefit increase between 1982 and 1986. About one-third of those increases were discretionary rather than automatic.

The most common vesting schedule for defined benefit plan participants was cliff vesting with 10 years of service, reported by 47% of participants; and 38% had cliff vesting with five years of service.

Of the 78% of the defined benefit plan participants who had to contribute to their plans in 1987, virtually all contributed a specified percentage of earnings. Those contributions ranged from 3% to 6% of pay for most workers, from 6% to 8% for most teachers and from 8% to 16% for almost half the police and firefighters.

Thirteen percent of the employees who had to contribute to their defined benefit plans could make their contribution on a pretax basis.

Among the employees participating in defined contribution plans, the most frequent vehicles were money purchase plans. In these plans, fixed contributions are placed periodically in the employee's account; the benefit paid at retirement is based on the amount in the account.



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HMO industry

Continued from page 3

Employers complain that as a result, they are charged HMO premiums that do not reflect the experience of their own employee group.

"As you know, every employer's cost experience is better than the community in your plans," he quipped, implying that most employers probably would end up paying a higher premium than the community rate if HMOs experience-rated their premiums.

And, while acknowledging that a common employer concern about HMOs is the quality of health care delivered, he said that "employers have no clue about quality."

"Benefit managers are angry that their employees don't complain, cost-effective health care is not being delivered," he said.

Employers eventually will realize that HMOs are the best mechanism for delivering cost-effective health care, he predicted.

"I just hope that the HMO industry doesn't get killed off in the process. By playing HMOs against each other, corporate America is killing off HMOs," Mr. Abramowitz charged, while also admitting that poor management and inade-

quate pricing by some HMOs could contribute to difficulties in the HMO industry.

In a discussion of the federal Health Care Financing Administration's Medicare Insured Groups experiment, he said "the trouble is that corporate America doesn't have much experience at managing health care, and it's going to be a long time before employers want to take responsibility for their retiree health care."

Under the MIG demonstration projects, employers receive funds from the Health Care Financing Administration, the federal agency that administers Medicare, employers receive an amount equal to 90% of the expected cost to provide health care for each Medicare-eligible retiree (BI, Nov. 9, 1987).

So far, two MIG projects are under way, including one being conducted by Detroit-based Chrysler Motors Corp.

HCFA also is conducting similar Medicare arrangements with federally qualified HMOs. However, the first Medicare HMO project—Miami-based International Medical Centers Inc.—ended following probes into the quality of care delivered by IMC and the federal indictments of the HMC's officers (BI, May 16).

"Situations like IMC obviously don't help the HMO industry," Mr. Abramowitz said.

Along with criticizing employers' health care cost control efforts, Mr. Abramowitz suggested that HMOs:

- Raise their rates to cover their expenses and be profitable.

"I personally think HMOs have an enormous future. But, if you get killed off by corporate America, you can't have a great future. You must have the resources to deliver cost-effective, quality care, and you can't keep giving away your services," he advised.

While he did not suggest possible increases, he said that if HMOs can maintain their current annual increases of 10% to 15%—compared with 20% and higher for indemnity plans—"you will be a better value than traditional insurance."

- Improve communication with benefit managers.

- Better manage cost information to develop premiums that will cover expenses.

- Invest in quality care.

- Invest in good management.

- Consolidate to preserve the industry.

"The general message to you is that you better learn how to make money: through better management, improved quality, better communication with benefit managers and higher prices," Mr. Abramowitz said. ■

Chicago survey

Continued from page 3

15.5% ranked government regulation second and 13% ranked it third.

Last year, 19% of the survey respondents ranked liability insurance affordability as their No. 1 problem, while only 17% called government regulation their biggest worry.

Regarding small businesses' concern with employee benefits, John Derse, senior consultant for William M. Mercer-Meidinger-Hansen Inc., said: "Small businesses are in a tough spot. Health care costs are up and there is little small business employers can do to influence directly, contain or control their own costs."

"Even though small business is not likely to commit itself to long-term promises such as pension plans, which are very costly, they still face high employee benefit costs because of the complexities of regulations, their costs and their administration," Mr. Derse said.

The survey also asked employers about their benefit packages and what percentage of payroll they contribute toward them.

According to the survey, 93% of small businesses offer group health insurance benefits; 76% offer group life insurance; 40% offer profit-sharing or 401(k) salary reductions plans; 29% offer short-term disability benefits; 26% offer defined benefit pension plans; 21% offer long-term disability benefits; and 4% offer retiree health benefits.

Mr. Derse said the survey indicates that employers are moving toward profit-sharing and 401(k) plans and away from defined benefit pension plans.

In addition, 29% of the small employers said they offered incentive programs (excluding overtime), 28% offered education benefits and 23% offered dental and/or vision care benefits.

"Increasingly, large and small businesses are looking at benefits as a component of compensation rather than a right of employment. Small employers have felt that way for a longer period of time and have sought to get out from under the expensive long-term benefits, like pension plans, that they were once saddled with," Mr. Derse said.

Fifty percent of the surveyed employers noted that they contributed an amount equal to less than 20% of total W-2 wages toward employee benefits. That amount pales in comparison with the 39.3% of payroll that respondents to the U.S. Chamber of Commerce's annual benefit survey say they contribute toward their employee benefits (BI, Jan. 18).

Mr. Derse said that employers participating in the Chicago survey may have underestimated the magnitude of benefit costs.

Only 38% of the employers said their employees contribute to benefit costs, with the other 62% picking up the entire tab.

Concern about direct labor costs was ranked among the top three concerns of small businesses by 39.8% of the respondents, with 12.3% ranking direct labor costs their top problem, 15.6% ranking it second and 11.9% ranking it third.

Almost 42% of the employers listed the quality of labor as one of their top three problems, with 17.9% ranking labor quality first, 10.3% ranking it second and 13.5% ranking it third.

Employers also ranked among their top concerns interest rates; competition from big business; competition from foreign business; stock market conditions; and utility costs.

Copies of the survey results are available without charge by calling Alice Shea of Touche Ross at 312-397-8300.


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Workplace safety

Canada's WHMIS targets hazardous materials

By Jerome Karter

IN NON-WHIMSICAL fashion, the Canadian government recently adopted WHMIS—the Workplace Hazardous Materials Information System—to reduce a rising incidence of illnesses and injuries caused by hazardous materials in the workplace. The hazards were estimated by a 1985 federal study to have caused some \$600 million Canadian (\$498 million at current exchange rate) in social costs for 1984 alone.

WHMIS establishes a national standard that recognizes the interests of workers, employers, suppliers and regulators. To satisfy those interests, the federal Hazardous Products Act has been amended to include WHMIS, establishing requirements concerning labeling standards and disclosure of product information. Moreover, all federal and provincial occupational safety and health regulations must be amended to include WHMIS at federally regulated workplaces. The federal amendments become effective Oct. 31, but the legislation provides compliance transition periods for the provinces and territories.

In principle, WHMIS will ensure that suppliers provide information regarding the hazards of materials produced, sold in, imported to, or used within Canadian workplaces to employers and, in turn, to employees. The term "supplier" applies to anyone who sells, advertises or imports a controlled product and includes manufacturers, agents, formulators, distributors, custom packagers or customer processors.

Essentially, federal legislation establishes the following basic WHMIS requirements:

- Employers must identify and provide information about hazardous materials in the workplace.
- Suppliers and employers must adopt a cautionary labeling system for containers and requirements for disclosure of information in material safety data sheets.
- Employers must provide education and training programs for employees.
- A mechanism will be established to protect sensitive proprietary information.

Let's look closely at each element.

To begin, WHMIS requires that suppliers evaluate a product's potential to affect a user's health adversely or to pose physical hazards such as flammability or corrosiveness.

WHMIS is triggered when hazard criteria, identified in the Controlled Products Regulations of the Hazardous Products Act, are met for one or more of the following hazard classes: compressed gas; flammable and combustible material; oxidizing material; poisonous and infectious material; corrosive material; and dangerously reactive material.

Manufactured articles, wood and wood products, tobacco and tobacco

products are excluded from WHMIS. Also excluded are products that are currently regulated and labeled under other statutes, such as consumer products, foods, drugs, pesticides and radioactive materials. These exempt classes are expected to be harmonized into the system over the next several years, however.

The second basic WHMIS requirement imposes a system of labeling and data disclosure on both suppliers and employers.

For example, suppliers must label all controlled products distributed or sold in Canada with a product identifier—that is, a brand, code or chemical name—appropriate hazard symbols and the name and address of the manufacturer or supplier. In addition, labels on containers weighing more than 100 milliliters (approximately 3.3 ounces) must include a description of the product's risk as well as precautionary and first

their contents. If an original label becomes illegible, or is accidentally removed from the controlled product or container, the employer must replace the label with either a supplier or workplace label.

Also, the employer must provide supplier information, via a supplier or workplace label, for individual containers that are received as part of a bulk multicontainer shipment.

Other WHMIS provisions govern the use of portable containers and decanted products and establish labeling procedures in laboratories.

Employers are responsible for obtaining from suppliers an MSDS for each controlled product used in their workplace. The employer may develop an MSDS to use at the workplace in place of a supplier MSDS, as long as the employer-developed MSDS contains at least the same information found on the supplier MSDS and

employee who elects workers compensation benefits waives all rights to sue at common law. But, since Canadian workers comp policies are experience-rated every three years, the early benefits of WHMIS may not be readily apparent.

As a final measure, WHMIS establishes a mechanism to protect sensitive proprietary information, such as "trade secrets." WHMIS defines a trade secret as "something that gives a producer an opportunity to gain an advantage over competitors." This may include a process, a confidential device, a pattern, a chemical formula or information that is not patented.

A trade secret claim will be validated only if the following conditions are met:

- The information must not be known outside the firm.
- Confidentiality must be protected within the firm.
- The extent of measures taken to guard confidentiality must be satisfactorily demonstrated.
- The information must represent significant present and future value to the firm, as well as to competitors, if disclosed.
- The information must represent a significant development cost.

Requests by suppliers and employers for non-disclosure of information on the MSDS must be submitted to the independent Hazardous Materials Information Review Commission for review and validation. The self-financed HMIRC, which has separate screening and appeals branches, comprises representatives from federal, provincial and territorial governments, as well as organized labor and industry.

If a claim is approved, information will be kept confidential from the time that the claim is filed until three years after the claim is validated by the HMIRC. However, confidential information must be disclosed to a medical professional when required for diagnosis or treatment in an emergency.

In summary, WHMIS seeks a single national standard for all affected parties. Success, says the WHMIS Project Steering Committee, will alleviate the need for multitudinous supplier regulations and will minimize inefficiency through lost sales and potential interprovincial trade barriers.

So, don't let WHMIS give you the whims-whams. Just keep in mind the potential benefits to all parties if it succeeds.

International issues

Employers must ensure that the containers of all substances used, handled or stored on site are clearly labeled to identify their contents, whether employer-produced or obtained from suppliers. And, if an original label becomes illegible or is accidentally removed, the employer must replace it.

aid measures.

Supplier labels must be legible, prominently displayed in both official languages and must make reference to the availability of an material safety data sheet.

Certain labeling exemptions are permitted for laboratory reagent chemicals, laboratory samples, materials shipped in bulk and materials packaged as multicontainer shipments.

As a further condition of sale, suppliers must develop MSDS in both English and French for each controlled product they sell or import. Minimum content requirements for WHMIS data sheets include: hazardous ingredients; physical data; fire and explosion data; reactivity data; toxicological properties; prevention and first-aid measures; and the name and phone number of persons or corporate departments to be contacted for additional information and date of preparation.

The MSDS must be updated at a minimum of every three years, or whenever additional hazard information becomes available.

At the worksite, employers are responsible for proper product labeling, whether employer-produced or obtained from suppliers. For example, the employer must attach a workplace label to any controlled product manufactured on-site. Moreover, employers must ensure that the containers of all substances used, handled or stored on-site are clearly labeled, tagged or signed to identify

indicates that a supplier MSDS is available.

For materials produced on-site, employers are responsible for producing MSDS to accompany workplace labeling for controlled products.

Where appropriate, employer MSDS, which must be prepared in both English and French, may be issued in other languages as well.

The third basic WHMIS requirement, education and training programs for employees, is intended to ensure that workers benefit from the information that suppliers and employers are required to provide through product labels and MSDS. WHMIS requires that employers establish education and training programs for employees who work with or are in proximity to hazardous materials. The program must include training in work procedures and education about the hazards. Moreover, the programs must be developed in conjunction with mandated joint workplace health and safety committees and must be reviewed annually, or whenever new hazard information becomes available, or when an existing worker education program becomes outdated through process changes.

It is anticipated that education and training programs will reduce workers compensation costs by raising employee awareness of the hazardous materials they handle.

Presently, workers compensation is an exclusive remedy in Canada; any

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



ASK A CASUALTY ACTUARY

Many issues affect consultant bidding

Q

We are about to go out to bid for our actuarial consulting work. What questions should we ask the various bidders to help us better discern which consultant would best serve our needs? How can we find out which consultants are located in our area?

A

First, it would be helpful to clearly define your needs. In a general sense, you need appropriate conclusions that are clearly communicated. The questions you should ask should fall into one of two categories based on this definition:

- ✓ How can I be better assured that the findings presented will be appropriate?
- ✓ How can I be confident that these findings will be clearly communicated and easily understood?

Numerous issues can affect the appropriateness of the findings you will receive. The following are some general questions to ask the bidders:

- Are you a Fellow or Associate of the Casualty Actuarial Society? Are you a member of any other professional organizations? If so, what requirements do these organizations have, if any, to assure that its members have an in-depth knowledge of property/casualty insurance and claims?
- How much prior experience have you had: in performing this type of study (reserves, funding, cost allocation, etc.) for this type of claim (workers compensation, general liability, auto, homeowners, professional liability, etc.); for other types of claims; and in doing actuarial analyses (of any type) for this type of claim?

Each of the above should be broken down by the type of role you served in completing these studies (e.g., consulting, internal insurer, bureau).

- How many years of consulting experience do you have? Provide a percentage breakdown of your consulting experience by: type of claim; type of study; type of client (public, corporate, hospital, etc.); or any combination of the above that would be specific to the work to be performed.
- Provide a breakdown of hours for the specific staff that will be performing the analysis.
- What peer review procedures will be used in checking the appropriateness of the methods, assumptions and selections that will affect the results?
- Do you have loss experience for similar types of risks and similar types of claims? Describe the extent of this information. How will you determine to what extent you will rely on this external information vs. our own experience in arriving at your findings?
- Briefly and generally describe the full range of types of actuarial methods that could be applied in performing this study. Which of these methods do you intend to use or not use? Explain.

There may be other questions relevant to your individual situation. Don't hesitate to ask prospective consultants how they will handle specific aspects of the project, such as changes in case reserving practices or changes in underwriting practices.

Another issue that is often key in affecting the appropriateness of the findings of an actuarial study is the form in which they will be presented. This should be determined in advance by discussion with the prospective consultant and probably should cover such issues as:

- Is a point estimate or a range of estimates to be presented? If a range is presented, will the

assumptions that underlie each estimate in the range be clearly spelled out?

- Will estimates be presented at different levels? Will the confidence levels presented be appropriate to the purpose at hand?

- Will the value of investment income be presented?

- What caveats and restrictions on distribution will probably be a part of the report?

- What will happen to the fees for the engagement if there are major problems and inconsistencies in the data provided? If these problems make it necessary to re-do a significant part of the study, how will that affect fees?

- For clients that you have served for a number of successive years, have you experienced any general patterns in terms of whether your prior estimates have proven to be too low, too high or randomly low or high?

- What proportion of your clients are repeat clients?

The clarity and lucidity of the prospective consultants' answers (whether oral or written) to the above questions should provide you with an excellent idea of their abilities to communicate in clear and understandable terms. You should also request copies of some of the consultants' prior reports (the consultants may blank out the names of their clients) and sample articles or papers written by the consultant as further evidence of these skills. Such sample reports will also provide you with clues as to the ease of understanding exhibits and tables and the form in which results might be presented.

