

# business insurance

update

**Jury verifies existence of 'lost' Manville policies**  
 SAN FRANCISCO—Manville Corp. says it's pleased with a state Superior Court jury ruling that verified the existence of several so-called "lost" liability policies, though insurers point out that Manville will not get all the coverage it wanted.  
 In the first phase of the massive coverage litigation between Manville and liability insurers that addresses the existence and terms of the "lost" policies.  
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Reporting weekly for corporate risk, employee benefit and financial executives/\$1.50 a copy; \$52 a year  
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## Survey details salaries, traits of risk managers

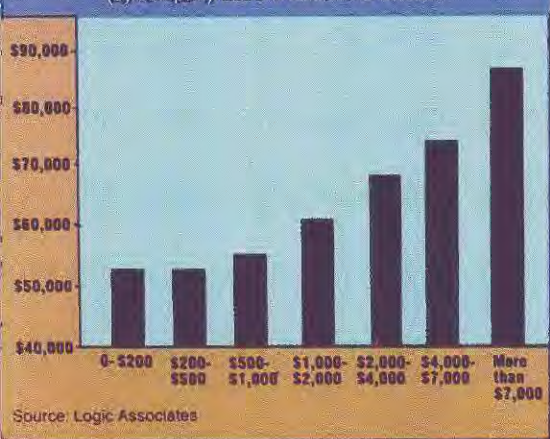
The Logic Associates 1984 Risk Management Compensation Survey, an annual study by the New York professional recruiting firm, shows that most risk managers made more in salary and bonuses in 1984 than they had in 1983.

But, the huge increases in compensation that showed up in last year's survey were absent this year, and compensation reported by risk managers at the largest companies actually declined.

This week, *Business Insurance* examines what the survey reveals about salary and bonuses for risk managers. And, *BI* looks at the profile the survey offers of the risk management professional, including age, experience, education and gender. Finally, four corporate benefits offered to risk managers are examined. This week's report begins on page 3.

Next week, *Business Insurance's* report on the Logic Associates survey concludes with a look at the risk management departments at companies of various sizes, including the departments' duties, staff size, involvement with captives and risk management information systems.

**Compensation of risk managers**  
 (by company sales in millions of dollars)



## Transit Casualty sues MGAs and reinsurers

By DOUGLAS McLEOD

DALLAS—Transit Casualty Co.—which has temporarily stopped writing all new and renewal business—is suing two of its former managing general agents and three offshore reinsurers to recover millions of dollars of losses on business written by the two MGAs.

The lawsuit, which was amended last week in U.S. District Court in Dallas, now names Donald F. Muldoon & Co. Inc. of New York and Miro & Associates Risk Management Inc., a Dallas-based MGA to which Muldoon gave binding authority for Transit.

Also named are three reinsurers of business produced by Miro: Lafayette Reinsurance Co. Ltd. of Grand Cayman; a successor company, Lafayette Reinsurance Co. Ltd. of Douglas, Isle of Man; and Southern Oil Insurance Ltd., another Cayman reinsurer.

Carlos Miro, chairman of Miro & Associates and a named defendant in the suit, was a director of Lafayette-Isle of Man. Mr. Miro also had an interest in Southern Oil Insurance Ltd. (SOIL), according to the lawsuit.

Transit's complaint, charging several breaches of the MGA agreements, claims that Miro & Associates failed to report \$68 million in premium that should have been collected on policies it had written.

Nearly half this amount—\$32.2 million—represents premium that should have been collected on workers compensation and general liability policies issued to Wal-Mart Stores Inc. of Bentonville, Ark., the complaint alleges.

Transit also accuses Miro and Muldoon of failing to maintain adequate reinsurance for Transit on risks

written by Miro, and accuses SOIL and the Lafayette companies of breaching contractual duties to maintain adequate excess-of-loss and aggregate stop-loss reinsurance.

SOIL and the Lafayette companies haven't paid Transit claims on Miro-related business, the complaint charges. Transit says that as of May 7, it had paid claims that exceeded by \$18.1 million the amounts recovered from letters of credit posted by the reinsurers.

SOIL is currently running off its business, while Lafayette-Cayman is not listed in the island's register of companies, according to a Cayman official. Lafayette-Isle of Man has stopped writing new business (*BI*, April 15).

Transit, which announced in January that it would no longer accept new business from MGAs, temporarily suspended all new and renewal underwriting on April 19, according to Glenn Jourdon, chief examiner for the Missouri Division of Insurance. Transit is domiciled in Missouri.

In January, Transit announced it would quit writing excess and umbrella liability coverage and captive insurance and reinsurance programs that had been produced by its MGAs, which left it writing only public transportation risks. (*BI*, Jan. 29; Nov. 26, 1984).

All underwriting was suspended in April while Transit awaits the results of a Touche Ross & Co. audit of the captive insurance company fronting programs written by Muldoon, Mr. Jourdon said.

"They've done that as a remedial action until they find out where their liabilities are," Mr. Jourdon explained. "They hope it's temporary."

A triennial exam of Transit recently completed by

**Transit's suit alleges that Miro failed to report \$68 million in premium that should have been collected.**

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## States can mandate benefits offered by health insurers

By JERRY GEISEL

WASHINGTON—A Supreme Court ruling that allows states to require group health insurance policies to offer certain benefits could raise employers' health insurance costs and cause them to reduce other benefits if states mandate more benefits.

The ruling may also give employers another incentive to self-fund their health benefits, since the court noted that states cannot require self-insured health plans to provide certain benefits.

And, insurers predict that states will mandate more benefit provisions.

The high court issued the ruling last week on a petition by two insurers to overturn a 1976 Massachusetts law requiring all group health insurance policies to offer minimum mental health benefits (*BI*, March 4).

The insurers argued a "pre-emption" provision in the Employee Retirement Income Security Act of 1974 bars states from regulating benefit plans covered by ERISA. But in an 8-0 decision, the court said the scope of the pre-

emption provision was explicitly limited by another provision in ERISA known as the "savings clause," which preserves any state law regulating insurance.

The Massachusetts law dictates the terms of certain insurance contracts and "seems to be saved from pre-emption by the savings clause as a law 'which regulates insurance,'" says the opinion.

"The plain language of the savings clause, its relationship to the other ERISA pre-emption provisions and the traditional understanding of insurance regulation all lead us to the conclusion that mandated-benefit laws... are saved from pre-emption by the operation of the savings clause," Justice Harry Blackmun wrote.

The court also ruled that federal labor laws do not pre-empt the Massachusetts law and that the state law does not interfere with collective bargaining processes.

The decision is a blow to group health insurers and their policyholders, who had hoped to escape the now costly administrative burden of tailoring policies to meet the varying requirements of different states.

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## Work comp can weather job-related illness: Panel

By CAROL CAIN

KANSAS CITY, Mo.—State workers compensation programs should continue to be the principal vehicle for compensating workers with occupational diseases, rather than a federal program or the courts, according to a special report released Sunday.

However, improvement of some workers compensation laws and changes in administrative procedures—as well as a constant vigil by legislators and regulators to assess new developments—will be necessary to assure continued financial integrity of the state workers compensation system, the report's authors note.

"Neither the tort system nor a specially devised federal compensation program is likely to be fairer or less costly for all parties involved than the state workers compensation system," according to the report, which is the culmination of almost two years of study by an advisory committee to the Workers Compensation Task Force of the National Assn. of Insurance Commissioners.

This final report on compensating occupational disease also concludes that the pricing and reserving practices of workers compensation insurance are adequate at the present time but warns changes

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**New York to take action on CGL forms within weeks**  
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**More price hikes coming, executives tell NAIB meeting**  
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**Are guaranty funds equipped to deal with current problems?**  
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## update

## Jury rules on Manville coverage

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policies, the jury found that Commercial Union Insurance Co. wrote primary liability policies for Manville from 1934-1945 and excess coverage from 1960-1963.

The jury also verified coverage issued by Reliance Insurance Co. from 1927-1933, but it denied verification for 1925 and 1926.

The early CU policies had aggregate limits of \$250,000 per year while the coverage written from 1960-1963 had \$1 million annual limits, the jury found. The Reliance policies had annual limits of \$10,000 per person and \$20,000 per accident, but did not contain aggregates.

Attorneys for CU and Reliance say Manville did not get all it wanted in the decision. An attorney for CU pointed out that Manville had argued that the early CU policies did not have aggregate limits.

An attorney for Reliance also pointed out that Manville had originally claimed coverage under the Reliance policies from 1922-1934 but that it had given up some of its claims before trial.

The attorneys said various issues were still to be decided before it is determined whether Manville can recover under the policies.

The decision comes at the conclusion of the first phase of the litigation, which began March 4. Five asbestos defendants and more than 75 insurers are fighting over the nature and scope of coverage.

Exclusions in the policies and when the coverage is triggered are still to be addressed.

Manville also announced last week the terms of its recent insurance settlement with Peerless Insurance Co., one of 21 defendants with which it is in litigation in California (*BI*, May 13).

The \$1.3 million settlement calls for two payments. The first payment of \$800,000 was made upon signing of the agreement and has been placed into an escrow account. A final payment is due in March 1986.

Manville has already settled with six other liability insurers for approximately \$426 million in coverage and cash.

## Wausau's Schoneman quits

WAUSAU, Wis.—John A. Schoneman, chairman and chief executive officer of Wausau Insurance Cos., has resigned from the company, citing a "friendly difference of opinion" with the chairman of the executive committee of the board of directors over how the company should recover from its \$206.6 million loss last year.

Mr. Schoneman is being replaced by the executive committee's chairman, Thomas Hancock.

Mr. Hancock, who has been a Wausau director since 1969, is retired chairman of the Trane Co. in La Crosse, Wis., a major manufacturer of air-conditioning equipment.

## Loan offer is extended

LONDON—Members of Lloyd's of London syndicate 895 now have until July 2 to decide whether to accept a five-year interest-free bank loan to help them pay anticipated losses of 19 million pounds (\$23.9 million).

The offer was extended last week after members agents representing only 73 of 243 syndicate members accepted the offer.

Spicer & White (Underwriting Agencies) Ltd. is managing syndicate 895 on behalf of parent Willis Faber P.L.C.

The steering committee for syndicate members has recommended the offer be rejected and is collecting money from members to start litigation.

It has also asked Lloyd's Chairman Peter Miller to nominate independent management for the syndicate.

Members of syndicate 895 face losses of 92,000 pounds (\$116,000) for every 20,000-pound (\$25,200) line written on their behalf.

## Insurers halt TMI settlements

HARRISBURG, Pa.—Liability insurers for the ultimate owner of the Three Mile Island nuclear plant will no longer attempt to settle personal injury suits stemming from the 1979 TMI accident, including several suits filed last week.

The newest suits, filed in Dauphin County Court in Harrisburg, represent part of "several hundred" similar cases still outstanding, said Jack Harward, a claims vp at American Nuclear Insurers in Farmington, Conn.

The suits, filed by area residents, claim personal injury and emotional distress as a result of the 1979 mishap and seek damages from General Public Utilities Corp, the holding company for the three utilities that owned the nuclear facility.

"We'll see them in the courtroom," Mr. Harward said.

ANI and Mutual Atomic Energy Liability Underwriters, which provided \$140 million in primary liability coverage for the plant at the time of the accident, earlier this year paid out-of-court settlements to 280 claimants that lived near TMI (*BI*, Feb. 18).

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## N.Y. department weighs approval of CGL forms

By MICHAEL BRADFORD

NEW YORK—The New York Insurance Department will decide in several weeks whether to join more than two dozen other states that have approved the Insurance Services Office's controversial commercial general liability policy forms.

Insurance Superintendent James P. Corcoran says he will base his decision on whether to approve ISO's proposed occurrence and claims-made CGL forms in part on testimony received at a recent public hearing, including the first public statement by the Risk & Insurance Management Society against the proposal (see story, page 39).

At the public hearing held by the Insurance Department last month other representatives of buyers and brokers expressed steadfast opposition to the new claims-made form, while industry officials argued for its approval.

Mr. Corcoran says he will first review the decision of Richard Hsai, the hearing officer who presided at the May hearing. The superintendent's final decision will follow and should be announced "within a month or so," said Mr. Corcoran.

The commissioner said he will consider all the major issues being debated by opponents and supporters of the proposed ISO claims-made form, including whether all coverage for pollution incidents should be excluded

and how the form would affect pricing and the availability of coverage.

"The form is an effort by the industry to define its liabilities and find a solution to rate problems."

Unlike an occurrence policy, which covers losses occurring during the policy period regardless of when a claim is filed, only claims filed during the policy period are covered under a claims-made form.

Mr. Corcoran also said he will consider whether defense costs should be included within the limits of the proposed policies, even though ISO has not yet decided whether defense costs should be capped (*BI*, May 20). "Defense costs can be tremendous, sometimes themselves exceeding the (policy) limits," said Mr. Corcoran. "If they want to exclude them, we can see why, but we can also see why they might not want to. We're here to balance things out."

He said the New York department has to "make sure the public understands the significance" of the claims-made form, which would go into effect Jan. 1. "Even the unsophisticated buyer should understand it."

While the New York Insurance Department is often perceived as a trend-setter in insurance regulation, regulators in other states say they won't be influenced by New York's decision on the proposed ISO forms.

In Maryland, Insurance Commissioner Edward Muhl said he approved the forms last week, after weighing

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## Court says city, not insurers, must pay fees

By ROBERT A. FINLAYSON

SAN FRANCISCO—The city of Richmond, Calif., is out another \$694,000 as a result of 27 civil rights claims filed against it charging a pattern of racially motivated police brutality.

The city can't recover from general liability insurers to cover an award of attorneys' fees to the plaintiffs with whom the city entered into consent decrees to settle the civil rights claims, a federal appeals court ruled late last month.

The attorneys' fees are more than double the amount the city paid to settle with the plaintiffs, bringing to nearly \$1 million the cost to the city to dispose of the claims.

The city has paid the losses out of its self-funded reserves.

The 9th U.S. Circuit Court of Appeals upheld an earlier ruling by a U.S. District Court that said the city's insurers did not have to pay the attorneys' fees awarded in the civil rights cases because city officials had failed to consult their insurers prior to entering into two settlement agreements.

Richmond, which is just north east of San Francisco, was the target of three civil rights suits filed

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## Unocal sues insurers to reinstate D&amp;O cover

By STEVE TARAVELLA

LOS ANGELES—After successfully fending off corporate raider T. Boone Pickens Jr., Unocal Corp. is now fighting for the reinstatement of \$70 million in directors and officers liability insurance that was canceled in the wake of the takeover threat.

The oil company is suing its primary directors and officers liability insurer and three of its five excess D&O insurers that abruptly canceled their participation in Unocal's \$100 million of D&O coverage after Mr. Pickens, chairman of Mesa Petroleum Co., announced on Feb. 15 that Mesa Partners II had acquired 7.9% of Unocal's outstanding stock.

Last month, Los Angeles-based Unocal won a Delaware court decision that is effectively preventing Mesa from taking over the holding company for Union Oil Co. of California.

Unocal charges in its suit, filed June 4 in Los Angeles Superior Court, that the underwriters, led by the primary insurer, Los Angeles-based Harbor Insurance Co., canceled the D&O coverage without good cause.

Unocal is asking the court to declare that the canceled policies are still in effect and to award it reimbursement for the \$6.5 million in additional premium and the \$13 million in loss reserve deposits it paid to obtain replacement coverage; reimbursement for all costs incurred in obtaining other coverage, like letter of credit fees; and unspecified punitive and exemplary damages.

Unocal's broker is Marsh & McLennan Inc. Harbor canceled its \$20 million primary policy immediately after the takeover threat emerged, effective April 19.

Federal Insurance Co., a unit of Chubb Corp. in Warren, N.J., subsequently canceled its excess layer participation of \$20 million excess of \$20 million, effective April 19. First State Insurance Co., a Boston unit of the Hartford Insurance Group, canceled its policy for \$20 million excess of \$40 million effective May 8.

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## Liability insurers are abandoning day care centers across the U.S.

By MARGARET LeROUX

Leading liability insurers for day care centers are pulling out of the market.

The overall tightening of the property/casualty insurance market and recent news reports of alleged child abuse at day care centers are behind their withdrawals.

And, other day care center insurers are adding exclusions to liability policies, increasing rates and, in some cases, canceling policies.

Insurers are trying to rid themselves of "an unattractive and unprofitable class of business," says a spokesman for Aetna Life & Casualty Co. in Hartford, Conn., who added that Aetna is looking carefully at the risks it underwrites.

A recent survey showed that two-thirds of 250 day care center respondents have had their liability insurance canceled or not renewed, or have had substantial premium hikes. The poll was conducted by the Child

Care Action Campaign, a New York-based advocacy group, and by the Child Care Information Exchange, a magazine for day care centers.

Maintaining adequate liability coverage is becoming more crucial to day care centers since eight states recently passed legislation requiring the centers to have specific limits of liability insurance. The states are California, Nevada, Kansas, Pennsylvania, Illinois, Arizona, Idaho and Minnesota.

If day care centers are forced to cease operation because of the lack of liability insurance, employers whose workers rely on the centers could feel the repercussions. If employees cannot find adequate care for their children they may turn to their employers for company-sponsored day care. At the least, morale and productivity could fall among employees worried about their children's care.

One of the largest underwriters of day care center liability risks—Transit Casualty Co. of Los Angeles

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# Where do you fit?

## Risk managers' salaries grow—but only modestly

By ALISON KITTRELL

Risk managers' average compensation generally increased in 1984, but not by the huge leaps reported during 1983, a new survey reveals.

And, the compensation reported by risk managers at the largest companies actually declined.

These are the findings of the 1984 Risk Management Compensation Survey conducted by New York-based Logic Associates.

For example, total compensation for risk managers at companies with up to \$200 million in annual sales increased 7.5%, to \$52,682 in 1984 from \$48,984 in 1983. However, last year's survey reported that the total compensation for risk managers in this category had increased a whopping 33.6% over 1982.

Risk managers at companies with \$4 billion to \$7 billion in annual sales and risk managers at companies with more than \$7 billion in annual sales actually reported a decrease in total compensation. However, the small number of respondents in each of these categories may make year-to-year comparisons invalid.

Among risk managers at companies with \$4 billion to \$7 billion in annual sales, total compensation declined 0.8%, to \$74,570 from \$75,145 in 1983. And, among risk managers at the largest companies, with more

than \$7 billion in sales, total compensation declined 2.3%, to \$86,662 in 1984 from \$88,714 in 1983.

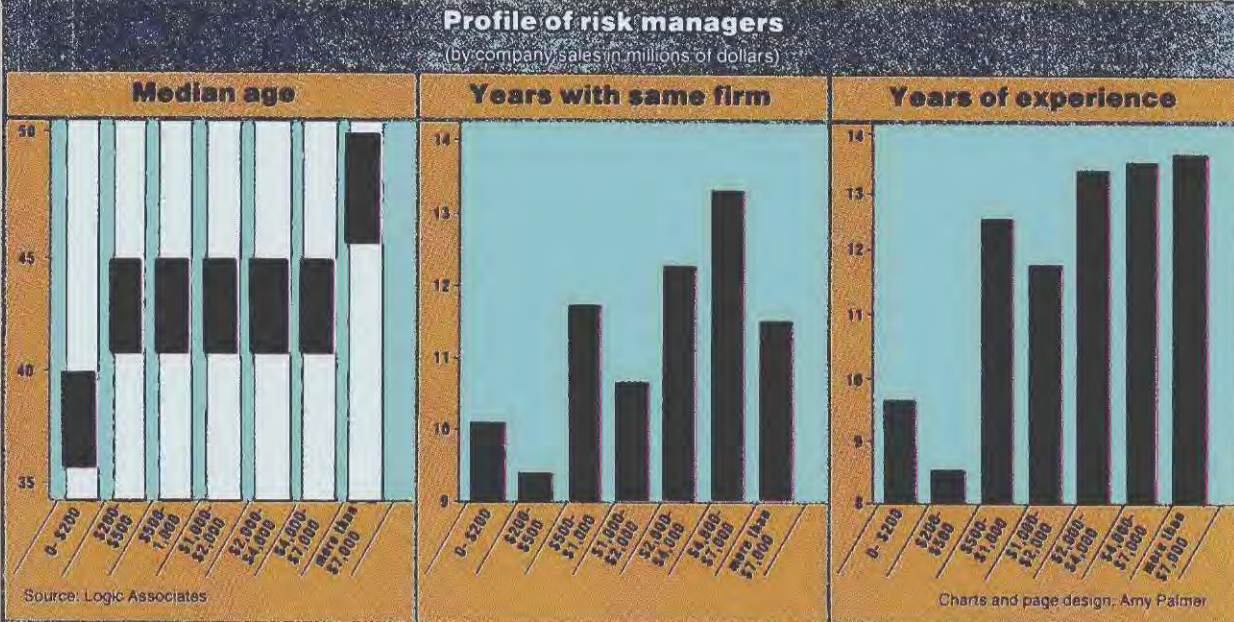
Risk managers at the other companies surveyed reported increases in compensation, but in each category, the increase in 1984 was not as great as in 1983.

For instance, risk managers at companies with \$201 million to \$500 million in sales saw their compensation rise an average of 7.1% last year; these risk managers reported a 20.2% increase in 1983.

Compensation rose an average of 7% in 1984 for risk managers at companies with \$501 million to \$1 billion in sales, compared with a 10.6% jump in 1983; compensation rose 3.4% at companies with \$1 billion to \$2 billion in sales, compared with a 9.7% increase in 1983; and compensation rose 6.7% last year at companies with \$2 billion to \$4 billion in sales, compared with a 7.2% rise in 1983.

However, officials at Logic Associates, a recruiting firm specializing in the risk and safety management professions that conducted the survey, say despite the modest increases—and in some cases decreases—in compensation, the salary outlook for

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## Poll paints gray-flannel portrait of the 'average' risk manager

By ALISON KITTRELL

The "average" U.S. risk manager is a married man between 41 and 45 years old. He is a college graduate with possibly an advanced degree, and he has worked about a decade with his current company.

That is the profile that emerges from the Logic Associates 1984 Risk Management Compensation Survey. A total of 917 risk managers answered this year's survey conducted by the New York professional recruiting firm, for a response rate of 31%.

The risk managers answered questions about their education levels, gender, marital status, professional designation and experience, as well as questions about their salaries and benefits (see related stories). As with the other questions, responses were grouped according to company sales volume.

Risk managers at larger companies are more likely to hold professional designations than are their colleagues at smaller firms.

For example, only 9.7% of risk managers at companies with up to \$200 million in sales—the smallest companies surveyed—hold the Chartered Property & Casualty Underwriter designation, and 19.4% hold the Associate in Risk Management designation.

However, at the largest companies—with more than \$7 billion in sales—23.1% have a CPCU and 26.9% have an ARM.

The highest percentage of risk managers with a professional insurance designation was at companies with \$2 billion to \$4 billion in sales, where 25.4% have a CPCU and 28.8% have an ARM.

At companies with \$201 million to \$500 million in sales, 14.1% have a CPCU and 21.7% have an ARM. And, at companies with \$501 million to \$1 billion in sales, 22.2% reported having a CPCU, and an equal

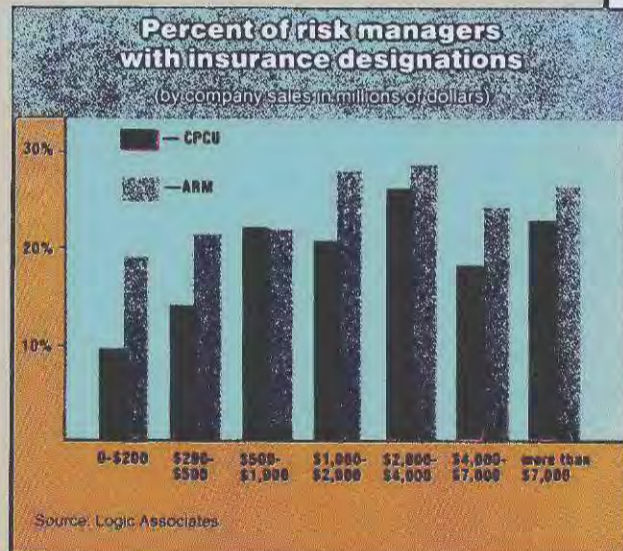
number reported having an ARM.

Some 20.8% of risk managers at companies with \$1 billion to \$2 billion in sales are CPCUs, and 27.8% are ARMs. And, at firms with from \$4 billion to \$7 billion in sales, 18.2% are CPCUs and 24.2% are ARMs.

As might be expected, the youngest risk managers generally work for the smallest companies—those with up to \$200 million in annual sales—while the risk managers at the largest companies—with more than \$7 billion in sales—are generally older.

The median age of risk managers at the smallest companies is 36-40 years old, and the median age of

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# More price hikes coming, experts tell NAIB

By LINDA COLLINS

SEA ISLAND, Ga.—Insurance buyers should expect another round of price hikes, less capacity and adoption of the new claims-made commercial general liability form, according to several industry leaders.

"Clearly another round of price increases is absolutely necessary for the business," asserts William O. Bailey, president of Aetna Life & Casualty Co. in Hartford, Conn.

"A lot of people are going to go without insurance" because they won't be able to buy it, predicts John K. Lundberg, chairman and chief executive officer of Crum & Forster Inc. in Morristown, N.J.

The occurrence form may be retained for insuring some smaller commercial risks, but "I think we are going to see a claims-made form dealing with some major exposures in the marketplace," offers John H. Bretherick Jr., president of The Continental Corp. in New York.

These predictions emerged in a candid discussion of "Critical Issues Facing the Insurance Industry" by six insurance company

leaders who participated in a panel program at the National Assn. of Insurance Brokers' annual meeting at The Cloister in Sea Island, Ga., late last month.

In their wide-ranging discussion, the panelists also acknowledged that insurance buyers and regulators could fight price hikes, urged reform of the civil justice system, expressed concern about insurers' liability for financial guarantee products and predicted consolidation of forces in the insurance distribution system.

It's "an underwriters' strike," said New York-based The Home Insurance Co. President Steven H. Newman, crediting a broker with that description of current market conditions.

"I submit that the insurance industry is much weaker than we recognize," said Mr. Bailey of Aetna. "Clearly another round of price increases is absolutely necessary for the business."

"We have to get realistic. It's going to get worse, not better, this year. The question is:

Will it continue to get worse next year?"

But, Mr. Bailey noted, "When I sense the next downturn starting to come, I'm going to say goodbye to you all. I've been through enough of these. I don't want to go through one more."

Mr. Newman attributed current capacity problems to two key conditions:

- A substantial reduction in reinsurance capacity, which, in turn, reduces the gross capacity of the primary insurers.
- Underwriters' unwillingness to write business at a loss.

"We found it necessary to withdraw from classes in which we simply couldn't get close enough to underwriting profit to have a go," Mr. Newman explained.

Mr. Bretherick of Continental agreed with Mr. Newman that insurance capacity is shrinking because of a restriction in reinsurance capacity and because underwriters "don't choose to make (coverage) available, even though they have the financial ability" to do so.

But, Mr. Bretherick said it is not clear at this point whether there will be additional restrictions on capacity later this year.

Mr. Bailey of Aetna suggested that if the asbestos claims facility and its attendant settlement of insurance coverage disputes doesn't succeed, "I think that the spillover of that will carry us all into another year" of capacity problems.

The success or failure of the asbestos claims facility will be a major influence on market capacity, he said.

"The asbestos claim facility and the settlement with the major producers is hanging by a thread. It's touch and go," he reported.

"If it doesn't succeed," Mr. Bailey warned, "you're going to have the most incredible amount of litigation between producers and insurers, and insurers and reinsurers that this country has ever seen."

Mr. Lundberg of Crum & Forster suggested that capacity also is limited by insurers' concerns that they maintain their premium-to-surplus ratios within limits that satisfy insurance regulators.

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## Supreme Court

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Insurers say the administrative cost of complying with varying state laws—a cost that is passed on to employers—equals at least 10% of the policy premium.

These laws, found in at least 26 states, usually require policies to offer coverage for mental illness, drug abuse and alcoholism.

In addition, states have been mandating more benefits, such as extension of coverage after an employee terminates employment.

