

business insurance

National Distillers files action against manager of Delta

NEW YORK—National Distillers & Chemical Corp.—accused in a recent lawsuit of inflating the value of an insurance unit it sold to Delta Holdings Inc.—has filed a third-party complaint against Delta's manager, American Risk Management Inc.; Frederic M. Reiss, ARM's chairman and president; and Peat Marwick Mitchell & Co., which conducted a pre-sale audit of the insurance unit, Elk.

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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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Confusing rules for 401(k) plans may halt growth

By JERRY GEISEL

WASHINGTON—"Tax simplification was forgotten when the administration came to 401(k) plans," says benefit consultant Don Hasbargen of Hewitt Associates.

This omission—coupled with other restrictions placed on 401(k) plans—will abruptly halt the growth of the enormously popular salary reduction plans, predict the nation's top benefit consultants.

They say the new rules are so complex, confusing and vague that many employers will not want to deal with the administrative headaches and costs that will result. Meanwhile, the restrictions laid down by the new rules will make the plans less popular among both lower-paid and highly paid employees, reducing current high participation levels.

Most confusing and costly to employers would be the new discrimination tests proposed to control the tax-free contributions highly paid employees can make to the plans (see story, page 29).

Most unappealing to employees would be the administration's proposal to slash the maximum annual contribution to a 401(k) plan to \$8,000 from \$30,000 and to remove a current provision that allows "hardship" withdrawals of funds to purchase a new home, pay medical expenses or fund a child's college education.

Under 401(k) plans, named for the section of the Internal Revenue Code that authorizes them, employees can reduce their salaries and contribute those pretax dollars to accounts where the money earns tax-free interest until withdrawn. Because the accounts are funded by pretax dollars, employees' federal tax liability is reduced.

The funds can be withdrawn when employees reach age 59½, when they terminate employment or when they face hardship.

The Treasury Department estimates that between 6 million and 7 million employees are covered by 401(k) plans, though other surveys indicate that as many as 20 million employees may be covered (BI, May 27).

But, if Congress adopts the administration's proposed rules, "the days of 401(k) plans being the fastest-growing employee benefit are over," said Kevin Meehan, manager of defined contribution plan consulting at The Wyatt Co. in Washington.

At a minimum, employers may stop adding 401(k) features to existing savings plans, consultants say.

"With the extra layers of administration and fewer benefits to executives, companies will not be as anxious to start new plans," says Frederick Rumack, director of tax and legal services for Buck Consultants in New York.

And some companies, particularly smaller ones, may scrap existing plans.

"The Treasury is imposing administrative burdens that will kill some plans," says

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N.Y. tries to nab Hall's insurer

By DOUGLAS McLEOD

NEW YORK—The New York Insurance Department is seeking a court order to liquidate Union Indemnity Insurance Co. of New York, a unit of broker Frank B. Hall & Co. Inc.

The department says Union Indemnity was insolvent by \$138 million at the end of 1984.

The liquidation petition, filed in New York State Supreme Court, followed two New York department examinations that found that Union substantially understated loss and expense reserves and liabilities for unauthorized reinsurance in 1983 and 1984.

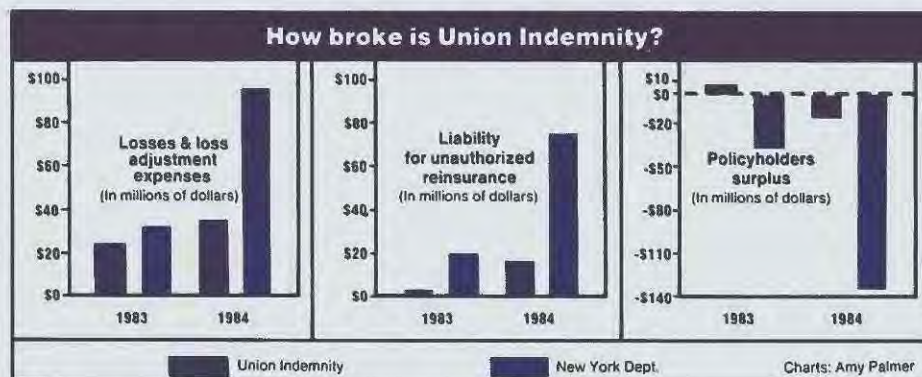
One of the company's unauthorized reinsurers is Mentor Insurance Ltd., for which Bermuda regulators are now seeking a liquidation order (see story below).

Other significant unauthorized reinsurers of Union include two Bermuda captives owned by PepsiCo Inc., a Hall brokerage client; and several captive insurers managed by Parker & Co. InterOcean Ltd., Hall's captive management unit.

Frank B. Hall Underwriting Managers in Bermuda, which had underwritten U.S. risks that were fronted by Union and ceded to one of two captive reinsurance pools, reduced its use of Union as a policy-issuing company throughout 1984, according to Robin Spencer-Arscott, president of Hall (Bermuda) Ltd.

"Over the last two years, premium volume has dropped due to the unacceptability of the company," Mr. Spencer-Arscott said, adding that Hall Underwriting Managers had written \$3 million in premiums using Union in 1984, down from a peak of \$5 million to \$6 million in 1982 and 1983.

The first New York Insurance Department examination of Union, completed in January, concluded the company was insolvent by \$27.9 million at the end of 1983.



The second examination, completed in March, found that the insolvency had ballooned to \$138.5 million by year-end 1984.

The 1983 exam also noted that Union's accounting and record-keeping systems were "totally inadequate" and that improper accounting in some areas—including reinsurance recoverable—had "served to grossly overstate surplus to policyholders."

Union's latest financial statements reflect an insolvency, but not nearly of the magnitude claimed by the New York department.

In its annual statements, Union reported a negative policyholders surplus of \$14.6 million at the end of 1984 and a surplus of \$9.3 million at year-end 1983.

The New York department's 1984 exam increased Union's liability for unpaid losses and expenses by \$60.3 million to \$96.1 million from \$35.9 million that the company reported. The 1984 exam also increased Union's liability for unauthorized reinsurance by \$56.2 million to \$75.6 million from the \$19.4 million reported by the company.

Department examiners boosted Union's total 1984 liabilities to \$192.8 million from the \$77.5 million the company reported,

while reducing its assets to \$54.3 million from the \$62.9 million Union reported.

The examination for 1983 increased Union's total liabilities to \$70.3 million from \$51 million while reducing its assets to \$42.4 million from the \$60.3 million the company had reported.

Monroe Birnberg, who resigned as Union's president earlier this year, called the department's figures "absolutely ridiculous."

Thomas G. O'Brien III, vp, secretary and general counsel of Frank B. Hall, said Union hasn't decided whether it will fight the liquidation petition. The insurer must respond to the petition by June 27.

Union's response will depend partly on the results of an audit of Union's operations conducted by Tillinghast, Nelson & Warren and Touche Ross & Co., Mr. O'Brien said.

In a May 23 letter to the New York department, Hall Vice Chairman William C. Bartholomay said the Tillinghast study will show a "maximum deficit" due to increased loss and expense reserves of \$30 million.

Mr. Bartholomay also said in the letter that Union estimated a maximum addi-

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Bermuda grabs for ODECO's Mentor

By KATHRYN J. MCINTYRE

HAMILTON, Bermuda—Bermuda's Supreme Court will consider this Friday a petition by the government for a court-ordered liquidation of Ocean Drilling & Exploration Co.'s captive insurer Mentor Insurance Ltd.—the very day ODECO had planned to move the day-to-day runoff operations of its captive to its New Orleans headquarters.

The petition for liquidation, filed June 6 by Registrar of Companies Verbena Daniels, cites Bermuda's Companies Act and Sections 33 and 35 of the Insurance Act of 1978, sources say.

Section 33 defines an insurance company insolvency and Section 35 empowers the registrar of companies to seek a court-ordered liquidation, or "winding up" as it is called in Bermuda.

Bermuda's Minister of Finance Dr. Clarence James said the petition resulted from Mrs. Daniels' "scrutiny of Mentor's annual return. She felt obliged to take action under the insurance act. I am unable to discuss the matter further."

A public statement issued by Mentor just 24 hours before the Bermuda government went to court—and promptly withdrawn

after the liquidation petition was filed—said that Mentor had capital and surplus of \$645,000 at year-end 1984 after establishing discounted reserves for losses and loss expenses of \$130.2 million and other required reserves.

Until it stopped underwriting in January, Mentor was one of Bermuda's largest reinsurance companies with 1983 gross written premiums of \$110.3 million.

The petition filing stopped all claims payments by Mentor and precludes ODECO from completing the planned airlift of the captive's computers and records to ODECO's New Orleans headquarters to continue the 6-month-old runoff of the captive's business.

At a preliminary hearing held last Thursday in chambers, the government asked the court to appoint Charles Kempe, a chartered accountant in Bermuda, as an interim provisional liquidator. The hearing was still in progress at press time.

Meanwhile, on the same day that the Bermuda government went to court, but in a separate action, two Kemper Group reinsurance companies demanded arbitration of a previously reported dispute with Mentor over an attempt by Mentor to "re-cede" \$25.8

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Personal computers provide workers with benefit details
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update

National Distillers files action

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horn Re Insurance Co.

Delta's lawsuit, filed last month, charged that National Distillers falsely represented Elkhorn's net worth as \$18 million, when the insurer was actually \$48 million insolvent as of its September 1983 sale date (*BI*, May 27).

National Distillers—one of 27 corporate shareholders of Delta—recently filed an answer denying Delta's allegations.

National Distillers also filed the third-party complaint charging that ARM and Mr. Reiss were negligent in advising Delta to buy Elkhorn. ARM knew before the sale that Elkhorn was under-served by \$3.5 million and didn't demand a reduction in the purchase price, the complaint charges.

The complaint also charges Peat Marwick with negligence for not discovering the true financial condition of Elkhorn during its audit.

Louisville, Ky.-based Elkhorn—later renamed Delta America Re Insurance Co.—was ordered into rehabilitation May 29 by Franklin Circuit Court Judge William L. Graham after the Kentucky Insurance Department concluded that it was insolvent by \$66.7 million at the end of 1984.

High court to rule on MPPAA

WASHINGTON—The Supreme Court last week agreed to decide the constitutionality of a 1980 federal law that gives multiemployer pension plans the power to demand hefty payments from employers leaving underfunded plans.

The case involves a lawsuit filed by a small California construction firm that said the Multiemployer Pension Plan Amendments Act allowed an unconstitutional taking of company assets.

At the same time, the Supreme Court also will review whether multiemployer pension plans can be required to pay termination insurance premiums to the federal Pension Benefit Guaranty Corp. Currently, multiemployer plans pay an annual premium of \$1.80 per plan participant.

Award against township cut

TRENTON, N.J.—In a major victory for property/casualty insurers and policyholders, a New Jersey appellate court substantially reduced a lower court award in a widely publicized pollution case.

In the case, Jackson Township, N.J., was sued by residents whose wells were contaminated by chemicals leaking from a sanitary landfill owned by the township. A trial court had awarded the residents \$15 million in damages.

But, the appellate court June 4 cut the award by about \$10 million. The appellate court eliminated a \$2 million award for pain and suffering, saying New Jersey tort law largely prohibits such awards against government entities.

The appellate court also threw out \$8.2 million awarded for medical monitoring of the residents, saying that evidence in the case was too tenuous to demonstrate the residents were at an increased risk of disease as a result of exposure to the pollution.

Still to be resolved is an underlying lawsuit involving Jackson Township and its general liability insurers. A trial court judge ruled that the insurers must provide coverage for the \$15 million award. The insurers appealed the decision, but that suit is on hold pending a final decision in the suit brought by the residents.

Agent groups, ISO to meet

NEW YORK—Officials of the Independent Insurance Agents of America and the National Assn. of Professional Insurance Agents will meet today with Insurance Services Office officials to discuss coverage for defense costs under the new commercial general liability policy.

The meeting was scheduled after the two agent groups announced June 6 that they will oppose efforts by ISO to include defense costs within the CGL policy limits and that they will lobby state insurance commissioners to block such a change if ISO proposes it.

ISO announced in April that it is studying ways to control defense costs and that the results of the study would be made public July 1. But IIAA and PIA officials said they have learned the ISO study group plans to recommend to ISO's executive council June 27 that defense costs be included in the policy limits of the new CGL forms scheduled to go into use Jan. 1, 1986.

ISO officials would not comment on the study group's conclusion. The PIA and IIAA said more time is needed to study the effect on policyholders, agents and insurers of limiting defense coverage.

Accountant reports on Beckett

LONDON—A report by accountant Price Waterhouse on Lloyd's of London syndicates managed by Richard Beckett Underwriting Agencies Ltd. says the syndicates engaged in improper reinsurance transactions and overwrote their capacity.

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Hotel strike won't affect BI conference

NEW YORK—The Grand Hyatt Hotel—site of the 1985 *Business Insurance* Employee Benefits Communication Conference—is one of the few New York hotels operating with a full staff.

Most New York hotels are short-staffed due to a hotel workers' strike, but Grand Hyatt employees are on the job because the hotel has agreed to honor any forthcoming union contract if they do not strike in sympathy with other workers.

"We have every confidence that our selection of a first-class hotel will provide us with no less than first-class service," according to Ronnie I. Drach-

man, *Business Insurance's* director of communications.

The two-day conference, "The Dollars & Sense of Communicating Employee Benefits," will include sessions on the foundations of effective employee benefits communication, case studies, print communication and solving problems posed by registrants.

For more information and to register for the conference, contact Conference Registrar Ann Vazquez, *Business Insurance* Communication Services Department, 220 E. 42nd St., New York, N.Y. 10017; or call 212-210-0137.

Insurers' results reflecting signs of hardening market

By JUDY GREENWALD

The long-awaited turn in the commercial property/casualty insurance market is beginning to show up in insurers' results, industry observers say.

"From our standpoint, I think the worst of the cycle is over," says Paul J. Robitaille, director of investor relations for American International Group Inc. "We're going on the up slope now."

For instance, the aggregate combined ratio posted by the 28 commercial property/casualty insurers surveyed by *Business Insurance* declined in the first quarter.

Also, the surveyed insurers' net written premiums increased a robust 15% in the first quarter, compared with only a 5% increase in the first quarter of 1984.

"We're encouraged by what we saw in the first quarter," says David Seifer, vp at First Boston Corp. in New York. Pointing to large rate increases and the continuing withdrawal of underwriters from both the direct

and reinsurance markets, "We see no reason for the seller's market to abate in the foreseeable future."

Most observers agree, predicting the insurers will post significantly improved operating results during the second half of 1985, and say the earnings momentum will increase during 1986 and 1987.

"We think the second half will be a lot better than the first half," says Michael A. Lewis, a vp at New York-based E.F. Hutton.

But, the recovery will not be rapid, others point out. There will be no "magic year" when the industry's problems will suddenly disappear, says John Donahue, vp of the commercial insurance division at Hartford Insurance Group. Instead, he says, there will be a "month-by-month and quarter-by-quarter type of improvement."

The results of *BI's* survey of major commercial property/casualty insurers' first-quarter results show the

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United's plan to recoup assets is largest ever

By JERRY GEISEL

CHICAGO—The proposed restructuring of United Airlines' pension program would reap the nation's largest airline \$962 million—the largest reversion of corporate pension assets in history.

United's proposal is also unusual because it would affect plans covering union pilots, flight attendants and machinists. Most other large reversions have involved only salaried employees' plans.

It was not clear last week whether United would need union approval to recover the assets, though United contends it does not. Spokesmen for all three unions last week would not comment on the plan until their attorneys studied the proposal.

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Wausau to meet with M&M about memo on insurer's health

By JUDY GREENWALD

WAUSAU, Wis.—Wausau Insurance Cos. officials plan to meet with Marsh & McLennan Inc. officials this week to request that M&M revoke a memo instructing all M&M offices not to place any new or renewal business with Wausau.

"We are aware that the memo exists. We are arranging a meeting with M&M," says Dwight Davis, Wausau's vp for training and communications. "Our desire is to sit down with them and discuss the matter before making any comment on it."

Two essentially similar memos were sent to the heads of all M&M offices on June 7 and June 11 by John W. Foley, head of M&M's security committee.

The June 11 memo, which was read to *Business Insurance*, said, "Effective immediately, no new or renewal business should be placed with the Employers Insurance Co. of Wausau or its affiliated fire and casualty companies. In addition, you should recommend to our current clients that permission be given to M&M to seek alternate quotes for their current business."

The memo continues that if clients do switch insurers, it will "probably result in additional premiums" because of current rate increases and capacity reductions.

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Andersen wins coverage dispute

By STEPHEN TARNOFF

CHICAGO—Arthur Andersen & Co. is entitled to an additional \$4 million from Harbor Insurance Co. following a court ruling in a coverage dispute over the settlement of a multimillion-dollar damage award against the Big Eight accounting firm.

Cook County Circuit Court Judge Arthur L. Dunne ruled June 7 that Andersen's 1971 excess professional liability policy should respond to a \$45 million settlement of a suit against Andersen brought in 1975 by Fund of Funds Inc., a 77,000-member mutual fund (*BI*, Nov. 12, 1984).

In his ruling, Judge Dunne granted Andersen's motion for summary judgment and declined to adopt Harbor's position and that of several other insurers that Andersen's 1975 policy or that both the 1971 and 1975 policies were triggered by the claim.

Judge Dunne ruled that under the language of Harbor's 1971 policy, Harbor was obligated to follow the decision of Andersen's primary insurer, underwriters at Lloyd's of London, which selected 1971 as the applicable policy year.

All of the insurers on Andersen's \$50 million 1971 policy—with the exception of Harbor—have indemnified Andersen for the \$45 million settlement, although some excess insurers on the 1971 policy paid the claim under a reservation of rights, contending the 1975 pol-

icy should respond.

Harbor, which wrote \$5 million in limits on the 1971 policy and \$1 million in limits on the 1975 policy, paid its limits under the 1975 coverage. Under the ruling, it would have to pay Andersen an additional \$4 million.

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errors & omissions

• The policyholder surplus of Transit Casualty Co. as reported to the Missouri Division of Insurance was \$21.9 million at year-end 1984, according to George P. Bowie, chairman and general counsel (*BI*, June 10). Policyholder surplus reported to the New York Insurance Department was \$9.1 million at year-end 1984. The difference, Mr. Bowie said, was that unauthorized reinsurance that was acceptable to the Missouri department was not acceptable to the New York department.

• In the June 10 issue, a photo of Franklin W. Nutter, president of the Alliance of American Insurers, was inadvertently identified as Peter B. Walker, director of McKinsey & Co. Inc.

Carrying the load

Risk managers' duties not always the same: Survey

By ALISON KITTRELL

Risk managers at smaller companies are more likely to be responsible for employee benefits than their counterparts at larger employers, a new study confirms.

The survey also found that roughly the same percentage of risk managers at all sizes of companies are responsible for common risk management duties, like risk financing, claims handling, claims handling and negotiating the placement of coverage (see chart).

But, risk managers at larger companies are more likely to be involved with captives, self-insurance with large retentions and other more specialized areas of risk management, the survey shows, probably because larger companies are more likely to have these types of programs.

These findings in the Logic Associates 1984 Risk Management Compensation Survey confirm the results of previous years' studies (BI, May 7, 1984; May 23, 1983; March 1, 1982).

The most recent survey by the New York recruiting firm elicited responses from 917 risk managers at companies with annual sales volumes of up to more than \$7 billion. The responses were broken down according to company sales volumes.

Overall, the percentage of risk managers having direct responsibility for credit insurance, bonds, safety and fire loss-control engineering, security, contingency planning, negotia-

tion of coverage placement, benefits administration and pension and profit-sharing administration decreased as companies grew in size.

But, the percentage of risk managers with direct responsibility for marine insurance, claims handling, captive management, captive administration, self-insurance financing and self-insurance with retentions exceeding \$500,000 per claim was higher at the larger companies than smaller firms.

More than three-fourths of the risk managers in all the corporate categories reported they had direct responsibility for casualty insurance and property insurance. And, most of the rest reported that they either supervised or advised in these traditional risk management functions.

Perhaps the greatest variance in the responsibility of risk managers at different size companies comes in the areas of benefit and pension and profit-sharing administration.

At the smallest companies, those with up to \$200 million in annual sales, 26% of the risk managers reported a direct, hands-on responsi-

bility for pension and profit-sharing administration, while 32% said they had a supervisory or advisory role.

Also, some 38% of the risk managers at these companies reported a direct responsibility for benefits administration, while 35% said they had an advisory or supervisory role.

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Risk managers' areas of responsibility (By company sales in millions of dollars)							
	0- \$200	\$200- \$500	\$500- \$1,000	\$1,000- \$2,000	\$2,000- \$4,000	\$4,000- \$7,000	More than \$7,000
Risk financing	74%	72%	77%	60%	78%	64%	79%
Negotiation of coverage placement	15%	13%	16%	12%	16%	33%	16%
Claims handling	90%	83%	92%	87%	86%	89%	79%
Safety/fire loss engineering	9%	10%	5%	9%	7%	8%	21%
Security	48%	45%	57%	54%	54%	54%	53%
Benefits administration	25%	45%	40%	40%	39%	43%	47%
Pension/profit sharing administration	36%	29%	23%	26%	23%	36%	24%
Supervisory/advisory responsibility	58%	59%	67%	59%	71%	52%	74%
Direct, hands-on responsibility	10%	8%	7%	9%	3%	7%	5%
Supervisory/advisory responsibility	67%	56%	60%	55%	57%	52%	61%
Supervisory/advisory responsibility	38%	14%	12%	9%	3%	3%	5%
Supervisory/advisory responsibility	35%	38%	37%	23%	27%	33%	16%
Supervisory/advisory responsibility	26%	11%	9%	7%	2%	0%	3%
Supervisory/advisory responsibility	32%	22%	18%	13%	16%	3%	8%

Source: Logic Associates

Chart: Amy Palmer

Size of risk management staff grows with sales

By ALISON KITTRELL

Risk managers at larger companies have larger staffs to back them up than those at smaller companies.

The Logic Associates 1984 Risk Management Compensation Survey found the size of the risk management department grew according to company sales volume, as did the educational level of the departments' professionals and the departments' involvement with captives.

Also, larger companies were more likely to have a risk management information system (see story, page 24).

Some 917 risk managers at companies with annual sales of up to more than \$7 billion answered the fourth annual risk management survey by the New York professional recruiting firm, specializing in the risk and safety management professions, for a response rate of 31%.

Responses to the survey are grouped into seven categories,

according to annual sales volume reported by the respondents' companies.

Risk managers at the smallest companies, with up to \$200 million in sales, reported the smallest risk management departments: an average of 1.45 professional staffers, including the risk manager, and 1.65 clerical staffers, for a total of 3.1 staff members (see chart, page 27).

Risk managers at the next-smallest companies, with from \$201 million to \$500 million in annual sales, had only slightly larger departments: 1.8 professional staffers and 1.33 clerical staffers, for a total of 3.13.

The departments at companies with from \$501 million to \$1 billion in annual sales averaged 5.08 people—2.44 professional staffers and 2.64 clerical staffers. And, there were an average of 3.62 professional staffers and 2.62 clerical staffers—or a total of 6.24 people—at risk management departments at com-

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Civil justice reform could put insurers back on track: Panel

By CAROL CAIN

KANSAS CITY, Mo.—Civil justice reform—including placing restrictions on punitive damages—would allow the insurance industry to make coverage available and affordable, a panel of insurance executives say.

"The civil justice system has become a tool for social policy," said Peter Lardner, president and chief executive officer of Bituminous Casualty Corp., in Rock Island, Ill.

"Today, the demands are for punitive, to teach a lesson... Today our society uses, or misuses, the civil justice system to make well through awards he or she who is injured and to teach a lesson on the way," Mr. Lardner said. "And we're not coping very well..."