A final issue in the communications area relates to the consultant's prior experience in presenting findings to some of the audiences that may also be recipients of the analysis. Such audiences can include regulators, auditors, investment analysts, lawyers and tax advisers. Obviously, each of these specialists has a unique vocabulary and set of concerns and effective communication with them is often dependent on having prior experience in working with them. To the extent that this is a need in your case, you may want to explore this with each

Largest casualty actuarial consulting firms

(By number of Casualty Actuarial Society members)

Firm	Number of CAS members		Offices (CAS members)
	1988	1986	
Tillinghast/TPF&C	78	58	Hartford, Conn. (16); Atlanta (11); Dallas (6); Philadelphia (6); St. Louis (6); Washington, D.C. (6); Boston (4); Chicago (4); London (3); New York (3); Bermuda (2); Denver (2); Jacksonville, Fla. (2); Toronto (2); Darien, Conn. (1); Irvine, Calif. (1); Minneapolis (1)
Coopers & Lybrand	41	23	New York (10); San Francisco (8); Chicago (5); Los Angeles (5); Atlanta (3); Boston (3); Seattle (3); Philadelphia (2); Bermuda (1); Toronto (1)
Milliman & Robertson	35	16	New York (9); Milwaukee (8); Pasadena, Calif. (6); Boston (3); Philadelphia (2); San Francisco (2); Cincinnati (1); Denver (1); Hartford, Conn. (1); Minneapolis (1); Seattle (1)
The Wyatt Co.	11	6	Montreal (3); Chicago (2); Toronto (2); Detroit (1); San Diego (1); San Francisco (1); Washington, D.C. (1)
Mercer-Meldinger-Hansen	9	3	Irvine, Calif. (5); New York (4)
Peat Marwick Main & Co.	8	5	New York (4); Atlanta (1); Bermuda (1); Columbus, Ohio (1); Hartford, Conn. (1)
Touche Ross	8	3	Hartford, Conn. (5); Minneapolis (2); Detroit (1)
Ernst & Whinney	7	3	New York (4); Chicago (3)
Huggins & Co.	7	5	Philadelphia (7)
Fred S. James	5	4	Short Hills, N.J. (5)
Price Waterhouse	5	4	Hartford, Conn. (2); Chicago (1); Miami (1); Philadelphia (1)
E.W. Blanch	4	1	Minneapolis (4)
Johnson & Higgins	4	3	Los Angeles (2); Boston (1); New York (1)
NAC Re Corp.	4	3	Greenwich, Conn. (4)
Liscord, Ward & Roy	3	3	Concord, N.H. (3)

prospective consultant.

In answer to the last question, the accompanying chart includes a compilation of the largest casualty actuarial consulting firms and their office locations. In addition to those shown, there are many consultants who are not associated with a firm that has three or more members of the Casualty Actuarial Society. The best way to obtain information on these firms is to order a copy of the latest yearbook of the CAS. A copy may be obtained by sending \$10 to: Casualty Actuarial Society, 250 W. 34th St., New York, N.Y. 10019. This yearbook also will provide you with the names, addresses and phone numbers of actuaries at any of the firms of interest.

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

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

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

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

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



Mr. Sherman

Finding a middle ground

By Arthur E. Parry

Speaking out

EVERYTHING is the result of change, Marcus Aurelius said. Change is an important factor in marketing, in insurance, in manufacturing and in many areas that affect business and government. Change is needed whenever any product offered is not adequate nor satisfactory to the user.

Insurance matters may depend heavily on change, because the insurer for a premium (a consideration) offers to perform certain functions in the future if an intervening event (fire, accident, etc.) takes place. The policyholder is required to perform immediately and hopes that his insurance company will perform if the event defined in the policy occurs.

Often, the only measure of future performance by an insurance company is the willingness of that company to consider changes in the policy contract that are considered important by the policyholder.

Can changes in the terms and conditions of insurance policies be made when the facts so warrant? The following 10 examples confirm that proper understanding of all factors in an individual situation and how adjustments to a policy may prove beneficial to the policyholder without jeopardizing the position of the insurer can result in significant change:

✓ Example 1. A policyholder had a four-year running battle with its insurer over complex rating calculations. An intermediary sought an appropriate forum where the insurer's peers could evaluate the insurer's actions.

It was suggested following the inclusion of the matter as an agenda item at that forum that an off-the-record offer to settle "without prejudice" could eliminate both the peer review and placate the irate policyholder.

Result: The offer was made and accepted; both the insurer and policyholder "won."

✓ Example 2. Whereas prior loss experience before the current policy period seemed to indicate a worsening loss ratio, final loss figures for the current period showed a significant reduction in a policyholder's losses. Unfortunately, the renewal quote had already been affected by the earlier worsening loss experience.

An intermediary, sitting down with the agent and underwriter, described the various matters involved with a request for relief that would be mutually beneficial.

Result: Not only did the underwriter "discover" some retrospective credits but was able to provide a retrospective rating adjustment well ahead of the contractual adjustment language.

✓ Example 3. A client had moved from a very onerous incurred loss retrospective rating plan to a fronting program. Of considerable interest to the client was the ability to satisfy its insurer's needs for protection against unreimbursed losses through with a letter of credit spanning long into the future. Additionally, the client wanted the opportunity to arbitrate individual loss reserve estimates.

Several meetings took place with the underwriter to discuss these changes.

Result: The underwriter acceded to both requests and all parties involved were quite satisfied.

✓ Example 4. A major property loss occurred and the policyholder was prepared to settle. Through an intermediary it was determined that certain specific policy language favoring the policyholder was overlooked. Additional meetings with the insurer were held on the policy language.

Result: A compromise settlement was reached that was one-third higher than the settlement that had been previously offered.

✓ Example 5. A policyholder with a marine risk with considerable land-side exposure had a problem. The umbrella insurer refused to cover

certain land exposures connected to marine activities, maintaining that all operations from such property were marine in nature.

Subsequent discussions were held with the protection and indemnity underwriter.

Result: The protection and indemnity coverage was extended at a modest charge to cover the land-side exposure and eliminate a serious gap in protection.

✓ Example 6: A public entity client had no coverage for punitive damages and the underwriter was unwilling to extend such protection. Through discussion with the underwriter it was confirmed that the likelihood of punitive damages being sought without other damages was non-existent.

Result: The underwriter agreed to provide defense in any action in which punitive damages were sought along with other damages but without any obligation to pay such punitive damages.

✓ Example 7. A directors and officers liability underwriter added a "failure to maintain insurance" exclusion to a renewal policy. A variety of specific situations were presented to the underwriter for clarification of coverage application.

Result: The insurer withdrew the exclusion from its policy.

✓ Example 8. The various insurers involved in a large property schedule had specific insurance, coinsurance and loss handling requirements if a loss should occur. Through discussion and negotiation, a blanket, agreed-upon cover with simplified loss provisions was effected even though coverage was underwritten by several major companies.

Result: A large explosion occurred and loss adjustment was handled with a minimum of difficulty. The settlement was acceptable to all parties. The adjusting company involved commented that it had not

previously seen such a workable, acceptable adjustment approach.

✓ Example 9. The client was concerned that it would not have an adequate amount of business interruption insurance, based on coinsurance requirements, should a loss occur in the next 12 to 18 months. Review of actual sales figures by month resulted in a satisfactory replacement approach to the annual business interruption worksheet calculation.

Result: Not only did the insurer handle the policyholder's problems, but a major adjustment firm stated the approach was direct and very satisfactory.

✓ Example 10. The insurer offered a policyholder a renewal at rates far above what was standard in the market. The policyholder, upon advice, went through an "assignment" to avoid such an unacceptable price and coverage was voluntarily written by another insurer on an offset basis. A lawsuit followed between the client and the former insurer.

Result: The lawsuit resulted in a significant award to the policyholder.

These examples have illustrated that change *does* occur.

The risk manager should be aware that quite often standard approaches do not satisfy a company's needs and also that such approaches are not mandated by insurers. When a specific situation is not properly addressed by the standard form or rating method, there may exist an opportunity for change.

It will be necessary to identify both the insurer's intent as well as the policyholder's needs and communicate these to both parties.

Insurance underwriters are reasonable people, just as are risk managers. When the needs and goals of both parties have been identified, a satisfactory middle ground can usually be found.

Arthur E. Parry is a principal consultant-Risk Management Services for The Wyatt Co. in Dallas.

Benefits denied for crippling suicide attempt

The Court of Appeals of South Carolina denied an employee workers compensation benefits for destroying his own eyesight in a suicide attempt where no abnormal or unusual working conditions associated with his employment had been established.

In September 1981, Christopher Yates took a job with Life Insurance Co. of Georgia and worked as a "debit" salesman, collecting premiums as well as selling insurance.

Mr. Yates became dissatisfied with his job, as he disliked pressuring clients, mostly low-income individuals, to pay their premiums. He also disliked canceling their insurance when they did not pay.

Mr. Yates began to view himself as a failure and dreaded going to work. On May 5, 1983, he returned to his apartment for lunch and decided to kill himself. At 2:40 p.m. he shot himself in the head.

Mr. Yates only succeeded in destroying his eyesight. He filed for workers compensation benefits, which the Industrial Commission awarded but, on appeal, the trial court reversed.

On further appeal, Mr. Yates argued that it was wrong for the trial court to condition compensation

Legal briefs

for a mental disorder that results in a suicide on a prior physical injury. The appellate court emphasized that a compensable injury under South Carolina law requires an accident arising out of and in the course of employment. Although the court agreed that Mr. Yates had suffered from a temporary mental disorder, there was no evidence that an employment-related accident caused his mental problem. *Yates vs. Life Insurance Co. of Georgia*, Court of Appeals of South Carolina, Feb. 2, 1987 (BI/05/March-\$10)

'Employer's premises'

An employee, while on the employer's premises coming to or going from work, is engaged in a necessary act of employment, the Supreme Court of New Mexico ruled.

Alberta Dupper, an employee of J.C. Penney Inc., signed out for the day and was on her way to the employee parking lot when she tripped over a lawn

sprinkler head and injured herself. Liberty Mutual Insurance Co., Penney's insurer, denied her workers comp claim asserting that the accident occurred after she had left her employment, thereby precluding her recovery under the state's "coming and going" rules. The trial court awarded her benefits.

The appellate court noted that New Mexico had remained the only jurisdiction that heretofore had refused to recognize that an injury occurring on the premises was one occurring within the scope of employment. The court said that it took this opportunity to "redeem New Mexico from its orphan status and extend the 'course of employment' meaning... to the instant case." *Dupper vs. Liberty Mutual Insurance Co.*, Supreme Court of New Mexico, Feb. 3, 1987, rehearing denied March 12, 1987 (BI/01/April-\$10)

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

Competition surges for renewals

By LINDA J. COLLINS, MARK A. HOFMANN
and LAURA MAZZUCA

Competition among commercial property/casualty insurers rages on, even though insurer executives have publicly admonished their staffs to hold the line on pricing.

The market during the July 1 renewal season was "more competitive than it was in either January or last year at this time," observed Charles E. Keller, president and chief executive officer of Republic Hogg Robinson Inc. in Boston.

"In the last three or four months, we've seen real acceleration in the rate of competition," observed James R. Rabenstein, vp and manager-intercompany and government relations for Liberty Mutual Insurance Co. in Boston.

Maintaining current rates for casualty insurance has cost Liberty Mutual some renewal accounts, Mr. Rabenstein pointed out.

While insurers admit that rates for most lines of property/casualty insurance have softened and will continue to soften slightly during the next few months, they predict that the market will not slide precipitously into a pricing bog resembling the competitive market of the early 1980s.

Insurers cite their increased tax liabilities, deteriorating first-quarter results, low interest rates and the antitrust litigation pending against the property/casualty insurance industry as factors that will deter cutthroat competition (see related story).

Brokers, however, are skeptical that the market will stabilize anytime soon.

While various factors could reduce insurers' profitability, they still may not be sufficient to temper competition, noted Thomas J. Rodell, deputy managing vp in Alexander & Alexander Inc.'s Chicago office. "I think it's sort of a wish list," he said.

Although insurers are "truly concerned about different factors like the tax law, reserves and results, I can't see any signs of any of those things" curbing competition, agreed Richard A. Maxwell, executive vp-professional standards and marketing for Corroon & Black Corp. in New York.

"People see the handwriting on the wall, but will they read it?" quipped Samuel Alcorn, senior vp-operations of Bayly, Martin & Fay International Inc. in Fort Worth, Texas.

And while many insurers and brokers stressed that insurers are attempting to impose solid underwriting guidelines, others questioned the success of those efforts.

"I don't believe it's as soft or there's as much carelessness as there was at the height of the soft market, but I certainly feel it's not tight underwriting," said Martin L. Vaughn III, executive vp of the retail division at Poe & Associates Inc. in Tampa, Fla.

Determining whether insurers still are writing property/casualty insurance above a break-even rate level is sort of like "the story of the statistician who drowned in water of an average depth of one inch. Some insurers are doing well, it's just a matter of underwriting and controls," said John F. O'Sullivan, managing director at Marsh & McLennan Cos. Inc. in New York.

Insurers are "doing a good job of underwriting and analyzing, but they are also aggressively going after the accounts they want. They will do whatever it takes, within reason," to attract those accounts, said Norman Barham, deputy manager of Johnson & Higgins' New York office.

"I see more signs of the 'greater fool' theory at work than I

did a year ago," observed Dan Vicenti, senior vp-commercial insurance division at Transamerica Insurance Co. in Los Angeles.

The theory: a broker takes a particular piece of business to a series of insurers, with each successive underwriter offering a lower price, Mr. Vicenti explained. The underwriter who is willing to write the business at a loss is the "greater fool."

And although insurers' home offices vow they are holding the line on pricing, branch offices sometimes are "willing to throw the book away" because of pressures to retain their books of business, observed Bernard H. Mizel, president and chief executive officer of broker ABI Management Inc. in San Francisco.

Even within individual insurance companies, "competition varies by branch" in different parts of the country, said Corroon & Black's Mr. Maxwell. While many insurers are giving branches more autonomy because they are closer to the risk, this presents a "double-edged sword" because insurers "can't turn the spigot on and off as quickly as they would like."

But several insurers say they are vigilantly monitoring branch offices to curb excessive competition.

Lowell Tornow, executive vp-field operations for Wausau Insurance Cos. in Wausau, Wis., said his company keeps close tabs on its field offices and doesn't "let people run off with the store." In keeping with this philosophy, bonuses of field office managers are contingent on meeting price guidelines.

Edward T. Laugle, senior vp and senior marketing officer at Fireman's Fund Corp., and Thomas E. Rowe, senior vp-national accounts for the Novato, Calif.-based insurer, say they are monitoring pricing practices closely. For example, Mr. Rowe said a computer data base monitors pricing trends for every large account.

But brokers point out that insurers now have such an appetite for premium volume that they are frequently visiting them to seek out new business.

"They're here in your offices and looking for business. Before, you couldn't even get them on the phone," observed Howard Kaye, co-president of Walter Kaye Associates Inc. in New York.

"There is no question that there is more interest by the underwriters... they're more responsive, where a year ago they wouldn't even answer your phone calls," agreed Donald R. Weber, chairman and chief executive officer of Financial Guardian Group Inc. in Kansas City, Mo.

Overall, brokers say competition is most heated for property insurance business.

"Typically there is a very competitive property marketplace, both in the U.S. and London," said Larry Sorensen, senior vp and director of marketing for Rollins Burdick Hunter Co. in Chicago.

"We see more and more foreign markets seeking U.S. property business. The market is feeding on itself, and I expect 1989 to be the same way," stressed James E. Goulard, president of the Hall Services Division of Briarcliff Manor, N.Y.-based Frank B. Hall & Co. Inc.

One indicator of the magnitude of competition is the fact that "the earthquake market is back to where it used to be. You wouldn't even think we had a problem a year-and-a-half ago," noted J&H's Mr. Barham.

"There's lots of capacity in property and earthquake, with extremely competitive prices. I think we're back to about the 1983 pricing market," agreed Mary Ann Little, senior vp of

Jardine, Emett & Chandler San Francisco Inc.

"Depending on the risk, a property account could see a 20% to 25% reduction easily," and possibly 50%, "in both primary and excess layers across-the-board," said Patrick Gallagher, vp of Arthur J. Gallagher & Co. in Rolling Meadows, Ill.

"We are seeing 40% to 50% overall (property rate) reductions. We were projecting 20% to 30%, but it's worse than we were projecting," observed Frank A. McDougald Jr., senior vp-marketing for Fred S. James & Co. Inc. in New York.

The discounts become larger with the size of the account, he said, adding that some property premiums are now set lower than expected losses.

"Every type of insurer is competing for property business. Last year rates went down 15% to 20%. They're probably seeing at least 50% off in 1988 in larger accounts," with smaller accounts seeing smaller cuts, BMF's Mr. Alcorn said. Most insurers agree that property insurance rates are plummeting.

Liberty Mutual's Mr. Rabenstein said rate reductions of 25% to 40% for primary property insurance layers are not unheard of. He added that Liberty Mutual is aggressively seeking large industrial property accounts.

But Thomas Waugh, senior vp-products division at Zurich-American Insurance Co. in Schaumburg, Ill., says the primary property insurance market is showing "some slight downward movement, but not as much as we anticipated." He estimates rates fell 10% to 15% over the past year.

Brokers also report sizable rate reductions on most types of casualty business, although several were quick to point out that competition for casualty risks is far more prevalent among U.S. insurers than among London or other overseas underwriters (see story, page 27).

"Most of the casualty market is in the U.S. There are no foreign markets competing aggressively for U.S. casualty business," said Corroon & Black's Mr. Maxwell.

"I don't think London will really have an appetite for U.S. casualty business until the blood has dried and the (Lloyd's of London) names are no longer getting gouged from the past," said Mr. Alcorn.

But U.S. insurers are not hesitant about competing for casualty business, brokers point out.

"Primary coverages excess of a self-insured retention are coming down 20% to 30%. In some excess umbrella policies, we are seeing reductions of 50% to 60%. That is a very competitive area," Mr. Gallagher said.

