

business insurance

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

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Ex-Florida exchange chief proposes new Atlanta facility

MIAMI—The former president of the Insurance Exchange of the Americas in Miami has announced plans to form a new exchange in Atlanta.

Atlanta Insurance Bourse Ltd. hopes to attract membership from among "admitted and authorized" U.S. and foreign insurers and reinsurers, managing general agents, brokers and underwriting agencies, according to the former president.

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A net loss?

By STACY SHAPIRO

WIMBLEDON, England—Insurance is bouncing onto the courts of championship tennis.

When Martina Navratilova won the French Open earlier this month and captured a \$1 million prize from the International Tennis Federation for winning tennis' "Grand Slam," the money was paid by London, U.S. and European underwriters, confirmed Christopher Stokes, financial administrator for the ITF.

The policy was brokered through Lloyd's of London broker Clarkson Puckle Group's "Sportsecure" division.

In 1982, the ITF—which is based at the All England Tennis Club, where the Wimbledon championships are played—offered the \$1 million bonus for any male or female tennis star who wins the Grand Slam by winning the French, U.S. and Australian Opens and Wimbledon within a 12-month span.

"The player can start the run at any stage, but he or she must win all four in a row," Mr. Stokes said.

But, in order to offer the prize money, the ITF had to find insurance that would cover the expense.

"Otherwise, the risk would have been too great," he said. "We only entered into the agreement once we knew we could insure it."

Through Clarkson Puckle, the ITF purchased a three-year non-cancelable policy that would pay "\$1 million for any male or female tennis player achieving the Grand Slam at any time for three years," the coverage says.

The policy runs from the 1982 Australian Open to the 1985 U.S. Open.

The policy, which cost the ITF \$100,000, has annual limits of \$2 million. That means that even though insurers already have paid \$1 million to Ms. Navratilova, they could be hit with \$2 million more in claims if both a man and a woman win the Grand Slam before the coverage expires, Mr. Stokes said.

Mr. Stokes would not name the underwriters, but he said 50% of the risk is placed with non-Lloyd's insurers in London.



Mr. Stokes said he didn't know whether the policy will be renewed. However, if it's not renewed, he doubts that the ITF will offer the prize after next year's U.S. Open.

Photo: Wide World

Conference panel denies deductions for claims reserves

By JERRY GEISEL

WASHINGTON—Employers are one step closer to losing the ability to deduct contributions to self-funded reserves established to pay property/casualty claims.

A congressional conference committee approved provisions in tax bills already cleared by the House and Senate that would deny tax deductions for reserves to pay self-funded losses known in the current year but not payable until the future (BI, March 19, April 23).

The conferees, though, haven't taken any actions on provisions on other risk management-related provisions in the Senate and House bills, including proposals that would alter the tax treatment of income received by offshore insurance subsidiaries or a proposal in the Senate bill to increase to 4% from 1% the federal excise tax on property/casualty reinsurance premiums paid to foreign insurers.

The conferees—who have been meeting since June 6 to iron out differences in the House bill, H.R. 4170, and the Senate bill, H.R. 2163—did approve one benefit issue. They agreed to change the order of withdrawals from pension plans that are substantially funded by employee contributions.

Substantially employee-funded plans refer to pension plans in which at least 85% of benefits are derived from employee contributions, though it is not known how many of these plans exist.

The new provision, similar to what the Senate initially proposed, says that employees who want to withdraw funds from such a plan would first withdraw the accumulated interest, which is taxable, before they could withdraw their own contributions.

The House had originally proposed scrapping such pension plans altogether.

This provision will not affect individual retirement plans, such as Individual Retirement Accounts and Keogh plans.

But, as of late last week, the conferees had not discussed several major employee benefit issues, like the tax treatment of contributions to 501(c)(9) trusts and protection for flexible spending accounts from highly restrictive proposed Internal Revenue Service rules.

While benefit managers still have to wait for conferees to make those crucial decisions, the verdict on the provision affecting the tax deductibility of self-insured property/casualty reserves has been rendered and it confirms earlier predictions.

With little discussion, the conferees accepted virtually identical provisions.

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Coverage changes loom for satellites

By STACY SHAPIRO

LONDON—The recent loss of a \$102 million communications satellite, coupled with the memory of \$182 million in losses on a February space shuttle flight, may force major changes in the way satellites are insured, underwriters and brokers say.

The June 10 loss of the Intelsat V probe, owned by the Washington-based International Satellite Organization, a multinational communications organization, boosted satellite launch insurance losses to \$284 million in the last four months. This brings to \$500 million the amount underwriters have paid out on satellite launch claims in the past three years.

In contrast, satellite insurers' estimates of the total amount of premium they've received since they began writing coverage in the late 1960s ranges from \$230 million to \$330 million.

"Everybody is—in three words—shocked, dismayed and stunned," said one U.S. insurance source who wished not to be named.

"We were all looking at the (June) launch to redeem our losses... Now we have a catastrophic, phenomenal problem. Can we convince anybody that satellite insurance is prudent?"

Richard Rankin, a vp at Corroon & Black Inspace Inc., a Washington brokerage specializing in satellite coverages, said, "What has happened has ominous tones. It could have more long-term effects than people

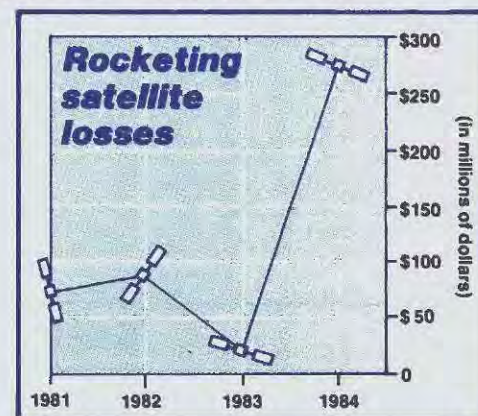
think.

"The feeling is that it is more of a confidence factor now—that the satellite technology may not totally have its act together—and that leaves underwriters wondering."

According to underwriters and brokers, satellite insurers' skyrocketing loss ratio may cause:

- Some smaller underwriters to write only high-level excess satellite launch policies instead of primary and low-level excess coverage.
- Insurers to require a one-loss deductible for all satellite launch coverages. In other words, a satellite owner's first launch failure would not be covered.

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Graphic: Amy Palmer

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update

Atlanta exchange proposed

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cording to Chairman Alan Teale, whose contract as president of the Miami exchange recently expired.

Unlike other U.S. exchanges, the Bourse will require no new capitalization from members, who will be allowed to write whatever classes of business they are allowed to write by state and national insurance regulators, Mr. Teale says.

Other organizers of the Bourse include Jimmy Bentley, a former Georgia insurance commissioner, and Charlotte C. Rentz, a former director of Educational Testing Service.

Harold Hines dies at age 59

CHICAGO—Harold H. Hines Jr., 59, president and chief executive officer of Chicago-based brokerage Rollins Burdick Hunter and executive vp of parent company Combined International Corp., died of a heart attack June 14 in Chicago.

Mr. Hines' career in the insurance brokerage business spanned over 30 years, beginning with Wineman Brothers Inc., an insurance agency in Chicago, and including 12 years with Marsh & McLennan Inc., where he was president from 1978-1980. In 1980, he became president of Ryan Insurance Group, which was acquired by Combined in 1982.

Mr. Hines was best known in the insurance community for his insightful speeches and writings on the development of the commercial insurance business.

Combined President Patrick G. Ryan, who is also chairman of RBH, is acting as chief executive officer of RBH.

Increase in excise tax nixed

WASHINGTON—A congressional conference committee late last week dropped a provision in the Senate tax bill, H.R. 2163, that would have increased to 4% from 1% the federal excise tax on property/casualty reinsurance premiums paid to foreign insurers (see earlier story, page 1).

North American Re cuts staff

NEW YORK—North American Reinsurance Corp. has cut back staff in its facultative reinsurance operations, citing previous overstaffing and the need for expense control.

Company officials could not say exactly how many employees were laid off, but the number was not more than 60, one North American Re executive said.

The layoffs included salaried and clerical workers in the home and branch offices, although no branch offices were closed and the company hasn't cut back on services, according to a spokesman.

In 1983, North American Re booked net premiums of \$508.2 million, losses of \$410.4 million and underwriting expenses of \$140.2 million, for a combined ratio of 110.7%.

The cuts follow North American Re's consolidation last May of its treaty and facultative marketing and underwriting operations.

Gulf cargo rates rise again

LONDON—Minimum cargo war risk rates have doubled for the southern region of the Persian Gulf off the coasts of Saudi Arabia, Bahrain and the United Arab Emirates, the Joint Cargo War Risk Rating Committee announced last week.

The committee announced that all ships south of the 27th parallel and the 56th meridian will be charged 10 cents per \$100 of insured cargo value, up from 5 cents. This includes ships docking in southern Saudi Arabia, Bahrain and the UAE, but does not include Iranian ports.

The move followed last week's shelling of the Kuwaiti tanker Kazimah, which was struck by Iranian fire off the coast of Bahrain. It was the 13th vessel to be damaged in the escalation of the Iran-Iraq War.

\$2.6 billion suit filed in fire

NEW YORK—A \$2.6 billion suit was filed in U.S. District Court in Manhattan last week by parents of four teenagers killed in a May 11 fire at the Great Adventure Amusement Park in Jackson Township, N.J. (BI, May 21).

Defendants named in the suit are Bally Manufacturing Corp. and its subsidiaries, Six Flags Corp. and Six Flags Great Adventure, and George Mahana, builder of the attraction that burned. Attorney Morris Eisen of New York is representing the plaintiffs.

Plaintiffs in the suit are listed as the families of four Brooklyn teens who died: Samuel Valentin Jr., 17; Eric Rodriguez, 18; Lenny Ruiz, 17; and Jose Carrion Jr., 17.

A Six Flags spokesperson earlier confirmed St. Paul Fire & Marine Insurance Co. was the primary liability insurer for the attraction.

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M&M continues loss probe after firing treasurer, others

By DOUGLAS McLEOD

NEW YORK—Investigations into the massive bond trading losses at Marsh & McLennan Cos. Inc. are continuing after the recent dismissal of the company's treasurer and several subordinates.

Chairman John M. Regan Jr. announced at M&M's annual meeting June 8 that the company had fired Chester A. Gan, vp and treasurer. Also dismissed were Richard O. Post Jr., vp and head of the company's investment management group, and Dorothy M. Conway, M&M's chief bond trader.

In all, Mr. Regan said, "six or eight" employees were terminated in the wake of the bond trading debacle, which produced \$90 million in aftertax losses for the company. However, he declined to name any of the terminated employees except for Mr. Gan, Mr. Post and Ms. Conway.

M&M and its outside law firm, Willkie, Farr & Gallagher, also are developing information that may lead to claims against "various parties" to recover some of the losses.

One of these parties is apparently Arthur Andersen & Co., M&M's outside auditor for 61 years.

"We are still reviewing what claims the company may have in connection with the bond losses, and we are of course reviewing the performance of various people, including our auditors," Mr. Regan told the shareholders.

Meanwhile, the New York Insurance Department is

examining M&M's use of client premium funds in the trading, and a spokesman said that disciplinary action against the company—probably in the form of a fine—is "likely."

M&M, the world's largest insurance broker, announced earlier this year that some of its treasury department personnel, acting against company rules, had accumulated a portfolio of more than \$2 billion in intermediate and long-term government bonds between April 1983 and April 1984 (BI, April 16).

The bonds, bought on margin and liquidated when senior management discovered their existence, produced pretax losses of \$165 million, including \$10 million to cover the cost of investigating the trades.

M&M found that client premium funds held in fiduciary accounts had been used to buy bonds and make margin payments on the leveraged positions, a violation of New York insurance law, which requires fiduciary funds to be held in bank accounts or invested in bank instruments like certificates of deposit or money market accounts (BI, May 28).

The losses led M&M to restate its 1983 results, charging \$55 million of the losses to last year. The remaining \$110 million was charged to the first quarter of 1984, resulting in a \$28.3 million net loss for the quarter (BI, May 21).

Recounting the affair at the annual meeting, Mr. Regan offered some background on the treasury department's activities and details of how the losses de-

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Firms sued for \$63 million

By MICHAEL BRADFORD

SAUGET, Ill.—Monsanto Co. and two other manufacturers that operate plants in Saugat are facing claims of more than \$63 million for the release of chemicals that have allegedly caused respiratory and other ailments in area residents.

Two class actions, filed June 6 in St. Clair County Circuit Court in Belleville, Ill., seek compensatory damages of at least \$15,000 for each of the more than 200 residents represented in the suits. They also seek \$60 million in punitive damages.

The allegations not only name Monsanto, East St. Louis-based Amax Zinc Co. and Edwin Cooper Co., a subsidiary of Ethyl Corp., but also name the safety directors of each of the Saugat plants operated by the three companies.

However, plaintiffs' attorney John E. Norton of John E. Norton & Associates in Belleville said naming the safety directors is strictly a legal strategy, adding the directors will not be held personally for damages.

"The reason for naming the individual safety directors is to keep

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J&H chairman fires salvo in battle to end low rates

By DOUGLAS McLEOD

NEW YORK—Johnson & Higgins Chairman Robert V. Hatcher Jr. conceded that he took a risk when he called last week for an end to the property/casualty industry's debilitating rate wars.

"It might be considered a business risk, but somebody has to speak out," Mr. Hatcher said. "We don't mind taking a leadership role even if we lose clients. But we don't expect to lose clients."

In a letter sent to J&H field offices and about 25 insurance companies, Mr. Hatcher said J&H will emphasize insurer quality and security over price in placing clients' risks.

"It is obvious that the rate war of the 1980s has sapped the strength of insurance companies to a dangerous degree," he wrote. "An insurance company's low bidding price can easily prove the least durable of competitive advantages."

Mr. Hatcher took the opportunity of adding that J&H, the nation's largest privately held brokerage, will raise its commission rates or charge supplemental fees where it finds its own compensation inadequate.

Although this will occur in all lines, property insurance will be most noticeably affected, he said.

J&H is developing a computer software system to help it with fee-based billing of its property/casualty accounts, and it plans to have the system in all its offices by fall, Mr. Hatcher said. Fees then will be used to supplement, and in some cases replace, commissions.

Commercial insurance buyers should be aware of the deteriorating condition of the insurance marketplace and should be ready to pay a "fair price" for their coverage, Mr. Hatcher said.

Clients that are "unduly abusive of a fair price" may find J&H unable to handle their business "in all conscience," he added.

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Cessna appealing \$29 million verdict

By STEVE TARAVELLA

WICHITA, Kan.—Cessna Aircraft Co. is appealing a recent \$29.3 million jury award resulting from a June 1980 private plane crash that killed three people.

A U.S. District Court jury in Camden, N.J., earlier this month awarded \$4.3 million in actual damages and \$25 million in punitive damages to the families of those killed in the crash and to the accident's sole survivor.

"We were, of course, disappointed (with the verdict), and we intend to appeal," a spokeswoman for Cessna said last week.

A defect in the design of the pilot's seat caused the Cessna 172 to crash at Cape May County Airport in southern New Jersey, the jury found. A locking pin in the seat slipped, causing the seat to slide backward and the pilot to pull back on the yoke. The plane stalled, then crashed into brush surrounding the airport.

errors & omissions

• Lloyd's of London underwriter Henry Chester is not connected with Janson, Green Ltd., as indicated in an article in the June 4 issue.

Cessna was aware of the defect in the plane, which was built in 1966, but "willfully, wantonly and recklessly failed to recall, fix, replace, redesign, or take any step to make the seat track mechanism safe," the suit charged.

The plaintiffs who won the judgment are: Thomas Cannuli of Philadelphia, the sole survivor of the crash; the family of passenger Joseph M. Guarnere, Philadelphia; and the family of pilot and plane owner Keith E. Harper of Wildwood Crest, N.J., and his son, passenger Brian Harper.

The punitive damages are to be divided among the plaintiffs on a pro rata basis, according to their portion of the actual damages, explained Frederick W. Klepp, with Beasley, Hewson & Casey in Philadelphia, the firm representing the family of Mr. Guarnere.

The three plaintiffs filed suits separately, but the suits were consolidated into one trial, which ended June 8.

"I think our chances are fantastic of getting it (the judgment) affirmed," Mr. Klepp said of appellate proceedings. He expects the size of the punitive award to remain unchanged, he added.

David Edwards, corporate secretary and in-house counsel at Cessna, said the company's liability insurance "far exceeds" the \$29 million award, which he

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Manville, claimants report progress

By STEPHEN TARNOFF

NEW YORK—Manville Corp. and representatives of asbestos plaintiffs are hammering out the details of a tentative agreement to compensate thousands of asbestos victims.

However, the plan—proposed as part of Manville's bankruptcy proceedings—is opposed by some of Manville's other creditors, according to a joint statement released by Manville and the committee representing asbestos victims in U.S. Bankruptcy Court for the Southern District of New York.

And, many issues remain to be resolved before the proposal could be put in effect.

The plan, which is intended to cover both present and future asbestos victims, calls for creation of a \$2 billion trust fund by Manville. The company would contribute \$100 million in cash, an estimated \$600 million from liability insurance policies and a "large percentage" of Manville common stock.

The amount of common stock to be contributed is still undecided, but the company's management has "reluctantly" concluded that 66.7% of the stock may be an "appropriate maximum" to contribute. A contribution of 40% to 80% had been discussed, according to the joint statement.

The trust, which would be managed by a board of five independent trustees, would assume all the asbestos-related personal injury liabilities of Manville.

Manville's operating businesses would be transferred to a new group of operating companies and would be protected from asbestos-related lawsuits by a permanent injunction issued by the bankruptcy court.

Under the plan, a facility would be established to settle asbestos claims outside the court system while reserving plaintiffs' right to go to court if negotiation and arbitration fail. However, plaintiffs could no longer seek punitive damages from Manville.

"The only claims going from this claims settlement system to the state and federal courts would be those where either party declined to accept the award proposed in non-binding arbitration," the joint statement said.

This tentative agreement in bankruptcy court follows closely the announcement last month that other asbestos defendants and their insurers were considering an agreement that would end the massive asbestos insurance coverage litigation.

That plan, developed under the auspices of the center for Public Resources, would establish a facility for handling asbestos claims on an industrywide basis (BI, May 28).

Manville was not a part of that proposed agreement, but its recent tentative pact with claimants offers the prospect that Manville could join the facility.

Manville and its three major insurers also announced this month that they had reached

an accord to end their asbestos coverage litigation.

Under the plan, which involves Travelers Indemnity Co., The Home Insurance Co. and underwriters at Lloyd's of London, Manville would ultimately be provided with \$315 million in coverage (BI, June 4).

The insurers would contribute their shares by Dec. 31, 1985, if a reorganization plan is approved by then.

Parties involved in the tentative agreement between Manville and the asbestos victims estimate Dec. 31, 1985, is the earliest a reorganization plan could be confirmed by the bankruptcy court.

Both Manville and the plaintiffs' representatives emphasize that numerous issues remain to be resolved before the proposal could take effect.

For example, the committee representing Manville shareholders says that a contribu-

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Hospitals eye underwriting health plans

By ESTHER FRITZ KUNTZ

Hospitals are getting into the group health insurance business to corner the patient market and satisfy demand for health care services at a guaranteed price.

Large hospital chains are beginning to develop various health care products for sale to employers that not only make the hospitals take the risk of health care cost increases but also cut out insurance companies.

These products are an outgrowth of both health maintenance organizations and preferred provider organizations. And, they reflect the new competition for patients among hospitals.

No one knows what to call these products, but essentially they are prepaid preferred provider organizations. The hospital guarantees to provide certain medical care for each covered employee at a predetermined annual cost when the employee uses the services of the hospital or participating doctors.

These new products differ from the majority of PPOs today in which the hospitals negotiate with insurers or employers to provide services at discounted rates. Under these new hospital products, the hospital caps the annual cost of medical services. And, they differ from HMOs because employees are free to use other health care providers, although at additional cost to the employee.

Hospitals' experiences with HMOs and PPOs, in which they agreed to provide health care at set prices and to assume the risk for any cost overruns, are causing some hospitals to reason that if they are going to assume the risk anyway, why not market their own health care insurance products?

If a hospital has to deliver health care for a limited amount per person, why should it pass along 10% to 15% of that capitated amount to an insurance company? asks Frederick Meyer, executive vp of Health Pacific Corp., the parent company of Pacific Medical Center in San Francisco.

Mr. Meyer also is chairman of SELECTHealth, a preferred provider organization run by the hospital company that contracts directly with employers to provide health care to 40,000 employees on a fee-for-service basis. Its largest contract is with the city and county of San Francisco. SELECTHealth, like many of its PPO competitors, is investigating the possibility of marketing its own health insurance plan at a guaranteed cost, Mr. Meyer said.