"Our library has eight binders covering these (mandated benefit) laws," said John Hickey, a partner with consultant Kwasha Lipton in Fort Lee, N.J.

"It is extremely difficult and costly to administer policies with varying requirements," said Richard Blackwell, vp and insurance counsel with Metropolitan Life Insurance Co., which along with The Travelers Insurance Co. filed the

Supreme Court petition.

In addition, "The decision could open the door for additional statutes like Massachusetts'," Mr. Blackwell said.

The added cost of requiring certain benefits in group health insurance policies could force employers to drop other benefits, he adds.

"This eliminates a certain amount of choice in selecting benefits," he said. "There is only a finite amount of money available for employee benefits, and if a state mandates that certain benefits must be provided... employees may have to forgo other benefits that they would have preferred."

Plan administrators have previously said they have been forced to drop certain benefits because of the expense of adding benefits required by states.

"We were forced to drop vision and dental care after New Hampshire mandated mental health benefit coverage" in the mid-1970s, said James Dawson, administrator

of the Northern New England Carpenters Health & Welfare Fund in Manchester, N.H.

The multiemployer plan, which has about 5,000 participants, could not afford dental and vision coverage because of the expense of mental health care coverage, he said.

Mr. Dawson called the Supreme Court decision "horrible. It won't help the family whose children have a mouthful of cavities and can't get dental coverage."

In addition, the Supreme Court ruling will give employers yet another incentive to self-fund their health benefits. The court made it clear that ERISA does pre-empt states from imposing benefit requirements on self-funded or uninsured group health plans.

Apparently, administrative services only plans purchased from insurers also would not be affected by state laws.

"We are aware that our decision results in a distinction between insured and uninsured plans, leaving

the former open to indirect regulation, while the latter are not. By so doing we merely give life to a distinction created by Congress... a distinction Congress is aware of and one it has chosen not to alter."

The court invited those who want similar regulations for insured and self-funded plans to direct their arguments to Congress, and insurers say they are considering asking to Congress amend ERISA to overturn the ruling.

"We would seriously consider going to Congress to rectify the decision," said Mr. Blackwell.

"I think you will see efforts by the commercial industry Blue Cross & Blue Shield and by some employers to try to educate Congress on how this decision unbalances the employee benefit marketplace," said Linda Lanam, executive Washington representative for BC/BS.

Asking Congress to amend ERISA could cause a confrontation between insurers and employers

that self-fund their health benefits, depending on the legislative strategy pursued by the insurers.

Insurers could arouse the anger of self-funded employers if they lobby Congress to narrow the ERISA pre-emption to give states the power to impose benefit requirements on self-insured plans.

"All hell would break loose. The self-funding employers and their administrators would fight it tooth-and-nail," said Fred Hunt, executive director of the Society of Professional Benefit Administrators in Washington.

On the other hand, a move to create a pre-emption for all plans would not ruffle self-insurers.

Insurers say they haven't decided which approach to take.

It's also not known whether Congress would consider proposals to amend ERISA to overturn the Supreme Court decision.

Congress last made changes in ERISA pre-emption rules in 1982, when it passed legislation that gave the states the right to regulate self-funded multiple employer benefit trusts (BI, Dec. 27, 1982).

Because the failure of unregulated self-funded METs had become a national scandal, Congress acted to narrow the scope of ERISA pre-emption to give states the authority to regulate the trusts.

That same sense of national urgency isn't apparent in the latest pre-emption case. The major reason insurers want to overturn the Supreme Court decision is to eliminate the competitive disadvantage they face with self-insurers.

"The life and health insurers are at a great disadvantage in this compared to self-funded plans," said David Brummond, an ERISA pre-emption expert and assistant general counsel for the National Assn. of Independent Insurers in Des Plaines, Ill.

Observers also suggest the Supreme Court decision is likely to lead to further litigation. For example, the decision did not directly address whether states can require certain benefits in group health policies that are issued outside the state but cover state residents. In most cases, mandated benefit laws apply to insurance contracts written in the state, but states now might try to expand their authority to impose benefit requirements on policies written in other states.

"The next round of litigation could be on the territorial issue," said Ms. Lanam of BC/BS.

Last week's decision involved a Massachusetts law that requires insured employee benefit plans to offer at least \$500 of coverage annually for outpatient mental health care. In addition, the law requires plans to provide coverage for at least 60 days of inpatient mental health care a year.

In 1979, Massachusetts asked a state superior court to declare that the mental health care law applies to insurance policies sold to employers. The state also asked that Travelers and Metropolitan be ordered to comply with the law.

The superior court, and later the Massachusetts Supreme Judicial Court, ordered the insurers to comply with the law. The insurers then appealed those rulings to the U.S. Supreme Court.

The insurers argued the savings provision in ERISA was meant to exempt from pre-emption so-called "traditional" state insurance laws, like reserve and solvency requirements, and not "innovative" laws that set benefit requirements.

But the Supreme Court said there was nothing in ERISA to distinguish between different types of insurance laws.

"The presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their preemptive scope. Further, there is no indication in the legislative history that Congress had such a distinction in mind," the ruling said. ■

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BI-6

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# So we've reconstructed them.

## NAIB panel

Continued from page 3

"At the moment, many companies, including our own, feel under constraints from our risk ratios (imposed) by the regulators," Mr. Lundberg said.

"We tell our underwriters that our first priority is to get as much of a price increase as (we) can because the products are so under-priced," Mr. Lundberg added. "In the next breath we tell them 'but total premiums can't grow by more than 15% next year because of our balance sheet constraints,'" he said.

While insurance regulators recently have been preoccupied with solvency issues, Mr. Lundberg suggested that they may reassess their attitudes on what constitutes an adequate surplus ratio.

Regulators are going to have to determine which companies truly have solvency problems and which ones "can comfortably write with greater leverage than they are now writing with, knowing that the underlying reason for the greater leverage is that they are getting greater prices for insuring the same exposures."

Higher prices "can't be anything but healthy for those companies," Mr. Lundberg declared.

Insurance regulators already are fielding complaints from consumers concerned about capacity, Mr. Lundberg noted. As that heat grows over the next year or two, regulators may reassess their attitudes on what constitutes an adequate surplus ratio, he said.

John J. Mackowski, chairman of the board of The Atlantic Cos., said he hopes the capacity shortage never ends, "at least the perception that there is a capacity shortage." He said an oversupply of capacity created the current massive underwriting losses because many entities entered the underwriting field in anticipation of tremendous profits, forcing prices down.

"I think this is the best time for us," Mr. Mackowski said. "For brokers and companies such as Atlantic, what we want to bring (into the marketplace) is responsible capital, lasting capital that recognizes the cycle and is willing to stay through the ups and downs."

He added that with the cycles inherent in the insurance industry "you are (always) going to have either excess capital or excess demand."

Only two of the panelists addressed the proposed claims-made commercial general liability form, but both endorsed it.

The new claims-made form is an "attempt to carve out that which is insurable in the marketplace and to provide a market... but on a different basis," Mr. Bretherick said.

In the competitive insurance market, Mr. Bretherick said, insurers broadened their policies to cover risks that should not have been insured. This action, coupled with judicial interpretations that broadened policy coverage, has resulted in insurers being held liable for "some aspects of the uninsurable."

Although tort reform would be the most desirable solution to the current insurance marketplace dilemma, the industry "can't bet a marketplace on tort reform," Mr. Bretherick stressed. The claims-made policy is a short-term remedy to protect the financial stability of insurers, he suggested.

However, Mr. Bretherick added that other specialist markets may move into the marketplace to offer occurrence form coverage to specific types of risks.

Mr. Bailey added that although the claims-made form is only one of a variety of solutions the industry has come up with to buy a little time until an ideal solution can be found, "I would urge you all to support those efforts in spite of your views of claims-made—against a bunch of lousy alternatives, that

seems to be the least lousy."

And, Mr. Bailey predicted that "it's quite probable" that the new Insurance Services Office's general liability forms, both claims-made and occurrence, will be amended to include defense costs within policy limits.

Insurance buyers and legislators will not necessarily swallow insurance industry price hikes, two panelists warned.

When risk managers recover "from the shock of price increases," they will seek alternative risk-bearing measures, predicted Jack W. Cates, president of Industrial Risk Insurers in Hartford, Conn.

"The problem that has to be faced, partly by all of us," he said, is

Coverage of NAIB's annual meeting continues on pages 10-17.



to convince risk managers they are not going to get better coverage elsewhere "and still have a viable program."

Mr. Bailey advised there could be some major marketplace changes if the hardening market puts too much stress on the system.

"It's relatively easy for state leg-

islators, with the stroke of a pen, to produce all kinds of mandatory programs that are detrimental to the way we do business," he said.

But, insurers are all aware that there comes a point when the contraction of the marketplace becomes counterproductive, Mr. Bailey said. This becomes evident when pressures, political and otherwise, start to well up for change.

"We've got to reduce our costs on an exponential basis," suggested Mr. Mackowski. "This is the most inefficient God-awful expensive business in the world. We can't keep spending" like the industry has in the past, he said.

"We know we can't keep increasing our prices to cut policy-

holders." If a company did, its clients probably would go someplace else, he said.

In the long range, Mr. Bailey advised, tort reform is needed so that insurers do not find their reserves depleted by such tort claims as asbestos, pollution and medical liability.

"This business doesn't have a good clear answer on that, and that is a tragedy," Mr. Bailey said. "The time is right to start engaging in some serious efforts for tort reform. This is no longer an insurance problem, it's a societal problem."

Mr. Lundberg said that in order to resolve any of the problems facing the industry, industry repre-

Continued on next page





Photo: Linda J. Collins

Jack W. Cates, right, president of Industrial Risk Insurers, listens to comments by John J. Mackowski, chairman of The Atlantic Cos.

Continued from previous page  
sentatives must educate the public in the tort liability reform area. "We need the help of everybody who has any awareness of this problem... even (those) with peripheral involvement."

Mr. Bailey pointed out that already the insurance industry is lobbying to reform the Superfund legislation "so that we don't have another five-year extension of the existing Superfund statute that makes lawyers rich but doesn't clean up any of the dump sites."

He said insurance lobbyists are making substantial progress in their Superfund efforts and he's encouraged.

The heart of insurers' liability

problems, Mr. Bailey said, is that "courts will misinterpret language willfully as they constantly search for more and more money to deal with societal problems, which a decade ago we took care of through the tax mechanism on the part of the government."

"We've all said to our government we're not willing to fund those programs through the government mechanism, so society has turned to the private sector to deal with these problems," he continued. "Someone with deep pockets is going to be tapped as long as there are any deep pockets around."

Mr. Cates of Industrial Risk Insurers complained it is becoming harder and harder to write any

kind of a contract "that you have any faith in of lasting very long."

And, he is concerned that there have been recent discussions to use property insurance policies "to solve some of the problems that perhaps the liability side could take care of with their own changes."

Specifically, he said later, he has heard discussion that the debris removal clause in the property form could be expanded to cover the cost of cleaning up pollution.

Financial guarantee insurance products present insurers with a whole new challenge, several panelists agreed.

The Home is not writing financial guarantees, Mr. Newman said, because "the talent is at such a high level, the motivation seems so great and so much money is being made that I would feel like a sitting duck being the last person on the line accepting the risk."

Crum & Forster is writing financial guarantee products, said Mr. Lundberg, but "the kind of people you want underwriting those risks are credit people," he urged. "It's important not to rely on insurance people to evaluate those risks."

And, price competition in the financial guarantee marketplace is evident, he noted. Crum & Forster is "steering away from plain vanilla municipal-type guarantee business because the premiums are just not adequate," he said of the municipal bond guarantee product.

Financial guarantees represent an important business to Aetna, Mr. Bailey observed, and will earn the company in excess of \$20 million in profits in 1985.

But, Aetna is limiting the amount of financial guarantee exposures it will accept, Mr. Bailey said, because the product is a "heavy user of capital and capacity." And, the financial guarantee risks Aetna has assumed are "carefully watched and separately managed in our company," he added.

Analyzing the future of the distribution of insurance, Mr. Bretherick observed that "independent agents have continued to lose market share and, frankly, with respect to commercial business, we believe that there's every opportunity that this is going to continue. National brokers, heavy into commercial business, have about 35% of the total business. We think this will grow somewhat."

Mr. Bretherick also says if deregulation occurs and banks enter the underwriting business, they will take more business from the direct writing insurers than from the agency or brokerage insurers.

Mr. Newman commented that he is seeing a concentration and merging of economic clout "at all levels of the producer community." He said that a number of entities "are seeking to put together what would be viewed as top 10 national brokerage operations," and he would not be surprised if within the next three years there are three new national networks that are only modest-sized today.

At the local level, Mr. Newman said he anticipates a flourishing of "strong regional producers and a great deal of enthusiasm from banks, who are viewing themselves for the first time as national." He said he expects banks, in some parts of the country, to become a "significant part of our landscape."

But, Mr. Bailey argued that although it is clear that several major banks want to distribute insurance products, "my own perception of this is that you people have more to fear from each other than you do from the banks."

"Why in the world would a group of professionals like you worry about a bunch of amateurs like banks taking over your business?" Mr. Bailey asked. "You have far more important concerns."

The panel was moderated by John P. Keyser, senior vp and director of Johnson & Higgins in its Chicago office. ■

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## opinions

# A bright spot to the hard market

ON THE SURFACE, the results of the Logic Associates 1984 Risk Management Compensation Survey appear to indicate that risk managers did not do as well in 1984 as they did in 1983.

Risk managers' compensation increases reported in 1984 were much more modest overall than those reported in the 1983 survey, and compensation actually decreased for risk managers at the largest companies (see story page 3).

But, in this case, appearances may be deceiving. We agree with the authors of the survey that the future for risk management is bright.

First of all, the moderate increases in compensation for risk managers, like corporate pay hikes in almost all other professions, reflected the general slowing in the U.S. inflation rate. For the most part, double-digit salary increases have gone the way of double-digit inflation.

But, most importantly, the current hardening in the insurance industry is going to make the risk manager much more valuable to his or her company.

Senior management, lulled by years of low prices and expansive capacity, already is shocked by the higher prices and lower limits being demanded by insurers.

As premiums increase and coverage becomes harder

to find, more companies are going to realize the need for an effective risk manager.

And, companies are going to be more willing to pay to get the expertise they need. A risk manager who saves his or her company substantial amounts in insurance costs—either by reducing exposures or finding more economical risk-financing methods—will have a strong case for receiving some of the savings in increased salary or bonuses.

However, the authors of the Logic Associates survey offered a caveat, with which we agree: Only the talented risk manager will benefit—or, indeed, will survive—in the current hard market.

Negotiating the best and most cost-effective coverage in this market will take considerably more skill than has been demanded by the soft market of the last several years.

And, creativity and savvy will be needed to develop and implement alternative risk-funding programs when the conventional market fails to provide needed products at acceptable prices.

Risk managers who cannot cut it will find their deficiencies painfully obvious.

But, those with talent and courage have an opportunity to make a real difference for their employers—and for themselves as well.

## California courts get on track at last

AT LAST, a California court has issued an opinion we can applaud.

California courts are notorious for expanding manufacturers' liability for plaintiffs' injuries in a never-ending effort to provide plaintiffs with compensation that otherwise is not available under social programs.

But, much to our surprise and satisfaction, a California court has finally said "enough" and refused to accept a new expansive theory of liability, at least for punitive damages.

As we reported last week, the 2nd District California Court of Appeals ruled recently that manufacturers and suppliers of the anti-miscarriage drug DES cannot be held liable for punitive damages if the plaintiff can't identify the specific manufacturer or supplier of the drug that caused the injury.

The court refused to extend the 1980 landmark Cali-

fornia case of *Sindell v. Abbott Laboratories* to punitive damages. That earlier decision provided that DES plaintiffs could recover compensatory damages from all manufacturers of a product according to their marketshare of the product if the plaintiff could not identify the specific manufacturer of the product that caused the injury.

The appellate court said it would not extend this marketshare theory of liability to the awarding of punitive damages for "public policy considerations," including: "preservation of the right of future claimants to compensatory damages, the potential for overkill, the punitive effect of numerous and substantial awards to present and future claimants, the attenuated deterrent effect of long belated awards and the inherent unfairness of punitive damages in the marketshare scheme."

Hear. Hear.

## letters

### Call for government understanding is a little late

To the editor: Reinsurance Assn. of America President Andre Maisonpierre told the National Assn. of Insurance Brokers at their recent annual meeting that there is an abysmal ignorance in Washington of how the property/casualty industry operates. There is no effort to understand the role of the industry in the economy of the country, he said.

But, he also said that the responsibility lies, in part, with the industry, which has been "extremely fearful" of any federal government look into the mechanism and activities of insurance. The industry must rethink its position, not about state vs. federal regulation, but about the government having a right to know what the industry is all about, he suggested.

Early in 1980, when I was counsel and director of government relations for the NAIB, that organization was vehemently

opposed to a proposal by the Carter administration to establish an office that would do just what Mr. Maisonpierre now thinks should be done—learn more about the industry.

The proposed "Office of Insurance Analysis," to be housed in the Treasury Department, was to be a repository of information and a source of insurance industry knowledge for the administrative branch. It was to have no regulatory powers.

But, the insurance industry was truly apologetic at the thought of a federal agency with any insurance interest at all. The argument most cited was the proverbial (and ever-popular) "camel's nose."

### Kentucky does not prohibit dual licensing

To the editor: The article concerning risk management and insurance consultants incorrectly states that Kentucky prohibits an insurance consultant from holding an insurance agent license (BI, May 27). Kentucky permits a person to hold both an insurance consultant and an insurance agent license.

At one time, Kentucky prohibited a person from holding both an insurance consultant and an insurance agents license.

However, this restriction was repealed

As Congress is once again getting down to areas of serious concern to the insurance industry, the industry is heard to complain that members of Congress don't understand the industry.

There are many clichés that immediately spring to mind—the one about cake and eating it seems appropriate. But, perhaps this case is best described by that popular philosopher possum of Okefenokee Swamp, Pogo, who said, "We have met the enemy, and they is us."

**Beth Kravetz**  
Associate Counsel  
Home Owners Warranty Corp.  
and HOW Insurance Co.  
Washington

by the Kentucky General Assembly on July 15, 1982.

Persons seeking further information concerning insurance consultant licensing in Kentucky should request the Insurance Consultant Information Summary from the Licensing Division, Kentucky Department of Insurance, P.O. Box 517, Frankfort, Kentucky 40602.

**Patrick Watts**  
Counsel  
Kentucky Department of Insurance  
Frankfort, Ky.

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Published weekly at 740 Rush St., Chicago, Ill. 60611, Telex 25-4248, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017, Telex 604207 CRAIN COM NYK; Suite 814, National Press Building, Washington, D.C. 20045; 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 20-22 Bedford Row, London WC1R 4EB, England. \$1.50 a copy. \$52 a year in U.S. Canada and all other foreign add \$16 for surface mail. Europe and Middle East only add \$45 for air delivery. First-class mail to U. S. and Canada only, add \$48. Bermuda only, \$97 per year expedited delivery. WILLIAM STRONG, vp-circulation. ROBERT FIORITO, circulation manager. ROGER DIGREGORIO, fulfillment director. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 740 Rush St., Chicago, Ill. 60611, or phone 312-649-5221. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611, 312-649-5303. For reprints or reprint permission contact: Reprint Department, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017, 212-210-0229.

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## Consultant dreams up cures for industry's ills

By LINDA J. COLLINS

SEA ISLAND, Ga.—Like many others, Peter B. Walker says he has been kept awake at night by the current crises facing the insurance industry.



Mr. Walker

But, Mr. Walker, director of McKinsey & Co. Inc., an international management consulting firm in New York, says he has spent his sleepless nights identifying several major problems facing the industry and looking for solutions.

He shared his insights with the

members of the National Assn. of Insurance Brokers at the group's annual meeting last month at The Cloister in Sea Island, Ga.

And, top brokerage executives who heard Mr. Walker's speech, "Late Night Thoughts on the Property/Casualty Industry," seemed impressed with his conclusions. Comments like "Fantastic!" and "That's the best speaker I've ever heard," were heard after the speech.

Mr. Walker, who began his address by giving a synopsis of the historical industry cycles and their causes, asked the audience: "What is it about this business that makes it so difficult to manage?"

He then identified several key points for the industry to consider during this chaotic time:

- The capacity shortage is real in the short-term.

- However, the structure of the industry, not short-term capacity, will be the key to the industry's long-term financial results.

- There is an urgent need to invest in critical skills that the industry has ignored for about the last five years.

- Insurance cannot solve society's problems.

- The leadership challenge that must be faced by the industry is enormous.

Mr. Walker said the capacity shortage is real, in that companies are pulling out of the market and many insurers' Best's ratings are deteriorating. "You can't argue with the mathematics," he said.

But, he said the basic measure of capacity in the insurance industry—premium-to-surplus ratio—is flawed.

"Any measure that makes you look worse as you get your prices up has a fundamental problem," he explained.

"The other problem with the basic premium-to-surplus measure is that companies who have the greatest problems in terms of being squeezed are the ones who are going to bend the most on their reserves.

"And, until the industry finds a way in long-tail lines to be able to accurately project reserve positions, then measuring surplus without that accuracy of measurement is somewhat of a hopeless exercise," he added.

Mr. Walker said each insurance company's capacity for risk should be judged individually.

He said some insurers could run their businesses with little or no capital. As an example, he cited State Farm Insurance Co.'s auto and homeowners business, which he said has a positive cash flow because of its large numbers of policyholders and its control of the marketplace.

At the other end of the spectrum, he said, he questions whether there ever will be enough capital for new entrants into excess/surplus lines or reinsurance that do not understand the business.

Several factors jeopardize the industry's long-term financial recovery, he said.

First, anyone can enter the insurance market, and pressure on the market is created when new entrants, looking for economic gain, push prices down.

On the other hand, he said, not anyone can leave the market. There are barriers to those companies that want to withdraw—"not officially, not legally, but in practice they're real."

Continued on page 12

**re·spon·si·bil·i·ty** (ri spon' se bil'i te), n. 1. the state or fact of being responsible. 2. an instance of being responsible. 3. a particular burden of obligation upon one who is responsible. 4. something for which one is responsible; dependability, esp. in meeting debts or payments. 5. on one's own initiative or authority.

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## Consultant's cures for industry ills

Continued from page 10

"You cannot own a large (property/casualty) company and decide to get out of the business, because of the size of the capital that you've got and the economic pain you take of winding down a business," Mr. Walker explained.

"Some people would argue that it's probably impossible, given the long-tail nature of the business, to actually wind out of it... What happens is that ownership changes, but the capacity doesn't actually leave the business itself."

Another market pressure on the property/casualty industry is exerted by self-insurance.

"It's always there as a substitute product," he said. "As the rates continue to push up... there's a rekindled interest in captives, paid-loss retros and all the various forms of self-insurance programs, and that alternative will always be a counterbalance to industry pricing

on commercial lines."

And, finally, he said, "The commercial insured has learned how to shop."

In essence, Mr. Walker said, the current capacity crisis is a short-term tactical problem for the industry to solve.

"The fundamentals that drive the returns in this business have not really changed, despite those short-term numbers."

What really drives the business and creates market cycles, Mr. Walker said, is an issue of leadership.

"We at McKinsey have a number of bright-eyed, bushy-tailed Stanford/Harvard MBAs who come in and view the insurance industry as a relatively monolithic business where all they've got to do is equate claims to cost to goods sold, and sales to premium, and get on with it," he said.

But, he added, six to nine months later, they come back with a feeling that it is the most complex business they ever have encountered.

Mr. Walker said that a new chief executive officer told him after about a year in the post that running an insurance company "is like running a national grocery chain where the price of bread is set by the checkout clerk."

This, Mr. Walker observed, is an excellent analogy, because "the key decisions in this business are made by underwriters and claims adjusters, who on the average have a couple of years of experience, very little training, and they're out there without a great deal of guidance."

"How do you manage a business where your key decision-makers are 10 layers away?" Mr. Walker asked.

Another problem, he said, is that too often members of the boards of directors of insurance companies don't understand the insurance industry—what they understand is profits.

Because of this, Mr. Walker explained, senior company officials feel compelled to go back to their boards and show them positive figures, often by using quick-fix measures, like holding back on reserve additions until earnings catch up.

But, Mr. Walker emphasized, front-line risk taking, underwriting and claims adjusting skills are not affected by these short-term actions.

"What you need is someone who can come into this business with a very long-term perspective, an unwavering commitment to the fundamentals of what it takes to make money, and who glides through the cycles and makes tactical moves, but never wavers from the fundamental principles," Mr. Walker said. But, he said, very few insurers live up to this ideal.

Because of the pressures brought by market cycles and by insurer boards of directors, many companies give in and change direction, management and structure on a regular basis, he said.

Unless a company can develop a long-term commitment to sound practices and enforce that commitment at every level, including the board level, Mr. Walker said, he is skeptical that the company will ever be able to earn attractive returns on a long-term basis.

The long-term outlook for insurers that tap the agency system is still questionable, Mr. Walker said. If direct writers start moving for increased market share and thus force prices downward, the pressure will "go right back to the agency companies, and the agency companies are still essentially at a competitive disadvantage because of their distribution costs."

Another major problem in the overall industry outlook is that profits on workers compensation insurance show very little evidence of improving, Mr. Walker said.

Continued on page 14



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## Consultant's cures for industry ills

*Continued from page 12*

But, Mr. Walker said, the current capacity problems could have an unexpected beneficial effect.

"There is a silver lining in this situation over the short-term because... the real marginal players in this industry that have had a disproportionate effect on pricing in this industry are being squeezed out, and even the stronger companies are starting to focus their attention on areas of strength... as opposed to pushing into new areas.

"If this capacity situation forces companies to pull back to where they are good and really focus their attention on those (areas), everybody will be better off for it," Mr. Walker said.

"Companies... should be willing to walk away from whole markets where they are marginal players and do nothing but disrupt the market for those who have the skills."

**'How do you manage (when) your key decision-makers are 10 layers away?' Mr. Walker asks.**

Another problem facing the industry, he said, is that many insurers have lost sight of the fundamentals.

He said the most critical challenge now facing the industry is that, "We have a whole generation of underwriters who have essentially learned that the market sets the price. We need to rebuild skills so that people understand that, with few exceptions, most risks can be written at the right price. It's a question of bad prices as opposed to bad risks."

He stressed that insurers spend a lot of money on consolidation and data processing, but underwriters and claims supervisors—who represent the most vital functions in the companies—are in most cases underskilled and underpaid.

"The industry needs to invest heavily and smartly over the next couple of years to rebuild those front-line skills," Mr. Walker urged.

"If that means letting the emphasis on expense slip for a while or letting some data processing projects slip for a while, then my experience is that that might be a very sound investment. Very little attention has been paid to (the skills) side of the house."

In addition to these operational problems, Mr. Walker said, insurers must deal with problems caused by the fact that insurance is being used to deal with society's problems, especially losses associated with product liability and pollution.

Courts continue to award damages, which are paid by insurers, to compensate victims, and in amounts far in excess of what insurers expected when they priced the insurance.

"If, by the time you understand the numbers, the government and the society have, through the judicial system, changed the game two times over, all this industry does is become the funder for the rest of society for those ill," he said.

Industry leaders, he said, should step back and say, "We are not going to be the bankrollers of this problem for the rest of American industry and continue to absorb the losses."

"Let's put the monkey on the backs of the people who are making the products and providing the services that are creating these problems and work with them and help them solve the problems," he advised.

Meanwhile, insurers are underwriting financial guarantees, which he suggested is extending insurance "to those areas of the market where this industry really doesn't have any business playing."

Mr. Walker said the industry already is seeing losses in the financial guarantee area.

All the problems facing the industry, Mr. Walker concluded, represent a major challenge for leadership.

"What we need is leadership that is committed to longer-term investment in critical skills and understands that this is a risk business and that pricing and underwriting is the heart of it, and (that) claims adjusting comes second," he said.

"We need stability at the top... designing jobs well, paying them well and having a sense of conviction at the top that cycles will come and go, and new players will come and go, but we're going to move through them with our eyes on the ball."