"We are in danger (today) of socially mandated solutions, which do not solve any problems," said N. David Thompson, president of New York-based North American Reinsurance Corp. "We must address the problem of punitive damages... and sooner or later we will have to return to some kind of balance of what leads to liability and re-define what contributory negligence means."

Mr. Lardner and Mr. Thompson were among panelists discussing the ills brought upon insurers by the civil justice system at last week's summer meeting of the National Assn. of Insurance Commissioners. Also on the panel were Edward J. Noha, chairman and chief executive officer of Chicago-based CNA Insurance Cos., and Jack B. Riffle, president and chief executive officer of Utica Mutual Insurance Co. in Utica, N.Y.

Peter Miller, chairman of Lloyd's of London, as well as Bruce Foudree, NAIC president and Iowa's insurance commissioner, also offered their views on the problems existing within the civil justice system.

"The large verdicts of recent years... have placed an added burden on regulators. We must assure ourselves that the civil justice system is not allowed to irreparably damage the insurance mechanism," Mr. Foudree said.

"More specifically, we must take steps to assure the problems in the civil justice system do not destroy the heart of the insurance process, namely underwriting, and thereby threaten solvency of insurers. Our primary goal (as regulators) is to protect policyholders by making sure their insurance coverage remains sound and is not ruined by financial failure of their insurers," he said.

CNA's Mr. Noha said: "Today... private insurance companies are reaching a pivotal point. It is becoming prohibitively difficult for them to meet their obligations, whether to the individual or to society in general, especially in liability lines."

He said circumstances that are hampering insurers' ability to perform their basic function with any kind of logic or accuracy include:

- Insurers no longer ordinarily can count on a reasonably consistent application of the law or reasonably consistent interpretations of contracts by the courts.
- As soon as insurers revise contracts to avoid judicial reinterpretation of their intent, that clear intent is

Continued on next page



Mr. Noha

Computers serve menu of benefit information

By DIANE LYNN KASTIEL

Last week, the employees of RCA Consumer Electronics Division in Indianapolis who were eating lunch in the employee cafeteria got an unexpected interruption—a ribbon-cutting ceremony for a new personal computer.

Normally, RCA doesn't bother with a ribbon-cutting ceremony each time it installs another computer, but this one is different: It is strictly for employees' use to teach them about their group benefits.

As soon as the ribbon was cut, employees started to line up to use the computer and the line continued throughout the day.

Late in the afternoon, the divisional vp for employee relations showed up at the office of Linda Wych, manager of benefits planning.

"He told me, 'Every time I go over there, there's a bunch of employees waiting to use the computer,'" Ms. Wych recalled.

"That's great!" I said.

"No it's not!", he moaned. "I can't even get a turn!"

RCA is one of a small, but growing, number of companies that are using computers to educate employees about their benefits programs and help them choose the benefit options that suit their needs.

Others blazing this new electronic trail in benefits communication include American Express Co., Eastman Kodak Co., NCR Corp. and The Hanes Group.

"You need to be able to provide people with informa-

tion—any information—when they need it, where they need it and in a form they will use," said Peter O'Donnell, director of employee benefits for RCA in Princeton, N.J.

Computerized employee benefits communications revolves around easy-to-operate personal computers and user-friendly software.

The computers are installed in high-traffic areas on employee turf, such as lunchrooms and lobbies. And, they are designed so any employee can operate them without external instructions.

The electronic communications programs, which are being developed by the employers themselves or by insurers and benefits consultants, can do just about anything the employer wants and is willing to pay for. They can help employees design their own retirement savings programs, choose appropriate options under a flexible benefit plan or understand a new wellness program or changes in medical coverage.

The cost of communicating electronically, which depends on the extent of the program designed, can range anywhere from a few thousand dollars a year on up.

But, the cost may be worth it. Computerized communications is being lauded by benefit experts. They credit it with increasing employees' participation in and appreciation of their benefits by forcing them to take an active role in understanding their plans.

Electronic communications programs also are easy to update when benefit plans are changed, and they allow

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Photo: Michael A. Marcotte

Employees at the Chicago operations of NBC, a unit of RCA Corp., use a personal computer to learn about their benefits.

Civil justice reform

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undermined by some newly invented doctrine or by the expansion of an existing legal theory.

- Even when there is agreement on intent, the size of awards often bears no economic relationship to actual damages.

- Determining insurance needs has become exceedingly more difficult because of the justice system's tendency to hold defendants liable for damages far beyond the degree of fault.

- Some attorneys seem to bring suits for the purpose of producing fees rather than seeking justice.

Mr. Noha said that even though he believes the civil justice system must shoulder the massive share of blame for these problems, the insurance industry is not entirely blameless.

"Insurers have made a number of mistakes, particularly in the way they've responded to the highly

competitive environment of the last few years," he said.

"This includes the direct insurers, of course, but it's also true that the availability of cheap reinsurance greatly exacerbated the problem.

"And so did the widespread action of agents who sold their products as commodities on price alone and underplayed their roles as responsible risk managers," according to Mr. Noha.

"I must also tell you that lack of effective solvency regulation in many states contributed its share to worsening this problem," he added.

Mr. Noha also pointed to the shrinking capacity of reinsurance and accelerating prices.

"Even responsible reinsurers are running scared in response to the excesses within the civil justice system. And the London market wants no part of it either," he added.

North American Re's Mr. Thompson said that due to the na-

ture and working of reinsurance, large liability exposures tend to accumulate disproportionately with reinsurers. And, the larger the liability exposure, the greater the uncertainty surrounding the outcome and expense.

"Reinsurers approach the unknowable with skepticism," Mr. Thompson said.

In his keynote address, Lloyd's Chairman Mr. Miller said:

"The present legal system in the United States makes it impossible for the liability or casualty insurer to operate, certainly to the extent necessary to satisfy the public's insurance needs. This stems from the total uncertainty facing an insurer as to how the U.S. courts will interpret various policy word-

"We need reform in so many areas—in limiting the abuse of the discovery procedures, in a reform of the contingency fee system, in a limit upon pain and suffering damages, in the elimination of punitive damages—to name but a few of the reforms which are necessary," Mr. Miller said.

"These will be incredibly difficult to achieve, but the problem of (shrinking) capacity will not go away until they are. I believe that we can no longer live with the uncertainty engendered by the vagaries of the American legal system as it stands today," Mr. Miller said.

The U.S. panelists agreed, and the insurer executives, citing the civil justice system as the cause, discussed recent coverage restriction

decisions.

For instance, Utica Mutual no longer will offer municipal liability coverage in New York state (BI, May 20). "Currently, we insure some 230 governments across New York state, and a year from now, we will insure none," Mr. Riffle said.

Utica Mutual is pulling out of this market, he said, because of the proliferation of suits. "Every time someone has an auto accident in New York state...the governments get sued."

He also noted the pure loss ratio on the business has risen to more than 200% in the past two years and the claims frequency is "frightening."

CNA, which has substantial experience in many difficult lines like professional liability, "has not been able to cope effectively with some of the ways the civil justice system affects (its) operations," Mr. Noha said.

To deal with the judicial system's "reinterpretation" of existing insurance contracts, CNA has introduced claims-made contracts in some professional liability lines; introduced partial or full pollution exclusions; placed legal expenses within policy limits in some lines; reduced limits of liability or introduced aggregate limits; and added exclusions to directors and officers policies for such activities as regulatory agency suits.

"In addition to changing language, we've been forced to take greater rate increases than expected as the mounting costs of the civil justice system have become more apparent," according to Mr. Noha.

Bituminous is taking similar action. Its president, Mr. Lardner, said the company won't provide coverage where it believes a loss is certain.

"We won't insure asbestos removal because we don't know how to do it... We won't insure community dump sites. I don't know how... We're avoiding anything that smacks of environmental injury liability because I don't know how to do it and none of the people I work with know how to do it," Mr. Lardner said, underscoring the uncertainty in the insurance market today.

But, Bituminous "is pricing fairly where there is chance, not a certainty, but a chance of profit," he said.

"We're working hard to meet the insurance needs of our customers on a responsible basis, while we avoid social problems, which we feel are not insurance problems," Mr. Lardner said.

Bituminous, as well as CNA and Utica Mutual, provide financial support to the Institute for Civil Justice. The institute is a research arm of the Santa Monica, Calif.-based Rand Corp., that studies the civil justice system.

"We're supporting the Institute for Civil Justice because I think independent research to quantify and evaluate the problem is a lot more persuasive than anecdotal statements such as mine," Mr. Lardner said.

"CNA strongly supports a number of proposed reforms. We believe regulators should be aware of specific solutions that will have a real impact on insurance rates," Mr. Noha said.

"Regulators also might want to monitor judiciary committees of legislatures for civil justice reforms, since many significant changes go through judiciary, rather than insurance committees in state legislatures.

"Research has shown that the reforms that would have a major effect on insurance rates are caps on non-economic awards, arbitration, mandatory offset of the award by collateral sources, caps on contingency fees, no-fault insurance and limits on punitive damages," he said.

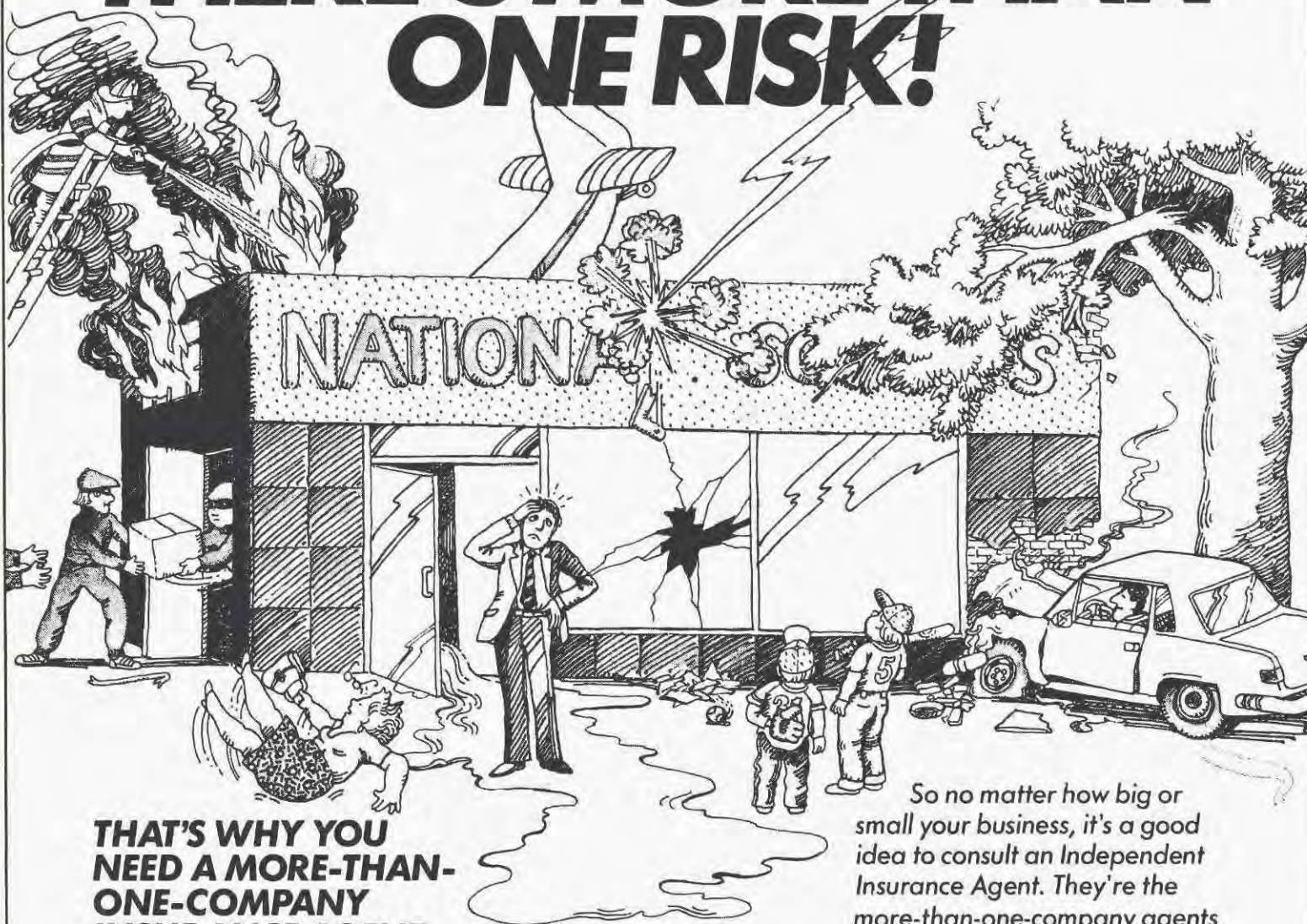


Mr. Thompson



Mr. Miller

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Coverage dispute

Continued from page 2

Harbor President Edwin V. Hughes would not comment on the ruling, except to say he "assumes" the insurer will appeal.

The decision also means that Andersen will not have to pay a \$952,000 deductible it would have been required to pay if the 1975 policy had been triggered. According to court papers, Andersen had already paid the deductible on the 1971 policy.

Under the 1971 policy, Andersen retained the first \$830,000 of each claim and paid 5% coinsurance on the first \$1 million of primary coverage provided. The \$3 million annual aggregate limit on the primary layer was subject to one annual reinstatement.

The 1975 policy provided \$101 million in coverage. Under this policy, Andersen retained the first \$952,000 of each claim. There was no coinsurance provision.

The \$10 million annual aggregate limit on the primary layer was subject to one annual reinstatement.

Harbor wrote 25% of a \$20 million excess of \$20 million layer of the 1971 policy, while it wrote 5% of a \$20 million excess of \$20 million layer of the 1975 policy. It also wrote 15.9% of the \$51 million excess of \$50 million layer of the 1975 policy, but that layer apparently would not have been tapped by the Fund of Funds claim.

In 1981 a federal court jury in New York ordered Andersen to pay \$80.7 million to Fund of Funds.

The mutual fund had sued Andersen, charging it with violation of federal securities laws, fraud and breach of contract.

This award was subsequently reduced twice by the judge hearing the case (*BI*, Aug. 9, 1982) and the suit was ultimately settled out of court in March 1983 for \$45 million.

All of Andersen's professional liability insurers on a \$50 million professional liability policy underwritten in 1971—except Harbor—indemnified Andersen for the \$45 million settlement.

At the heart of the coverage dispute was when Andersen's claim in the Fund of Funds lawsuit was actually filed.

Andersen put its professional liability insurers on notice in 1971 that the company had been sued in conjunction with the auditing of another firm.

This litigation, *Dietrich Corp. vs. King Resources Corp.*, was filed against Andersen in the U.S. District Court for the District of Colorado. Andersen was the auditor for both King Resources and Fund of Funds from 1968 to 1970.

The Dietrich litigation was a class action by securities and debentures holders of King Resources, seeking recovery against Andersen for wrongdoing in connection with the revaluation of certain properties owned by King Resources.

The case, in which the plaintiffs charged that Andersen overvalued these properties, was ultimately settled for an undisclosed amount.

However, apparently Andersen still had \$45 million in coverage remaining under the 1971 policy.

In 1975, Andersen was named by Fund of Funds in a suit that involved two issues.

One concerned its revaluation of certain properties owned by Fund of Funds that were related to those owned by King Resources. The Fund of Funds lawsuit charged that Andersen overvalued the properties. The second issue involved the pricing of property sold to Fund of Funds by King Resources while Andersen was auditor for both entities.

Following the settlement of the Fund of Funds lawsuit in 1983, Harbor sued Andersen, contending the settlement triggered Andersen's 1975 coverage—the year in which the Fund of Funds suit was

filed—not the 1971 coverage.

Alternately, Harbor argued that portions of both the 1971 and 1975 policies should respond to the Fund of Funds suit.

Harbor also argued that it was not obligated to follow the selection by the primary insurer of the year in which the Fund of Funds claim was made.

Andersen contended, however, that the Dietrich and Fund of Funds litigation arose out of related actions by Andersen and that its notification to insurers in 1971 regarding the Dietrich litigation also applied to the Fund of Funds lawsuit, even though that suit was not filed until 1975.

Andersen subsequently brought into the coverage litigation the more than 50 insurers that wrote its professional liability insurance in 1971 and 1975.

While most of the insurers agreed 1971 was the proper policy year to respond to the Fund of Funds suit, at least three other ex-

cess insurers paid their limits under a reservation of rights and filed counterclaims that 1975 was the proper policy year.

These insurers included American Re-Insurance Co., North Star Reinsurance Corp. and United States Fire Insurance Co.

They also alleged that the decision that the 1971 coverage should apply to the settlement was made in bad faith, though American Re has withdrawn its bad-faith allegations.

If the full limits of both policies were available to respond to the Fund of Funds settlement, it would appear that American Re would owe \$2 million under either of the policies.

North Star paid \$3 million under the 1971 policy but would only have had to pay \$500,000 under the 1975 policy.

U.S. Fire paid \$1.6 million under the 1971 policy but would have owed nothing under the 1975 policy.

In his June 7 ruling, Judge Dunne severed the bad-faith action from the coverage dispute and told the three insurers they could pursue it as a separate action.

"Under the circumstances, I agree with the decision that Lloyd's of London made and I adopt the arguments of... Arthur Andersen as the court's decision in this case," Judge Dunne said in his ruling from the bench.

"With respect to the counterclaim, though, I'm severing that and transferring it to the law division. If you want to litigate this bad-faith question, that's your privilege. If you want to conduct discovery on the bad-faith question, that's your privilege as well. But I do not perceive that to be, as it is presently... a matter for the court's concern."

An attorney for Andersen said the company was pleased with the ruling. "Obviously, we're very pleased," said Jeffrey Tone, with the Chicago firm of Sidley & Aus-

tin.

An attorney for the 1971 lead underwriter on the primary layer, a Lloyd's of London syndicate managed by Merrett Syndicates Ltd. and underwritten by Robin A. Jackson, said the decision avoids problems that would have ensued if excess insurers were allowed to determine what policy year applied to claims.

Howard Kastel, with the firm of McDermott Will & Emery, said the "viability" of insurance programs would have been at stake if the lead underwriter could not decide whether coverage should respond to a loss.

Assuming the full limits of the policies are available to pay the Fund of Funds claim, Lloyd's is liable for \$8.7 million of the settlement under the 1971 policy, but would have been liable for \$13.2 million under the 1975 policy.

Attorneys for U.S. Fire, North Star and American Re declined to comment on the ruling. ■

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Computerized programs require simple touch

To be successful, a computerized employee benefits communications program must be easy for employees to use and understand, say the insurers and consultants that market the programs.

When Metropolitan Life Insurance Co. developed a computerized employee benefits communications system, it first "test marketed" it on its own employees to make sure it could be used without "coaching."

"At Metropolitan, we have employees who have no computer training and don't even work with word processing equipment—and they walked up to it and used it with absolutely no problems," said Pamela Keeler, director of advanced benefits communications at Metropolitan in New York.

Computerized communications also must allow employees to absorb information at their own pace and retrieve information that requires review or clarification.

"What's ideal about the software is that it is as slow or fast as the employee," said Kim Hofmann, manager of William M. Mercer-Meidinger Inc.'s Communications Resource Center in Chicago, which designs computerized employee

benefits communications. "The employee is in the driver's seat."

The system should look as "friendly" as possible so as not to scare employees away. Its appearance also should serve to attract employees to use it.

For example, the system's name, "Showcase," intrigues employees, Metropolitan believes. "We wanted something that wasn't 'tech-y,'" said Ms. Keeler.

At Mercer-Meidinger the emphasis was on making the program for communicating 401(k) plans fun to use.

"It's really more like a computer game than it is a straightforward text," said Karen B. Greenbaum, senior communications consultant at Mercer-Meidinger in Chicago.

The program consists of screens of information accompanied by attractive, colorful, dynamic charts, graphs and pictures. For example, instead of graphics flashing on the screens in finished form, they're "drawn" on the screen as the employee watches.

The Wyatt Co. in Chicago and Hewitt Associates in Lincolnshire, Ill., also offer computerized benefits communica-

tions programs.

Wyatt offers two versions of a computerized 401(k) communications program, called "WISE" (Wyatt Investment Savings Statement). One is appropriate for a plan in which the company matches employee contributions. The other is designed for a plan to which the company doesn't contribute. The customized software costs between \$2,000 and \$3,000. Programs are maintained and updated for an annual fee of about \$500, according to Mike Tomback, a communications consultant at Wyatt.

Hewitt Associates offers clients three computerized communications programs: a retirement planning program, a 401(k) program and a flexible compensation program.

The flexible compensation program explains the plan to employees and allows them to complete hypothetical enrollment forms on the computer to see the effect of different combinations of choices. Once the employee decides which options are best, he or she can instruct the computer to make a printout of those choices. The employee then simply transfers the information on the printout to the plan enrollment form.

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¹ 1964 Commissioner's Disability Table

^{*} Product not approved in all states. All benefits are not available to all occupation classes. Benefits may vary in certain states.

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Communications

Continued from page 3

benefit department personnel to expand their duties beyond addressing employees' queries.

"When you look at the growing complexity and types of benefits plans, there is a need for employees to become more knowledgeable and, oftentimes, more active in their plans," said Pamela Keeler, director of advanced benefits communications for the Metropolitan Life Insurance Co. in New York.

Under the direction of Mr. O'Donnell, RCA designed its own electronic communications system—the Employee Information System. It contains information on all of RCA's benefit plans, including health care, life insurance, long-term disability, retirement programs and savings plans.

To use the system, employees go to any terminal and enter their Social Security and employee identification numbers.

The computer responds with a "menu," or list, of the employee's benefit plans. The employee then selects a plan and the computer runs through a series of screens of information.

To eliminate confusion, RCA designed a metal overlay that covers the computer keys that will not be used by the employee. This also prevents employees from tampering with the computer.

After benefits information has been presented, employees can opt to be quizzed by the computer to make sure they understand their benefits. If this option is chosen, a series of multiple-choice questions appears on the computer screen, and the employee types in his or her answers.

If the employee answers a question correctly, he or she proceeds to the next question. If an answer is incorrect, the employee can try to answer the question again or ask the computer to display the correct answer. And, they can ask the computer to display information that explains the correct answer.

The computer also allows the employee to "ask" the computer questions by creating hypothetical situations.

For example, an employee can "ask" the computer how the deferral of a specific percentage of salary into the company's 401(k) savings plan will affect his or her taxable income and how much that amount will yield in savings after a specific period of time. The employee can type in several hypothetical deferral amounts and see what the effect of each will be.

To test the useability of the program, employees were asked, one at a time, to run through the program without assistance. Then, the group discussed their reactions to the system.

"The reaction was very, very
Continued on page 10

opinions

An important statement

WHETHER OR NOT the Bermuda government's petition for a court order liquidating Mentor Insurance Ltd. is granted by the Bermuda Supreme Court, the government's very act of seeking the petition makes an important statement to everyone who owns a Bermuda-based company or does business with a Bermuda-based insurer.

And, the government's action will benefit the insurance and reinsurance policyholders of Mentor.

By petitioning for a liquidation order, the Bermuda insurance regulators have put everyone on notice that they will enforce the Insurance Act of 1978 as their judgment dictates, even if that means going to court against a major U.S. corporation such as Ocean Drilling & Exploration Co., the owner of Mentor.

In the past, questions have been raised about the Bermuda government's willingness to enforce its insurance law. It has been asked if the government would risk the loss of new or existing insurance companies whose owners might not want to operate in a domicile that vigorously enforces its insurance law.

Such questions have contributed to some observers' qualms about the financial security of insurance companies with a Bermuda license, costing Bermuda-based companies not only respect but business.

Now, insurance buyers and insurance companies licensed elsewhere in the world are likely to afford more respect to a Bermuda-licensed insurer.