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NAIC offers ideas, policies

State regulators adopt a new plan for coordination of health benefits

By CAROL CAIN

NEW ORLEANS—State insurance regulators are offering employers a new way to coordinate the payment of health care benefits when both spouses in a family are covered by group plans.

Coordination of benefits was developed to eliminate the potential for profit when a person is covered by more than one group health care plan. It limits the total benefits received to no more than the actual amount incurred for care.

The National Assn. of Insurance Commissioners, meeting earlier this month, amended its "Regulations and Guidelines Relating to the Use of Overinsurance Reduction of Benefit Provisions in Group Health Insurance Policies and Group Service Plan Corporation Contracts," commonly referred to as "COB Guidelines."

The major changes affect the order of benefits when a claim for a dependent child is involved and permit plans that coordinate benefits to preserve the deductibles and coinsurance features of the plan that is most generous to the employee.

The amendments also allow a family member whose own health care coverage is terminated to re-enter the group plan of another family member.

Under the current rule for covering dependent children, the father's plan pays first and the mother's plan pays second, explained Jack B. Helitzer, assistant vp of Metropolitan Life Insurance Co. in New York and chairman of the ad hoc advisory committee to the NAIC's COB Task Force.

The new guideline "replaces the male/female rule with what we call the 'birthday' rule. Under the new rule, the plan covering the parent whose birthday falls earlier in the year pays first, and the plan covering the parent whose birthday falls later in the year pays second," Mr.



Photo: Carol Cain

The Louisiana World Exposition was a relaxing contrast to the hustle-bustle of this month's NAIC meeting in New Orleans.

Helitzer explained.

This birthday rule avoids any problems of sex discrimination that could arise under the current male/female rule, he noted, but he added two caveats.

"It is essential that the new birthday rule not become operative until July 1, 1985. . . Insurers and medical care providers must have this time to adapt claims forms, claim procedures and claim payment systems to operate under the new rule.

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Wellness makes business sense, members of NAIC panel explain

By CAROL CAIN

NEW ORLEANS—Insurance regulators want to do their bit for health care cost containment.

"If we can encourage individuals to take care of themselves, then the rest will follow," said Oregon Insurance Commissioner Josephine M. Driscoll, who chairs the Accident and Health Insurance Committee of the National Assn. of Insurance Commissioners.

To encourage this action, one of the sessions at the NAIC's recent summer meeting in New Orleans was an informational panel discussion on wellness and preventive health care.

But, that session was attended by only about 60 people, compared with the several hundred who listened just before to a keynote address by Rep. Claude D. Pepper, D-Fla.

Many of those attending the session were from small insurance companies or fraternal organizations. Some said they were going to take the information back to their home office to share, while others noted that they use the information in their personal lives.

"Wellness is true cost containment," said Ms. Driscoll, who served as moderator of the discussion.

William P. Daves, a member of the Texas Board of Insurance, added, "We can't continue to abuse our bodies and then turn to the doctor and medical science for miracle restoral at a high cost to our employers as well as to ourselves.

"I think we are discovering, or rediscovering, an ancient truth: that the only practical way to reduce health care cost is to reduce disease and accidents," he said.

Several U.S. corporations have recognized this potential for reducing health care costs and have introduced fitness plans, smoking cessation classes or other wellness program for their employees in recent years.

But, "It is essential that we all understand that wellness, health pro-

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New reinsurance law adopted; passage by states is next step

By CAROL CAIN

NEW ORLEANS—Reinsurers and insurance regulators who worked intensely for more than a year to draft a model law to regulate reinsurance transactions are taking a short breather before hitting the legislative circuit trying to have the law adopted state-by-state.

The model law on credit for reinsurance was adopted by the National Assn. of Insurance Commissioners earlier this month during its annual summer meeting.

The model law grants credit for reinsurance to a domestic ceding insurer under certain circumstances, including:

- When the assuming insurer is licensed or accredited in the state where credit is taken or licensed in another state where credit requirements are substantially equivalent to those in the state granting credit and where the assuming insurer meets the standards of solvency in the granting state.

- When the assuming insurer maintains a trust account in a United States bank or trust company for the payment of the valid claims of its U.S. policyholders and ceding insurers, their assigns and successors in interest.

- When the assuming insurer does not meet either of the first two requirements, but only with respect to the insurance of risks located in jurisdictions other than the United States where such reinsurance is required by applicable law or regulation of that jurisdiction.

- When the assuming insurer is not licensed or accredited to transact insurance or reinsurance in the state then the credit permitted under the first two requirements shall not be allowed unless the assuming insurer agrees that in event of its failure to perform its obligations under the terms of the reinsurance agreement, then it shall, at

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Mr. Olson

Wellness plans

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motion and wholistic medicine are a philosophy and not facilities," said Ronald J. Cook, the corporate manager of health education and physical fitness programs for Sentry Insurance in Stevens Point, Wis., and a member of the panel.

Sentry, which employs 10,000 people, has fitness facilities, including racquetball courts and swimming pools, at its four major centers in Stevens Point; Concord, Mass.; Atlanta; and Scottsdale, Ariz. Employees may use the facilities on their own time, which is made easier because Sentry offers flex-time schedules.

Sentry has offered health education and fitness programs through a professional staff for the past seven years, "but it was 50 years in the making," Mr. Cook noted.

"Our wellness philosophy had its first action stage in the 1930s, when there were two tennis courts out-

side the old home office. In the early 1950s, the Bunker Health Club was started by a group of officers. They converted the old coal bunker into a mini health club," Mr. Cook said.

But wellness goes beyond facilities and physical exercise, he stressed.

The idea of wellness also requires enlightened leadership, Mr. Cook said, pointing out that Sentry Chairman John Joanis believes that wellness at the worksite is sound business.

"And worksite wellness promotes a sense of community," Mr. Cook said.

"Sentry has a strong commitment to employee wellness. Employees and their families are encouraged to participate in wellness activities. Each individ-

ual is encouraged to accept personal responsibility for his or her health and well-being. On a continuing basis the company strives to increase employee knowledge of the personal benefits derived from a well-balanced lifestyle.

"We believe wellness, fitness and health promotion will help develop a positive mental attitude, improve the quality of life, strengthen the family, improve productivity, reduce turnover, result in less illness, reduce health care (illness) cost and nurture an environment conducive to personal, family and corporate well being," Mr. Cook said.

This sense of community "is difficult to describe or measure, but you know it's there," he said.

Some of the special wellness programs at Sentry include:

- A program designed to assist employees with personal problems like alcohol and drugs, personal relations, family and marriage problems, stress and life-stage development. It is open to employees,

spouses and dependents.

- A stress management program, available at all offices. This three-hour course may be taken on company time.

- A monthly publication, *Fitlines*, slated to be published in 1985 and sent to all employees. It will announce new programs, provide health messages and recognize wellness participation.

- Various screenings for blood pressure, stress testing before exercising, fitness testing and glaucoma screenings.

Sentry also recently introduced an eight-point policy on smoking in the workplace.

"We feel it is a standard for any industry to adopt," Mr. Cook said.

The points in the policy include:

- Supervisors should accommodate the wishes of non-smokers by providing seating arrangements that segregate smokers and non-smokers.

- Banning all smoking in conference and meeting rooms.

- Banning all smoking in restrooms.

- Sponsoring stop-smoking clinics for employees and their families.

- Identifying what health concerns of employees are caused by smoking in the work area, monitoring air in the work area and using mechanical devices to circulate and remove smoke from the air.

- Limiting work-area smoking to individual desks.

- Continuing current no-smoking/smoking segregated areas in the cafeteria.

- Posting the company's policy on smoking in conspicuous areas to be seen by employees and visitors.

Sentry developed its wellness programs for its own company, but a group of employers in Omaha, Neb., got together in 1981 to form the Wellness Council of the Midlands, so they could share wellness information and programs.

"The Wellness Council exists to promote wellness programs at the worksite," said Fred Schott, a founder and current president of the council, who also is vp of training and development at Central States Health & Life Co. of Omaha in Omaha, Neb.

"Worksite wellness is not new. There have always been a small but significant number of leaders, like my boss at Central States of Omaha, Bill Kizer, who for years felt worksite wellness and health promotion made good sense," Mr. Schott said.

That thought is the motto of the council, also known as Welcom: "Good health is good business." That motto appears in 30-second public service television commercials and in payroll stuffers.

"The Wellness Council firmly believes that the private sector and not government is the logical provider of appropriate information, skills and motivation that enable people to make informed choices about the way they live. At the same time, the council supports a more prudent use of the existing health care system," Mr. Kizer says in a brochure about Welcom. He serves as chairman of the council and is president of Central States of Omaha.

"We always envision the Wellness Council operating on private dollars," Mr. Schott said. "We will support ourselves through membership fees, contributions, gifts from foundations and so on. We will not solicit nor accept government funds."

The founding member firms totaled 53 and together represented a workforce of more than 55,000.

For the employer, the council acts as a clearinghouse and consultant, Mr. Schott said.

For the workforce, it disseminates information and identifies programs, he noted. And for the community, it emphasizes the advantages of healthy and the harmful effects of unhealthy lifestyles.

"Welcom's written goal is to foster a total community environment," Mr. Schott said.

The mission of the council is guided by the convictions that the quality of life in any community is in large degree measured by the health of its people and that as more employers offer quality programs, not only will more individuals benefit, but also the spiraling costs of health care can be better contained.

Clarence E. Pearson, assistant vp of the health and safety education division of Metropolitan Life Insurance Co. in New York, also participated in the panel discussion, giving an overview of cost-containment efforts by employers.



Mr. Cook



Mr. Schott

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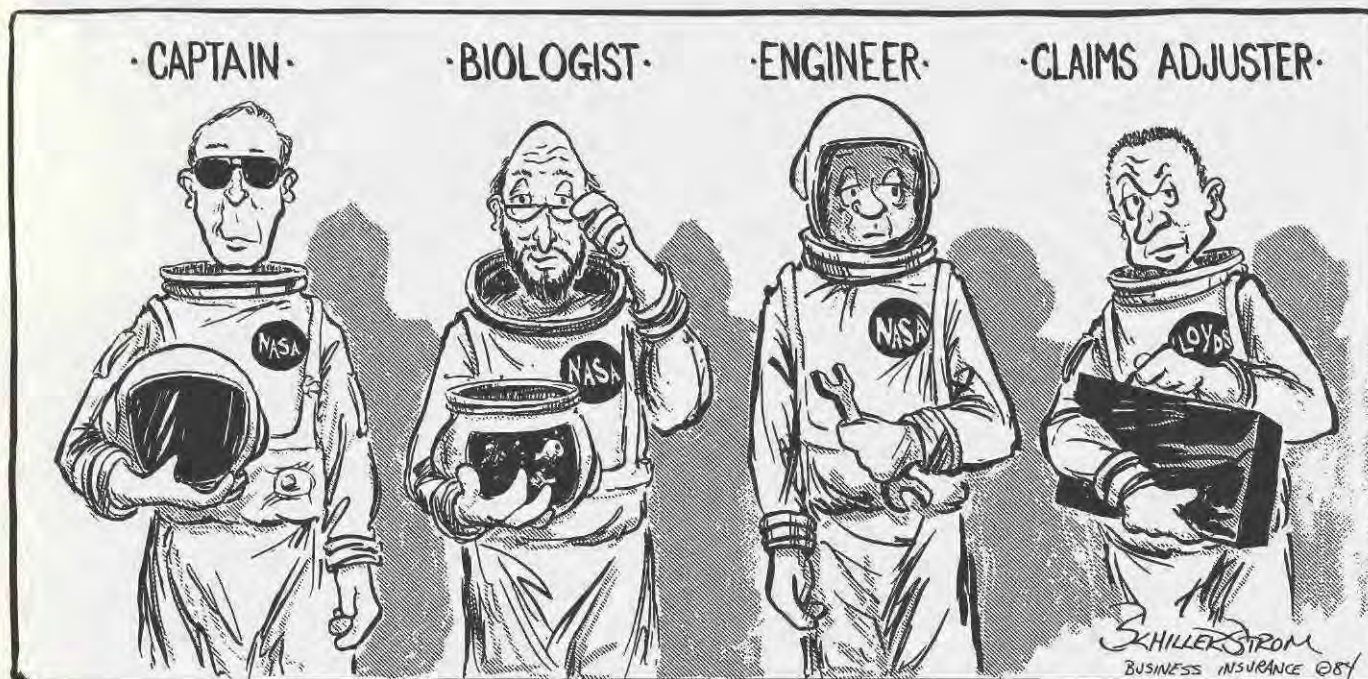
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opinions

Meet the next space crew



Little cause for celebration

THE NATIONAL Assn. of Insurance Commissioners has wasted precious time formulating complicated procedures for determining how two health insurance plans covering the same person ought to pay claims.

One major concern was eliminating any vestige of sexism from the current rules that say when a claim for treatment for a dependent child covered by two health plans is submitted, the father's plan pays first and the mother's plan pays second (see story, page 3).

The new guideline replaces the male/female rule with a 'birthday' rule. Under the birthday rule, the plan covering the parent whose birthday falls earlier in the year pays first, and the plan covering the parent whose birthday falls later in the year pays second.

Ah, but the birthday rule creates new problems. What if the parents have the same birthday? The rules say then the plan that is in effect longest is primary. But, the commissioners didn't consider what happens if one parent was born on Feb. 29 and it's not leap year when the dependent's claim is filed. We've got it: Look

to the grandmothers' birthdays!

Seriously, ladies and gentlemen. Rather than making a bad situation worse, you should consider alternatives to coordination of benefits rules that will require people to select one plan and pay their fair share.

One alternative is to entirely eliminate secondary coverage. This approach, which was advocated by a consultant writing for *Business Insurance* (March 12), makes sense. Any spouse who is eligible for medical coverage through his or her place of employment would not be eligible as a dependent under his or her spouse's plan. Children also should be covered under only one plan, to be selected by the parents. However, if a spouse ceases employment, he or she must be eligible for coverage under the employed spouse's plan.

Eliminating secondary coverage will eliminate duplicate coverage and also reduce administrative expenses.

And when no one is covered under two plans, we can get rid of the birthday rule.

letters

Argument on brokers blanket bonds continues

To the editor: I must comment on Earl H. Nemser's article, "Stockbrokers Blanket Bond—Another Response" (*BI*, April 9), that refers to my reply to his original article on "Stockbrokers Blanket Bonds and Their Pitfalls" (*BI*, Dec. 26, 1983).

I object to Brokers Blanket Bond No. 14, considered the uniform and standard bond. There are domestic companies that are not members of the Surety Assn. of America, as well as Lloyd's, that write their own forms of stockbrokers blanket bonds that are satisfactory to the New York Stock Exchange.

I object to the use of the words "fine-print exclusions." The exclusions in all stockbrokers blanket bonds are printed in the same type as the insuring agreements and conditions.

While Mr. Nemser is correct in stating that certain exclusions, for instance the trading exclusion, can be eliminated or modified, a general statement that proper shopping and negotiating could result in the elimination of "tricky or onerous exclusions" goes too far. There is always a possibility of amendment in individual cases.

Mr. Nemser calls my statement that courts generally interpret ambiguities in insurance policies or bonds in favor of insured as "dangerously misleading." He calls the rule of "contra preferentem" as having been superseded "since at least

1976," and in support of his statement he quotes two sentences from decision of the 5th and 2nd U.S. Circuit Courts of Appeals, respectively.

Mr. Nemser was kind enough to furnish me with copies of the entire decisions, which disclosed that they do not contradict my statement.

The sentences quoted by Mr. Nemser are contained in footnotes. The 5th Circuit Court of Appeals in *Calcasieu-Marine National Bank of Lake Charles vs. American Employers Insurance et al* specifically states, "Another general principle of insurance law is that ambiguities in a policy are to be resolved in favor of the assured."

The 2nd Circuit Court of Appeals in *Sharing Corp. vs. Home Insurance Co.* states in footnote No. 2 that it is "the accepted maxim requiring ambiguities in insurance contracts to be construed against the insurer."

There is a generally recognized exception to this rule to which Mr. Nemser apparently refers: that the usual ambiguity rule does not apply where the policy or bond has been drafted, not by the insurer, but by the insured or in cooperation with a sophisticated trade organization like the American Bankers Assn. But, this is not the case with the stockbrokers blanket bond.

Unfortunately, Mr. Nemser does not

differentiate between bankers blanket bonds and stockbrokers blanket bonds, although the risks are different in many respects and the bonds with different coverages are not interchangeable.

Mr. Nemser is incorrect with regard to availability of a new and more competitive stockbrokers blanket bond with Lloyd's of London. The introduction of the new financial institution policy by Lloyd's in 1983 refers exclusively to the bankers blanket bond and not to the stockbrokers blanket bond.

The substantial losses in previous years have caused many underwriters, including some of the largest companies, to withdraw from this field, so it is not always possible to obtain the most desirable bond for a stockbroker who may engage in certain types of transactions that prevent a particular company from writing this risk.

Henry Salfeld
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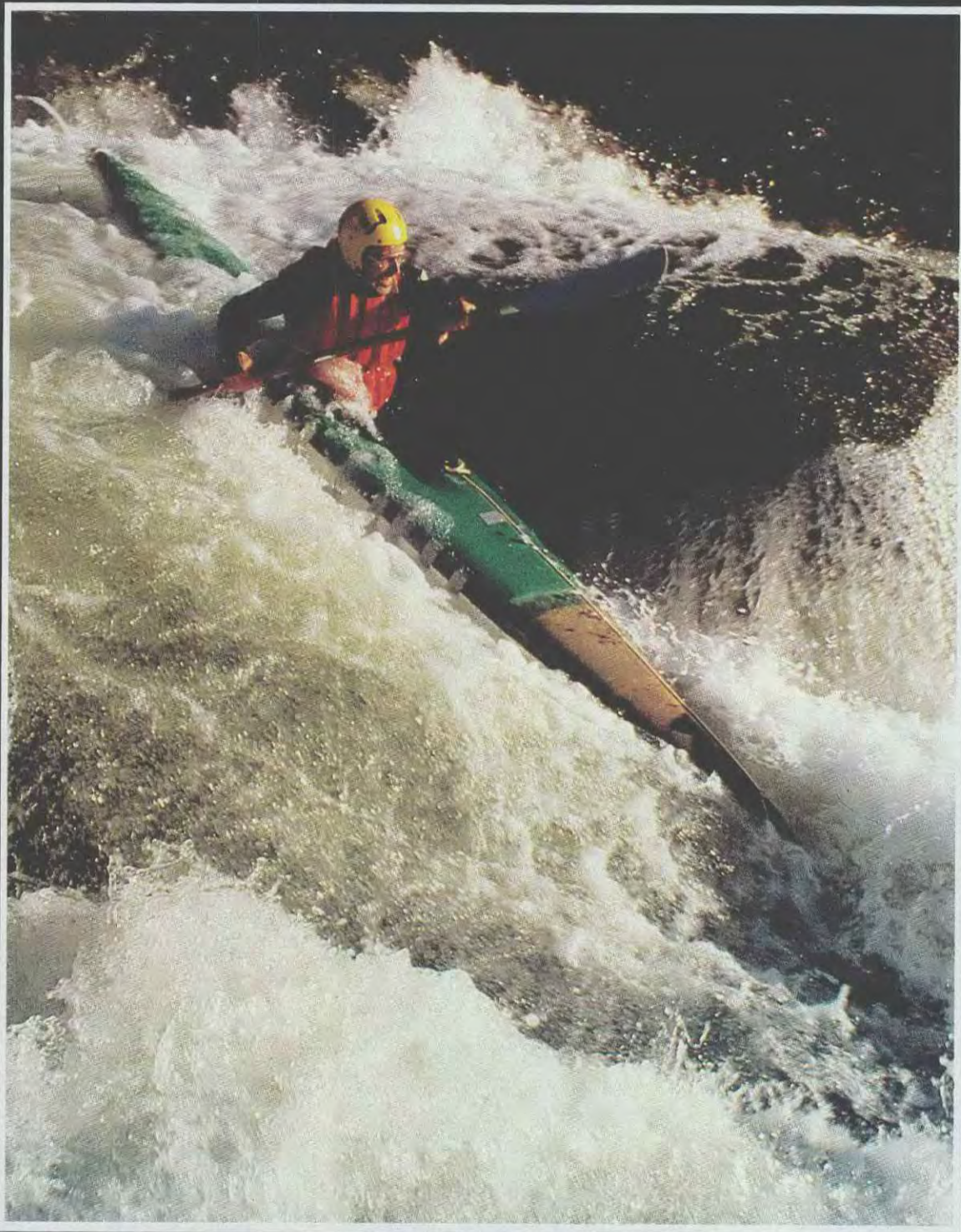
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NAIC adopts coordination of benefits plan

Continued from page 3

"The programming of this change by our industry will take every day of that full year. It may appear to be a simple job, but it is not. Any earlier effective date will have two serious negative consequences: significant delays in processing claims for dependent children and significantly increased claims processing costs. An orderly phase-in of the rule should avoid these problems," he said.