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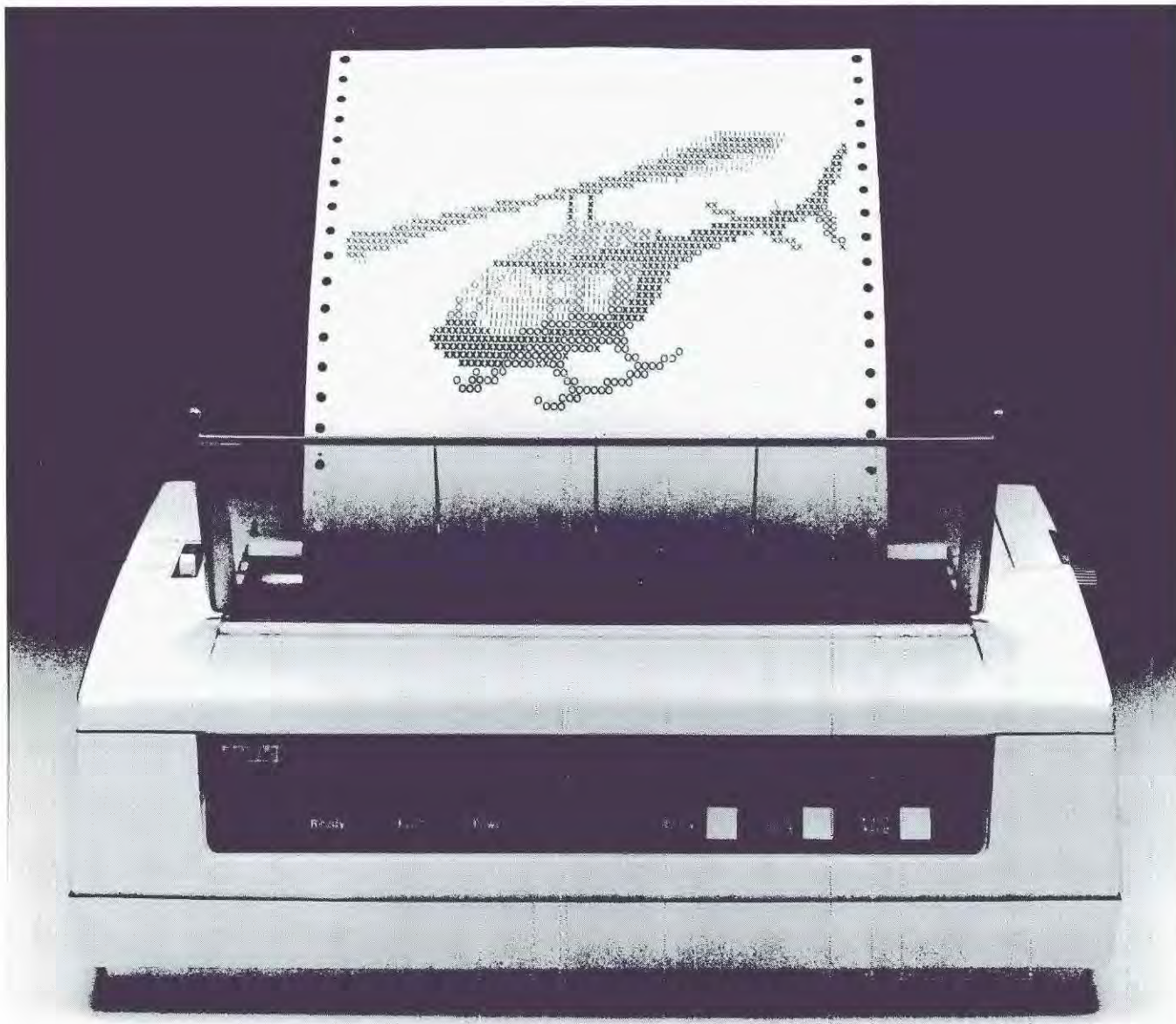
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## Changing market creates new role for brokers: Miller

By LINDA J. COLLINS

SEA ISLAND, Ga.—The tightening property/casualty insurance market is creating new responsibilities for insurance brokers, says Lloyd's of London Chairman Peter North Miller.

"There is more to placing insurance than just driving the hardest bargain possible for one's client. The broker has a responsibility to his client to see that the insurance industry continues to exist," Mr. Miller told the National Assn. of Insurance Brokers' annual meeting.

Brokers in recent years have too frequently tried to place business at any rate due to fear of competition and loss of business, said Mr. Miller, former chairman of Lloyd's broker Thomas R. Miller & Son (Insurance) Ltd. He said that brokers



Mr. Miller

should realize and stress to others that brokers, underwriters and clients all need to take a long-term view of the industry, rather than

focusing on short-term gains.

"We, the brokers, have a job to do as intermediaries when one of the parties with which we must negotiate is in one of three positions: either no longer there, because he has gone out of business or been sacked because of losses; or enfeebled and unable to give us the insurance answers which our clients require; or demanding prices and policy forms which make our clients shudder."

Turning to capacity problems created by the tightening market, Mr. Miller noted that Lloyd's capacity, expressed in terms of the British pound, has increased by 29% in 1985 over 1984.

"However, over 60% of Lloyd's income is receivable in United States dollars, which have been steadily strengthening against the pound sterling. The effective rate for 1984 for premium income limit purposes was \$1.45 equaled 1 pound, and that for 1985 is \$1.16 equals 1 pound—being the exchange rate in each case at the first of January."

Taking this into consideration, Mr. Miller said: "One is left with a figure of true increase (in capacity at Lloyd's) in 1985 of perhaps 15%."

"The crisis of capacity, so much talked about, is not at Lloyd's," he stated.

However, Mr. Miller said that the projected shortfall in U.S. property/casualty insurance capacity, which the Insurance Services Office has estimated may reach more than \$62 billion by 1987, will continue to plague insurance buyers. "There is little or nothing that Lloyd's can, or indeed should, do to try to create all the new capacity apparently needed" in the U.S. marketplace.

"Our underwriters must—and I am sure will—remember they are actually in business to make a profit, and at last they have a chance of making an underwriting profit as well as a profit on investment income," Mr. Miller said.

The current U.S. legal climate and current liability policies written on occurrence forms are the major factors deterring Lloyd's underwriters from accepting certain types of U.S. liability risks, Mr. Miller explained.

"We begin to feel in England that it is not possible to insure liabilities in the United States, because the legal system is so heavily weighted against insurers," he said.

"We insurers have little faith that we shall receive justice at the hands of the American legal system," he added.



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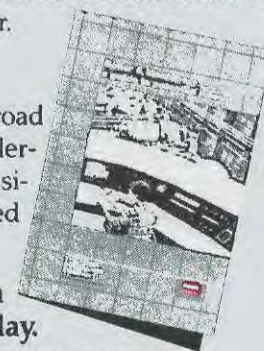
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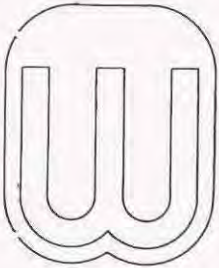


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# Finance panel's Durenberger to fight health care tax floor

By JERRY GEISEL

WASHINGTON—Sen. David Durenberger, R-Minn., isn't buying the Reagan administration's proposal for taxing employer-provided health care benefits.

Under the administration's new tax reform package, the first \$10 a month of employer contributions for individual coverage and \$25 a month for family coverage would be counted as taxable income to employees (BI, June 3).

Sen. Durenberger, a key member of the Finance Committee, favors a health care tax cap. The Reagan proposal must make it past the Finance Committee to become law.

"I am outraged by this approach. I did not mince my words about it in a note I sent to the secretary of the treasury (James Baker) in which I pointed out the new proposal was regressive tax policy and just plain lousy health policy," Sen. Durenberger said.

"The taxation of health premiums at the low end would...do nothing to encourage more prudent health insurance policy," he said.

Sen. Durenberger says he favors a health care tax cap in which employees would be taxed on employer health care contributions that exceed a certain level.

Under a bill, S. 1211, which was introduced by Sen. Durenberger late last month, employees would be taxed on employer health care contributions that exceed \$100 a month for individual coverage and \$250 a month for family coverage.

If employees know they will be

## washington

taxed if employer contributions exceed a certain level, they will have an incentive to "buy smart" and choose lower cost plans, he said.

And when employees choose lower cost plans that require them to pay more of their health care bills, the demand for health care services will ease, he said.

Under another part of the Durenberger bill, called the Health Equity and Fairness Act, employer-provided health care plans would have to offer catastrophic protection so an employee would not have to pay more than \$3,500 in health care expenses in one year.

The measure also would require employers to extend health insurance coverage for up to one year after an employee stops working for the company, although the employer could require the former employee or dependents to pay for the coverage.

## Hearings scheduled

The Senate Commerce Committee will hold hearings on June 18 and June 25 on whether a victims' compensation provision should be part of federal product liability reform.

Backers of the victim compensation concept say a pending federal product liability bill, S. 100, introduced by Sen. Robert Kasten, R-Wis., should be amended to include a type of no-fault compensation

plan to make it easier for accident victims to recover damages for economic losses such as out-of-pocket medical expenses.

Backers of the victim compensation proposal, like Sen. Chris Dodd, D-Conn., say a way is needed to compensate victims in cases where it is difficult to prove whether a manufacturer or consumer is at fault (BI, May 27).

Insurers, though, have opposed the idea; they fear a flood of new claims under a no-fault system.

Meanwhile, the Commerce Committee refused last month to send the Kasten bill to the Senate floor until it completed hearings on the victim compensation concept.

The June 18 hearing will begin at 10 a.m., while the June 25 hearing starts at 9:30 a.m. Both hearings will be held in Room 253 of the Russell Senate Office Building.

## OSHA vacancy

The Labor Department is seeking a new chief of the Occupational Safety and Health Administration after last month's resignation of OSHA Chief Robert Rowland.

Mr. Rowland, who held OSHA's top slot for 11 months, resigned shortly after the White House Office of Government Ethics released a report clearing him of conflict-of-interest charges relating to stocks he owns in various industries for which OSHA sets health and safety regulations.

Mr. Rowland said the release of the report and his resignation, effective July 1, are not linked. ■



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# Buyers will feel reinsurance market woes

By MEG FLETCHER

CHICAGO—Insurance buyers can expect more difficulty finding some types of insurance and desired limits because capacity in the reinsurance market is still shrinking, three reinsurance experts predict.

Treaty reinsurers will reduce the amount of reinsurance they will provide when treaties renew in July—the second largest treaty renewal season after Jan. 1 renewals—according to one reinsurance brokerage executive.

The reduction in treaty reinsurance capacity on July 1 renewals will be “even more dramatic than the first of January,” says Simon Harrap, London-based managing director of Stewart Wrightson (North America) Ltd.

“We see a further continuation of problems,” agreed Paul S. Mavros, senior vp in charge of the Chicago branch of reinsurance broker E. W. Blanch & Co.

It’s “bad news, bad news,” said Joseph W. O’Connor, Midwest regional vp in Chicago for General Reinsurance Corp.

Reinsurance capacity has shrunk and it will continue to shrink, he predicted.

The three reinsurance experts spoke last month at a seminar sponsored by The Assn. of Lloyd’s Brokers, a group of Illinois brokers and managing general agents who place business with Lloyd’s of London.

Already, the tightening reinsurance market has had “a very swift and direct effect” on the primary market, said Mr. Mavros.

The reinsurance market has lost as much as 45% of its capacity to write facultative property reinsurance, according to one estimate cited by Mr. O’Connor.

As a result, primary insurers can pass only a much smaller portion of property risks to reinsurers than previously. Insurers that don’t want to keep the risk formerly ceded to reinsurers are cutting back the insurance they will provide. Thus, would-be insurance buyers may find that for some risks there is no insurance at any price.

Reinsurers are cutting back the most on the amount of facultative reinsurance they will write, especially for excess property and casualty risks, Mr. O’Connor said, referring to reinsurance written for specific risks.

Reinsurers, especially major

reinsurers, are more willing to provide treaty reinsurance for the so-called working layers of coverage, he said.

Working layers are those layers where losses are expected, and the losses are more predictable and less volatile, Mr. O’Connor later explained.

There is a “definite” capacity shortage in excess umbrella coverages, Mr. Mavros noted. And, reinsurance rates are now 40% to 60% of gross umbrella premiums, he noted. Lloyd’s of London underwriters may not be able to solve commercial insurance buyers’ problems as readily now as they have in the past, Mr. Harrap noted.

While Lloyd’s will be providing increased capacity, it is quite possible that capacity problems are going to hit every syndicate, he warned.

Contributing to a somewhat more limited capacity from syndicates today is their “more responsible” attitude of reserving capacity for long-term customers whose coverage expires the second half of the year, Mr. Harrap said.

In addition, syndicates’ overall capacity is limited by the weak British pound against the dollar and the far stricter monitoring of premium limits by Lloyd’s authorities, Mr. Harrap added.

When available, reinsurance premiums may be 400% of what was paid last year, pointed out Mr. Harrap.

As recently as last year, reinsurers were charging premiums 40% below those of 1977, he said.

Mr. Harrap said he is “embarrassed” by such wide fluctuations in prices, which reflect the “ridiculous, irrational and thoroughly unprofessional way” insurance and reinsurance has been priced.

While acknowledging “a certain sympathy for the risk managers,” who are suffering the fallout in higher prices and reduced coverage, Mr. Harrap said “this sympathy is limited.”

“I have no sympathy for those who were encouraging the switching of markets and bottom premium dollar purchasing; they played Russian roulette with the industry and may have lost,” Mr. Harrap said.

Risk managers and primary insurers also will be affected by reinsurers forcing a move toward a claims-made policy.

To remain a viable marketplace, it is essential for the whole industry to move to a claims-made form rather than occurrence form for U.S. commercial risks, Mr. Harrap maintained.

“Lloyd’s (syndicates) have now given notice to insurers that they are not prepared to continue participating in treaties in 1985 unless there is fundamental agreement that the original carrier is considering moving away from the existing ‘occurrence’ wording... to a claims-made approach with a finite defense cost protection,” Mr. Harrap explained.

“In the general liability and products field, the only way that the reinsurance community should allow the direct market to proceed is on a claims-made, defense-costs-inclusive, no-pollution basis,” Mr. Harrap said.

“If this is adopted, additional capacity will gradually emerge,” he predicted.

“This is bound to be an emotional problem for many risk managers, and yet there are definitely several areas where clarification of the loss date could be a decided advantage.” In addition, he said, “a claims-made policy would give up-to-date limits for modern-day awards,” and policyholders would not have to keep policies on file for years and years.

However, not all reinsurers wholeheartedly endorse the Insurance Services Office’s proposed claims-made form, according to Mr. Mavros.

The panelists reminded the audience that the current restrictions in capacity follow six years of overcapacity in reinsurance and primary markets, from 1978 to 1984.

The marketplace quickly changed from overcapacity to undercapacity when the combination of poor underwriting, large court awards and lower interest rates turned profits into losses.

All three men issued a clarion call for a return to professionalism and better training of insurance personnel to help the industry return to profitability and prevent crises from reoccurring.



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# Asbestos pact isn't for reinsurers: Exec

By STACY SHAPIRO

HARROGATE, England—Reinsurers should analyze asbestos claims on a case-by-case basis and not generally support the asbestos claims-handling facility set up under the Wellington Agreement, advises George S. Nimmo, president of Prudential Reinsurance Co. and chairman of the Reinsurance Assn. of America.

Under the Wellington Agreement, which may be implemented this month, asbestos producers and their insurers have agreed to settle their coverage disputes and participate in a claims-handling facility.

Mr. Nimmo said that, in principle, "the agreement is a step in the right direction."

However, he said reinsurers were not included in any stage of the development of the agreement. And, reinsurers are now concerned what financial impact the implementation of the agreement will have on them, he reported.

"We are not opposed to the concept, and reinsurers are not being negative about the agreement," Mr. Nimmo told *Business Insurance*.

"But, we do not want to end up being financiers of the agreement."

"Rather than any general support of the facility, we must apply the terms of our reinsurance agreement on a case-by-case basis," Mr. Nimmo asserted.

Mr. Nimmo also stressed his reservations about the claims facility in a speech to the conference of the Reinsurance Office Assn. in Harrogate earlier this spring.

In addition, he shared with his colleagues the U.S. reinsurers' fears about earthquake and pollution liability, and about a capacity crunch.

Of the Wellington agreement, he told the ROA, "The insurers negotiated with the asbestos producers without the official involvement of the reinsurance industry."

"While the proposed claims handling facility would reduce the expenses of handling claims dramatically, the agreement would also cause the reinsurers who covered these risks in the 1970s to assume a greater share of the eventual liability, even though it excluded them from negotiations."

The council heading the facility has set up a study group of reinsurers. The study group, which met recently for the first time, hopes to "set up a framework for individual negotiations between cedant and reinsurers," Mr. Nimmo said.

The asbestos claims-handling facility, however, is not the only concern of U.S. reinsurers. For example, he said, they are concerned about possible earthquake losses.

"Most recent estimates for the worst possible scenario—an earthquake measuring 8-plus on the Richter scale along the Newport-Inglewood fault in Los Angeles in the middle of the afternoon—would result in 23,000 deaths and \$70 billion in damage," he said.

The RAA is proposing a federally enacted program to create an earthquake reinsurance corporation to provide catastrophe protection to insurers and reinsurers (*BI*, Feb. 4).

The proposed corporation would provide reinsurance for earthquake and related losses for a premium paid by the insurers and reinsurers. The corporation's policies would be backed by the U.S. government.

The RAA has not yet approached Congress with the proposal, but it is being considered by several trade associations, he added.

Mr. Nimmo continued that pollution risks pose an even bigger threat than earthquakes to the reinsurance and insurance industry.

A recent study by the Environmental Protection Agency puts the

cost of cleaning up the 2,500 known U.S. hazardous-waste sites at more than \$22 billion, Mr. Nimmo said. And, the EPA claims that there may be as many as 300,000 more sites that will require cleaning up in the future, he added.

"The specter of billions of dollars of potential pollution liability threatens to place the lion's share of cleaning up hazardous-waste sites upon the insurance industry," Mr. Nimmo said.

The insurance that currently is most likely to apply to pollution cleanup is the comprehensive general liability policy, he said.

The current CGL form excludes coverage for all pollution damages except for that caused by "sudden and accidental" pollution. But, U.S. courts have held that the pollution exclusion is ambiguous and have

awarded coverage to the policyholder in most cases, he said.

The Insurance Services Office proposed revision of the CGL forms—which will be called commercial general liability forms—are expected to go into effect in 1986 and will exclude from coverage virtually all pollution damage. But, buyers will be able to purchase pollution coverage on their CGL policy for an additional premium.

But, Mr. Nimmo believes that provision also should be eliminated, so that pollution coverage is totally excluded from CGL policies. Then, pollution risks could be covered under a separate policy with a separate premium, he said.

"The revision of ISO's commercial general liability forms which goes into effect in 1986 is a step in the right direction," he said. "But,

reinsurers obviously—and, in my opinion, rightfully—still have reservations.

"While the new forms exclude pollution absolutely, they still leave a means for primary companies to provide sudden and accidental coverage. This fault is a clear contradiction to what we had believed was the intent of the absolute pollution exclusion.

"One of the solutions to the problem may be to make an airtight exclusion for pollution in all CGL contracts and thereby create a greater demand for an (environmental impairment liability) market," he said.

Finally, Mr. Nimmo said U.S. reinsurers are concerned about the capacity crunch. He said he believes "a serious capacity crunch will hit the industry during the

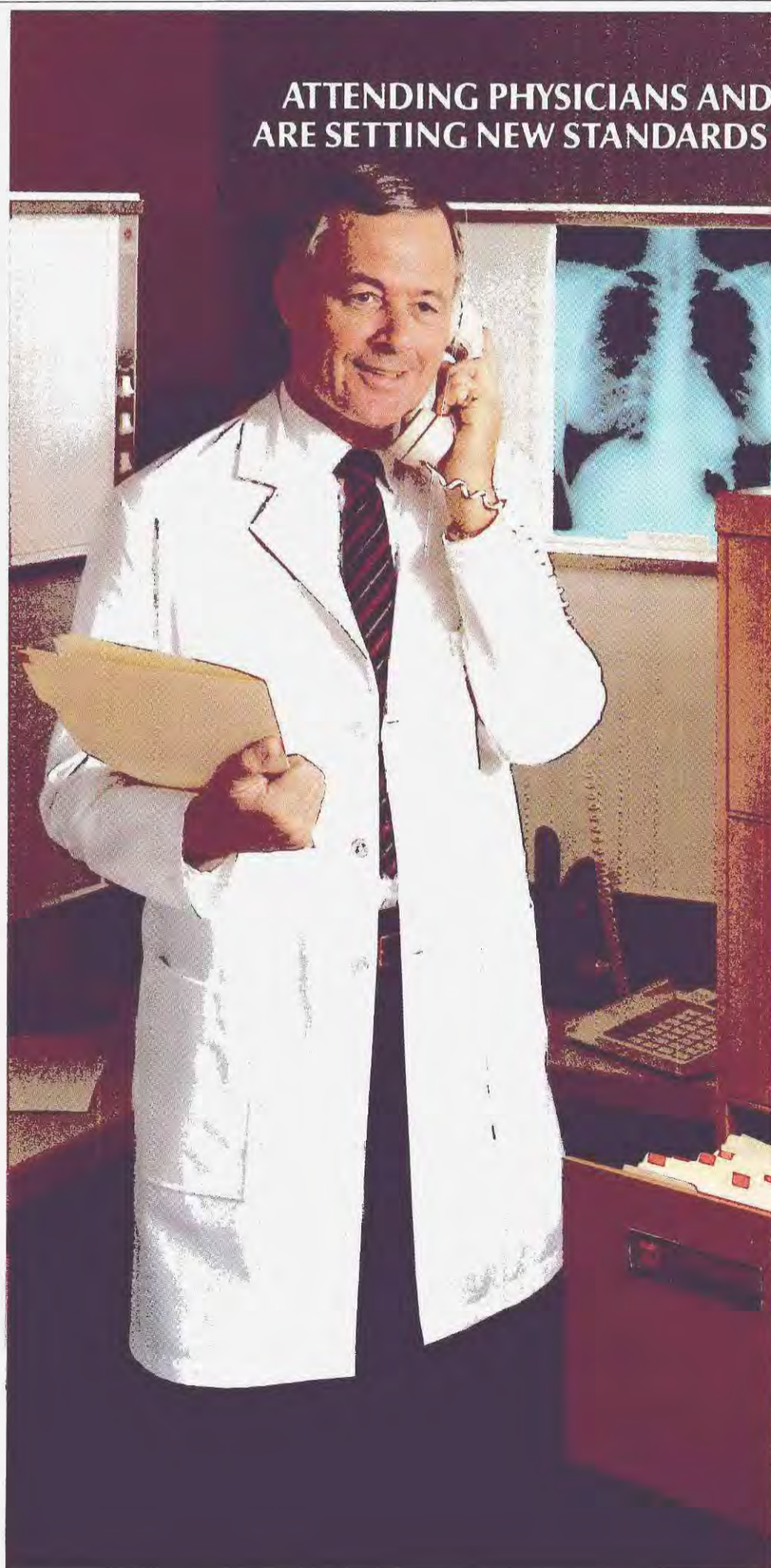
next three years."

Already, 17 life insurers and 15 property/casualty insurers became insolvent last year in the United States, he said.

And, "some have projected that as many as 35 property and casualty companies will go under this year," he said.

In addition, ISO examined financial scenarios for the next three years and concluded that the capacity shortfall for the next three years combined may be \$62 billion. And, 90% of this shortfall will be in commercial lines, Mr. Nimmo said.

"In combining the ISO projections with the exposures I mentioned earlier, the inescapable conclusion seems to be that new players with new capacity will be needed in the insurance and reinsurance markets," he concluded. ■



# Electronic network planned for London market

By STACY SHAPIRO

HARROGATE, England—An electronic network linking Lloyd's of London brokers to Lloyd's underwriters and the rest of the London market by mid-1986 would help speed payment of claims, said A.N. Coppel, deputy chairman of Sedgwick Group Finance & Administration Ltd.

The proposed network, called LINK, would serve as a kind of electronic post office, linking brokers and insurers belonging to Lloyd's, the Institute of London Underwriters and the Policy Signing & Accounting Centre Ltd., all of which have central signing offices to administer policies and claims, Mr. Coppel told members of the Reinsurance Offices Assn. meeting in Harrogate.

Through the network, underwriters would receive information from brokers about the risks they are being asked to underwrite, and brokers could pass messages to underwriters about policies and claims without walking door to door with the information.

"The functions performed by the LINK network would be to route packages of data correctly addressed to the recipients, provide proof of dispatch and of subsequent receipt, hold the message in the system until the recipient is ready to receive it and generally automate the flow of information concerned with the administration of risks placed," Mr. Coppel said.

Brokers and underwriters would be charged on a per-message basis, "just like paying for a stamp with a conventional post office service,"

he said.

But, LINK would not change the actual underwriting of risks, Mr. Coppel said. "Underwriting will be done on a face-to-face basis between broker and underwriter," he said.

The idea for the LINK network was born in 1982, after Lloyd's then-Chairman Peter Green and senior members of the Lloyd's committee visited North America.

While they were in the United States, discussions with U.S. insurers, brokers and clients "highlighted the need for Lloyd's to streamline its procedures, particularly in the claims area," Mr. Coppel said.

The Lloyd's delegation also saw many North American insurers investing in technology.

As a result, a small study group

of underwriters and brokers was set up by Lloyd's. That group, the Business Processing Study Group, recently completed a feasibility study of the network.

Among the conclusions of the feasibility study, Mr. Coppel said, were:

- A communications network is technically feasible and available.

- Underwriting information from brokers should be input by brokers and passed through the network to computers managed by LINK and made available to the underwriters. Brokers and underwriters will not have direct access to each other's computers and data bases.

- For the network to work, the London market must develop standard forms for such items as premium advice, treaties and claims

advice. The Technical Coordination Group was set up by the study committee in 1983 to look into standardizing forms.

• Participation in the network should be voluntary.

The Lloyd's Insurance Brokers Committee is examining the study and, if it approves the study, plans will go ahead to start up the network.

"The concept of a London market network is generally well received," Mr. Coppel said. "The idea of being able to reduce data entry costs, reduce duplication, reduce the amount of paper, provide better information and generally speed up processing is attractive."

One supporter of the electronic network is the Policy Signing & Accounting Centre, the signing office for 129 non-marine insurers and reinsurers in the London market.

The PSAC, which was begun in 1976, does for its non-marine members what the Lloyd's Policy Signing Office does for Lloyd's members: administers policies, claims and premiums, and keeps track of important data, like how long it takes brokers to pay premiums to member companies.

In its first year of operation, PSAC processed \$23 million pounds (\$28.8 million at current exchange rates) in premiums; this has increased to 1.3 billion pounds (\$1.6 billion) today, said PSAC Chairman Philip D. Evans, managing director of English & American Insurance Group P.L.C.

PSAC now operates with a modern IBM mainframe computer that maintains a large central policy data base containing all the entries since 1977, Mr. Evans said.

And, members can use their own terminals to link up with the PSAC computer and get data base information, Mr. Evans said. There are 15 of these terminals in 11 different companies.

"PSAC is very well-placed to exploit quickly whatever network is adopted," Mr. Evans said. "In short, PSAC is ready to play, but to get the game going we need one player—the broking community."

Mr. Evans said the LINK network would allow claims to be paid faster and more efficiently.

"There is no question that the present methods of non-marine claims processing in London are grossly wasteful of human resources," he said.

"On the other hand, there is such widespread distrust and concern in this area that people are most unwilling to release their individual control of claims settlement activities."

"We believe the development of a claims advice system which keeps people economically and promptly advised of all movements on claims will, once it has been operating successfully for a period, provide the basis for much more streamlined claims settlement," he said. ■

## Storm damages set at \$58 million

NEW YORK—Hail, wind and tornadoes caused an estimated \$58.3 million in insured property damage in parts of Texas and Oklahoma on May 6-8, according to C.E. Hermanson, vp of the Property Services Division of American Insurance Services Inc.