The scope of the petition for liquidation of Mentor is not certain, since the petition is not yet public record in Bermuda. But, it is known throughout the insurance community in Bermuda that the government petition cites a section of the Bermuda insurance law governing the liquidation of insolvent companies.

We are not at this time judging the merits of the government's petition or the assertions by Mentor that the company has sufficient assets to cover its ultimate liabilities. We do not have access to the financial state-



ments to do so. It is up to the Bermuda court to determine whether the liquidation is warranted.

But no matter how the court rules, the interests of Mentor's policyholders will have been protected by the government's aggressive action.

If the court finds that the petition is justified and orders the liquidation of Mentor, then Mentor's insurance and reinsurance policyholders will be protected by a liquidation that fairly allocates assets to creditors.

If the court refuses to grant the petition, Mentor's policyholders will be assured that there are sufficient assets to cover Mentor's ultimate liabilities. And that would provide an element of certainty that is greatly valued when an insurer is running off its business.

letters

Are casualty insurers taking policyholders for a ride?

To the editor: The current underwriting approach of the casualty insurance industry (sharply increased premiums accompanied by reduced capacity), coupled with the Insurance Services Office's recommended new commercial general liability claims-made form and the current ISO study for the charging of defense costs against the aggregate policy limit, bears a striking resemblance to past actions of the local Regional Transportation Authority here in Chicago.

The RTA increased the fares and reduced the hours and frequency of service provided to its patrons.

As one wag said at the time, "One wonders when they are going to take out the seats."

That question was answered recently, when the Regional Transportation Authority did in fact announce a proposed reduction in the number of seats on buses and rapid transit cars—"in order to improve service."

If the insurance industry doesn't have the brains or courage to solve its problems without transferring the risk of uncertainty back to the insured and controlling its own cost of defense (not the insured's), we are indeed in for a bus ride down a descending road—and probably without any seats.

Thomas R. Wiley
Vp
Schwartz Brothers Insurance Agency Inc.
Chicago

Courts should not decide what broker a buyer can use

To the editor: Regarding the court injunction to limit a buyer's ability to switch brokers (BI, April 22), my business contacts tell me that any "non-compete" agreement is difficult to enforce. In my judgment, they can (and should) be viewed as nothing more than gentlemen's agreements. Their effectiveness must necessarily rest on the integrity of the parties entering into the agreement. Presumably, those parties recognize the significance of the agreement and should not be allowed (or required) to test the agreement in court.

Firms change brokers for a reason. While these reasons are many and varied, I believe one can generalize and say that

moves are normally made in the interests of some combination of better prices/service/value. When any broker fails to measure up to the expectations of his client, he should not be surprised to learn that he has lost the business.

Granted, this is not an easy matter to resolve and there are likely cases where a broker wins an account only to see it fol-

low an employee to another firm. However, my vote as a risk manager is to tolerate these situations as a business "risk" rather than have the courts decide what broker a firm must use.

R.H. Bagley
Risk Manager
BellSouth Corp.
Atlanta

Cost-control programs generated savings

To the editor: The "more than \$200 million" saved last year through cost-containment programs for John Hancock Mutual Life Insurance Co. clients did not "reflect changes in benefit plan designs like increased coinsurance and deductibles" as stated in your cost-containment issue (BI, March 18).

The more than \$200 million savings for the most part was attributed to cost-containment programs including coordination of benefits, the monitoring of reasonable and customary charges, using generic drugs, pre-admission certification, hospital reviews and second surgical opinions.

John Hancock also was not mentioned in your report on benefit modeling and

benefit data services, although an article on our system was previously published (BI, July 9, 1984).

John Hancock developed the first comprehensive benefit modeling system that not only recalculates each claim but also measures the behavioral effect of plan design changes in addition to projecting the savings attributable to the adoption of cost-containment programs.

Robert J. Grudzinski
Director
Group Insurance Claims
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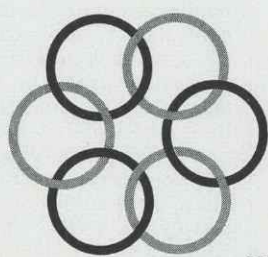


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Benefit plans

Continued from page 7
positive," Mr. O'Donnell said. "We found that employees had no problems using it."

Mr. O'Donnell said he gave the system a rather general name because "we didn't want to limit it to just benefits. We plan to use it for other things too, like employee training, announcements and notifications of job openings."

The sequential screens may be replaced by an interactive videotape in the future, Mr. O'Donnell said.

"It makes more of an impact on an employee to have a (videotaped) nurse explaining health care, rather than just reading textual information on a series of screens."

Overall, Mr. O'Donnell is pleased with the electronic communication program.

"We saw a way to increase the productivity of our benefit people who can now spend less time an-

swering questions and more time working on the substantive aspects of their job. At the same time, employees can get the information they need in a very efficient way."

NCR Corp. in Dayton, Ohio, is using a computerized program designed by Hewitt Associates in Lincolnshire, Ill., to communicate its new, multi-option retirement program to employees.

The new retirement program, which was effective May 1, includes a defined benefit pension plan based on career average earnings, a profit-sharing plan, a 401(k) savings plan and a payroll-based employee stock ownership plan.

The multiple-investment program replaces a defined benefit pension plan based on the average salary earned by an employee during his or her five highest-paid years over the last 10 years.

The computerized communications program, "EstiMATE," figures each employee's potential retirement income, including employer-provided income, Social Security and personal savings and investment programs.

Employees can base investment choices on information provided by the computer showing how such choices will specifically affect their retirement income. "It lets the employee see the effect of any of the various scenarios he can conceive of, so that he can see the impact of his investment choices," said Douglas M. Bartlett, director of U.S. employee benefits for NCR.

Beginning in August, American Express Co. will have a computer in the lobby of its New York headquarters that will communicate the company's 401(k) savings plan to employees.

The system, designed by Metropolitan Life Insurance Co., will operate for a six-month trial period.

"It's kind of a fun way to learn about benefits," said Margaret Gagliardi, vp of employee benefits and health services for American Express. "We do all the traditional forms of communication, but we feel this will be a useful tool to encourage people to become familiar with the plan and to motivate them to participate in it."

Ms. Gagliardi said she is hoping for a 75% usage rate during the pilot program.

"I have no doubt in my mind that it will be successful, and therefore, I have no doubt in my mind that the program will be continued" after the six-month trial period, she said.

On April 1, Eastman Kodak Co. in Rochester, N.Y., also launched a six-month pilot program using Metropolitan's computerized communications system to explain four benefit plans.

The seven terminals, which have been available to 7,000 employees at four locations, have had a 50% usage rate so far, according to Paul Allen, senior editor of employee information in Kodak's corporate communications department.

"They're not much more complex than a push-button phone," Mr. Allen said. "We've pretty much designed it for people who are not computer-literate."

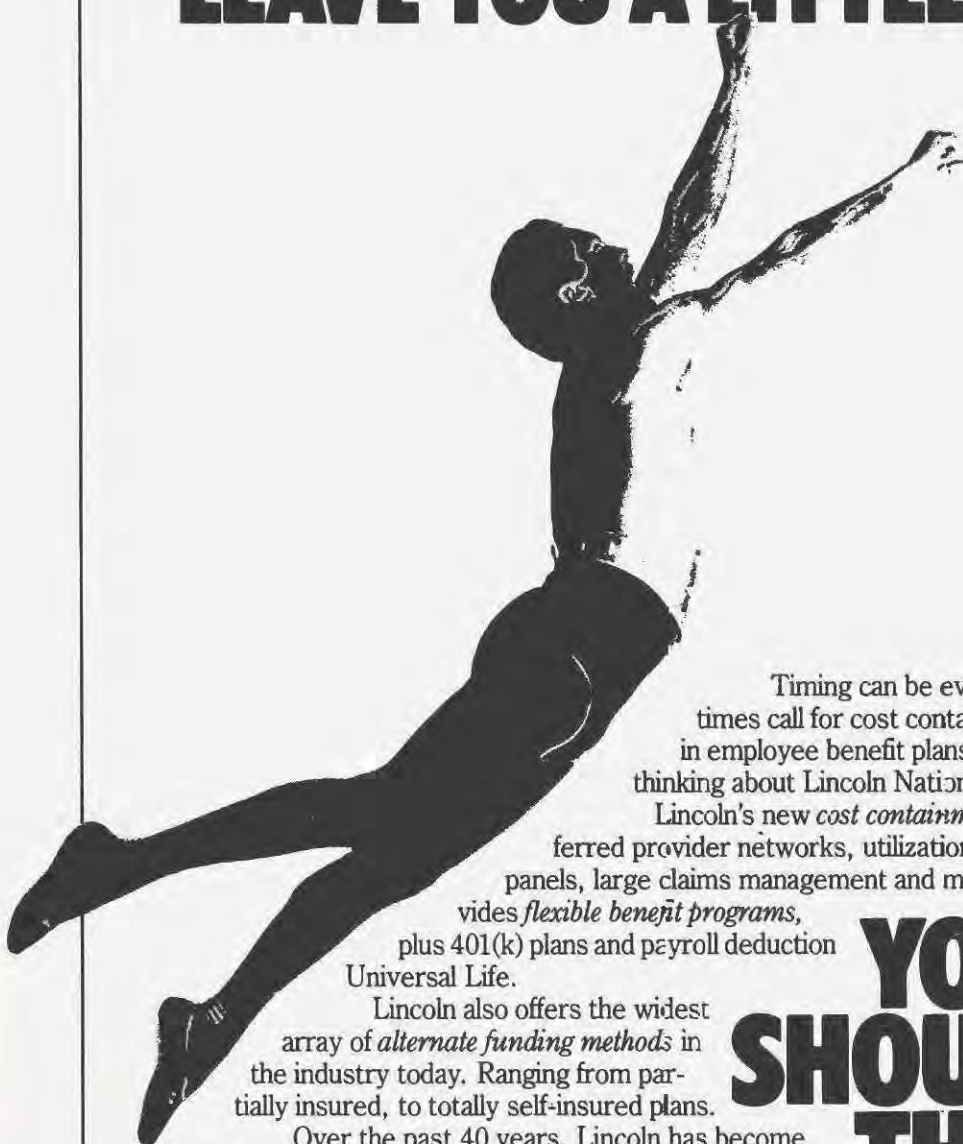
The Kodak system explains and compares the choices available to employees under its flexible health care plan. It also explains the options available under a flexible life insurance program, showing the employee how much life insurance he or she has, based on which option the employee chooses.

Two interactive programs also allow the employee to ask the computer questions, and explain Kodak's 401(k) plan and tax withholding.

Through the 401(k) program, employees can check their account balance, how much of that balance is available for the employee to borrow, and the impact of a loan repayment on the employee's paycheck. (Under the plan, the com-

Continued on page 12

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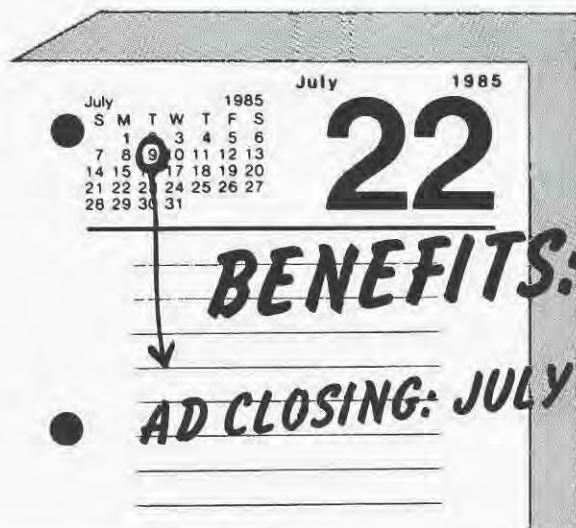
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Benefit plans

Continued from page 10

pany will loan employees up to 50% of their account balance to a maximum of \$50,000. The money in the their 401(k) accounts serves as collateral.)

The tax-withholding program allows employees to see how changes in their income and exemptions will affect their paychecks.

Although Kodak gives employees printed material on their benefits and has personnel available to answer employees' questions, the computer is a valuable supplement to these traditional communications methods, Mr. Allen says.

"During the year, if an employee has a question or is considering changing something, the only way for him to get information is to go to an employee relations person," Mr. Allen said. "They may not have the time to do that or may not be able to get an appointment with

(an employee relations person) because they're fairly busy.

"These machines are within walking distance (of an employee's work station) and, in a five-minute session with the machine, they can probably get their questions answered."

The Hanes Group of companies — which includes L'eggs Products Inc., Hanes Hosiery Inc. and the Bali Co.—are using a computerized communications system developed by William M. Mercer-Meidinger Inc. to communicate their 401(k) plan, which will be offered on July 1.

The computer program was instituted as part of a communications package, said Karen B. Greenbaum, senior communications consultant at Mercer-Meidinger.

"We did a videotape and a slide show, but the real problem was that employees didn't know how this was going to affect them exactly," she said.

They wanted to know how their participation in the plan would affect their paychecks specifically and how much they ultimately will have saved for retirement, she said.

The computer's ability to communicate this information has been a strong incentive to employees to participate in the program, Ms. Greenbaum said.

"Often, the reasoning, especially on the part of younger employees, is, 'I can't afford to save for my retirement now. I have other things to spend my money on,'" she explained. "But, when they actually see the projected figures, that's impressive."

"When they see how (their contribution) grows in 10 or 20 years, employees realize that they can afford to participate—in fact, they can hardly afford not to participate," Ms. Greenbaum added.

Employees also can print out information on the effects of various contribution choices and take the printouts home to discuss their plans with their families.

"We think it's important to get the families as involved as possible," said Ms. Greenbaum.

"The printouts are a real nice feature because the employees can take them home and show them to their families."

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Group to fight work comp tax

COEUR D'ALENE, Idaho—State workers compensation administrators are planning a lobbying effort against proposed revisions in the Internal Revenue Code that call for taxing workers compensation benefits.

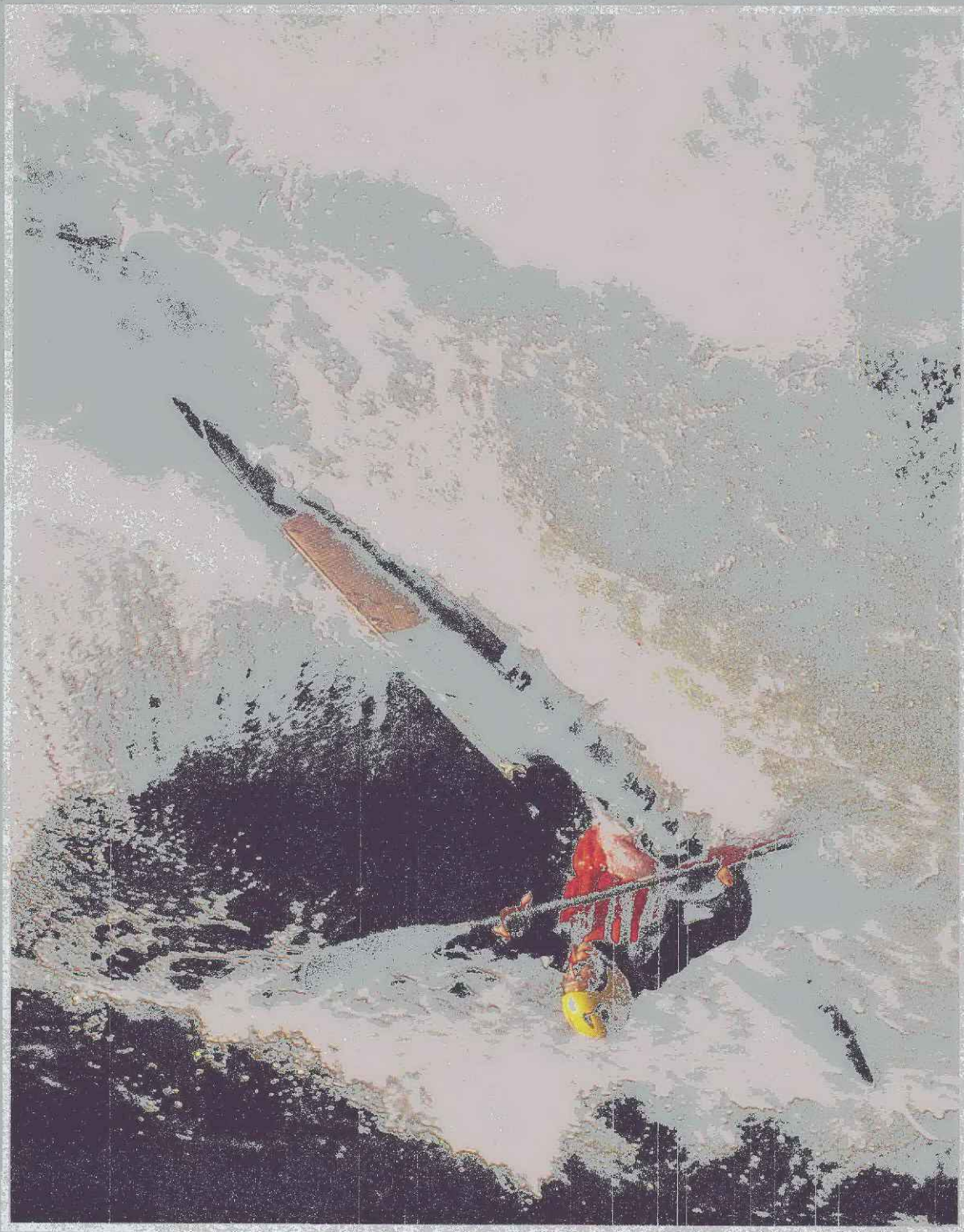
The Legislation Committee of the International Assn. of Industrial Accident Boards & Commissions adopted a resolution last month opposing the provision in President Reagan's tax simplification plan that calls for taxation of workers compensation benefits (BI, June 3).

The committee's action took place during the IAIABC's All-Committee conference, in preparation for the association's annual meeting, slated for August.

However, rather than hold final action on the resolution until later this summer, the executive committee was expected to be polled for final approval of the resolution and the lobbying efforts should be underway soon, according to Robin W. Waller, chairman of the committee and commissioner with the Connecticut Workers' Compensation Commission.

Members of the IAIABC will write President Reagan and members of Congress directly to oppose taxing workers comp benefits, according to Mr. Waller. The members also will write national business and labor leaders, urging them to do the same, he added.

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HCS

Comp benefits halted for family of worker who died during sex

By MEG FLETCHER

LANSING, Mich.—The Michigan State Workers Compensation Appeal Board says the family of man who died of carbon monoxide poisoning while having sex with a co-worker should not receive additional workers compensation benefits.

The appeals board rejected an earlier decision by an administrative law judge who found that the death of Domenico Signorelli, who was on an overseas training program when he died in 1979, was work-related.

By its decision, the appeals board blocked payment of potentially more than \$129,500 in additional benefits to Mr. Signorelli's family. They already have received about \$31,000 in benefits, which they can keep.

Mr. Signorelli's survivors are seeking to appeal the board's decision to the state Court of Appeals.

Mr. Signorelli, 37, was a project engineer for GKN Automotive Components Inc. of Southfield, Mich., where he had worked less than two months before being sent to England for training. He collapsed March 23, 1979, in his secretary's London apartment after the two had sex near a faulty space heater. He lapsed into a coma and died; his secretary recovered.

GKN Vp Frank Mordell said the company was "encouraged" by the appeals board's decision. "It would appear that the decision may signal a start toward sensibility in workers compensation laws in this state. However, the decision may have been rendered because of the notoriety in this case and it is probably somewhat subjective," he said.

A spokesman for Zurich-American Insurance Co., GKN's workers compensation insurer, said the insurer was "pleased" with the decision.

The appeals board decision, written by Nancy J. Day, noted Mr. Signorelli's workday ended at 5 p.m., and "We can find no business purpose whatsoever for his visit to (the secretary's) flat several hours later."

In his March 1980 decision granting benefits to Mr. Signorelli's family, Administrative Law Judge Leo LaPorte said Mr. Signorelli's work assignment in England "exposed him to situations and hazards that were different in nature and degree than those found in Michigan."

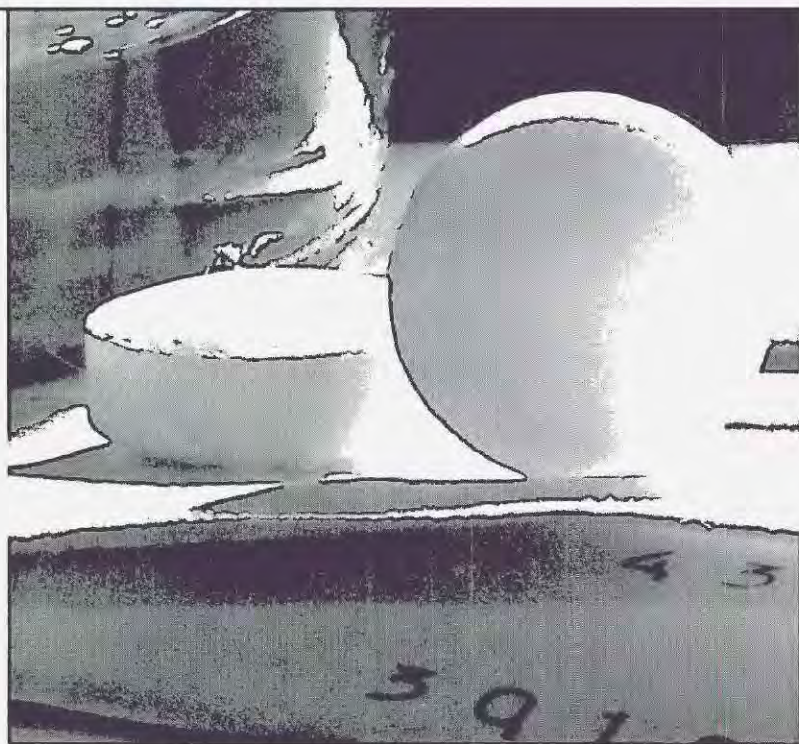
"Man is by nature a social creature. It is not reasonable to expect that an employee who is on assignment in a distant land will simply stare at the walls of his hotel room after work," his opinion said.

That decision may have influenced the Legislature to modify the work comp law so an employee killed or injured on the job would be ineligible for benefits if the "major purpose" of his activity was "social or recreational," said Karl Benghauser, appeals board chairman (BI, April 5, 1982).

The appeals board's decision stops workers compensation benefits to Mr. Signorelli's survivors. While the case has been under appeal, Gayle Signorelli, Mr. Signorelli's widow, and two dependent children received 70% of the benefits they were granted by Judge LaPorte, or a total of about \$31,000. Ms. Signorelli and the children were entitled to receive \$167 weekly until Ms. Signorelli's remarriage made her ineligible for benefits. Her two children subsequently were entitled to \$161 per week.

If their appeal is unsuccessful, the survivors will not have to repay the benefits they have received. Zurich-American will be repaid from the state's second injury fund, Mr. Benghauser said.

If the appeal succeeds, Mr. Signorelli's widow will receive the additional 30% she was entitled to until her remarriage, plus interest and a \$1,500 burial benefit. Her children will have their full benefits reinstated with interest until they turn 21.



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Tort reform measure introduced in House

By JERRY GEISEL

WASHINGTON—A second federal product liability reform bill is now before Congress.

Rep. Norman Shumway, R-Calif., late last month introduced

legislation, H.R. 2568, in the House that would pre-empt state tort laws with a uniform federal product liability law. Sen. Robert Kasten, R-Wis., earlier this year introduced a federal product liability bill, S. 100 in the Senate.

The Shumway bill has been introduced in previous congressional sessions but, unlike the Kasten bill, has never come up for a vote (BI, May 9, 1983; March 15, 1982). The Senate Commerce Committee last month declined to report the Kasten bill to the full Senate until more hearings are held (BI, May 28).