Mr. Barham said it is "not unusual to see 25% reductions, depending on the risk," for primary liability insurance.

For excess coverage, "depending on how much of a reduction the client got in 1987, reductions can be substantial—25% to 50% to 75%—at better terms," he said.

James' Mr. McDougald said that he is seeing a more stable primary casualty marketplace "than we would have expected, with rate reductions averaging 15% to 25%."

However, the increasing willingness of insurers to write excess liability coverage for clients for whom they do not write primary coverage has triggered some rate cuts of up to 50%, he added.

Insurers also are concerned that casualty rates are being cut—sometimes significantly.

Primary casualty insurance rates have dropped 15% to 25% on average, estimated Liberty Mutual's Mr. Rabenstein.

"A strong downward movement" in rates for both excess

Continued on page 24

Insurers rule out rock-bottom prices

While property/casualty insurers concede that rates will continue to drop for at least the rest of 1988, they rule out a return to the cutthroat competition of the early 1980s.

For instance, property/casualty insurers' increased tax liability under the Tax Reform Act of 1986

"will have a major impact on how far companies are willing to go with pricing," said Jack Powers, New Jersey regional vp of Morristown, N.J.-based Warwick Insurance Cos.

The tax law "has to help maintain some sensibility" by "serving to put a floor under price cutting,"

agreed Dennis E. Hoffmann, president of John Deere Insurance Group in Moline, Ill.

Dan Vicenti, senior vp-commercial insurance division for Transamerica Insurance Cos. in Los Angeles, pointed out that insurers that have not realistically projected their costs of doing business under the new tax law could find themselves in serious trouble.

State guaranty fund assessments could also temper price competition if a major insurer insolvency occurs, said W. Bradley Wallace, vp of commercial lines for United States Fidelity & Guaranty Co. in Baltimore.

And general economic issues may impact competition as well, insurers pointed out.

"Concerns about the long-term health of the economy," particularly as reflected in Wall Street's uneven performance, is inhibiting competition, noted Thomas Waugh, senior vp-products division of Zurich-American Insurance Co. in Schaumburg, Ill.

Stable interest rates could also curb competition, since pricing will have to reflect a relatively low return on investment, predicted Lowell Tornow, executive vp-field operations for Wausau Insurance

Cos. in Wausau, Wis.

Another factor that may reduce competition is the antitrust litigation suits filed against the property/casualty insurance industry by 19 state attorneys general (BI, June 20).

"We're obviously watching the attorneys general's suits," said Claus G. Dorfi, executive vp-insurance operations for New York-based Atlantic Mutual Cos.

For example, "if there's a rollback or legislative or regulatory attempt to force insurers to write pollution coverage, that would obviously have some very serious implications for the marketplace."

But, it's still too soon to tell whether falling first-quarter profits will slow competition, Mr. Dorfi said.

Competition could wane if second- and third-quarter insurer earnings are also weak, said James S. Kemper III, commercial lines underwriting senior vp for Kemper Group's national property/casualty companies in Long Grove, Ill.

The fact that "earnings have deteriorated at a rate significantly higher than CEOs and CFOs anticipated" brings home the point that insurers should be cautious

about rate cutting, added Transamerica's Mr. Vicenti.

Yet, most insurers agree that the earliest the market will turn is 1989—if then.

Wausau's Mr. Tornow does not foresee "much change in '88" but expects "the market will firm up in '89 in all pricing for all lines."

Brian O'Hara, president of Barbados-based X.L. Insurance Co. Ltd., expects that "the market is going to continue to soften through year-end and the first quarter of 1989. Then it will begin to harden due to insurer losses and their tax bill."

"I don't see anything on the horizon that will change the competitive picture" in 1988 or early 1989, said Joseph R. Wiedemann, president of American Home Assurance Co., a unit of American International Group Inc.

While John R. Cox, chairman of Bermuda-based A.C.E. Insurance Co. Ltd., said it is difficult to project when the market will begin to stabilize, he speculated that insurers may react to their earnings pinch by mid-1989 by taking "some remedial action."

"How long does it take the dinosaur's brain to feel it when it gets whacked in the tail?" he asked. ■

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Agenda

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Benefits Communicators — The New Dimension
Wesley Poriotis, Chairman and Chief Executive Officer of Wesley, Brown & Bartle, a management consulting and executive search firm in the benefits and communications field, sets the tone for the 1988 EBC Conference with a look at the benefits communicator as business person, creative artist, benefits practitioner, or all three. Who are they, where are they coming from and what does the future hold?

Employee Assistance Programs
If you don't use it, you lose it. To achieve high participation and maximum value for your company's EAP investment, you've got to do more than just communicate. You've got to market the product to your employees. Hear the strategy applied by one company.

Long Term Care
Problems & Solutions. This session presents a case study from one of the first corporations to introduce long term care as an employee benefit. See this company's success story.

EBC Awards Luncheon
Recognizing outstanding communications programs, Alfred Malecki, Publisher, Business Insurance, presents the 16th Annual EBC Awards. Also shown will be the first place a-v winner.

Concurrent Sessions
These three workshops all on state-of-the-art interactive communication programs are presented as concurrents, giving you the opportunity to attend all sessions. These case studies will be presented by both company and consultant firm. Time will be provided after Monday's sessions for additional demonstrations and informal questions/answers.

#1 Flexible Benefits
Abbott Lab's Flex Benefits System, developed by Alexander & Alexander Consulting Group, gives employees a unique tool for making complex benefit decisions. This direct access, interactive system allows employees to model 'what if' scenarios for health care, flexible spending accounts and their 401(k) plan.

#2 Pension/Profit-Sharing & Retirement Planning
Projecting financial scenarios for employee retirement — Allstate's "Search For Security" program, developed by their consultant, Mercer-Meidinger-Hansen, offers new visions. And because it's educational and fun to use, information is better retained.

#3 Benefits Communication & Management
Becton Dickinson is using technology, developed by their consultant, The Wyatt Company, to communicate and administer its long term savings plan. Employees can sign-up, check account balances, calculate loans and more, in a private, secure, user friendly environment.

401(k) Under Tax Reform **Tuesday, August 2**
Communicating 401(k) plans and changes to employees within this new tax reform environment can be complicated, even for a seasoned communicator. Here's what has worked — and what hasn't — for one company.

You Be The Judge
A-V Excellence. Presented annually, this energetic session presents audio-visual programs submitted to the EBC Competition. You be the judge — see what other industry professionals are doing in this medium.

Luncheon
Jerry Geisel, BI's Washington Editor, gives you a *View From The Capitol*.

Wellness Programs
Michael Scofield, PhD, leads this panel on effectively communicating the health promotion message to employees. Panelists representing large, medium and small size companies discuss the communication channels needed for a very different benefit area — promoting good health and positive lifestyles. They'll look at what works and what has backfired for their own companies.

Adjournment
Until next year ...

Speakers

Craig Bryars Consultant THE WYATT COMPANY WORKSHOP #3: Interactive Communication	Daniel McCarthy Asst. VP, Comp & Benefits Planning ALLSTATE INSURANCE COMPANY WORKSHOP #2: Interactive Communication
Catherine A. Corse Asst. VP/Mgr., Employee Benefits BARNETT BANKS INC. Employee Assistance Programs	Kathryn J. McIntyre, A.R.M. Editor BUSINESS INSURANCE OPENING REMARKS
Pattie Duca Mgr. Employee Benefit Planning BECTON DICKINSON & COMPANY WORKSHOP #3: Interactive Communication	Laurel Nicholson Principal MERCER-MEIDINGER-HANSEN WORKSHOP #2: Interactive Communication
Jerry Geisel Washington Editor BUSINESS INSURANCE LUNCHEON SPEAKER: From the Capitol	Wesley Poriotis Chairman & CEO WESLEY, BROWN & BARTLE KEYNOTE SPEAKER
Beth Leaman Vice President BENEFITS, INC. ALEXANDER & ALEXANDER CONSULTING GROUP WORKSHOP #1: Interactive Communication	Robert Schumacher Director, Corporate Benefits ABBOTT LABORATORIES WORKSHOP #1: Interactive Communication
Alfred Malecki Publisher BUSINESS INSURANCE LUNCHEON SPEAKER: EBC AWARDS	Michael Scofield Mgr. Employee Health Promotion A T & T Wellness Programs
Karen Manning VP, Employee Benefits AMERICAN EXPRESS TRAVEL RELATED SVCS. CO., INC. Long Term Care	Russel Wert Director of Benefit Services AETNA LIFE & CASUALTY 401(k) Under Tax Reform
	Herb Zeltner President HERBERT ZELTNER CONSULTING INC. You Be The Judge

Registration

The BI Conference opens Sunday, July 31, with registration check-in and a cocktail reception from 5-7pm. Sessions begin Monday, August 1 at 8:30am. The conference adjourns Tuesday, August 2 at 3:30pm.

The cost is \$650. A 10% discount is offered to additional registrants from the same company. The fee includes sessions, workbook, educational materials, and scheduled functions.

Payment required with registration. All registrations will be confirmed.

Cancellations must be received in writing. A refund will be made on cancellations received before July 1.

A \$100 service charge will apply to cancellations received after July 1. No refund will be made on cancellations received less than 5 business days prior to the conference. If your plans change, you may substitute another person from your company without penalty.

To register, complete the form and send it with your payment to:

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We have set aside a limited block of rooms at a special rate of \$145 single/\$165 double, at the Grand Hyatt Hotel in New York City. These rates are available to Conference Registrants only, and will be honored until July 15. You must mention the *Business Insurance Benefits Conference* when making your reservations. Hotel cards will be included with your Conference Registration Confirmation. Or call the Grand Hyatt Hotel at (212)850-5900; or toll free at (800)228-9000.

Awards Luncheon
A luncheon ticket is included with your Conference registration. A limited number of additional seats are available for the EBC Awards Presentation Luncheon. Additional tickets are \$60 each, available on a first come-first serve basis; reservations required. Contact Registrar.

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Business Insurance

Market overview

Continued from page 22

property and casualty coverages—particularly in the \$20 million to \$100 million layer—and an influx of new capacity has driven some package rates down by as much as 40%, Zurich-American's Mr. Waugh pointed out.

"We don't see any abatement of competitiveness on rates," said Joseph R. Wiedemann, president of New York-based American Home Assurance Co., a unit of American International Group Inc. He estimated that primary casualty rates have dropped about 15% and excess rates about 20%.

Among U.S. insurers, New York-based Continental Corp., Liberty Mutual, Chicago-based CNA Financial Corp. and AIG were cited by more than one broker as being particularly competitive for casualty business.

However, Donald O. Scruggs, executive vp-agency group at Continental, said, "We're not remotely interested in increasing market share at the expense of pricing."

While Continental views itself as competitive, the insurer closely follows its pricing guidelines, he said.

Liberty Mutual's Mr. Rabenstein said the insurer would rather lose business than engage in cutthroat casualty pricing.

Spokeswomen for CNA and AIG would not comment.

Jardine, Emett & Chandler's Ms. Like noted that not only is there competition among insurers, but that she also has seen competition between an insurance group's subsidiaries and between an insurer's regional offices.

Ms. Like said she recently submitted an application for primary and excess general liability coverage for a difficult contracting risk to Lexington Insurance Co., an AIG unit, only to lose the business to another broker who placed it with New Hampshire Insurance Co., another AIG unit.

New Hampshire wrote the primary \$1 million layer for about half the premium quoted by Lexington and offered a \$4 million layer excess of \$1 million at about the same premium that was quoted by Lexington for a \$3 million layer excess of \$1 million, she said.

Ms. Like also recently submitted an application for property and casualty coverage for a Phoenix, Ariz.-based chain of restaurants to the San Francisco office of Wausau, which "declined to write the risk." She lost the account, but later found out that Wausau's Phoenix office "wrote it for a very competitive price on a direct basis."

A Wausau spokesman said it is not the company's practice for a branch office to undercut another branch's quotes.

Brokers and insurers point out that rates are holding stable for some long-tail lines of liability coverage, but insurers are offering more capacity for these risks.

"There are still parts of the market that remain difficult,

but even those are eroding," said Mr. Gallagher.

He explained that there is a "burgeoning market" for professional liability and directors and officers liability coverage and malpractice coverages. And, while some D&O and malpractice risks are still "real tough" to place, there are "cracks in the dike."

RBH's Mr. Sorensen cited product liability, chemical and pharmaceutical risks as "still difficult," but added that there is "better availability" of coverage for those risks.

And Mr. Gallagher and other brokers agreed that "for last year's price, you can get terms and conditions improved a lot."

"We continue to be able to negotiate exclusions out of programs and to enhance and tailor coverages," said A&A's Mr. Rodell.

"Generally speaking, a lot of restrictions and exclusions have disappeared. We can get a broader coverage form as well as a better price," said Mr. Alcorn.

"It's a lot easier to put together a beautiful policy form," agreed J&H's Mr. Barham.

For example, brokers pointed out that many insurers are now willing to write commercial general liability coverage on the Insurance Services Office Inc.'s old 1973 occurrence form as opposed to the more restrictive 1986 occurrence form, while use of ISO's claims-made CGL form has been limited to the most difficult long-tail liability exposures.

"The claims-made policy is a thing of the past except on professional liability coverages and very difficult product liability risks," stressed Hall's Mr. Goulard.

Some insurers also noted that they have modified policy restrictions.

Mr. Wiedemann said American Home has "tried to keep (underwriting) terms as tight as possible" but has modified some policy restrictions and exclusions and has decreased the percentage of business it writes on a claims-made basis. It is also providing pollution coverage on a named-peril basis.

"We've sat here for about a year wrestling with pollution," said Dennis E. Hoffmann, president of John Deere Insurance Group in Moline, Ill. He added that the insurer will write pollution coverage for equipment dealers and automobile dealers with underground storage tanks if the policyholders meet the insurer's safety requirements.

However, pollution-related risks are still tough to place, brokers stressed.

"Any EIL exposure, even with exclusions, there's still a reluctance from the marketplace to write," explained James' Mr. McDougald.

"There's still a cry for pollution coverage on a sudden and accidental or named peril basis, although in excess layers we are starting to see some movement toward acceptance of named peril coverage," added RBH's Mr. Sorensen.

Despite the bargains that can be negotiated, many buyers are not lowering the high deductibles and retentions they were forced to assume during the tight market of the mid-1980s, insurers and brokers say.

"Our clients who had high self-insured retentions and liked them are staying with them for a lower rate. Others who did not are dropping their SIRs to lower levels for the same premium," said Jardine Emett & Chandler's Ms. Little.

"We have not seen a big swing" yet to lower deductibles, but customers are "beginning to reconsider their options," said Liberty Mutual's Mr. Rabenstein.

The small businesses that purchase insurance from Warwick Insurance Cos. in Morristown, N.J., were never comfortable with high deductibles they assumed during the hard market, said Regional Vp Jack Powers. "For their business, higher deductibles don't work that well."

"On the primary side, we see a trend toward reducing SIRs and deductibles," said American Home's Mr. Wiedemann.

Brokers agree that while interest in forming new captives or risk retention groups has slowed, companies that already are using these alternatives are not abandoning them.

"They might modify them a bit, but unless there are dramatic changes in the client or the market, they stick with them," said Hall's Mr. Goulard.

And top officials of the two largest offshore excess liability insurance facilities formed during the hard market say they are not witnessing a mass exodus.

Brian O'Hara, president of Barbados-based X.L. Insurance Co. Ltd., said that X.L. has lost only five policyholders to competition and another five policyholders to mergers and acquisitions since it issued its first policy in May 1986. The facility, which writes \$75 million of general liability insurance excess of \$25 million, and \$25 million of D&O coverage excess of \$25 million, now has 381 policyholders.

While Mr. O'Hara described competition in the liability insurance market as "hot and heavy," he noted that X.L. is in "its own little niche" and "we don't play to the market tune." X.L. is lowering its rates only by 5% to 10% upon renewal, he explained.

John R. Cox, chairman of Bermuda-based A.C.E. Insurance Co. Ltd., said the captive has lost only one policyholder since the captive was formed in November 1985—and that was due to a merger.

Mr. Cox said that A.C.E.'s "pricing is exactly the same" as when the facility was formed, though A.C.E. has "significantly broadened" the terms of its D&O coverage. While liability market competition is intense for underlying layers, "we don't have any competition," he explained.

A.C.E. writes \$150 million of general liability insurance excess of \$100 million and \$50 million of D&O coverage excess of at least \$25 million. ■

Risk managers report renewal bargains

Risk managers searching for bargains are basking in the sunshine of July 1 property/casualty insurance renewals.

Property insurers are slicing renewal rates by as much as 50%, risk managers report. And, in some cases, insurers are reducing policyholders' premiums even though insured values have increased dramatically.

While competition among casualty insurers is not as rampant—rate cuts of 5% to 30% are the norm—risk managers who have recently renewed their coverage found more than enough capacity, even for tough-to-place risks like directors and officers liability.

But risk managers are worried that the competition of 1988 could abruptly trigger another tight property/casualty insurance market, leading to a coverage drought rivaling the hard market of the mid-1980s.