Virtually all the damage—\$57.3 million—occurred in Texas. Most of the losses were caused by extensive hail damage in Lubbock and vicinity.

The remaining \$1 million in damage occurred in western Oklahoma. The storm was assigned Catastrophe Number 66 by the Insurance Services Office. ■

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# OUTDATED WEAPONS

State guaranty funds not equipped to deal with current problems

By Harold M. Tract and Donald B. Henderson Jr.

**D**URING 1984, 27 property and casualty insurance companies went into rehabilitation, conservatorship, liquidation, receivership, or some other condition of involuntary dissolution.

This number of insolvent companies was the highest since 1975, and represented a dramatic increase over 1983, when seven companies went into some condition of insolvency.

Of these 27 insurance companies, 22 were stock companies, four were mutuals and one was a reciprocal organization.

Based upon disastrous underwriting results announced for 1984 and the number of insolvencies reported during the early months of 1985, it appears that the number of insolvencies in 1985 will exceed the 1984 figure.

One of the most dramatic insurer insolvencies in recent months was Ideal Mutual Insurance Co., which was placed first into rehabilitation and then into liquidation by the New York Insurance Department (BI, Jan. 14).

The New York department determined that as of Dec. 31, 1983, Ideal was \$155 million short of meeting its liabilities of \$310.6 million, on a statutory basis. The New York Department said that the insolvency was due partly to fronting programs for Bermuda-based captive insurers, partly to a pooling arrangement with affiliate Optimum Insurance Co. of Illinois and partly to increasing losses under business

produced for Ideal under managing general agency contracts.

Ideal Mutual was admitted in all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands and Canada.

This increasing number of insolvencies is now being viewed in hindsight as the inevitable result of several years of cash-flow underwriting, meaning the setting of premiums at unrealistically low rates in order to

**'The anticipated (insurer) insolvencies during 1985, along with the insolvencies during 1984, may create substantial financial difficulties for state guaranty funds.'**

generate funds for investment.

Many insurance companies set rates that were projected to be inadequate to cover even expected losses.

With the drop in investment returns, investment income has been unable to make up the underwriting losses.

In addition to those companies that are in financial difficulty due to cash flow underwriting, the insolvency of a number of such companies also could result in financial difficulties for companies that are currently financially healthy, if reinsurance balances cannot be paid to the healthy companies because of the

insolvencies of reinsurers.

The Insurance Services Office has recently projected that property and casualty companies are underreserved by 10% to 15%.

As evidence of the concern over the financial strength of the property and casualty industry, A.M. Best Co. has announced it is instituting a new service to give more advanced information about the financial strength of property and casualty companies. Best's will now publish ratings based on 1984 financial data as the ratings are assigned, through weekly advance reports, in addition to the "Best's Insurance Reports" which will be published as usual in the fall.

In addition, Best's subscribers will be able to tie their IBM personal computers into the Best's central computer in order to get information as quickly as possible.

The anticipated insolvencies during 1985, along with the insolvencies during 1984, may create substantial financial difficulties for state guaranty funds. These funds may be inadequate to pay claims of policyholders if a few large insurers, or a significant number of smaller insurers, go into insolvency during 1985.

At first glance, the state funds would seem to be able to cover almost all situations that can be reasonably anticipated. On a nationwide basis, the financial capacity of guaranty funds is very large. Such capacity is estimated to have been \$1.2 billion during 1982, not including the balance in the New York fund.

This capacity can be assessed on an annual basis. In addition to making assessments, guaranty

*Continued on next page*

# State guaranty funds need to be updated

Continued from previous page  
funds are generally authorized to borrow funds with a pledge of future assessments as collateral, and such funds have priority over general creditors when claiming assets of an insolvent insurance company.

However, guaranty funds are maintained on a state-by-state basis, and the insolvency of an insurer that has a substantial market share in one particular state could cause the guaranty fund in that state to be inadequate, particularly since the insolvent insurer would not be contributing to the fund in the year when the assessment is required.

This appears to be occurring in Delaware in the life and accident and health lines, as the result of the insolvency of Tara Life Insurance Co. of America. The amount of covered claims resulting from the Tara Life insolvency could exceed the annual assessment capacity of the Delaware life and health fund. Claims may be paid only over a number of years, as additional assessments are made by the fund.

The insolvency of a larger number of smaller insurers could similarly threaten the capacity of a state's fund.

Property and casualty guaranty funds exist in all 50 states and in the District of Columbia, in one form or another. In all states except New York, the funds are post-assessment funds. The funds can assess licensed companies a percentage of written premiums in that state to pay claims of insurers that have been declared insolvent.

The terms of guaranty funds can differ widely. For example, New York pays up to \$1 million per claim, while Illinois only pays up to \$150,000. Some states pay up to \$5,000 for claims of return premiums, while other states make no payments.

Guaranty funds in 22 states are triggered only if a liquidation order is entered. Guaranty funds in the remaining states are triggered upon the order or initiation of rehabilitation.

Generally, policyholders must go to their own states' guaranty funds if claims are not paid. In some instances there may be questions concerning which state's fund should make payments.

For example, a corporation may be domiciled in one state, have its corporate headquarters in another state, and have losses at a branch office in third state. In such circumstances, the administrators of funds in two or more states may have to negotiate as to the payment of claims.

Most property/casualty guaranty funds are based upon the model law adopted by the National Assn. of Insurance Commissioners in 1969.

The model law resulted from concern in the insurance industry over possible federal action in the field of company insolvencies. During 1966, Sen. Christopher J. Dodd, D-Conn., proposed the creation of Federal Motor Vehicle Guaranty Corp. The response of the NAIC was the endorsement of uninsured motor vehicle coverage.

However, in 1969, Sen. Dodd again introduced the proposal, which led directly to the adoption of the model law

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and a recommendation that each state that did not have a guaranty fund adopt a post-assessment fund.

Within two years, 45 states had adopted legislation creating such a fund.

Under the model law, a non-profit association is established by each state, and all licensed companies in the state writing the specified lines of insurance to be covered by the fund are required to be members.

The fund is obligated to pay covered claims of insolvent licensed companies, limited to claims existing prior to the determination of insolvency and arising within 30 days after that date. Claims are limited to the lesser of policy limits or \$300,000, (other than workers compensation, for which there is no dollar limit). There is a deductible of \$100 for unearned premium claims.

Under the model law, the definition of covered claims are those arising out of insurance policies in the lines of insurance covered by the fund, issued by a licensed insurer that becomes insolvent. The fund only pays covered claims of

initial liability is generally that of the fund of the state of residence of the insured. Two exceptions are claims for damage to property that has a permanent location and workers compensation claims, where the initial liability is to the state of the location of the property, and the state of residence of the claimant, respectively.

The New York scheme differs somewhat from the model law, particularly in the assessment scheme.

The New York fund pays unreimbursed claims up to the lesser of policy limits or \$1 million. Return premium claims are allowed with no deductible. No claims are allowed by shareholders of the insolvent company who own, directly or indirectly, a 10% or more interest in the company.

To fund the payment of these claims, and to provide funds for administration, authorized insurers that write policies in covered lines are assessed, on a quarterly basis, an amount equal to 1/2 of 1% of net direct written premiums.

Assessments are made to maintain a

**'Many of the new insurance products have high policy limits, and there are substantial questions as to whether these products, with their potential for high losses, should be covered by the (state guaranty) funds to the same extent as policies in traditional lines.'**

insured parties who are residents of the the state, and claims involving property that is permanently located in the state.

The fund does not cover any claims of insurers or reinsurers, as to subrogation recoveries or otherwise. When the model law was adopted, the position of the NAIC was that insurers and reinsurers should know the financial condition of companies they deal with and should not rely upon the guaranty fund.

Funds for the payment of covered claims and the expenses of the guaranty fund are derived from assessments against licensed companies writing the covered lines. These amounts are collected as needed.

For years in which no covered claims are paid and expenses incurred, no assessments are made.

Assessments are made on a pro-rata basis, based on the volume of net direct written premiums of licensed companies on policies in covered lines of insurance. Some states allow assessments to be recouped by the companies by crediting the assessments against future state premium taxes.

Assessments in any year are limited to 2% of net direct written premiums. If claims and expenses are greater than total assessments for any year, unpaid amounts are paid in future years as funds become available, or as an alternative, the fund can borrow necessary amounts and repay the indebtedness out of future assessments.

Once covered claims are paid and expenses incurred, the fund has priorities as to reimbursement out of the assets of the insolvent company. The fund has the same priority as to claims that the insured party would have had, and the same priority as to expenses as the liquidator's expenses.

If more than one state fund could be liable for payment to an insured, the

balance for the fund before actual claims are made against the fund, which distinguishes the fund from the model law and guaranty fund of every other state.

However, no assessments are made as long as the fund balance is at least \$150 million. If the fund falls below \$150 million, contributions are resumed by those insurers writing policies in the lines as to which payments were made during the year that caused the balance to fall below \$150 million.

Earnings on the fund balance are divided among the guaranty fund, the general fund of the state, and the New York property insurance underwriting association.

Earnings credited to the guaranty fund increase the principal of the fund, but after the fund reaches \$250 million, the fund does not share in any additional earnings.

In addition to the large underwriting losses sustained by the property and casualty industry during the past few years, there are several additional concerns as to the ability of guaranty funds to maintain their role as the guarantor of solvency for policyholders, and as to the proper roles of such funds in the changing insurance industry.

Guaranty fund legislation originally was conceived as consumer protection for the unsophisticated average insurance buyer of small financial means, who could not bear the risk of the loss that results from an insolvent company not being able to pay claims.

Today insurance companies are writing new types of insurance, including insurance products like financial guaranty insurance, which are not within the traditional concepts of insurance. These new products are marketed to the more sophisticated and financially secure buyers. Nevertheless, depending on the

definition of covered lines under the laws of the various states, these new products can be covered under guaranty funds.

Many of the new insurance products have high policy limits, and there are substantial questions as to whether these products, with their potential for high losses, should be covered by the funds to the same extent as policies in traditional lines. High losses in these new lines could cause insolvencies for which the more traditional insurance companies, and ultimately their policyholders or state taxpayers, would become liable, even though the purchasers of the new products may have been substantial commercial accounts.

In addition to new types of insurance products, some insurance companies today are being required to pay losses of the type that were not contemplated when the policies were issued, such as certain types of environmental losses.

Potential losses under these new theories of coverage, as well as potential losses under these new specialized products, could lead to large unanticipated losses that could cause the insolvency of companies that now appear to be financially healthy.

The challenges to the ability of guaranty funds to deal with insolvencies are a cause for concern, not only from a financial standpoint, but also from the standpoint of potential federal intervention into the regulation of the insurance industry.

While regulation has been reserved to the states in the past, some consumer groups are now advocating the creation of a federal agency to assume this regulatory function.

Any failure of a guaranty fund would provide these groups with an effective argument for the creation of a federal insurance agency to assume all or part of the role that is now being fulfilled by the states.

To protect the solvency of the guaranty funds and to avoid federal regulation, the NAIC and state legislatures should consider revising guaranty fund laws to be more in line with the original consumer protection concepts.

As part of this revision, states should consider whether any insurance products are currently being written under covered lines that are not appropriate for coverage under a guaranty fund.

In addition, the establishment of pre-assessment funds would insure that all licensed companies would contribute to the funds annually, at least until the funds reach prescribed maximum amounts, rather than only those companies that are both licensed and solvent at the time that the fund is activated.

A pre-assessment fund would also allow amounts to be invested and income earned for the credit of the fund.

These measures may assist guaranty funds to continue to protect those policyholders who were and are the primary focus of protection against loss resulting from the insolvency of an insurer.

However, no guaranty fund can substitute for prudent business judgment on the part of insurers, and careful and timely regulation and investigation by the state regulators, which are cornerstones of the stability and security of the insurance industry. ■

# Latest edition improves a good book

"Risk Management and Insurance,"  
Fifth edition

By C. Arthur Williams Jr. and  
Richard M. Heins  
McGraw Hill Book Co., 1221 Avenue  
of the Americas, New York, N.Y.  
10020

\$31.95; 755 pages

By Ellen S. Feliciano

THE FIFTH EDITION of "Risk Management and Insurance" by C. Arthur Williams Jr. and Richard M. Heins is, like the four previous editions, an outstanding source of information on risk management in an extremely readable format.

There are several major changes in the fifth edition as well as many minor changes and updates.

Unlike previous editions, the book opens with a discussion of the importance of the study of risk management. More emphasis is placed on the concept that effective risk management may mean the difference between survival and failure of a company. It is pointed out that risk management is a valuable topic of study for managers in areas other than risk management as well.

The section on the scope of risk managers' duties has been updated to reflect the broader scope of the job today. A more recent survey has been substituted for the previous one.

In the discussion of risk analysis, a section has been added describing the importance of on-site inspections as an important tool in the risk analysis process. This rectifies an important omission from earlier editions.

Two valuable learning tools have been added throughout the book. The first is a definition of objectives at the beginning of each chapter. These are very specific, and if read carefully before and after reading the chapter, they help to solidify and clarify the information that is presented.

The second learning aid is a definition

## books & ideas

of key concepts at the end of each chapter. Like the listing of objectives, these key concepts with definitions are a distinct benefit to the reader.

Many of the other changes in the book from previous editions are less obvious, but the reader who has studied previous editions of the book will notice a subtle change overall. Throughout the book, sentences and paragraphs have been shortened; shorter words have been substituted for longer ones. In some cases, material that has lesser importance has been relegated to footnotes or omitted entirely.

Some of the longer sections have been broken into subsections, and as a result, the focus of the sections is clearer. One example of this is the sections on coinsurance, which now has three subsections: "How It Works," "The Rationale," and "Difficulties in Application."

The overall result is that the book, which always was smoothly written, is now even clearer and easier to read.

Exhibits throughout the book have been updated to show current data. Many examples have been altered to reflect prices or wages more realistic in the mid-1980s.

More emphasis is placed on quantitative methods in the practice of risk management. A section has been included on the "Capital Asset Pricing Model, Portfolio Theory and Worry Factor". The point is made that, although there are many doubters of CAPM, it is widely regarded by financial theorists; therefore the serious student of risk management should have some familiarity with it.

Under "Tools of Risk Management," the discussion of Haddon's theory of "Destructive Release of Energy" has been totally rewritten. The examples are very straightforward, making it simple to grasp the concept. This is a major

improvement.

The discussion of the various funding arrangements to support risk transfer has been updated. An expanded discussion of captive insurers is included.

The section on "Contract Analysis" includes a fuller discussion of personnel insurance than previous editions. A clear distinction is made between life and health insurance contracts: Life (and disability) contracts are not contracts of indemnity, while medical insurance generally is.

Chapter 18, on "Property Insurance Contracts" has been totally rewritten, and the result is an important improvement in the book. The chapter opens with a detailed description of the 1943 New York standard fire policy ("the 165 lines"). Following this, various forms and endorsements are discussed in detail. This is an excellent addition, since many students of risk management have had little or no previous exposure to insurance.

The overall organization of the two chapters on insurance contracts is more logical and more informative. The basics are discussed early in each chapter, which then moves toward discussions of more complex forms of insurance, such as package contracts. Throughout the two chapters, specific terms and conditions are defined.

The section on social insurance reflects recent changes in Social Security, and the discussion of issues related to Social Security are all new, reflecting current concerns. The issues are categorized according to whether they affect coverage, benefits or financing.

In the section on national health insurance proposals, much of the detail has been cut out, reflecting less interest at the present time.

The section on health maintenance organizations is virtually unchanged from the fourth edition, despite the

growth in popularity of HMOs. Perhaps this section will be updated in a sixth edition.

The discussion of employee benefits has been expanded in the area of variable benefit plans. A discussion of savings and thrift plans is now included.

Newer forms of life insurance are discussed, including universal life insurance, extralife, econoplan, extraordinary life, joint life and flexible premium variable life.

The section on Individual Retirement Accounts has been updated to reflect the liberalization of the laws in 1982.

The increasing trend toward insurance companies in financial service combinations has been reflected in the chapter on selection of an insurer. The new designations of Chartered Financial Consultant (ChFC) and Certified Financial Planner (CFP) have been included in the sources of information section on "Selection of a Broker."

International risk management is discussed in much greater depth in this edition, reflecting the increasing growth of international and multinational companies.

Special emphasis is placed on the increased difficulties of risk analysis in international risk management.

Overall, this new edition of "Risk Management and Insurance" is greatly improved, not just updated. Even more than in the past, the book is well-organized and well written.

This has always been one of the best sources of information on risk management, and this edition will continue the tradition. ■

Ellen S. Feliciano is a  
risk management con-  
sultant in Chicago.



# Suicide can be compensable, court rules

In a case of first impression, the Supreme Court of Montana ruled that suicide is compensable under the Workers' Compensation Act if a compensable injury produces mental derangement and the latter produces suicide.

On Jan. 8, 1974, Raymond Campbell seriously injured his back while working for Young Motor Co. The back injury led to two surgeries. However, Mr. Campbell still was unable to work for 2½ years after being injured.

During the time he was unable to work, Mr. Campbell abused alcohol daily and was depressed most of the time. Pain medication did not relieve the pain, but he claimed that alcohol did. He returned to work on his original job, but his pain—and his drinking—continued.

He became more and more withdrawn. His marriage began to deteriorate because of his drinking. He was hospitalized for alcohol treatment for four days, but he quit drinking for only one month.

He switched to a new employer as a truck driver. His family life continued to deteriorate, and his wife and children left him.

*These abstracts were prepared by Cases Unlimited Inc. A copy of an entire decision may be obtained by sending a check for \$5 made out to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. List the number for each opinion.*

## legal briefs

On or about Jan. 10, 1979, Mr. Campbell committed suicide, leaving a note to his mother implying that his reason for suicide was the loss of his wife to another. Mrs. Campbell, his widow, filed for compensation benefits. The Compensation Court awarded benefits.

On appeal, the employer argued that the suicide was of personal origin and was a superceding intervening cause as a matter of law.

The appellate court said that no jurisdictions recognize suicide as an intentional act that automatically breaks the chain of causation to defeat a claim for death benefits.

The court believed that the employer's argument adopted "too hard and fast a rule on the dynamics of cause and effect." The court concluded that it was more reasonable to look to see if the suicide arose out of severe pain and despair that resulted from a compensable injury to such a degree as to override normal and rational judgment.

The court was satisfied that Mr. Campbell's industrial accident was a substantial contributing cause of his suicide, thus warranting workers compensation benefits to his widow. *Campbell v. Young Motor Co.*, Supreme Court of Montana, June 28, 1984 (BI/04/Ju.-\$5)

## 'Off-duty' driver's injuries compensable

A truck driver who, while seated in the cab of a truck at a delivery point, was struck by a pipe and shot by an assailant, was acting within the course of his employment regardless of whether he had logged on- or off-duty, a North Carolina appellate court ruled.

Robert Hobgood drove a truck for Anchor Motor Freight delivering new cars to various cities. After he had made a delivery in Goldsboro, N.C., he logged in as "off-duty" until he continued to a second city the next day.

However, while he was still in the Goldsboro delivery site and seated in the truck, he was shot in the head by an assailant. Mr. Hobgood filed a claim for benefits, which were awarded.

The appellate court said that an employee, like Mr. Hobgood, whose work entails travel away from the employer's premises, acts within the course of his employment continuously during the trip, unless there was proof of a "distinct" or "total" departure on a personal errand.

Since Mr. Hobgood was still in his employer's truck at the time of the injury, the appellate court said it was irrelevant whether he was logged on- or off-duty. The award was affirmed. *Hobgood v. Anchor Motor Freight*, Court of Appeals of North Carolina, June 5, 1984 (BI/05/Ju.-\$5) ■

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HB5

## comings & goings: buyers

### M.A. Hanna Co. taps McCoy to head insurance division

**Dan A. McCoy**, 43, has been named president of the Insurance Services Division of the M.A. Hanna Co. in Cleveland. Mr. McCoy will join the company June 28 with responsibility for risk management for the company and coordinating all insurance consulting and management services provided to clients. He replaces **Richard Ausbrook**, who resigned for personal reasons. Mr. McCoy will report to John S. Pyke Jr., vp and corporate secretary of Hanna. Mr. McCoy received a bachelor of science from Illinois Wesleyan University in 1964 and a master's in business administration, specializ-

ing in risk management and insurance, from Indiana University in 1966. He has the Chartered Life Underwriter and Associate in Risk Management designations.

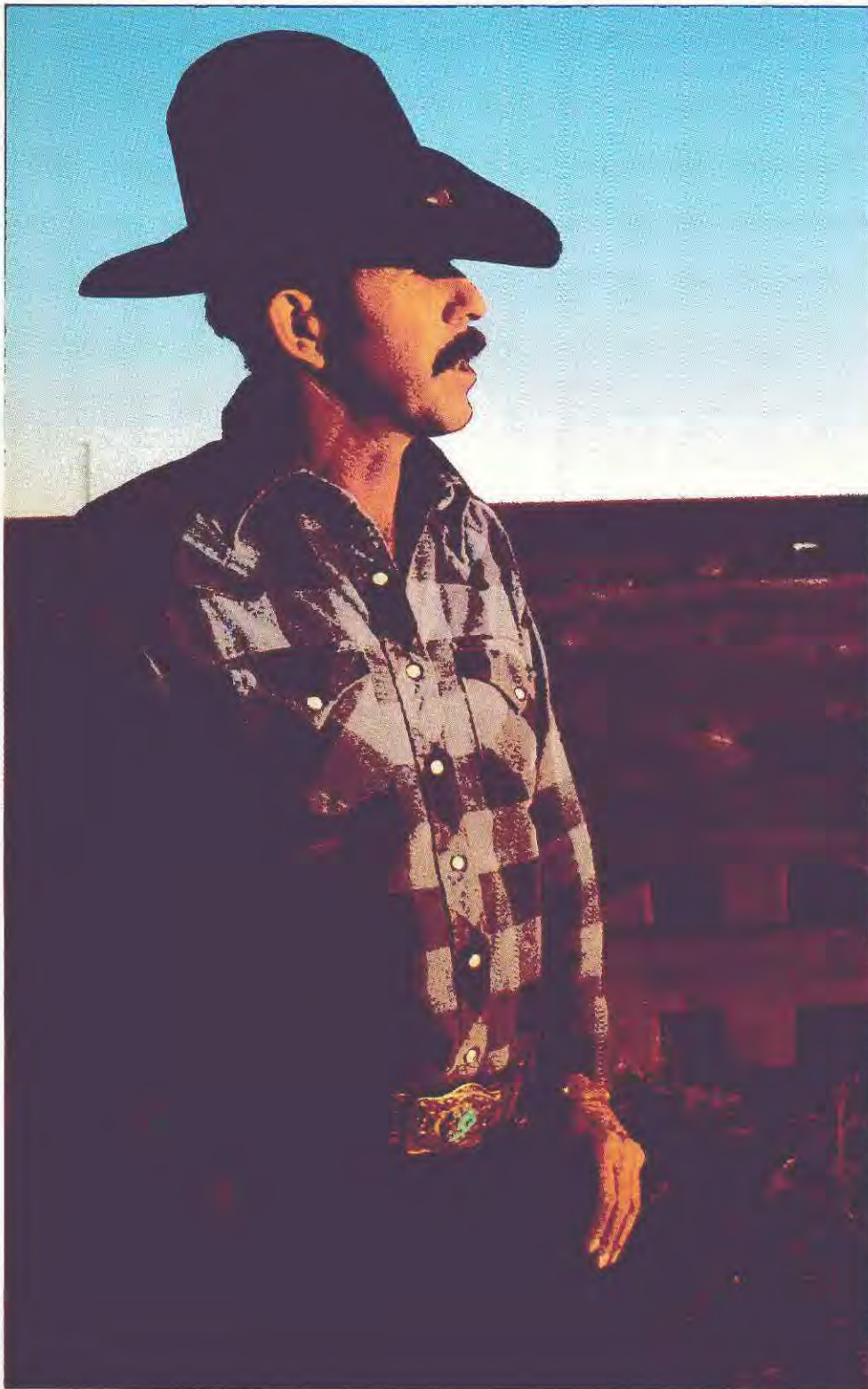
**Richard H. Wagner**, 41, has been appointed executive director of compensation and benefits for Estee Lauder Inc. in New York. Mr. Wagner is responsible for the design and administration of all compensation and benefits plans. He reports to Thomas Moorhead, senior vp of corporate affairs, and replaces **Alexander A. Stanich**, who is now vp of employee relations at the Equitable Life Assurance Society of the United States in New York. Mr. Wagner had been a principal in compensation consulting for The Wyatt Co. in New York. He earned a bachelor of arts in English from the College of the Holy Cross in Worcester, Mass., in 1965 and an executive master's degree in business administration from Southern Methodist University in Dallas in 1978.

**John P. Lenihan**, 31, has been named risk manager for Jaguar Cars Inc. in Leonia, N.J. In this new position, he is responsible for placing property/casualty insurance, coordinating product liability cases with Jaguar's investigation service and supervising warranty litigation. He reports to Edward J. McCauley, vp of finance and administration. He had been insurance and safety manager for the Grand Union Co. in Elmwood Park, N.J. He received a bachelor of arts degree in business administration from William Paterson College in Wayne, N.J. in 1976. He is an Associate in Risk Management and a member of the Risk & Insurance Management Society.

**Michael E. Murkey**, 36, has been promoted to director of risk management for the Hilton Hotels Corp. in Beverly Hills, Calif. He is responsible for administering the company's property/casualty insurance programs. He replaces and reports to **John S. Surabian Jr.**, who was promoted to vp of risk management. Mr. Murkey had been risk manager for the Hilton and will retain those responsibilities. He earned a bachelor of science degree in business administration from California State University and a master's degree in business administration from Pepperdine University.

**Thomas Southworth**, 40, has been named chief of the risk management division of Montgomery County, Md. He is responsible for the county's self-insurance, property/casualty, employee safety and loss-control programs. He reports to Max Bohnstedt, director of finance, and replaces **Robert Peter**, who retired. Mr. Southworth had been risk manager for the state of Maryland's National Park & Planning Commission. He received a bachelor of arts degree in economics from Hobart and William Smith Colleges in Geneva, N.Y., in 1967 and a master's degree in business administration, specializing in insurance and risk management, in 1976 from Temple University. He has the Associate in Risk Management designation.

We'd like to report on staff changes in your company's risk management, safety or employee benefits department. Just drop a note to Diane Kashtiel, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5393. Please send a photograph, too.