While both the Shumway and Kasten bills propose the pre-emption of state tort laws with a federal statute, there are major differences in the bills. Lobbyists have described the Shumway bill as a "wish list" of everything manufacturers would like included in a federal product liability, while the Kasten bill doesn't go as far in reducing manufacturers' exposure to product liability suits.

For instance, the Shumway bill would limit punitive damages to twice a plaintiff's actual damages, not to exceed \$1 million.

By contrast, the Kasten bill does not place a monetary cap on punitive damage awards. Instead, it says that punitive damages only could be awarded in cases where the harm suffered was the result of "reckless disregard" for the safety of product user. In addition, judges, not juries, would set the amount of an award.

Under the Shumway bill, consumers generally would be barred from filing personal injury suits in cases involving products more than 10 years old. In cases where the injury is caused by prolonged exposure to a product and may take years to manifest itself, the statute of repose would be 15 years.

As a result, the Shumway bill would, if enacted, protect manufacturers of asbestos from thousands of future product liability suits.

washington

Exposure to asbestos has been linked to various diseases, including cancers. However, these diseases may not manifest themselves for decades.

The time limitations on filing suit based on the age of a product only would apply to suits filed after the Shumway's bill's effective date, which is 60 days after enactment.

Sen. Kasten's bill would bar product liability lawsuits in cases involving major capital goods that are more than 25 years old. No time limits would apply for consumer products, home appliances or in cases where the injury was caused by prolonged exposure.

The Shumway legislation would also absolve a manufacturer from liability if its product complied with mandatory federal, state or local contract specifications unless the product was available commercially. The Kasten bill lacks a similar provision.

Rep. Shumway's bill would allow introduction of expert testimony in a case only if corroborated "by substantial objective evidence based on generally accepted scientific or technical knowledge." There is no similar provision in the Kasten bill.

The bills have some similarities. Under both the Shumway and Kasten bills:

- Manufacturers no longer could be held liable for failing to warn of obvious product dangers.

- Product liability awards would be reduced by the extent that a plaintiff's negligence caused an accident.

- Manufacturers would be protected from product liability suits if their products were altered or modified without their permission and the alteration caused the accident.

The Shumway bill, known as the Product Liability Act of 1985, has been referred to the House Energy and Commerce Committee.

lawful speed when he applied the car's brakes "without effect" to avoid hitting a car in front of him. Mr. Heftel then steered to avoid a collision and hit a tree. He was knocked unconscious and sustained injuries to his head, face and various parts of his body. He also suffered extreme "pain and suffering," according to the suit.

Rep. Heftel's staff did not comment on whether the congressman has taken a position on federal product liability legislation.

A Washington-area auto dealer and leasing company also are named in the suit.

Mandatory retirement

Employers no longer could force employees to retire when they reach age 70 under legislation, S. 1054, introduced by Sen. John Heinz, R-Pa. The measure would amend the Age Discrimination in Employment Act, which now allows companies to force workers to retire at age 70.

Eliminating mandatory retirement will "remove the most visible symbol of age discrimination in the work place," Sen. Heinz said.

If enacted, by Congress, the measure generally would go into effect on Jan. 1, 1986. However, in the case of employees covered under a collective bargaining agreement, the effective date would be delayed until Jan. 1, 1989, or the expiration of the agreement, whichever comes first.

Sen. Heinz introduced a similar bill during the previous congressional session, but no action was taken.

OPIC authority

The underwriting authority of the Overseas Private Investment Corp. would be extended another four years under legislation introduced in the House.

Legislation, H.R. 1988, sponsored by Rep. Don Bonker, D-Wash., would extend OPIC's insurance programs through 1989. OPIC's underwriting authority expires on Sept. 30.

OPIC is a federal agency that sells political risk insurance to U.S. companies investing in less-developed countries abroad. The coverages written by OPIC protect companies' overseas investments against losses resulting from currency inconvertibility, expropriation and war and revolution (BI, May 27).

The legislation also would allow OPIC to provide coverage for business interruption losses.

Under current law, OPIC generally cannot provide coverages for investment projects in countries with a per-capita annual income of more than \$2,950. Rep. Bonker's legislation would increase that threshold to \$3,887. In addition, the legislation would require OPIC to give preferential consideration to investment projects in countries that have a per capita income of less than \$896, up from the current per capita threshold of \$680.

Congressman sues

A Hawaii congressman is seeking \$5 million from General Motors Corp. for injuries he incurred in May 1983 while driving a 1983 Oldsmobile.

A lawsuit filed in U.S. District Court in Washington by Rep. Cecil Heftel, D-Hawaii, charges that the brakes on the Oldsmobile Cutlass Ciera were defective.

In addition, Rep. Heftel said GM should be liable because the company did not equip the car with air bags or other passive restraints.

GM "knew or reasonably should have known" of passive restraint technology and the failure to include passive protection "constitutes a defect..." according to the suit.

The absence of passive restraints was the proximate cause of the injuries and harm suffered by Rep. Heftel, according to the suit.

Rep. Heftel now drives a Mercedes-Benz equipped with air bags. GM has denied the charges and said it will contest the suit.

According to the suit, Mr. Heftel was driving at a reasonable and

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MALVERN, Pa.—Video and audio tape recordings of the Society of Chartered Property & Casualty Underwriters' recent national teleconference are now available.

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SEARCH FOR STABILITY

Industry must solve problems that undermine a stable market

By Franklin W. Nutter

AS AT ANY POINT in time, insurance industry executives and analysts are focused on the industry's operating results, company ratings, the market's capacity needs and the direction of rates. Current market conditions dominate the trade media and industry meetings. Bear with me if you will when I suggest that something is occurring (and should occur) that is more fundamental to the business and more important than today's rate increase and the latest report of operating results.

Ten years ago John Carleton, then senior vp of Liberty Mutual Insurance Co., raised before this same annual gathering (the annual meeting of the Alliance of American Insurers) a self-evident truth: Insurance is based on the premise that stability is a "good thing." Such stability, he asserted, manifests itself in company financial strength as well as policyholder confidence and loyalty to a single company over time.

I suggest that Mr. Carleton could not have been more correct at that or any other time nor more distressed and disillusioned by the market's performance in the intervening 10 years.

Stability lacks excitement. I believe, however, that today's industry is now reacting to the excesses in its environment and seeking stability, or at least certainty, as best it knows how, and that such efforts have far-reaching consequences for the role government takes in our business, for the expectation of the insurance-buying public and for the long-term operating performance of its member companies. I would like to address that environment, the industry's response to it and the ramifications of these responses.

Key developments that have contributed in recent years to the instability of the industry's environment include:

- Risk management by commercial enterprises. In commercial lines, insurers today are faced with an increasingly informed and sophisticated buyer. To the purchaser, insurance is no longer a mystery not worth solving. The buyer has created or has access to captives and the use of risk management counseling. He or she uses the private market to shift higher exposures and self-insures on a more-informed basis. Commercial buyers generally understand their own financial infrastructures and that of the insurance industry.

- Shift to casualty lines. The industry has shifted a dramatic measure of its surplus to casualty lines. In so doing, it faces increased difficulty in estimating its future costs for a product it prices today. As a cost-based product, casualty insurance challenges insurers to price on the basis of past losses that do not necessarily reflect future trends. Lengthy claim development, inflation and the expansion of the concepts of liability inhibit accurate pricing. Solvency concerns become increasingly important and more difficult to guarantee because of the subjectivity of assessing future exposure.

- Entry of non-insurance capital and affiliation of financial service products. The affiliation of insurers with other financial service industries as well as traditional product manufacturers has resulted in new capital, new management philosophies and new corporate goals into which the insurance company must mesh.

- High-yield investments. Much has been written about cash-flow underwriting to generate investment dollars. As a result of high investment yields, evaluation of performance by underwriting results has

given way to evaluation by underwriting results.

- The basis for liability has become uncertain. The necessity of insurance is established by the desire for security—threatened by the prospect of liability. The liability system is fuel for the insurance engine. However, rapidly expanding theories of liability, unpredictability in assessing risk for insureds and insurers and judicial interpretation of insurance contracts on the "reasonable expectation of the insured" have distorted the stability of insurance coverage.

As stated by a dissenting judge in a recent case: "The decision makes the contents of a written insurance policy irrelevant in the determination of coverage. Any person who reads his insurance policy would be a fool, since it is far better to plead ignorance. . . ." (*Darner Motor Sales vs. Universal Underwriters*, Supreme Court of Arizona).

- Marketing creativity. Customer loyalty and, therefore, company stability are under attack by the industry's own creative marketing: department store outlets, aggressive commercial marketing and ties with financial institutions.

Writing in February 1963, J.W. Gunn of Employers Mutual Insurance Co. set forth a highly accurate, if not

'Today's industry is reacting to the excesses in its environment and seeking stability. . . as best it knows how, and such efforts have far-reaching consequences.'

as yet completely fulfilled, prophecy regarding the then-newly proposed competitive rating laws:

"The proposed change would promote all-out unrestricted rate-cutting to a degree not seen since the last century. Only a few big combinations could afford the underwriting losses that would follow, and in the end, the federal government would have to step in and save the industry from its own folly."

With that warning, into this environment of destabilizing factors, legislatively permitted, regulatorily encouraged and market-driven open competition enters. In its wake occur several significant developments.

Notably, regulators become less able to stabilize prices. This, of course, is exactly what was intended. However, the companies themselves begin to de-emphasize underwriting in several major lines and loss control and safety engineering—both fundamental aspects of the insurance concept. As a result of the highly competitive rate environment, underwriting is diminished as a barometer of insurability of certain products, services and risks.

In this deregulated environment, courts drift toward adjudicating cases solely on the facts before them—taking into account the deep pocket, but minimizing the public policy issues raised for established concepts of liability, insurance coverage and contract integrity. The process tends toward a compensation system and away from a fault-based one.

Open competition leads as well to the disappearance of the traditional underwriting cycle, which appears to be indigenous to a regulated pricing system. While the cycle might be viewed as a historical anachronism, it traditionally has served as a guidepost to companies on operating performance and industry trends.

Competitive rating laws and regulations are the manifestation of the competitive environment, not the cause of it. I do not condemn the laws or the environment. However, competitive rating has raised as yet unresolved questions and caused the industry to seek stability through other methods as best it can.

The jury probably is still out in the question of whether, under competitive rating, market forces will

regulate for rate adequacy. Even if we agree that this will occur over time, we must conclude that interim dislocations creating affordability problems and company financial hardship result. I believe we also can agree that open competition has restricted a company's ability to obtain completely adequate information to assess its exposures and be informed of its competitors' activities. Such a result may be exciting economic theory but questionable public policy if a continuously stable financial condition is a desired goal.

The conditions cited above as having a destabilizing impact on the industry indeed have led to solvency and financial concerns, but have caused a more subtle development with far-reaching consequences. The implications of this now may be seen in individual and collective corporate actions—indeed, sound and advisable ones—to seek certainty in the insurance business.

Faced with instability, insurers have three options: change their environment, restrict coverage and modify prices to reflect exposure. In search of certainty, insurers are proceeding with all three. Their efforts are directed toward:

- Reform of the civil justice system and the liability framework that fuels it. Radical reform is not the goal; such reform only creates greater uncertainty. The system generally has been good to the insurance concept.

- Capping defense costs. This initiative changes a fundamental part of the current coverage, but imposes a governor on this dramatically uncontrollable cost.

- Coverage modifications through claims-made contracts and coverage restrictions, notably environmental coverages and pollution exclusions.

- Guaranty fund modifications designed to limit coverages and further fix assessments to mitigate the possible domino effect and clearly establish exposure.

- Price increases to recoup known losses and more accurately price future ones.

The drive to re-establish certainty is in part designed to remedy the expectation of the insurance-buying public—not just for the right to insurance, but for the right to recover damages at all. The industry's actions are in part a statement that the competitive rating environment brings into question the widely held, but inaccurate, belief that insurance is, in all cases and at all times, a mere pass-through mechanism. The message is clear: Insurers are not the bankers of the tort system, and insurance, although probably the most efficient system of risk distribution ever devised, cannot accommodate every social and economic demand placed on it.

Initiatives such as these on the part of insurers raise a fundamental question about insurance as a social institution and as part of the public policy process of addressing social and economic demands of our country. It would be difficult to dispute that insurers have created a demand for the security their product brings and that business and the public have been conditioned to the need.

Moreover, the industry, for the most part, has opposed government assumption of risk and coverage. There clearly exists an expectation of insurance for new products and new technology.

The question is thus posed: What is the industry's social responsibility when it cannot fulfill the expectations of government, commerce or the public? Are there indeed "uninsurable risks?"

From my perspective, political reality may dictate the answer. Legislators cannot be expected to permit people to be forced out of business, to forgo new technological development, to be denied care, environmental security or protection against catastrophic risk for lack of insurance. If the past is prologue, withdrawal from lines of insurance, types of coverage or insurance markets will lead to the following government alternatives:

Continued on next page



This article is the text of a speech made by Franklin W. Nutter, president of the Alliance of American Insurers, to the annual meeting of the Alliance on May 15.

RMIS should make risk manager's job easier

WHAT CAN A risk management information system do for you?

Many erroneously consider the RMIS as a glorified filing cabinet. Others mistakenly misjudge it as a super-calculator designed to replace all thinking processes.

Both extremes are inaccurate.

The objective of an RMIS is simply to make the risk manager's job easier and more productive. To illustrate this objective, five key uses of an RMIS will be traced, in ascending order of sophistication:

- **Data base management.** Beyond the advantages an electronic filing cabinet provides, an RMIS' data base management system can categorize and correlate many unrelated files of exposure data, claims information, personnel records and any other pertinent information from other departments.

Whereas, under a manual system, the user may spend minutes and even hours compiling research material to answer simple questions, a well-constructed data base management system provides the desired material in seconds or minutes through a variety of formats.

In other words, a well-designed data base and data base management system should be able to:

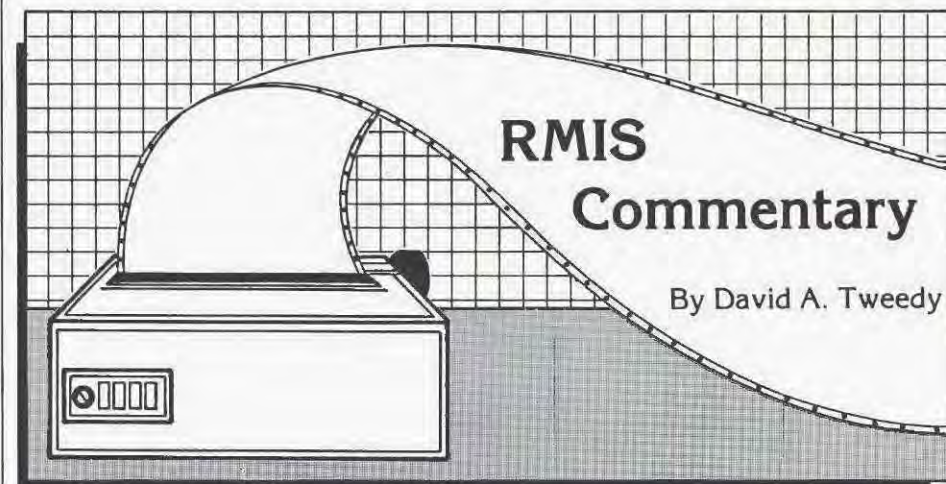
- Respond to a variety of inquiries, including ad hoc ("what if") queries, as well as enter and refine exposure data as necessary.
- Allow creation of new data bases by the user.
- Direct subsets of the overall data base into formats for financial analyses (forecasting, reserve analysis, etc.).
- Produce a variety of customized or standardized reports with necessary graphics as needed.

For example, suppose a risk manager desired a breakdown of claims by state,

reserve amount (only reserves exceeding \$25,000 aggregate), for back-related injuries only. With necessary data already existing in memory, the risk manager only needs to set specific parameters supplied by the RMIS' data base management component. The report will be produced quickly.

When comparing the time expended under a manual setup vs. the RMIS-generated information, it is plain to see the advantages an RMIS offers to the risk manager in handling the continual line of questions of this type.

• Claims and loss control/



prevention management. One result of a well-designed data base management system is a responsive and comprehensive claims management tool. Whether monitoring the activities of a claims department of an insurance company or a claims administrator in a self-insured situation, the RMIS is a valuable tool to the risk manager. Not only can the efficiency of adjuster be measured—i.e., ratio of open to closed cases, measurement of elapsed time between claim report and adjuster contact, etc.—but also associated claims expenses (legal costs) can be monitored and evaluated per location or profit center. And, if specific, detailed information is necessary on a claim, the risk manager can use the RMIS to get it.

Also, because claims information can be broken down in as much detail as desired, trends as to greatest loss frequency and severity per location, per shift or per supervisor can be gathered. Specific trouble areas can be identified quickly by the risk manager, who can then take immediate action.

Further, with hard facts backing up his or her recommendations, the risk

manager can present an effective case before senior officials to take any corrective action necessary to minimize or eliminate significant problem areas.

- **Analytical capabilities.** Building upon the previous two functions of the well-designed RMIS, the third key use is in the varied analytical capabilities the system brings to bear on the collected data. In fact, within the past two years, there have been more advances in providing sophisticated analyses than in the entire RMIS industry during the 1970s. Loss forecasting models, actuarial analyses, reserve analysis models, capital

budgeting and other packages—including custom-built ones—are generally available within many of the sophisticated systems now being marketed.

Of course, sufficient claims volume and assurances of accurate data are crucial in developing accurate projections for loss forecasts and other advanced models. Nevertheless, the risk manager need not rely on his or her actuary alone to get a reasonable estimate on future losses.

One of the more popular analytical packages used is the Cost of Risk Allocation module. Essentially, this helps the risk manager to design, test and distribute experience-rated premium or budget allocations to different profit and cost centers.

For example, a common application of decision support capabilities is in the building of a loss-forecasting model. Assuming sufficient claims volume per year and a well-defined historical data base for the past five years, a risk manager desires to project losses for the upcoming year and supply the information to the chief financial officer. In the past, the firm's actuary probably

would be used to develop the pro forma statement. But, with a decision-support RMIS with proper financial analytical models, the statement can be developed by the risk manager.

Other applications include reserve analysis packages and comparison of funding alternatives.

- **Decision support capability.** By its very title, "decision support capability" implies a sophisticated computer assistance capability. In other words, a decision support risk management information system digests the data and results of the last three uses and presents summary results in a format that helps the risk manager or other system user make an informed decision.

For example, results from a loss-forecasting model graphically represented (loss frequency vs. loss severity) would help the risk manager determine the proper levels of stop-loss insurance in a self-insured situation. Graphs and charts are significant decision support tools, especially in dealing with busy senior executives.

Yet, remember this important distinction: Decision support capabilities must not replace independent thinking processes and are not designed for this reason. This is not yet artificial intelligence. Results can be misleading, and it takes a skilled professional to ensure correct analysis and reporting. Nevertheless, decision support capabilities are a very powerful tool for a busy risk manager, enabling him or her to sort through the morass of information he or she faces daily.

- **Management tool.** This may be the best use of a risk management information system. A well-designed system can produce reports as complex and detailed as desired for the risk manager, treasurer or comptroller, or as summarized as desired, for senior-level executives.

Because the RMIS is producing information drawn from a number of data bases within the company, these reports have widespread value.

From detailed loss forecasting model printouts—useful to the comptroller—to loss frequency/location analysis—useful to the safety engineer—to the variety of internal risk management department reports—OSHA reports, certificates of insurance management—the well-designed RMIS serves many uses.

David A. Tweedy is a risk management consultant for D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He is the assistant editor of *Betterley Risk Management Commentary* and the author of

RMIS Update, a yearly publication analyzing major risk management information systems and vendors. His column on risk management information systems usually appears the third Monday of every month.



Industry must solve problems that undermine stability

Continued from previous page

- Socially based rather than economically priced protections, like assigned risk pools, FAIR Plans, state workers compensation funds.

- "Temporary" solutions to short-term availability problems—joint underwriting associations, market assistance plans.

- Federal solutions designed to secure financial assistance, like earthquake reinsurance, crime insurance or environmental cleanup funds.

- A return to regulated pricing. If there is a conflict between competitive pricing and socially approved public policy goals, regulated rates could be implemented to achieve non-economic objectives.

- Government assumption of underwriting for the problem risk. Paul Wise admonished this forum on an earlier occasion of the vulnerability of insurance to

government takeover because of the similarity of function.

Any one of these responses to the industry's search for certainty may be and has been acceptable under a given set of facts and circumstances. The problem with each is that it is used to address social, economic and political problems with solutions restricted to insurance. Where the industry fails to provide coverage voluntarily but also fails to address—and demand that others, particularly government, address—the underlying problem, we are doomed to the alternatives above.

Insurers must remain flexible and innovative on coverage, price and contract terms. Regulators must be encouraged to allow companies their freedom. Companies must again emphasize loss control and safety engineering.

Most importantly, insurers must resist the pressure created by the competitive environment to take actions, individually and collectively, in the narrow gauge of their own self-interest. Insurers must be willing to address broad social and economic problems by seeing themselves in the broader spectrum—seeking solutions with policyholders, recognizing that individual action cannot be taken in derogation of the industry as a whole and working with government to determine what is socially demanded and economically feasible.

Participation in the Alliance of American Insurers is important as we work together to stabilize laws, the economic environment and social expectations. However, our members also must see themselves as part of the political process—expressing their views to legislators and supporting candidates capable of balancing complex social and economic needs.

URW contract gives workers an option

AKRON, Ohio—Goodyear Tire & Rubber Co. and Firestone Tire & Rubber Co. now have three-year contracts with the United Rubber Workers union that offer employees a 401(k) savings plan if they give up first-dollar health care coverage.

The contracts give employees a choice between keeping the first-dollar coverage they enjoyed under their previous contracts and switching to a new plan that requires them to pay deductibles and copayments on health care expenses.

However, employees who choose the less-generous option may defer pretax dollars into 401(k) savings plans.

Goodyear's new health care option requires workers to pay \$100 per-person deductibles, with a \$300 family maximum, and 15% of the next \$1,000 in expenses exceeding the deductible.

The new Goodyear 401(k) plan allows workers to defer up to 6% of their pretax pay to the savings plan, with a company match of 25 cents on the dollar.

The Goodyear contract also increases pension benefits of future retirees to \$20 a month per year of service, from \$16.50 under the previous contract. In addition, current retirees receive a 50-cent monthly increase for each year of service.

Life insurance benefits also increased to \$17,000 from \$15,000 under the new contract.

Sickness and accident pay also was raised to \$200 a week, from \$195 under the old contract. The benefit will be increased again in 1986 to \$215 and in 1987 to \$225.

Aetna Life Insurance Co. is the major underwriter of Goodyear's medical, life and sickness and accident benefits.

The URW ratified the Firestone contract May 30. Like Goodyear, it offers workers a choice between first-dollar coverage identical to that under the previous contract and a plan that requires deductibles and copayments in exchange for participation in a 401(k) savings plan.

Auto mechanic wins asbestos award

LOS ANGELES—Raymark Corp. must pay \$2 million to a former automobile brake lining mechanic who developed mesothelioma, a cancer of the lining of the lung linked to asbestos, a state Superior Court jury recently ruled.

The ruling is believed to be the first where an asbestos manufacturer or distributor must pay damages to a brake lining worker, says Helen Eisenstein, attorney for plaintiff Richard Hedblom.

Harry Day, Raymark's vp and general counsel, said the company had filed a motion for a new trial, including a request that damages be reduced. Depending on the outcome, the company will decide whether to appeal.

Raymark is currently litigating with its liability insurers over the extent of its coverage for asbestos claims (BI, Dec. 5, 1983).

Raymark is currently defended and indemnified by its first-layer excess insurers under a formula ordered by Cook County (Ill.) Circuit Court Judge James Murray. Insurers on this layer include American Home Assurance Co., First State Insurance Co., Globe Indemnity Co., American Centennial Insurance Co. and Northbrook Excess and Surplus Insurance Co.