The second caveat, according to Mr. Helitzer, is that it must be understood that not all states will adopt the new amendments, and not all plans will be affected by the change at the same time.

"It is essential to have a clear, workable rule to deal with the case of a plan with the male/female rule coordinating with a plan with the birthday rule. Such conflicts are inevitable," he said.

"When this occurs, in half the cases, the male will have the earlier birthday. In this half of the cases, no problems will arise. However, when the female has the earlier birthday, much can go wrong.

"If a woman's birthday falls before her husband's, and her plan uses the birthday rule while her husband's plan uses the male/female rule, both plans are primary! Even worse, if the woman's plan uses the male/female rule and her

husband's plan uses the birthday rule, both plans are secondary! Neither result can be allowed," Mr. Helitzer said.

"The only workable, constitutional and practical solution is for the male/female rule to be followed in all such cases. No other solution is possible," he said. "As states adopt the revised guidelines and mandate the use of this new birthday rule, this initial problem will disappear. An orderly and complete phase-in of the rule is essential."

Oregon Commissioner Josephine Driscoll wondered about situations when both spouses' birthdays are on the same day.

In those cases, according to Mr. Helitzer the policy in effect longest would be primary. This type of rule would be time-consuming to administer on every claim, he said, but is workable in the few situations when both spouses have the same birthday.

The new changes also address cost-containment features—deductibles and coinsurance—already in force in many plans. The new rules permit plans that coordinate benefits to preserve the deductible and coinsurance features of one plan, the plan that is most generous to the employee for the claim involved.

Now often when coverage is coordinated under two plans, the

secondary plan covers all the employee's share of costs under the deductible and coinsurance provisions of the primary plan.

"Preservation of deductibles and coinsurance is recognized as an important element in the battle to prevent the overutilization of medical care. . . . With perhaps half the families in our country having both spouses in full-time employment, the failure to address this problem could seriously impede effective medical care cost containment," Mr. Helitzer said.

Under the new guidelines, plans are permitted, not required, to preserve the deductibles and coinsurance provisions of one plan. In collective bargaining situations, this provision can afford labor and management the opportunity to trade off unnecessary and costly excessive benefits for others, or to retain traditional COB.

Families that cannot recover

100% of expenses will be inclined to drop duplicate coverage, insurers predicted. However, this will require that such families be granted unrestricted re-entry into a plan that was dropped if the family subsequently loses the coverage that it retained.

This re-entry provision is somewhat complex, but it assures re-entry on terms that are neither more nor less favorable than those that would exist if coverage had not been dropped.

Other changes in the COB guidelines:

- Prohibit plans from taking an "always secondary" position and from coordinating against a "phantom plan"—a plan under which a person is not covered, but for which he or she is eligible.

- Treat the cost of a private hospital room as an "allowable expense for COB purposes" only when its use is medically necessary.

Simplification of language is newest task

NEW ORLEANS—The work of an advisory committee to one of the National Assn. of Insurance Commissioners' task forces never seems to be done.

No sooner had the Coordination of Benefits Task Force adopted a report from its advisory committee that amends the NAIC's COB guidelines (see story, page 3) than it decided the committee should look at rewriting the guidelines into simple language.

The chairman of the task force, Wisconsin Commissioner Thomas Fox, asked that people interested in serving on the ad hoc committee contact him at the Wisconsin Insurance Department, P.O. Box 7873, Madison, Wisc. 53707.

In addition to looking at the language, the task force also wants the committee to review the guidelines to see how traditional plans can interface with health maintenance organizations and self-insured plans.

New reinsurance law adopted

Continued from page 3

the request of the ceding insurer, submit to the jurisdiction of any court of competent jurisdiction in any state, abide by the final decision of that court and designate the commissioner or a designated attorney as its attorney.

The initial draft of the uniform law on credit for reinsurance was submitted to the NAIC last September and was expected to be adopted in December, but representatives from the life insurance constituency requested adoption be postponed so that the model could be fine-tuned to represent both property/casualty and life interests.

The only note of public dissent on the model at this meeting came from Stewart Keir, a member of the task force and chief of the insurance exchange and excess line bureau with the New York Insurance Department. Without elaborating, Mr. Keir said the model still contained certain deficiencies and ambiguities. But since New York already has a similar law and since the model would establish a framework for other states, he supported adoption.

The whole issue of drafting such a model came up after the advisory committee to the NAIC's Reinsurance and Anti-Fraud Task Force surveyed the states and concluded there was little uniformity.

"Based upon the experience of its own members, the advisory committee further concluded that stat-

utory standards for credit for reinsurance were generally inadequate and that a uniform law was needed to upgrade those standards," reads a March 1984 report from the advisory committee.

Task Force Chairman Lyndon Olson Jr. was beaming after the model law finally was adopted. Mr. Olson, who also is chairman of the Texas Board of Insurance, considers this bill the first of many that will regulate reinsurance.

"We have to put some discipline in the system," he said.

"The next step? I've got a commitment from the reinsurers that they will publically go to the legislatures and get (this model law) passed. We're going to adopt it in Texas. . . . We'll testify before state legislative committees," he said.

The Reinsurance Assn. of America is planning an affirmative action program to have the model adopted by individual states, said Andre Maisonpierre, president of the Washington-based trade association.

"We'll start the wheels spinning this year," he said.

"All of the members of the advisory committee are supportive of this bill and we'll do everything we can to have it adopted," said Wes Kinder, president of Fremont Reinsurance Co. in San Francisco and chairman of the advisory committee, whose members consisted primarily of reinsurers.



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Reinsurance task force drops subgroups

NEW ORLEANS—Poet Robert Burns said it in 1785: *The best laid schemes o' mice and men gang aft a-gley.*

The Reinsurance and Anti-Fraud Task Force of the National Assn. of Insurance Commissioners is feeling the meaning behind those words. The task force's 9-month-old subgroups were dissolved earlier this month at the NAIC's summer meeting here.

"We've had an incredible turnover. . . . I question the value of our subgroups. I don't want to create subgroups just to say we've got subgroups, if they're not working," said Lyndon Olson Jr., chairman of the task force and chairman of the Texas Board of Insurance.

"We didn't get the right kind of input when (we) were broken down into subgroups," said Alaska Director of Insurance Kenneth Moore, who suggested that the work of the task force be brought back under the entire panel.

The subgroups were formed last September to add discipline to the structure of the task force, which had been asked to deal with several problems in reinsurance regulation (BI, Oct. 3, 1983). Subgroups may still be used, Mr. Olson said, but on a de facto basis.

The task force just finished work on a model bill for credit for reinsurance (see story, page 3) and will next tackle the issue of delegating authority to managing general agents, Mr. Olson said.

The task force and its advisory committee, made up primarily of reinsurers, will consider supporting guidelines that say whenever an insurer delegates authority to underwrite and cede reinsurance to some entity, notice of that transaction should be given to both domiciliary regulators.

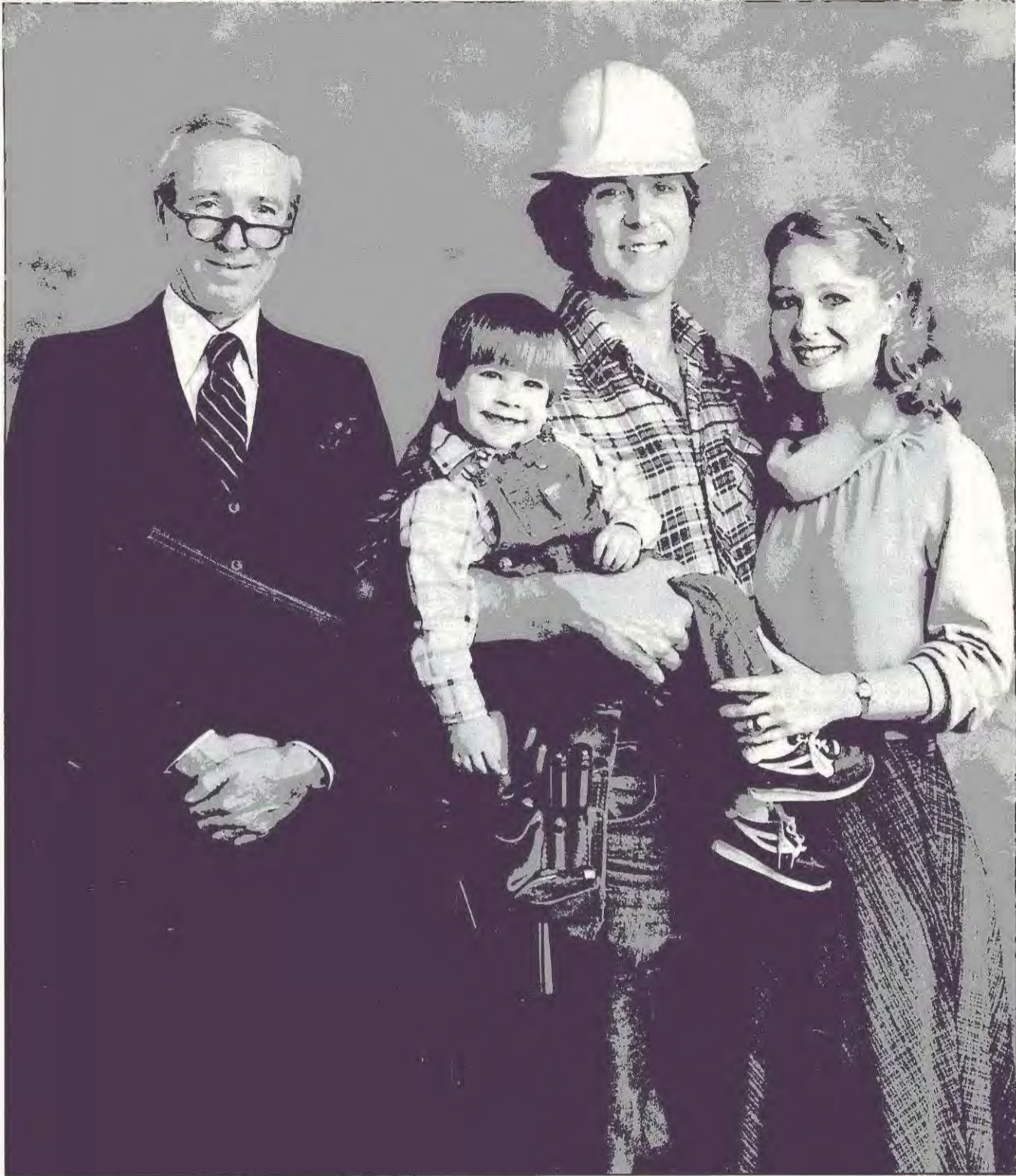
"That would be a first step, but a needed first step," said Wes Kinder, president of Fremont Reinsurance Co. in San Francisco and chairman of the advisory committee.

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1. You're the risk manager of a large financial institution, currently reviewing your excess liability forms before marketing the coverage. Which of the following is generally not included in a standard umbrella form?

- (a) Worldwide coverage.
- (b) Excess workers compensation.
- (c) Defense costs after primary limits.
- (d) Personal injury.

2. As the benefits manager of a financial services firm, you feel that your medical benefit expenditures are too high. What percentage of all surgery could be handled effectively in an outpatient setting?

- (a) 1% to 5%.
- (b) 5% to 10%.
- (c) 10% to 20%.
- (d) 20% to 40%.

3. You're the risk manager for a large commercial bank. Will your directors and officers liability policy cover both your bank officers and the members of your trust department?

- (a) Yes, it always covers both.
- (b) No, it covers neither.
- (c) Yes, but only when written on an occurrence basis.
- (d) No, it only covers the bank officers.

4. You're the risk manager of a large commercial bank that relies on a single computer center to record all of your branches' transactions. If the computer center is destroyed by fire, what coverage will enable you to continue to meet your computer needs?

- (a) Business interruption.
- (b) Extra expense.
- (c) Expense to reduce loss.
- (d) Property damage only.

5. As the benefits manager for a national lending institution, you have been asked to investigate the impact of dental disease on productivity. How many hours are lost to business and industry each year because of dental disease?

- (a) 20 million.
- (b) 50 million.
- (c) 100 million.
- (d) 200 million.

6. You're the risk manager of a bank that's just started a discount brokerage operation. A standard, unamended Form 24 bankers blanket bond, with all insuring agreements, does not cover loss arising from:

- (a) Securities forgery.
- (b) Fraudulent trading by employees.
- (c) Check forgeries
- (d) Theft of securities from a messenger.

7. You're the risk manager for a company with a foreign government contract to install a telecommunications system. If the government suddenly cancels the contract, what type of insurance can cover your loss?

- (a) A surety bond.
- (b) Political risk coverage.
- (c) A place-in-funds letter.
- (d) Accounts receivable insurance.

8. As the benefits manager of a nationwide cable television network, you're interested in ways to keep track of medical costs. In benefit language, a DRG is a:

- (a) Patient classification method.
- (b) Standard medical procedure.
- (c) Health care association.
- (d) Computerized information system.

9. You're the risk manager for a large city newspaper that has decided to market your renewal. Which of the following is not normally covered by a standard general liability policy?

- (a) Premises liability.
- (b) Incidental contractual coverages.
- (c) Care, custody and control coverage.
- (d) Manufacturers and contractors liability.

10. You're the risk manager of a communications conglomerate, with a fleet of jets used to transport executives. Which of the following is likely to have the greatest impact on how your insurer prices your coverage?

- (a) Higher deductibles on aircraft hulls.
- (b) A reduction in the number of annual hours flown.
- (c) Hiring a new chief pilot from a commercial airline.
- (d) Recurrent training program performed by an outside facility.

11. You're the benefits manager of a large newspaper. You'd like to increase benefits, but the cost is too high for your employer. What can you do without incurring additional costs?

- (a) Put in a COLA for retirees.
- (b) Adopt an employee-paid 401(k) plan.
- (c) Put in a thrift plan.
- (d) Cancel defined benefit plan and put in a profit-sharing plan.

12. You're the risk manager of an independent telephone company reviewing your separate policies for named perils, difference-in-conditions, boiler and machinery, time element, fidelity and transit. Which form enables you to best address your specific policy needs?

- (a) All risk, with property and business interruption.
- (b) All risk, with business interruption and a boiler and machinery endorsement.
- (c) Tailored manuscript form.
- (d) None of the above.

13. You're the risk manager of a construction company that has just been awarded a major project. Which of the following states has unique local restrictions dealing with wrap-up insurance programs?

- (a) New Jersey.
- (b) Illinois.
- (c) Texas.
- (d) Maine.

14. You're the benefits manager of a large construction firm's defined benefit pension plan, for which 25% of your employees have yet to qualify. When a worker leaves the company, you're required to provide:

- (a) Notice of employee's accrued benefits.
- (b) Notice of whether or not a benefit is due.
- (c) A benefit statement outlining accrued vested benefits.
- (d) None of the above.

15. You're the risk manager for a construction company with a project in Saudi Arabia, for which you plan to use Korean labor. In which of the two countries do you need workers comp for the Korean laborers?

- (a) Saudi Arabia.
- (b) Korea.
- (c) Both Saudi Arabia and Korea.
- (d) Workers comp would be optional.

16. You're the risk manager for a pipeline construction company. A project foreman has called to say... "A pig got stuck at the river crossing and we broke the line trying to free it." The pig the foreman is referring to is:

- (a) A valve.
- (b) A cleaning device.
- (c) A filter.
- (d) A measuring device.

17. You're the benefits manager of a construction firm with a large number of male employees between ages 30 and 35. What are the chances that one out of six of these employees will become disabled before age 65?

- (a) 98%.
- (b) 75%.
- (c) 60%.
- (d) 45%.

18. You're the risk manager for a firm specializing in high-rise commercial and institutional building construction and construction management and design. Which of the following is the foundation coverage upon which your property/casualty insurance program is built?

- (a) Professional liability.
- (b) Umbrella liability.
- (c) Builder's risk.
- (d) General liability.

19. You're the risk manager for a large university with four campuses and more than 50,000 students. Since you plan to self-insure a portion of your liability risk, which of the following is important to consider?

- (a) Prior loss patterns.
- (b) Financial ability to absorb losses.
- (c) Insurance coverage above self-insured areas.
- (d) All of the above.

20. You're the benefits manager of a large city school district looking into a true group auto plan. You find that auto premiums remain fairly stable from year to year because auto-related insurance costs have an annual inflation rate of about:

- (a) 2%.
- (b) 6%.
- (c) 12%.
- (d) 18%.

Continued on page 16

See how well you did... Turn to page 17



business insurance

presents
an important conference

THE DOLLARS & SENSE OF COMMUNICATING EMPLOYEE BENEFITS

July 30 and 31
The Grand Hyatt Hotel, New York City

AGENDA

Sunday, July 29 REGISTRATION

5:00 - 7:00 p.m.

Advance conference check-in. Meet speakers and attendees during a cocktail reception. Browse the EBC Gallery; collect material available in the Literature Gallery.

Monday, July 30 REGISTRATION

8:00 a.m.

A continental breakfast will be served. Chat informally with speakers and attendees. The EBC Gallery and Literature Gallery will be open.

GENERAL SESSIONS

Opening Remarks

Kathryn J. McIntyre, Editor, BUSINESS INSURANCE

Washington vs. Employee Benefits

Jerry Geisel, Washington Editor, BUSINESS INSURANCE

Recent legislative and regulatory developments affect the type of employee benefits programs you offer and how you fund them. Mr. Geisel will explain the reasons behind — and the latest news about — the attacks on employee benefit plans waged by Congress and the Internal Revenue Service. He will also alert you to what you can expect out of Washington in the future.

Strategic Planning

Richard M. Coffin, VP, TOWERS, PERRIN, FORSTER & CROSBY

Developing your plan, setting objectives, analyzing your audience, and being alert to emerging trends, are the keys to every successful communication effort. Mr. Coffin will define 'strategic planning' and explain why it's especially needed in benefits communication. He'll focus on the principles and components needed as well as the specific steps to be followed in developing your own strategic plan.

Budgeting

Julio Esteban, VP, Manager of Creative Services, BENEFACTS INC.

Effective budgeting requires organized thinking, logic and an intense business sense. Mr. Esteban's unique approach provides insight in the common elements used in budgeting for benefits communication. He positions these principles as the 'heart' of the proposed presentation.

Media Selection

Polly Carpenter, President, CARPENTER GRAPHIC DESIGN, INC.

Mary Anne Pakosta, Sales & Client Services, FRAME ONE, Inc.

Two experts offer innovative ideas for print and state-of-the-art audio-visual communication approaches. In this two part session, they'll look at when, where, why and how to select the right medium for your communication needs.

Luncheon/EBC Awards Presentation

Alfred Malecki, Publisher, BUSINESS INSURANCE

Business Insurance honors the winners of the 12th annual EBC Competition. One of the winning audio-visuals selected for excellence in communicating an employee benefits program will be shown.

Media Selection

Part two.

CONCURRENT SESSIONS

Concurrents afford you the opportunity to zero in on specific communication programs. Sessions will be repeated in the afternoon and again on Tuesday morning so that you may attend all three sessions. These smaller work-groups are presented as 'Case Studies' dealing with:

Flexible Benefits

Robert E. Mathieu, Asst. VP - Benefits, MELLON NATIONAL CORPORATION

David M. Kieffer, Sr. VP, WILLIAM M. MERCER-MEIDINGER, INC.

In 1983, the judges of the EBC Competition called Mellon National Corporation's award winning program "one of the most effective descriptions of flexible benefits ever seen." Mr. Mathieu and Mr. Kieffer will walk you through the communication concepts used to provide a clear understanding of flexible benefits so that employees can make well educated choices.

Communicating On Your Own

Russ Ringl, Personnel Director, PLAYBOY ENTERPRISES

Their objectives seemed simple ... to effectively communicate a high standard of benefits to serve as a motivating factor to employees; to keep employees informed, updated and clear about the company's benefits. Focusing on their booklet component, Mr. Ringl tells how his firm did it on its own - providing benefits in a serious yet personal manner.

Flexible Spending Accounts & The IRS

Ed Dewees, Director, Department of Human Resources,

THOMAS JEFFERSON UNIVERSITY

ESA's - everyone came up with a different way to design and communicate their plan. If you are confronted with a program in the works or on the drawing board, you won't want to miss Mr. Dewees' program. He went ahead with a program and anticipated restrictive IRS regulations.

