

business insurance

Reporting weekly for corporate risk, employee benefit and financial executives/\$1.50 a copy; \$60 a year

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FBI questions 2 employees of Florida Insurance Dept.

TALLAHASSEE, Fla.—Two employees of the Florida Insurance Department have been interviewed by the FBI, a department spokeswoman confirms, but she will not identify the employees or the subject of the interviews.

However, those employees, as well as former department employees and an insurance lobbyist, are anonymously quoted in Florida newspapers
Continued on next page

'Liberty Weekend' seeks insurance

By AVRA WING and JENNIFER PELLET

NEW YORK—With the Fourth of July "Liberty Weekend" less than a week away, those involved in orchestrating the extravaganza are still working to obtain additional liability coverage for numerous events around the city that are expected to attract 13 million people.

However, at least some liability insurance for the celebration's biggest risk, the official fireworks display, has been secured, sources say.

While municipalities around the country are canceling July Fourth fireworks displays for lack of insurance, about \$25 million in coverage has been assembled by insurance broker Fred S. James & Co. Inc. for the Liberty Weekend organization to cover the official fireworks displays, sources say.

Liberty Weekend was hired by the Statue of Liberty-Ellis Island Foundation to produce many of the events.

James confirmed that its New York office is brokering insurance for Liberty Weekend, but declined to

Continued on page 26

Senate panel approves product liability measure

By JERRY GEISEL

WASHINGTON—Federal product liability legislation is heading to the Senate floor.

The Senate Commerce Committee last week accomplished what many thought unlikely: It passed a comprehensive product liability bill that supporters say has a chance of winning full Senate approval.

Committee approval came after three weeks of debate and votes on numerous amendments and some five years after business groups began to lobby seriously for federal product liability legislation to preempt varying state statutes and case law.

Commerce Committee Chairman John Danforth, R-Mo., whose persistence and negotiating skills are credited by business lobbyists as a major reason the bill was approved, said he was encouraged by last week's 10-7 committee vote.

"It is a step forward" for product liability reform, Sen. Danforth said. "There is now one approach, not 100 approaches."

Lobbyists said the bill may have attracted more committee support had a controversial provision not been included.

That provision, introduced by Sen. Danforth, would cap non-economic damages—excluding punitive damages—at \$250,000 if a plaintiff rejected certain settlement offers.

Sen. Danforth said the vote might have been 13-4 if the cap on pain and suffering damages had been deleted, noting that Sens. Daniel Inouye, D-Hawaii, Donald Riegle, D-Mich., and Ted Stevens, R-Alaska, probably would have supported the bill.

But Sen. Danforth said he is not committed to the settlement approach as drafted. "At least it is an idea. Let's see if someone has a better one" before the bill is voted on by the Senate, he said.

"Something can be worked out," added Tom O'Day, assistant vp with the Alliance of American Insurers in Washington.

Some reform provisions sought by business and insurance groups either were soundly defeated or never were voted on because supporters knew they lacked sufficient support.

Reforms the committee rejected or did not consider included caps on punitive damage awards, separate trials for compensatory and punitive damages, limits on contingency fees paid to plaintiffs' attorneys and a provision that judges—not juries—set punitive damage awards.

But insurers say sufficient reforms are contained in the bill that, if enacted in its current form, could stabilize the rising cost of product liability insurance.

"This is not substantive tort reform, but it is a step in the right direction... that will probably have a positive effect on stabilizing rates," said Peter Lefkin, counsel for the American Insurance Assn. in Washington.

The reforms approved by the committee would:

- Eliminate joint and several liability for non-economic damages in product liability suits.

- Shield manufacturers from product liability lawsuits stemming from accidents involving capital goods products that are more than 25 years old.

In the case of consumer goods—except automobiles and aircraft parts and other transportation products—products would be assumed not to be defective 10 years after they were manufactured. Suits involving transportation products could be filed regardless of the age of the product.

- Offset product liability awards by workers compensation benefits received by those injured in workplace accidents and eliminate subrogation actions between an injured worker's employer and the manufacturer.