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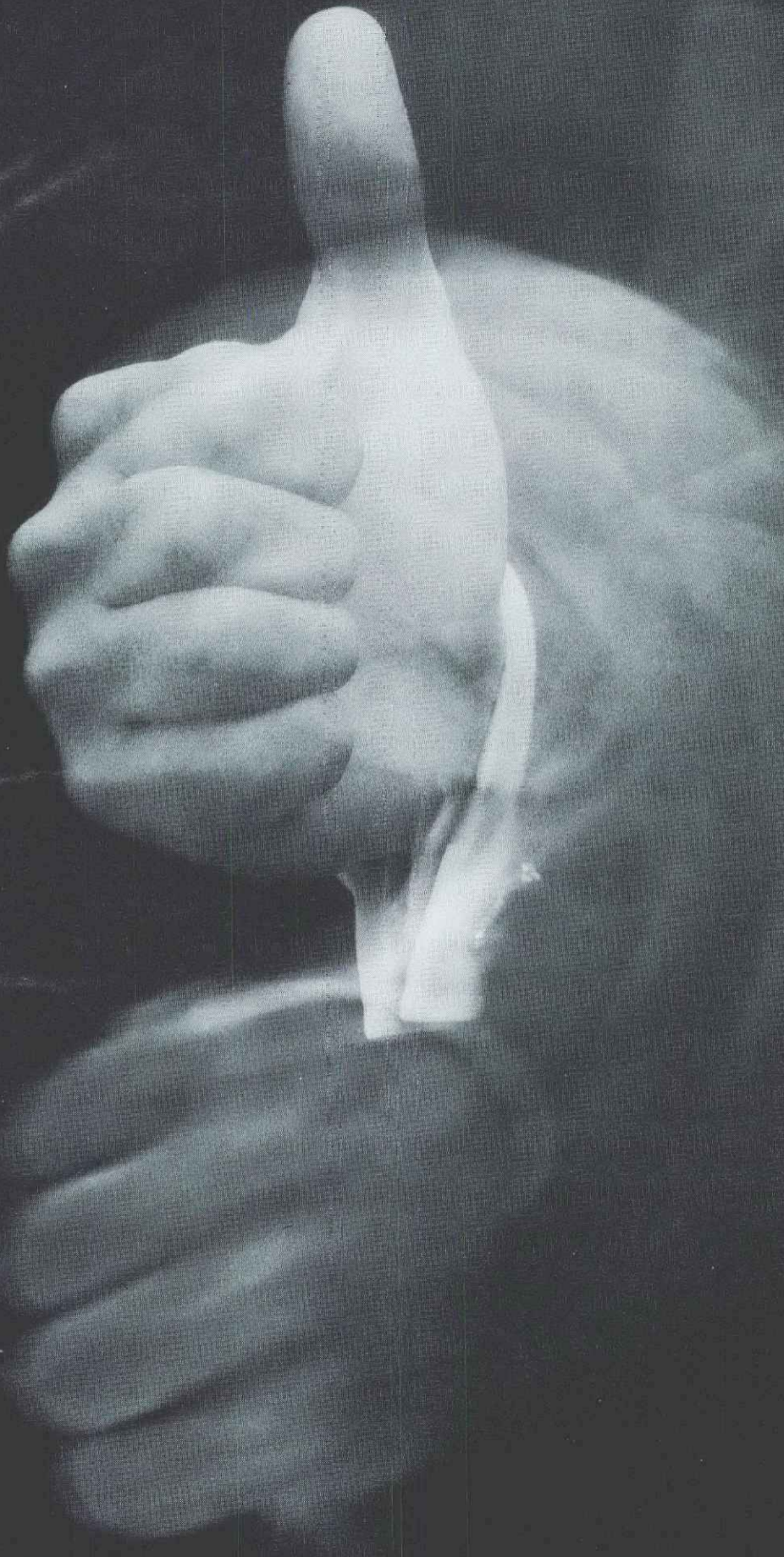
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# U.S. underwriting losses felt worldwide

By STACY SHAPIRO

LONDON—The impact of underwriting losses in the United States is being felt all over the world, according to international insurance and risk managers.

These losses, affecting rates and capacity for liability coverage in other world markets, were discussed by insurance and risk managers at the Assn. of Insurance & Risk Managers in Industry & Commerce conference in London on May 15-16.

British risk managers—whose loss records are fairly low compared with their American counterparts—say that this lack of capacity has made it difficult for them to complete their excess liability coverages.

Some risk managers are finding only half the limits of liability coverage they had been able to find, said Terry Sparkes, former AIRMIC chairman and insurance manager for Metal Box P.L.C.

Also, British companies that either have American subsidiaries or export goods to America are finding it difficult to find coverage for these U.S. exposures, said Mr. Sparkes, whose company has 40 factories in the United States.

Insurers also are canceling coverage mid-term in the United States, he said. "It will be interesting to see July 1 renewals."

"Premiums are hardening, particularly on the liability side," added David Pollock,

AIRMIC chairman and insurance risk manager for Scottish & Newcastle Breweries.

Those paying higher premiums for their U.S. liability risks include pharmaceutical and chemical companies, he said.

"Underwriting losses in the U.S. are likely to affect the whole world market," Mr. Sparkes said, pointing out U.S. courts award much higher damages in liability cases than do foreign courts.

Foreign risk managers are having more trouble dealing with this situation than are their American counterparts, who have lived with U.S. liability exposures for many years and have designed their programs to accommodate them, pointed out Richard Hackenburg, president of the Risk & Insurance Management Society in New York.

"The problems in the U.K. (and Europe) are more oriented to property risks and property insurance programs. They are not involved heavily in the casualty areas like their U.S. counterparts. But the explosion of liability costs has impacted local U.K. needs. And, yes, indirectly, they are impacted by what happens in the U.S.," he said.

Liability awards made in the U.S. courts also have made American companies more aware of the need to use risk management techniques to protect corporate assets, Mr. Hackenburg added.

Many risk managers at the conference

expressed concern about the current capacity crunch and high rates that have come with the abrupt hardening of the market.

Harry Purchase, group marketing director of Stewart Wrightson Insurance Broking Group, pointed out that not too long ago rates were moving downward 30% to 40% a year. And, rates for all-risk packages for industrial accounts were being quoted at 1 cent for every \$100 of insured value, less a 15% special discount.

"We were probably only a stone's throw away from the day when we gave our clients a box of chocolates with the renewal documents," Mr. Purchase said.

"I suppose we all believed that the brakes would be applied gradually, that the market would bottom out and then the price increases would begin in earnest."

But, nearly everyone was surprised that the market seemed to turn almost overnight, he said.

Mr. Purchase pointed out that the insurance market started to harden when reinsurers pulled out of underwriting certain classes of business, particularly in the casualty field.

But, Alan Preston, director and chief executive of Victory Reinsurance Co. Ltd., said reinsurers have had to raise their rates and cut back on their lines and limits.

"We have been trying to keep in the market and live in the market. But the situation

is so acute that we must hike (rates) quickly or go under, which is happening to some right now. After 40 years, we are saying to some clients that we cannot bleed anymore."

In his prepared remarks, Mr. Preston said: "I think it will be some time before insurers find their way back to profitability, but more selective underwriting, more work in the field of risk management and loss control and disaster planning may well reinstate some of the ailing profits. Reinsurers will be more cautious, certainly no less than their clients, to grant the wide-ranging treaties of the past."

Many European risk managers are considering captives as a risk management tool, AIRMIC members said. But, reinsurers no longer give captives lower rates than primary insurers, as many used to.

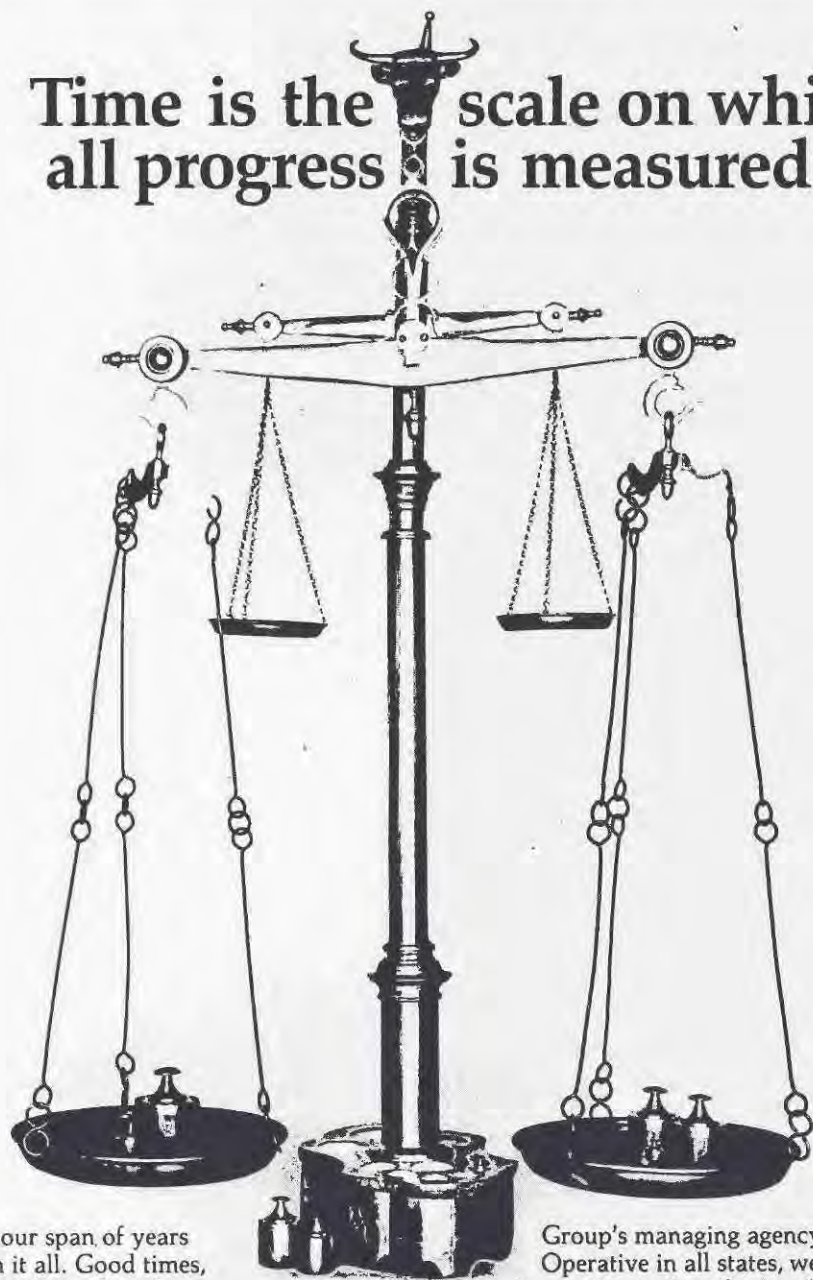
Mr. Preston said, "I am quite happy to deal with a captive as I deal with other (ceding companies). I hesitate to give a lesser charge."

Still, Mr. Hackenburg noted, "the insurance market will continue to be cyclical."

"There are patterns for loosening in the future. It will happen...but (now) you must belly up to the bar and pay those premiums," he said.

More than 250 British insurance and risk managers, reinsurers, insurers and brokers attended the two-day conference. ■

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## Kidnap, extortion coverage doesn't add to crime: Expert

By STACY SHAPIRO

LONDON—Buying kidnap and ransom insurance or product extortion coverage does not encourage the crime, a security expert says.

Although concern has been expressed by governments and law enforcement agencies that these insurance coverages might encourage kidnapers and extortionists, "insurance has not led to the increase of crime," said Nigel Churton of Control Risks Ltd. in London.

In fact, companies with insurance are probably more aware of the risks and take greater precautions, he said.

He told the members of the Assn. of Insurance & Risk Managers in Industry & Commerce at their conference last month in London that there are more than 350 kidnappings a year worldwide involving corporate personnel.

"A kidnapping will place new strains on corporate management," Mr. Churton said. "The company will be dominated by the safety of the hostage; the commercial impact on the company—limiting the financial and operational damage caused by the kidnapping; and the implications on society."

Therefore, companies must be prepared for the kidnapping of executives and should have a security plan in place, Mr. Churton said.

A security plan that addresses kidnapping and ransom situations also can address product extortion situations, he added.

The plan should include setting up a crisis management committee and coordinating team to work together throughout the kidnapping, said Mr. Churton.

The coordinating team should be based at the corporate headquarters and be led by the company chairman or chief executive, a senior vp and/or legal advisers and finance executives. Executives in the international or public relations departments also can play a role.

The crisis committee should be based at the site of the kidnapping and should include a senior local executive, a representative from corporate headquarters, legal counsel, a negotiator and possibly a security consultant.

The crisis committee should find someone to talk to the kidnapper, negotiate tactics, give a day-to-day risk assessment to corporate headquarters, look after the victim's family, deliver the ransom and be responsible for taking the victim out of the country after release.

A senior executive should be assigned to head each of these committees all throughout the kidnapping situation, Mr. Churton said.

He added that, before a kidnapping occurs, a company should decide how it would answer key questions, including whether the company would pay a ransom and whether, if the ransom were paid quickly, the company would be encouraging future abductions.

"How much will you pay? How long will you sit there negotiating? What are the long-term implications? How should the team be controlled?" he asked.

Mr. Churton also said companies must determine which of their personnel are most likely to be targets of a kidnapper and then take measures to prevent abduction.

If a kidnapping occurs, a company might have to consider finding someone else in the company to take over the kidnapped victim's corporate responsibilities.

"And what condition will he be in when he is freed? Will he be fit to come back to work?" asked Mr. Churton.

During a kidnapping situation, the company must make sure the kidnap victim's family members stay in control, and don't release delicate information vital to the negotiations, said Mr. Churton.

In the case of extortion attempts involving product tampering, he said, companies should know how to go about recalling its product and how to deal with local police. And, the company should be ready with press releases and public statements.

Finally, he said, company employees should know how to handle a product extortion or ransom demand made over the telephone. "The operator shouldn't switch the call all over the company." ■

## Salary survey

Continued from page 3  
risk managers is bright.

Richard Meyers, a survey author and a senior vp at Logic, said reduced compensation increases in 1984 compared with 1983 may be partly due to the fact that this year's survey sample was more representative—and yielded more accurate data—than last year's.

Bill Perry, the other author and also a senior vp at Logic, said the modest salary increases were "just a reflection of the economy."

"The amounts of raises that were given out were more in line with the general growth of the economy and the inflation rate," he said.

Both Mr. Meyers and Mr. Perry agree that risk manager's salaries are likely to increase more in 1985.

First, Mr. Perry says, the general employment picture for risk managers has changed.

"It's a different type of job market in risk management today. There are fewer people out of jobs, and it is going from an employer's market to an employee's market.

"We may see raises going up, more from a person making a move (to another company) than from staying in his own company. If people are going to make a move, it will require a prospective employer to do more for the individual than two years ago, when so many people were out of work," he said.

And, Mr. Perry and Mr. Meyers emphasized that the tightening commercial property/casualty market is making risk managers more valuable to their companies.

Companies are being faced with higher premiums and retentions and, in some cases, are having trouble finding coverage at all.

"What happens now is that middle and upper management are saying to themselves, 'Holy cow!'" Mr. Meyers said. "They are wondering, 'Do I have the proper person?'" to negotiate coverage.

In addition, he said, "Companies that have functioned without a risk manager now are saying, 'Maybe I ought to have someone who is going to have some immediate dedication to my firm.'"

"The bottom line is that the hard marketplace, in effect, has made the hiring marketplace more viable for the risk manager," he said.

And, Mr. Perry added, "We will probably see in next year's survey even higher salaries because of what is going on in the marketplace today. The quality clients are looking for is getting higher."

Mr. Meyers pointed out that, when measured against the huge increases in the cost of coverage, companies will find it more cost-effective to pay higher salaries for their risk managers.

"The justification is definitely there" for higher salaries, Mr. Perry agreed.

This year, 917 risk managers answered the survey, for a response rate of 31%. Responses are grouped according to the sales reported by respondents' companies.

As in prior years, large industrial states were most-represented in the survey. This year, 74% of the responses came from California, Connecticut, Illinois, Massachusetts, Michigan, New York, New Jersey, Ohio, Pennsylvania and Texas.

However, this year's survey included more responses from risk managers at larger companies. In the 1983 survey, 68% of the responses came from risk managers at companies with less than \$1 billion in annual sales. This year, only 59% of the responses came from the smaller companies.

Mr. Meyers said this year's sampling is the best in the survey's four-year history.

He said the survey sample included more risk managers from larger companies and more better-known risk managers.

The survey's goal, he said, is to "make it as close to a realistic as-

essment of what risk managers do" as possible, so as to show "what a prospective employer would be looking for in a prospective risk manager."

Based on annual company sales volume, the survey shows:

- Risk managers in the smallest category, less than \$200 million in annual sales, had a 7.5% increase in total compensation in 1984. Their average base salary rose 11.5%, to \$49,423 from \$44,324 in 1983. However, this was offset by a drop of 30% in their average bonus, to \$3,259 in 1984 from \$4,660 in 1983.

- In the category of \$201 million to \$500 million in annual sales, risk managers had an increase in total compensation of 7.1%, to \$52,586 in

1984 from \$49,119 in 1983. However, this was considerably less than the 20.2% increase they had in 1983 over 1982.

- In this category, base salaries rose 5.8%, to \$48,213 in 1984 from \$45,553 in 1983. And, bonuses grew 22.6%, to \$4,373 from \$3,566 in 1983.

- Total compensation increased an average of 7% for risk managers from companies with annual sales of \$501 million to \$1 billion; the increase in 1983 was 10.6% over 1982.

- Total compensation increased to \$55,351 in 1984, from \$51,744 in 1983. Base salaries were up 6.2%, to \$51,584 from \$48,576, and bonuses were up 18.9%, to \$3,767 from \$3,168.

- Total compensation for risk

managers at companies with \$1 billion to \$2 billion in sales increased 3.4% in 1984, to \$60,716 from \$58,731 in 1984. But, this gain also was less than the 9.7% increase reported in 1983 over 1982.

- Base salaries increased 3.2%, to \$55,387 in 1984 from \$53,676 in 1983. And, bonuses increased 5.3%, to \$5,329 in 1984 from \$5,060 in 1983.

- Among risk managers at companies with \$2 billion to \$4 billion in annual sales, total compensation increased 6.7% in 1984, to \$68,707 from \$64,416. Total compensation for this group had increased 7.2% in 1983 over 1982.

- In 1984, base salaries rose 5.5%, to \$61,771 from \$58,551 in 1983, and

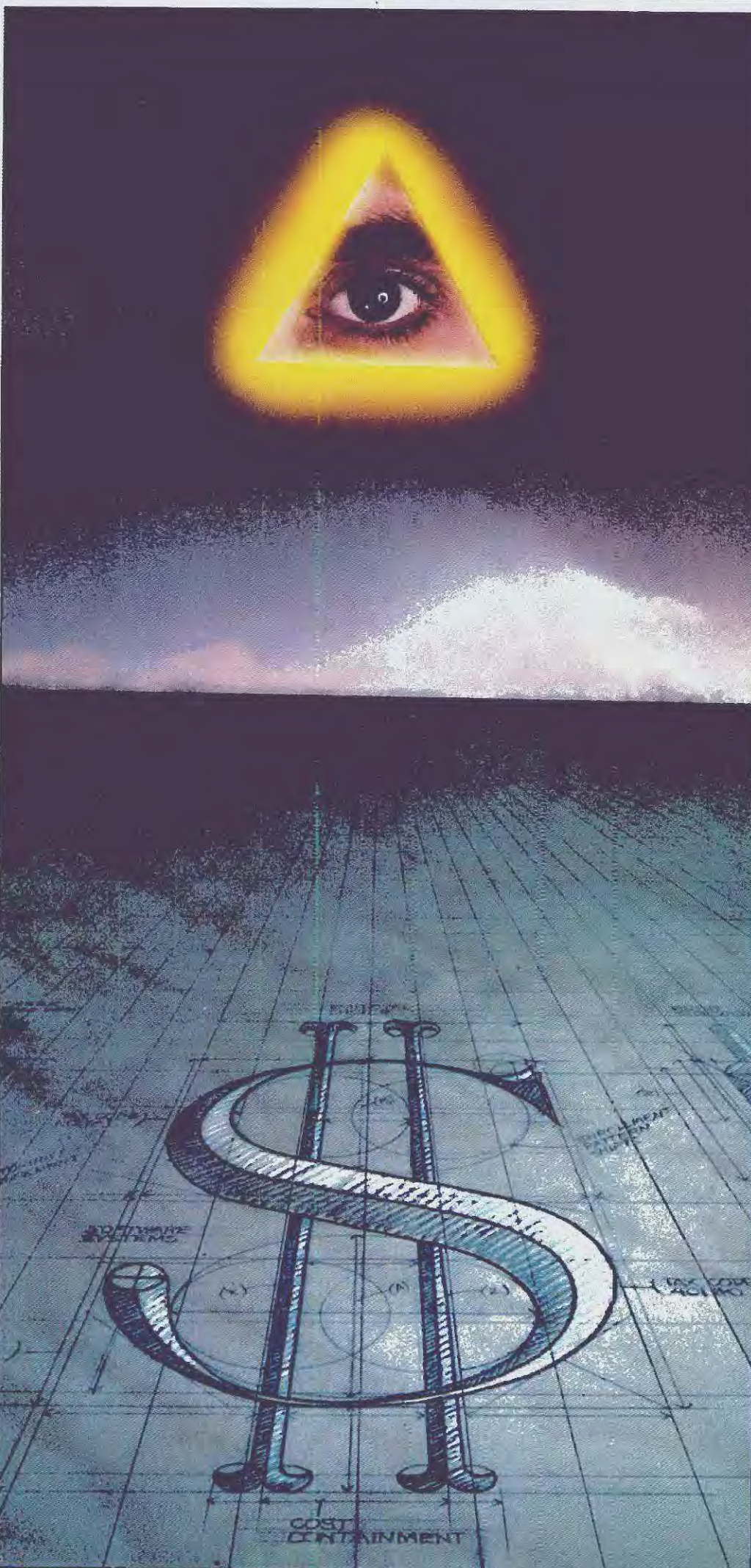
bonuses rose 18.3%, to \$6,936 from \$5,865.

- Only a large increase in the average size of bonuses kept total compensation for risk managers at companies with \$4 billion to \$7 billion in annual sales from falling more than 0.8%. In this category, the base salaries dropped 3.8%, to \$66,590 in 1984 from \$69,200 in 1983. However, bonuses increased 34.2% to \$7,980 in 1984 from \$5,945 in 1983.

In 1983, risk managers in this category reported a 6.2% increase in total compensation.

However, only 61 risk managers responded in this category this year, while only 49 responses were

Continued on next page



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# Risk managers' benefits generally improve

Risk managers at larger companies are more likely to have better benefits than those at smaller firms, but risk managers at all sizes of companies generally are getting improved benefits, according to the Logic Associates 1984 Risk Management Compensation Survey.

The study looked at four corporate benefits: company car, stock options, pension plans and company-paid life insurance.

Although benefits for risk managers generally improved in 1984, the survey revealed that some ben-

efits had been cut back.

For instance, according to the survey, risk managers at smaller companies are now much less likely to have a company car.

In 1983, a whopping 41% of the risk managers at companies with annual sales volumes of up to \$200 million reported they had a company car. But, this percentage plummeted to 12.9% by 1984.

However, more risk managers among the largest companies surveyed—with more than \$7 billion in annual sales—had company cars

in 1984. Some 23.1% reported receiving that benefit in 1984 compared with 18% in 1983. But, the small number of respondents in this category could skew the data.

Among risk managers at companies with annual sales of \$201 million to \$500 million, those with company cars also rose slightly, to 19.6% from 19% in 1983.

The percentage of risk managers with company cars declined in the other size categories. For example, at firms with \$1 billion to \$2 billion in sales, it fell to 11.7% from 15%.

At companies with \$2 billion to \$4 billion in sales, the percentage of risk managers with a company car fell by more than half, to 10.2% in 1984 from 22% in 1983.

But, survey respondents across the board were more likely to get stock options in 1984 than in 1983.

At companies with up to \$200 million in sales, 33.7% had a stock option in 1984, compared with 23% in 1983. Companies with the largest sales volume also saw a large increase in this benefit: Some 65.4% of the risk managers go: this bene-

fit in 1984, up from 40% in 1983.

At companies with \$201 million to \$500 million in sales, 40.2% of the risk managers reported a stock option in 1984, compared with 37% in 1983. At companies with \$501 million to \$1 billion in sales, the percentage with stock options increased to 40% in 1984 from 36%.

Some 53.2% of risk managers at companies with \$1 billion to \$2 billion in sales had a stock option in 1984, compared with 48% in 1983. At companies with \$2 billion to \$4

*Continued on next page*

## Salary data

*Continued from previous page*  
received in 1983.

• A drop in bonuses accounted for the decrease of 2.3% in total compensation for risk managers at the largest companies, with more than \$7 billion in sales. Their base salaries actually rose 0.5%, to \$75,295 in 1984 from \$74,877 in 1983. But, bonuses fell 17.8%, to \$11,367 from \$13,836 in 1983.

Risk managers in this category were the only ones to report a decline in total compensation in the 1983 survey, when their total compensation fell 9.2% from 1982.

Only 38 responses were received in this category, and only 24 were received in 1983.

The survey showed few geographical trends among the 10 large industrial states that made up the bulk of the respondents.

For comparison, it is enlightening to look at responses among companies with \$201 million to \$500 million in annual sales and with \$500 million to \$1 billion in annual sales, which were the biggest response categories.

Six of the 10 largest states—California, Connecticut, Michigan, New Jersey, New York and Texas—reported average total compensation for risk managers in the \$201 million to \$500 million sales category that was higher than the national average of \$52,586.

The highest total compensation in this category—\$63,626—was reported in Connecticut.

Illinois, Massachusetts, Ohio and Pennsylvania reported total compensation below the national average for risk managers in this category. The lowest—\$36,305—was reported in Illinois.

Among risk managers at companies with \$501 million to \$1 billion in sales, five of the 10 largest states reported total compensation above the national average of \$55,351. The states were Illinois, Ohio, Connecticut, Texas and California, which reported the highest total compensation for this category—\$64,120.

New York, New Jersey, Michigan, Pennsylvania and Massachusetts reported total compensation lower than the national average for risk managers in the \$501 million to \$1 billion category. The lowest total in this category—\$45,309—was reported in Pennsylvania.

The highest total compensation in this year's survey was reported by the risk manager of a New Jersey conglomerate with more than \$7 billion in annual sales. He or she took home \$157,800 in total compensation in 1984—\$106,000 in base salary and \$51,800 in bonus.

The second-highest compensation was reported by the risk manager of a Connecticut utility with more than \$7 billion in annual sales. That risk manager made \$101,000 in base salary and \$45,000 in bonus in 1984, for a total of \$146,000 in compensation.

•  
Copies of the survey can be purchased for \$60 from Logic Associates, 170 Broadway, Suite 1708, New York, N.Y. 10038; Attention: Risk Management.



Continued from previous page billion in sales, 49.2% received options in 1984, up from 44%.

Overall, more risk managers had a pension plan in 1984. And, like in 1983, larger companies were more likely to offer a plan.

At the smallest companies, with less than \$200 million in sales, the percentage of risk managers covered by a pension plan increased to 93.5% in 1984 from 81% in 1983. Again, the second-largest percentage increase in pension plan coverage—to 100% from 90%—was among the largest companies.

All the respondents at companies with \$4 billion to \$7 billion in sales also were covered by a pension plan in 1984, unchanged from 1983.

Among risk managers at companies with \$501 million to \$1 billion in sales, 95.6% had a pension plan in 1984, up from 92%. And, 98.3% at companies with sales of \$2 billion to \$4 billion had a pension plan in 1984, up from 98%.

But, the percentage of risk managers with pension plans dropped in two categories. At companies with \$1 billion to \$2 billion in sales, it fell to 92.2% in 1984 from 96%.

And, only 87% of the risk managers at companies with \$201 million to \$500 million in sales had a pension plan in 1984, down from 89%.

Life insurance benefits for some risk managers improved last year, but those in some categories reported less generous life insurance.

In 1983, risk managers in all seven categories reported company-paid life insurance equal to twice their salary. In 1984, risk managers in five categories had more life insurance, but those in two categories had less.

Employer-provided life insurance declined in 1984 at companies with \$201 million to \$500 million in sales and those with \$501 million to \$1 billion in sales. In both cases, it fell to 1.98 times salary.

The biggest increase in the risk manager's life insurance benefit was at companies with \$1 billion to \$2 billion in sales, where coverage rose to 2.81 times salary.

Other hikes ranged from 2.03 times salary to 2.27 times salary. ■

**Women in risk management**

| Company sales             | Percent women risk managers | Number of women risk managers |
|---------------------------|-----------------------------|-------------------------------|
| 0-\$200 million           | 9.7%                        | 10 out of 104                 |
| \$201-\$500 million       | 9.7%                        | 21 out of 218                 |
| \$501 million-\$1 billion | 7.8%                        | 17 out of 219                 |
| \$1-\$2 billion           | 7.8%                        | 13 out of 162                 |
| \$2-\$4 billion           | 6.8%                        | 8 out of 115                  |
| \$4-\$7 billion           | 9.9%                        | 6 out of 61                   |
| more than \$7 billion     | 11.5%                       | 4 out of 38                   |

Source: Logic Associates  
Chart: Amy Palmer

**Survey profile**

Continued from page 3 their colleagues at the largest companies is 46-50 years old.

However, the median age in all five other sales volume categories is the same: 41-45 years old.

In a change from last year's survey, which indicated that more women were risk managers at smaller companies, this year's study shows the highest percentage of women risk managers at the largest companies.