Tuesday, July 31

CONCURRENT SESSIONS

Repeated this morning

A Look At This Year's Winners

Herb Zeltner, HERBERT ZELTNER INC., Marketing & Communications Consultant

Mr. Zeltner, invited for a return engagement at the Conference, takes an in-depth look at what makes a winning program. This two part session is lively, entertaining and informative. It has been the highest rated by past attendees.

Luncheon

Exchange ideas with speakers and attendees. Spend some additional time in the Galleries.

A Look At This Year's Winners

Part two. This is your best opportunity to see what other professionals are doing.

Management Training

David M. Kieffer, Sr. VP, WILLIAM M. MERCER-MEIDINGER, INC.

You've planned, budgeted, and selected your media ... but your program can still fall flat without properly trained managers, meeting leaders, counselors, human resource personnel and, sometimes even employees to carry the communications program through. Mr. Kieffer will focus on inter-personal communication and the important issues essential in such training.

Closing Remarks

Kathryn J. McIntyre, Editor, BUSINESS INSURANCE

The Conference adjourns at 3:30 p.m.

In today's economic climate, corporations are particularly sensitive to the rising cost of benefits and are concerned about more efficient and effective ways to communicate the value of benefits to employees.

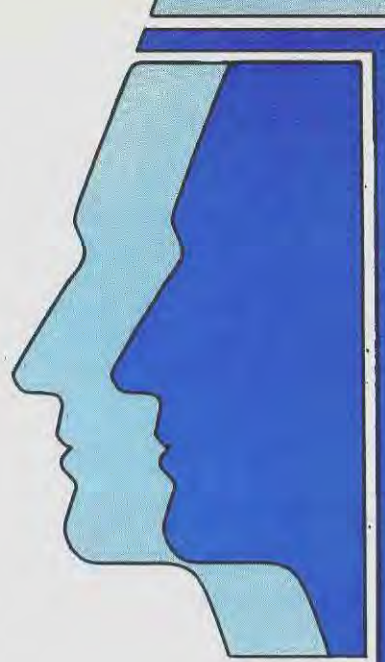
The *BI Employee Benefits Communication Conference* is a valuable investment of your time and dollars that makes sense for your company and for you as a benefits professional.

While exploring issues that are critical to your professional responsibilities, the *BI Conference* will focus on the foundation of effective communication. A clearer understanding of the methods used by the experts in your field will help you achieve better targeting of communication and more efficient utilization of your company's benefits programs.

You'll leave this Conference with a new perspective that's bound to have a positive effect on your company's bottom line!

Sessions and speakers have been selected to help you meet the challenges of your profession. General sessions focus on the planning and implementation of communication efforts. Concurrent sessions afford you the opportunity to zero in on specific communication programs. You can attend all three of these work-groups, presented as 'Case Studies.'

Highlighting this year's conference is the 12th annual EBC Competition Awards Presentation. Competition programs will be available for review in the EBC Gallery. The Benefits Literature Gallery makes it possible for you to collect some of the latest information available from consultants, insurance companies and service organizations.



REGISTRATION

The cost is \$545. 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.

(Check or credit card accepted, see registration form.)

All cancellations must be received in writing. A full refund will be made on cancellations received prior to July 1. A \$100 service charge will apply to cancellations received after July 1. No refund will be made on cancellations received less than five 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 East 42nd Street, New York, NY 10017

For additional information call:
Ann Vazquez 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. These rates are available to Conference registrants only: \$95 single room; \$120 double room.

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 15.

TRAVEL ACCOMMODATIONS

We are pleased to announce that Travel Headquarters Ltd. has been selected to help you coordinate money-saving flights to New York for the BI Conference. Travel Headquarters will provide travel arrangements for registrants, from every major city in the U.S. and Canada, at substantial discounts without sacrificing your comfort or convenience. Space is limited and reservations will be accepted on a first come-first serve basis.

For special airfares and reservations call:

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or toll-free from anywhere in the U.S., (800)621-1676.

You must mention the Business Insurance Benefits Conference when making your reservations. Airfares and reservation cards will be included with your Conference Registration Confirmation.

It's all there at the BI Benefits Communication Conference.
"The Dollars & Sense of Communicating Employee Benefits,"
July 30 and 31 at The Grand Hyatt Hotel in New York City.
This Conference makes good sense for you and your company.
Register NOW and save on your hotel and airfare too.

REGISTRATION FORM

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July 30 and 31 at The Grand Hyatt Hotel in New York City

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\$ _____ for _____ registrants.

Test yourself

Continued from page 13

21. You're the risk manager for an American university in the Middle East. You've just bought some German school buses that will be driven to your school. Besides a German policy, what do you need to meet government regulations.

- (a) The German policy is enough.
- (b) A "green card" cover.
- (c) Visa stamps from countries requiring them.
- (d) A surety bond to guarantee re-export.

22. You're the risk manager of a large university, looking to self-insure your workers comp program. What percentage of your total cost of risk would you expect claims administration costs to represent?

- (a) Less than 1%.
- (b) 4% to 6%.
- (c) 10% to 12%.
- (d) 15% to 20%.

23. As benefits manager at a state college, you want your employees who become disabled to be adequately covered. What disability protection guarantees a certain level of income?

- (a) Workers compensation.
- (b) Social Security.
- (c) Long-term disability insurance.
- (d) All of the above.

24. You're the risk manager of a large university whose library contains a collection of valuable books. Which valuation clause would provide you with full recovery in case of loss?

- (a) Actual cash value.
- (b) Stated amount.
- (c) Replacement cost.
- (d) Market value.

25. You're the risk manager for a multinational energy conglomerate looking into geothermal energy. Which of the cities listed below has been successful with geothermal space heating?

- (a) Carlsbad, Calif.
- (b) Reykjavik, Iceland.
- (c) San Juan, Puerto Rico.
- (d) Kaiserslautern, Germany.

26. As the benefits manager of an energy company with 500 employees, you know that all the following are basic to group health insurance except:

- (a) Evidence of insurability seldom required.
- (b) Administrative costs other than with individual plans.
- (c) All individuals insured under single master policy.
- (d) Contracts issued to all the individuals in the plan.

27. You're the risk manager of a natural gas plant in Ecuador with full insurance to value against fire, lightning and explosion under the standard free-of-charge fire policy. If you suffer a fire due to an earthquake, you'll be:

- (a) Covered in full.
- (b) Covered for 80% of damage by the earthquake clause.
- (c) Covered subject to the earthquake deductible.
- (d) Not covered at all.

28. As the risk manager of one of the top 10 oil companies, managing your risk information effectively is a must. With the advent of computerized risk information, which of the following can be done in a fraction of the time it used to take?

- (a) Allocate premiums and losses back to cost centers.
- (b) Format ad hoc reports on-line to your office.
- (c) Check claims in litigation and attorneys responsible.
- (d) All of the above.

29. You're the benefits manager for a large energy concern with a recently established defined contribution plan for your employees. You want to invest part of the funds in a safe, fixed-term vehicle with a high rate of return. Which of the following most accurately fits that description?

- (a) Equity real estate.
- (b) Recurring deposit guaranteed investment contract.
- (c) Intermediate term bond fund.
- (d) Single-sum deposit guaranteed investment contract.

30. You're the risk manager for a large oil company. Your company is considering the purchase of a topping cycle cogeneration system. To comply with the 1978 National Energy Act, the useful thermal energy output can't be less than:

- (a) 51% of total energy output.
- (b) No minimum requirement.
- (c) 5% of total energy output.
- (d) 30% of total energy output.

31. You're the risk manager for a municipality. Which of the following exposures represents the potential for a severe loss?

- (a) Police and fire departments.
- (b) Road maintenance.
- (c) Hospitals.
- (d) All of the above.

32. As the benefits manager of a county government, you're well aware that over the last 10 years the nation's fastest growing new group insurance benefit has been:

- (a) Long-term disability.
- (b) Vision insurance.
- (c) Dental insurance.
- (d) Short-term disability insurance.

33. You're the risk manager for a county and you're planning a self-insurance program. What rule of thumb should you use to arrive at the percentage of annual premiums you set aside to pay claims?

- (a) 2%.
- (b) 10%.
- (c) 25%.
- (d) 50%.

34. You're the risk manager of a suburban township reviewing the insurance for your police force. Which of the following are excluded from coverage under a standard public officials E&O policy?

- (a) Dishonesty and fraudulent acts.
- (b) Bodily injury claims.
- (c) Acts of misfeasance.
- (d) All of the above.

35. You're the benefits manager for a government agency. What is the average percent of premium that goes toward medical claim costs?

- (a) 80% to 95%.
- (b) 60% to 75%.
- (c) 45% to 55%.
- (d) 30% to 45%.

36. You're the risk manager for a county government with a fleet of 200 school buses, generating an unusually high number of third-party liability claims. Which of the following is the most efficient way to gather information to trace the major cause of the claims?

- (a) Interview each driver.
- (b) Manually compare the loss runs of

the past five years.

- (c) Follow randomly chosen bus drivers each morning.
- (d) Perform an on-line loss cause analysis by coverage.

37. As the risk manager for an owner/operator of a growing number of nursing homes, you've been considering a captive program. Which of the following states is favorably disposed toward the establishment of a captive?

- (a) New York.
- (b) Vermont.
- (c) Texas.
- (d) California.

38. You're the benefits manager of a county hospital considering true group auto for your employees. What is the average percentage of the U.S. employee population that drives to work?

- (a) 85%.
- (b) 75%.
- (c) 40%.
- (d) 25%.

39. You're the risk manager of a country-wide chain of hospitals. As you develop your risk management program, you must take into consideration that some states have restrictions on self-insuring which of the following coverages?

- (a) Auto liability.
- (b) General liability.
- (c) Product liability.
- (d) Professional liability.

40. You're the risk manager for a large metropolitan hospital. Which of the following coverages will protect your hospital administrator from professional liability while performing official duties?

- (a) Premises and operations—CGL coverage part.
- (b) Hospital malpractice policy.
- (c) The administrator's individual malpractice policy.
- (d) An endorsement to the hospital malpractice policy.

41. As the benefits manager for a chain of nursing homes, you're concerned with controlling health care costs for your employees. What percentage of individuals who seek a second opinion are able to avoid elective, non-emergency surgery?

- (a) 5%.
- (b) 10%.
- (c) 30%.
- (d) 40%.

42. You're the risk manager of a large hospital. A staph infection that has spread through one of your floors may cause state health authorities to close the hospital. If so, what type of extension to Section I of the hospital package would cover the loss?

- (a) Standard all-risk property insurance.
- (b) A manuscript staph infection form or endorsement.
- (c) None is available.
- (d) Regular all-risk business interruption insurance.

43. You're the risk manager of a manufacturing company exporting goods to 10 different countries. What coverage would protect your company against losses incurred when your government stops trading with a country you export to?

- (a) Expropriation.
- (b) Currency inconvertibility.
- (c) Embargo.
- (d) Accounts receivable.

44. You're a manufacturer's benefits manager. You're looking for a way to increase the interest rate in the actuar-

ial assumptions in order to lower the required contribution to your company's defined benefit program. Which of the following would enable you to do this safely and effectively?

- (a) Investing more funds in the general account.
- (b) Establishing a dedicated bond portfolio for retirees.
- (c) Investing in more risky equities.
- (d) Investing more in the guaranteed short-term account.

45. You're the risk manager of a large manufacturer concern planning to expand its operations. In which of the following cities will a standard general liability policy cover your liability exposures?

- (a) Seoul.
- (b) Tokyo.
- (c) Buenos Aires.
- (d) San Juan.

46. You're the risk manager of an electronics equipment maker, developing your annual risk management program budget. According to industry standards, what percentage of your total cost of risk should you set aside for loss control?

- (a) 1% to 2%.
- (b) 9% to 10%.
- (c) 15% to 20%.
- (d) 25% to 30%.

47. You're the benefits manager for a paper manufacturer with a significant number of disability claims. A determining factor in evaluating disability is:

- (a) Person's inability to work.
- (b) Physical incapacitation.
- (c) Wheelchair confinement.
- (d) Loss of limb.

48. You're the risk manager of a manufacturing firm that gets all of its processed raw materials from its plant in Sweden. A fire has just destroyed the plant and it will take eight months to rebuild. What type of coverage would protect you against loss of income while your plant is being rebuilt?

- (a) Extra expense.
- (b) Contingent business interruption, with interdependencies.
- (c) Standard business interruption.
- (d) Expediting expenses.

49. You're the risk manager of a large department store chain, with workers comp exposures in more than 20 states. Which of the following can play an important part in your coverage program in monopolistic states?

- (a) Stop-gap employer's liability.
- (b) In rem.
- (c) Outer continental shelf.
- (d) Broad-form property damage.

50. You're the benefits manager for a distributor of stereo components, looking into true group auto insurance as a benefit. All of the following are advantages of true group auto insurance except:

- (a) Conversion privilege.
- (b) Guaranteed issue.
- (c) Low cost to employer.
- (d) Individual underwriting.

51. You're the risk manager for a retailer with warehouses and a distribution network in a half dozen Latin American countries. In which of the following countries is insurance a national monopoly?

- (a) Costa Rica.

Continued on page 17

A.R.M. exercises will appear July 2 instead of June 25.

Continued from facing page

- (b) Brazil.
 - (c) Argentina.
 - (d) All of the above.
52. You're the risk manager of a chain of retail drug stores considering self-insurance. What percentage of your total incurred losses would your first year payout for general liability claims probably represent?
- (a) 10%.
 - (b) 20%.
 - (c) 40%.
 - (d) 80%.
53. You're the benefits manager of a regional department store chain with a dental program. The biggest factor influencing employee use of the plan is:
- (a) Their appearance.
 - (b) Their out-of-pocket cost.
 - (c) Convenience of the dentist's office.

- (d) Employer's promotional plan.
54. You're the risk manager of a large department store whose manuscript property form excludes precious and semiprecious stones, costume jewelry and garments trimmed in fur. What is the most cost-effective way of dealing with this exposure?
- (a) Purchase a jewelers block and furriers block policy.
 - (b) Delete the exclusion from the policy by endorsement.
 - (c) Take jewelry and fur-trimmed garments off the shelves.
 - (d) Self-insure the exposure.
55. You're the risk manager of a major manufacturer of corporate aircraft. If one of your prototype jets crashes while en

- route to an aircraft exhibition, you'll recover your loss with:
- (a) Aviation product liability coverage.
 - (b) Aviation personal accident insurance.
 - (c) Maker's hull coverage.
 - (d) Grounding liability.
56. You're the benefits manager of a cross-country trucking firm, interested in containing health care costs. Which of the following acronyms is applicable to cost-containment initiatives?
- (a) PAT.
 - (b) TBA.
 - (c) GRO.
 - (d) WHS.
57. You're the risk manager for a commercial airline. Major insur-

- ers consider the most important single factor in pricing cargo liability to be:
- (a) Air miles flown annually.
 - (b) Loss experience.
 - (c) Aircraft manufacturer and model.
 - (d) First pilot's hours in the particular make and model.
58. You're the risk manager for a shipping company with cargo going into Indonesia. According to local regulations, your marine cargo cover must be written by:
- (a) A locally licensed insurer.
 - (b) The government-controlled monopoly insurer.
 - (c) Lloyd's of London.
 - (d) A company with local representation.

59. You're the benefits manager for a shipping company that has invested the pension plan in stocks and bonds. What ways can you further diversify the investments in your pension plan considering the following:
- (a) Equity real estate.
 - (b) Venture capital.
 - (c) International investments.
 - (d) All of the above.
60. You're the risk manager of an export company whose primary products are fragile items susceptible to water damage. What percentage of non-fortuitous transportation losses are preventable?
- (a) 10%.
 - (b) 75%.
 - (c) 50%.
 - (d) 25%.

Here are the answers

- 1.b 31.d
- 2.d 32.c
- 3.d 33.b
- 4.b 34.b
- 5.c 35.a
- 6.b 36.d
- 7.b 37.b
- 8.a 38.a
- 9.c 39.a
- 10.d 40.d
- 11.b 41.c
- 12.c 42.b
- 13.c 43.c
- 14.b 44.b
- 15.c 45.d
- 16.b 46.a
- 17.a 47.a
- 18.c 48.b
- 19.d 49.a
- 20.b 50.d
- 21.b 51.a
- 22.b 52.a
- 23.c 53.b
- 24.c 54.b
- 25.b 55.c
- 26.d 56.a
- 27.d 57.b
- 28.d 58.a
- 29.b 59.d
- 30.c 60.b

If you scored 45 to 60 correctly, you have an extraordinary breadth of knowledge about the industry and are in touch with the marketplace.

If you got 20 to 44 correct, you are very aware of the many different insurance products and services available today.

If you answered 10 to 19 correctly, you are knowledgeable in certain aspects of the insurance industry, most likely in matters concerning your particular business.

If you scored fewer than 10 correctly, you and your company would benefit greatly if you expanded your awareness of the insurance products and services on the market.



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Regulators hear plan for computerization

By CAROL CAIN

NEW ORLEANS—If state insurance regulators are going to do their job of keeping watch over thousands of insurers, they need more money and manpower to modernize and computerize their departments.

Insurance regulators and legislators have been saying that for years, but earlier this month they were presented with an outline of a four-phase plan of action by the joint liaison committee of the Conference of Insurance Legislators and the National Assn. of Insurance Commissioners.

The committee met in New Orleans during the NAIC's annual summer meeting.

"We have been talking for some time about enhancing the basic regulatory function of monitoring for solvency, and now it is time to get serious and do something about

speeding up a system that is too slow," said New York state Sen. John R. Dunne, in advocating a computerized system. He heads the COIL constituency on the committee.

Regulators appeared to be in agreement with COIL's proposal, but some noted that insurance regulation needs to be taken a step further in the form of a national network among the departments.

Representatives from both groups have been appointed to a task force to study the plan and report at the NAIC fall meeting.

Under the four-phase proposal, included in a report entitled "Closing the Regulatory Time Warp," insurance examiners working in their departments and through the NAIC to computerize their operations would gain the capabilities to:

- Verify, correct and analyze annual statement data from insurers, which would significantly re-

'We have been talking for some time about enhancing the basic regulatory function of monitoring for solvency, and now it is time to get serious and do something about speeding up a system that is too slow,' Sen. Dunne says.

duce the time currently devoted to manually checking and preparing the reports for analysis.

- Do the same thing with quarterly data from insurers.

- Receive annual and quarterly data in computer-usable form, thus eliminating the need for key punching and enabling examiners to run early warning tests, make trend analyses and make projections immediately.

- Access financial condition data as it is accumulated and stored in insurers' computers.

The plan is designed to achieve instant and paperless access by examiners to insurers' annual statement data.

"This proposal is intended to help commissioners and the NAIC build on the initiatives and progress they have already made toward gearing state insurance departments to meet the new challenges of financial services deregulation, possible regulatory realignment and inevitable comparisons with federal regulatory agencies that have already achieved a high degree of computerization," said Missouri state Sen. Truman E. Wilson, COIL president.

"It would be Neanderthal to oppose this type of concept in this day of financial integration," said Lyndon Olson Jr., chairman of the Texas Insurance Board. "It's a fait accompli (an established fact). We can do it, or Washington can do it."

He noted that because smaller states would not have the budgeting capacity or the manpower to establish such a computerized program, there is a need for a national network of shared information, and the NAIC's early warning system—Insurance Regulatory Information System (IRIS)—may become part of the plan.

The proposal calls for an immediate joint effort by COIL and the NAIC to obtain the necessary public funding through the state budget approval process for achievement of the first phase—a computerized audit of insurers' annual reports—by year-end 1985, Sen. Dunne said.

The four-phase plan was partially based on a COIL survey of state insurance commissioners which revealed that although most commissioners requested budget

increases of their governor for additional manpower and equipment, few succeeded in winning their governor's support.

More importantly, the survey pointed out that most of the departments responding said they did not receive support from the insurance industry for their budget requests.

And the survey also revealed that few commissioners requested specific increases to improve their monitoring for solvency, Sen. Dunne said.

"State insurance commissioners, governors and legislators are going to have to do a lot better if they expect state regulation to meet the challenges inherent in overnight takeovers of insurers by financial conglomerates, and instant fund transfer. All of us are going to have to do better than we are now, if we expect state insurance regulation to stand comparison with the state-of-the-art methods in use or in rapid development at federal agencies like the Federal Deposit Insurance Corp., the Fed, the comptroller and the Securities and Exchange Commission," the survey report noted.

The biggest objection to the plan may come from legislators and executives who don't see insurance regulation as a priority on demands for money that will compete with other state needs, Sen. Dunne said, which is why COIL and the NAIC need to work together in a concerted effort.