Risk managers who renewed their companies' property insurance programs this summer report the greatest rate cuts.

"We saw a 40% savings on our property coverage, with improved conditions," said Dave Fisher, risk and benefits manager with Mitsubishi Electric America Inc. in Torrance, Calif.

He noted that Mitsubishi's recently renewed property coverage now includes some coverage for on-site pollution exposures, a risk that previously was uninsured.

William L. Mather, administrator of risk management for The Gillette Co. in Boston, said he expected "reductions probably in the neighborhood of 20% to 25%" when he renewed Gillette's domestic all-risk property insurance program on July 1.

"We are seeing increased capacity and a willingness to commit that increased capacity on the part of our insurers," he explained. Gillette elected to remain with its incumbent insurers to maintain "continuity in relationship," he added.

These insurers include The Home Insurance Co., CIGNA Corp., National Union Fire Insurance Co. of Pittsburgh, Aetna Casualty & Surety Co. and Industrial Risk Insurers.

George Mills, risk manager for the Woodbridge-based New Jersey Highway Authority, found the property insurance market "extremely favorable" and obtained a 38% rate reduction when renewing the au-

thority's property coverage for its bridges.

Tony G. Rodolakis, corporate director-risk management and insurance for Holiday Corp. in Memphis, said that although his incumbent property insurer, Waltham, Mass.-based Arkwright Mutual Insurance Co., doubled the hotel chain's earthquake and flood limits, he was still anticipating a 20% reduction in premium on July 1, following a 25% rate reduction last year.

Arkwright offered the 1987 and '88 adjustments as part of Holiday's three-year property insurance program that does not expire until July 1, 1989, Mr. Rodolakis said.

Xerox Corp. was able to increase its earthquake limits by 50% and still reduce its overall premium by about 25%, pointed out Charles M. Armstrong Jr., risk manager for the Stamford, Conn.-based company.

Mr. Armstrong estimated that buyers could purchase around \$150 million in earthquake coverage "from responsible markets" this year, compared with \$100 million in 1987.

Rorer Group Inc., the Fort Washington, Pa.-based pharmaceutical manufacturer, "saw quite a bit of competition" when renewing its property coverage, commented Thomas D. Lewison, Rorer's risk manager. Many brokers are claiming that "whatever (price and coverage) we've got, they can do better."

"From what we're seeing, availability has increased, and we're seeing some significant price reductions" for property insurance, agreed Henry Guidry Jr., risk manager at Cajun Electric Power Cooperative in Baton Rouge, La.

"There has been some broadening of coverages," and insurers are offering "extras," such as higher limits for flood coverage, he added.

"The market has softened to the point where I'm back to the pre-1984 stage" in terms of premium rates, said D.K. Willy Bach, risk manager of American Safety Razor Co. in Staunton, Va., a manufacturer of razors and related products, such as industrial blades.

Liability insurance rate reductions are generally more modest, risk managers report. However, risk managers say they have had no problem finding all the capacity they

need.

"Insurers are willing to look at and quote even on unique exposures," said Gregory L. Daniels, director of the risk management division of the American National Red Cross in Washington.

"Underwriters and brokers are looking for casualty business, no doubt. All six markets that bid on our business offered some improvements in terms and conditions," observed Larry R. Sutton, corporate risk manager for Johnstown, Pa.-based Crown American Corp., which manages a chain of department stores, shopping centers and hotels in 10 Eastern states.

The insurer he selected wrote the coverage on the Insurance Services Office Inc.'s 1973 occurrence form, rather than the more restrictive 1986 form, which had been used for the coverage that expired July 1.

And, despite the change to the 1973 form and other coverage enhancements, Mr. Sutton saw "a 25% reduction on combined costs on all lines for all operations" for Crown American's primary liability coverage.

"For umbrella, we can quadruple our limits, by preliminary indications, for the same price," he added.

Mitsubishi received an 18% rate cut when it renewed its general liability insurance and a 15% to 20% rate cut when its commercial auto liability coverage renewed, Mr. Fisher noted.

William R. Shirley, director of risk management for United Telecommunications Inc. in Westwood, Kan., received 15% to 20% rate reductions for directors and officers liability, fiduciary liability and crime coverages, including employee dishonesty and fidelity bonds, with "significant" improvements in terms and conditions.

American Red Cross' Mr. Daniels said rates for excess liability insurance decreased by 12.5% and that the company's D&O rates dropped 40% after transferring coverage for wrongful termination to the general liability coverage from the D&O policy.

"What we found was a climate that was vastly improved from two years ago and significantly improved from a year ago," observed Denis Julien, corporate risk manager for Florida Progress Corp., a St. Petersburg-based electric company that recently ren-

ewed its directors and officers liability coverage, while a subsidiary's risk manager renewed its excess liability coverage.

This year underwriters were very attentive "and trying to please us as best they could," Mr. Julien stressed.

And, while Amfac Inc. in San Francisco did not receive significant rate cuts when its property and casualty insurance programs were renewed July 1, the company still benefited from the softening marketplace.

Amfac—which currently is undergoing a major restructuring, including major divestitures—was able to keep its manuscripted program intact with existing insurers, explained Ralph Perry, Amfac's vp-risk management.

"Our main objective was to have our insurers live with us through this unsettled period," Mr. Perry stressed, noting that this would have been much more difficult to accomplish during the past three renewal seasons.

Risk managers also report that July 1 renewals often were completed well in advance, unlike two or three years ago, when renewals often were not completed for months after the renewal date.

Chicago-based Hartmarx Corp., whose property insurance expired June 30, "started talking with our existing underwriter in February, and by late April or early May, we had already completed our renewal," said John C. Wagner, Hartmarx's corporate risk manager.

Despite increased property values and a rate cut last year, Hartmarx' premium reduction this year was "in the 50% range for the whole package," he added.

Despite the generally softening marketplace, risk managers observed that the market remains extremely tight for pollution exposures.

In renewing Crown American's liability insurance program, Mr. Sutton noted that "basically whatever (enhancements) we asked for, we could get, except for pollution or asbestos coverage. There were no concessions there; those were absolute exclusions."

And, despite the competition, most insurers were still exercising underwriting guidelines, some risk managers observed.

Continued on next page

Surplus lines underwriters losing business

By MICHAEL BRADFORD

Standard market insurers hungry for business are continuing to snatch renewals from surplus lines companies at a ravenous pace during July renewals.

"The standard markets are the big dogs fighting for the bone," said Roland Miller, president of National Fire & Marine Insurance Co. in Omaha, Neb. "They're trying to get back what they let go of" during the hard market of the mid-1980s, when surplus lines underwriters picked up business that was rejected by admitted insurers.

"The surplus lines market will always be a market that doesn't control its own destiny," said Charles Garrison, president of E&S Facilities Inc., a wholesale broker in Birmingham, Ala. "We're being driven back into the true surplus lines business. We're seeing a lot of very bad or dangerous risks."

Large surplus lines insurers and wholesale marketers are hardest hit by the stream of business flowing back to the standard market, while some of smaller players and those specializing in specific risks say they are weathering the competitive storm a little better.

Kenneth Woods, president of CIGNA Corp.'s Excess & Surplus Division in Los Angeles and president of California Union Insurance Co., pointed out that the hemorrhaging of surplus lines business is so bad that admitted insurers charging cheaper rates are attracting virtually all but the "very, very hard-core" surplus lines risks like heavy product liability and railroad liability accounts.

Standard market insurers are renewing property risks at prices at least 30% lower than those quoted by CIGNA E&S, Mr. Woods said, while admitted insurers are undercutting his company's casualty rates by 45%.

To hang on to an account, Mr. Wood said CIGNA E&S has to offer a price 10% to 20% cheaper than last year's already discounted rates.

"We're losing a substantial amount of business to the major stock companies," added Donald Sherwood, president of wholesale broker Sherwood Insurance Services in San Francisco.

Mr. Sherwood and other surplus lines market observers pointed out that much of the business that is flowing to the standard market was written by admitted insurers earlier in the decade.

"A lot of the business should not

have been written by the E&S market in the first place," Mr. Sherwood said. "They did it during the tight market and when the market softened, the business went back."

"The property and umbrella market is a catastrophe," summed up Joseph Walsh, president of American Empire Surplus Lines Co. in Cincinnati.

"We're losing 40% of last year's direct written premium, about what we anticipated," he said, explaining that translates into about \$85 million in business.

Like other insurers, Mr. Walsh said American Empire will quote discounts of up to 20% to retain accounts. However, he adds that the discounts are rarely offered because "frankly, we're not even seeing the business."

Surplus lines insurers point out that 20% discounts are about the best they can offer because they cut rates up to 40% last summer.

Ralph Palmieri, president of First State Insurance Co. in Boston, a Hartford Insurance Group unit, said the drop in 1988 rates "hasn't been as big a drop to the extent we saw it last year."

"Most would agree that the downward spiral in casualty rates began in earnest last July 1," said Mr. Palmieri. "Were that to happen again, with 30% to 40% drops in pricing, it would be a catastrophe because it would be compounding what the market has already done."

"That's not to say prices are not less this year—they certainly are," he said. "But you don't have to be a math major to know that if prices were cut in July of '87 by 40%, you can't cut them by another 40% in July of '88. At that rate, pretty soon you'd be off the chart."

The admitted market's voracious appetite that first began roaring for large property and umbrella accounts in 1987 continues unabated, brokers and insurers report, with property accounts especially appealing to standard insurers.

Orville Jones, Dallas-based president of Crump E&S Group, said some admitted insurers are writing property risks at rates 50% below what surplus lines insurers would have charged.

Thomas Bloom, president of McAlear Associates Inc. in Grand Rapids, Mich., called the property insurance market "hypercompetitive. We're seeing insurers write things it is hard to imagine they could make any money at."

The story is the same for umbrella liability risks.

"We lost one that we wrote last October for \$3 million," said Mr. Jones. "Our new quote was for \$1.1 million and it went for \$600,000."

Mr. Bloom said standard market insurers are luring buyers with increased excess liability insurance capacity.

Admitted insurers that would write maximum liability limits of \$1 million a year ago are now offering \$5 million in limits, explained Mr. Bloom. When the admitted insurers were only offering \$1 million in capacity, "that allowed us to still offer some excess," he pointed out, adding that opportunity now is gone.

"So far, the only thing we have been able to hang on to is the heavy primary casualty, particularly the products-related business," Mr. Bloom said.

"I think the hazard classifications for most surplus lines companies has tended to increase since 1986 and continued gradually in 1987 and 1988," observed First State's Mr. Palmieri.

Surplus lines insurers are cutting rates for directors and officers liability insurance, market observers report, but admitted insurers are again competing for business.

"Some of the admitted markets seem to be getting more aggressive" in writing D&O and errors and omissions coverage, said Mr. Bloom.

Bob Ougheltree, a vp with Swett & Crawford Group in New York, said D&O prices are "very uneven. Rates overall have declined, but unevenly from class to class."

And buyers are having an easier time finding both D&O and E&O coverage in the heated-up marketplaces, he said. "There is more capacity now than six months ago on both E&O and D&O. There is easily over \$200 million in capacity in D&O in an aggregated amount among all facilities," while aggregate capacity for professional liability risks is somewhat less, he said.

The reason for the increased capacity and reduced prices is "supply and demand fully at work," he explained.

The softening in the D&O and E&O market "is more evidenced on the D&O side," said Mr. Ougheltree. "There, underwriters are taking potshots at business. Within the last three months, it's become obvious that the market is softer."

In fact, that capacity for nearly all types of risk is abundant in the surplus lines market.

Mr. Palmieri said, "I don't think

the surplus lines market is being counted on by insureds, agents and brokers for the mega-limits of the early '80s."

Instead, many surplus lines buyers are looking for limits of from \$5 million to \$10 million "and that's generally available," said Mr. Palmieri.

"There are ample limits out there," said Janet Nelson, senior vp of St. Paul Specialty Underwriting Inc. in St. Paul, Minn. "I don't think you'll find anybody coming up short of what they want to buy. There are major players out there with significant capacity."

Kenneth F. Goldstein, president of St. Paul Specialty Underwriting, added: "Certainly two or three years ago that was not the case. They were limited to what was a very small amount of capacity."

But today, he added, "if somebody wants to buy \$25 million... \$50 million or even more, we think there's capacity out there to do it."

Capacity is especially abundant for earthquake risks, observers add.

"You can buy all the earthquake coverage you want if you're willing to pay the premium," said Mr. Sherwood. Policyholders can find \$300 million in coverage worldwide "without any strain," he said.

However, Mr. Sherwood cautioned, "it gets pretty expensive in the upper layers."

While insurers and wholesalers that primarily handle large accounts are reporting a steady flow of business back to the admitted market, some other markets are not as hard hit.

Anthony F. Markel, president of Essex Insurance Co. in Richmond, Va., said the liability risks that Essex writes are "relatively low-profile stuff. As a result, we don't see the tremendous flow back to the standard marketplace."

"What we do see is pressure on our rates and surcharges" above advisory rates established by the Insurance Services Office Inc., he said.

Mr. Markel said his rate of renewals this year has held relatively firm, though he noted there has been "some erosion. We've been forced to come off our pricing somewhat to retain business."

Policyholders are using premium savings to purchase higher liability insurance limits, he added. Instead of writing average limits of \$300,000 to \$500,000, Essex is writing limits generally ranging from \$500,000 to \$1 million, ac-

cording to Mr. Markel.

The Charter House Inc., a wholesaler based in Hendersonville, Tenn., that specializes in coverage for municipalities, has not seen the admitted market take aim on its book of business.

"The majors have not returned" to the public entity market, said Charter House President David Van Dyke.

"Our pricing is down, but we anticipated it would be down. We're not losing accounts, but our pricing is dropping," he said.

Charter House, which can place \$1 million in primary liability coverage for municipalities and \$1 million in excess limits, expects to write \$26 million in premium this year, compared with \$30 million in 1987, he said.

Oil and gas accounts written by surplus lines insurers generally stay put during market swings and that is holding true in the current competitive market, said Robert Kopal, president of wholesaler FG Special Risks Inc. in Houston.

"Most of our book is marine or oil and gas," said Mr. Kopal. "We've been able to retain the vast majority of our business and have written a lot of new business."

Rates for oil and gas liability risks have been cut by 5% to 20%, depending on the size of the account, said Mr. Kopal.

Capacity is abundant for those risks, he added, with anywhere from \$50 million to \$100 million in limits available.

Surplus lines market observers agree that they do not expect market competition to end soon.

Mr. Bloom pointed out that "this isn't the best year the surplus lines industry has ever had; 1989 will be even tougher."

"If you follow the trend lines and extend them to a logical curve, you arrive at the conclusion that the market—although it's bad now—will get softer for the next year or so. It should turn around in 1990," Mr. Bloom said.

Mr. Miller of National Fire said, "I look for it to last a couple of more years yet. If interest rates go up high like they did in the early '80s, that could stretch it out a bit."

Ms. Nelson of St. Paul Specialty Underwriting pointed out that any change in market conditions will be promoted by admitted—not surplus lines—insurers. "It won't get created or generated out of the surplus lines market. When it comes time to happen, it will happen because of things going on in the standard market." ■

Risk manager renewal reports

Continued from previous page

"We haven't heard of anybody going hog-wild like they did in the last soft market," said Arthur N. Dushary, insurance coordinator for Sisters of Mercy Health Corp. in Southfield, Mich.

"The same questions" asked by insurers during the hard market of the mid-1980s still are asked today, said Lea Sirota, risk manager for Gardenia, Calif.-based Elixir Industries, which manufactures parts for recreational vehicles and mobile homes. She renewed excess liability coverages on June 30.

However, Peter Lilienthal, treasurer at Munsingwear Inc. in Minneapolis, noted that one insurer that bid on the apparel manufacturer's property insurance renewal stipulated that the quote was contingent upon review of the company's facilities. Mr. Lilienthal said that indicated that the underwriters were simply interested in issuing the quote quickly and "didn't do their homework."

Some risk managers cautioned against abandoning alternative risk financing mechanisms to take advantage of rate reductions in the marketplace, since risk managers may need to rely on those vehicles again when the market begins to harden.

"Risk managers should not burn any bridges" and should continue to examine alternative markets, both domestic and European, cautioned Douglas S. Williams, associate director of corporate insurance for Boehringer Ingelheim Corp., a Ridgefield, Conn.-based pharmaceutical manufacturer.

Racine, Wis.-based S.C. Johnson & Son Inc. will be "pretty well set" to weather the next market swing by relying on captives and other alternative mechanisms, said James S. Hodnik, director of corporate risk management for Johnson Wax.

Bert Schecter, vp-insurance and risk management for CalFed Inc., a Los Angeles-based holding company for California Federal Savings and Loan, which is not involved in alternative market mechanisms, said risk managers that established such alternatives should not dissolve them for short-term gains.

"The market is going to turn hard again, there's no question about that," he predicted.

In fact, while most risk managers now are reaping the benefits of a softening commercial property/casualty insurance marketplace, some are expressing their concern that competition may become too rampant, triggering another violent turn in the market.