At companies with more than \$7 billion in sales, 11.5% of the risk managers are women, up from 4.6% last year. And, at companies with \$4 billion to \$7 billion in sales, 9.9% are women, compared with 6.1% in 1983.

However, the relatively small number of respondents in these corporate categories allows a large margin for error.

The lowest percentage of women risk managers—6.8%—was reported among companies with \$2 billion to \$4 billion in sales.

The percentage of women risk managers was 7.8% at companies with \$501 million to \$1 billion in sales and at companies with \$1 billion to \$2 billion in sales.

And, the two smallest sales volume categories—up to \$200 million and \$201 million to \$500 million—each reported that 9.7% of their risk managers are women.

Risk managers at larger companies also are more likely to have more years of risk management experience and are more likely to have spent more years with the same company.

In addition, risk managers in the two smallest sales volume categories have more years with their current employer than they have years of risk management experience, suggesting that they held another position at the company before they joined the risk management department.

Risk managers at the smallest companies have an average of 9.55 years of risk management experience and an average of 10.16 years with the same employer.

Risk managers at companies with from \$201 million to \$500 million in sales have an average of 8.55 years of risk management experience and an average of 9.32 years with their current employer.

Risk managers at companies with from \$501 million to \$1 billion in sales have an average of 12.6 years of risk management experience and an average of 11.8 years with the same company. In the \$1 billion to \$2 billion category, risk managers report an average of 11.8 years

Continued on next page

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**Next week**

Coverage of the Logic Associates 1984 Risk Management Compensation Survey will conclude next week in *Business Insurance*, with a look at the makeup and duties of risk management departments at companies of various sizes.



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## Survey profiles risk managers

Continued from previous page

experience and 10.6 years with their current employer.

And, at companies with \$2 billion to \$4 billion in sales, risk managers reported they have 13.5 years experience and 12.3 years of service with their company.

The most years of service with the same employer—13.33—were reported by risk managers at companies with \$4 billion to \$7 billion in sales. These risk managers also reported an average of 13.67 years risk management experience.

Risk managers at the largest companies had slightly more years risk management experience—13.69—but they had been with their current employer only for an average of 11.62 years.

The vast majority of risk managers are married, and no trend in marital status emerges according to size of company.

At the smallest companies, 87.1% of the risk managers are married, 6.6% are single, and 6.5% are divorced. At the largest companies, 88.5% are married, 7.7% are single and 3.8% are divorced.

The highest percentage of married risk managers was reported at companies with \$4 billion to \$7 billion in sales, where 93.9% are married and 6.1% are divorced.

The lowest percentage of married risk managers—and the highest percentage of divorces—was reported at companies with \$201 million to \$500 million in sales: 78.3% of the risk managers are married, 10.9% are single, and 10.8% are divorced.

At companies with \$501 million to \$1 billion in sales, 85.6% are married, 8.9% are single, and 5.5% are divorced. Some 85.7% of risk managers at companies with \$1 billion to \$2 billion in sales are married, 5.2% are single, and 9.1% are divorced.

At companies with \$2 billion to \$4 billion in sales, 89.8% of the risk managers are married, 6.8% are single, and 3.4% are divorced.

**Risk managers in all categories reported an educational level slightly above a bachelor's degree.**

To measure a risk manager's level of education, the survey used a ranking system, assigning a ranking of 1 for no degree, 2 for a bachelor's degree, 3 for a master's degree and 4 for a law degree.

The highest educational level—2.5 on the 4-point scale—was reported by risk managers at companies with \$4 billion to \$7 billion in sales. Risk managers at companies with more than \$7 billion in sales reported the lowest educational level, an average of 2.1 on the scale.

However, the small number of respondents in these categories may make this data suspect.

Risk managers at companies with up to \$200 million in sales reported an average education rank of 2.4, as did those at companies with \$2 billion to \$4 billion in sales.

The rank was 2.3 for risk managers at companies with \$201 million to \$500 million in sales.

And, the ranking was 2.2 for risk managers at companies with \$501 million to \$1 billion in sales and for those at companies with \$1 billion to \$2 billion in sales.

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## Day care cover

Continued from page 2

geles—has terminated its Kinder Cover day care insurance program, leaving "hundreds of centers" without a market as their policies come up for renewal this year, said Joel Lubin, a partner in Lubin, Schwarz & Goldman of Troy, Mich., the broker for the program.

He was "trying to nail down another market" late last week.

The National Assn. for the Education of Young Children, a day care trade association with 47,000 members, saw its association-sponsored liability insurance program canceled last year by Granite State Insurance Co., a unit of American International Group.

It is working out the details of a new insurance program to be underwritten by CIGNA.

BMF Marketing Insurance Services of Sherman Oaks, Calif., which also places day care center insurance programs, is looking for a new market to replace Mission Insurance Co. BMF Executive Vp Joseph Silverman says he does not expect Mission to remain in the day care market.

A Mission spokesman would not comment on the insurer's plans.

Meanwhile, Fireman's Fund Insurance Cos., which was a smaller market for day care liability insurance, also has ceased writing the coverage.

And, American States Insurance Co. in Indianapolis, St. Paul Fire & Marine Insurance Co. and Hartford Insurance Co. are severely restricting the coverage they will provide.

Although day care center liability insurance represents less than 1% of American States' total premium volume, it issued new underwriting guidelines for day care centers earlier this year.

The insurer now requires that centers be located only in buildings designed specifically for use as day care centers and that play areas be enclosed with chain-link fencing. The insurer also requires a child-to-staff ratio of 3-to-1 for infants and 4-to-1 for toddlers.

Currently, only three states—Kansas, Massachusetts and Wisconsin—have such strict licensing requirements for infant care, and only four have these standards for toddlers.

In the past five years, St. Paul has increased its base rate for day care liability insurance by almost 100%, while its property insurance rates for the same centers have remained the same.

For centers in Los Angeles, for example, liability rates increased to \$27 per 100 square feet of space in October 1984 from \$15 per 100 square feet in 1980.

In the Minneapolis/St. Paul area, rates rose to \$33 per 100 square feet at the end of 1984, from \$17 per 100 square feet in 1980.

In California, "almost all centers or day care agencies are seeing incredible increases in the liability premiums," says Carol Stevenson, director of the Child Care Law Center in San Francisco.

"We've heard of a number of programs in Orange County that have closed because of the insurance problem," she added.

In Michigan, a survey of the state's 2,488 licensed day care centers generated cries for help from directors "telling us their liability policies are being canceled or not renewed," said Bill Hankins, program manager of day care services for the state Office of Children and Youth Services.

Even Kindercare, which is the largest for-profit day care business in the United States, is feeling the pinch.

The premiums for Kindercare's "very high limits of liability have not been immune to market conditions," said Tom Scott, president of Insurance Management Inc. of Kansas City, Mo., Kindercare's bro-

ker.

Kindercare's program is underwritten by Maryland Casualty Co.

Insurers say high losses they have experienced on the day care insurance they underwrote influenced their decisions to cease or restrict underwriting.

Fireman's Fund in Novato, Calif., for example, wrote \$200,000 in premiums for day care liability coverage in 1984 and paid \$250,000 in losses, a spokesman said.

Some insurers complain that day care center liability insurance was sorely underpriced during the recent soft insurance market so rates needed to be hiked now.

Centers got liability limits of \$250,000 to \$1 million "for little more than the cost of a homeowner's policy," said Marc H. Rosenberg, vp-federal affairs for the Insurance Information Institute.

"When you read about day care centers' liability premiums being increased from \$400 a year to \$1,200, you can't help but think there's a great number of commercial enterprises that would be thrilled with those rates," Mr. Rosenberg said.

But, day care supporters point out few commercial enterprises operate on the shoestring budgets common in the day care industry. For example, in 1983 day care center employees were paid an average of \$168 a week, according to the most recent records of the Bureau of Labor Statistics.

Except for the large day care chains—like Kindercare which had net income of \$160 million in 1984—most of the estimated 20 million children in day care in the United States are in non-profit centers associated with churches or other community-based organizations.

Brokers and child-care professionals further contend insurers are over-reacting by canceling policies and raising rates.

"If underwriters want to look at spread of risk, we've got it in day care," said BMF's Mr. Silverman. "But, all they can see is the long tail of liability, because we're dealing with, for the most part, kids under 5 years old. They can file a lawsuit until they reach the age of majority. That long a statute of limitations makes insurers very nervous."

Recent reports of sexual abuse in day care centers in Florida and California also has caused many insurers—like St. Paul and CIGNA—to exclude from coverage any claims arising from alleged physical or sexual abuse.

But brokers counter that the loss experience of most day care centers has been very good and that few child-abuse claims have been filed.

"We've arranged coverage for family day care homes for seven years and added day care centers in 1983, and in that time there has only been one loss that exceeded \$325,000," said Mr. Silverman.

"I've arranged liability insurance for 1,000 day care providers in the past seven years, and the only serious claim was for \$20,000 for plastic surgery resulting from a dog bite," said Evans Brown, principal of the Independent Insurance Center in Okemos, Mich., an insurance agency.

"Insurance companies can't justify their actions based on the claims data that's available," said Alan LaRue, manager of special projects for Work/Family Directions, a Boston child care consultant.

"There's no question that they have very little historic data on instances of child abuse or settlements of child abuse claims originating from day care centers," he added.

"Decisions are being made on the basis of concern over publicity rather than on anything actuarial," charges James Strickland, executive director of Child Inc., an Austin, Texas, child care agency that administers 13 day care centers in Texas. All the Child Inc. centers

have liability coverage with American States Insurance Co.

Mr. Strickland, who also heads a task force on insurance for the Child Care Action Campaign, met with AIG Chairman Maurice R. Greenberg last month, and Mr. Greenberg agreed to lend AIG's assistance in collecting loss data on day care liability claims.

Earlier this spring, Mr. Strickland wrote to insurance commissioners in all 50 states requesting such loss information. "So far the response I'm getting is, 'We don't keep information like that.'"

One possible solution to the lack of day care liability insurance, Mr. Strickland said, is "some sort of captive arrangement." But, he cautioned, a captive insurance company should be viewed "only as a short-term solution."

Another possible solution to the liability insurance problem is state legislation, Mr. Strickland said. "We could seek legal limits on liability or lobby the states to establish assigned risk pools to cover day care centers," he said.

Day care centers also can mitigate their liability insurance problems by purchasing both an accident policy for the center's children and a liability policy for the center, said BMF's Mr. Silverman.

An accident policy that will cover expenses related to a child's injuries often will dissuade the parents from suing the center.

The BMF program currently underwritten by Mission includes a medical reimbursement plan underwritten by AIG Life Insurance Co. The plan has limits of \$10,000 per occurrence and no deductible.

The proposed new CIGNA policy sponsored by the National Assn. for the Education of Young Children also includes accident coverage underwritten by Hartford.

The CIGNA program also includes tight underwriting standards. For example, CIGNA will not insure any center that is not accredited by the association under a program to begin this summer.

To be eligible for accreditation, a day care program will have to be of sufficient size in number of children cared for and available space, been in operation at least one year and meet appropriate state and local licensing requirements and health and safety standards.

Staff members also must meet educational and experience standards.

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# Group plan to cover birth of septuplets

Patricia Frustaci, the California woman who last month gave birth to septuplets, has group health insurance coverage that will pay all but \$1,000 of the medical expenses associated with the birth, which may total as much as \$700,000.

Mrs. Frustaci's medical bills will be paid by the New York Life Insurance Co., which writes group health insurance provided by her husband's employer, the John R. Birmingham Co. Inc., a manufacturer's representative in Buena Park, Calif.

The health plan for the eight-employee firm is administered by Coordinated Benefit Plans Inc., a multiemployer trust headquartered in Tampa, Fla. The plan is fully insured with New York Life; the MET does not pay any benefits.

## benefit beat

According to Charles Lynch, MET account executive for New York Life, the group plan requires a \$250 per-person deductible, with a family maximum of \$500, and a 20% copayment on the the first \$2,500 exceeding the deductible. After that, the plan pays 100% of expenses.

Although Mr. Lynch could not say how much the Frustaci family's hospital bills will total, he did say that "it could be the largest health claim we've ever paid in group."

Mr. Frustaci has been quoted as estimating the total cost at \$700,000, based on information he received from couples who also had multiple births.

Alfred Hanser, an assistant vp at New York Life, agreed that \$700,000 is a "reasonable" estimate. "I've seen triplets born, and they've had costs upwards of \$300,000," he said. "So (\$700,000) is reasonable."

Mr. Lynch said the claim will be paid in full, despite the fact that

Mrs. Frustaci took fertility drugs, which have been linked to multiple births.

"That's what insurance is for," Mr. Lynch said. "Just because she took a fertility drug and had a multiple birth, that's no reason why we would not pay a claim or would cut back on coverage."

Under Birmingham's health care plan, Mr. Frustaci paid half the \$223.14 monthly premium for dependent coverage; the company paid the balance, as well as the entire \$132.95 monthly premium for Mr. Frustaci's coverage.

## Bethlehem Steel deal

An agreement reached between Bethlehem Steel Corp. and its non-union retirees under which the retirees' contributions to health insurance premiums are capped for life took effect June 1, says the attorney representing the retirees.

Retirees' attorney Richard E. Moot, with the Buffalo law firm Moot & Sprague, says Judge John T. Elfvig gave his final approval to the settlement April 29, and no one objected during the 30 day-period allowed for appeal, which ended May 31.

Under the settlement agreement, retirees pay \$11 a month for health care premiums if the retirees are under age 65 and \$6 a month if they are 65 or over; Bethlehem may not increase this premium contribution at any time (BI, March 18).

Retirees took Bethlehem Steel to court after its previous plan, which had paid 100% of all medical costs, was replaced in April 1984 with another plan that featured premium contribution, deductible and copayment provisions.

The retirees won the first round in September, when Judge Elfvig ruled that Bethlehem Steel did not have the right to modify the retirees' health benefits because retirees were clearly told they were entitled to the benefits for life. The agreement reached with Bethlehem Steel combines elements of the old and new plans.

## Plan termination

Another property/casualty insurance company has told the federal Pension Benefit Guaranty Corp. that it intends to terminate an overfunded pension plan.

Crum & Forster Inc. says it will terminate its 27-year-old defined benefit plan and recapture, before expenses, \$52.8 million in excess assets. The plan is overfunded because of favorable investment re-

sults. Most, if not all, of the excess assets will be added to policyholder surplus, a spokesman said.

The termination of the plan, which has 9,114 participants, is part of a restructuring of the company's benefit programs. A flexible benefits plan will be offered and the company is adding a 401(k) salary reduction feature to an existing savings plan. Crum & Forster also will set up a new defined benefit plan to replace the terminated plan.

Crum & Forster will purchase annuities to guarantee benefits to participants in the terminated plan.

Other property/casualty insurers that are terminating overfunded pension plans and the excess funds that they expect to recapture include Fireman's Fund Insurance Co., \$120 million; Wausau Insurance Cos., \$109.4 million; Chubb Corp., \$87.5 million; The Home Insurance Co., \$65 million; Commercial Union Insurance Co., \$50 million; and American Mutual Liability Insurance Co., \$20 million.

*Benefit beat keeps benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Diane Kastiel, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5393.*

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# New England Re withdraws from facultative reinsurance

New England Reinsurance Corp. in Boston no longer will write facultative reinsurance to concentrate on treaty business, its management has announced.

Graves D. Hewitt, chief executive officer of New England Re's parent and manager, Cameron & Colby Co. Inc., said New England Re's facultative business—representing about \$5 million in reinsurance contracts—would be run off gradually. The reinsurer has not accepted any new facultative business since Jan. 1.

Both companies are affiliates of Hartford Insurance Group.

Mr. Hewitt said the company's annual facultative reinsurance premiums amounted to less than \$800,000 at the start of 1985 and represented less than 3% of Cameron & Colby's total reinsurance business.

The move was prompted by "general market conditions and senior management's decision to concentrate its business capital in

treaty reinsurance," surplus lines and excess insurance operations, Mr. Hewitt said.

He said the withdrawal from the facultative market should have a "minimal impact" on market capacity, because New England Re has been reducing its facultative business gradually since 1983.

## Work comp HMO

A St. Paul, Minn.-based provider of specialized care for the elderly is marketing what is believed to be the first health maintenance organization specializing in workers compensation cases.

CompPlus, which went on the market last month, already has almost 10 clients—all employers that self-insure their workers compensation coverage. The new HMO hopes to have a contract with an in-

## markets

surer by this summer, and other workers compensation insurers have expressed an interest, said Jerry Nye, director.

Mr. Nye said the HMO's goal is a savings of between 15%-25% in both medical and indemnity workers compensation costs.

CompPlus is a prepaid system of coordinated care and case management that begins immediately when a worker is injured and continues through rehabilitation. Supervisors at the job site are trained to step in immediately after an accident and direct injured workers to the employer's designated workers compensation physicians and hospitals, he said.

Because state laws allow employees to go wherever they wish after a workplace injury, use of this HMO is not mandatory, Mr. Nye said. In those instances where injured workers seek medical care from their own physicians, CompPlus will manage the cases on a fee-for-service basis.

CompPlus also offers enhanced occupational health communication, supervisory training on early intervention in the care of injured employees, employee education programs, claims administration services, follow-up audits and compatible services for out-of-network claims.

Some seven hospitals and 600 health care practitioners, including chiropractors, work with the CompPlus HMO. Occupational health specialists form the core of the program, Mr. Nye said.

CompPlus is a program of Senior Health Plan Inc., a corporation sponsored by three Minnesota health care providers: St. Paul-Ramsey Medical Center; Health Central System, a subsidiary of Health Central Corp.; and the Amherst H. Wilder Foundation.

For more information contact CompPlus, 315 Iris Park Place, St. Paul, Minn. 55104; 612-647-0406.



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# RIMS opposes adoption of new CGL forms

By MICHAEL BRADFORD

NEW YORK—The Risk & Insurance Management Society opposes the adoption of the Insurance Services Office's proposed commercial general liability forms, even though RIMS worked with ISO when it designed the forms.

Jon Harkavy, director of governmental affairs for RIMS, noted at a hearing held by the New York Insurance Department last month the society's participation in the drafting process does not translate into approval of the new CGL forms, particularly the claims-made form.

The new forms and the "manner and speed under which they are to be implemented will have a devastating impact on policyholders and potential claimants," Mr. Harkavy said at the hearing.

The proposed forms "serve only the interests of the insurer, with little or no concern as to the impact that these changes will have on the insured," he added.

Mr. Harkavy noted that ISO's decision to draft a claims-made form was a result of insurers' problems underwriting long-tail risks, like asbestos exposures.

"There are those insurers who contend that coverage on a claims-made basis may al-

leviate many of their problems. They may be right. However, the burden is passed back to the insurance buyer," he said.

Mr. Harkavy also criticized a provision in the proposed claims-made form that would allow the insured to buy an extended reporting period or "tail" endorsement to avoid gaps in coverage caused by cancellation or non-renewal.

The new CGL policies would carry a 30-day cancellation clause and an automatic 60-day mini-tail if the coverage is canceled. That means policyholders would have 90 days from notice of cancellation to file claims under a claims-made policy.

The tail endorsement would cover any claims that occurred between the retroactive date of the claims-made policy and the policy's expiration date, even if the claims are not reported during the policy period.

However, the premium for the extended tail could amount to as much as 200% of the premium for the final year of the claims-made policy, Mr. Harkavy pointed out.

"Buyers who purchase the new claims-

made policies will be locked into one insurer unless they purchase tail coverage. This isn't insurance, it's legal blackmail."

Also, the new claims-made policy would only worsen an already desperately clogged civil justice system, he said. The claims-made form would encourage policyholders to solicit the timely filing of claims against themselves or their insurers in order to guarantee indemnification and "will only exacerbate the already high level of insurer/policyholder litigation," Mr. Harkavy said.

He remarked that ISO's "non-insurance approach to insurance" is not limited to the claims-made policy, because both the occurrence and claims-made forms "virtually eliminate all pollution coverage from general liability policies."

He said RIMS knows underwriting environmental impairment liability coverages is difficult, but added, "excluding such coverage entirely from the CGL form is not a legitimate insurer response. Surely, ISO has sufficient resources to draft 'sudden and accidental' language which, while restricting coverage, will not eliminate it altogether."

Mr. Harkavy also noted that ISO counters criticism of the claims-made form by saying the occurrence form will still exist. But, he said, "It takes no great insurance analyst to

divine the fact that if insurers have their way, occurrence coverage will be as difficult to obtain as parts for a 1938 Ford. Numerous carriers have stated that they will no longer offer occurrence coverage on most lines."

RIMS believes that "clearly, only the interests of the insurer are served by these proposed CGL changes," Mr. Harkavy said. "Until the legitimate needs of the insurance-buying public and potential claimants are also accommodated, RIMS urges the New York Insurance Department to reject the new ISO CGL formats."

RIMS President Richard Hackenburg said last week that while ISO was open to RIMS' suggestions during drafting of the forms, "In the end we felt we had to come out and make a definitive statement about the form."

He expressed concern that the new policy would affect the ability of risk managers to do their jobs. "There is a lack of broad-based information on how it will be implemented and used and how it will impact on risk managers."

Mr. Hackenburg said of ISO's attempts to win quick acceptance of its proposed forms, "What we've got going is a freight train. It's building momentum. What we've got to do is slow that freight train down. A lot of people have to be more educated."



Mr. Harkavy

## CGL approval

Continued from page 2

the "tremendous concern" expressed by agents, brokers, insurers and buyers.

Any decision by the New York department would not have influenced Maryland's choice to approve the forms, and there will be no second-guessing the decision, Mr. Muhl added.

"We work to our own drum here."

Mr. Muhl said approval of the claims-made form was necessary to ensure that insurers would continue to write long-tail risks in Maryland.

"The claims-made form places the insurer in a better position of not having to get out a crystal ball and predict what prices are going to be 20 to 30 years down the road," said Mr. Muhl.

"We have insurance companies and reinsurers that are taking a terrible beating. The claims-made form puts them into the position of just having to project one year into the future."

However, Mr. Muhl also admitted that, with the advent of the claims-made form, the occurrence version of the CGL contract will likely become a dinosaur.

"Unless there is a dramatic change in the tort system," said Mr. Muhl, the occurrence form "will fall by the wayside in a couple of years." Changes in the legal system, like the implementation of caps on damage awards, would be necessary for the occurrence form to survive, he added.

Illinois Insurance Commissioner John Washburn said he will hold hearings on the proposed forms later this summer. While he said he is paying attention to New York's and other states' decisions, Mr. Washburn doesn't think their actions will influence the Illinois department.

"It is a major change," Mr. Washburn said of the claims-made form. "We will be looking closely at how it will impact the industry, how it is to be presented and what its actual effect will be."

Among other states that have not yet acted on the proposed forms, the Arizona Insurance Department has scheduled a June 20 public hearing on the proposals, while Louisiana officials say they will discuss the forms next month.

Although New York's decision may not bear on whether other states approve the proposed ISO forms, the New York department's decision will have another type of impact, one regulator says.

Bruce Foudree, Iowa's insurance

commissioner and president of the National Assn. of Insurance Commissioners, said New York's decision will have somewhat of a ripple effect because of the number of large insurance buyers throughout the country that have New York operations.

"It will be important from that standpoint," he said. Companies with New York operations "will have a number of details to work out" after the state announces its decision, said Mr. Foudree without elaborating.

Iowa has approved the ISO forms, said Mr. Foudree, as part of "a determined effort" to control pricing for long-tail risks.

"Some argue that (the new form) is only buying time. That may be. But it is very likely that we will see some adjustments later."

Although ISO reports that its new forms have been approved by at least 27 states, at least one state is balking at approving the forms.

North Carolina has twice rejected the claims-made form in separate filings by ISO, and a state Insurance Department spokesman said the matter "is still under study."

The spokesman would not say specifically what the North Carolina department objects to, but he did say that one of the disapprovals was caused in part by a so-called "90-day deemer," a state law that says any filing not acted on by the department within 90 days is deemed approved.

Disapproving the form to avoid the automatic acceptance was a way to give the North Carolina department more time to study the form, he noted, adding the department is still studying the proposed forms.

At last month's hearing in New York, which was not required by law but was held as an educational forum for the Insurance Department, various representatives of insurance buyers—including RIMS—voiced strong opposition to the proposed claims-made form.

Eugene Anderson, an attorney who often represents policyholders in insurance coverage disputes, urged the department not to approve the proposed forms or, at a minimum, to delay consideration until certain questions are answered.

Specifically, Mr. Anderson, with the New York law firm of Anderson, Russell, Kill & Olick, said the department should:

- Delay consideration of the proposed forms until ISO determines whether to include defense

costs within policy limits.

- Solicit views of risk managers of government agencies within the state that buy general liability insurance, particularly with respect to the elimination of pollution coverage.

- Deny approval of the forms unless ISO provides an assurance that the occurrence form will be available at reasonable rates.

- Schedule more hearings if ISO contends the new forms are a financial necessity. The hearings would determine what financial problems call for a claims-made form and would investigate other solutions to these problems.

- Require that the new forms, if approved, be accompanied by a comprehensive explanation of the differences between the new forms and existing CGL policies.

James W. March, executive director and counsel of the Insurance Brokers' Assn. of New York, also expressed disappointment with the ISO proposal.

"It appears that ISO... is merely attempting to avoid any unpredictability," Mr. March testified. "We do not regard the solution to be a simple transfer of uncertainty from the underwriter to the insured."

While the proposed claims-made form would help alleviate insurers problems by allowing them to underwrite with greater predictability and would initially cost less than an occurrence form, Mr. March said the claims-made form would eventually cost as much as an occurrence form because rates would rise as the probability of claims being filed became greater.

He said the new form could be harmful to an unsophisticated buyer who might not fully understand policy wording.

Mr. March pointed out that his association has established a task force to analyze and evaluate the form and is offering its assistance to ISO "in whatever way is deemed appropriate."

David F. Lambert III, executive director of the National Assn. of Insurance Brokers, said the NAIB "does not believe that the proposed claims-made contract offers insureds or claimants the financial security required by the demands of today's society."

He argued that the claims-made form would provide only a short-term response to underwriting and capacity problems. "Use of a claims-made form could ease the capacity shortage. But since insureds who purchase claims-made coverage would also need to purchase higher limits, it is doubtful that use of the

claims-made form would significantly affect capacity."

However, Richard Winchester, a past president of the Professional Insurance Agents of New York and a now a member of the board of the National Assn. of Professional Insurance Agents, heralded the claims-made policy as a way to ease capacity problems while offering a financial advantage to insurance buyers during the first years they are covered by the form.

"We feel the new policy will avoid an availability crisis primarily based on the refusal of reinsurance companies to continue writing contracts covering occurrence policies," said Mr. Winchester.

However, Mr. Winchester also suggested that the Insurance Department should make sure buyers are well-educated in the differences between the occurrence and the claims-made forms.

In addition, he said, "We also suggest that the buyer sign a statement that he has been fully informed of the implications of his choice" and understands the differences in the forms.

Others who testified in support of the proposed claims-made form included Paul Mattered, assistant counsel at Liberty Mutual Insurance Co. in Boston, who remarked: "The ISO claims-made policy is the only sensible solution to price-making problems."

The form's hallmark, said Mr. Mattered, is "the rate of certainty of the trigger of coverage." He predicted the form would eliminate

confusion about when coverage was triggered for the long-tail risks.

As for educating consumers, Mr. Mattered said Liberty Mutual has already formed a "transition team" that will help buyers and the insurer's own employees understand the claims-made policy.

Mr. Mattered said Liberty Mutual will still offer occurrence policies, but added that the occurrence form would be kept in the insurer's "hip pocket."

"We intend to have both available but will aggressively market the claims-made form." The occurrence form, he added, won't be used "unless we have to."

Theodore Bayer, vp of line operations at ISO, who was given time at the beginning of the hearing to briefly highlight the proposed forms, appeared again after other parties had testified.

Implementation of the new claims-made form is "absolutely essential to re-establish a healthy property/casualty marketplace," Mr. Bayer said. "We clearly have a situation that cannot persist."

He said the pollution liability exclusions in the proposed forms were "essential to put this potentially ruinous coverage on a rational basis... It should be defined in one place and covered or excluded."