"But before state regulators can achieve the computer capability they need, there are some battles to win within the state budget-making process. Those of us who have worked to improve state insurance regulation and want to see it continue are ready to help convince our legislative colleagues and state governors of the urgent need for this kind of program," Sen. Wilson said.

The key problem currently facing most insurance departments is the time lag in receiving and manually processing annual report data, the survey report says.

For instance, in New York, some 13 insurance examiners check the accuracy of about 1,200 annual

statements. In California, 20 examiners do the same exercise on 1,334 annual statements.

In smaller states, the workload is just as awesome and worse, the report notes. In South Dakota, the insurance department's two examiners review the annual statements for 1,070 insurers. In Arkansas, four examiners have 1,475 annual statements to check.

In all, examiners across the country check more than 58,000 annual statements that contain more than 348 million bits of information, the report says.

This checking for accuracy, or desk audit, generally takes from eight to 10 weeks, according to the COIL survey. A more in-depth review of the statements takes from four to six weeks more.

With these time lags, including the duration of the reporting year, the two-month period of compilation within companies, the time needed for examiners to perform both mathematical and analytical functions, the system can easily produce information analyses and findings that are too old to be useful in identifying a potential insolvency.

"Sudden surges in premiums, underwriting or investment losses and embezzlements may change key ratios that help indicate financial condition and may not come to the attention of regulators until as much as 14 months after the deterioration first became pronounced and should have been known," the report says.

Although it is technically possible to build a monitoring system today, it would be impractical to try to implement such a system immediately, the report concludes, which is why a four-phase plan is suggested.

"To (implement it immediately) would be a herculean task. Insurance companies would resist it, some holding that much of their information is not yet on computer. This is especially true in the case of many small companies that have nowhere near the necessary computer capability," the report notes.

Implementation of the plan also will be expensive for insurance departments.

The report estimates that the cost of purchasing the equipment, training and the installation needed to implement phases one and two would be between \$100,000 and \$250,000 for each state insurance department.

Estimates for additional costs include computer software, \$100,000; monthly servicing costs, between \$600 and \$1,800; and key punching the information, \$130 per report. ■

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NAIC weighs world conference

NEW ORLEANS—Insurance is an international business. Right?

So why aren't regulators from around the globe putting their heads together and exchanging information and ideas?

That question was raised by some members of the National Assn. of Insurance Commissioners, which held its summer meeting in New Orleans earlier this month.

The commissioners decided to explore the idea of holding an international symposium on insurance regulation. They directed James W. Schacht, chief deputy director of the Illinois Department of Insurance, to put together details for such a conference, including what the conference will encompass, possible substantive areas and possible sites.

"Kenilworth started us thinking about it," said Mr. Schacht, who represents Illinois on the NAIC's International Insurance Relations Task Force. The demise of Kenilworth Insurance Co., which was

liquidated by the Illinois department in 1982, involved insurers and reinsurers from several different nations.

"There was considerable international involvement," he said.

Regulators from other countries also have an interest in U.S. insurance regulation, according to comments Mr. Schacht heard last year when he gave a speech on reinsurance at a meeting of the United Nations.

"I got to meet a number of regulation officials from developing countries. They had a real desire to get information about regulation in the United States and elsewhere," Mr. Schacht said.

That thought was echoed by Tom Muir, director of the Insurance Division of the British Department of Trade and Industry, who attended the NAIC meeting in New Orleans as an observer.

Mr. Schacht is expected to present a report at the regulators' winter meeting. ■

Hospitals consider offering health care plans

Continued from page 3

PPOs have sought to preserve the fee-for-service payment mechanism, but that has made marketing difficult for many. Insurers and employers have been wary of contracting with PPOs because they fear that the providers may make up for reduced rates by admitting patients to hospitals more often or keeping them a day or two longer.

To combat this perception, PPOs have made utilization review an integral part of their programs. In utilization review, a patient's health status is reviewed before, during and after a hospital stay to determine if prescribed care is appropriate.

Utilization review, however, hasn't convinced many insurers and employers that signing up with a PPO will keep their health care costs from escalating. PPOs are too new to have proven that they actually are an effective shield against rising health care costs.

Insurers and employers are at risk if they pay a PPO on a fee-for-service basis, said Walter McClure, Ph.D., president of the Center for Policy Studies in Minneapolis, a research group specializing in health care policy. "They want data systems to tell them that a PPO actually is less costly," he added. And good data systems are hard to find.

Some PPOs are deciding that to convince employers and insurers to buy into their plans, they have to guarantee health care for a flat rate per year for each enrollee.

"PPOs are having to place themselves at risk to demonstrate to employers that they can control utilization," said James Czesak, senior vp of marketing at GreatWest Hospitals Inc. in Santa Ana, Calif., a for-profit hospital management company.

"You can't guarantee that an employer's health care costs won't go up without assuming risk," added Layton Crouch, executive vp, CarePlus Network. CarePlus is a PPO set up by HealthWest Foundation, Chatsworth, Calif., a non-profit hospital management company.

After a PPO assumes the risk, it is one short step to underwriting the health care plan, Mr. Crouch said. An employer would then pay health care premiums directly to the PPO.

Humana Inc. in Louisville, Ky., is one of the first hospital management companies to actually act as an insurance company and underwrite its own health insurance plan. It is the nation's second-largest multihospital system.

The HumanaCare Plus product differs from an HMO in that it replaces the insurance plan offered by participating employers, said Henry Werronen, senior vp and chief operating officer in Humana's Group Health Division. HMOs are simply another option

offered to employees along with a regular health insurance plan.

HumanaCare Plus has been operating in the Louisville area since January. It has 11,000 enrollees at 30 companies with more than 50 employees. The largest employer it covers is Citizens Fidelity Bank, with 1,700 employees.

What makes the plan attractive to employers is that Humana guarantees the premium for the first year and limits annual increases in subsequent years of a four-year contract to the Consumer Price Index. When health care premiums are increasing at an average rate of 20% per year, premiums that increase on the basis of an annual CPI of about 5% mean substantial savings, said David H. Talbot, first vp at Drexel Burnham Lambert Inc. in New York.

The cost of the plan depends on the benefits provided under each contract.

HumanaCare Plus is providing health care insurance benefits comparable to those of major insurance companies, Mr. Werronen said, but there are some restrictions. Unlike an HMO, employees are free to see the physician of their choice; but they must go to a Humana hospital to get full hospitalization coverage.

Exceptions are made if a patient is traveling outside the area, in the case of an emergency or if a Humana hospital doesn't provide the needed service. Employees who go to a non-Humana hospital for other reasons are responsible for a \$500 deductible per stay and a 20% copayment after that up to \$1,000 to \$2,000, depending on the contract.

The advantage Humana has over insurance companies in keeping the lid on premiums is that it has control over the cost of care in its hospitals, said Randall Huyser, health care analyst at Montgomery Securities Inc. in San Francisco. And 60% of the health insurance dollar goes to hospitalization.

HumanaCare Plus is the answer to filling up empty beds at Humana hospitals, Mr. Werronen said. Many factors, including new insurance products with incentives for subscribers to use less-expensive alternatives to hospital care, have resulted in steadily declining patient occupancy in hospitals across the country. Humana hospitals are now just under 60% full on average, Mr. Werronen noted.

National hospital occupancy figures were down 7.2% in the first two months of this year, compared with the same period in 1983, according to the latest American Hospital Assn. statistics. "Clearly, hospitals with declining patient volume must take patients from someone else to retain or gain market share," Mr. Huyser said.

Humana has contracted with Equitable

Life Insurance Co. in Des Moines, Iowa, to handle claims processing for HumanaCare Plus. It is also contracting with reinsurance companies for various levels of stop-loss insurance, Mr. Werronen said.

The multihospital system recently began offering HumanaCare Plus in three Florida metropolitan areas—Tampa, Miami and Orlando—and in Las Vegas, Nev. It also plans to open in Texas and in 10 other markets later this year.

In some states, the HumanaCare Plus plan is licensed as an insurance company, and in others as an HMO.

Health care industry experts believe that other hospital groups will follow Humana's lead in entering the insurance business through the PPO door.

Indeed, Hospital Corp. of America is testing a health care product on its employees that combines utilization review and a guaranteed cost per covered employee (BI, May 28).

Control is a major factor motivating hospitals to underwrite their own PPOs. The party that underwrites the product controls it, said Walter C. Kopp, associate, Health Care Advisory Services, at the public accounting firm of Laventhol & Horwath, San Francisco.

In fact, the issue of who is in control has caused a breakdown in negotiations between many PPOs and insurers, Mr. Kopp said. One of the reasons some hospitals are considering underwriting their PPOs is that they haven't been able to find anyone else who will, he noted. Both PPOs and insurers want one-sided contracts—payment on their own terms at their rates and under their own utilization review, he added. It's a stalemate.

But, "Can hospitals manage their own business well enough to guarantee health care at a certain price?" asks Gerald L. McManis, president of McManis Associates Inc. in Washington, D.C., management and research consultants specializing in health care.

A hospital must be able to keep its costs within the premium limits, Mr. Meyer of Health Pacific says. He suggests that physicians be given monetary incentives to control costs by sharing in profits and losses.

Hospitals will need some insurance or reinsurance to cover catastrophic illnesses Mr. Meyer also notes. A hospital-based PPO might take the risk for the first \$10,000 or \$25,000 in health care services per person and contract with a reinsurance company to underwrite claims above that amount. It's not cost-effective to buy reinsurance for services costing less than \$10,000 per person, he added.

Marketing is more difficult than underwriting risk, contends Terry Worthylake, president of Preferred Health Network in

Los Angeles, a PPO that includes 21 hospitals and more than 2,000 physicians in Southern California. Insurance companies have an army of agents pushing products in the marketplace, he noted.

Although many hospital-based PPOs are scouting out the insurance territory, few will begin underwriting their programs for another 18 to 24 months, Mr. McManis predicted. "But then we'll see a lot of them."

Some hospitals are hesitant to compete with the major insurance companies, especially ones that reimburse them for their services, Mr. Crouch of CarePlus said.

Underwriting PPOs isn't something most hospitals will jump into soon, other experts agree. It's a different business. "You don't just wander into it," said Stephen Gregg, president of Metro Care Inc., a Minneapolis PPO.

"Right now most hospitals are trying to figure out what a PPO is," said Robert P. Range, senior vp for development, St. Vincent Charity Hospital and Health Center in Cleveland. St. Vincent's subsidiary PPO, Ohio Health Choice Plan, has 17,000 subscribers in Cleveland and Columbus, Ohio. Hospitals have "got to put their toe in water first," Mr. Range asserted. "Getting into the insurance business would be a big transition."

Hospitals will have to get an insurance license in many states to offer guaranteed-cost health care. That means complying with numerous regulations and putting up substantial reserves, which probably will preclude smaller hospitals from offering the product.

Hospitals' entry into the insurance business "fundamentally threatens the health care insurance industry," Mr. McManis noted. But it also creates new opportunities for insurance companies, he added. "A number of insurance companies will probably get out of health care altogether; others will see it as an opportunity."

Insurance companies will create 15 to 20 new products to complement health care plans underwritten by hospitals, Mr. McManis predicted. They will offer multiple forms of insurance to absorb risk beyond that underwritten by hospital PPO plans, he explained. Heart and lung transplants may be covered by separate policies, for example.

Insurance companies also may become joint partners with hospitals in offering health care products, putting up some of the insurance reserve money, Mr. McManis suggested. Ideally, a reserve fund is equal to a year's operating expenses, and few hospitals have that, he said. As a joint partner, an insurance company also might handle the administrative side of the underwriting, including claims processing, he added.

Study says HMOs save money

The results of a recent experiment strongly suggest that health maintenance organizations reduce the cost of health care by reducing the amount of hospitalization.

The study, which was conducted by a research team from the Rand Corp. and published in The New England Journal of Medicine on June 7, compared medical use in a large Seattle HMO with that in the types of fee-for-service arrangements most people have with their physicians.

The researchers found that the cost of providing care through the HMO was 25% less than the cost of providing care through the traditional fee-for-service arrangements.

The study found that the hospitalization rate was 40% less for people served by the HMO. This lower rate was the reason for the lower cost, the researchers said. "Services delivered in the hospital account for about half of all U.S. expenditures on personal health services," the article said.

The researchers said in their article that their findings suggest "that the style of medicine at prepaid group practices (HMOs) is markedly less 'hospital-intensive,' and, consequently, less expensive."

The experiment involved 2,362 people in the Seattle area who were randomly assigned to receive care either from a fee-for-service physician of their choice or at the HMO. Also, 733 prior members of the HMO were studied as a control group.

The fee-for-service participants were divided into two groups: One group received their services at no cost, and one group shared the cost of their medical care. The latter group paid either 25% (the approximate amount required by many copayment insurance plans) or 95% (approximately the same as "catastrophic" coverage), but the families in the cost-sharing plan had a \$1,000 annual limit on their out-of-pocket expenses.

The samples for all the groups were virtually the same in such characteristics as age, sex, race, family size, income and general health.

The researchers found the number of visits for preventive care was higher in the HMO. However, they said that did not explain the lower rate of hospitalization, because most preventive visits were for pediatric or gynecologic care, which represent a very small percentage of hospital admissions.

Rather, the article concludes, the HMO structure itself results in a lower rate of hospital admissions. The HMO physicians, according to the article, "were simply practicing a different style of medicine from that of fee-for-service physicians."

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Doctors differ with public on health care

By ALISON KITTRELL

U.S. physicians are fairly satisfied with the state of the nation's health care and conservative in their opinions about what should be done to contain health care costs, a recent survey shows.

The survey, conducted by Louis Harris & Associates Inc. for the Equitable Life Assurance Society of the United States, also shows that the doctors' opinions differ sharply from the opinions expressed by 1,501 members of the general public in a similar 1983 survey conducted for Equitable by Harris (BI, Nov. 28, 1983).

And, the opinions of the 500 doctors from across the country who participated in the most recent survey differ in some interesting ways from the opinions of 100 physician leaders—heads of local and state medical societies—who participated in the 1983 survey.

According to the 1984 survey, 48% of the physicians feel that "on the whole, the health care system works pretty well, and only minor changes are needed to make it work better."

An equal percentage feel that "there are some good things in our health care system, but fundamental changes are needed to make it work better."

Only 3% agreed that "The American health care system has so much wrong with it that we need to completely rebuild it." One percent of the doctors surveyed had no opinion.

In the 1983 survey, 68% of the physician leaders said that only minor changes in the system were needed, compared with 48% of the doctors responding to the latest survey. However, only 21% of the respondents from the general public said they felt that way.

Fifty percent of the general public said they felt the system needed fundamental changes, and 25% said the system needed to be completely rebuilt.

The survey reveals that older physicians, physicians that belonged to the American Medical Assn. and physicians from the South were more likely to be satisfied with the health care system.

For example, 54% of the AMA members, 55% of the physicians from the South and 55% of those that had been graduated from medical school for 11 to 20 years felt the system needed only minor changes.

Doctors and physician leaders also were much more satisfied with the quality of health care generally. Sixty-two percent of the doctors and 84% of the physician leaders said they were satisfied with the quality of health care, but only 30% of the public said they were satisfied.

The doctors and the public also were divided over the reasons for the high cost of health care.

The use of new and more-expensive

medical treatments and equipment was cited as the main reason for escalating costs by 59% of the physicians, 46% of the physician leaders and 49% of the hospital administrators. But, only 34% of the public said that was the main reason for high costs.

The increasing cost of routine services was cited as the main reason for high health care costs by 44% of the public, but only 16% of the hospital administrators, 19% of the physician leaders and 17% of the doctors cited increased rates for routine services as the main culprit behind rising health care costs.

In the sections of the survey that dealt with specific health care cost-containment suggestions, physicians were most supportive of proposals that would increase the amount of cost-sharing on the part of employees and that would reduce length of hospital stays, particularly for chronically ill patients.

However, other cost-containment suggestions, including increased use of health maintenance organizations and preferred provider organizations, met with less support.

In several cases, the physicians acknowledged that a cost-containment option was or would be effective, but said it was unacceptable for an unspecified reason.

A sampling of the responses includes:

- Requiring employees to pay part of their health insurance premium. The majority of the physicians surveyed felt that this cost-containment option would be both effective (72%) and acceptable (82%). In the 1983 survey, only 65% of the public found this to be an acceptable option.
- Increasing health plan deductibles. Some 85% of the physicians said this would be effective, and 75% found it acceptable. Higher deductibles were acceptable to 89% of the physician leaders, but raising deductibles was acceptable to only 58% of the public.
- Requiring patients to pay a greater part of their medical bills. This was felt to be an effective option by 81% of the doctors responding, and it was acceptable to 71% of the doctors and 82% of the physician leaders. However, only 52% of the public said that requiring patients to pay a greater part of their bill was an acceptable cost-containment strategy.
- Requiring employees to pay taxes on employer-paid health insurance premiums over a certain amount. This was acceptable to

only a minority of the doctors (41%) and the public (39%). It was acceptable, however, to 62% of the physician leaders.

• Insurance plans that would encourage the care and treatment of the chronically ill at home. These were felt to be both effective and acceptable by 93% of the doctors and were acceptable to 78% of the public.

• Second opinions for non-emergency surgery. Only 54% of the doctors felt that second opinions were effective cost-containment tools, but they were acceptable to 74% of the doctors and to 88% of the public.

• Outpatient care. A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals was considered an effective cost-containment option by 92% of the doctors and was acceptable to 93% of them. It was acceptable to 99% of the physician leaders, to 84% of the hospital administrators and to 83% of the public.

• Prior approval for costs and lengths of stay for non-emergency hospitalizations. Although 60% of the physicians said that requiring the approval of insurance companies before non-emergency hospitalization would be effective, only 41% of the doctors and 34% of the physician leaders said it was acceptable. However, pre-certification was acceptable to 57% of the public.

• Utilization reviews. This cost-containment option was felt to be effective by 61% of the doctors, but only 53% felt it was acceptable. The general public was not asked about utilization reviews.

• Fixed fees for diagnosis-related groups. Some 58% of the doctors said that a system of fixed fees for DRGs was effective, but only 37% said it was acceptable. DRGs were acceptable to 76% of the public.

• Government price controls. Forty-nine percent of the doctors surveyed said that government price control of doctors' and hospital fees would be effective, but only 13% of the doctors and 7% of the physician leaders said such a system would be acceptable. Interestingly, government price controls were acceptable to 61% of the public.

• Preferred provider organizations. PPOs were considered effective tools by 62% of the doctors, but only 41% found them acceptable. PPOs were acceptable to 61% of the public.

• Health maintenance organiza-

tions. HMOs were considered effective by only 39% of the doctors and were acceptable to only 40%. HMOs were acceptable to 61% of the public.

• An insurance plan in which a patient selects a physician from a list of doctors who provides basic medical care for a predetermined fee and authorizes all services from labs, specialists, etc. This option was considered effective by 68% of the doctors, and was acceptable to 52%. It was acceptable to 69% of the public.

• Health and safety incentives. Doctors reacted more favorably than the public to insurance plans that offer incentives to people with good health and safety practices, like not smoking, wearing seat belts and maintaining the correct weight. These plans were considered effective by 83% of the doctors and were acceptable to 95%. They were acceptable to only 80% of the public.

• Use of paraprofessionals. A system that encourages the use of midwives, nurse practitioners and physician's assistants was considered effective by 50% of the physicians and was acceptable to 43%. It was acceptable to 63% of the public.

Physicians, physician leaders, hospital administrators and the general public all disapproved of the government paying lower fees for Medicare and Medicaid patients and shifting the cost to private patients.

Disapproval of cost shifting was expressed by 87% of the physicians, 95% of the physician leaders, 87% of the hospital administrators and 74% of the general public.

Ronald J. Craven, regional health care director for Equitable in Chicago, noted that the company expected that opinions of rank-and-file physicians expressed in the 1984 survey would differ from those of the physicians leaders expressed in the 1983 survey.

When Equitable talked about the earlier survey with physicians, he said, "There appeared to be a lot of disagreement from the standpoint of the individual practitioner."

In fact, he said, Equitable was surprised that the difference in the opinions of the doctors and their leaders was not even greater. "We thought there might be considerably more," he said.

Copies of the survey are available free of charge from Mark Jacobs, Equitable Life Assurance Society of the United States, 1633 Broadway, Room 1604, New York, New York 10019.