Although the jury granted Mr. Hedblom \$2 million, the verdict will be reduced by approximately \$150,000 as a result of settlements with several other defendants prior to the verdict.

However, spokesmen for both Firestone and the URW refused to give details on the contract until all scheduled plant meetings, during which the contract is explained to workers, are held.

The URW earlier last month ratified a new, three-year contract with The BFGoodrich Co. in Akron, Ohio. That contract, retroactive to April 1, grants union members higher pension benefits, more life insurance and more-generous sickness and accident benefits.

Pension benefits for future retirees were raised to \$20 a month per year of service, up from \$16.50 under the previous contract. The pensions of current retirees also were raised by 50 cents a month per year of service.

In addition, workers will receive

\$17,000 in life insurance under the new contract, up from \$15,000 under the old one.

Sickness and accident benefits also were increased. As of April 1, the weekly payment was increased to \$200 a week, up from \$185 a week under the old contract.

On April 1, 1986, the weekly benefit will increase again, to \$215, and on April 1, 1987, it will increase to \$225.

The Goodrich contract does not address health care benefits, which were negotiated under a separate contract in November 1984 (BI, May 6).

Goodrich self-insures its health and sickness and accident benefits; Aetna Life Insurance Co. underwrites its life insurance benefits.

Like Goodrich, Uniroyal ratified a separate health care contract, in

September 1984. Therefore, Uniroyal did not negotiate health care benefits in its master contract, which was ratified May 23.

Uniroyal's master contract increases pension benefits for future retirees to \$13.50 a month for each year of service, from \$12.50 under the previous contract. All current retirees will receive a minimum lump-sum payment of \$100 on Dec. 1, 1985, 1986 and 1987. The amount may be increased, however, depending on company profits.

The contract also establishes, for the first time, a vision care program that reimburses workers for various services based on a fixed fee schedule and requires no deductible.

The contract also calls for increases in the employer contributions to the company savings plan.

Workers who were receiving company matches of 10 cents on the dollar will now receive 12 cents on the dollar; workers who receive a company match of 15 cents on the dollar now receive 18 cents on the dollar.

Under the savings program, the company match varies according to seniority.

Life insurance benefits also were increased under the new contract, to \$17,000 a year from \$13,000.

And, sickness and accident insurance benefits were increased to \$200 a week from \$185. In April 1986, that amount will increase again, to \$215; in April 1987, it will increase again, to \$225.

Equitable Life Insurance Co. underwrites Uniroyal's life insurance benefits; the company self-insures its sickness and accident benefits.

Business Insurance

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BI 6/17

business insurance

Survey shows the prevalence of RMIS

By ALISON KITTRELL

Risk managers at larger companies are more likely to have access to a risk management information system than small-company risk managers, a survey reveals.

More than three-fourths of the risk managers at the largest companies surveyed reported they have an RMIS; about one-quarter of those at the smaller companies said they have an RMIS.

For the first time this year, the Logic Associates Risk Management Compensation Survey examined the prevalence of risk management information systems.

Some 917 risk managers from across the country replied to the 1984 survey by Logic Associates, a New York professional recruiting company. The responses were grouped according to the annual sales volume of the respondents' companies.

Richard Meyers, one of the survey authors and a senior vp at Logic Associates, said, "We included (the RMIS question) this year because, from the experience we have had in dealing with clients, we have found that it has become a much more popular addition to the risk management function."

The survey found that 25.8% of risk managers at the smallest companies—with up to \$200 million in annual sales—had an RMIS. That percentage fell slightly, to 23.9%, for risk managers at companies with \$201 million to \$500 million in sales.

There was a big increase in automation in the next sales volume category—\$501 million to \$1 billion—where 45.6% of the survey respondents reported having an RMIS.

That jumped to 62.3% among risk managers at companies with \$1 billion to \$2 billion in annual sales. Some 62.7% of the risk managers at companies with \$2 billion to \$4

billion in sales had an RMIS.

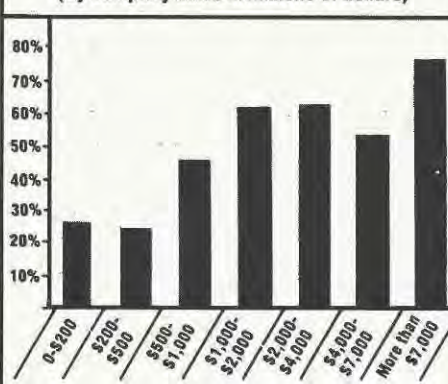
Only 51.5% of the risk managers at companies with \$4 billion to \$7 billion in sales had an RMIS. Among risk managers at the largest companies—more than \$7 billion in sales—76.9% reported having an RMIS.

However, the relatively small number of respondents in the largest two sales volume categories makes these results suspect.

Both Mr. Meyers and Bill Perry, the other survey author and also a senior vp, said they were not surprised at the prevalence of RMIS. And, they said computerization is going to become even more important.

Mr. Meyers said, "The ability to interact with computerization as a mechanism of reporting losses and maintaining pertinent information to make a decision about a particular liability or exposure is going to become a much more valuable asset to the risk management function."

Risk management departments with information systems
(By company sales in millions of dollars)



Source: Logic Associates

Chart: Amy Palmer

Duties vary

Continued from page 3

The involvement in benefit activity dropped dramatically among risk managers at companies with \$201 million to \$500 million in sales, where 11% have direct responsibility and 22% have supervisory or advisory responsibility for pension and profit-sharing administration. Fourteen percent have direct responsibility and 38% have advisory or supervisory responsibility for benefits administration.

Responsibility for both pension/profit-sharing and benefit administration continued to fall with the increasing size of the company.

For instance, none of the risk managers at companies with \$4 billion to \$7 billion in sales reported direct responsibility for pension and profit-sharing administration, and only 3% have advisory or supervisory responsibility. Only 3% have direct responsibility for benefits administration, though 33% have advisory or supervisory responsibility.

At the largest companies, with more than \$7 billion in sales, only 3% of the respondents reported a direct responsibility and 8% have advisory or supervisory responsibility for pension and profit-sharing administration, while 5% have direct responsibility and 16% have advisory or supervisory responsibility for benefits administration.

However, the relatively small number of respondents in this category—38—could skew the results.

The survey also reveals that risk managers at larger companies are more likely to be involved with specialized risk management programs like captives, probably because these programs are more prevalent among larger companies (see chart).

For example, only 6% of the risk managers at companies with annual sales volumes of up to \$200 million had direct responsibility for captive management, while 31% of those at companies with \$4 billion to \$7 billion in sales and 26% of the risk managers of those had companies with more than \$7 billion in sales had such direct responsibility.

Only 5% of the risk managers at companies with \$201 million to \$500 million in sales had responsibility for captive management, while 13% had this responsibility at companies with \$501 million to \$1 billion in sales. Fourteen percent had captive management responsibility at companies with \$1 billion to \$2 billion, while 30% had this responsibility at companies with \$2 billion to \$4 billion in sales.

Most of the risk managers in all categories reported either direct or supervisory responsibility in traditional areas like risk financing, negotiation of placement, claims handling and safety and fire loss engi-

Continued on next page



In health claims processing you don't just need hardware..

Duties vary

Continued from previous page

Some 74% of the risk managers at companies with up to \$200 million in sales reported direct responsibility for risk financing, and 15% said they have an advisory or supervisory role. At companies with \$201 million to \$500 million in sales, 72% reported direct responsibility and 13% reported supervisory or advisory responsibility.

Among risk managers at companies with \$501 million to \$1 billion in sales, 77% reported direct responsibility for risk financing, and 16% reported advisory or supervisory responsibility. At companies with \$1 billion to \$2 billion in sales, the percentage reporting direct responsibility for risk financing fell to 60%, and 12% said they play an advisory or supervisory role.

But, 78% at companies with \$2 billion to \$4 billion in sales have di-

rect responsibility for risk financing, and 16% have advisory or supervisory responsibility. And, 64% at companies with \$4 billion to \$7 billion in sales have a direct role, while 33% have a secondary role.

At the largest companies, with more than \$7 billion in sales, 79% of the risk managers said they have direct responsibility for risk financing, and 16% have supervisory or advisory responsibility.

Virtually all the risk managers at the smallest companies say they have responsibility for negotiation of coverage placement: 90% have direct responsibility, and 9% have supervisory or advisory responsibility.

At companies with \$201 million to \$500 million in sales, 83% are directly responsible for negotiating coverage placement, and 10% have advisory or supervisory responsibility. And, at companies with \$501 million to \$1 billion, 92% have direct responsibility and 5% have secondary responsibility.

Some 87% of risk managers at companies with \$1 billion to \$2 billion are directly responsible for negotiating coverage placement, and 9% supervise or advise. And, 86% at companies with \$2 billion to \$4 billion have direct responsibility, while 7% supervise or advise.

At companies with \$4 billion to \$7 billion in sales, 89% have direct responsibility and 8% have supervisory or advisory responsibility for negotiating coverage placement. And, at the largest companies, 79% have direct responsibility and 21% have supervisory or advisory responsibility.

Only about half the risk managers overall report direct responsibility for claims handling, but most of the rest said they have supervisory or advisory responsibility. For example, direct responsibility for claims handling was reported by 48% of the risk managers at companies with up to \$200 million in sales, but secondary responsibility was reported by 25%. And, at com-

panies with \$201 million to \$500 million, 45% reported direct responsibility, and an equal number said they have supervisory or advisory responsibility.

Some 57% of risk managers at companies with \$501 million to \$1 billion have direct responsibility for claims handling, and 40% have supervisory or advisory responsibility. And, 54% have direct responsibility and 40% have secondary responsibility at companies with \$1 billion to \$2 billion.

Fifty-four percent of the risk managers at companies with \$2 billion to \$4 billion and at those with \$4 billion to \$7 billion report direct responsibility for claims handling; 39% at companies with \$2 billion to \$4 billion in sales had supervisory or advisory responsibility, while 43% at companies with \$4 billion to \$7 billion in sales have this type of responsibility.

And, at the largest companies, 53% have direct responsibility and 47% have secondary responsibility

for claims handling.

Less than 40% of the risk managers surveyed said they have direct responsibility for safety and fire loss-control engineering, but most of the others said they had some responsibility in this area, too.

For example, direct responsibility for loss-control engineering was reported by 36% of the risk managers at companies with up to \$200 million in sales, but 58% said they play a supervisory or advisory role. At companies with \$201 million to \$500 million in sales, 29% have direct responsibility, and 59% have secondary responsibility.

At companies with \$501 million to \$1 billion in sales, 23% of the risk managers surveyed have direct responsibility for loss-control engineering, and 67% have supervisory or advisory responsibility. At companies with \$1 billion to \$2 billion in sales, 26% have direct responsibility and 59% have indirect responsibility.

Some 23% of the risk managers at companies with \$2 billion to \$4 billion in sales have direct responsibility for loss-control engineering, and 71% have indirect responsibility.

At companies with \$4 billion to \$7 billion in sales, 36% report direct responsibility and 52% have supervisory or advisory responsibility. At the largest companies, 24% have direct responsibility and 74% have indirect responsibility in this area.

Finally, in the area of security, 10% or less of the respondents have direct responsibility, but at least five times as many have some kind of supervisory role.

At the smallest companies, 10% of the risk managers have direct responsibility for security, but 67% have some responsibility. Eight percent have direct responsibility at companies with \$201 million to \$500 million in sales, and 56% have indirect responsibility.

Some 7% of the risk managers at companies with \$501 million to \$1 billion in sales have direct responsibility for security, but 60% have supervisory or advisory responsibility. At companies with \$1 billion to \$2 billion in sales, 9% have direct responsibility and 55% have indirect responsibility.

At companies with \$2 billion to \$4 billion in sales, 3% report direct responsibility for security and 57% have indirect responsibility. At companies with \$4 billion to \$7 billion, 7% have direct responsibility and 52% have secondary roles.

At the largest companies, 5% of the risk managers have direct responsibility for security, and 61% have supervisory or advisory responsibility.

In other areas of responsibility, the survey found:

Continued on next page



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Different title, but same job

When is a risk manager not a risk manager?

When he or she is a director of risk management, an insurance manager or an assistant treasurer.

According to the Logic Associates 1984 Risk Management Compensation Survey, only 28.3% of the 917 risk managers surveyed have the title "risk manager."

Some 33.1% are called "director of risk management," and 11.3% have the title of "insurance manager."

In addition, 6.9% are called "vp-risk management," and 6.4% are called "assistant treasurer-risk management."

Two percent are called "assistant secretary-risk management," 4.9% are called "insurance risk administrator" and 7.1% have some other title.

Duties vary

Continued from previous page

• **Casualty insurance.** Direct responsibility for casualty insurance was reported by 84% of the risk managers at companies with up to \$200 million in annual sales; 88% at companies with \$201 million to \$500 million; 91% at companies with \$501 million to \$1 billion; 88% at companies with \$1 billion to \$2 billion; 90% at companies with \$2 billion to \$4 billion; 85% at companies with \$4 billion to \$7 billion; and 84% at companies with more than \$7 billion in sales.

• **Property insurance.** Direct responsibility for property insurance was reported by 84% of the risk managers at companies with up to \$200 million in sales; 83% at companies with \$201 million to \$500 million; 92% at companies with \$501 million to \$1 billion; 86% at companies with \$1 billion to \$2 billion; 91% at companies with \$2 billion to \$4 billion; 82% at companies with \$4 billion to \$7 billion; and 84% at companies with more than \$7 billion in sales.

• **International insurance.** Direct responsibility was reported by 55% of the risk managers at companies with up to \$200 million in sales; 37% at companies with \$201 million to \$500 million; 51% at companies with \$501 million to \$1 billion; 52% at companies with \$1 billion to \$2 billion; 56% at companies with \$2 billion to \$4 billion; 57% at companies with \$4 billion to \$7 billion; and 58% at companies with more than \$7 billion.

• **Marine insurance.** Direct responsibility was reported by 55% of the risk managers at companies with up to \$200 million in sales; 62% at companies with \$201 million to \$500 million; 73% at companies with \$501 million to \$1 billion; 60% at companies with \$1 billion to \$2 billion; 70% at companies with \$2 billion to \$4 billion; 72% at companies with \$4 billion to \$7 billion; and 61% at companies with more than \$7 billion.

• **Credit insurance.** Direct responsibility was reported by 29% of the risk managers at companies with up to \$200 million in sales; 67% at companies with \$201 million to \$500 million; 19% at companies with \$501 million to \$1 billion; 23% at companies with \$1 billion to \$2 billion; 22% at companies with \$2 billion to \$4 billion; 21% at companies with \$4 billion to \$7 billion; and 16% at companies with more than \$7 billion.

• **Bonds.** Direct responsibility was reported by 74% of the risk managers at companies with up to \$200 million in sales; 65% at companies with \$201 million to \$500 million; 72% at companies with \$501 million to \$1 billion; 59% at companies with \$1 billion to \$2 billion; 75% at companies with \$2 billion to \$4 billion; 72% at companies with \$4 billion to \$7 billion; and 66% at companies with more than \$7 billion.

• **Data security.** Direct responsibility was reported by 3% of the risk managers at companies with up to \$200 million in sales; 6% at companies with \$201 million to \$500 million; 5% at companies with \$501 million to \$1 billion; 10% at companies with \$1 billion to \$2 billion; 2% at companies with \$2 billion to \$4 billion; 7% at companies with \$4 billion to \$7 billion; and none at companies with more than \$7 billion.

• **Benefits financing.** Direct responsibility was reported by 41% of the risk managers at companies with up to \$200 million in sales; 31% at companies with \$201 million to \$500 million; 29% at companies with \$501 million to \$1 billion; 21% at companies with \$1 billion to \$2 billion; 22% at companies with \$2 billion to \$4 billion; 25% at companies with \$4 billion to \$7 billion; and 21% at companies with more than \$7 billion.

• **Pension and profit-sharing in-**

vestment. Direct responsibility was reported by 6% of the risk managers at companies with up to \$200 million in sales; 6% at companies with \$201 million to \$500 million; 5% at companies with \$501 million to \$1 billion, and none in any of the other categories.

• **Captive administration.** Direct responsibility was reported by 6% of the risk managers at companies with up to \$200 million in sales; 2% at companies with \$201 million to \$500 million; 15% at companies with \$501 million to \$1 billion; 14% at companies with \$1 billion to \$2 billion; 17% at companies with \$2 billion to \$4 billion; 15% at companies with \$4 billion to \$7 billion; and 18% at companies with more

than \$7 billion.

• **Self-insurance financing.** Direct responsibility was reported by 48% of the risk managers at companies with up to \$200 million in sales; 46% at companies with \$201 million to \$500 million; 60% at companies with \$501 million to \$1 billion; 61% at companies with \$1 billion to \$2 billion; 66% at companies with \$2 billion to \$4 billion; 67% at companies with \$4 billion to \$7 billion; and 58% at companies with more than \$7 billion.

• **Self-insurance administration.** Direct responsibility was reported by 45% of the risk managers at companies with up to \$200 million in sales; 46% at companies with \$201 million to \$500 million; 46% at

companies with \$501 million to \$1 billion; 53% at companies with \$1 billion to \$2 billion; 48% at companies with \$2 billion to \$4 billion; 54% at companies with \$4 billion to \$7 billion; and 50% at companies with more than \$7 billion.

• **Self-insurance with large retentions** (minimum \$500,000 per claim). Direct responsibility was reported by 29% of the risk managers at companies with up to \$200 million in sales; 16% at companies with \$201 million to \$500 million; 34% at companies with \$501 million to \$1 billion; 40% at companies with \$1 billion to \$2 billion; 51% at companies with \$2 billion to \$4 billion; 43% at companies with \$4 billion to \$7 billion; and 53% at companies

with more than \$7 billion.

• **Contingency planning.** Direct responsibility was reported by 22% of the risk managers at companies with up to \$200 million in sales; 15% at companies with \$201 million to \$500 million; 26% at companies with \$501 million to \$1 billion; 22% at companies with \$1 billion to \$2 billion; 22% at companies with \$2 billion to \$4 billion; 36% at companies with \$4 billion to \$7 billion; and 16% at companies with more than \$7 billion.

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

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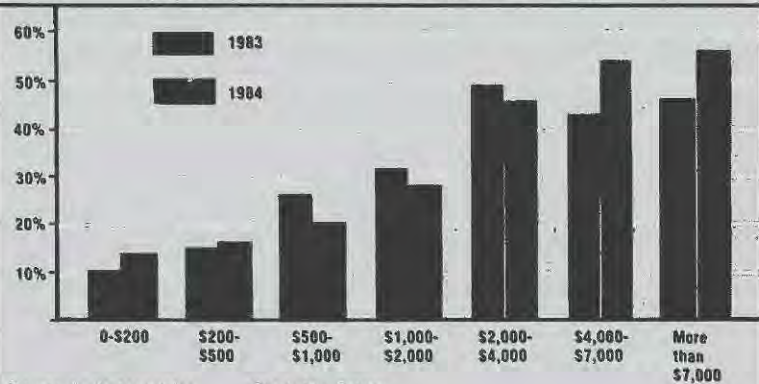
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—Was everything charged actually delivered to the patient?

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Risk management departments with captives (By company sales in millions of dollars)



Source: Logic Associates Chart: Amy Palmer

Staff size grows with sales volume

Continued from page 3
panies with from \$1 billion to \$2 billion in sales.

At companies with from \$2 billion to \$4 billion in sales, the average was 6.78 people—4.39 professional staffers and 2.39 clerical staffers.

Departments at companies with \$4 billion to \$7 billion in sales also had an average of 2.39 clerical staffers, but they reported an average of 5.12 professional staffers for a total of 7.51 staffers.

Risk managers at the largest companies—with more than \$7

billion in sales—reported only 3.19 professional staffers, but they reported 5.27 clerical staffers for a total of 8.46 people.

However, the relatively small number of responses in this sales volume category—38—could make these numbers suspect.

The percentage of risk management departments reporting that their company had a captive insurance company also increased according to increases in company sales volumes (see chart).

But, at companies in the midsize categories, the percent of respon-

dents reporting captives dropped from 1983 to 1984.

Some 12.9% of the risk managers at the smallest companies reported a captive, up from 10% in 1983. Among companies with \$201 million to \$500 million in sales, 15.2% had a captive, up from 14% last year.

But, 20% of the companies with \$501 million to \$1 billion in sales had a captive in 1984, down from 26% in 1983. Among companies with \$1 billion to \$2 billion in sales, 27.3% had a captive in 1984, down from 32% in 1983.

And, at companies with \$2 billion to \$4 billion in sales, 45.8% had a captive in 1984, down from 49% in 1983.

At companies with \$4 billion to \$7 billion in sales, 54.5% had a captive in 1984, up from 43% in 1983. And, at the largest companies—with more than \$7 billion in sales, 57.7% reported a captive in 1984, up from 46% in 1983.

The average number of captives insurance companies reported per company also increased slightly according to increases in company sales volume.

The average number of captives per company was one among companies with up to \$200 million in sales, 1.21 at companies with \$201 million to \$500 million in sales, 1.28

Departments reporting a captive also increased according to company size.

at companies with \$501 million to \$1 billion in sales, 1.19 at companies with \$1 billion to \$2 billion in sales, 1.15 at companies with \$2 billion to \$4 billion in sales, 1.78 at companies with \$4 billion to \$7 billion in sales, and 1.27 at companies with more than \$7 billion in sales.

A higher percentage of the professional risk management staff members—including the risk manager—reported having law degrees or master's degrees at the larger companies.

But, the larger companies also reported a higher percentage of professional staffers with no college degree.

For example, 9.7% of the risk management professionals—all professional staffers including the risk manager—at the smallest companies have a law degree. Some 19.4% have a master's degree, 45.2% have a bachelor's degree, and 25.7% have no degree.

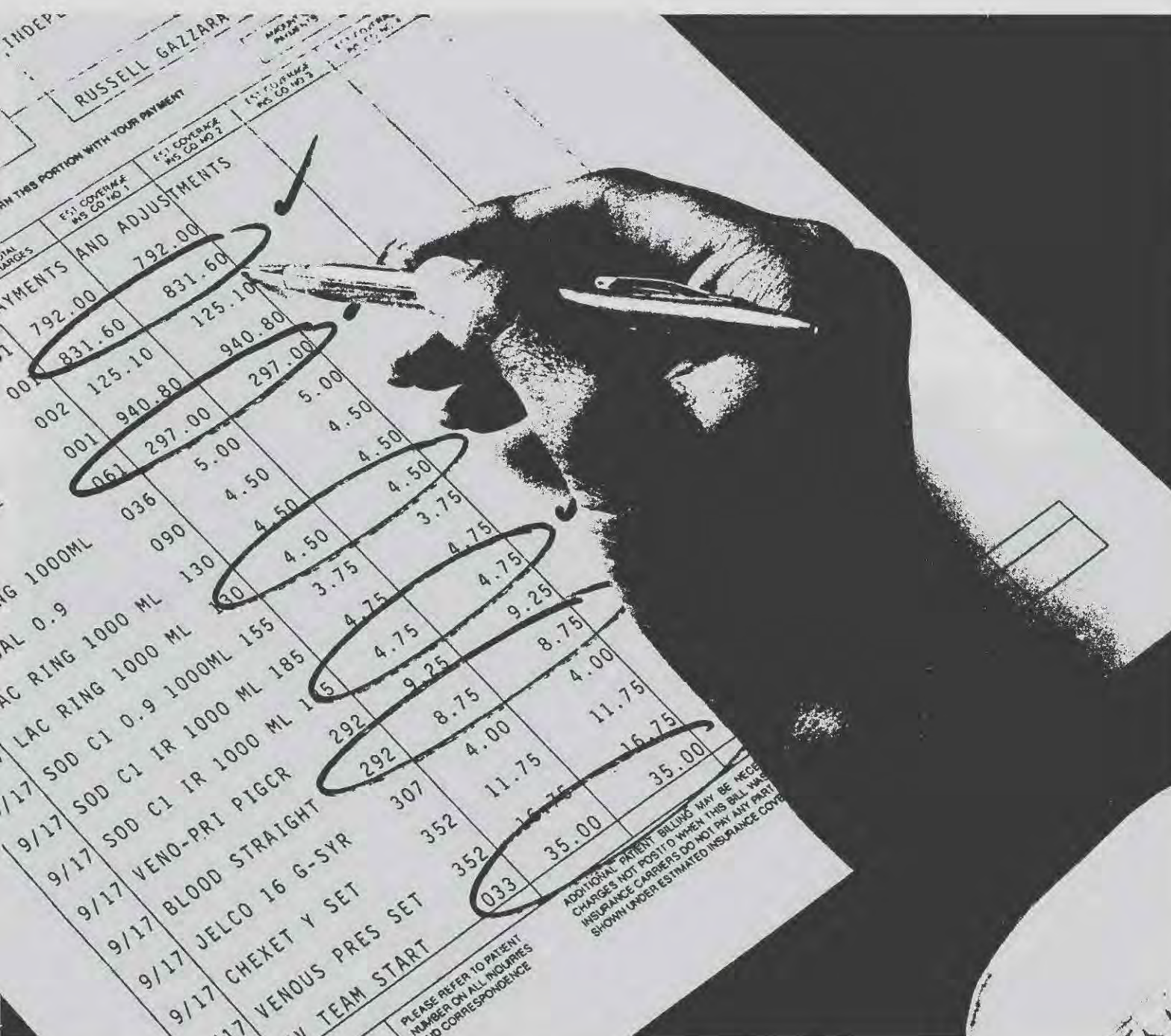
Among companies with \$2 billion to \$4 billion in sales, 13.6% of the professionals have a law degree, 13.2% have a master's degree, 30.2% have a bachelor's degree, and 43% have no degree.