"The purpose of all this is not to cut back the amount of protection. We're trying to design a standard, continuous scope of coverage, one and only one policy that will apply," he said.

## Bill prompts rash of malpractice suits

SPRINGFIELD, Ill.—In response to an agreement reached last month on proposed legislation to restrict medical malpractice litigation, attorneys in Illinois are scrambling to file malpractice suits.

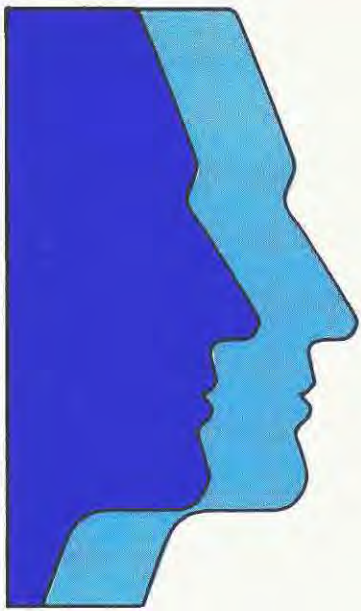
Throughout the state, huge increases are being reported in the number of medical malpractice suits filed in the last two weeks, since Republican and Democratic legislative leaders proposed legislation that includes many provisions backed by the medical profession.

The legislation—S.B. 1200—was passed by the House Judiciary Committee and sent to the House floor for a vote last week.

The bill would:

- Limit attorneys' contingency fees to one-third of the first \$150,000 of medical malpractice awards, 25% of the next \$850,000 and 20% of any amount exceeding \$1 million.
  - Call for review panels to screen malpractice cases before suits can be filed.
  - Tighten rules on the qualifications of expert witnesses who testify in malpractice trials.
  - Abolish punitive damages in medical malpractice suits.
  - Make attorneys and victims liable for costs and defense attorneys' fees if false allegations are made without reasonable cause. Under current law, only the victim may be held liable.
- Three thousand doctors rallied last month at the state Capitol to push for the reform package.
- Attorneys oppose the proposed medical malpractice measure and are lobbying against it.

# business insurance



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After interviewing more than 29,000 employees and examining written survey responses from 85,000 others, Ms. Kenney will present fascinating data on how employees feel about their benefits. What are employees saying, what questions are they asking, and what choices are they making about benefits?

##### Working With Consultants: The Consultant Side

*George Heiring, Managing Partner, HEWITT ASSOCIATES*

In the first of a two part series, Mr. Heiring offers a practical approach, injected with gentle humor, to the ever-changing relationship between consultant and client. He addresses such issues as what should the client expect, what is unreasonable for the client to expect, and how clients can get the most results from their consultant.

##### Working With Consultants: The Company Side

*Steve Wasserman, Director, Benefit Communication & Training, DART & KRAFT, INC.*

In part two, Mr. Wasserman addresses the client side of the consultant-client relationship. He will make practical suggestions on when, where, why and how you should use consultants. Further, Mr. Wasserman will recommend what groundwork should be done prior to and while working with a consultant — groundwork that will save you time and money.

##### You Be The Judge

*Herbert Zeltner, HERBERT ZELTNER CONSULTANT INC.*

A dynamic speaker who sparks controversy and leads you in an energetic session, Mr. Zeltner returns once again to the *BI Conference*. He will introduce selected audio-visual programs submitted to the *EBC Competition* and will offer you a glimpse of what other industry professionals are doing.

#### CASE STUDIES encourage group interaction.

##### Your Retirees: An Untapped Health Care Cost Containment Weapon

*Jeffrey M. Ostroff, President, JEFFREY M. OSTROFF ASSOCIATES*

*Vivian Anderson, Corporate Personnel, ALLSTATE INSURANCE COMPANY*

Providing medical benefits to retirees can be very costly; and expenditures will continue to rise as the retiree population grows. Mr. Ostroff will present a brief overview of the post-retirement health benefits issue. In addition, Ms. Anderson will walk you through a communications program Allstate used to effectively deal with this problem. Attendees will be given strategies which offer companies the opportunity to contain health care costs for both retirees and active workers.

##### Benefits Overhaul

*Steve Wasserman, Director, Benefit Communication & Training, DART & KRAFT, INC.*

How long does it take to design, implement, and communicate an employee benefits program? This company was faced with redesigning a portion of its benefits package in a

limited amount of time. While it normally would have taken six months to execute, they completed the renovation, communication and sign-up in just three weeks. In an informative presentation, Mr. Wasserman explains what approach they took and how they accomplished their goal.

##### Computers Can Talk Benefits

*Pam Keeler, Director, Advanced Benefit Communications, METROPOLITAN LIFE INSURANCE COMPANY*

In an effort to increase employee understanding and perception of their benefits program, Met Life took a new look at the employee communications field. After a careful study of benefit communications needs, Metropolitan designed an innovative program. Now, Met employees can directly access their benefit and savings plan information through interactive computer terminals stationed throughout Met Life headquarters. Ms. Keeler will explain the intricacies of this unique communications vehicle and what it takes to make it succeed.

#### PRINT WORKSHOPS address specific communications needs.

##### The Power of Personalizing Print

*Deborah K. Huffman, Senior Vice President, FRANK B. HALL CONSULTING COMPANY*

Ms. Huffman will address the pros and cons of personalizing print communications. How technology is distancing the workforce from management, the pressure that "personalizing" can place on your data base, and current applications for personalized benefits communications, are just some of the issues she will discuss. Additionally, Ms. Huffman will compare the strengths and weaknesses of traditional vs. laser print materials, and will provide good and bad examples of personalized communications using both techniques.

##### Standard Print Communications & Print Enhancement

*Martin Lapidus, Consultant, TOWERS, PERRIN, FORSTER & CROSBY*

To effectively communicate benefits to employees you must have a precise understanding of the issue at hand. You must also anticipate what reaction management expects from employees. Mr. Lapidus suggests that it is the nature of the benefits program (positive change, negative change, update, etc.) that helps determine the elements of effective communication. Further, he offers a practical approach to what management's goals should be in communicating benefits to employees.

#### TASK FORCE is a challenging professional forum.

Designed to encourage idea-sharing among attendees, the task force is perhaps the most intriguing component of the *Business Insurance Conference*. At the time of registration we invite you to submit questions, problems, or issues on benefits communications (see registration form). During this session the group will be divided into small task force units. Within this unique "give and take" framework you will discuss and evaluate the proposed communications problems with your professional counterparts. Each task force will then have the opportunity to state the problem and present their findings to all attendees. The task force is a stimulating forum where your input is an integral part of the *BI Conference* learning experience.

# August 5 and 6 The Grand Hyatt Hotel, New York City



This year our Conference format covers four major areas. While meeting as a large group, the general sessions focus on the foundation of effective communication. Small case study meetings encourage group interaction, and rotating schedules afford you the opportunity to attend all three sessions. Print workshops will center on two techniques — standard and laser printing — and you can select the one which best suits your needs. The task force, a new component of the *BI Conference*, is a challenging forum where you actively partake in evaluating the “real life” problems confronting communicators. We encourage you to submit your problems, questions or postulates of benefits communications on the attached registration form.

Highlighting the 1985 *BI conference* is the 13th annual EBC Competition Awards Presentation. Print programs submitted to this year's Competition will be available for review in the EBC Gallery. Another feature, the Benefits Literature Gallery, is where you can collect some of the latest information available from consultants, insurance companies and service organizations.

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At a luncheon honoring the winners of the 13th annual EBC Competition, awards will be presented to those companies who have excelled in communicating their employee benefits programs. One of the winning audio visual programs will be shown.

A limited number of additional seats are available for the EBC Awards Presentation luncheon. Tickets are \$50.00 each, available on a first come-first serve basis; advance reservation is required. Please contact the Registrar.

### REGISTRATION

The Business Insurance Conference opens Sunday evening, August 4, with advance registration and cocktail reception. Sessions begin Monday, August 5, at 8:45 am and adjourn Tuesday, August 6, at 4:15 pm.

The cost is \$575. A 10% discount is offered to additional registrants from the same company. The fee includes sessions, workbook and educational materials, breakfast, coffee breaks, luncheons and cocktail reception.

#### Payment required with registration.

All cancellations must be received in writing. A full refund will be made on cancellations received prior to July 5. A \$100 service charge will apply to cancellations received after July 5. No refund will be made on cancellations received less than 5 business days prior to the conference.

However, if your plans change at any time, you may substitute the name of another person from your company without penalty.

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To register, simply complete the form and send it along with your payment to:  
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For additional information call: Ann Vazquez, Registrar, at 212/210-0137

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### REGISTRATION FORM

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(attach additional sheet if required)

## City must pay

Continued from page 2

by 27 blacks between May 1979 and October 1980 charging that city police routinely harassed and beat blacks. The suits sought damages and injunctive relief for personal injuries and civil rights violations stemming from an alleged pattern of racially motivated police misconduct (BI, July 25, 1983).

The three suits, which were consolidated and brought before U.S.

District Judge William H. Orrick, were settled Aug. 12, 1981, when Richmond and the plaintiffs agreed to a consent injunction that provided for binding arbitration.

The city sought coverage under general liability policies for the cost of any awards made in the binding arbitration but lost that demand for failure to notify the insurers of the suits and failure to consult them about the settlement.

Atlanta International Insurance Co. and Mead Reinsurance Co.

were among the city's liability insurers during the period the alleged civil rights violations occurred.

Despite its loss for coverage of damages, which amounted to about \$280,000, the city tried to recover from Atlanta and Mead Re the attorneys' fees of \$694,000 awarded to the plaintiffs in 1982.

The city argued that the signing of the consent decrees in the civil rights cases did not constitute voluntary assumption of the obligation to pay attorneys' fees and that the

city did not realize that the signing of a consent decree would result in an attorneys' fee award.

The appeals court rejected the arguments. "The obligation voluntarily assumed, in violation of the insurance contracts, was to pay whatever attorneys' fees the court might eventually assess," the court wrote. "Under the broad terms of the consent decrees it was foreseeable that fees would be assessed."

By failing to notify the insurers of the underlying litigation or the

drafting and execution of the consent decrees, the city breached the cooperation clause of its insurance policies, the court held.

"There is a definite message in this case for brokers and risk managers," said Robert N. Schiff, a partner with Fisher & Hurst in San Francisco, the law firm representing Mead Reinsurance. "That is: If they think insurance coverage is a possibility, let the insurers know early." Otherwise, insurers might contest coverage, he adds. ■

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##### Financial:

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Secretaries, treasurers, controllers and other financial personnel ..... 7,167

##### 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 ..... 8,206

#### Sub-total ..... 22,627

Associations ..... 1,081  
Government, unions and educational systems ..... 944

#### Commercial Consumers

#### Sub-total ..... 24,652

Insurance agents and brokers ..... 9,524  
Insurance companies ..... 5,867  
Financial institutions ..... 556  
Actuaries, attorneys, adjusters, appraisers and consultants ..... 3,265  
Others allied to the field ..... 1,143

#### TOTAL ..... 45,007

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

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## Transit Casualty

Continued from page 1

the Missouri Division of Insurance concluded that the company's policyholders surplus amounted to \$22.8 million at the end of 1983, he said. Transit had reported \$39.8 million in policyholder surplus at year-end 1983.

However, the Missouri division will review the results of the audit of the Muldoon business along with the triennial exam in assessing Transit's financial condition, Mr. Jourdon said.

In its 1984 annual statement, Transit reported policyholder surplus had been reduced to \$9.1 million at year-end.

The insurer reported earned premiums of \$50.7 million last year, losses and expenses totaling \$74.2 million and a net underwriting loss of \$23.1 million.

Investment gains amounted to \$9.5 million, and Transit produced a net operating loss of \$15.5 million.

Transit's operating loss accounted for much of the surplus drain, although the insurer also deducted \$8.2 million as a change in liability for unauthorized reinsurance.

Meanwhile, Transit shareholders may challenge the Missouri division's demand that Beneficial Standard Corp., the insurer's former parent company, repay \$7.2 million in dividends collected from Transit in 1983 and 1984, Mr. Jourdon said.

The repayment demand followed the department's reassessment of Transit's financial condition.

Beneficial Standard completed a liquidation of its assets May 15. The assets—including non-transferable interests in a liquidating trust holding 79% of Transit's stock—have been distributed to Beneficial Standard shareholders. The remaining 21% of Transit stock is held by Beneficial Holdings.

Transit's lawsuit against the MGAs and reinsurers is an amendment of an earlier complaint, filed in a Dallas federal court last December, that named only Miro & Associates and Mr. Miro.

In 1981, Transit entered its MGA agreement with Muldoon, which was to underwrite and service insurance policies issued to companies with captive insurance companies. The risks were to be reinsured with the captives, with Transit receiving a fee for providing the fronting policies. The average fee was 9%, according to the complaint.

Muldoon later signed an MGA agreement appointing Miro as a sub-agent of Transit, the suit says.

The lawsuit charges the two MGAs with several breaches of their contractual and fiduciary duties to Transit. In cases of alleged wrongdoing by Miro, the complaint charges Muldoon with failing to correct the actions of the sub-agent.

The alleged breaches include:

- Failure to issue only authorized insurance policies.
- Miro's MGA agreement didn't include all of the restrictions contained in the Muldoon agreement on the type and amount of insurance to be written for Transit, and Miro wrote policies at rates that were not approved by Transit and on file with state insurance departments.
- Failure to obtain required premium, properly report risks incurred and pay required fronting fees to Transit.

Miro—which took commissions of 13% on business produced for SOIL and 18% on business produced for Lafayette—used incorrect experience modifiers and underestimated payrolls in rating workers compensation policies, and failed to correct the mistakes with later audits and additional premium collection.

Miro also underreported or totally failed to report premiums collected on policies it issued or to pay Transit the fronting fees owed on those premiums.

Miro didn't report policies issued after August 1984 or pay Transit's fees on the approximately \$16.1 million in associated premiums. Miro also didn't report premiums of \$2 million on policies issued in May 1984.

- Failure to service policies. Miro didn't audit policyholders to determine whether additional or return premiums were due, and in cases where it received voluntary audits, Miro did not collect additional premiums.

For example, an outside audit of a 1983-84 workers compensation policy written for Wal-Mart found that additional premium was owed, but Miro failed to bill the premium on a timely basis. A later bill sent to Wal-Mart's broker, Alexander & Alexander Services Inc., was not forwarded to the insured, the complaint says.

Miro failed to report and collect \$19.5 million in additional premiums due on two Wal-Mart workers compensation policies. It also failed to report \$1.8 million in additional premiums collected from Wal-Mart on a retroactive endorsement to a workers compensation policy and \$883,766 collected on a retroactive combined general liability and automobile policy. In all, unreported premiums on Wal-Mart policies totaled \$32.2 million, the complaint charges.

The complaint doesn't make clear whether Wal-Mart eventually paid these premiums. A Wal-Mart executive refused to comment.

- Failure to properly handle premium trust accounts. Miro did not always place premiums owed to Transit in trust accounts, and disbursements from trust accounts were made without Transit's authorization.

- Failure to fund claims. Muldoon and Miro breached their duties by failing in some cases to properly set up and fund claims reserves; to notify reinsurers—including excess and stop-loss reinsurers—of claims that might be in excess of a captive's retention; to require reinsurers to fund reserves; and to deduct reserve contributions from amounts owed to reinsurers when the reinsurers failed to fund the reserves themselves.

In addition, Miro improperly used premium from currently issued Transit policies to pay claims on previous policies rather than requiring reinsurers to pay those claims, the complaint charges.

- Failure to maintain reinsurance. The Muldoon and Miro MGA agreements required them to maintain reinsurance of Transit on business they wrote, and Muldoon had "sole responsibility and authority" to place the reinsurance on Transit's behalf, says the complaint.

Muldoon entered into the reinsurance agreements with SOIL and the Lafayette companies covering Miro-produced risks, the complaint says. SOIL became a reinsurer of Transit starting Jan. 31, 1981, Lafayette-Cayman starting Jan. 31, 1982 and Lafayette-Isle of Man starting Oct. 1, 1983.

All of these agreements provided for 100% reinsurance of Transit and included restrictions by reinsurers on liability limits to be written, the complaint notes.

And, the complaint charges that premium payments and reports required by reinsurers may not have been made.

After September 1983, Miro failed to remit any funds to Muldoon except Muldoon's commissions and failed to properly handle amounts owed to reinsurers that should have been paid to Muldoon, the complaint says.

Transit's suit also accuses SOIL and the Lafayette companies of breaching contractual duties to Transit.

The SOIL and Lafayette-Cayman reinsurance agreements provided that the offshore companies would maintain excess-of-loss reinsurance with limits of \$20 million

per occurrence excess of \$250,000 per occurrence, as well as aggregate stop-loss reinsurance with limits of \$1 million attaching at 100% of net written premiums, the complaint says.

The Lafayette-Isle of Man agreement provided only that Transit "will allow" the reinsurer to buy excess-of-loss reinsurance.

Miro's records "do not reflect that such reinsurance was always obtained by SOIL and Lafayette," the complaint says.

Miro's records also indicate that SOIL and the Lafayette companies failed to fund their share of loss and unearned premium reserves with cash, deposits to trust or fiduciary accounts or letters of credit, the suit charges.

Transit's 1984 annual statement shows paid and unpaid losses recoverable from Lafayette-Isle of Man of \$9.3 million and an unearned premium balance of \$4.7 million. Funds withheld from the reinsurer totaled \$2.1 million.

Paid and unpaid losses recoverable from SOIL totaled \$4.2 million, and the annual statement shows no funds withheld from SOIL.

Lafayette-Cayman doesn't appear in Transit's 1984 list of reinsurers.

Transit's complaint, however, says the company has been forced to pay claims on Miro business that were \$18.1 million in excess of the amounts it recovered from reinsurers' letters of credit.

The lawsuit doesn't include a specific demand for damages, which Transit says it will have to determine in the course of discovery.

However, the complaint says that Miro should have collected and reported \$128 million in premiums on the business it wrote, but instead reported only \$60 million.

With fronting fees averaging 9%, Transit's income on the premiums that weren't reported would have been over \$6 million, the complaint says.

In addition, the complaint charges that Miro:

- Took credit of \$10.5 million for the cost of excess of loss and aggregate stop-loss reinsurance through September 1984, while its own cash records reflect actual payments of only \$9.9 million.
- Reported to Transit that it had paid or funded losses of \$8.1 million through September 1983 when its records reflect payments of only \$6.5 million.

Lawyers for Transit, Miro and Muldoon either declined to comment on the lawsuit for the record or failed to return phone calls.

Transit officials also failed to return several telephone calls.

In its answer to the original complaint filed last December, though, Miro & Associates argued that:

- Transit "actually or impliedly consented" to Miro's actions.
- There was no obligation of Miro & Associates to arrange excess of loss and aggregate stop-loss reinsurance.

- Transit never advised Miro of any underwriting guidelines required under the MGA agreement.

- Transit never advised Miro that the reinsurance it had arranged was unacceptable.

- Muldoon received copies of all policies, claims and bordereaux produced by Miro. Muldoon also had Reitman & Co. conduct an audit of Miro in 1983, and was thus apprised of Miro's activities.

Mr. Miro, who is a Mexican citizen and says he resigned from Miro & Associates last December, filed a motion in March to dismiss Transit's complaint, arguing that it was not properly served on him and failed to state a claim against him personally.

Miro & Associates also filed in January a third-party complaint against Muldoon & Co. demanding that Muldoon indemnify it if Miro & Associates is found liable to Transit.

## BankAmerica files second D&O claim

SAN FRANCISCO—A second claim is pending against BankAmerica Corp.'s canceled directors and officers liability insurance relating to the \$95 million in losses incurred by a subsidiary bank's involvement with allegedly fraudulent mortgage-backed securities.

The first claim, filed in March in an effort by the bank to recover its \$95 million pretax loss in 1984, did not involve a third-party plaintiff (BI, March 11).

Now, the second claim against the coverage stems from a suit filed April 11 in U.S. District Court in San Francisco by shareholder Ned Schwartz. The suit, which was filed before the effective cancellation of BankAmerica's D&O insurance, charges top officials of the parent company and its bank with negligence and mismanagement and with attempting to "shift the blame for their own breaches of fiduciary duty and acts of negligence" to lower-level employees.

In addition to the losses related to the mortgage-backed securities, the shareholder complaint cites allegedly reckless lending practices that resulted in \$60 million in losses in Paraguay. It also alleges that the bank's tarnished reputation led federal officials to deny Bank of America's application to open 13 limited-services banks outside California.

The shareholder suit seeks an unspecified amount of damages.

BankAmerica's board has formed a committee to investigate the charges and named Morrison & Foerster of San Francisco as committee counsel.

BankAmerica's \$100 million of directors and officers liability insurance written by Employers Insurance of Wausau and First State Insurance Co. was canceled effective May 15 by First State and April 15 by Wausau.

Unable to find replacement D&O coverage, the company formed a Cayman Islands-based captive insurer, which has not been able to find reinsurance (BI, April 29).

## Unocal sues D&O underwriters

Continued from page 2

And, New York-based Royal Indemnity Co., part of Royal Insurance Group, canceled its layer for \$10 million excess of \$80 million effective May 17.

These canceled policies, whose inception dates vary but were all due to expire Sept. 25, cost Unocal \$140,145 in premiums, according to court papers.

Two other underwriters that participated in the excess D&O coverage did not cancel their policies and are not named in the Unocal suit.

They are Continental Casualty Co. in Chicago, which wrote \$20 million excess of \$60 million, and International Insurance Co., a Crum & Forster unit also in Chicago, which wrote \$10 million excess of \$90 million. The two policies cost about \$10,000.

Continental had issued a cancellation notice effective April 19, but for additional premium subsequently agreed to reinstate the coverage and extend it to September 1986.

International never canceled its layer and agreed to extend the coverage through September 1986 for additional premium.

To replace the canceled coverage and maintain \$100 million in D&O limits, Unocal says it had to pay a total premium of \$6.6 million to Continental Casualty; International Insurance; National Union Fire Insurance Co. of Pittsburgh, Pa.; and United National Insurance Co. in Philadelphia.

The suit does not identify which

of these insurers participate on which layers.

Unocal also had to put up a loss reserve deposit of \$13 million for the replacement coverage, which will be returned when it is "ascertained that there is no further claim pending," Unocal says in its lawsuit.

And, Unocal had to agree to indemnify United National for any claims the insurer might pay under its \$50 million excess policy, the company says.

Unocal alleges in its suit that the defendant insurers engaged in a conspiracy to cancel the policies "at the first sign of a hostile takeover attempt or of any other event to give rise to a claim under the policies."

The oil company says that if it had known of this "secret and undisclosed intent," it never would have purchased the insurance.

The excess insurers contend that they have the right to cancel their policies if Harbor cancels its primary policy, according to Unocal.

Unocal says Harbor has not shown good cause for canceling that coverage.

"These defendant insurance companies cannot cancel policies they issued solely because of Pickens Group's announcements and the suspicion by the insurance companies that a loss might occur which would be covered by their policies," the oil company contends.

All four defendant insurers declined to comment on the Unocal suit.

## Court orders tougher disclosure rule

PHILADELPHIA—A federal appeals court says the U.S. Labor Department must strengthen parts of its Hazard Communication Standard, which requires manufacturers to alert workers to the harmful effects of toxic substances in the workplace.

Various unions and civic groups had challenged the Labor Department's labeling standard. Objections included that the standard applied only to workers in manufacturing, it allowed chemical manufacturers to avoid full disclosure of information by contending the information was a trade secret and that such "secret" information could, in an emergency, be released only to health professionals, who would have to promise confidentiality.

The court ruled that the Occupational Safety and Health Administration must extend the standard to cover workers in other industries, that it must come up with less-restrictive rules on disclosure of trade secrets and that workers and union representatives should receive more information about hazardous chemicals, says a spokesman for the AFL-CIO.

A spokesman said OSHA had not decided if it would seek review by the U.S. Supreme Court, but he said the agency had asked for a 30-day extension beyond the 14-day period allowed for appeal.

The groups challenging the standard included the Public Citizen Litigation Group, the United Steelworkers and the AFL-CIO.

## Work comp report

Continued from page 1

could be necessary in the future; recommends that the relationship between the tort and workers compensation systems be studied; and recommends changes in the administration of occupational disease claims.

*Business Insurance* received an advance copy of the voluminous report, which was presented to the Workers Compensation Task Force Sunday at the opening of the NAIC's summer meeting in Kansas City, Mo.

A draft of the report was released for public comment at the NAIC's winter meeting in December (*BI*, Jan. 21).

The task force was expected to adopt a resolution supporting the conclusions and recommendations reached by the advisory committee. That resolution is expected to be supported by the full NAIC later this week.

The report also will be presented for endorsement later this summer to state workers compensation administrators at the annual conference of the International Assn. of Industrial Accident Boards and Commissions.

A former president of the IAIABC, James C. Pullin, secretary of the Georgia Board of Worker's Compensation, and James W. Newman Jr., a vp with CIGNA Corp. in Philadelphia, were co-chairmen of the advisory committee that developed the report. At least 40 other workers compensation experts, including employers, insurers, employees, workers compensation administrators and attorneys, contributed to the report.

"This is a report, not a model bill," stressed Mr. Newman. "It will serve to inform, to educate...to get people thinking...to serve as a resource tool."

A resolution from the NAIC and a resolution from the IAIABC "together will be a fairly strong endorsement," Mr. Newman said.

Because of the current concern about compensation for occupational diseases and the extensive research by acknowledged heavyweights in the area of workers compensation, the advisory committee report is expected to become a guide for future workers compensation laws.

In fact, it could become as influential as the 1972 report of The National Commission on State Workmen's Compensation Laws.

The 1972 report studied the state workers compensation system overall and also concluded that the state system is the best means of compensating injured workers.

The NAIC advisory committee—in a section not included in earlier drafts of its report—concludes that the insurance industry is currently adequately pricing and reserving for occupational disease claims.

However, the report warns, changes in the legal system or the discovery of a new occupational disease could produce much higher claims costs, leaving the future uncertain.

To compensate for this uncertainty, the advisory committee recommends:

- The development of improved ratemaking methods so insurance prices may be more responsive to future occupational disease trends.

- The development of better techniques for gathering meaningful occupational disease data, including the use of sources outside the insurance industry.

- Limiting the exposure of individual insurers or self-insurers to long-latent disease claims. This might be achieved by having state second injury funds pay long-latent claims or through voluntary pooling arrangements, the report says.

The advisory committee also says legislators, regulators and others "must remain alert to new developments and new information" concerning occupational diseases and "be prepared to take timely action to assure the continued financial integrity of the workers compensation system."

Committee members did disagree on exactly how serious a problem funding for occupational disease claims will present for insurers because of the uncertainty of what lies ahead for the industry.

To develop its recommendations on pricing and reserving, the advisory committee worked with a computer model and hypothetical claim patterns developed by the National Council on Compensation Insurance, a New York-based workers compensation ratemaking and research organization.

Another key issue addressed in the final version of the advisory committee report is the relationship between tort and workers compensation remedies for occupational disease.

The committee believes a means must be found to establish a rational and equitable interface between the tort and workers compensation system, pointing out that more frequently the exclusive remedy provisions of state work comp laws are being circumvented to allow workers to sue their employers for damages in addition to workers comp benefits.

The committee recommends that the NAIC appoint an interdisciplinary advisory committee to examine the appropriate relationship between the tort and workers compensation, unless the NAIC determines the subject is being covered adequately by other studies.

The report's authors note that this country's workers compensation system began in the early 1900s in response to the inability of the civil justice system to provide workers with an adequate remedy for disabling work-related injuries.

But, the report cites several other reports that predict an upward trend in the "successful" pursuit of dual recoveries by workers and an increase in transaction costs associated with multiple claims and recoveries, third-party suits and related litigation.

"While none of the studies focus specifically on occupational disease claims, there is no reason to believe that a different pattern would emerge for these claims," notes the NAIC report.

Several recommendations of the advisory committee report deal with the legal and administrative

aspects of occupational disease. The report says:

- Although statutes of limitation on workers compensation claims are necessary, they should run for a defined period from a current event—such as the date of disability or the date the worker knew or should have known of the disabling condition and its relationship to the employment—rather than from a past event, such as the date of last exposure.