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William J. Gombocz, 40, is now manager of insurance and risk management at American Can Co. in Greenwich, Conn. He will handle insurance programs worldwide; he had been casualty insurance manager. He earned his master of business administration from Lehigh University in Bethlehem, Pa., in 1971 and a juris doctorate from Pace University in New York in 1981. He reports to Richard Inserra, director of insurance and risk management. Also at American Can, **George Blackall**, 24, has been named insurance administrator, responsible for liability insurance and workers compensation. He had been insurance analyst for property and loss control. He earned his bachelor of science in fire safety engineering from Oklahoma State University in Stillwater in 1981. He reports to Mr. Gombocz. And **Douglas S. Williams**, 34, was named insurance administrator, in charge of property insurance and property loss control. He had been

casualty administrator. He got his bachelor of business administration at Pace University in New York in 1983. He reports to Bruce Hackett, property insurance manager.

Jim Maher, 54, is now vp of DFC Insurers, a subsidiary of Dunfey Hotels Corp., in Hampton, N.H. He also directs the corporate risk and insurance program for Dunfey Hotels Corp. He had been assistant vp and risk manager. He succeeds **Eugene Soles**, who now is a part-time consultant for Dunfey. Mr. Maher received a bachelor of arts from Fordham University in New York in 1951 and holds the Chartered Property & Casualty Underwriter designation. He reports to James T. Stamas, senior vp of Dunfey Hotels Corp.

Penny Troup, 48, is now insur-

ance manager for U.S. Rentals Inc., a construction equipment renting and leasing company, and its subsidiaries in Irvine, Calif. She will administer claims and group benefits and handle risk financing and loss control. She had been the insurance administrator for U.S. Rentals since 1979. Ms. Troup earned her bachelor of science in education from the University of Nebraska in Lincoln in 1958 and holds the Associate in Risk Management designation. She reports to Edward Godwin, vp of risk and asset management.

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Senator warns of more attacks on benefits

By JERRY GEISEL

WASHINGTON—Congressional and regulatory attacks on the tax-free status of employee benefits will continue, a U.S. senator warns.

"Deep in... the Treasury Department, Internal Revenue Service and, to some extent, on congressional committees, there exists a theory that all compensation should be taxed," said Sen. Bob Packwood, R-Ore.

Speaking before the Washington spring conference of the Employers Council on Flexible Compensation, held June 4-5, Sen. Packwood noted that a growing number of regulators believe that the nation's tax code should not be used for social policy purposes.

"This is the battle we face: that all compensation will be taxed," he said.

Sen. Packwood said he will do his part to protect provisions in the Internal Revenue Code that allow employers to receive tax deductions for the cost of providing ben-

efit programs and that will allow employees to collect those benefits without paying taxes on their value.

Next month, the Senate Taxation and Debt Management subcommittee, of which Sen. Packwood is chairman, will hold three days of hearings to lay a foundation to protect employee benefits from more regulatory and congressional attacks.

"They (will be) historic hearings," he said.

Sen. Packwood said he hopes the hearings will provide a record that can be used to ward off attacks from regulators who want to tax benefits.

If the hearings don't get off the ground, the consequences to the tax status of employee benefits could be severe.

Next year, as part of yet another tax bill that is expected to be introduced after the presidential election, there will be provisions to broadly tax benefits, Sen. Packwood predicted.

Since he was elected to the Senate in 1968, Sen. Packwood has been one of the most vocal congressional supporters of employer-provided benefit programs.

That support, he said, dates back to his years as a labor law attorney in the 1950s, when he represented employers during collective bargaining negotiations with unions.

Reflecting on that experience, he noted that union demands for certain benefits often were based on the sex and age of their members. A predominately female union was not interested in the same benefits sought by a union composed of mostly men, Sen. Packwood said.

This collective bargaining experience gave him an appreciation of the need for benefit diversity, he said.

That need for diversity can be best met through employer-provided benefit plans and not through a uniform federal government plan like national health insurance, he said.

Not only can employers provide a mix of benefits that is tailored to meet the specific needs of their work force, but companies also can deliver benefits at a much lower cost than the federal government can, Sen. Packwood maintained.

"Can you imagine the cost of a British-type (national health insurance) system here?" Sen. Packwood asked.

Already, the two biggest public health programs in the United States—Medicaid, which provides health care benefits to the poor, and Medicare, which offers medical and hospital benefits to the elderly—are producing major cost overruns, he said.

Sen. Packwood also said that he has endorsed—despite some reservations—a proposal by Rep. Barber Conable, R-N.Y., to save flexible spending accounts from Internal Revenue Service rules that would wipe out FSAs as a health care cost-containment tool.

Sen. Packwood and Rep. Conable want to attach the proposal to the tax bill that is being hammered out by a congressional conference committee (see related story).

The Conable-Packwood proposal would require employees participating in FSAs to choose in advance the benefits they want to fund and would place a cap on the value of benefits offered in an FSA.

But employees would be allowed to roll over unused benefits into a benefits bank for use the next year. The IRS rules, by contrast, re-

quire participants to forfeit unused benefits in their individual FSAs at the end of the year.

Sen. Packwood admitted that he and Rep. Conable have had their differences on the FSA proposal. For example, Sen. Packwood wanted the proposal to allow employees to "cash out" at least a portion of unused balances in their FSAs at the end of the year.

But, despite differences of opinion, Sen. Packwood said he endorsed Rep. Conable's proposal, noting that the proposal should benefit the overwhelming majority of employers that have set up FSAs.

Time is running out in battle to save FSAs, Conable says

By JERRY GEISEL

WASHINGTON—Congress must act quickly if it is going to save flexible spending accounts from proposed Internal Revenue Service rules, says Rep. Barber Conable, R-N.Y.

Employers with FSAs hope that a congressional conference committee working on a tax bill will attach a proposal by Rep. Conable that will save FSAs from the IRS assault (see story, page 1).

But, if that effort fails, Congress is unlikely to take up the FSA issue again this year because of a shortage of time. Although the current session probably won't end until Oct. 1, Congress will be gone much of the summer for the Republican and Democratic conventions.

"I would not advise" relying on later congressional action this year, Rep. Conable told the annual spring meeting of the Employers Council on Flexible Compensation held June 4-5.

The ECFC represents 151 companies that have or are interested in flexible benefit programs.

Rep. Conable, the ranking minority member of the House Ways and Means Committee, said he will not waver in his efforts to protect FSAs from the IRS.

"I stand ready to salvage a program that is necessary," he said.

Rep. Conable said his proposal, which would allow employees to roll over unused benefits in a benefits bank for use the next year, is a plan that the Treasury Department should be able to accept.

However, Rep. Conable, who is retiring from Congress at the end of the current session, said further compromises may be necessary to quell Treasury Department opposition.

Employers that don't understand why Congress and the IRS are attacking their benefit plans have to take the offensive if their programs are to survive, Rep. Conable said.

Businessmen, Rep. Conable explained, need to explain to their senators and representatives how their employee benefit plans work because the legislators simply lack the time to learn all the details themselves.

"There is less time to learn about more and more issues," Rep. Conable said.

Most congressmen, for example, don't understand how flexible benefit plans can slow the growth of health care costs or don't know that the plans help working parents by offering dependent child care as a benefit option.

"You (employers) will have to tell your congressmen how these plans work," he said.

Section 125 of the Internal Revenue Code, the section that governs flexible and cafeteria benefit plan arrangements, is also arcane to most congressmen, he said.

"We are not specialists. We are generalists and depend on your skills" to understand an issue, Rep. Conable said.

The New York Republican stressed that congressmen will take the time to see employers that want to discuss employee benefit issues. "Most of us make a serious effort to see as many people as possible," he observed.

Rep. Conable noted that if Congress passes a tax bill this year, that action is likely to set the stage for passage of an even bigger tax increase proposal next year.

Next year, the budget deficit will be even larger and pressure will build for tax increases to reduce the red ink, which is putting pressure on interest rates.

The Tax Equity and Fiscal Responsibility Act of 1982 and the 1984 tax legislation are only modest starts on reducing the federal deficit.

Next year's tax bill will be taken up when congressmen aren't facing re-election pressures. As a result, the 1985 tax bill will be discussed in a different context than this year's legislation, which is being hammered out on the eve of the November elections.

"There are going to be some overwhelming fiscal problems. Prepare yourselves for the tax bills that will follow," Rep. Conable advised.

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M&M continues inquiry, fires officials

Continued from page 2

In early 1983, M&M centralized its cash management functions, moving half the company's cash—about \$500 million—to the treasurer's department from various operating subsidiaries, he said. About \$125 million of this was M&M's own corporate cash, and \$375 million was fiduciary money, Mr. Regan said.

The company's policy was to invest "a limited portion" of the cash in government securities where state laws permitted such investments.

About half of the cash—\$250 million—was approved by senior management for trading in the "when issued" market. Investors in that market buy positions in bond issues that have been announced by the U.S. Treasury Department but not yet actually issued. Profit or loss for the investor depends on whether the bonds' price rises or falls between the announcement of the new issue and the date payment is due after the issue.

But "there was no thought by senior management of 'leveraging' by buying on margin, nor was it intended to acquire government securities of over two years' maturity," Mr. Regan said.

In its investigation, M&M found that treasury department personnel had accumulated "substantial" positions in government bonds with terms in excess of two years and that they had been using repurchase agreements, in which the company acquired bonds from securities dealers on credit.

"They thought this combination of acts could result in a profit for the company should the value of the bonds in the market rise above the company's cost," Mr. Regan told the shareholders.

"As it turned out, when the market went down, those engaged in these activities did not

accept and realize losses by selling, but rather continued the activity and made it worse by making additional purchases, presumably in the hope that the entire portfolio would soon rise in value."

Mr. Regan said that M&M senior managers—including Vp of Finance James W.S. Macdonald—were unaware of the nature and size of the investments.

However, an M&M spokesman later said that Mr. Gan had authorized the use of about \$25 million to buy bonds with maturities ranging to up to 30 years and that some of Mr. Gan's superiors knew about his authorization of long-term bond purchases.

The company would not comment on which superiors knew of the authorization.

Treasury department personnel covered up the investments by recording margin payments as purchases of new securities, Mr. Regan said. The maturities of the bonds were also concealed by entering coupon dates as maturity dates in company records, he said.

Mr. Regan said M&M is now investing its cash exclusively in certificates of deposit.

"Getting into government (securities) seems to me to be the error we made," he said. "I'm not sure we will ever buy a Treasury bill again."

He added that Mr. Macdonald will be reassigned to an as yet undetermined duties with M&M's London subsidiary, C.T. Bowring & Co. Ltd. The move comes at Mr. Macdonald's request and is not connected to the bond trading losses, according to Mr. Regan.

A successor to Mr. Macdonald as vp of finance has not yet been chosen.

Meanwhile, M&M is considering possible avenues of recovery, including filing claims with its insurers, though Mr. Regan would not reveal the names of the company's insurers or

the types of policies that might be involved.

M&M is also reviewing the involvement of Arthur Andersen.

M&M shareholders voted at the meeting to retain Arthur Andersen for another year. The auditor earned \$1.2 million in fees from M&M in 1983.

But, Mr. Regan noted that M&M's board of directors has the authority to change auditors and take action against Arthur Andersen if it decides such action is necessary.

Last November, Mr. Regan said, M&M "specifically asked Arthur Andersen to look into the activities of the investment management group as part of and in addition to their regular audit activities."

But the auditor—apparently relying on the company's faulty records—failed to uncover the bond positions, valued at \$1.2 billion at the end of last year.

The positions were discovered by accident April 5 when Mr. Post, the head of the investment group who claims he resigned from the brokerage March 9, was told by an executive of securities firm Drexel Burnham Lambert Inc. that M&M owed his firm large amounts on government bond trades.

A spokesman for Arthur Andersen declined to comment.

The New York Insurance Department is waiting for M&M to provide more information on the bond trading activity, a department spokesman says.

Disciplinary action against the brokerage is "likely" in light of its violation of restrictions on fiduciary fund investments, and will probably take the form of a fine, the spokesman added. Such a fine could amount to \$100,000 or more.

The Insurance Department hopes to wrap up its investigation within a month, the spokesman said.

Suit seeks \$63 million from Monsanto, others

Continued from page 2

the case out of federal court," said Mr. Norton. By suing an individual who is a resident of the state, the attorney hopes to keep the case in an Illinois courtroom.

"The verdicts are better in state court," he says, "because the jury is drawn from a smaller area than in federal court."

The first of the two suits, directed solely at Monsanto, stems from a Jan. 22 chemical release from the plant. It was filed on behalf of four area clergymen, who represent a class of more than 200 residents, property owners and visitors to Rush City, a subdivision in Sauget, which is located near East St. Louis.

The suit, which also names Jim Pace, the safety director at Monsanto's Sauget plant, charges that the defendants negligently allowed chemicals—including sulfur dioxide and hydrogen chloride—to be discharged into the atmosphere. It further states the impurities drifted into the nearby Rush City area, where residents became nauseous, suffered physical and mental pain and lost time from work and other activities because of respiratory problems.

That suit seeks \$25 million in punitive damages.

The second class action, which names all three companies, was filed on behalf of the same group of plaintiffs as well as other property owners and residents who "regularly sustain or sustained physical harm as a result of the discharges by defendants."

Although no specific dates are referred to in the second complaint, it says "certain harmful and offensive chemicals" have been discharged "regularly and frequently" in the past.

Mr. Norton says the action involves incidents that "go back as far as I can go back."

Named as defendants in the second complaint are Monsanto and Mr. Pace, Amax and Cooper and Donald Schneider and Richard

Rutherford, who are referred to in the suit as Amax's and Cooper's safety managers.

This claim seeks \$35 million in punitive damages.

Although both suits claim that residents have suffered respiratory problems because of the leaks, Mr. Norton says the leaks may also be linked to a higher-than-average incidence of mental disease, birth defects and cancer in the Rush City area.

Both complaints allege the defendants companies are responsible for at least one of the following charges:

- Failure to develop a safety program that would adequately control a likely discharge of harmful chemicals.
- Failure to design the facilities to prevent the discharge.
- A lack of maintenance at the facilities that would prevent chemical leaks.
- Absence of an adequate warning system that would let residents know when a discharge had occurred and lack of adequate information concerning protection against such leaks.
- No precautions against recurring environmental conditions, such as heavy icing, that could damage storage facilities and result in the escape of vapors.

All three of the defendants acknowledge that some plant leaks have occurred, and a spokeswoman for Monsanto notes that some area residents have already received compensation for the Jan. 22 incident.

However, none of the companies has yet filed a response to the complaint or acknowledges any of the claims.

The cause of the leak was attributed to an accumulation of ice that damaged a storage facility, the Monsanto spokeswoman said, adding that the problem was weather-related, not a breakdown of the plant's safeguards.

"The January incident is the first Monsanto has been involved in in

several years at that plant."

She added that the plant complies with both state and federal environmental protection regulations.

The Monsanto spokeswoman notes the company instructed its liability insurer, Insurance Co. of North America, a CIGNA Corp. affiliate, to settle claims with residents who suffered injuries because of the Jan. 22 discharge. About 100 people reportedly sought medical treatment as a result of the incident.

"Each resident talked with the insurance people, and it was settled per resident," she said.

A spokesman for CIGNA would not comment while the case is in litigation, and the Monsanto spokeswoman would not comment on the company's insurance limits.

Although no figures were available on how much was paid in compensation or how many claims were settled, plaintiffs' attorney Mr. Norton said residents received from Monsanto amounts ranging from \$400 to \$1,000 per settlement. He added that he does not think the residents were adequately compensated for their losses, although residents that settled with Monsanto are not members of the class.

Sam McWilliams, manager of Cooper's Sauget plant, which produces petroleum additives, also acknowledges that leaks have occurred at that facility.

"We had an incident in July of last year," that sent more than 100 people to the hospital, noted Mr. McWilliams, who said he had not seen a copy of the complaint.

Mr. McWilliams said the three companies are working together with the Illinois Environmental Protection Agency and the state attorney general's office to produce a warning system that would give residents a chance to protect themselves from future leaks. The alert would be signaled by a siren and families would have prior instructions on how to react to the situation.

"We expect to have it in operation in about three months," said Mr. McWilliams.

A spokesman for Travelers Insurance Co. confirmed that it writes general liability coverage for Cooper's parent, Richmond, Va.-based Ethyl Corp., and said the manufacturer's divisions are also probably covered.

Officials at Ethyl would not comment on its insurance except to acknowledge Travelers as its insurer and to say no other insurers would be involved with the claims.

Amax Zinc, which manufactures a variety of metals, has had a few problems with vapor leaks, according to a company spokesman, though he does not regard them as serious.

"We have some sulfur dioxide emissions. . . you might get a taste in your mouth but basically that's the only thing."

He added that Amax uses a multimillion-dollar recovery and reuse system that allows very little sulfur dioxide to leave the facility. "The emissions are regulated and permitted by the state of Illinois."

The spokesman would not name the company's insurers, but said there were "probably four or five that are involved or could be."

Amax will file a detailed response to the complaint in early July, he said, when the other firms are also expected to answer the charges.

Storm damage told

Preliminary estimates of insured damages from a storm system that hit nine Midwestern states April 25-28 is \$92 million, according to C.E. Hermanson, vp of the Property Claim Services division of American Insurance Services Group Inc.

Wind, hail and tornadoes did widespread damage in North Dakota, South Dakota, Nebraska, Kansas, Oklahoma, Minnesota, Iowa, Wisconsin and Illinois, he said.

Conference panel deals blow to employers

Continued from page 1

sions in the House and Senate tax bills to bar tax deductions for contributions to self-insured reserves.

If the proposals do become law, they would overturn a landmark victory employers won last year in a court battle involving Kaiser Steel Corp. (BI, Oct. 17, 1983).

In that decision, the 9th U.S. Circuit Court of Appeals ruled that self-insured employers can deduct reserves to pay for uncontested workers compensation claims if:

- All events governing the fact of the employer's liability occur during the tax year. For workers

compensation, courts have said that the only event determining liability is the worker's injury.

- The amount of the liability can be determined with "reasonable accuracy." The court held that aggregate reserve accuracy—rather than on a case-by-case basis—is sufficient to meet this requirement.

The provisions accepted by the conferees would replace this current "all-events" test with a so-called "economic performance" test, under which deductions would not be allowed until a claim is actually paid.

The substitution of the economic

performance test for the all-events test will mean that employers will lose a key financial advantage to self-funding their property/casualty exposures.

Under the all-events test, employers can take immediate tax deductions for reserves that won't be tapped for many years to pay for future claims.

But some observers say the economic performance test approved by the conferees contains an exception that would provide some extremely limited financial help to self-insurers.

That exception says that "recur-

ring" items can be treated as incurred in a taxable year so long as economic performance—or payment—begins no later than 8½ months after the end of the year.

But other sources say that 8½-month extension only applies to recurring business expenses like advertising costs and supplies—and not to property/casualty claims.

As an example, a congressional tax committee staff member said the 8½-month extension would apply in a case where an employer takes a tax deduction for supplies ordered at the end of one year and not delivered and paid for until the next year.

The conference committee report, which will be written after conferees complete action on the tax bills, probably will provide examples of recurring items that qualify for the 8½-month exception, noted Walter Vinyard, an attorney with Zuckert, Scoutt & Rasenberger in Washington.

In any case, even if property/casualty claims are considered recurring items, that won't provide much help for self-insurers since many property/casualty claims are not paid until years after a reserve is set up to pay for the claim.

On the benefit front, conferees, as of late last week, had not publicly discussed how they intend to resolve a radical difference between the House and Senate bills on the tax treatment of reserves held by 501(c)(9) trusts and experience-rated benefit plans.

The House bill says that employers cannot receive tax deductions for contributions to trusts or premiums paid to experience-rated plans if reserves held by the trusts or plans exceed 75% of average claims paid out over a company's most recent two years.

By contrast, the Senate bill would impose financial penalties on employers if too many trust benefits go to top executives. The provision in the Senate bill is aimed at small, professional companies, and it would have no effect

on the thousands of trusts sponsored by large and medium-sized employers, trade associations and unions.

Tax committee staffers previously have labeled the 501(c)(9) trust issue as extremely controversial and expect that it will be among the last items considered by the conferees.

In addition, as of late last week, Rep. Barber Conable-R.N.Y., and Sen. Bob Packwood, R-Ore., had not yet attempted to attach to the tax bill a proposal that would save FSAs from proposed IRS regulations.

The Conable-Packwood proposal would require employees participating in FSAs to choose in advance the benefits they want to fund and would place a cap on the value of benefits offered in an FSA.

However, employees would be allowed to roll over unused benefits into a benefits bank for use the next year.

The IRS rules would require participants to forfeit unused benefits in their individual FSAs at the end of the year. Those rules, experts say, would kill FSAs as health care cost-containment vehicles.

Benefit experts agree that Sen. Packwood and Rep. Conable face an uphill battle to get the conference committee to accept their proposal.

Rep. Conable earlier warned that some conferees may say that the proposal is not "conferable" or relevant to the tax bill and thus should not be considered.