At companies with \$201 million to \$500 million in sales, 5.4% have a law degree, 28.3% have a master's, 54.3% have a bachelor's and 12% have no degree. At companies with \$501 million to \$1 billion in sales, 5.5% have a law degree, 21.1% have a master's, 78.9% have a bachelor's, and 5.5% have no degree; apparently, some respondents in this category gave more than one answer.

Among companies with \$1 billion to \$2 billion in annual sales, 7.8% have a law degree; 28.5% have a master's degree, 38.9% have a bachelor's degree and 24.9% have no degree.

At companies with \$4 billion to \$7 billion in sales, 12.1% have a law degree, 33.6% have a master's degree, 23.8% have a bachelor's degree and 30.5% have no college or post-graduate degree.

Continued on next page



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Staff size grows with sales volume

Continued from previous page

And at the largest companies, with more than \$7 billion in sales, 7.7% have a law degree, 34.6% have a master's degree, 27.5% have a bachelor's degree and 30.2% have no degree.

But, the relatively small number of respondents in the two largest-volume categories could skew the results.

The authors of the survey said that, overall, the respect afforded to risk management departments is increasing, especially in light of the current hard market, which is making coverage harder to find and more expensive.

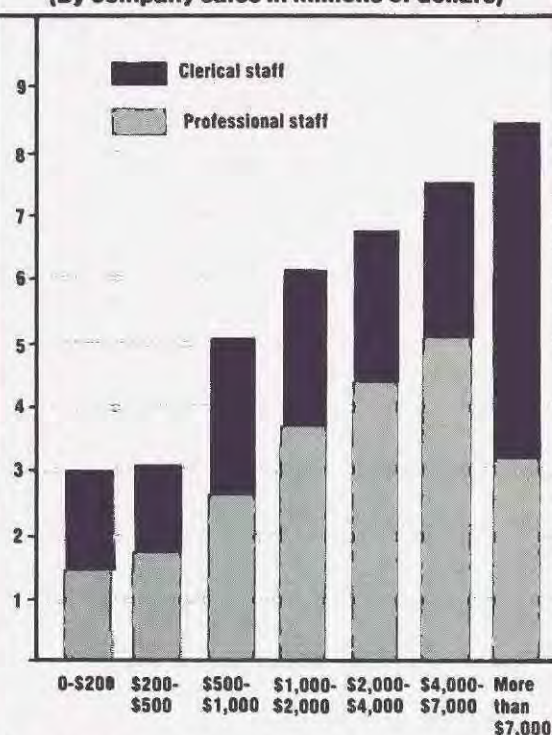
Richard Meyers, one of the survey authors and a senior vp at Logic Associates, said, "Risk management in the last 18 months probably has received the highest visibility ever" because of the current hard insurance market.

Mr. Meyers commented that, over the four years of the survey and in his experience placing risk management professionals for corporations, "One of the things that we have seen is that the risk management department is increasingly being looked on as another department making a financial decision having an effect on the bottom line."

He said that, in particular, recent catastrophic losses, like the disaster at the Union Carbide Corp. plant in Bhopal, India, have shown companies that, "Risk management should not be treated as a stepchild; it should be treated as a guardian, if not a parent."

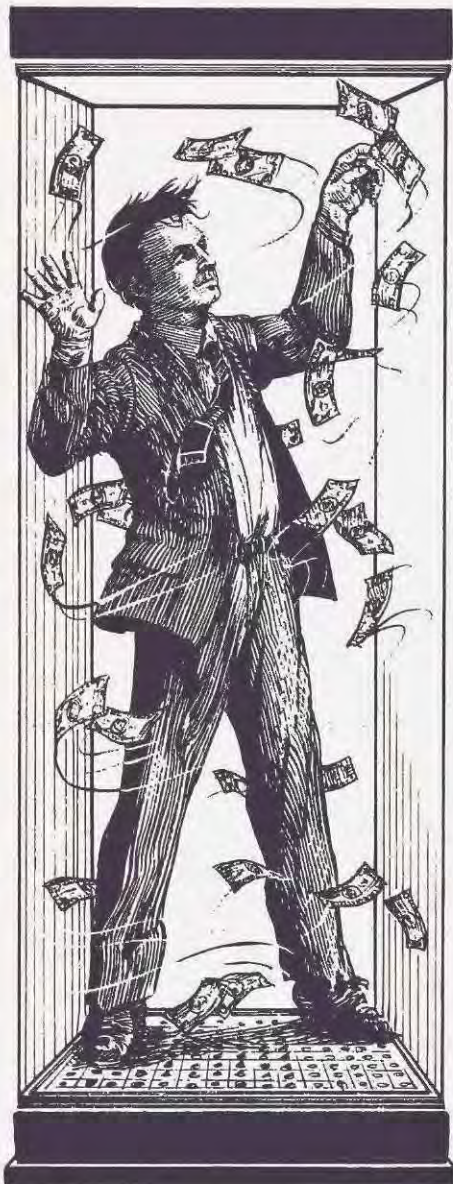
However, Bill Perry, the other survey author and also a senior vp at Logic Associates, commented that, especially in light of the tightening commercial insurance market, "It's important today that the risk managers are playing educators within their own corporations."

**Average size
of risk management departments
(By company sales in millions of dollars)**



Source: Logic Associates Chart: Amy Palmer

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Ex-Manville unit in Canada denied coverage by judge

MONTREAL—A Quebec Superior Court judge says a former Manville Corp. subsidiary is not entitled to coverage for asbestos claims because it failed to inform the insurer of the frequency of lung disease in workers exposed to asbestos.

According to J. Vincent O'Donnell, an attorney for Canadian Indemnity Co., Justice Pierre Boudreault ruled last month that Canadian Johns-Manville Co. Ltd. failed to give Canadian Indemnity sufficient information required under the Quebec Civil Code.

"The duty to divulge was on the applicant," said Mr. O'Donnell of the Montreal firm of Lavery, O'Brien.

Canadian Johns-Manville's coverage under a Comprehensive Business Liability Policy with Canadian Indemnity commenced in June 1970 and continued for slightly less than five years, Mr. O'Donnell said.

Manville will appeal the ruling, said Kathleen Page, an attorney Manville, which sold the Canadian unit in 1983 but is still responsible for its liabilities.

Ms. Page noted that the Quebec coverage decision will not affect the massive coverage litigation between Manville, four other asbestos defendants and more than 75 liability insurers now under way before a California Superior Court in San Francisco (BI, June 10).

She also said that the approximately \$5 million in coverage at stake in the Quebec litigation is not included in the \$600 million in insurance coverage Manville contends it is entitled to.

In his ruling, Justice Boudreault declared the two policies at issue null and ordered Canadian Johns-Manville to pay Canadian Indemnity \$9,935,33, the difference between the amount Canadian Indemnity paid on behalf of Canadian Johns-Manville's losses and the premium paid to Canadian Indemnity by Canadian-Johns Manville.

There was no allegation of fraud against Canadian-Johns Manville and its good faith was not questioned, the court noted in the ruling.

Meanwhile, in an action related to the California litigation, a California appellate court requested more information and said it would further consider whether asbestos defendants GAF Corp. and Nicolet Inc. can recover punitive damages from Insurance Co. of North America and certain underwriters at Lloyd's of London for alleged bad-faith conduct.

Previously, Superior Court Judge Ira A. Brown Jr., who is presiding over the coverage litigation, ruled that GAF and Nicolet could not recover punitive damages from Philadelphia-based INA, a CIGNA Corp. unit, or the Lloyd's underwriters, because the recovery of punitive damages was prohibited by Pennsylvania and British law (BI, March 11).

Non-smoker granted comp benefits

SALEM, Ore.—A state employee whose health problem was aggravated by on-the-job exposure to secondhand tobacco smoke is entitled to workers compensation benefits, according to a ruling by Oregon's Workers Compensation Board.

The board recently decided that Mary A. Downey, a proofreader in the Oregon Department of Revenue, was entitled to workers compensation benefits because a health condition she had prior to her employment, called rhinosinusitis—a nasal inflammation—was made worse by her on-the-job exposure to cigarette smoke.

The board based its decision

largely on a precedent for granting benefits to state employees who have a disease or condition that is made worse because of their employment.

Ms. Downey was initially denied benefits by the state's compensation insurer, the State Accident Insurance Fund Corp., in January 1983.

The denial of benefits was upheld in August 1984 by a state referee.

Ms. Downey worked with numerous smokers although she made a conscious effort to avoid cigarette smoke in the workplace, according to testimony delivered at the board hearing.

Rules designed to limit 401(k) tax break

By JERRY GEISEL

WASHINGTON—The new non-discrimination tests for 401(k) plans outlined in President Reagan's tax reform proposal are clearly designed to limit the tax breaks enjoyed by highly-paid employees who participate in the plans.

First, the tests no longer will be based on a comparison of the average salary deferrals made during the year by the highest-paid one-third of eligible employees and the lowest-paid two-thirds.

Instead, the proposal creates a new narrower category of higher-paid workers—called the prohibited group—and a new broader category of lower-paid workers—called the non-prohibited group.

This arrangement will effectively reduce the contributions of the higher-paid employees because they will be contingent on participation by a larger group of lesser-paid employees.

The prohibited group would include employees that:

- Earn \$50,000 or more in annual compensation. (This figure would be indexed annually for inflation).
- Own 1% or more of the company.
- Are among the top 10% of employees based on salary. An employee would have to earn at least \$20,000 annually (indexed for inflation) to be in this category.
- Are members of the family of an employee in the prohibited group.

And, instead of comparing the salary deferrals of the prohibited group as a whole against those of the non-prohibited group—as done under current law—the Reagan plan would force the deferrals of each prohibited group member to be individually compared against the average deferral of the non-prohibited group.

The Reagan tax plan also makes the actual deferral percentage test stricter.

Under the plan, the salary deferral elected by any individual member of the prohibited group could not exceed the greater of two amounts:

- 125% of the average deferral percentage (ADP) of the non-prohibited group.
- The lesser of 200% of the ADP of the non-prohibited group or the ADP of the nonprohibited group, plus 2%.

(Under the latter test, if the ADP of the non-prohibited group was 3%, the allowed deferral for a member of the prohibited group would be 5%.)

Under the current non-discrimination tests, the average deferral by the higher-paid one-third cannot exceed the greater of:

- 150% of the ADP of the lower-paid two-thirds.

- 250% of the average deferral among the lower-paid two-thirds as long as the difference between the average deferrals of the two groups does not exceed 3%.

(Under the 250% test, if the lower-paid employees contributed an average of 1% of pay, the higher-paid employee could contribute an average of 2.5%. But, if lower-paid employees contributed an average of 4% of pay, the higher-paid employees could contribute a maximum of only 7%—not 10%.)

The Reagan tax reform plan also mandates that employer matching contributions be considered in the discrimination tests, and creates tests separate from those described above for contributions that are not immediately 100% vested.

Under current law, employer contributions can be included in the discrimination tests at the discretion of the sponsor. Otherwise, such contributions only have to meet very general non-discrimination guidelines.

The new law says that employer contributions that are 100% immediately vested, subject to withdrawal restrictions and do not exceed 100% of an employee's contribution, would be added to the ADP of the non-prohibited group before the deferral discrimination tests described above are carried out.

For example, if the non-prohibited group defers an average of 4% of pay and the employer contributes 50 cents for every \$1 of salary deferred—or 2% of the employee's salary—the new non-prohibited group's ADP would be 6%.

But, if the employer contributions are not immediately 100% vested or do not meet the withdrawal restrictions or if they exceed 100% of the employee's contribution, the deferral ratio tests become stricter.

Then, no member of the prohibited group could have a combined salary deferral and employer matching contribution that exceeds the greater of:

- 110% of the new ADP of the non-prohibited group (basing the ADP on the employee deferral plus the employer's contribution).
- The lesser of 150% of the new ADP for the non-prohibited group, or the new ADP plus 1%.

In addition, if higher-paid employees are allowed to contribute to the plan amounts in excess of the allowed amount, the employer cannot take a tax deduction on the excess amount of the employee's salary that is deferred to the plan. In addition, a 10% excise tax would be due on the excessive contribution. The tax proposal isn't clear on whether the employer or the employee would pay the excise tax, consultants say.

To prevent the 401(k) plan from being disqualified, the excess contribution also would have to be distributed to the employee during the following year and this amount would be considered taxable income.

If the excess contribution were discovered before the end of the year, it could be returned to the employee and no excise tax would be levied.

Other new proposed rules that will affect 401(k) plans include:

- Limiting the maximum annual employee salary deferral to a plan to \$8,000. Under current law, an employee can defer up to \$30,000 of salary to a 401(k) plan.

- Reducing the maximum \$8,000 salary deferral cap by contributions an employee makes to an Individual Retirement Account.

If, for example, an employee contributed \$2,000 to an IRA, his or her maximum contribution to a 401(k) plan would be limited to \$6,000.

Currently, IRA contributions are not considered in determining how much money an employee may defer to a 401(k) plan.

- Eliminating in-service withdrawals of employee salary deferrals. Many employers now allow employees to withdraw funds from their 401(k) accounts to make a downpayment on a primary residence, pay for a child's college expenses or to cover uninsured medical bills.

- Imposing special taxes on pre-retirement distributions (generally before age 59½), such as when an employee leaves a company and his or her 401(k) account is closed.

The tax would be 10% if the distribution were used for the purchase of a first principal residence, a dependent's college expenses or replacement of unemployment benefits. A 20% tax would apply if the distributions were used for any other purpose.

These penalty taxes, which also apply to other savings and retirement plans, could be avoided if the employee rolled the 401(k) distribution into an IRA.

No special taxes would apply on distributions between ages 50 and 59½ that are paid as part of an annuity in which payments are spread out over at least 180 months.

- A special 10% tax would apply for distributions that exceed \$112,500 in any one year. This tax also would apply to large distributions from any other tax-favored retirement plan.

- A favorable method of taxing—known as 10-year forward averaging—distributions from 401(k) and other savings and retirement plans would be eliminated. Instead, distributions would be taxed as ordinary income.

401(k) plans

Continued from page 1

Gerald Uslander, a principal with benefit consultant William M. Mercer-Meindinger Inc. in Louisville, Ky.

However, other experts believe the administration will negotiate on possible changes in the rules as the tax reform package is considered by Congress.

In fact, Harry Conaway, attorney/adviser at the Treasury Department's Office of Tax Legislative Counsel, told a special meeting of the Assn. of Private Pension and Welfare Plans this month that the department is willing to "sit down and talk" to employers about changes.

"I'd like to think that the proposals are the starting point for negotiations," observed Theresa Stuchiner, a partner at benefit consultant Kwasha Lipton in Fort Lee, N.J.

"I don't believe this is the last word. It is an opening shot, not the last shot," she added.

"The regulations are so outrageously complex that employers will be forced to react... and they will get a sympathetic hearing in Congress," said Mr. Meehan.

Many of the optimists remember that employers and consultants last year were able to convince Congress to bar the Internal Revenue Service from retroactively enforcing flexible spending accounts rules that would have made many companies and employees liable for back taxes and penalties.

"The Treasury recognizes that there may be problems and they have asked for help," said Mr. Uslander at Mercer-Meindinger.

The administration's proposal to offset employee 401(k) salary deferrals by employees' contributions to Individual Retirement Accounts is one provision employers say must be changed.

Under the tax reform package, if an employee contributed \$2,000 to an IRA, his or her maximum salary deferral to a 401(k) plan would be reduced to \$6,000 from \$8,000.

But employers say such integration between 401(k) plans and IRAs would be impossible to administer and enforce because employers do not keep records on how much employees contribute to IRAs.

"Do you ask employees for notes about their IRAs? I can't figure out how such a requirement would be enforced," said Joseph Duva, director of employee benefits and compensation at SCM Corp. in New York.

To further complicate the issue, the tax reform package doesn't make clear whether IRA spousal contributions would be considered in calculating an employee's maximum 401(k) salary deferral.

Employers are also cringing at the extra, costly administrative duties they would have to assume to comply with the new discrimination tests for 401(k) salary deferrals.

For example, the proposal would divide employees into two new groups—prohibited and non-prohibited—for purposes of the deferral discrimination tests.

Current law compares the average deferral of the higher-paid one-third of employees against the average deferral of the lower-paid two-thirds of employees. The new provision narrows the category of the highly-paid "prohibited" employees and broadens the category of lower-paid, "non-prohibited" employees. In the end, this restricts the amount higher-paid employees can contribute to the plan.

But, the proposal also says any member of the family of a prohibited employee also would be placed in the prohibited group. But the proposal doesn't define family member. It is possible that "family member" could include children of

employees rather than just spouses.

Big, decentralized employers would have difficulty immediately identifying employees whose parents also worked for the company and were members of the prohibited group, said John E. Lanz, senior counsel for benefits at TRW Corp. in Cleveland.

The proposed law also changes the discrimination tests so that the average deferral of highly paid plan participants is no longer compared as a whole against the average deferral of the lower-paid plan participants. Instead, the deferral of each member of the prohibited group would have to be individually compared with the average deferral of the non-prohibited group.

The new law also sets up one discrimination test for employer matching contributions that immediately vest and another for those that aren't immediately 100% vested.

To meet these proposed new discrimination tests, employers and plan administrators would have to scrap existing computer software programs now used to calculate salary deferrals and matching contributions and purchase or design new ones.

Consultants and employers also fear that the new rules banning in-service withdrawals to purchase a home or pay medical expenses or a child's college tuition will drastically reduce salary deferrals by lower-paid employees. And, if these employees reduce their contributions, top executives—under the discrimination tests—also won't be able to contribute as much.

The accessibility of funds deferred into 401(k) plans is a key factor behind the high percentage of participation in plans. Often 70% to 80% of a company's eligible employees participate in 401(k) plans.

Under the proposed law, employees still would be allowed to borrow up to \$50,000 from 401(k) plans, but

experts say allowing loans causes administrative problems and is not a substitute for withdrawals.

"Every employee looks at accessibility hard before deciding whether to participate and how much to contribute," said Hewitt Associates' Mr. Hasbargen.

"Accessibility is the price you pay to get the lower-paid and younger employees to participate," he said.

If the lower-paid don't participate at all, the salary deferrals made by top executives would be curtailed. That could give companies another reason to decide to drop a 401(k) plan.

Most likely to drop plans would be small companies that could least afford the higher administrative costs, said William Chip, counsel for the Employers Council on Flexible Compensation in Washington.

"Small employers may say it is not worth the cost given the steep reduction in benefits available to those running the company," said Mr. Chip.

And if small companies drop 401(k) plans, that may well leave employees with no company-provided plan for retirement benefits; small companies are least likely to have defined benefit pension plans, Mr. Chip said.

United to recoup assets

Continued from page 2

United, a unit of UAL Inc., said last week it would recapture \$962 million in excess assets from six pension plans covering the union workers and several groups of salaried employees. The plans have 59,600 participants.

The largest reversion to date was the \$375 million netted by Occidental Petroleum Corp. when it terminated a number of salaried employees' pension plans in 1983. As of late last week, United hadn't filed official notices with the Pension Benefit Guaranty Corp. regarding the reversion.

Although United says it is not terminating the plans but merely changing funding methods, the United proposal resembles what is commonly known as a "spinoff termination." In such a transaction, an employer splits a defined benefit plan into two plans—one for retirees, and one for employees. The excess assets are placed in the retirees' plan, which the company then terminates. The company buys annuities to pay promised benefits to retirees and recaptures whatever is left over.

The other plan—the one covering employees—is retained.

In United's case, each of the six pension plans will be split.

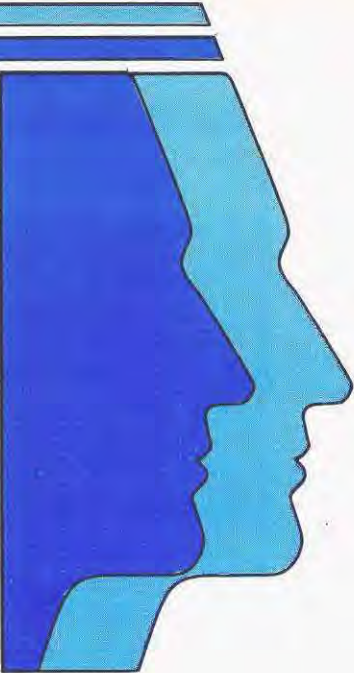
United said since its proposal affects only the funding of the plans, not the benefits promised to employees under collective bargaining agreements, it does not need union permission to recapture the excess assets.

However, a pension attorney says it's not clear whether United can recapture the assets without permission.

Whether a company can unilaterally terminate a union pension plan will depend on the terms and conditions in plan documents and labor agreements, said Dean Gaver, a partner at Hanoach Weisman, a Roseland, N.J., law firm.

Spokesmen for the unions—The Airline Pilots Assn., the Assn. of Flight Attendants and the International Assn. of Machinists—last week would not comment on United's proposal.

Meanwhile, United says the recapture of pension assets has nothing to do with the strike by its pilots. A tentative settlement in the strike was announced last week.



business insurance

Today there is a sense of urgency regarding the exorbitant expense of employee benefits. Industry professionals are concerned with the overall rise in health care costs. More specifically, employers are continuously faced with the task of effectively communicating the most efficient usage and bottom line value of benefits to employees.

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THE DOLLARS & SENSE OF COMM

AGENDA

GENERAL SESSIONS focus on the foundation of effective communication.

Listening To Employees

Suzanne Kenney, Manager, Employee Listening Services, HEWITT ASSOCIATES

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

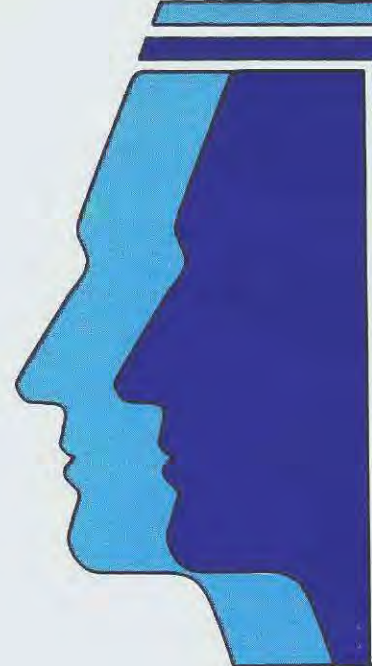
Martin Lapidus, Consultant, TOWERS, PERRIN, FORSTER & CROSBY

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.