- Statutes of limitation for death claims should run from the date of death.

- Disability benefits for all occupational diseases should be based on wages and benefit levels in effect at the time of disability or death rather than at the time of exposure to the harmful substance.

- Workers compensation benefits, Social Security disability benefits, death benefits and other employee benefit plans should be coordinated, but workers compensation benefits should be primary for active workers.

- Workers compensation income benefits paid to workers or their spouses before retirement should not continue after retirement without some offsetting for retirement benefits like Social Security. States should either make workers compensation benefits a secondary source of income benefits for retired people, or states should pay workers compensation income benefits to retired workers or their dependents only to replace a loss of Social Security retirement benefits due to a pre-retirement occupational injury or disease.

- Workers compensation should not provide income benefits for new claims brought after retirement. However, workers compensation should provide medical benefits for occupational injury or diseases that would have been compensable before retirement.

- A central data base including the latest and most relevant medical and scientific statistics should be established to assist workers compensation administrators and others.

- States should seek the advice of impartial experts to determine the compensability of individual occupational disease claims.

- State workers compensation administrators should make written findings of fact on compensability and conclusions of law in contested occupational disease cases.

- Comprehensive administrative guidelines should be developed for use by persons who decide the validity of occupational disease claims. However, it would not be appropriate to use statutory schedules of compensable occupational diseases or statutory presumptions.

- Courses, such as those taught at the annual IAIABC College, should be continued and expanded to educate and train administrators in evaluating occupational disease claims.

The NAIC advisory committee report also discusses the dilemma of "assignment of responsibility" for payment of workers compensation claims, but does not suggest any solutions, suggesting that the degree of the problem depends much on how the cause of an injury is determined.

This section deals with both the issue of which employer should pay claims stemming from a long-latent disease developed by a worker who had several employers during his career and how compensation should be apportioned for an injury that is not only linked to an employee's work but also his lifestyle.

"Insurance and self-insurance generally have been successful in internalizing the costs of industrial injuries and in promoting workplace safety, particularly for traumatic injuries...The long latency of many occupational diseases and the difficult causation issues that sometimes arise, however, cloud the issue of which employer should be held liable for the payment of workers compensation benefits," notes the report.

Some states apportion liability to more than one employer, while other states place responsibility on the last employer that "injuriously" exposed the worker to the hazardous substance or condition.

The committee recommends that liability fall to the last employer that either simply exposed the worker to a harmful substance or "injuriously" exposed the worker to a harmful substance, rather than to the employer that simply employed the worker last.

The advisory committee also notes that the uncertainty of the cause of many diseases raises questions about the equity of paying workers compensation benefits for disabilities that arise from or are aggravated by factors unrelated to the workplace.

The report notes that "employers have little or no opportunity to control or reduce non-work-related hazards to which workers are exposed," such as smoking, the use of alcohol or drugs and other personal habits that can contribute or exacerbate occupational disabilities.

The appropriateness of apportioning liability in such cases depends on the manner in which the cause of the injury is determined, notes the advisory committee.

It believes the traditional tests of compensability and proof of causation should be applied to determine that the disability arose out of and in the course of employment.

"When this is done, apportionment of liability (and the reduction of benefits that results therefrom) is not appropriate," the report concludes. However, it adds that apportionment of liability may be warranted in states that apply compensability tests that are less stringent.

The advisory committee notes that non-occupational exposures to injury—such as the use of tobacco—present problems for society "that are well beyond those that the workers compensation system can solve," and an acceptable solution is yet to be found for solving this particular complex problem.

Overall, the report notes that the committee's recommendations "constitute a balanced package...leading to an improved workers compensation system that will respond to occupational disease claims more promptly and efficiently and that will provide for a fairer distribution of costs and benefits."

Inaction by the states in this area could lead to serious further erosion of the exclusive remedy rule, federalization of workers compensation, or both, the committee concludes, noting this would be a prospect "that would not meet the needs of either workers and employers and that would probably be far more costly than an improved state workers compensation system."

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Copies of the NAIC occupational disease advisory committee's report are available at a cost of \$10 for a single copy or at \$7.50 each for 10 or more copies from the American Insurance Assn., Publication Department, 85 John St., New York, N.Y. 10038. Checks should be made out to the American Insurance Assn.

## Cumulative injury not covered: Court

RICHMOND, Va.—Labor unions and trial lawyers in Virginia want the legislature to neutralize a recent state Supreme Court ruling that cumulative trauma injuries are not covered by workers compensation.

The unions and lawyers have asked Gov. Charles S. Robb to call a special session of the General Assembly to deal with the issue. The legislature isn't scheduled to go into regular session until January.

At issue is the April 26 Virginia Supreme Court ruling in *Western Electric Co. vs. Brenda E. Gilliam*. In that ruling, the court said any disease that is "gradually incurred on account of repeated, work-related trauma" is not covered by the state work comp system.

Ms. Gilliam, an assembler at the Arlington, Va., plant of Western Electric, now AT&T Technologies Inc., complained of severe pain in her hand that was diagnosed as tenosynovitis, an inflammation of the tendon sheath. According to testimony, the condition was related to repetitive hand motion on the job.

The Virginia Industrial Commission granted benefits to Ms. Gilliam, and Western Electric appealed to the state Supreme Court.

The effect of the court's ruling is still unclear. Some observers say it applies only to cumulative trauma injuries, a term generally used to describe injuries that develop over a long period due to repetitive motions.

But others, notably unions, believe the decision will be far-reaching and ultimately apply to other occupational diseases, such as asbestosis and black lung.

Occupational disease claims are still being paid in Virginia, despite the court ruling. But, lawyers say the Virginia Industrial Commission is denying benefits to other workers who claim to have tenosynovitis, carpal tunnel syndrome, back pains or other cumulative trauma occupational diseases.

Andrew Edelman, claims manager for the Industrial Commission, however, says there have been no admin-

istrative rulings barring these types of claims nor are any expected. "We just follow the opinion and hopefully apply it properly. Each claim is handled on a case-by-case basis," he said.

The court decision "is the greatest case of abandoning the workers in the state of Virginia...a disenfranchisement," said David Laws, president of the Virginia AFL-CIO. The union is circulating petitions among legislators to support the call for a special session.

But, employers in Virginia have steadfastly been against paying workers compensation benefits for cumulative trauma injuries.

"We forevermore have been opposed to workers compensation covering gradually imposed work related injuries," said E.C. Luther, executive vp of the Virginia Chamber of Commerce, noting the group views the recent court decision as a success.

Still, some wish the issue had not been decided by the state Supreme Court.

"(The court decision) is regrettable. We do not want to get into cumulative trauma...it's an enormous expense. This case will act as a spur to those who want cumulative trauma (claims paid) in Virginia...It will result in a ground swell to adopt cumulative trauma (laws)," said an employer lobbyist who asked not to be identified since he will be involved in this "emotional" issue at the General Assembly.

C. Torrence Armstrong, the Alexandria, Va., attorney who represented Western Electric, pointed out that the Virginia workers compensation statute excludes occupational diseases that are considered to be "ordinary diseases of life," like back strain, tenosynovitis and carpal tunnel syndrome. It is difficult to distinguish in these cases whether the condition was caused by the job or the worker's lifestyle, he said.

"Employers have no defense to these cases if they're allowed," Mr. Armstrong added.

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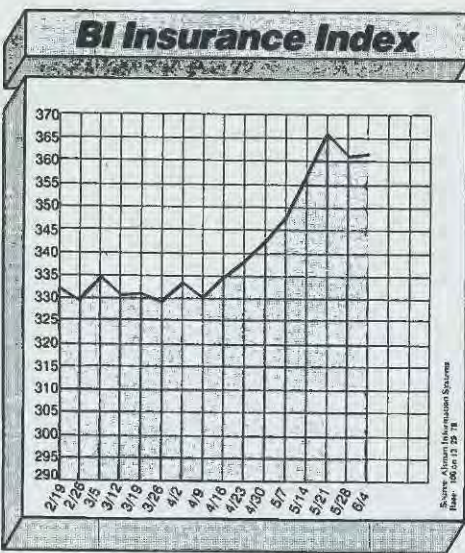
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# Brokerages' profit picture robust despite 'leakages'

By LEONARD M. WILSON  
Special to Business Insurance

CHANGE FOR THE better has come to insurance brokerage. The first-quarter results for the publicly held brokers decisively established that. Gains ran well into double-digit territory, as profit margins widened markedly. The trauma of the past few years is receding.

Taking the public brokers as a group, the average rise in commissions and fees was in the area of 19% to 20% over last year's comparable quarter. Higher premium rates clearly were an important factor, but advancing prices were offset to a degree by the restraints of tight capacity and, in some instances, by slippage in commission as a percent of premium.

We call these influences leakages. They dilute the pure effect of price on brokers' revenue growth.

Everybody talks about the tightening of capacity. Clearly, renewal premiums on difficult lines frequently reflect a reduction in the amount of coverage. In addition, commissions are bound to increase less than premiums on those renewals where a quantum jump in cost has occurred.

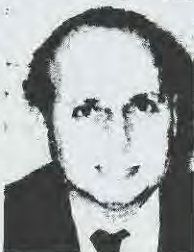
These leakages make it difficult to estimate the impact on brokers' gains from rate change. Our guess is a 7% to 10% contribution from rising prices, far less than the talk about increases would suggest.

But, the trade-off between higher prices and constrained capacity is an inevitable feature of the cycle at this stage.

In the period from 1975 to 1977, the last up cycle in property and casualty insurance, we believe commissions may have eased marginally as a percent of commercial premiums. The slippage, though, was small and not the result of any conscious program by underwriters to diminish compensation to the public brokers.

We doubt that overall commissions in the

Leonard M. Wilson, a special limited partner at L.F. Rothschild, Unterberg, Towbin in New York, specializes in insurance brokerage stocks. He is a member of the New York Society of Security Analysts.



Mr. Wilson

current environment will display any material attrition.

The brokers already have experienced a sharp decline in commissions per unit of insurance as a result of the 40% to 50% price trimming in commercial lines over the past five years.

Brokerage compensation does not need any further correction on the downside.

Despite the tightness of commercial insurance markets, contracts indicate that not all lines are undergoing pronounced price increases. Retrospective policies, property and workers compensation are relative laggards in the price department.

This has to be considered as well in gauging the potential for brokerage revenue growth. In our view, these various leakages or restraints are likely to hold a typical public broker's 1985 commission growth to 20% to 25% against the previous year.

Expenses in the first quarter behaved relatively well. The average rise for the public brokers was 10% to 11%, and several, perhaps aided by the strong dollar's effect on foreign costs, contained increases to 6% to 7%.

The credit for this solid performance probably belongs to the lingering disciplines of cost control put in place during the past two or three years.

Brokerage head counts have not begun to rise much. Increased costs seem to be linked to the improvement in production and profitability. Brokerage expenses lagged behind the slowdown in revenue growth, and now seem to be lagging the pickup in revenues as well.

We expect an acceleration in head-count expansion as the year proceeds, but on an average for the year, it would be surprising if brokerage staff typically increased more than 2% to 3%.

For the public brokers, the modest advance in costs coupled with robust revenue gains led to earnings progress of 30% to 50% compared with 1984. This is the positive operating leverage that we have discussed in the past.

There is little doubt this progress will continue through the balance of 1985 and into 1986.

Almost all other components of brokerage revenues were strong. Reinsurance probably surpassed primary brokerage in rate of gain. Employee benefits mostly increased in the 10% to 15% range, while investment income was propelled upward by the higher level of

premium throughput in the face of downward trending interest rates.

The dramatic upswing in the fortunes of the industry unavoidably lead to speculation as to how long the rising phase will last. In our view, the generous rate increases in 1985 coupled with another round in 1986 could come close to restoring rate adequacy by the end of 1986. That does not necessarily mean that competition in virulent form will then reassert itself.

We think interest rates will be an important factor in protecting the property and casualty underwriters from their tendency toward competitive excess. Lower interest rates seem to be foreshadowed by the absence of inflation and probable tax legislation that may discourage private debt formation.

Consequently, we believe that the environment for insurance brokers may be quite favorable even after most of the necessary rate increases have been secured.

In the meantime, the public brokers are likely to achieve marked earnings progress this year and next. They have been rehabilitated as growth issues, judging by current price-to-earnings ratios.

## CIGNA stock offering

CIGNA Corp. is offering 5 million shares of its \$4.10 cumulative convertible preferred stock through a public offering. Goldman, Sachs & Co. is manager of the underwriting group.

The preferred stock will have a stated value of \$50 per share and is convertible at the holder's option into common shares at the rate of .7326 share of common stock for each share of convertible stock, subject to adjustments.

The stock can also be exchanged, at CIGNA's option, for the corporation's 8.20% convertible subordinated debentures or redeemed for cash at redemption prices declining to \$50 per share on July 10, 1995. However, the preferred stock will not be exchangeable or redeemable until 1988.

CIGNA says the proceeds from the offering will be added to its general corporate funds.

## Armco contribution

Armco Inc. has agreed to a New Jersey Department of Insurance order requiring it to contribute \$80 million to its financially troubled Universal Reinsurance Corp. unit, based in Holland Township, N.J.

Armco will contribute \$65.7 million in cash to Universal Re, which stopped writing new business and began running off its book on April 1, 1984 (BI, April 8).

Also, Universal Re will get a \$14.1 million loan from Armco.

Universal Re reported a deficit of \$65.8 million at the end of 1984, but the New Jersey department concluded that the insurer's liabilities exceeded its assets by \$80 million at the end of last year.

## New York Marine stock offer

New York Marine & General Insurance Co. has filed a registration statement with the Securities & Exchange Commission for the proposed public offering of 500,000 new shares of common stock. PaineWebber Inc. will manage the underwriting group that plans to offer the shares to the public. Proceeds from the proposed sale will be used to increase the company's surplus.

## American General dividend

American General Corp. declared a quarterly dividend of 25 cents per share on American General common stock, payable June 1 to shareholders of record May 13. American General also reported the following quarterly dividends, all payable June 30 to shareholders of record June 10:

- \$2.64 convertible preferred stock: 66 cents per share.
- Adjustable rate preferred stock, series A: \$1.51 per share.
- Adjustable rate convertible preferred stock, series B: \$1.42 per share.

| British Issues          |       |       |       |       |                 |
|-------------------------|-------|-------|-------|-------|-----------------|
|                         | Price | P/E   | Div.  | Yield | 1 Week High-Low |
| <b>4 June Companies</b> | pence |       | pence | %     | pence pence     |
| Comml Union             | 226   | N/M   | 16.9  | 7.5   | 225-220         |
| Gent Accident           | 605   | 102.5 | 28.6  | 4.7   | 605-593         |
| Gdn Royal Exch          | 703   | 20.4  | 37.1  | 5.3   | 703-693         |
| Royal                   | 660   | N/M   | 33.9  | 5.1   | 660-640         |
| Sun Alliance            | 470   | 22.6  | 21.1  | 4.7   | 470-455         |
| <b>Brokers</b>          |       |       |       |       |                 |
| CE Heath                | 648   | 10.6  | 30.0  | 4.6   | 648-620         |
| Hogg Robinson           | 266   | 15.2  | 11.6  | 4.3   | 266-255         |
| JH Minet                | 212   | 13.9  | 8.9   | 4.2   | 212-206         |
| Sedg Grp                | 400   | 17.5  | 14.3  | 3.6   | 400-390         |
| Stew Wrightson          | 620   | 16.3  | 25.7  | 4.1   | 620-600         |
| Willis Faber            | 693   | 23.7  | 18.6  | 2.7   | 693-675         |

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

| BI Industry Stock Report                |         |        |      |         |        |      |        |           |         |                               |         |        |         |        |       |     |           |        |         |
|---|---------|--------|------|---------|--------|------|--------|-----------|---------|-------------------------------|---------|--------|---------|--------|-------|-----|-----------|--------|---------|
| June 4, 1985 5/29/85 thru 6/4/85        |         |        |      |         |        |      |        |           |         |                               |         |        |         |        |       |     |           |        |         |
| Brokers                                 | Price   | % Chg. | P/E  | \$ Div. | % Yld. | High | Low    | Vol.(000) |         | Price                         | % Chg.  | P/E    | \$ Div. | % Yld. | High  | Low | Vol.(000) |        |         |
| Alexander & Alexander Svcs              | NYSE    | 27.50  | 0.5  | 0.0     | 1.00   | 3.6  | 27.50  | 26.75     | 581.1   | Avenco Corp                   | NYSE    | 29.00  | 3.6     | 13.4   | 0.60  | 2.1 | 29.13*    | 28.38  | 8.2     |
| Baldwin & Lyons Inc                     | NYSE    | 65.00  | 0.0  | 11.8    | 0.80   | 1.2  | 70.00  | 65.00     | 2.9     | Business Mens Assurn Co Amer  | OTC     | 54.50  | 0.9     | 7.5    | 2.08  | 3.8 | 55.00     | 54.50  | 45.3    |
| Corroon & Black Corp                    | NYSE    | 47.00  | 1.6  | 0.0     | 1.00   | 2.1  | 47.00  | 45.50     | 130.5   | Chubb Corp                    | NYSE    | 73.75  | 7.1     | 18.6   | 2.20  | 3.0 | 74.50*    | 70.25  | 184.8   |
| Crumph E H Cos Inc                      | OTC     | 31.25  | -2.0 | 23.5    | 0.44   | 1.4  | 31.50  | 31.25     | 145.0   | Combined Intl Corp            | NYSE    | 48.13  | -0.5    | 9.4    | 2.16  | 4.5 | 48.13     | 47.75  | 129.3   |
| Emett & Chandler Cos Inc                | OTC     | 21.50  | 2.4  | 102.4   | 0.00   | 0.0  | 21.50* | 21.25     | 56.6    | Continental Corp              | NYSE    | 44.75  | -0.6    | 22.8   | 2.60  | 5.8 | 45.00     | 44.13  | 456.2   |
| Gallagher Arthur J & Co                 | OTC     | 44.75  | 2.9  | 26.8    | 0.28   | 0.6  | 44.75* | 43.50     | 17.9    | Crown Life Ins Co             | OTC     | 142.00 | 3.6     | 8.6    | 5.00  | 3.5 | 142.00*   | 142.00 | 0.5     |
| Hall, Frank & Co Inc                    | NYSE    | 28.63  | 6.0  | 0.0     | 1.00   | 3.5  | 28.63* | 27.50     | 483.3   | Burhan Corp                   | OTC     | 40.00  | -1.2    | 7.7    | 1.28  | 3.2 | 40.00     | 39.50  | 9.4     |
| Marsh & McLennan Cos Inc                | NYSE    | 70.88  | 7.4  | 19.7    | 2.40   | 3.4  | 70.88* | 64.75     | 404.3   | Farmers Group Inc             | OTC     | 61.25  | -2.2    | 10.7   | 1.76  | 2.9 | 62.13     | 61.13  | 414.9   |
| Poe & Assoc Inc                         | OTC     | 8.00   | 0.0  | 0.0     | 0.00   | 0.0  | 8.00   | 8.00      | 0.0     | Fresnost Gen Corp             | OTC     | 27.25  | -0.9    | 0.0    | 0.48  | 1.8 | 27.50     | 27.00  | 151.5   |
| Reed Stenhouse Cos Ltd                  | OTC     | 20.13  | -1.8 | 26.1    | 0.60   | 3.0  | 20.38  | 20.00     | 106.4   | Great West Life Assurn Co     | OTC     | 366.00 | 0.0     | 9.4    | 14.00 | 3.8 | 366.00    | 366.00 | 0.5     |
| AGENTS/BROKERS                          | AVERAGE |        | 44.0 |         | 2.1    |      |        |           |         | Manover Ins Co                | OTC     | 43.25  | -4.9    | 73.3   | 0.56  | 1.3 | 44.38     | 43.25  | 57.8    |
| <b>Conglomerates &amp; Holding Cos.</b> |         |        |      |         |        |      |        |           |         | Hartford Steam Boiler Insaptn | OTC     | 45.75  | 2.2     | 39.4   | 1.50  | 3.3 | 46.25*    | 45.00  | 13.6    |
| American Express(Fireman's Fd)          | NYSE    | 46.75  | 3.0  | 16.0    | 1.28   | 2.7  | 46.75* | 45.75     | 4,193.8 | Kans City Life Ins            | OTC     | 77.00  | 0.0     | 8.8    | 2.88  | 3.7 | 77.00     | 77.00  | 3.1     |
| Anderson Clayton(Ranger/PanAm)          | NYSE    | 38.88  | -0.3 | 33.5    | 1.32   | 3.4  | 39.25  | 38.88     | 75.7    | Kemper Corp                   | OTC     | 55.38  | -5.9    | 23.9   | 1.80  | 3.3 | 58.25     | 55.38  | 246.4   |
| Araco Inc                               | NYSE    | 8.25   | 8.2  | 0.0     | 0.00   | 0.0  | 8.25   | 7.63      | 539.6   | Liberty Corp S C              | NYSE    | 31.75  | 0.0     | 14.8   | 0.72  | 2.3 | 31.75     | 31.25  | 13.5    |
| Berkley W R Corp                        | OTC     | 15.50  | 0.0  | 0.0     | 0.32   | 2.1  | 15.75  | 15.38     | 56.7    | Lincoln Natl Corp Ind         | NYSE    | 44.75  | 2.3     | 11.8   | 1.84  | 4.1 | 44.75     | 43.25  | 282.5   |
| CIGNA Corp                              | NYSE    | 55.75  | -1.3 | 796.4   | 2.60   | 4.7  | 55.75  | 55.13     | 1,123.6 | Mission Ins Group Inc         | NYSE    | 7.75   | 1.6     | 0.0    | 0.00  | 0.0 | 7.75      | 7.50   | 39.1    |
| City Investing Co. (Home Ins.)          | NYSE    | 35.38  | -1.0 | 5.5     | 0.00   | 0.0  | 35.75  | 35.25     | 756.4   | Monumental Corp               | OTC     | 32.13  | -3.0    | 23.6   | 1.30  | 4.0 | 33.13     | 32.13  | 35.7    |
| CNA Finl Corp (CNA)                     | NYSE    | 53.50  | 7.3  | 20.6    | 0.00   | 0.0  | 54.00* | 50.25     | 97.1    | Northwestern Natl Life Ins    | OTC     | 27.13  | -11.4   | 6.5    | 0.80  | 2.9 | 29.25     | 27.13* | 1,551.9 |
| General Re Corp                         | NYSE    | 81.50  | -2.1 | 53.6    | 1.56   | 1.9  | 83.25  | 81.38     | 352.1   | Ohio Gas Corp                 | OTC     | 59.13  | -0.8    | 21.9   | 2.80  | 4.7 | 60.50     | 59.13  | 196.4   |
| ITT (Hartford Group)                    | NYSE    | 31.25  | -4.6 | 9.8     | 1.00   | 3.2  | 32.50  | 30.88     | 2,568.4 | Old Rep Intl Corp             | OTC     | 33.13  | 1.1     | 8.0    | 0.74  | 2.2 | 33.13     | 32.63  | 73.5    |
| Optium Hldg Corp                        | OTC     | 0.50   | 0.0  | 0.0     | 0.00   | 0.0  | 0.50   | 0.50      | 2.6     | Orion Cap Corp                | NYSE    | 27.25  | 0.0     | 0.0    | 0.76  | 2.8 | 27.25     | 26.25  | 105.6   |
| Sears Roebuck & Co. (Allstate)          | NYSE    | 38.50  | 5.8  | 9.6     | 1.76   | 4.6  | 38.63* | 37.13     | 8,373.1 | Protective Corp               | OTC     | 19.50  | -9.3    | 6.6    | 0.66  | 3.4 | 21.25     | 19.50  | 228.5   |
| Teledeyne Inc (Argonaut)                | NYSE    | 258.75 | 1.9  | 5.6     | 0.00   | 0.0  | 259.50 | 256.75    | 227.0   | Provident Life & Acc Ins Co   | OTC     | 23.00  | -5.2    | 6.2    | 0.88  | 3.8 | 23.75     | 23.00  | 269.6   |
| Transamerica Corp                       | NYSE    | 30.75  | 0.4  | 15.1    | 1.64   | 5.3  | 30.75  | 29.75     | 599.9   | St Paul Cos Inc               | OTC     | 69.88  | 0.2     | 0.0    | 3.00  | 4.3 | 69.88     | 69.13  | 466.7   |
| (Occidental & Fred S. James)            | NYSE    | 30.75  | 0.4  | 15.1    | 1.64   | 5.3  | 30.75  | 29.75     | 599.9   | Old Rep Intl Corp             | OTC     | 41.50  | -1.5    | 14.8   | 1.60  | 3.9 | 42.50     | 41.38  | 424.5   |
| CONGLOMERATES/HOLDING COS.              | AVERAGE |        | 11.4 |         | 1.7    |      |        |           |         | Sri Corp                      | OTC     | 18.75  | -1.3    | 89.3   | 0.68  | 3.6 | 19.00     | 18.50  | 52.1    |
| <b>Insurers</b>                         |         |        |      |         |        |      |        |           |         | Seibels Bruce Group Inc       | OTC     | 21.63  | -0.6    | 0.0    | 0.80  | 3.7 | 21.75     | 21.50  | 140.8   |
| Aetna Life & Cas Co                     | NYSE    | 46.25  | 1.6  | 23.5    | 2.64   | 5.7  | 46.25* | 45.25     | 1,214.3 | Statesman Group Inc           | OTC     | 4.63   | -2.6    | 0.0    | 0.15  | 3.2 | 4.88      | 4.63   | 33.3    |
| American General Corp                   | NYSE    | 34.25  | -1.4 | 11.1    | 1.00   | 2.9  | 34.50  | 33.25     | 1,186.0 | Tokio Marine & Fire Ins Co    | OTC     | 189.00 | 8.3     | 32.7   | 0.00  | 0.0 | 189.00*   | 179.00 | 3.1     |
| Amern Heritage Life Invst Co            | NYSE    | 33.75  | 7.1  | 10.0    | 1.20   | 3.6  | 33.75* | 31.88     | 4.4     | Torchmark Corp                | NYSE    | 47.13  | -6.5    | 10.4   | 1.00  | 2.1 | 49.88     | 45.75  | 309.3   |
| American Indty Finl Corp                | OTC     | 20.75  | 0.0  | 0.0     | 1.12   | 5.4  | 21.13* | 20.75     | 9.3     | Travelers Corp                | NYSE    | 48.00  | 0.5     | 11.6   | 2.04  | 4.3 | 48.00     | 47.38  | 717.3   |
| American Intl Group Inc                 | NYSE    | 84.00  | 2.1  | 24.9    | 0.44   | 0.5  | 84.00  | 80.75     | 389.3   | United Fire & Cas Co          | OTC     | 22.00  | 0.0     | 0.0    | 0.80  | 3.6 | 22.00     | 22.00  | 0.2     |
| Aneco Reins Ltd                         | OTC     | 1.50   | 0.0  | 0.0     | 0.00   | 0.0  | 1.50   | 1.50      | 1.1     | United States Fid & Gty Co    | NYSE    | 36.88  | 2.4     | 39.7   | 2.20  | 6.0 | 36.88     | 36.00  | 655.0   |
|   |         |        |      |         |        |      |        |           |         | USLife Corp                   | NYSE    | 35.50  | -4.1    | 8.1    | 1.04  | 2.9 | 35.88     | 34.75  | 639.0   |
|   |         |        |      |         |        |      |        |           |         | Washington Natl Corp          | NYSE    | 24.13  | -8.1    | 7.1    | 1.08  | 4.5 | 26.50     | 24.13  | 129.5   |
|   |         |        |      |         |        |      |        |           |         | Zenith Natl Ins Corp          | OTC     | 15.25  | 5.2     | 0.0    | 0.68  | 4.5 | 15.25*    | 15.00  | 39.2    |
|   |         |        |      |         |        |      |        |           |         | INSURANCE COMPANIES           | AVERAGE |        |         |        |       |     |           |        |         |
|   |         |        |      |         |        |      |        |           |         |                               |         | 16.3   |         |        |       |     |           |        |         |

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