In addition, the conferees did not take any action on a provision in the Senate tax bill that would exclude interest from tax-free bonds in determining whether a retiree must pay taxes on his or her Social Security benefits. However, they did discuss this proposal at length.

Currently, up to one-half of retirees' Social Security benefits are taxed if their income, including interest from tax-free bonds, exceeds \$25,000 for an individual and \$32,000 for a married couple.

Cessna is appealing crash verdict

Continued from page 2
called "grossly excessive."

He declined to discuss the company's insurance in detail, but said Cessna believes it is covered for the punitive portion of the award, as well as for actual damages. The company purchased its insurance in Kansas through broker Dulaney, Johnston & Priest in Wichita.

Cessna won't be covered if its general liability policy excludes punitive damages. However, many policies written in Kansas do not exclude the coverage of punitive damages, according to Dick Brock, administrative assistant to the Kan-

sas insurance commissioner in Topeka.

But, until very recently, insuring against punitive damages was not permitted under any conditions in the state, Mr. Brock noted. He explained that the Kansas Legislature recently enacted a bill that permits the sale and purchase of liability insurance against punitive damages in "vicarious situations."

For example, the law, which took effect April 26, permits an employer to purchase insurance against punitive damages that may result from acts of employees out-

side their direct line of work. Mr. Brock pointed out that the coverage may be tapped if an employee driving a company car on personal business causes an accident that results in punitive damages.

In addition, the laws in New Jersey, where the accident occurred and the case was tried, do not address the coverage of punitive damages in liability policies, explained Eileen Costello, supervising rate analyst in the state Insurance Department's Trenton office.

However, a lawyer for the plaintiffs said it was unlikely that New Jersey law would apply. ■

Exxon to pay \$1.5 million to New York to settle suit

By DOUGLAS McLEOD

NEW YORK—Exxon Corp. will pay New York state \$1.5 million to settle a lawsuit that accused the company of polluting the Hudson River while illegally taking millions of gallons of fresh water for use in its refineries.

The cost of the settlement will not be covered by insurance, an Exxon spokesman says.

Exxon earlier agreed to a \$500,000 settlement of claims brought by the federal government and two environmental groups over the same Hudson River activity (BI, May 7). That payment was also uninsured.

The state's lawsuit, filed April 24 in New York Supreme Court in Ulster County, had sought \$15 million in damages.

It alleged that chartered tankers operated by Exxon made more than 160 trips up the Hudson River after 1971, removing more than 3 million tons of fresh water for use in its refining operations in Aruba, an island off the coast of Venezuela.

Water that was not used in the refinery was sold to the government of Aruba, which paid Exxon

more than \$5 million, the lawsuit claimed.

Exxon barges also took more than 125,000 tons of water for use in the company's Bayonne, N.J., refinery, the state charged.

While taking on the water, the Exxon vessels discharged pollutants, according to the suit. The state charged that the company's failure to apply for permits to take the water or discharge pollutants violated state law.

Exxon denied violating any state laws and said its activities didn't harm the river, which is a source of drinking water for several upstate New York communities.

Under the terms of its settlement with the state, Exxon—which stopped sending ships up the Hudson last October—will continue that suspension until June 30, 1985, or until the state Legislature enacts laws defining when and how river water can be removed by private interests.

Such legislation is now being drafted in the state Assembly.

Meanwhile, U.S. Sen. Daniel P. Moynihan, D-N.Y., has sponsored a bill, S. 2239, that would require federal licensing of any shipments of fresh water outside the United

States.

Initial hearings on the bill were recently held by the Banking, Housing and Urban Affairs Subcommittee.

The state filed its lawsuit against Exxon after an earlier round of settlement talks broke down.

Although Exxon was able to settle with the federal government and the two environmental groups—the Hudson River Fishermen's Assn. and the Natural Resources Defense Council—the company's \$1.1 million offer to the state was turned down by Gov. Mario M. Cuomo.

One of the major roadblocks to the agreement was Exxon's demand that the money be used to fund Hudson River environmental projects.

Under the terms of the settlement, the oil company's \$1.5 million payment to New York will go into the state's general fund, with no restrictions on its use. ■

Rehabilitation plan approved

INDIANAPOLIS—The Marion Circuit Court has approved an order directing Indiana Insurance Commissioner Don H. Miller to implement a rehabilitation plan for three Indiana insurance companies affiliated with Baldwin-United Corp.

Under the rehabilitation plan, policyholders of the three companies—University Life Insurance Co. of America, National Equity Life Insurance Co. Inc. and S&H Life Insurance Co.—will be sent details of several alternatives for their annuities. The plan is essentially the same as one approved for three Baldwin-United affiliates in Arkansas.

The court order in Indiana directs Mr. Miller to send every policyholder, certificate holder and other interested person information about the plan and its options, as well as specific information about the policyholder's individual policy.

The implementation of the rehabilitation plan does not preclude later possible offers of "enhancements" to policyholders. However, Mr. Miller said that the plan should not be delayed while enhancement possibilities are explored.

Baldwin-United has sought protection from its creditors under Chapter 11 of the federal Bankruptcy Code. ■

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Manville, asbestos victims prepare pact

Continued from page 3

tion of 66.7% of Manville common stock is not needed to adequately fund the trust fund.

Also, before a plan could be finally agreed upon, the parties would have to work out differences with other groups that represent Manville's lenders and suppliers, shareholders, co-defendants in asbestos litigation and future claimants.

Issues, such as dealing with property damage claims brought by school districts and municipalities, the need for tax rulings and an injunction to prevent suits against Manville, also must be put into effect.

"It is still conceivable that no plan will be doable," said Robert Rosenberg, the attorney representing the asbestos litigants in the bankruptcy, in a speech at a conference in New York earlier this month.

Even if there is confirmation of a plan by Dec. 31, 1985, Mr. Rosenberg estimated that it will be 1986 before the 32,000 to 35,000 asbestos claims expected to be filed by then will begin to be administered and a long time after that before any money will actually be paid.

But, Mr. Rosenberg, with the New York law firm of Mcses & Singer, said that the \$2 billion in the trust would be adequate to handle projected asbestos claims through the year 2000. However, he admits if projections on claims are

wrong, there might not be enough money to go around.

"We feel that under present circumstances and present projections that is adequate funding through the end of the century," Mr. Rosenberg added.

He would not speculate on how future asbestos claimants would be compensated if they are significantly more than the number Manville and the plaintiffs estimate.

He said the plaintiffs' committee estimates are lower than those of some researchers, including Dr. Irving Selikoff of the Mount Sinai School of Medicine, who has estimated that hundreds of thousands will die from asbestos-related cancer and other diseases in the next generation.

"We are not using Dr. Selikoff's numbers," Mr. Rosenberg said. "If we were, there could not be a plan here because there would not be enough money."

"You may be eminently correct that ultimately there is not enough," he added, "but in the context of Chapter 11, it is every last dime that is available within a reasonable time."

Mr. Rosenberg also said that the claims handling system proposed for claims against Manville and the claims facility recently negotiated between other asbestos-litigation defendants and insurers under the auspices of the Center for Public Resources could ultimately be merged if both are put into prac-

tice.

"It seems enormously wasteful of time, resources and effort to have two parallel dispute resolution systems that are not integrated," Mr. Rosenberg said.

"It would not surprise me if down the road, the two managed to get integrated" if certain problems

were worked out.

Arthur Olick, who represents Keene Corp., another asbestos producer, said that co-defendants were not part of the negotiations between Manville and the plaintiffs' representatives and might object.

"The co-defendants have not been consulted," said Mr. Olick of

the New York firm of Anderson Russell Kill & Olick.

If co-defendants' interests aren't considered in a consensual plan, they are "quite apt to be forced into a litigating position," he said.

"This may or may not be a viable proposal for an overall solution. We will wait and see."

info

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security, etc. 6,604

Associations 1,133

Government, Unions,
Educational Institutions 799

Commercial Consumers
Sub-total 24,376

Insurance Agents
& Brokers 9,655
Insurance Cos. 5,461
Financial Institutions 441
Actuaries, Attorneys,
Adjusters, Appraisers
& Consultants 2,977
Others allied to the field 1,083

TOTAL 43,993

*Source: Business/Occupational
breakdown of qualified circulation,
November 7, 1983 issue, as submitted
to BPA for December 1983, BPA
Publisher's Statement.

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Russell steps down at Crum & Forster

B.P. Russell will step down as chairman of the board and chief executive officer of Crum & Forster Inc. July 1. He will continue on Crum & Forster's board of directors and as chairman of its executive committee. He also will remain on the board of the Xerox Corp., which acquired Crum & Forster in January 1983.

John K. Lundberg will replace Mr. Russell as chairman and chief executive officer. He currently is vice chairman of the board and chief financial officer.

Also at Crum & Forster, President **Sidney F. Wentz** will serve as chief financial officer and chairman of the company's finance committee. And, **Donald H. McComber**, senior executive vp, will become chief insurance officer. **James J. Cutro Jr.**, executive vp, will be the fourth member of Crum & Forster's senior management and planning group.

Other insurer changes:
Joseph DeLuca has been named vp of property underwriting at American Nuclear Insurers in Farmington, Conn. Mr. DeLuca has almost 20 years experience in the risk and insurance management field. Before joining ANI, he was corporate insurance manager for the Washington Public Power Supply System.

Frank C. Mobley joined Carriers Insurance Co. in Des Moines, Iowa, as vp of its subsidiary Carino Insurance Services Inc. Mr. Mobley had been vp of the Des Moines office of Marsh & McLennan Cos. Inc.

Larry D. Morris elected vp of claims at Westchester Fire Insurance Co., a unit of Crum & Forster's U.S. Insurance Group subsidiary. Mr. Morris joined USIG's Dallas office in 1982 as managing trial attorney. In his new position, he will be located in Basking Ridge, N.J.

Also, **Robert H. Calhoun** elected resident vp of the Westchester Fire Insurance Co. He will be in charge of the Dallas branch office. Mr. Calhoun joined the company in 1960, and he had been Nashville branch manager.

Thomas S. McDaniel named vp of underwriting operations for Omaha Indemnity Co., the property/casualty subsidiary of Mutual of Omaha Cos. He joined Omaha Indemnity in 1983 as an assistant vp.

Malcolm B. Burton named senior vp of Chubb & Son Inc. in Warren, N.J. He has been with the company 21 years and was senior claims counsel and national manager for casualty claims.

Lucien L. Lucas, a senior vp at Maryland Casualty Co., named senior field executive for its Western region, headquartered in Sacramento, Calif. Mr. Lucas has been with the company since 1937.

Maryland Casualty also announced two appointments at its Maine Bonding & Casualty Co. subsidiary in Portland, Maine: **David E. Bergson Jr.** appointed vp and director of marketing and branch operations, and **Kenneth L. Hall** appointed vp and director of claims. Mr. Bergson joined Maine Bonding in 1970 and most recently was regional marketing manager. Mr. Hall joined the company in 1949 and was named vp and regional claims manager in 1979.

Raymond Barrette elected senior vp and actuary at Fireman's Fund Insurance Co. in Novato, Calif. He began his career with Fireman's Fund of Canada in 1973, and most recently was vp and actuary of Fireman's Fund.

Brian Jessick named senior vp at Pacific Compensation Insurance Co. in San Bruno, Calif. Mr. Jessick joined Pacific Comp in 1983 as vp and division manager of the South-

comings & goings: industry

ern California office. In his new position, he will be in charge of the firm's field operation.

Agent/ brokers

Steven W. Fetterman joined Berkfield & Co. Ltd. of Birmingham, Mich., as vp. He previously had been with Liberty Mutual Insurance Co.

Edward A. Schirick promoted to vp at Rhulen Agency Inc. in Monticello, N.Y. He has been with the company eight years, most recently as assistant vp.

Robert E. Stanley named chief executive officer of A&A Australia Ltd., a subsidiary of Alexander &

Alexander International Inc., which is an operating subsidiary of Alexander & Alexander Services Inc. Before joining A&A Australia, Mr. Stanley was with Sedgwick Ltd. in Australia.

W. Ned Miller named vp of Johnson & Higgins of Ohio Inc. in Cleveland, a subsidiary of Johnson & Higgins. His responsibilities will be in the business development department. Mr. Miller most recently was manager of another insurance brokerage firm.

Reinsurers

George E. Ratcliffe promoted to president and chief executive offi-

cer of Skandia America Reinsurance Corp. in New York, a unit of the Skandia America Group. Mr. Ratcliffe had been president and chief operating officer of treaty.

Robert F. Lyncheski named vp and manager of treaty casualty claims at North American Reinsurance Corp. in New York. He joined North American Re in 1973, and most recently was assistant vp.

Richard A. Lang named regional vp and co-manager of the Monogram Reinsurance Corp. Midwest office in Arlington Heights, Ill. Before joining Monogram Re, Mr. Lang was assistant vp of reinsurance marketing at the General Reassurance Corp. of Greenwich, Conn. The Puritan Life Insurance Co. is the parent of Monogram Re, which is headquartered in Johnston, R.I.

Other suppliers

Gary B. Lanham joined M&M Protection Consultants in Chicago as vp and senior consultant for health care quality assurance. Mr. Lanham joined the Professional Liability Group of Marsh & McLennan Inc. in 1981.

June Narus Novak named vp at American Claims Evaluation Inc., a hospital-bill review firm based in Jericho, N.Y. Ms. Novak has been with American Claims for two years, most recently as national director.

Charles H. Pardue appointed vp and manager of the employee benefits department in the Dallas office of Reed Stenhouse Associates Inc. of Texas. He was vp and manager of the benefits department in the Houston office.

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Changes looming for satellite coverage

Continued from page 1

• Rates to soar. Several brokers and underwriters say launch insurance rates will at least double from the levels quoted before the February losses.

If underwriters take these measures, some brokers believe that some of the smaller companies that own satellites may be forced out of business because they will not be able to afford higher premiums.

Other observers, though, note that companies will continue to build and launch satellites but will pass their higher costs to clients. For example, the cost of long-distance telephone services that rely on satellite transmissions could rise.

So far, no underwriters have quit writing launch coverage because of the soaring losses.

For instance, Lloyd's of London underwriter Stephen Merrett, chairman of Merrett Holdings P.L.C., which wrote part of the coverage for the Intelsat V and the two probes lost in February, said he will continue to underwrite satellite insurance despite the losses.

Brian G.R. Hughes, senior vp at United States Aviation Insurance Group in Washington, probably the largest U.S.-based satellite insurer, said it was too early to tell whether USAIG will continue underwriting launch insurance.

And, John Higginbotham, vp at International Technology Underwriters in Washington, also believes it is too soon to predict exactly what will happen, though he said that INTEC would not withdraw from the satellite insurance industry.

But, the insurers haven't had to decide whether to accept new risks because satellite owners have not purchased launch coverage since the February losses. However, a French telecommunications service is now in the process of placing \$130 million in launch insurance for a series of satellites, one of which is scheduled to be launched in August (see related story).

Brokers and underwriters agree that companies looking for coverage will have more problems because of the June 10 loss of the Intelsat V, which failed to achieve a geostationary orbit after it was launched by the National Aeronautics and Space Administration's new version of the usually reliable Atlas Centaur rocket.

"Officially, we do now know what happened," said Neil Hosenball, NASA's general counsel in Washington. "We feel sorry for what happened," he said, but pointed out that the rocket had successfully launched 40 probes since its last failure in 1977.

The Intelsat V, which was the second in a series of five satellites, is now in an orbit where it can be recovered on a space shuttle mission, but Mr. Hosenball would not comment on any possible recovery plans.

Some 62% of the \$102 million in coverage for the Intelsat V was written in the London market, with Mr. Merrett as lead underwriter. The London coverage was brokered by Lloyd's broker Crawley Warren & Co. Ltd.

The other 38% was insured mostly with U.S. underwriters, though the specific underwriters are not known. Corroon & Black Inspace Inc. served as Intelsat's U.S. broker.

However, satellite underwriters and brokers are not as concerned about this latest loss as they were about the two satellites lost during the February space shuttle mission: the \$107 million Westar VI, owned by Western Union Corp., and the \$75 million Palapa B2 orbiter, owned by the Indonesian government.

First of all, Intelsat will pay an additional premium because of the loss, noted Corroon & Black's Mr. Rankin.

London sources say that, because of the loss, Intelsat will pay a premium of \$43.9 million for coverage for the five-satellite package, compared with a minimum premium of \$24 million had no losses occurred. And, if one of the three remaining Intelsat probes is lost, the premium will rise to \$63.9 million.

In addition, the loss of the Intelsat V does not have the same implications that accompanied the shuttle losses, adds Richard N. Nausch, president of broker Nausch, Hogan & Murray Inc. in New York, a satellite insurance specialist.

"I have the gut feeling that what happened in February is more traumatic than what happened with the Intelsat because it was the loss of two in a row and it was the shuttle, which used to almost guarantee success."

Underwriters are also more worried about the shuttle losses because they are concerned about the reliability of the PAM-D launch motors built by McDonnell-Douglas Corp., which are believed to have caused both February losses.

McDonnell-Douglas has not yet released its report on what went wrong during the February shuttle mission, notes NASA's Mr. Hosenball, though he adds that the company has conducted tests on other PAM-Ds and believes they can be trusted.

As a result, two satellites worth a total of around \$160 million will be fitted with the motors for their

scheduled August shuttle launch, Mr. Hosenball confirms. The satellites are the \$98.6 million American Telephone & Telegraph Co.'s Telstar 3C and the \$70 million SBS IV satellite, owned by Small Business Systems Inc.

The combination of the three recent losses will mean major changes in the market, brokers and underwriters agree.

One U.S. insurance source said underwriters will again insist on at least a one-loss deductible before writing launch coverage, adding that insurers insisted on such deductibles when they first began offering the coverage in the late 1960s.

John Howes, deputy chairman at Crawley Warren in London, predicts that rates will double.

For example, he noted that the rate for a satellite launched aboard the space shuttle, which had been between 5% and 6% of insured value before the February losses, may rise to 10% to 12%.

Mr. Merrett believes there will be a further tightening of policy conditions. For example, he said, policies will be worded differently depending upon the type of launch vehicle used.

A. Fred Dassler, executive director of the International Assn. of Satellite Users, a Washington group that represents 185 satellite users and owners, suggests that NASA should indemnify satellite owners for launch risks.

"If things get bad, one should petition NASA to provide insurance from the government," he said.

But, NASA's Mr. Hosenball says the agency has no intention of providing launch insurance. "It would take federal legislation to do that," he said. "NASA has no intention of getting into the insurance industry."

Finally, some suggest that rising rates and more restrictive coverage terms could force some companies out of the satellite business.

French meet some resistance

LONDON—Last week's loss of a \$102 million communications satellite came at the wrong time for the French Telecommunications System.

French Telecom, an French government agency, is now trying to place \$130 million of launch insurance to cover three communications satellites to be launched aboard the European Space Agency's Ariane rocket, says Jean-Marie Ancelin, deputy head of the aviation department of Faugere et Jutheau S.A., French Telecom's broker.

So far, F&J and Lloyd's of London broker C.T. Bowring & Co. Ltd. have placed a portion of the coverage, mainly with Lloyd's underwriters, at a rate of between 13% and 15% of the satellites' insured value. But, the coverage has not been completed, Mr. Ancelin admitted, adding that last week's loss of the Intelsat V probe is not making the job any easier.

"It is pretty difficult, but we think we will complete the coverage," Mr. Ancelin said. "Unfortunately, the recent loss will not help us."

He noted that some underwriters are wary of accepting new risks because they are waiting for satellites that have already been insured to be launched. In addition, he said it is difficult to find sufficient capacity to cover a series of satellites that will use the same method of launch.

Mr. Ancelin notes that F&J and Bowring do not have a lot of time to fill out the coverage. The first of French Telecom's probes, Telecom 1A, is scheduled to be launched Aug. 4, along with a European Communications Systems satellite that is already insured for \$65 million.

"Only the big boys in the satellite industry will be able to play that kind of game," says Mr. Rankin of Corroon & Black, "because the small boys will not be able to afford to self-insure one-loss deductibles or pay incredibly higher premiums."

In addition, venture capital firms will not invest in fledgling satellite companies without assurance that the ventures are covered by insurance, he added.

"The higher the cost of insurance, the higher your capital investment and the lower your profit return," Mr. Nausch notes.

"I do not know if companies will go out of business, but it will be difficult. There is no question that they will have to pay more; the question is if they can afford it."

However, the IASU's Mr. Dassler

doesn't think changes in the insurance market will have an impact on the satellite industry.

"In my opinion there are no small companies in this new business," Mr. Dassler says. "To get into the satellite insurance business you need \$250 million to \$300 million," he says, adding that satellite owners will be able to absorb higher rates.