UNICATING EMPLOYEE BENEFITS

EBC COMPETITION

EBC AWARDS LUNCHEON

Alfred Malecki, Publisher, *BUSINESS INSURANCE*

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.

All registrations will be confirmed in writing.

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

Business Insurance, Communication Services Department
220 E. 42nd St., Suite 930, New York City, NY 10017

For additional information call: Ann Vazquez, Registrar, at 212/210-0137

HOTEL ACCOMMODATIONS

We have set aside a block of rooms at a special rate at the Grand Hyatt Hotel in New York City. Rates available to Conference Registrants only: \$100 single; \$125 double.

You must mention the *Business Insurance Benefits Conference* when making your reservations. Hotel cards will be included with your Conference Registration Confirmation. Or call the Grand Hyatt Hotel at 212/883-1234; or toll free at (800)228-9000. These rates will be honored only until July 22.

REGISTRATION FORM

Please register me for the 1985 BI Conference
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August 5 and 6
The Grand Hyatt Hotel in New York City

Mail to:
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220 East 42nd Street, New York, NY 10017
For additional information call: Ann Vazquez at 212/210-0137.

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I want to attend the following Print Workshop—select *only* one:

- ☐ The Power of Personalizing Print
☐ Standard Print & Print Enhancements

Registrants are invited to propose their day-to-day benefit communication problems or issues for evaluation at Task Force sessions. Due to time restraints, not all proposals can be addressed. Use the space provided below to submit your suggestion:

Additional Registrants from my organization:

Name _____
Title _____

☐ Payment Enclosed ☐ Visa ☐ Mastercard ☐ American Express
Account # _____ Exp. Date _____
Signature _____

(attach additional sheet if required)

Mentor liquidation sought

Continued from page 1

million in premiums to its reinsurers under a canceled reinsurance treaty covering the years 1981-1983 (BI, April 15).

The Kemper companies contend Mentor cannot now correct what Mentor calls an accounting error and cede these premiums to the reinsurers. Kemper also charges that Mentor apparently recognizes that losses on those premiums "will substantially exceed the premiums." Kemper Reinsurance and its Bermuda-based affiliate, Kemper Reinsurance Co. (Bermuda) Ltd., had 20.5% of the disputed treaty.

The government's petition on Mentor is only the second time it has sought court-ordered liquidation, and it is the first time the Registrar of Companies has asked the court to order liquidation of a captive owned by a major U.S. corporation.

The Bermuda government first sought a liquidation order against an insurer in 1983. Then, the government sought and obtained a liquidation order against Dover Insurance Co., a company affiliated with a West Coast insurance group.

Mentor executives would not discuss the government's action.

In a March 29 filing with the Securities and Exchange Commission, ODECO reported that Mentor was insolvent by \$12.3 million based on generally accepted accounting principles (BI, May 6).

While stating the GAAP-recorded deficit would not be covered by additional funds from ODECO, the oil company said Mentor had sufficient funds to cover its ultimate liabilities.

The same assertion was made in Mentor's public statement released and then withdrawn in Bermuda.

"Mentor believes that the provisions for loss and loss expenses are adequate to cover the ultimate liability net of unreported premiums and discounted for future investment

income. However, in the settlement of claims, as is normal in the insurance industry, such estimates may be more or less than the amount ultimately paid," the company added.

Mentor also said it would cooperate fully with Bermuda authorities and would comply with insurance act requirements while conducting the runoff in New Orleans.

The move to New Orleans is necessary since Mentor is no longer underwriting, the statement said, and "Mentor's management does not believe that it can attract and retain staff to conduct the runoff in Bermuda itself."

The statement also said that ODECO staff members would be used to assist in the runoff and that "general and administrative expense is estimated to be substantially less" in New Orleans.

Also disclosed was financial information as of Dec. 31, 1984, which Mentor said was contained in its statutory accounts filed with the Bermuda government:

- Discounted loss and loss expenses provisions totaled \$130.2 million.

"Being in a runoff situation, the company and its auditors deemed it appropriate to discount the provisions for loss and loss expenses to the present value at 31 December 1984."

"Management felt that the discounting of the loss and loss expenses provisions was the best way to present the effect of investment income and cash flow on settling future liabilities."

- Under U.S. GAAP financial statement presentation, the loss and loss expense provisions amounted to an undiscounted \$149.6 million.

- Prior to discounting the GAAP-basis loss reserves, the company's auditors required that Mentor increase the loss ratios used for property and commercial multiperil lines by 20 percentage points.

- No other balance sheet liabilities have been discounted.

- Cash, investments and accrued investment income available totaled \$131.4 million.

- Ceding reinsurers hold \$11.8 million in funds.

Mentor said these funds are available to cover loss and loss expenses provisions and the return of unearned premiums, but were not taken into consideration in calculating net, discounted loss and loss expenses provisions.

The statement also sheds more light on the change in the accounting treatment of certain reinsurance policies that reduced Mentor's year-end capital and surplus.

The change in the accounting treatment of "three aggregate stop-loss policies from reinsurance arrangements to financing arrangements resulted in a charge of \$18.4 million to capital and surplus," the statement said.

"Under these agreements, \$18.5 million has been paid to a reinsurer which will yield \$54.3 million on certain stipulated dates in 1992 and 1993. These payments are guaranteed by bank letters of credit."

"Out of the available \$54.3 million to be received, only \$22.1 million has been recognized in the financial statements. This amount represents the amortized value of those investments as at Dec. 31, 1984."

Mentor also pointed out its capital and surplus of \$645,000 would be about \$7 million if commissions that had been expensed for statutory financial reporting (but would not be incurred if unearned premiums were returned) were added back to surplus.

Financial statements published by Mentor covering the 10 years it underwrote insurance and reinsurance show earned premiums of \$175 million from 1974-1980; net written premiums of \$150 million from 1981-1983, and earned premiums in 1984 of \$78.8 million.

Also contributing to this report was Roger Scotton, a financial reporter in Bermuda.

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Business Insurance

Circulation Breakdown*

Commercial Consumers

Administrative:

CEO's presidents and owners 2,513
Vice-presidents, general managers and other administrative personnel ... 2,573

Financial:

Chief financial officers and vice-presidents of finance 2,168
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.

Union Indemnity

Continued from page 1

tional liability of \$25 million for unauthorized reinsurance.

Mr. Bartholomay's letter outlined a proposal for rehabilitating Union—later rejected by the New York department—that included placing loss portfolio reinsurance with F&G International, a Bermuda-based unit of United States Fidelity & Guaranty Co.

Mr. O'Brien said negotiations with F&G are ongoing despite the New York department's rejection of the proposal. He also said that Hall has no plans to contribute more money to Union, though he added that "this is an evolving situation."

He would not comment on whether Hall would have any legal obligation to support Union if it is taken over by New York department liquidators, adding that generally a parent company would not have such an obligation.

Hall, contributed \$11 million in capital to Union last December.

In October, Hall said it planned to dispose of its direct underwriting operations, including Union; Union's wholly owned subsidiary, Union International Insurance Co. of Delaware; Great Plains Insurance Co. Inc.; and two other underwriting units.

Hall took a \$16 million aftertax charge against its third-quarter 1984 earnings for losses connected to the disposal of the underwriting operations.

In March, following further review of the operations, Hall restated its fourth-quarter and year-end 1984 results to reflect an additional \$16 million charge.

Along with the problems involving Union Indemnity, Hall has agreed to cover amounts that Great Plains will not be able to collect from one of its reinsurers, Kent Insurance Co. of Miami, which is insolvent, according to Mr. O'Brien. Reinsurance recoverable from Kent and guaranteed by Hall may add up to \$12 million, Mr. O'Brien said.

Hall acquired Union Indemnity from Union Insurance Society of Canton, Hong Kong, in 1977 and reactivated the company, which had been dormant since 1974.

Union was licensed in 43 states and the District of Columbia, Puerto Rico and Canada. The company was also approved as a non-admitted reinsurer in California, Maryland, North Carolina and South Dakota.

Most of Union's \$68.3 million in 1984 direct written premiums, however, was produced in New York, Florida, Michigan, New Jersey and Illinois.

New York accounted for \$30.4 million in 1984 direct written premiums; Florida for \$7.3 million; Michigan for \$7 million; New Jersey for \$3.8 million; and Illinois for \$3.2 million.

Mr. O'Brien said that Union had "very few" managing general agency contracts under which the MGA had binding authority for Union. Union's business instead was produced by independent agents, Mr. O'Brien said.

Most of Union's business in Florida was produced by Union Underwriters Inc. of Miami and it involved mostly private passenger auto coverage, according to the Florida Insurance Department.

One of Union's New York-based commercial casualty agents was Louis Mazzella, who was recently indicted for insurance fraud on business unrelated to Union (BI, May 6).

Most of the states in which Union operated have either suspended the company's license or ordered it to stop underwriting, according to court papers filed by the New York Insurance Department. Mr. O'Brien said a few states, including Florida, have revoked Union Indemnity's license.

In a Feb. 13 letter to the New York department, Union Chairman Douglas L. King agreed to stop writing new business and Union ceased renewing existing business when the liquidation petition was filed June 5.

Union Indemnity's gross premium volume grew to \$94.1 million in 1984 from \$6.7 million in 1979.

Net premiums written in 1984 were \$40 million, up from \$454,843 in 1979.

The company's largest lines—and those that produced the largest losses—were commercial multiperil and "other liability," which a New York department spokesman said included product liability, municipal liability and various forms of professional liability.

New direct and reinsurance premiums written in the commercial multiperil line were \$16 million in 1984 while net paid losses amounted to \$5 million and net unpaid losses amounted to \$12.6 million, according to Union's 1984 annual statement.

Net direct and reinsurance premiums written on "other liability" policies were \$11.6 million in 1984 while net paid losses amounted to \$5.9 million. Net unpaid losses were \$16.5 million, according to the annual statement.

The New York department, however, disputed Union's estimates of its liability for unpaid losses, along with other elements of its financial statement.

While Union reported total net unpaid losses of \$32.2 million in 1984, the department's examiners increased that amount by \$46 million to \$78.2 million.

About \$30 million of the increase was tied to "other liability" reserves, while \$10 million related to multiperil, ocean marine and aircraft business.

The department also added \$14.2 million to Union's reported reserves for loss adjustment expenses in 1984, bringing that total to \$17.9 million from the \$3.7 million the company reported.

The department made similar—but smaller—increases in its examination of Union's 1983 results. The examiners increased Union's net unpaid loss reserves to \$26.9 million from the \$23 million reported by the company, and boosted loss adjustment expense reserves to \$5.1 million from the \$2.4 million the company reported.

In both years, the department also made sizable additions to Union's liability for unauthorized reinsurance.

For 1984, examiners boosted this liability by \$56.2 million to \$75.6 million from the \$19.4 million Union reported in its annual statement.

For 1983, the department hiked the liability by \$19.1 million to \$20.3 million from \$1.2 million.

In its examination report for 1983, the department said that Union had improperly included "substantial" amounts of reinsurance recoverable—most from unauthorized reinsurers—as "agents' balances or uncollected premiums," an asset.

The result was an \$8.5 million understatement of Union's unauthorized reinsurance liability and an overstatement of its surplus, the department said.

Also, the report for 1983 noted that Union provided no substantiation for \$1.2 million in letters of credit for unauthorized reinsurers for which it had taken credit.

The company also failed to provide complete reinsurance contracts, in some cases providing only cover notes and in others providing only unsigned draft copies of reinsurance agreements, the department says.

Union reported 195 unauthorized reinsurers in its 1984 annual statement. Total reinsurance recoverable from these companies amounted to \$15.1 million on paid losses and \$25 million on unpaid

losses. Premiums in force added up to \$13.7 million.

In addition, the company reported a total of \$32.8 million in letters of credit and other funds withheld from unauthorized reinsurers.

Among Union's most significant unauthorized reinsurers are Bermuda captives that are managed by Hall or owned by Hall brokerage clients.

Among those companies managed by Hall are Titania Insurance Co. Ltd., owned by Wackenhut Corp., with \$2.4 million in reinsurance payable to Union and \$747,896 in premiums in force; Paumanock Insurance Co., owned by Grumman Corp., with \$2.2 million payable and \$996,593 in premiums in force; and Knightsbridge Reinsurance Co., owned by Percenterprise Completion Services, with \$270,000 payable.

Mr. Spencer-Arscott said that Hall Underwriting Managers wrote U.S. risks using Union as a fronting company, which then ceded the business to a captive reinsurance pool that included Paumanock, Titania, Knightsbridge and others.

This business was separate from the non-U.S. risks that the underwriting manager wrote directly for Paumanock and reinsured in another pool that included some of the same captives, he explained.

Two of Union's other unauthorized reinsurers are Anderson Hill Insurance Co., with \$1.1 million in reinsurance payable to Union on paid losses and no premiums in force; and PepsiCo Casualty Insurance Ltd., with \$1.3 million in reinsurance payable on unpaid losses and \$8,175 in premiums in force.

Both reinsurers are owned by PepsiCo Inc., a Hall brokerage client, and were formerly managed by Hall before switching to in-house management.

Other significant unauthorized reinsurers are Caja Nacional de Ahorro y Seguro de Buenos Aires, with \$5.2 million in reinsurance payable to Union and \$87,797 in premiums in force; and Mentor, a captive owned by Ocean Drilling and Exploration Co., with \$2 million in reinsurance payable and \$257,594 in premiums in force.

Union's 1984 annual statement also shows \$16.6 million in reinsurance recoverable from 111 authorized reinsurers.

In his May 23 letter to the New York department, Hall's Mr. Bartholomay said that the broker supported Union "in principle," and outlined a proposal for dealing with the company's loss reserve and unauthorized reinsurance liabilities.

To cure what he said would be a maximum \$30 million deficit from underreserving, Mr. Bartholomay proposed a loss portfolio transfer with F&G International, which would put up a \$30 million letter of credit to cover its obligations.

He added that Union would also consider lining up an aggregate stop-loss reinsurance agreement that would cap further loss development.

To deal with the unauthorized reinsurance liability, Mr. Bartholomay said Union would arrange for letters of credit to be posted by the relevant reinsurers.

Finally, Mr. Bartholomay asked the New York department to agree that Union "will not be exposed to further statutory examination or action for at least one year."

Richard Karpin, assistant chief of the department's property companies bureau, rejected the proposals in a May 30 letter to Mr. Bartholomay. The letter noted that the loss portfolio proposal had been raised by Union and rejected in previous meetings with department staff.

Mr. Karpin's letter also noted that Union had proposed securing letters of credit from its unauthorized reinsurers in September 1984 and that its past efforts in that area were unsuccessful.

update

Accountant reports on Beckett

Continued from page 2

The report also says incomplete information was released to syndicate members, who may have lost 130 million pounds (\$163.8 million at current exchange rates) since 1979 (BI, June 3).

Although the full report is not yet public, portions were released by a committee of Beckett members, which requested the report.

According to the report, "The syndicate reinsurance program has been wrongly implemented in a manner which is prejudicial to the interests of the non-marine syndicates."

In addition, "A large number of possible reinsurance recoveries on non-marine syndicates have not been claimed or credited to the syndicates' accounts."

"Syndicate accounts were manipulated in such a way as to conceal serious over-writing," the report adds.

The report also says names were given insufficient information when they accepted an offer last year by Beckett's parent, Minet Holdings P.L.C., and Alexander & Alexander Services Inc. of 38.17 million pounds (\$48.1 million) to cover losses resulting from alleged misappropriation of funds when the syndicates were managed by PCW Underwriting Agencies Ltd., Beckett's predecessor.

"Information was available at the time of the offer last year to show that the non-marine syndicates were under-reserved, on the basis now being used, by some 36 million pounds gross. This information was not given to names," the accounting firm said.

Minet contends that the report has uncovered nothing new beyond problems already found. It also says names were given all available information last year when it and A&A made its offer.

Minet adds there is no ground for litigation, but it has made a provision in its accounts for further legal costs.

Wellington sign-up 'on track'

NEW YORK—A spokesman for asbestos producers and insurers seeking to establish a claims-handling facility said last week that the final sign-up for companies that have conditionally signed an agreement establishing the facility was still set for Wednesday.

"It's still on track. I believe it will go," said Scott Gilbert, one of the negotiators of the agreement and an attorney with the Washington law firm of Covington & Burling.

The agreement, called the Wellington agreement, is intended to set up an out-of-court mechanism for handling asbestos claims more fairly, more quickly and at a savings of millions of dollars. It also would resolve most of the insurance coverage disputes between asbestos producers and insurers that join.

About 44 producers and 22 insurers have conditionally signed the agreement. A final sign-up has been postponed several times, most recently last month (BI, May 13).

Comp report endorsement

KANSAS CITY, Mo.—The National Assn. of Insurance Commissioners was expected last week to endorse a package of recommendations regarding the compensation of occupational disease claims.

The NAIC's Workers Compensation Task Force last week endorsed the recommendations in a 200-page report by its advisory committee, and the entire NAIC was expected to act on the endorsement last Friday at the close of its summer meeting.

That task force endorsement reversed action taken June 9, when some members asked for more time to study final revisions. The June 12 resolution is a general endorsement of the report, rather than an endorsement of specific recommendations.

The report concluded state workers compensation programs should remain the principal method for compensating workers with occupational diseases, rather than a federal program or the civil justice system (BI, June 10).

Spectrum's loss estimate grows

LONDON—PWS International P.L.C. is paying more than expected to cover losses of its Bermuda-based subsidiary, Spectrum Insurance Co. Ltd.

Last December, PWS Chairman Malcolm Pearson said the 295,000 pounds (\$371,700) reserved by PWS would cover Spectrum's losses. But, PWS now says it will have to make an additional provision of 440,000 pounds (\$554,400) to cover the property insurer's losses.

PWS was listed on the London Stock Exchange only last July and has had to report a 14% drop in pretax profits, to 1.7 million pounds (\$2.1 million) for the fiscal year ending in March as a result of the continuing losses at Spectrum.

Spectrum no longer underwrites on its own account.

New syndicate may join IIE

CHICAGO—The Illinois Insurance Exchange was scheduled to take action last week on whether to accept a 13th member, a syndicate being formed by Lloyd's of London syndicate H.S. Weaver (Underwriting) Agencies Ltd.

The NUA Syndicate, capitalized at \$10 million, would join seven other exchange members that are actively writing business.

If approved, the syndicate will be managed by National Underwriting Agency in Chicago.

India rejects interim aid

NEW YORK—The Indian government will not accept \$5 million in interim relief offered by Union Carbide Corp. to survivors of the poisonous gas leak at its Bhopal chemical plant, though the money may still be distributed to victims through the U.S. and Indian Red Cross.

Also, a Union Carbide spokesman indicated negotiations with Indian officials would resume this week over a possible out-of-court settlement to compensate survivors. Negotiations broke off two months ago.

Wausau to discuss M&M memo

Continued from page 2

Further, the memo adds, "As a reminder, it should be noted that no new or renewal business should be placed (with Wausau) unless the client requests us to do so, and then only if a signed disclaimer is received from the client."

The memo notes Wausau's policyholder surplus as of March 31 was \$267 million compared with \$302 million at the end of 1984. If gross premiums written continue at the first-quarter pace, it says, Wausau's ratio of gross premiums to surplus would top 6-to-1.

The memo also notes the resignation of John A. Schoneman as chairman and chief executive officer of the company, which specializes in commercial insurance, including workers compensation and primary general liability coverages.

Thomas Hancock, chairman of Wausau's executive committee, replaced Mr. Schoneman. Mr. Schoneman said he resigned because of a "friendly difference of opinion" over how the company should recover from its 1984 loss of \$206.6 million (BI, June 10).

M&M's Mr. Foley would not comment on the memo, except to say, "It's our practice to discuss on a periodic basis any significant developments in the industry, including the security of the markets."

M&M Inc. President Robert Clements could not be reached.

Other brokers say they do not plan any changes in their relationship with Wausau before A.M. Best Co. releases its 1985 rating. The insurer had a B-plus rating last year, considered "very good."

Mr. Davis says Wausau officials are still meeting with Best's on its 1985 rating, which is expected to be released in about a week.

Fred S. James & Co. Inc. does not plan to take any action "in the immediate future," says Charles Ruoff, senior vp-property/casualty.

Mr. Ruoff says James distributes a list of acceptable markets. Any company rated A by Best's is automatically acceptable.

If a company is rated B, however, it must pass the scrutiny of the security committee or business cannot be placed with it without special client approval. The committee gave Wausau a favorable review last year when its rating dropped to a B-plus from an A, he says.

Peter Polstein, senior vp at Alexander & Alexander Inc. in New York, says the broker has asked Wausau for information, "and when we have it, we'll evaluate it."

Samuel Alcorn, senior vp of operations for Bayly Martin & Fay International Inc., says the brokerage is continuing to use Wausau as a market. "I seriously doubt that we will change our position" regardless of any new Best's rating, he said.

During the first quarter, Wausau reported a 126.2% combined ratio, increased from a 121.5% combined ratio for the comparable period a year ago. Net written premiums were \$312.3 million, a 15.1% increase over 1984. The company had a pretax underwriting loss of \$81 million, a 38.4% increase over a year ago, while investment income increased to \$41.2 million, up 8.8% from 1984's first quarter.

Employers Insurance Co. of Wausau, a mutual, is the lead member of the Wausau group. The mutual owns all outstanding shares of Employers of Wausau Insurance Co. and Wausau Service Corp.

Wausau Service, an intermediate holding company, in turn owns directly or indirectly all the outstanding capital stock of Wausau Underwriters Insurance Co. as well as several other companies.

Wausau's largest line of business is work comp, which generated about half of its \$1.4 billion premium volume in 1984. Other major lines include general liability, commercial auto and property lines.

First-quarter results

Continued from page 2

effect of the tightening market on insurers' fortunes:

- Underwriting losses among the surveyed insurers increased 13.4% to \$2.6 billion, compared with the first quarter of 1984. But, this performance was a dramatic improvement over calendar year 1984, when the insurers' underwriting losses rose by 62.3%.

- The combined ratio for the quarter was 119.4%, a slight improvement over the 120.1% combined ratio posted by the insurers during the first quarter of 1984 and a major gain over the combined ratio of 122.1% posted by the insurers at the end of 1984.

- Net written premiums, fueled by rate increases, rose by 15% to \$13.9 billion.

- Thanks in part to increased cash flow generated by higher premiums, pretax investment income rose to \$1.9 billion, a 10% increase over the first quarter of 1984 and an improvement over 1984's 7.6% increase.

- Policyholders surplus increased by 1.4% to \$14.6 billion, compared with an 8.3% decrease in surplus reported by the insurers last year.

Regardless of all these favorable indicators, the surveyed insurers' aggregate net operating income plunged to \$230.6 million, down 46% compared with the first quarter of 1984. The insurers' net operating income had declined 52.4% during calendar year 1984.

Despite the continued drain on profits in the first quarter, industry observers are sanguine about the future.

"We look ahead optimistically, even though we were disappointed with the first quarter," says James A. McIntyre, president and chief executive officer of Fremont General Corp., whose results improved in the first quarter despite posting a \$5.9 million operating loss.

"I think the industry is going to get healthy very, very quickly," says David O'Leary, director of research at Hartford, Conn.-based

Fox-Pitt, Kelton Inc. "We're on the verge of very dramatic improvement."