"Right now, if rate competition stopped where it is, I would say this was a return to normal pricing. Or, if it slows down, it would be OK. But if the trend continues, I think we will have real problems two years down the road," said the Red Cross' Mr. Daniels.

"If the pricing trend continues, I will be alarmed. If pricing would level off now, I would feel comfortable, but it would be irresponsible for insurers to keep cutting beyond this," agreed Crown American's Mr. Sutton.

"I'm concerned about the competition," said United Telecommunication's Mr. Shirley. If prices dip too low, "then we're going to pay for it later" through higher premiums and restricted coverages.

The severe swings in the market destroy continuity and often cast an unfavorable light on risk managers in the eyes of their superiors, Florida Progress' Mr. Julien pointed out.

"Risk managers, whether they like it or not, are painted with the same brush as the insurance industry" by their management, he explained.

"I'd like to see the marketplace act a little less volatile," with an emphasis on long-term contracts rather than the short-term gratification of a premium reduction, agreed

CalFed's Mr. Schecter. He predicted that if insurers do not temper rate reductions, "in a year or two" rates are going to go back up.

While Holiday Corp.'s Mr. Rodolakis says he believes property insurers are still acting responsibly in setting rates for large hotel chains, he is becoming alarmed at the degree of competition he sees among casualty insurers.

"In casualty, I am concerned, having gone through the last insurance crisis, that the market softening happened sooner than we anticipated and competition seems to be as extensive" as it was in the soft market of the early 1980s. "We're seeing some crazy things happen."

And George B. Netherton, director of corporate risk management for The Coca-Cola Co. in Atlanta, predicted that other factors, such as uncollectible reinsurance and the impact of the Tax Reform Act of 1986 on insurance companies, also could prompt insurers to tighten their reins within the next two years.

This story is based on reporting by Linda J. Collins, Laura Mazzuca and Mark A. Hofmann in Chicago; Judy Greenwald in New York; and Michael Bradford in Dallas. It was written by Ms. Collins.

Reinsurers not spearheading rate cuts

By JUDY GREENWALD and LINDA J. COLLINS

Competition among primary insurers—not rate cutting among reinsurers—remains the primary force driving the soft commercial property/casualty market, U.S. reinsurers and intermediaries say.

While reinsurers during July renewals generally lowered rates for property business and competition heated up for all types of facultative reinsurance, observers say reinsurance rate cutting is not rampant.

However, many restrictions in casualty reinsurance contracts—like sunset clauses and aggregate caps—that were imposed during the tight market of the mid-1980s are now being loosened, observers point out.

But, U.S. reinsurers generally appear much more wary of competition than do primary insurers.

"We have not gotten an awful lot of pressure on our accounts" for July renewals, said Frank Haftl, president and chief executive officer of Metropolitan Reinsurance Co. in New York. "We've been holding the line pretty well."

"I don't think the reinsurers are generally supporting the rate cutting," said Michael G. Fitt, chairman and chief executive officer of Employers Reinsurance Corp. in Kansas City, Mo.

"Most of the rate cutting is being done within the retentions of the primary companies," Mr. Fitt said.

"I don't see any material softening on the reinsurance side on either rates or terms and conditions," said William G. Clark, president and chief executive officer of Transamerica Reinsurance Co. in Stamford, Conn.

"I think it's a normal, rational negotiating process that's going on for the July renewals," said Paul Butler, president of St. Paul Reinsurance Management Corp. in New York.

"There's still a reasonableness of price to exposure on the reinsurance side, but there's just less premium available," said Paul Inderbitzen, executive vp of American Re-Insurance Co. in New York.

"In general, July 1 doesn't look any different from April 1," said Mark Mosca, vp and manager of the treaty department at NAC Re Corp. in Greenwich, Conn.

Any softening that is occurring is on a "small scale," said Mr. Mosca, with "no wholesale loosening of terms and conditions."

While there are instances of "serious" underpricing, he

added, "they tend to be relatively isolated, and not identifiable as part of one overall great trend."

However, James M. Dwane, president of Prudential Reinsurance Corp. in Newark, N.J., said the reinsurance market is becoming more competitive.

"Reinsurance intermediaries are obviously looking to generate more premium. The direct writers are doing the same thing," he said.

"The facultative market is definitely more competitive than it was a few months ago, but not nearly to the extent of the primary market," observed Salvatore D. Zaffino, president and chief executive officer of Crump Re, an intermediary based in New Hartford, Conn.

Often, primary insurers are retaining business rather than ceding it to facultative reinsurers, even though rates are being cut.

"Reinsurers on the facultative side are willing to write business at a 15% to 25% decrease on renewals, but that is usually not enough to retain the account," Mr. Zaffino said. "We lose the business to insurers who are keeping it net. Facultative reinsurers will compete to a point, and then they

Continued on next page

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Business Insurance

Circulation Breakdown*

Commercial Consumers

Administrative:
CEO's Presidents and Owners 2,779
Vice-Presidents, General Managers and Other Administrative Personnel 3,155

Financial:
Chief Financial Officers and Vice-presidents of Finance 2,732
Secretaries, Treasurers, controllers and other Financial Personnel 5,585

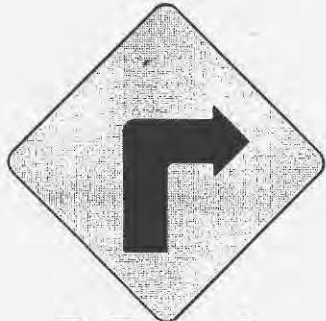
Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 10,021
Sub-total 24,272

Associations 481
Government, Unions and Educational Institutions 972
Commercial Consumers
Sub-total 25,725

Insurance Agents and Brokers 10,697
Insurance Companies 7,344
Actuaries, Attorneys, Adjusters, Appraisers and Consultants 4,311
Others Allied to the Field 1,982
TOTAL 50,059

* Source Business/Occupational breakdown of qualified circulation, Nov. 30, 1987 issue, as submitted to BPA for Dec. 1987 BPA Publisher's Statement.

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Continued from previous page

will walk away from the business. We don't see that changing."

Other observers also pointed out that less facultative business now is being written.

"There is no question that the facultative market is hurting," said Ronald J. Taylor, president and chief executive officer of G.L. Hodson & Son Inc. in New Hyde Park, N.Y.

"Insurance companies' premium volume is going down in this competitive arena," he explained. "The facultative market is the first place they attack. They want to keep their premium dollars net. The only choice (for facultative reinsurers) is to entice insurance companies to buy facultative."

To increase their business, facultative reinsurers now are welcoming high-hazard risks that they would not write several years ago.

Because many primary companies are retaining low- to moderate-hazard casualty accounts, reinsurers are writing relatively more moderate- to higher-hazard business, said Pru Re's Mr. Dwane.

While rates have been lowered somewhat, prices have not deteriorated significantly for this high-hazard facultative business, he added.

Crump Re's Mr. Zaffino observed that "during the really tight market, particularly in 1986, reinsurers did an awful lot of class underwriting. Right now, they are willing to entertain a lot of business they would not entertain a year or two ago on an individual risk basis. Even if it is a very difficult class of business, if the rates, form and conditions are correct, they will very likely quote on it."

"There is more of a market for difficult product liability risks," he pointed out. "Municipal business is much more acceptable than it was a couple of years ago," Mr. Zaffino said.

There is a little more capacity for pharmaceuticals, and "difficult auto business is very competitive now," Mr. Zaffino continued. "It is not difficult to place."

But some reinsurers, afraid of the growing competition, are withdrawing from the facultative market.

Met Re is not competing in the facultative arena both because of the higher retentions by primary companies and softer pricing, said Mr. Haftl. "We just can't meet most of the pricing going on so we just don't write it."

Overall, observers agree that both facultative and treaty reinsurers are offering more capacity for property risks.

"We see a very stable property market treaty reinsurance-wise," said Willis T. King Jr., chairman and chief executive officer of Willcox Inc. Reinsurance Intermediaries in New York. "The experience has been excellent, particularly in the catastrophe area. All reinsurers worldwide are interested in writing all of the U.S. property business they can get. Losses are running at six to eight points below normal losses for this business."

Michael Garrity, senior vp at Reinsurance Agency Inc. in Chicago, said the property reinsurance market has "definitely softened. Reinsurers are definitely looking for more

property business, both individual risks and treaty business."

There is "ample capacity" in the property reinsurance marketplace, said Michael W. Cashman, president and managing partner at Minneapolis-based E.W. Blanch Co. "There is a lot of capacity for property business right now and it's putting the pressure on prices."

However, ceding companies placing property treaties still are seeing "more modest rate reductions" than those in the insurance marketplace in general, added Mr. Cashman. Treaty reinsurers "are trying to maintain some stability. Depending on the program, we are seeing 10% to 20% reductions in property."

"As the supply increases, more reinsurers are coming to visit us, and most are asking us for our property business, but there is not a tremendous fluctuation in their rates," he explained.

"There have been more losses in property so far in 1988 than there were in 1987, but it has not impacted the reinsurance market," except possibly for some regional markets, said Robert F. O'Leary, Willcox's president and chief operating officer.

"It's rare that we sit down with a reinsurer who doesn't want property business," said Hodson's Mr. Taylor. "They all want good property business. That market has been and continues to be competitive."

"Competition is most active in the property working areas," said Michael E. Rothpletz, executive vp and chief operating officer at Hodson.

Mr. Taylor noted that "on catastrophe business, 10% to 12% rate reductions is a fair estimate," while Mr. Rothpletz said that rates have been cut 15% to 20% in the working layers.

"The property softening is based on experience," added Mario Leo, chief executive officer of TPF&C Reinsurance in Philadelphia. "If the experience of the ceding company has been good, it may see a 15% to 20% reduction on the treaty side."

Some observers cite the property per risk business—business in which limits and retentions are applied on a per-risk basis rather than on a per-accident or on an aggregate basis—as being particularly competitive.

"Property per risk is very competitive because less and less premium is out there," said Willcox's Mr. O'Leary. "Insurers are buying less and less risk coverage."

Per-risk property treaty business is "very competitive," agreed Pru Re's Mr. Dwane, who suggested that much of this business renewed on July 1 "may not be profitable" for reinsurers.

However, Mr. Garrity of the Reinsurance Agency said there has only been a "certain softening for per-risk excess coverage. If the broker can make the argument that the business was profitable, we are seeing probably a 10% to 15% reduction."

In addition to the rising competition among U.S. markets, London underwriters are more actively seeking U.S. property

reinsurance business, note some observers (see related story).

"London is more interested in U.S. property business and U.S. markets are competitive," said Mr. Garrity.

"I think most of the competition comes from across the ocean," particularly the London market, agreed Wendy Baker, senior vp at Continental Reinsurance Co. in New York.

Mr. Cashman also said "London has been quite competitive on property insurance. It is the major market outside of the U.S., particularly in the catastrophe area."

U.S. reinsurance market observers generally agree that there has been less competition for casualty business, although there has been some loosening in contract terms and conditions and rate reductions of perhaps 10% on more moderate risks.

"Casualty rates have held up pretty well," said TPF&C Re's Mr. Leo. "Reinsurers are holding the line. Their urge to preserve their market share has not overwhelmed realistic pricing. I think they have more sophisticated managements in place."

Mr. Taylor noted also that "there are concessions on terms and conditions. Today, our client may have the same rate, but bells and whistles have been eliminated: sunset clauses, aggregate caps, loss corridors."

Sunset clauses generally phase out coverage over a defined period of time, while aggregate caps limit total payouts under casualty contracts in a given year.

Under a loss corridor, the ceding company shares a portion of the risk with an excess-of-loss reinsurer. For example, in a \$100 million excess of \$100 million layer, the ceding company may be required to pay those claims falling within the "loss corridor" between \$110 million and \$125 million to make the ceding company "more cognizant of its rating," Mr. Taylor explained.

Blanch's Mr. Cashman said that more treaty reinsurers are willing to write casualty business, but with "no drop-off of rates to speak of." However, he added, "there is some loosening of terms and conditions."

Sunset clauses and aggregate caps for some riskier classes of casualty treaty business have been modified, while they have been eliminated altogether for better risks, Mr. Cashman said.

"Form is not as much of a concern" among facultative reinsurers, Mr. Zaffino added. "Other than for a few classes, everyone is back to occurrence."

Mr. Zaffino said automatic and semi-automatic coverage, where coverage on specific classes of business is automatically accepted within certain parameters unless specifically rejected, has reappeared in the marketplace as well. "There is a lot of it available right now."

Mr. O'Leary observed that "foreign reinsurers have not shown any appetite to write normal U.S. casualty reinsurance business, though London is offering clash coverage and its attachment levels are moving down."

"There is more casualty capacity in the U.S., but that has not radically changed pricing," he said.

London reduces rates to retain renewals

By STACY SHAPIRO

LONDON—The London insurance market, flush with capacity, is holding on to most U.S. property/casualty business that renewed July 1 despite competition from U.S. underwriters.

But, to retain this business, London underwriters are reducing rates, improving policy terms and increasing capacity. While casualty insurance rate cuts have been limited to about 10%, London insurers are actively competing for property risks, sometimes slashing rates in half.

As a result, policyholders that have traditionally tapped the London market are staying faithful to their underwriters.

"The July 1 casualty business has held strongly to London," said Dick Drain, director at Lloyd's of London broker Lloyd Thompson Ltd. "Buyers who have been here for a number of years want to stay here, but they can't ignore the domestic market. So, London has responded."

"We are all back to the same old rat race, cutting rates to smithereens," added John Sawkins, chairman of the North American division of Lloyd's broker Bain Clarkson Ltd.

"We have had a good July 1, keeping our big renewals although the rates have been reduced, more so on property. London underwriters are willing to give relief to loyal clients," Mr. Sawkins said.

"To be fair, the core of the (U.S.) property business is staying in London, and the heavier the class, the more likely it stays," added John Turner, managing director of the North American property division of Alexander Howden Ltd.

"We certainly are very busy," said Peter Wilson, managing director of H.S. Weavers (Underwriting) Agencies Ltd., one of the largest markets in London for U.S. liability business. But, for the less hazardous risks, "we don't see as many new inquiries as we have done. London doesn't necessarily want to entertain new business."

Brokers and underwriters agree that London underwriters are more anxious to compete this summer—compared with a year ago—because of the huge amount of untapped capacity in the London market.

For example, because of the strength of the British pound against the U.S. dollar, Lloyd's of London is "overcapitalized" with more than 11 billion pounds (\$18.7 billion) of premium capacity, Lloyd's Chairman Murray Lawrence told members of Lloyd's last week at its annual general meeting. "We are now looking at market matters to see how we can get more business into the room."

Lloyd's non-marine underwriters say they have used only between 50% and 60% of their total premium capacity so far this year.

In addition, Lloyd's marine underwriters, who also say they are writing no more than 60% of their capacity this year, are providing more non-marine capacity, furthering competition for non-marine risks.

For example, the London Market Energy Lineslip, the line slip tapped by major oil firms that was recently renewed by London marine underwriters, now includes more than \$100 million in non-marine liability limits, up from \$10 million last year.

Non-marine liability coverage is written through the slip only when clients also insure their physical damage risks on the line slip, said John Wallace, managing director of Lloyd's broker Sedgwick Offshore Resources Ltd.

The line slip provides up to \$1.05 billion in physical damage coverage, up from \$870 million last year, primarily for offshore oil installations.

In addition, Weavers—the leading U.S. casualty underwriter in London—is awash with new capacity and is competing strongly for U.S. business, including property risks, brokers say.

Weavers reshuffled the participants on its line slip twice this year following queries from Marsh & McLennan Cos. Inc. about the security of the slip (BI, April 18; Jan. 11).

"We are encouraged and enthused by the way Weavers has enhanced its stamp," said Clive Moore, director of the North American casualty division of Alexander Howden Ltd., echoing other London broker remarks.

Brokers, who have described Weavers as a "baby bird" needing to be fed more and more business, say Weavers is competing not only with U.S. underwriters but also with other London underwriters for business.

However, Weavers' Mr. Wilson strongly disagrees and says that he is "not taking business away from the London market."

While U.S. insurers have largely discarded the claims-made liability form, most London underwriters still are writing U.S. liability business solely on a claims-made basis, with the Weavers claims-made form being the market's standard.

Claims-made "is not scaring business away," because most of the U.S. liability risks written in London are heavy casualty risks that can be written on only a claims-made basis, Mr. Drain of Lloyd Thompson explained.

London brokers can now place up to \$50 million in limits on the Weavers claims-made form, compared with \$40 million a year ago.

Weavers alone can write 100% of a \$5 million layer excess of at least \$2 million per claim/\$4 million aggregate; 87.5% of the \$15 million layer excess of \$5 million; and an undisclosed limited participation on \$30 million excess of \$20 million.

A Lloyd's non-marine underwriter, however, says that between \$50 million and \$100 million in excess liability limits can be found in the London market and that deductibles could be negotiated.

Excess liability coverages on the Weavers claims-made form—which comprise the bulk of London liability insurance renewals—are seeing rate reductions of around 10%, said several Lloyd's brokers.