USAIG's Mr. Hughes notes the latest loss may not mark the end of the problems facing satellite insurers and owners: Fourteen more satellites for which coverage has already been placed are scheduled to be launched this year.

If one estimates that a launch has a 90% chance of success, then Mr. Hughes calculates there is a 77% chance that one of the 14 probes will be lost.

J&H takes offensive in war against low rates

Continued from page 2

However, J&H doesn't expect to lose any more clients to competitors than it has in recent soft market years.

"(Clients) who are financially oriented—those who understand the machinations of the insurance industry—would have to agree this is necessary, and will budget accordingly for 1985," Mr. Hatcher explained.

Whatever its effect on clients, Mr. Hatcher's letter is drawing mixed reactions from J&H's competitors.

"I don't find it very newsworthy because it's what we have all been saying for the last three years," offered John A. Bogardus Jr., chairman and chief executive officer of Alexander & Alexander Inc. "There has to be some change, not only for the good of the industry but for the good of the consumer," he said.

Mr. Bogardus added that the Hatcher announcement is an indication that, although rates in selected insurance lines are tightening, the market generally is still very soft.

However, Timothy J. Mahoney, senior executive vp with Fred S. James & Co. Inc., takes a different view.

Although brokers need to be concerned about underwriters' financial stability, they are also responsible for getting the best price possible for clients, he said.

"My feeling is that insurance companies are big boys," Mr. Mahoney said.

"If they want to continue doing what they're doing, I'm going to take advantage of it for my clients."

Lloyd's fines attorneys in Fidentia probe

HAMILTON, Bermuda—Two Bermudian lawyers, James A. Pearman and Richard S. Pearman, are the first Lloyd's of London members to be fined under Lloyd's new disciplinary powers.

The two brothers, both partners in the Bermuda law firm of Conyers Dill & Pearman, were cited for failing to appear before the Council of Lloyd's in connection with an investigation into Lloyd's syndicates managed by T.R. Brooks & Others.

James Pearman was fined \$1,000, while Richard Pearman received a \$500 fine.

The brothers are legal advisers to Fidentia Marine Insurance Co. Ltd. of Bermuda. Lloyd's is investigating allegations that underwriters Raymond Brooks and Terrence Dooley entered into improper reinsurance arrangements with Fidentia, in which they allegedly had a secret interest (BI, May 7).

Both James and Richard Pearman said last week they would again refuse to appear in London if asked. But, they added, they have no intention of resigning their membership in the Lloyd's insurance market.

Richard Pearman said that he was surprised that he and his brother were fined, even though the fines were the minimum amount that could be assessed.

"We bent over backward to be as helpful as we could," Mr. Pearman said, adding that they gave Lloyd's as much information in writing as they could without prejudicing their client, Fidentia.

"But they asked us to come to London and that was too much," he noted.

In fact, the only information that the brothers refused to disclose to Lloyd's concerned Fidentia's investments, which the reinsurer's

board of directors felt should not be released, Richard Pearman said. He added that he and his brother were forced to abide by the board's decision.

James Pearman noted that since the Lloyd's investigation into Fidentia is continuing, it is possible that he could again be called upon to give evidence.

"If that were the case and I was asked to appear in London, I think I would take the same view."

Richard Pearman said he would reach the same decision, though he added, "If this were to happen again I would have to consider resigning from Lloyd's. This would be the only way of becoming out of reach of an investigation."

Both brothers maintain the fines are unfair since they were following the instructions of Fidentia's board members, none of whom are Lloyd's members who could be fined by the market.

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Is investment in brokers a sure thing or a big risk?

By **LEONARD M. WILSON**
Special to Business Insurance

A FEW WEEKS AGO, I received a call from a professional money manager of long acquaintance. One of those rare types in the investment business who likes to buy when everybody else is selling, he wanted to talk about Marsh & McLennan's tribulations over lunch.



Mr. Wilson

Having gotten past the small talk, we launched into a discussion of the publicly owned insurance brokers. What did I think of the group? And could I provide him with an overview?

I laid out a case for the favorable long-term growth prospects of the insurance brokers. First, a turn in premium rates on commercial insurance seemed in the offing.

Although it was still difficult to call the precise turn, rising insurance rates and markedly deteriorating combined ratios had placed the primary underwriters in a terrible position.

The long period of competitive pricing, now drawing to a close, reflected structural changes as well as the normal cyclical forces inherent in property/casualty insurance.

But structural factors like chronic excess capacity, underwriters' quest for market share and high interest rates were already incorporated into the price level of commercial lines. The price reductions had assuredly gone much too far, and rates soon would embark on a period of firming that might last three or four years.

With rising premium rates, the public brokers might well experience an extended phase of prosperity and a hefty expansion in profitability. I warned to my subject. The reasons investors liked the insurance brokers in the 1970s were still valid.

The public brokers were likely to outstrip the growth rate of almost any other financial

Leonard M. Wilson, a special limited partner at L.F. Rothschild, Unterberg, Towbin in New York, specializes in insurance brokerage stocks. He is a member of the New York Society of Security Analysts.

business. Gains in market penetration domestically and a larger role in international insurance brokerage were the ingredients of this above-average growth potential. The earnings slowdown of the past few years had served to obscure a strong fundamental outlook.

In addition, the public brokers were great cash cows. With relatively light requirements for working capital and fixed assets, earnings could be regarded as almost entirely unencumbered cash flow.

This would translate into generous dividend expansion in the years ahead. This would also be an attraction for potential acquirers.

I had a few more points to make in favor of the brokers when my luncheon companion stopped me virtually in the middle of a sentence.

He had a different point of view.

Here is an industry, he began, that had not registered earnings growth since 1978. In fact, except for Marsh & McLennan, earnings had declined. He was only grudgingly prepared to concede that most industries are susceptible to some kind of cycle.

He then raised the issue of industry black marks like Marsh & McLennan's bond losses. No one in his wildest imagination would have forecast such losses.

The other public brokers have not gotten off unscathed, either. Alexander & Alexander Services Inc. piloted a near-flawless domestic acquisition program only to stumble over Alexander Howden Group P.L.C. and its tangle of underwriting activities. Frank B. Hall & Co. Inc. is now committed to a bailout of a short-term truck lessor that involves large-scale debt guarantees. Even Corroon & Black Corp. has felt the irregularities at Lloyd's of London broker Minet Holdings P.L.C. and their impact on earnings.

Outside the United States, Sedgwick Group P.L.C., the largest British broker, had to settle Australian bush fire litigation for something like \$30 million. Irregularities at Lloyd's of London and Alexander Howden wrote new chapters on what is supposed to be a business with a tradition of fiduciary responsibility.

Now, he was warming to his subject. In his view, the real problem was the tendency of brokerage managements to overreach. Insurance brokerage continues to be an attractive

business, albeit somewhat tarnished as a non-cyclical one.

Why, therefore, do insurance brokers have to be in underwriting, a la Alexander & Alexander through Howden, or—on a smaller scale—Frank B. Hall? Was Marsh & McLennan trying to be too clever in squeezing out a little more yield, paving the way unknowingly for unauthorized transactions that led to huge losses?

If managements would stick to the business they know, that of an insurance intermediary, he said that, as an investor, he might be more receptive to the insurance brokers. High-quality and low-risk earnings were what made the group attractive in the first place. Acquisitions or business initiatives should not be allowed to detract from that image.

He was also uneasy about internal controls. Public insurance brokerages are worldwide organizations. Commercial insurance involves contractual obligations and massive transfer of financial liability. Internal controls should be laced with redundancies and overlapping safeguards to prevent costly breaches that undermine investor confidence. Management energies would be well employed in fortifying controls and correspondingly reassuring investors.

At that point, the check arrived. My portfolio manager friend was unusually well-informed and proved to be anything but an easy convert to my more benign attitude toward the insurance brokers.

He may have overstated his case, but as we parted, the issues he had raised seemed to justify some reflection.

Financial briefs Italian insurers

Italy's two largest insurance companies have announced an increase in profits for 1983.

Assicurazioni Generali, the largest Italian underwriter, says that its profits rose 21% in 1983 to 63.1 billion lire (\$374.2 million), while R.A.S., the Milan-based insurance group, says that its net income rose 27% last year to 16.1 billion lire (\$95.5 million).

Another Italian commercial insurer, Toro Assicurazioni, owned by the Angeli family which also owns automaker Fiat, reported its profits rebounded in 1983 following its involvement with the Banco Ambrosiano scandal. Toro, the fourth-largest Italian insurer, posted a profit of 29.7 billion lire (\$176.1 million), up 170%.

The insurer's depressed 1982 profit was caused in part by its link with Banco Ambrosiano, which triggered a global scandal when it collapsed following the death of its chairman, Roberto Calvi.

Mr. Calvi had owned Toro through Ambrosiano's holding company, La Centrale, which was sold to the Angeli family last year.

Zurich Insurance Group

Increased investment income was largely responsible for the continued profit improvement at Zurich Insurance Group, according to the company's 1983 annual report.

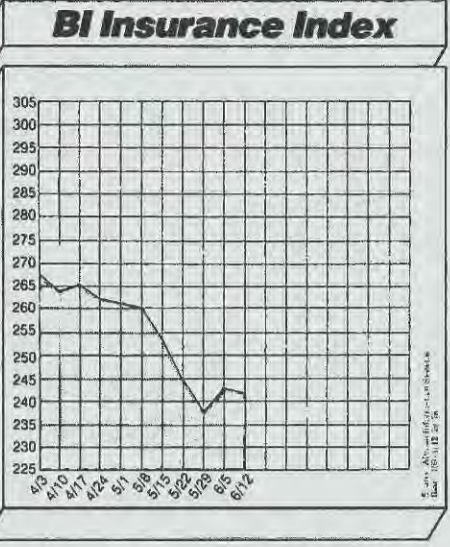
Net profits rose 12.5% to 101.4 million Swiss francs (\$46.1 million) in 1983 from 90.2 million Swiss francs (\$41 million). The group's premium income totaled 8.34 billion Swiss francs (\$3.79 billion) in 1983, an increase of 6.5%.

Chubb Corp.

Chubb Corp. has announced a quarterly dividend of 55 cents per common share payable July 5 to shareholders of record June 21. The dividend is up 5.8% from the last quarterly dividend, paid before a 3-for-2 stock split in May.

St. Paul Cos.

The St. Paul Cos. Inc. has declared a quarterly dividend of 75 cents per share, payable July 17 to shareholders of record June 29.



The Business Insurance index of insurance industry stocks remained basically unchanged from the results that were posted in the prior week. The BI index dropped 0.03 points to remain at 243.4 for the five-day trading period ending June 12. The losers barely outnumbered the gainers as 22 issues closed down, 21 stocks posted increases, and 17 were unchanged. The largest gains on the Business Insurance index were reported by Alexander & Alexander Services Inc., 7.9%; Crawford & Co., 6.8%; Foremost Corp. of America, 5.4%; Old Republic International Corp., 4.7%; and Marsh & McLennan Cos. Inc., 4.1%. The largest losses were reported by Bitco Corp., 7.1%; Integrated Resources Inc., 6.8%; Aneco Reinsurance Co. Ltd., 5.3%; Aetna Life & Casualty Co., 5.2%; and Travelers Corp., 5.1%. The Business Insurance index suffered a slight drop of 0.01% for the trading period, while the New York Stock Exchange composite reported a 0.8% drop for the same period.

British Issues

12 June Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence
Comm Union	214	19.5	16.88	7.9	221—214
Genl Accident	465	12.6	30.00	6.5	465—460
Gdn Royal Exch	575	12.8	36.43	6.3	575—570
Phoenix	440	15.7	31.43	7.1	458—440
Royal	562	15.6	42.86	7.6	570—562
Sun Alliance	373	15.3	22.86	6.1	375—372

Brokers	Price	P/E	Div.	Yield	1 Week High—Low
CE Heath	425	7.7	28.57	6.7	426—422
Hogg Robinson	183	12.2	10.43	5.7	186—180
JH Minet	156	10.4	9.00	5.8	157—155
Sedg Grp	243	11.0	12.86	5.3	244—242
Stew Wrightson	365	10.4	24.00	6.6	366—360
Willis Faber	810	14.5	35.00	4.3	812—807

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

Insurance Cos.	JUNE 12, 1984				6/6/84 THRU 6/12/84				Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)			
	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)											
Aetna Life & Cas Co	NYSE	29.63	-5.2	14.5	2.64	8.9	31.25	29.50*	6,469.6	United Fire & Cas Co	OTC	26.75	0.0	15.3	1.60	6.0	26.75	26.75*	0.7
American Bankers Ins Group	OTC	11.63	1.1	8.2	0.50	4.3	12.13	11.63	205.8	United States Fid & Gty Co	NYSE	43.75	-4.1	6.6	4.16	9.5	44.75	43.75*	331.0
American General Corp	NYSE	20.63	-1.2	6.9	0.90	4.4	21.00	20.63	348.4	United Svcs Life Ins Co	OTC	25.13	-2.0	7.3	1.00	4.0	25.50	25.13	8.1
American Indty Finl Corp	OTC	16.75	0.0	119.6	1.12	6.7	17.00	16.75	2.0	UsLife Corp	NYSE	24.25	-1.5	6.5	0.96	4.0	24.50	24.00*	109.5
American Intl Group Inc	OTC	59.75	-3.6	10.5	0.44	4.0	61.75	59.75	379.1	Washington Natl Corp	NYSE	18.75	-0.7	10.9	1.08	5.8	19.25	18.75	48.1
American Natl Ins Co	OTC	24.13	2.1	7.1	0.96	4.0	24.50	23.63	34.7	Zenith Natl Ins Corp	OTC	13.00	4.0	8.7	0.68	5.2	13.00	12.50	29.5
Aneco Reins Ltd	OTC	2.25	-5.3	6.6	0.00	0.0	2.25	2.25	7.5	INSURANCE COMPANIES				AVERAGE			11.2	4.2	
Aveco Corp	AMEX	16.88	-2.2	10.7	0.58	3.4	17.00	16.88*	8.8	Agents/Brokers									
Banks Iowa Inc	OTC	52.00	0.0	20.6	1.56	3.0	52.00	52.00	2.2	Alexander & Alexander Svcs	NYSE	20.38	7.9	0.0	1.00	4.9	20.38	18.75	141.1
Bitco Corp	OTC	9.75	-7.1	0.0	1.33	13.7	10.50	9.50*	20.4	Anderson Clayton(Ranger/PanAm)	NYSE	37.00	0.0	616.7	0.80	2.2	37.00	37.00	0.0
Carolina Cas Ins Co	OTC	3.25	0.0	0.0	0.00	0.0	3.25	3.25	1.4	Araco Inc	NYSE	15.13	-7.6	0.0	0.40	2.6	16.50	15.13*	268.6
Chubb Corp	OTC	45.38	4.3	12.4	2.20	4.8	45.38	44.63	95.6	Baldwin & Lyons Inc	OTC	23.25	0.0	14.6	1.00	4.3	23.50	23.13	31.7
Combined Intl Corp	NYSE	29.75	0.0	7.6	2.08	7.0	29.75	29.13	163.8	Corroon & Black Corp	OTC	12.50	0.0	15.6	0.40	3.2	12.50	12.50	25.3
Continental Corp	NYSE	26.38	-0.9	0.0	2.60	9.9	27.00	26.38	569.2	Crumm E H Cos Inc	OTC	9.25	0.0	20.1	0.00	0.0	9.25	9.25	0.1
Crawford & Co	OTC	15.75	6.8	10.7	0.66	4.2	15.75	15.25	11.6	Emett & Chandler Cos Inc	NYSE	21.88	0.6	29.6	1.00	4.6	21.88	21.63	87.9
Crown Life Ins Co	OTC	120.00	0.0	7.8	3.20	2.7	120.00	120.00	0.5	Hall Frank B & Co Inc	NYSE	18.88	-6.8	4.4	0.00	0.0	20.13	18.63	245.6
Employers Cas Co	OTC	30.50	0.0	7.2	1.20	3.9	30.50	30.50	2.2	Integrated Res Inc	AMEX	41.63	4.1	32.5	2.20	3.3	41.63	40.00	237.4
Equifax Inc	NYSE	27.25	2.8	12.1	1.60	5.9	27.38	26.50	10.1	Marsh & McLennan Cos Inc	NYSE	5.25	0.0	0.0	0.00	0.0	5.25	5.25	0.0
Farmers Group Inc	OTC	37.50	-3.5	8.9	1.52	4.1	39.00	37.50	261.3	Peo & Assoc Inc	OTC	11.75	-2.1	22.6	0.60	5.1	11.75	11.63*	72.1
Foremost Corp Amer	OTC	24.50	5.4	13.4	0.96	3.9	24.50	23.75	28.9	Reed Steenhouse Cos Ltd	OTC								
Fresnost Gen Corp	OTC	13.38	2.9	0.0	0.48	3.6	13.63	13.00	232.4	AGENTS/BROKERS				AVERAGE			24.0	3.5	
Great West Life Assurn Co	OTC	325.00	0.0	10.4	12.00	3.7	325.00	325.00	0.0	Conglomerates/Holding Cos.									
Hanover Ins Co	OTC	23.25	1.1	7.7	0.44	1.9	23.25	23.00	16.8	American Express(Fireman's Fd)	NYSE	26.50	-6.6	11.7	1.28	4.8	28.00	26.25	1,325.6
Hartford Steam Boiler Insptn	OTC	53.00	3.9	13.3	3.00	5.7	53.00	51.00	5.2	Anderson Clayton(Ranger/PanAm)	NYSE	26.13	-1.4	11.8	1.32	5.1	27.50	26.13	24.7
Jefferson Natl Life Ins Co	OTC	39.25	-0.9	17.8	0.76	1.9	39.63	39.25	0.8	Araco Inc	NYSE	15.13	-7.6	0.0	0.40	2.6	16.50	15.13*	268.6
Kepper Corp	OTC	35.25	0.7	11.6	1.80	5.1	35.50	35.25	94.0	Baldwin Utd Corp	NYSE	1.38	-8.3	0.0	0.00	0.0	1.50	1.38	120.3
Lincoln Natl Corp Ind	NYSE	31.25	1.6	7.6	1.68	5.4	32.25	31.25	402.3	CIGNA Corp	NYSE	31.88	-3.4	7.8	2.60	8.2	33.13	31.88*	2,256.5
Mission Ins Group Inc	NYSE	14.00	2.8	0.0	0.50	3.6	14.00	13.75	73.3	City Investing Co. (Home Ins.)	NYSE	39.50	0.0	9.4	2.00	5.1	40.38	39.50	588.1
Northwestern Natl Life Ins	OTC	39.75	3.2	8.9	1.50	3.8	39.75	39.00	33.3	CNA Finl Corp (CNA)	NYSE	22.63	-2.7	8.4	0.00	0.0	23.75	22.63	54.6
Ohio Cas Corp	OTC	40.63	-0.3	11.3	2.68	6.6	40.88	40.63	54.7	Control Data (Comm. Credit)	NYSE	30.88	1.2	7.5	0.66	2.1	31.88	30.75	524.6
Old Rep Intl Corp	OTC	33.50	4.7	7.3	0.88	2.6	33.50	32.88	59.8	General Rep Corp	NYSE	53.25	0.0	14.2	1.44	2.7	53.25	51.88	692.8
Orion Cap Corp	NYSE	22.50	2.9	13.2	0.76	3.4	22.50	22.00	34.3	ITT (Hartford Group)	NYSE	34.63	1.1	7.7	2.76	8.0	34.63	33.88*	950.3
Preferred Risk Life Ins Co	OTC	21.88	-2.8	7.6	0.74	3.4	22.63	21.88	4.1	Optimum Hldg Corp	OTC	3.75	0.0	0.0	0.00	0.0	3.75	3.75	0.1
Provident Life & Acc Ins Co	OTC	68.50	0.0	6.8	2.88	4.2	69.00	68.50	41.7	Sears Roebuck & Co. (Allstate)	NYSE	30.00	-1.6	7.6	1.76	5.9	31.13	30.00	1,332.2
St Paul Cos Inc	OTC	51.63	0.5	11.8	3.00	5.8	52.63	51.63	232.6	Teledyne Inc (Argonaut)	NYSE	216.00	9.2	16.4	0.00	0.0	216.00*	198.50	997.0
SAFECO Corp	OTC	29.00	2.2	8.1	1.50	5.2	29.13	28.38	564.5	Transamerica Corp	NYSE	22.38	-2.7	7.7	1.56	7.0	23.38	22.13	302.4
Spi Corp	OTC	15.75	1.6	9.3	0.68	4.3	15.75	15.50	62.3	CONGLOMERATES/HOLDING COS.				AVERAGE			81.0	2.8	
Seibels Bruce Group Inc	OTC	20.63	0.6																

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