Observers point to the 15% jump in net written premiums as an indication of higher rates and a portent of improved operating results in the future. Mr. O'Leary says average rate hikes of 30% to 50% in all commercial lines are common except for workers compensation, where he says rate hikes have averaged 10%.

As a result, first-quarter net written premiums were "significantly higher" than expected, Mr. O'Leary says, adding there will be increasing momentum for rate hikes during the rest of the year.

"We've got to do a tighter underwriting job and accelerate price hikes," says Rudolph F. Lancolt, senior vp at Kemper Corp. Kemper was the leading performer in the first-quarter survey, with operating income rising 768.6% to \$7.5 million in 1985 from a loss of \$1.1 million in the first quarter of 1984.

Also contributing to the overall increase in the industry's net written premiums were inflation, economic growth and higher net retentions by direct insurers that could not find the reinsurance capacity to cede as much risk as in the past, says Thomas P. Rosencrans, research director at Conning & Co. in Hartford, Conn.

For instance, Mr. Rosencrans notes that although AIG's net written premiums increased 32.7% during the first quarter, its gross written premiums were up by only 21%, indicating a "substantial increase in net retentions."

Some observers, however, are questioning whether insurers have sufficient capital to support the increase in net premiums, although most of the large insurers have managed to keep their premium-to-surplus ratios "within acceptable standards," says Gloria L. Vogel, a vp at Legg Mason Wood Walker Inc. in New York.

To avoid these potential problems, many insurers have "gone to market" in an effort to raise capital. Among the insurers that have recently made public offerings are Aetna Life & Casualty Co., The Travelers Corp., CIGNA Corp., The St. Paul Cos. Inc., General Re Corp., AIG, Chubb Corp., Continental Corp. and USF&G Corp., notes Myron M. Picoult, a senior vp with Oppenheimer & Co. in New York.

"They obviously need capital. Whether or not they employ it intelligently is something else," he says.

"My feeling is, if you can raise capital on a non-diluted basis, it's silly if you don't," says E.F. Hutton's Mr. Lewis.

Chubb has gone to market twice: a common stock offering last August that generated \$75 million and a preferred stock offering in April that raised another \$125 million,

notes a company spokesman. While the proceeds of the second stock offering are not reflected in first-quarter results, the common stock offering—plus the \$75 million generated when Chubb terminated its overfunded pension plan—helped boost its policyholders surplus by 46.9% to \$512.3 million as of March 31.

A spokesman for CIGNA, which raised \$250 million in a preferred stock issue (BI, June 10), notes that rates are now increasing and "we'd like to be able to take advantage of it."

Hartford's Mr. Donahue says that while Hartford's premium-to-surplus ratio is now in a "comfortable position," he adds the company is "concerned, because not only of the rate increases we're getting but because of expected significant growth."

"We are, in fact, looking at various ways we might increase the policyholders surplus," Mr. Donahue says, noting that Hartford cannot go directly to market because it is a subsidiary of ITT Corp.

AIG's Mr. Robitaille says, "We're always considering the need for additional capital, particularly in light of this environment, where premiums are going up so strongly."

"We could take any number of avenues to increase our capital positions. We are not contemplating one avenue over another," he says.

Another method insurers have used to generate additional capital is to terminate overfunded defined benefit pension plans and recoup the excess assets.

In addition to Chubb, insurers that have terminated pension plans in the past year include Fireman's Fund Insurance Cos., Commercial Union Insurance Cos., Wausau Insurance Cos., Chubb, The Home Insurance Group and American Mutual Liability Insurance Co. (BI, May 6).

Mr. Lewis notes, however, that not every insurer can tap this option, depending upon how well its pension plan is funded.

And, some insurers won't consider a pension plan termination as a means to increase capital.

"As a corporation, we view the pension plans as more of a long-term commitment" between company and employees, says a spokesman for Hartford Steam Boiler Inspection & Insurance Co.

One method of generating capital that has become popular with some insurers is put options. In a put-option transaction, a property/casualty insurer sells municipal bonds to another company for their cost plus a small premium. The buyer is also given a "put," entitling it to sell the bonds back to the insurer after a period of time.

The insurer then takes the proceeds of the sale, invests them in higher-yielding taxable instruments and eventually buys back

Continued on next page

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Summary of major property/casualty insurers' first-quarter results

(All amounts in thousands of dollars)
(Ranked by change in aftertax operating income)

Corporate				Property/casualty operations										
Rank 1985	Consolidated revenues 1985	Aftertax ¹ operating income 1985	Percent increase (decline) 1984-1985	Combined ¹ ratio 1985	Combined ¹ ratio 1984	Net premiums written 1985	Percent increase (decrease) 1984-1985	Pretax underwriting income (loss) 1985	Percent increase (decline) 1984-1985	Pretax investment income 1985	Percent increase (decrease) 1984-1985	Policyholders surplus 1985	Percent increase (decrease) 1984-85	
1	Kemper Corp.	679,125	7,522	768.6	119.7	119.2	173,289	(21.9)	(34,003)	21.0	17,931	(8.2)	299,790	(0.6)
2	Hartford Steam Boiler	71,580	4,770	696.3	100.0	127.8	57,393	42.4	(64)	99.4	5,255	4.1	123,041	(29.3)
3	Reliance Ins. Co. & subs.	385,006	9,796	275.9	114.9 ²	115.7 ²	337,811	4.2	(35,296)	29.0	45,764	7.3	387,900	(2.3)
4	Aetna Life & Casualty Co.	4,285,500	56,900	199.5	119.3	120.7	1,073,900	11.7	(185,100)	(1.1)	136,800	7.0	1,093,301	13.2
5	Mission Ins. Group Inc.	153,204	6,258	141.0	152.9	128.4	101,844	(15.7)	(10,208)	66.8	13,860	11.8	53,983	(77.6)
6	Chubb Corp.	570,700	24,200	86.2	109.4 ²	113.3 ²	434,000	31.3	(38,400)	13.7	44,900	24.4	512,263	46.9
7	Fremont General Corp.	128,796	(5,882)	39.1	132.9	130.9	102,030	47.7	(30,108)	(40.9)	17,743	65.3	103,848	6.2
8	CNA Financial Corp.	1,037,200	39,500	37.6	124.1	122.3	621,200 ²	37.8	(160,500) ²	(49.7)	131,900 ²	20.8	1,097,700	5.2
9	Sentry Ins. Cos. ²	131,236	(8,888)	24.9	118.7	120.4	231,380	8.6	(44,704)	5.0	25,130	11.0	154,054	(25.7)
10	Royal Group (U.S. subs.) ²	N/A	(35,900)	13.5	121.2	126.0	357,600	17.4	(78,200)	1.3	49,600	7.6	N/A	N/A
11	Continental Corp.	1,161,228	17,323	12.3	115.2	114.4	708,109	12.4	(96,919)	(18.2)	90,564	10.2	975,000	10.7
12	Ohio Casualty Corp.	259,818	4,416	12.2	113.7 ²	116.2 ²	245,813 ²	14.2	(33,062)	3.4	29,050	18.7	355,589	(8.1)
13	American General Corp.	1,390,000	110,000	11.1	111.5 ²	123.0 ²	271,000	3.8	(25,000)	54.5	33,000	—	756,000	4.9
14	The Travelers Corp. & subs.	3,784,200	73,100	6.9	111.2	113.4	1,101,900	24.7	(135,700)	(10.1)	68,100	(6.3)	1,177,700	2.2
15	Old Republic Int'l (inc. life) ³	157,500	13,800	6.2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
16	Fireman's Fund Ins. Cos.	979,419	9,298	(8.7)	122.4	119.7	832,187	5.4	(154,391)	(8.6)	114,786	20.2	975,920	35.0
17	CIGNA Corp.	3,874,977	(26,012)	(9.8)	125.1 ²	137.2 ²	1,165,029	19.0	(281,790)	(19.3)	160,201	16.9	1,340,000	24.7
18	General Re Corp.	512,366	29,424	(11.1)	113.4 ²	117.8 ²	323,564	30.5	(45,168)	(10.8)	64,164	32.2	719,102	(1.4)
19	American International Group	1,147,264	80,049	(26.4)	107.5	102.3	845,156	32.7	(65,053)	(205.5)	86,454	6.0	N/A	N/A
20	SAFECO Corp.	525,092	23,766	(27.6)	116.2	104.4	271,861	19.7	(41,164)	(312.6)	29,786	12.3	418,046	(13.3)
21	The St. Paul Cos. Inc.	608,331	2,672	(60.1)	122.8 ²	127.2 ²	456,254	6.4	(109,061)	6.2	87,253	17.1	645,394	(14.0)
22	Hartford Insurance Group	1,521,718	5,071	(79.4)	117.2	122.4	953,280	16.7	(90,110)	10.6	110,982	(3.3)	1,156,981	(14.3)
23	USF&G Corp.	770,100	(17,800)	(170.1)	123.0 ²	126.8 ²	645,000 ²	22.8	(137,100)	0.4	118,300	16.1	717,800	(2.4)
24	Crum & Forster Inc.	610,755	(9,800)	(189.8)	125.3	117.3	570,999	6.6	(137,367)	(49.2)	92,124	12.9	635,184	33.4
25	The Home Group Inc.	464,015	(182,963)	(1,223.6)	147.1 ²	131.7 ²	417,513	7.4	(291,272)	(186.8)	76,497	(7.1)	500,223	(27.0)
—	Liberty Mutual Ins. Co.	N/A	N/A	N/A	116.8	117.3	996,569	23.3	(141,320)	(32.0)	143,387	8.1	N/A	N/A
—	Wausau Insurance Cos. ²	N/A	N/A	N/A	126.2	121.5	312,288	15.1	(80,975)	(38.4)	41,154	8.8	N/A	N/A
—	Commercial Union Ins. (U.S.)	N/A	N/A	N/A	127.1 ²	114.8 ²	266,200 ²	(30.1)	(70,500) ²	(14.4)	39,900	(11.2)	373,900	(18.7)
Cumulative		25,209,130	230,620	(46.0)	119.4	120.1	13,873,169	15.0	(2,552,535)	(13.4)	1,874,585	10.0	14,572,719	1.4
¹ After dividends.				² Statutory.				³ Before dividends.				N/A—Company did not provide data.		

¹ After dividends.² Statutory.³ Before dividends.

N/A—Company did not provide data.

Continued from previous page
the municipal bond. By taking this approach, insurers can generate funds without dipping into their surplus (BI, March 25).

Commercial insurers that have recently completed put-option transactions include Aetna, which completed a \$220 million deal, and USF&G, which completed a \$76.7 million deal.

"The investments will become more and more creative as time goes on," predicts Mr. Lewis.

But, Mr. Picoult disagrees: "I think they're very wary of the creativity because it's generated so much criticism." He says he believes insurers will emphasize "cleaning up" the way they report their results. "At the moment they would opt for credibility as opposed to some of the 'futzin-around' stuff they've done."

James B. Stradtner, general partner at Alex. Brown & Sons in Baltimore, also believes that creative financing approaches such as put-option transactions will diminish

in popularity this year. "There was a necessity to do something imaginative last year—that, with improved earnings, is no longer called for, he says.

Another once-dark area that may be brightening is the adequacy of loss reserves.

"It looks like they're beginning to put a little bit away," says Mr. Picoult, who has been critical in the past of insurers' reserving practices.

Insurers are adding to reserves at higher levels now than they have in recent history,

but it is still uncertain whether reserves are sufficient, says David Anthony, an analyst with Smith Barney Harris Upham & Co. Inc. in New York.

Reserve problems will be resolved by the increasing premiums generated by the hardening market, says Fox-Pitt's Mr. O'Leary. By the end of 1986, he predicts, insurers' reserves will be adequate, and by the end of 1987, they will be redundant.

"The industry is on the road to riches," he says.

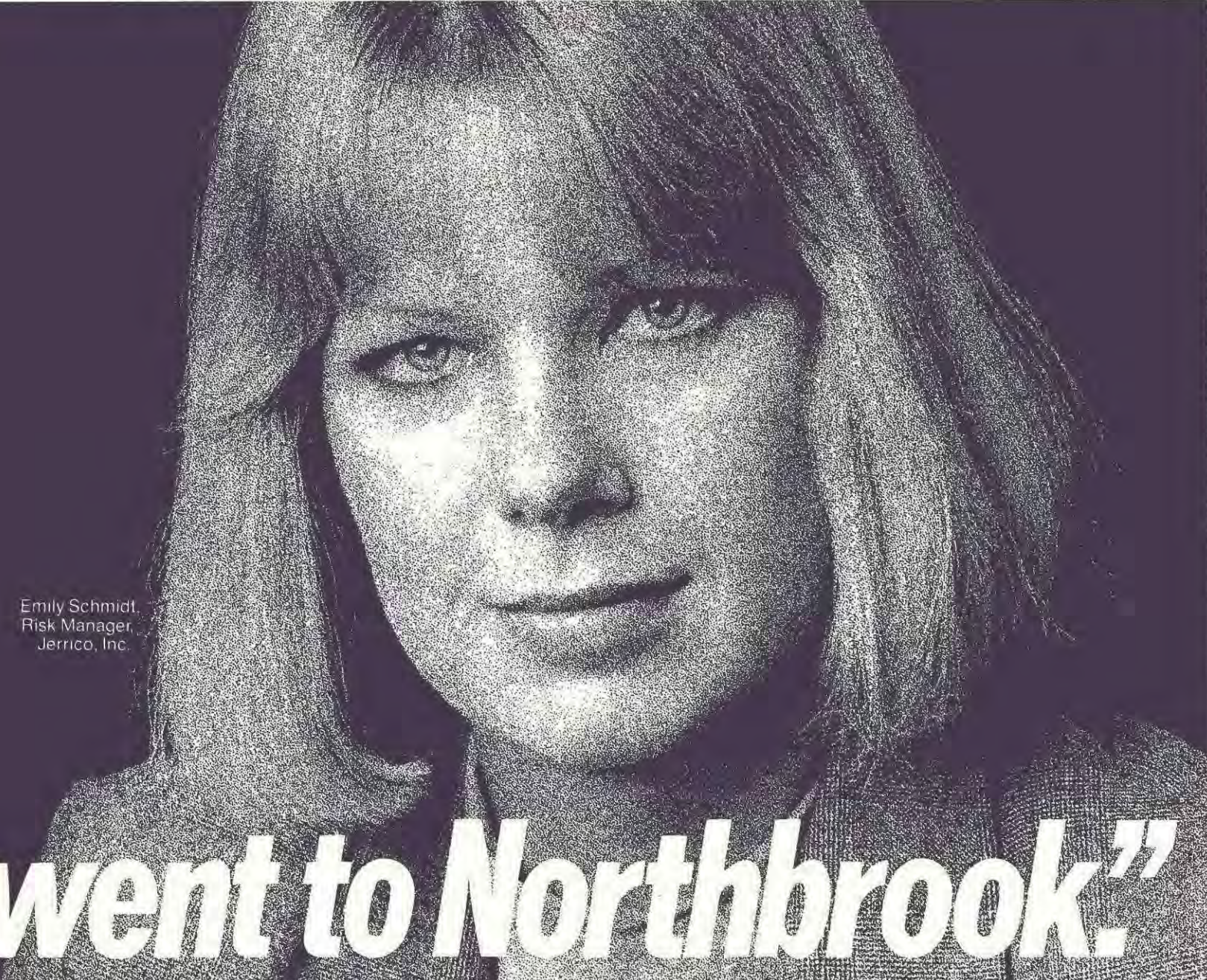
BI Industry Stock Report

June 12, 1985

6/6/85 thru 6/12/85

Brokers		Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol.(000)		Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol.(000)	
Alexander & Alexander Sycs	NYSE	29.63	7.7	0.0	1.00	3.4	30.50	29.00	998.5	Aveco Corp	NYSE	28.75	-0.9	13.3	0.60	2.1	29.50	28.75	10.5
Baldwin & Lyons Inc	OTC	64.00	-1.5	11.6	0.80	1.3	67.00	64.00	1.7	Business Mens Assurn Co Amer	NYSE	27.75	1.8	7.6	1.04	3.7	27.75	27.38	150.8
Corroon & Black Corp	NYSE	46.75	-0.5	0.0	1.00	2.1	47.00	46.25	128.0	Chubb Corp	NYSE	72.75	-1.4	18.3	2.20	3.0	73.25	72.38	232.8
Crum & E H Cos Inc	OTC	32.50	4.0	24.4	0.44	1.4	32.50*	31.25	30.7	Combined Intl Corp	NYSE	49.25	2.3	9.6	2.16	4.4	49.25*	48.50	102.6
Emett & Chandler Cos Inc	OTC	23.75	10.5	113.1	0.00	0.0	23.75*	21.50	62.4	Continental Corp	NYSE	43.88	-2.0	22.4	2.60	5.9	45.00	43.63	474.8
Gallagher Arthur J & Co	OTC	44.38	-0.8	26.6	0.28	0.6	44.75	44.13	41.1	Crown Life Ins Co	OTC	145.00	2.1	8.7	5.00	3.4	145.00*	142.00	0.6
Hall Frank B & Co Inc	NYSE	27.63	-3.5	0.0	1.00	3.6	29.38*	27.63	545.4	Durham Co	OTC	39.50	-1.3	7.6	1.28	3.2	40.50	39.50	4.3
Marsh & McLernan Cos Inc	NYSE	71.50	0.9	19.9	2.40	3.4	72.00*	70.38	505.3	Farmers Group Inc	OTC	61.38	0.2	10.7	1.76	2.9	62.13	61.38	874.9
Poe & Assoc Inc	OTC	8.00	0.0	0.0	0.00	0.0	8.00	8.30	1.1	Fremont Gen Corp	OTC	26.50	-2.8	0.0	0.48	1.8	28.00	26.50	164.9
Reed Stenhouse Cos Ltd	OTC	21.00	4.3	27.3	0.60	2.9	21.88	21.30	201.1	Great West Life Assurn Co	OTC	376.00	2.7	9.7	14.00	3.7	376.00*	371.00	1.5
AGENTS/BROKERS	AVERAGE		44.6			2.0				Hanover Ins Co	OTC	43.00	-0.6	72.9	0.56	1.3	43.50	43.00	133.1
Conglomerates & Holding Cos.										Hartford Steam Boiler Insnptn	OTC	47.00	2.7	40.5	1.50	3.2	47.00*	45.75	33.5
American Express(Fireman's Fd)	NYSE	46.75	0.0	16.0	1.28	2.7	47.38*	46.63	4,688.7	Kans City Life Ins	OTC	75.50	-1.9	8.7	2.88	3.8	77.50	75.50*	8.0
Anderson Clayton(Ranger/PanAm)	NYSE	39.00	0.3	33.6	1.32	3.4	39.00	38.88	51.6	Keeper Corp	OTC	56.50	2.0	24.4	1.80	3.2	56.50	55.88	132.2
Arco Inc	NYSE	8.25	0.0	0.0	0.00	0.0	8.38	8.25	438.4	Liberty Corp S C	NYSE	31.25	-1.6	14.6	0.72	2.3	32.00	31.25	11.2
Berkley W R Corp	OTC	15.50	0.0	0.0	0.32	2.1	15.75	15.50	155.2	Lincoln Natl Corp Ind	NYSE	43.25	-3.4	11.4	1.84	4.3	45.38	43.25	452.5
CIGNA Corp	NYSE	55.63	-0.2	794.6	2.60	4.7	56.38	55.63	794.8	Mission Ins Group Inc	NYSE	7.63	-1.6	0.0	0.00	0.0	7.75	7.50	66.2
City Investing Co. (Home Ins.)	NYSE	35.13	-0.7	5.5	0.00	0.0	35.25	35.00	900.6	Monumental Corp	OTC	31.75	-1.2	23.3	1.30	4.1	32.00	31.75	48.1
CNA Finl Corp (CNA)	NYSE	52.75	-1.4	20.3	0.00	0.0	53.25	52.63	180.7	Nobel Ins Ltd	OTC	10.00	0.0	14.1	0.33	3.3	10.50	10.00	54.2
General Re Corp	NYSE	82.13	0.8	54.0	1.56	1.9	85.13*	82.13	466.1	Northwestern Natl Life Ins	OTC	27.00	-0.5	6.5	0.80	3.0	28.38	27.00*	464.0
ITT (Hartford Group)	NYSE	31.75	1.6	9.9	1.00	3.1	33.00	31.75	2,815.9	Ohio Gas Corp	OTC	60.38	2.1	22.4	2.80	4.6	60.88	60.25	159.1
Optimum Hldg Corp	OTC	0.50	0.0	0.0	0.00	0.0	0.50	0.50	3.0	Old Rep Intl Corp	OTC	35.50	7.2	8.6	0.74	2.1	35.50*	33.25	214.1
Sears Roebuck & Co. (Allstate)	NYSE	37.75	-1.9	9.4	1.76	4.7	39.00*	37.63	3,520.2	Orion Cap Corp	NYSE	26.13	-4.1	0.0	0.76	2.9	27.38	26.13	42.3
Teledyne Inc (Argonaut)	NYSE	253.00	-2.2	5.4	0.00	0.0	257.25	253.00	79.4	Protective Corp	OTC	19.25	-1.3	6.5	0.66	3.4	20.00	19.25	253.9
Transamerica Corp	NYSE	31.00	0.8	15.2	1.64	5.3	31.13*	30.50	642.1	Provident Life & Acc Ins Co	OTC	23.25	1.1	6.3	0.88	3.8	23.50	22.75	230.5
(Occidental & Fred S. James)	NYSE									St Paul Cos Inc	OTC	70.00	0.2	0.0	3.00	4.3	70.38*	69.38	607.8
CONGLOMERATES/HOLDING COS.	AVERAGE		11.3			1.7				SAFE0 Corp	OTC	42.00	1.2	15.0	1.60	3.8	43.00	42.00	463.4
Insurers										Sri Corp	OTC	18.75	0.0	89.3	0.68	3.6	19.25	18.75	144.8
Aetna Life & Cas Co	NYSE	45.13	-2.4	22.9	2.64	5.9	46.63*	45.13	1,265.3	Seibels Bruce Group Inc	OTC	21.25	-1.7	0.0	0.80	3.8	21.63	21.25	142.6
American General Corp	NYSE	33.13	-3.3	10.8	1.00	3.0	34.75	33.13	1,387.0	Statesman Group Inc	OTC	4.88	5.4	0.0	0.15	3.1	4.88	4.63	64.1
Ameri Heritage Life Inv Co	NYSE	34.00	0.7	10.1	1.20	3.5	34.25*	33.75	2.8	Tokio Marine & Fire Ins Co	OTC	183.50	-2.9	31.7	0.00	0.0	190.75*	183.50	2.2
American Indty Finl Corp	OTC	20.25	-2.4	0.0	1.12	5.5	20.88	20.25	10.5	Torchmark Corp	NYSE	47.00	-0.3	10.4	1.00	2.1	47.50	47.00	248.0
American Intl Group Inc	NYSE	82.25	-2.1	24.3	0.44	0.5	86.00	82.25	430.5	Travelers Corp	NYSE	46.50	-3.1	11.2	2.04	4.4	47.63	46.50	555.6
Aneco Reins Ltd	OTC	1.50	0.0	0.0	0.00	0.0	1.50	1.50	1.0	United Fire & Cas Co	OTC	22.00	0.0	0.0	0.80	3.6	22.00	22.00	1.0
										United States Fid & Gty Co	NYSE	37.00	0.3	39.8	2.20	5.9	38.38*	37.00	622.1
										UsLife Corp	NYSE	35.75	0.7	8.2	1.04	2.9	37.00	35.75	669.5
										Washington Natl Corp	NYSE	24.13	0.0	7.1	1.08	4.5	24.75	24.13	51.5
										Zenith Natl Ins Corp	OTC	16.25	6.6	0.0	0.68	4.2	16.75*	16.25	203.6
										INSURANCE COMPANIES	AVERAGE		16.6		3.2				

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