And one Lloyd's marine underwriter said that general liability rate reductions average 20% in the marine market.

"Rates have eased," added a Lloyd's broker. "There are slightly softer conditions than last year."

However, Mr. Wilson denies excess liability rates are being cut, particularly on his company's claims-made wording.

"We are holding rates and are not advocating any reductions. They are not warranted," he said.

"Generally speaking, my rates are holding," said a Lloyd's non-marine underwriter.

While claims-made is the dominant liability policy form in London, a small market for occurrence-based coverage is building, brokers and underwriters agree.

The London market now can provide about \$5 million of excess liability coverage on an occurrence form, up from \$3 million last July. This coverage is most often used to fill in layers written by U.S. insurers, brokers say.

Rates for the occurrence-based coverage also are dropping, since the London underwriters follow the terms of the coverage written in the United States.

One of the London underwriters now writing U.S. excess liability risks on an occurrence basis is Turegum Insurance Co., a subsidiary of Zurich Insurance Group. Turegum, which writes both direct insurance and reinsurance, will offer \$2.5 million in general liability limits on an occurrence basis, confirmed casualty underwriter Elizabeth Dalla-Valle.

Additional capacity also is available for other types of U.S. casualty risks in the London market:

- \$25 million of capacity now is available for small to medium-sized chemical companies under an agreement between PRIMEX Ltd., a Barbados-based excess liability insurance facility, and Weavers (BI, June 27).

- Additional professional liability capacity is available from Lloyd's and the London insurance and reinsurance company market.

A medium-sized law firm, for example,

Continued on next page

London renewals

Continued from previous page

can find between \$20 million to \$25 million of professional liability coverage, said Mr. Moore of Howden. He added that the London price would be more expensive than U.S. rates.

However, one Lloyd's casualty broker disagreed, saying that there is only a maximum of \$10 million coverage for law firms, which is the same as last year.

He added that "a ton" of new U.S. hospital medical malpractice risks is flowing into the London market, probably because of "lack of a marketplace in the U.S."

The London market, led by Weavers, now writes the bulk of the first \$10 million layer of hospital medical malpractice coverage, with some participation from other U.K. insurers. London also writes a portion of another \$15 million layer, the broker said.

Rates cannot be compared with last year since this is new capacity. However, the rates charged by the London underwriters "are competitive" with those charged by U.S. insurers, he said.

The hospitals that have previously purchased medical malpractice coverage in London are seeing their rates cut 5% to 10% on renewal, the broker said.

Meanwhile, property insurance rates are continuing to dive, say London brokers.

For example, rates for standard property

risks are being cut by an average of 25% from last July when rates were cut by an average of 15%, said Mr. Turner of Howden.

Mr. Sawkins at Bain Clarkson said that property rates are being cut by 30% to 50% in London, compared with rate reductions totaling as much as 70% in the United States.

"London underwriters are willing to give relief to loyal clients. London underwriters will quote and try to get new (property) business, but they won't follow rates as far down as the Americans," Mr. Sawkins said.

Mr. Wilson of Weavers adds that London "is going to be more expensive than the American market" on property business. But policyholders that have long done business in London do not switch markets "just because the price is cheaper elsewhere."

In addition, the London market for U.S. property coverage, which is dominated by Lloyd's underwriters, is offering between 25% to 50% more capacity compared with a year ago, said Mr. Turner.

U.S. companies can buy \$150 million to \$200 million of property coverage in London this year, compared with \$100 million to \$125 million last year, said Terry Mann, deputy chairman and director of Lloyd's broker Price Forbes Ltd.

The leading U.S. property underwriters in London include Lloyd's syndicates managed by R.W. Sturge & Co. and Murray Lawrence & Partners.

And, Weavers—best known for its liability

insurance and reinsurance underwriting—also says it is now one of the leading London property underwriters. Weavers now writes 10% of a \$25 million property layer.

London underwriters are losing earthquake risks to U.S. insurers that are slashing rates, Mr. Mann said. But, instead of following competitive rates down, "London underwriters will wait until the next panic," he said.

London property underwriters no longer expect rates for U.S. policyholders to be affected by the 1.5 billion pounds (\$2.55 billion) in losses from the freak hurricane-force winds that swept through Southeast England, France and Norway last October.

However, the losses could increase property reinsurance rates at the end of the year, brokers and underwriters agree.

Generally, the property treaty reinsurance market now is "pretty steady" in offering capacity and prices, said Hady Wakefield, chairman of C.T. Bowring Reinsurance Co. Ltd.

London and U.S. underwriters, however, are competing for facultative property reinsurance and as a result "there is a bit of a gift in prices," he said.

Meanwhile, casualty underwriters in London report that U.S. ceding companies are continuing to tap the London market for catastrophe treaty reinsurance despite competition from U.S. reinsurers.

"We are still frightfully busy," said Chris

Burbidge, non-marine underwriter for Terra Nova Insurance Co. Ltd.

The London casualty treaty reinsurance market offers particularly competitive prices for "clash coverage," which is triggered when claims stemming from one incident are filed against two or more casualty insurance policies.

"There is coverage here on a catastrophe basis as long as the reinsurance has the right bells and whistles," such as sunset clauses and limited reinstatements, said Mr. Wakefield of Bowring. Although the London market may not be as competitive for other types of casualty treaties, the market "on clash covers offers a very competitive prices."

Rates for casualty clash reinsurance contracts for example are being cut by 5% to 10% by London underwriters, Mr. Burbidge said.

And, while London underwriters are sticking to restrictions like limited reinstatements and sunset clauses that were imposed during the hard market of the mid-1980s, "the sunset clause is under pressure," said Mr. Burbidge.

For example, a ceding company may be given seven years in which to file claims on a contract, up from five years, he said.

In both the U.S. and London market, U.S. ceding companies can now buy around \$45 million of clash coverage, compared with about \$30 million previously, Mr. Burbidge said.

Ohio tort reform law ruled unconstitutional

WASHINGTON—An Ohio law that set a statute of limitations for filing certain types of lawsuits against Ohio-based companies but did not grant the same protection to out-of-state companies with offices in Ohio is unconstitutional, the U.S. Supreme Court has ruled.

In an 8-1 decision, the court ruled June 17 that the statute is unconstitutional because it is discriminatory and interferes with interstate commerce.

The statute says suits alleging breach of contract or fraud against Ohio-based companies must be filed within four years of the occurrence.

The ruling came in a case involving Midwesco Enterprises Inc. of Niles, Ill., and Bendix Autolite Corp., a company that was incorporated in Delaware but that conducted most of its business in Ohio. Bendix was acquired by Allied-Signal Inc. in 1982.

Bendix had sued Midwesco in 1980 for breach of contract, charging that a boiler Midwesco installed in 1974 at an Ohio Bendix facility malfunctioned.

Midwesco said it was protected from the suit under Ohio's four-year statute of limitations.

The Supreme Court's ruling upholds a decision by the 6th U.S. Circuit Court of Appeals in Cincinnati, which affirmed a federal district court's ruling dismissing Bendix's action.

—By Brigitte Maxey

Vocational rehab

SAN FRANCISCO—Employers' reports on vocational rehabilitation plans for workers with short-term injuries in California will be reduced under a new regulation that took effect last week.

The new rule is intended to enhance early identification and referral of candidates for rehabilitation.

The most significant benefit for employers and insurers will be a reduction of paperwork and the elimination of a "disability status report."

Previously, the report had to be filed in all cases where total disability lasted for at least 180 days, said the California Workers' Compensation Institute.

Last year, more than half of the 63,000 reports filed involved cases that were already closed because the employee returned to work without the need for rehabilitation, the institute said.

Under the new regulations, employers generally will report only after a vocational plan has been developed, if a dispute arises, when vocational rehabilitation benefits are denied or a termination of services is requested.

"However, the employer and treating physician will be required to evaluate rehabilitation potential after 90 days of temporary total disability and continue the process until the injured employee either is released to return to his or her usual occupation or is determined to be eligible for vocational rehabilitation services," the institute stated.

Other changes in the rules include increasing the information an injured employee receives and modifying the selection and assignment process for independent vocational evaluators.

—By Meg Fletcher

Colorado legislation

DENVER—A medical malpractice law in Colorado that begins taking effect this week limits the liability of individual and institutional health care providers in civil cases.

Key provisions of the law include:

- Capping a plaintiff's recovery at \$1 million, including up to \$250,000 for non-economic damages, unless a judge decides those awards would be unfair in light of the victim's past or potential earnings, medical expenses, or both.

This provision goes into effect Jan. 1, 1989.

- Requiring a judge to order a defendant to pay future damages periodically for awards with a present value of \$150,000 or more. In addition, the law permits a judge or jury to order periodic payments for lesser amounts and allows lump sums to be paid to some plaintiffs.

- Requiring most doctors, dentists and health care institutions to demonstrate by Jan. 1, 1990, their financial ability to pay a \$500,000 claim.

And, individual health care providers must be able to pay up to \$1.5 million annually in claims, while hospitals are required to demonstrate that they can pay up to \$3 million in annual claims.

Health care providers can prove their ability to pay claims by depositing funds in a trust account, buying insurance or posting a surety bond.

Around the states

Excluded from the requirement are public entity health care providers or institutions.

- Requiring that any judgment be reported to the provider's insurance company or licensing agent or face a fine of up to \$2,500.

- Allowing providers to ask patients to sign an agreement that requires professional negligence claims be resolved through binding arbitration.

However, such an agreement must meet certain requirements, including acknowledging a patient's right to seek legal counsel and allowing the patient to rescind the agreement within 90 days.

However, the law emphasizes that a provider cannot withhold medical services if a patient refuses to sign or rescinds the agreement.

- Using "ordinary care" as the standard providers will be held to in cases where newborns' injuries are due to genetic causes.

- Requiring insurers and the insurance commissioner to consider the impact of tort reform measures in determining appropriate medical malpractice rates in the state.

- Providing immunity for most providers who responsibly administer vaccines to children.

- Requiring plaintiffs in professional negligence cases to give written notice of the medical benefits they received.

- Restricting expert testimony in medical malpractice cases to licensed physicians who can demonstrate "substantial familiarity" with the applicable standard of care and the practice or procedure under litigation.

—By Meg Fletcher

Kansas law killed

TOPEKA, Kan.—The Kansas Supreme Court has ruled that a 1986 law capping total recovery in medical malpractice actions at \$1 million violated the state's constitution.

The June 3 ruling upheld the 1987 ruling of the Shawnee County District Court.

In the meantime, however, Kansas has enacted new tort reform measures, including a cap of \$250,000 on all non-economic

damage awards and a \$5 million cap on punitive damages (BI, May 16). These took effect for cases filed after July 1.

In challenging the 1986 reforms, the declaratory judgment action was brought by the Kansas Malpractice Victims Coalition and a group of named and unnamed medical malpractice victims against Insurance Commissioner Fletcher Bell in his capacity as administrator of the Health Care Stabilization Fund.

The medical malpractice law called for the establishment of the fund to pay damages for personal injury or death in malpractice suits that exceed the providers' medical malpractice coverage. The fund is capitalized through surcharges on providers' primary medical malpractice insurance premiums.

The malpractice law barred recovery for future losses in excess of \$1 million and required investment of awards in annuities.

The law also limited to \$250,000 recovery for non-economic losses, defined as all damages other than costs of medical care and related benefits, lost wages and loss of earning capacity. Those damages include pain and suffering, mental anguish injury and disfigurement not affecting earning capacity.

The court ruled that the award caps violated the equal protection, right to a jury trial and justice without delay provisions of the Kansas Constitution.

The plaintiffs contended that capped provisions impaired their right to a jury trial "by truncating the jury's ability to fix damages," according to court papers.

The court found the remedy provided by the statute inadequate "because it treated every injury identically, irrespective of a court's findings."

—By Brigitte Maxey

New York regulation

NEW YORK—The New York Insurance Department late this year will begin regulating all risk retention and purchasing groups forming or operating in the state, under a law signed by Gov. Mario Cuomo.

The Risk Retention and Purchasing Groups law is modeled after a National Assn. of Insurance Commissioners model law.

Under the new law, which goes into effect Dec. 9, a risk retention group that wants to be chartered in New York must comply with most

provisions of the state law applicable to property and casualty insurance companies, including filing annual and quarterly statements with the Insurance Department and submitting to financial examinations by the department every three to five years.

A risk retention group that is chartered in another state but wishes to conduct business in New York must identify the state where it is chartered, submit a notice of intent to the Superintendent of Insurance, a copy of its plan of operations and financial information, including the group's capital and surplus and its reserving practices to pay claims.

"What we mainly see are groups that become licensed in another state and choose to operate in New York. The Risk Retention and Purchasing Groups law allows us to monitor the situation. Prior to this, there was no record of where the risk retention group was chartered," said a New York Insurance Department spokesman.

All risk retention groups also will be subject to the state's Unfair Claims Settlement Practice provisions regarding deceptive, false or fraudulent acts, examination requirements regarding financial condition and compliance with court injunctions and orders.

Every policy issued by a risk retention group operating in New York must include a notice on the declaration page stating that the policy may not be subject to all state insurance laws and regulations and that state insurance insolvency guaranty funds are not available for risk retention groups, the law states.

Purchasing groups and their insurers will be subject to all applicable state laws, which include filing rate and policy forms with the department.

And a purchasing group that intends to operate in New York must submit a notice of intention to the superintendent that includes the name and domicile of the insurer with which the group intends to do business.

The 1986 amendments to the Risk Retention Act allow risk retention groups to operate nationwide to provide all casualty coverages except workers compensation to member-owners. In addition, the law pre-empts state laws that prohibit employers from purchasing casualty insurance on a group basis.

—By Lauren Sinai

Section 89

Continued from page 1

that Section 89—at best—would be an administrative nightmare for employers and—at worst—would be unworkable and lead to massive violations of the law.

"This is an important first step to reduce Section 89's administrative burden. There is a willingness on the part of staff to cooperate and discuss changes to make the law workable," said Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington.

"While the proposed changes are not a panacea, they do provide some administrative relief," added Frederick Rumack, director of taxes and legal services for Buck Consultants Inc. in New York.

Still, benefit experts caution that even if the changes are adopted by Congress, Section 89 will remain an extremely complicated law, presenting employers with major new requirements in collecting and analyzing data on who is eligible for coverage and participating in their plans.

That can be an enormous admin-

istrative challenge for big, decentralized multistate employers with hundreds of health care plans.

"Even with the changes, Section 89 will be an extremely complicated statute. It may be less expensive to deal with, but still will be hard to understand," said Tom Butterworth, a partner in the Rowayton, Conn., office of Hewitt Associates.

And, employers shouldn't kid themselves that the proposed changes are any kind of signal that Congress intends to gut Section 89 or delay its Jan. 1 effective date, experts say.

"No one should expect the rules to go away. The die has been cast. Section 89 is a permanent part of the employee benefit plan regulatory waterfront," said Mr. Rumack.

Still, some members of congress have said that they will press for more changes in Section 89 as the technical corrections bill moves through Congress.

"All sides are pleased to see this progress. However, this progress has been modest. A lot more work needs to be done to provide the broad relief that is needed," said

Rep. William Coyne, D-Pa., in a letter to House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill.

For now, though, benefit experts are digging into the Section 89 changes included in the Ways and Means Committee technical corrections bill. The most significant change, they say, is the provision to allow employers to run the non-discrimination tests once a year, rather than "continuously."

Under this provision, in 1989, an employer could pick any date, such as Dec. 31, to run the tests.

In 1990, an employer could choose another date, such as the first of the year, but then would have to stick with that date in succeeding years. Generally, the annual testing date, which would have to be specified in plan documents, could not be changed without the treasury secretary's consent.

This once-a-year testing could cut in half some employers' compliance costs, said Mr. Butterworth. "There is a tremendous savings if you only have to conduct this snapshot once a year."

Continued on next page

Panel acts on education benefits

WASHINGTON—The House Ways and Means Committee last month tentatively approved extending the tax-favored status of tuition reimbursement benefits for three years.

Unlike previously, the benefit would have tax-favored status only for employees with incomes below an as-yet undetermined level. However, the benefit's tax-favored status would be restored retroactive to Dec. 31, 1987.

The committee extended the benefit's tax-favored status in legislation it was drafting to correct glitches in the Tax Reform Act of 1986. The technical corrections bill is expected to be approved this month.

Tuition reimbursement benefits became taxable benefits after sections of the tax code governing their tax-favorable status expired on Dec. 31, 1987. Under Section 127 of the code, employees were allowed to

collect up to \$5,250 annually in reimbursements for tuition and related expenses without paying federal and Social Security taxes on the funds (BI, Jan. 4).

Employers offering the benefit have found themselves in a difficult situation since the benefit's tax-favored status expired.

If they did not withhold taxes for the benefits and Congress did not extend their tax-favored status, employees could object when they learn they owe additional taxes but have not put aside any money to pay them.

However, if employers withheld taxes on the benefits and Congress retroactively extends the benefit's tax-favored status, employers will have to make adjustments in their withholding rates so employees do not pay too much in taxes.

—By Deborah Shalowitz

Proposal caps COBRA liability

By JERRY GEISEL

WASHINGTON—The latest congressional proposal to amend COBRA's penalty provisions would cap an employer's annual liability for COBRA violations.

Under amendments included in a technical corrections bill that could be approved by the House Ways and Means Committee this week, the maximum total liability an employer would face for COBRA violations would be \$500,000, or 10% of the prior year's health care costs, whichever is less.

This limit, though, would not apply to violating COBRA with willful neglect, such as failing to make a reasonable effort to correct violations.

Also under the proposal the penalty for violating COBRA would be \$100 per day of violation per beneficiary.

While some benefit lobbyists say the new \$500,000 penalty cap is too high, they acknowledge that the proposed amendment is a vast improvement over the current penalties contained in the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985: loss of the employer's tax deduction for health care expenses in the year a COBRA violation occurred and taxing highly compensated employees on the value of their health care benefits.

"While we think the cap is too high, we're glad that there is some kind of limit on liability," said Cathy Amkraut, director of public policy for the Washington Business Group on Health.

"While the penalty is a bit stronger than necessary, this certainly is a better approach," agreed Howard Weizmann, execu-

tive director of the Assn. of Private Pension & Welfare Plans in Washington.

The new proposal to amend COBRA also is different than expected regarding COBRA violations uncovered during an Internal Revenue Service plan audit.

The \$100 per-day penalty would be waived if the violation were inadvertent and corrected within 30 days, except when the IRS discovered a COBRA violation that was not corrected before the employer received notice of an IRS audit.

In that situation, the penalty would be \$2,500 per affected beneficiary or the excise tax that would be due based on the length of violation, whichever is less. And, violations considered more than "de minimus" would be subject to a \$15,000 fine.

Benefit experts had expected the penalty in this situation to be similar to those contained in an earlier bill killed last year by a congressional conference committee: a special minimum tax of \$18,000 per affected beneficiary or \$100 per day of non-compliance, whichever was higher.

By contrast, under the latest proposal, the special minimum tax could be as little as \$100 if the violation lasted only one day.

It is possible that congressional staff mean that the special minimum tax would be \$2,500 or a \$100 per day fine for non-compliance, whichever is greater. The confusion will be cleared up when actual bill language and a committee report are available. So far, the only explanation is provided in a document prepared by the Joint Committee on Taxation.

While employers applaud congressional staffers for drafting more reasonable COBRA penalties,

they remain very concerned about another provision in the new technical corrections bill that would expand COBRA coverage.

Under that provision, former employees would be allowed to retain COBRA coverage after they become covered under another employer's health care plan.

This "double coverage" would allow employees to sock former employers with big health claims.

For example, a former employee needing major dental work could pay a COBRA premium for one month, receive the dental work until the plan limit is exhausted and then stop paying the COBRA premium. The employee then could tap the entire dental plan limit offered by his or her new employer (BI, April 11).

Benefit experts say such a substantial change to COBRA has no place in a technical corrections bill. "This is a major conceptual change. My sense is that it goes beyond a technical change," said Andy Anderson, a consultant with Hewitt Associates in Lincolnshire, Ill.

The double coverage provision was drawn up by congressional staff after they heard reports that COBRA beneficiaries with pre-existing medical conditions had racked up huge uncovered medical bills after their former employers canceled COBRA coverage when they became covered by a new employer-sponsored plan. That happened because the new plan excluded coverage for pre-existing conditions.

Business lobbyists say that problem could be avoided by an amendment that would allow COBRA beneficiaries to retain COBRA coverage for pre-existing medical conditions only. ■

Update

Illinois requires auto insurance

Continued from page 2

prove in court they had coverage at the time of arrest. Offenders' vehicle registrations also would be suspended.

Instead of buying insurance, automobile owners could also purchase a bond to meet the financial responsibility requirements.

The law would expire Sept. 30, 1993, when it could be reinstated or modified. Similar legislation has been introduced in the Illinois Legislature every year for the past 17 years.

Forty other states already have mandatory auto insurance laws, according to the Alliance of American Insurers in Schaumburg, Ill.

Work comp covers Paris crash

PARIS—Many survivors of the 56 people who died and those who were injured when a commuter train rammed into another last week at the Gare de Lyon train station will be able to collect workers compensation benefits from the victims' employers.

Most of the victims were on their way home from work and, as a result, are entitled to workers comp, known in France as "accident du travail," said a spokeswoman for French insurance association Centre de Documentation d'Information de l'Assurance.

Survivors also could seek compensation from the self-insured government-run railroad, Societe Nationale de Chemins de Fer.

EPA sues for cleanup costs

WASHINGTON—The U.S. Environmental Protection Agency is suing Highland Park, Mich.-based Chrysler Corp. and 11 other parties for more than \$4.2 million for the agency's past cleanup costs and future oversight costs at two hazardous waste sites.

This is the first time the EPA has sued polluters that rejected settlement offers to clean up hazardous waste sites.

The EPA is seeking nearly \$3.3 million plus one-third of future oversight costs from Chrysler and Knotts Inc. of New Castle, Del., to clean up a hazardous waste site in Delaware.

Detroit-based General Motors Corp. is among the parties that in a negotiated settlement with the EPA agreed to clean up the Delaware site; in return, the agency will reimburse General Motors for one-third of its cleanup costs, estimated to exceed \$9 million.

The agency also is suing eight companies and two individuals for \$925,000 in clean up costs plus one-quarter of future oversight costs at a hazardous waste site in Pennsylvania.

Suit filed over CSX derailment

HOPKINSVILLE, Ky.—Residents near Crofton, Ky., who were made ill and forced to evacuate their homes last month after a CSX Transportation Co. train accident released noxious fumes, are seeking unspecified damages in a class-action suit against CSX.

The lawsuit, filed in Christian County Circuit Court, alleges that Jacksonville, Fla.-based CSX, which operated the train on company-owned track, was negligent and created a public nuisance.

CSX is self-insured for up to \$25 million, a company spokesman said previously (BI, Sept. 28, 1987).

A spokesman for Bermuda-based Railroad Assn. Insurance Ltd., which writes excess liability insurance for railroads, confirmed that CSX is a RAIL member.

RAIL writes \$50 million in liability coverage excess of \$50 million for third-party liability, evacuation, sudden and accidental pollution risks as well as liability under the Federal Employers Liability Act.

Forty of 121 cars derailed in the accident, including a tank car filled with 13,800 gallons of white phosphorous that leaked. The chemical ignites when it comes in contact with air, and as a result, noxious fumes covered several square miles of the community.

About three dozen people were treated for respiratory problems and nausea, but none was hospitalized, according to a spokesman for the state's emergency services. In addition, 15,000 residents were evacuated from their homes for several hours.

The cause of the accident still is being investigated. However, it is known that the train was traveling 35 mph in an area where the speed limit was recently reduced to 10 mph because of poor track conditions, a CSX spokesman said.

The railroad reported it sustained \$375,000 of damage to cars and \$15,000 of damage to track. CSX's risk manager could not be reached for comment.

CSX also faces two similar lawsuits seeking billions of dollars in damages that were filed after derailments forced evacuations near Gentilly, La., (BI, Sept. 28, 1987) and near Miamisburg, Ohio (BI, July 28, 1986).

Briefly noted

Union Carbide Corp. was ordered by an Indian district court judge to postpone settling any suits with individual victims of the December 1984 Bhopal poison gas disaster pending a July 29 hearing on the Indian government's request for the court to bar any settlements that do not involve the government (BI, June 27). . . . President Reagan last week signed into law legislation **expanding Medicare** to cover the costs of acute care for catastrophic illnesses and some of the costs of outpatient prescription drugs. . . . The 11th U.S. Circuit Court of Appeals on June 17 stayed an order by a district court consolidating all asbestos bodily injury claims against **Raymark Corp.** to hear requests to decertify the class-action suit (BI, June 20). . . . The London members of the **Asbestos Claims Facility** voted last week to dissolve the revolutionary claims-handling organization and to work to form a new smaller asbestos claims-handling organization (BI, May 30). . . . San Mateo County Superior Court Judge William Lanam last week denied a motion to stay the **Shell Oil Co.** litigation to await a possible appellate court ruling in the Aerojet-General Corp. litigation (BI, June 13; May 30).

Section 89

Continued from previous page

"This is a very key change. Staffers at last have realized that continuous testing could not have been done as a practical matter," added Henry Saveth, a managing consultant with A. Foster Higgins Co. Inc. in New York.

In addition, while experts say more clarification is needed, another change would allow employers to run the non-discrimination tests on a statistically valid random sample of employees rather than for all employees.

Sampling, which would have to be conducted by an independent third party, would be treated as valid only if the statistical method and sample size "produce a 99% level of confidence that the sample results have a margin of error not greater than 2%," according to a description of the provision prepared by the Joint Committee on Taxation staffers.

Another proposed change would add a second calculation that employers could use in running the 80% coverage test.

Under that test, a health care plan is considered non-discriminatory if it covers at least 80% of an employer's non-highly compensated employees—generally those earning less than \$50,000 annually.

This test is called an alternative test because if it is passed, the employer's health care plan would not have to pass two "eligibility" tests and one "benefits" test.

However, this test has not been considered much of an alternative since companies with multiple plans—such as those offering indemnity plans and health maintenance organizations—undoubtedly would fail because not enough lower-paid employees would be covered by any one plan.

Employers are allowed to aggregate different plans as one plan, such as two HMOs, in applying the alternative coverage test, only as long as the least valuable plan has a value at least 95% of the most valuable plan.

Many employers, though, offer health care plans whose values may differ by more than 5% and thus would not be allowed to aggregate, making the alternative

coverage test useless.

But under the Ways and Means Committee proposal, aggregation would be allowed for the alternative coverage test as long as the least valuable plan has a value of at least 80% of the most valuable plan.

At the same time, though, to use this test, 90% of employees—rather than 80%—would have to be covered by the aggregated plans.

Reducing the plan value threshold for aggregation to 80% from 95% could benefit a significant number of Fortune 100 companies

that offer similar, but not identical, health care plans, commented Kevin Meehan, an attorney in the Washington office of The Wyatt Co.

In another change that employers will welcome, the legislation makes clearer how employers will calculate whether an employee works enough hours to be included when running the non-discrimination tests.

Currently, employees who "normally" work at least 17.5 hours a week must be included. But it can be difficult for an employer to

know at the beginning of the year which employees will normally work at least 17.5 hours a week to include them.

Under the Ways and Means Committee proposal, employers in 1989 would only have to count—for non-discrimination testing—part-time employees who are scheduled to work at least 17.5 hours a week.

Then, starting in 1990, employers would be allowed to use the number of hours an employee worked the prior year to determine if the employee worked an average of 17.5 hours a week. ■

Government contractor defense

Continued from page 1

government of any defects known to the contractor.

Although the ruling was based on a case involving a Marine officer who died in a crash of a military helicopter made by United Technologies Corp., three of the justices who dissented in the case, as well as several attorneys, point out that the so-called government contractor defense could be extended to encompass non-military products.

The court's "breath-takingly sweeping" ruling "applies not only to military equipment like the CH-53D helicopter, but to any made-to-order gadget that the federal government might purchase after previewing plans—from NASA's Challenger space shuttle to the Postal Service's old mail cars," said the dissent by Justices William J. Brennan, Thurgood Marshall and Harry Blackmun.

"It is possible that manufacturers of consumer products requested by the government will invoke this defense," added Michael Athans, an attorney with Lord, Bissell & Brook in Atlanta. "Arguments can be made that the defense is not limited to military products."

"I think you could read the court's opinion to include civilian equipment," said Kenneth S. Geller, an attorney with Mayer, Brown & Platt in its Washington office, who filed an amicus curiae brief on behalf of 20 military contractors and six manufacturing trade groups. "The decision is not expressly limited to military equipment."

"The essence of the opinion is that if you make something for the federal government under a federal contract, state law is displaced," explained David Broiles, an attorney for Bell Helicopter Textron Inc. in Fort Worth, Texas, which also filed an amicus brief.

However, several attorneys had different interpretations. For example, John Bivona, a partner with Levy, Bivona & Cohen in New York, said he believes the court intended to limit the ruling to military products. "It would appear this ruling is limited to military contractors in personal injuries," he said.

In addition, the ruling explicitly extends the government contractor defense to litigation brought by civilians. Lower courts have restricted the defense to litigation filed by government personnel.

The three justices noted in their dissent: "The contractor may invoke the defense in suits brought not only by military personnel... or government employees, but by anyone injured by a government contractor's negligent design, including, for example, children who might have died had respondent's helicopter crashed on the beach."

"The court has expanded the defense to put civilians in the same position as servicemen," said Lewis T. Booker, attorney with Hunton & Williams in Richmond, Va., who represented United Technologies Corp. in the case before the court.

Mr. Geller agreed: "It is clear the defense applies to civilians" who bring product liability litigation against government contractors.

The Supreme Court's ruling stemmed from litigation between the family of Lt. David A. Boyle, a Marine who was killed April 27, 1983, when a CH-53D helicopter crashed off the coast of Virginia Beach, Va., and United Technologies.

Although Lt. Boyle survived the crash, he was unable to flee the helicopter and drowned because water pressure blocked the escape hatch.

A U.S. District Court ordered United Technologies to pay \$725,000 to Lt. Boyle's father.

But the U.S. 4th Circuit Court of Appeals reversed the lower court ruling, citing the government contractor defense. Lt. Boyle's father appealed to the U.S. Supreme Court, which upheld the appellate ruling.

"State law is displaced where judgment against the contractor would threaten a discretionary function of the government," said the majority opinion written by Justice Antonin Scalia. "State law which imposes liability for design defects in military equipment is displaced where:

- "The United States approves reasonably precise specifications.

- "The equipment conformed to those specifications.

- "The supplier warned the United States about dangers in the use of the equipments known to the supplier but not to the United States."

Justice Scalia continued, "The imposition of liability on government contractors will directly affect the terms of government contracts: Either the contractor will decline to manufacture the design specified by the government, or it will raise its price. Either way the

interests of the United States will be directly affected."

Justice Scalia was joined in the majority by Chief Justice William H. Rehnquist and Justices Anthony M. Kennedy, Byron R. White and Sandra Day O'Connor.

Justice John Paul Stevens filed a separate dissent.

The Supreme Court established a limited government contractor defense in 1940. Since then, dozens of state and federal courts have broadened the defense, though they have differed in how and when immunity should be granted to government contractors.

Last week's Supreme Court ruling is consistent with the broadest interpretation of the defense by the lower courts, according to several attorneys.

For example, the ruling is significantly broader than a 1985 ruling by the 11th U.S. Circuit Court of Appeals in *Shaw vs. Grumman Aerospace Corp.* That court ruled that to be immune from liability, a government contractor must prove:

- It did not participate or participated only minimally in the design of those products or parts of products found to be defective.

- It timely warned the military of the risk of the design and notified it of alternative designs reasonably known by the contractor and that the military, although forewarned, clearly authorized the contractor to proceed with the dangerous design.

The Supreme Court specifically rejected the 11th Circuit interpretation of the government contractor defense and refused to hear the case.

Attorneys last week pointed out that the Supreme Court decision will block claims filed by Vietnam veterans who opted not to participate in the \$200 million settlement between other veterans and seven companies that produced the defoliant Agent Orange (*BI*, June 27; May 14, 1984).

The veterans attempting to bring a new class action against the Agent Orange manufacturers will be bound by the Supreme Court ruling because they were military personnel at the time they were exposed to Agent Orange, which was a substance produced to meet military specifications, according to several attorneys.

Furthermore, the Supreme Court last week refused to hear two appeals to the class-action settlement.

Spokesmen for Monsanto Corp. and Dow Chemical Co., two of the Agent Orange defendants, cheered the Supreme Court ruling.

However, attorneys say the ruling is not likely to aid defendants in asbestos personal injury litigation.

First, most of the current asbestos personal injury litigation involves employees of non-military contractors. In addition, attorneys say the ruling probably will not apply in the remaining shipyard worker cases because asbestos was sold to defense contractors that built ships, rather than to the government itself.

Asbestos producers and their insurers have unsuccessfully tried to use the government contractors defense to escape liability for personal injury claims.

Because the Supreme Court ruling merely endorsed earlier lower court rulings, insurers say the decision will not lower the price or increase the availability of liability insurance for government contractors.

"We have underwritten these risks based on this standard" so there will be no change in rates, said Brian O'Hara, president of Barbados-based X.L. Insurance Co. Ltd.

Insurers have considered government contractors good risks for years because they have successfully invoked the government contractor defense, he said. "Government contractors have been mostly shielded from these suits, unless they designed the product outside the government specifications," he said.

John R. Cox, chairman of A.C.E. Insurance Co. Ltd. in Bermuda, also said he did not foresee any changes in the price of general liability insurance for government contractors.

However, Mr. Cox did say it is possible that rates for directors and officers liability insurance for government contractors will be reduced.

"If the liability elements are being reduced, there would be a more favorable effect on D&O, if anything," Mr. Cox speculated, explaining that reducing a government contractor's liability also reduces the chance of shareholder suits prompted by liability losses.

"The market (for government contractor liability insurance) is already flexible," said Patrice Bennett, assistant vp with Alexander & Alexander Inc. in New York. She said she brokered a government contractor risk last week and "the Supreme Court decision, by itself, had no impact on the price." ■

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Many insurer executives not in touch with reality

By MYRON M. PICOULT
Special to Business Insurance

FOR THE MOST part, insurance analysts are distrustful of the information provided by property/casualty managements. There is a feeling that, despite all of the noise about enhanced information systems, many executives are simply not in touch with reality.

Responses to analysts' queries about pricing revolve around averages; information about "risk-adjusted prices" is virtually non-existent. Such information could help to clarify uncertainty about pricing extremes, changes in terms and conditions and purposeful miscoding by underwriters.

Property/casualty executives clearly are frustrated by the industry analysts' reluctance to accept their explanations about current pricing and the operating environment. Managements are unhinged by analysts' emphasis on anecdotal information. The confluence of a deteriorating underwriting environment, the implementation of several Financial Accounting Standards Board accounting proposals (Nos. 96 and 97) and the restatement of prior-year results to provide a comparison doesn't help the situation.

Aside from the comparability problem with a particular company's earnings base, comparability among insurers will also suffer materially. Simply put, the industry's ac-

counting and nomenclature problems will deteriorate.

Regulatory authorities require the use of statutory accounting. In some quarters, this method is viewed as being too conservative, although it does reflect true cash flows. It should be noted that operating expenses and claims are paid out of cash flows and not from numbers generated by generally accepted accounting principles.



Mr. Picoult

Traditionally, stock market valuations have been based on GAAP data. If GAAP data are distorted by some unrealistic accounting proposals, valuation assumptions will also become distorted. Given the aforementioned, it might not be a bad idea to use statutory accounting as an interim standard until some sanity returns to the process. In any event, one could conclude that, for a while, GAAP earnings numbers may be equal to garbage.

As a famous philosopher once said: "...piling garbage on top of garbage only results in a bigger garbage pile."

The problem with the prospect of "funky" accounting has not gone unnoticed. Performance of property/casualty stocks over the past two years can be traced to some of FASB's initial proposals. Most industry observers agree that property/casualty stocks appear cheap. However, there is disagreement over whether the deteriorating operating environment and accounting confusion that lies ahead have been fully discounted at current price levels.

The changes in the operating environment go beyond the ups and downs of the tradi-

tional underwriting cycle. Basic structural changes are occurring subtly. They involve expense proficiencies, marketing prowess and more appropriate capital allocation.

In addition, as noted, some time-honored standards of measurement based on earnings figures may no longer be applicable due to the deterioration in the credibility of the earnings numbers. While book value may not be pristine, it may be a better intermediate-term measurement.

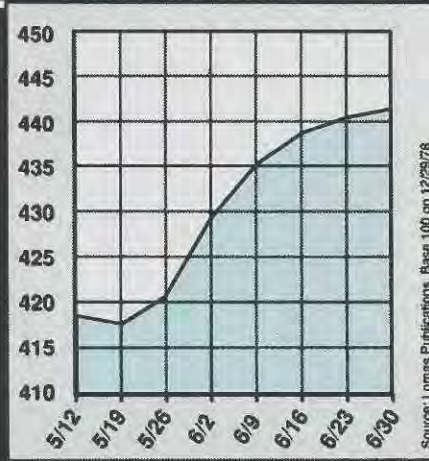
The ability of property/casualty insurer managements to manage their capital base effectively and enhance shareholders' equity will become increasingly important. In certain situations, this would include aggressive stock repurchase programs.

We believe that managements that manage their capital bases proficiently will have relatively consistent access to the capital markets. Mediocrity should not be rewarded. Hence, an increased emphasis on the relationship between return on equity and price/book values, overlaid with management ownership, may be a better way to look at the stocks.

In most instances, meaningful ownership stakes in the companies that they manage will make property/casualty executives think and act more like shareholders. For example, why maintain exposure to an unprofitable business segment where a company does not have sufficient critical mass? In addition, there are times to expose capital in one's basic business and times to husband it.

Finally, closer scrutiny of real cash-flow figures is another way to focus on new valuation standards. Cash flow should be divided into that which flows from operations and that which is derived from ancillary operations.

BI Insurance Index



Insurance industry stocks rose for the sixth consecutive week as the *Business Insurance* stock index jumped 1.3 points to 442.3 on June 30 from 440.9 on June 23. The biggest advances were tallied by Durham Corp., up 8.3%; AVECO Corp., up 7.7%; Hartford Steam Boiler Inspection & Insurance Co., up 7.0%; Frank B. Hall & Co. Inc., up 5.6%; and American Indemnity Financial Corp., up 5.0%. The largest declines were posted by: Tokio Fire & Marine Insurance Co., down 7.4%; Baldwin & Lyons Corp., down 6.3%; Statesman Group Inc., down 4.7%; Liberty Corp. of South Carolina, down 4.7%; and Farmers Group Inc., down 4.6%. The most active issues were: Farmers, 3.1 million shares traded; Sears, Roebuck & Co. (Allstate Insurance Group), 1.9 million shares traded; and ITT Corp. (Hartford Insurance Group), 1.3 million shares traded. The *BI* index, which gained 1.3%, outperformed the major market indicators: The Standard & Poor's 500 index dropped 1.3%; the NYSE composite fell 1.5%; and the Dow Jones 30 Industrials fell 6.6%.

British Issues

June 30 Companies	Price	P/E	Div. %	Yield %	1 Week	
					High	Low
Comml Union	379	14.4	21.9	5.6	380-375	
Genl Accident	888	10.3	47.9	5.3	894-880	
Gdn Royal Exch	947	14.1	55.2	5.8	948-944	
Royal	411	10.9	26.4	6.2	416-408	
Sun Alliance	986	16.1	43.1	4.2	988-970	
Brokers						
Bradstock	210	11.8	5.0	3.2	214-210	
CE Heath	427	16.4	34.5	8.0	443-427	
Hogg Robinson	183	14.6	9.6	5.1	183-182	
Lloyd Thompson	165	14.3	6.8	4.0	168-165	
PWS Holdings	204	8.6	14.4	6.9	204-198	
Sedgwick Grp	230	14.2	16.4	7.0	240-230	
Steel Brl Jones	197	12.2	13.7	6.8	197-197	
Willis Faber	263	13.9	15.4	5.8	275-263	

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kilcat & Aitken Stockbrokers, London

Insured weather losses total \$952 million in 1st half

NEW YORK—Insured losses from weather catastrophes increased 473% in the first six months of this year to \$952 million from \$166 million in 1987, according to the Property Claim Services division of the American Insurance Services Group.

In May alone, 24 states suffered wind, hail, tornadoes, explosions and fires totaling \$393 million in estimated damages. No catastrophes were reported in either April or May 1987.

"April and May are usually periods of intense tornado weather. In 1987 the analysts were proven wrong. There were none," said a spokesman for the Insurance Information Institute.

"So far, the catastrophic losses of the first half of 1988 have exceeded all of 1986 and 1987 (respectively)," he said. Insured damages caused by catastrophes of wind, hail and tornadoes in all of 1986 totaled \$872 million, or 8% less than the most recent six-month period. In all of 1987, insured damages totaled \$905 million, or 5% less than during the first half of 1988.

Since the beginning of June, the claim service identified three storms as catastrophe Nos. 62 through 64. The storms caused \$160 million in wind, hail and tornado damage in Texas, Oklahoma, North Carolina and Colorado.

BI Industry Stock Report

JUNE 30, 1988

6/24/88 THRU 6/30/88

BROKERS																											
		Price	Weekly % change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value			Price	Weekly % change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value		
Alexander & Alexander Svcs.	NYSE	23.63	2.2	33.1	24.50	17.75	329	1.00	4.2	15.0	3.40	6.95	Fremont Gen Corp.	OTC	10.25	0.0	6.4	13.50	8.75	133	0.60	5.9	548.0	16.75	0.61		
Baldwin & Lyons Inc.	OTC	15.00	-6.3	25.0	16.00	12.00	0	0.20	1.3	5.8	18.31	0.82	General Re Corp.	NYSE	53.38	-2.7	-4.5	56.38	45.50	571	1.20	2.2	10.6	26.21	2.04		
Corroon & Black Corp.	NYSE	31.50	0.0	11.5	34.75	28.00	30	1.08	3.4	4.8	12.42	2.54	Home Group Inc.	NYSE	13.00	0.0	9.4	14.38	11.50	264	0.20	1.5	2.8	17.65	0.74		
Gallagher Arthur J. & Co.	NYSE	18.38	2.1	14.9	18.00	13.88	12	0.48	2.6	12.2	5.16	3.56	Hanover Ins. Co.	OTC	24.00	1.6	3.2	26.25	20.50	60	0.36	1.5	5.3	25.10	0.96		
Hall Frank B. & Co.	NYSE	4.75	5.6	64.9	5.50	2.88	44	0.00	0.0	12.2	0.00	N/A	Harleysville Group Inc.	OTC	15.25	0.8	16.2	16.38	13.38	16	0.40	2.6	6.8	16.65	0.92		
Hilb, Rogal & Hamilton	OTC	11.25	0.0	15.4	12.75	9.75	8	0.00	0.0	12.2	0.00	N/A	Hartford Steam Boiler Insp	OTC	30.50	7.0	32.6	30.50	22.50	270	1.20	3.9	11.3	10.65	2.86		
Marsh & McLennan Cos. Inc.	NYSE	55.13	1.6	11.4	56.00	45.25	281	2.40	4.4	13.5	6.74	8.18	Kans City Life Ins	OTC	30.88	0.4	17.6	30.88	25.25	0	0.00	0.0	11.3	0.00	N/A		
Poe & Assoc. Inc.	OTC	9.00	0.0	28.6	9.25	6.75	0	0.40	4.4	8.7	0.57	15.79	Kemper Corp.	OTC	23.75	-0.5	15.9	25.25	20.75	556	0.72	3.0	7.4	26.50	0.90		
BROKERS	AVERAGE		0.7	25.6					2.5	10.0			Lawrence Ins. Group	AMEX	16.88	2.3	150.1	17.50	6.88	8	0.32	1.9	17.4	4.35	3.88		
CONGLOMERATES & HOLDING COMPANIES																											
Berkley W.R. Corp.	OTC	25.75	0.0	7.3	29.00	23.50	326	0.36	1.4	6.3	17.63	1.46	Liberty Corp. S.C.	NYSE	38.13	-4.7	7.4	47.25	34.50	12	0.80	2.1	14.1	17.40	2.19		
Berkshire Hathaway Inc. DEL	OTC	4100.00	1.9	39.0	4100.00	2755.00	132	0.00	0.0	20.0	69.38	11.10	Lincoln Nat'l Corp.	NYSE	47.00	-1.3	17.1	48.75	40.25	184	2.36	5.0	9.0	36.62	1.28		
ITT (Hartford Group)	NYSE	51.75	-2.1	15.0	53.38	43.25	1346	1.25	2.4	7.0	52.23	0.99	NAC Re Corp.	OTC	27.00	1.4	52.1	27.00	18.50	95	0.00	0.0	15.7	19.92	1.36		
Sears Roebuck & Co. (Allstate)	NYSE	36.88	-0.3	9.7	39.88	32.25	1945	2.00	5.4	9.1	34.74	1.06	Nobel Ins Ltd.	OTC	5.50	4.8	-37.1	9.50	4.50	23	0.44	8.0	26.2	9.37	0.59		
CONGLOMERATES	AVERAGE		-0.1	17.8					2.3	10.6			Northwestern Nat'l Life	OTC	29.25	-3.1	27.8	29.25	22.63	63	1.12	3.8	7.5	35.05	0.83		
INSURERS/REINSURERS																											
Aetna Life & Cas Co.	NYSE	45.13	-1.1	-0.3	49.88	39.50	781	2.76	6.1	6.4	53.56	0.84	Ohio Cas Corp.	OTC	33.50	0.0	-7.6	38.25	32.25	62	1.88	5.6	7.9	27.86	1.20		
American General Corp.	NYSE	30.88	0.0	-2.7	36.38	27.50	1030	1.40	4.5	8.4	27.99	1.10	Old Rep Int'l Corp.	OTC	24.00	0.5	20.0	24.75	19.13	42	0.74	3.1	5.6	27.82	0.86		
Amer Heritage Life Inv	NYSE	25.75	2.0	6.2	26.00	24.00	3	1.08	4.2	11.7	20.98	1.23	Orion Cap Corp.	NYSE	17.38	-0.7	28.7	17.63	13.13	6	0.76	4.4	5.8	9.34	1.86		
Amer Indty Fin'l Corp.	OTC	10.50	5.0	16.7	11.75	8.25	3	0.56	5.3	16.2	15.26	0.69	Phoenix Re Corp.	OTC	9.25	2.8	42.3	9.50	6.75	26	0.00	0.0	6.7	11.08	0.83		
American Int'l Group	NYSE	58.25	0.4	-2.9	65.38	49.00	1057	0.40	0.7	9.5	33.56	1.74	Protective Life Corp.	OTC	13.75	2.8	12.2	15.13	12.25	16	0.70	5.1	13.1	17.25	0.80		
Aneco Reins Ltd.	OTC	2.63	-4.4	-22.2	4.00	2.75	14	0.00	0.0	4.5	2.51	1.05	Re Capital Corp.	AMEX	10.00	0.0	-4.8	11.75	9.13	4	0.00	0.0	62.5	11.49	0.87		
Aon Corp.	NYSE	26.38	2.4	15.3	27.00	21.88	307	1.28	4.9	9.3	15.13	1.74	Provident Life & Acc Ins Co.	OTC	20.25	1.3	29.6	21.88	15.63	317	0.84	4.1	155.8	27.45	0.74		
Argonaut Group	OTC	43.00	-2.3	44.5	49.00	29.50	112	0.00	0.0	7.0	29.19	1.47	St. Paul Cos. Inc.	OTC	43.25	1.5	-6.0	51.00	38.25	523	2.00	4.6	6.2	35.83	1.21		
AVECO Corp.	NYSE	28.00	7.7	42.6	27.50	17.88	40	0.34	1.2	13.6	7.74	3.62	SAFECO Corp.	OTC	25.25	-1.9	-9.0	30.00	22.75	818	1.08	4.3	8.0	21.39	1.18		
Belvedere Corp.	AMEX	5.13	-2.3	17.1	6.00	4.38	2	0.04	0.8	7.4	7.87	0.65	SCOR US Corp.	OTC	9.00	0.0	-2.7	9.50	7.25	0	0.00	0.0	6.5	9.20	0.98		
Business Mens Assum Co.	OTC	34.50	-1.4	29.0	36.75	25.50	40	1.20	3.5	62.7	27.39	1.26	Seibels Bruce Group Inc.	OTC	13.25	0.0	17.8	14.25	11.00	51	0.80	6.0	8.6	12.51	1.06		
Chubb Corp.	NYSE	55.75	-2.0	-0.2	63.38	51.25	628	2.16	3.9	6.4	46.13	1.21	Selective Ins Group Inc.	OTC	24.50	0.0	28.9	24.75	19.25	56	1.24	5.1	5.6	19.52	1.26		
CIGNA Corp.	NYSE	46.88	-0.3	6.8	51.88	42.75	461	2.96	6.3	6.4	49.19	0.95	Statesman Group Inc.	OTC	3.63	-4.7	-22.6	2.75	1.75	98	0.05	1.4	5.6	3.48	1.04		
CNA Fin'l Corp.	NYSE	56.50	-0.7	1.6	64.25	51.00	115	0.00	0.0	8.2	46.40	1.22	Tokio Marine & Fire Ins	OTC	68.75	-7.4	4.4	85.88	63.25	55	0.19	0.3	61.4	0.00	N/A		
Continental Corp.	NYSE	39.13	0.6	1.0	41.63	34.75	525	2.60	6.6	7.4	42.10	0.93	Torchmark Corp.	NYSE	32.88	0.0	34.2	33.38	24.50	124	1.20	3.6	10.5	12.24	2.69		
Durham Corp.	OTC	29.25	8.3	36.0	28.00	21.50	89	0.92	3.1	30.2	26.00	1.13	Transamerica Corp.	NYSE	33.88	-2.9	13.9	36.75	29.75	-135	1.84	5.4	6.8	24.94	1.36		
Farmers Group Inc.	OTC	54.25	-4.6	34.8	65.75	40.50	3069	1.44	2.7	13.2	22.02	2.46	Travelers Corp.	NYSE	36.75	0.3	4.6	40.00	33.00	514	2.40	6.5	9.4	45.28	0.81		
Fireman's Fund Corp.	NYSE	32.88	3.6	26.5	33.50	25.75	929	0.50	1.5	548.0	26.17	1.26	Trenwick Group Inc.	OTC	12.50	0.0	22.0	13.00	9.75	29	0.16	1.3	10.8	15.41	0.81		
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