Continued on page 30

Two underwriters seek state help

Illinois hopes to rehabilitate Pine Top

By DAVE LENCKUS

CHICAGO—The Illinois Insurance Department expects that it will be able to rehabilitate Pine Top Insurance Co., the financially troubled reinsurance subsidiary of Phoenix, Ariz.-based Greyhound Corp.

The department placed Schaumburg, Ill.-based Pine Top into rehabilitation June 23 following the company's request for assistance a week earlier.

On May 20, the department had directed Pine Top to stop writing new and renewal facultative and treaty reinsurance business because the company's capital and surplus fell below the minimum state requirement of \$5 million for reinsurance companies.

"We're certainly looking at rehabilitation right now. That's certainly our goal," said Jack W. Traylor, chief operating officer in the office of the special deputy liquidator of

the Illinois Insurance Department.

Pine Top will continue to pay claims and process and service its business with the department's approval, according to Mr. Traylor. "We expect to continue to do that unless we find they don't have the ability to rehabilitate," he said.

Meanwhile, Greyhound announced it will not contribute any new capital to Pine Top and that it will take a \$12 million aftertax charge against its second-quarter earnings "to provide for all of its anticipated losses resulting from this action."

Pine Top reported only \$10.3 million of direct premiums written in 1985, most of it on a surplus lines basis. In addition to Illinois, where it wrote less than \$165,000 in direct premiums, it was licensed only in Arizona and Montana, where it wrote premiums of \$1.4 million and \$95,731, respectively.

Continued on page 29

Mutual Fire under 90-day supervision

By MICHAEL BRADFORD

PHILADELPHIA—Mutual Fire, Marine & Inland Insurance Co. is under the voluntary supervision of the Pennsylvania Insurance Department in an attempt to "improve the liquidity and financial condition of the company," according to its management.

The 90-day supervision is an effort by the Philadelphia-based insurer to overcome what it calls "financial difficulties" attributed to losses on insurance it wrote and reinsurance it assumed in 1982 through 1984 and to the default of about 620 limited partnerships for which the insurer provided financial guarantees in 1983 and 1984 through two managing general agents.

Mutual Fire, Marine has begun litigation against one of the MGAs and the limited partnerships that defaulted in an effort to recover about \$60 million in losses.

During the supervision, which began June 13, Mutual Fire, Marine is seeking "guidance and instruction" from the Insurance Department regarding claims payment and can pay claims only with the department's consent.

The insurer stopped writing new or renewal treaty reinsurance in March and direct insurance in April. First-quarter gross premiums totaled \$20.9 million; net premiums totaled \$5.4 million.

The insurer ranked last year as the fifth-largest surplus lines insurer based on \$72.9 million in premiums written on a non-admitted basis in 1984 (BI, Aug. 12, 1985). It wrote total gross premiums of \$189.7 million in 1984 and net premiums of \$55.1 million.

In 1985, however, premium volume fell dramatically short of original expectations. Mutual Fire, Marine wrote \$21.5 million in premiums on a non-admitted basis and gross

Continued on page 29

New York passes tort reforms, steps up insurer regulation

Page 2

Request for federal regulation falls on deaf ears at NAIC

Page 3

Benefit, insurer tax changes to be decided by conferees

Page 3

FBI questions Florida staffers

Continued from page 1

as also being interviewed by the FBI about "possible misconduct in the department."

Florida newspapers reported the investigation centers on how outside attorneys are hired and paid by the department.

The FBI refused to confirm or deny any investigation.

Florida Insurance Commissioner Bill Gunter, who could not be reached for comment last Thursday, told a press conference June 25 that the department could withstand any investigation.

Mr. Gunter, a Democrat, is running for re-election this year, and his press secretary suggested that the investigation may be politically motivated.

Panel OKs hazard reporting bill

WASHINGTON—Legislation calling for the creation of a federal system to notify, counsel and provide medical monitoring services to employees exposed to hazardous substances is expected to be taken up by the entire House later this summer.

The legislation, H.R. 1309, was reported out of the House Education and Labor Committee on June 25.

Employer groups oppose the bill, which calls for the identification of groups of workers who are at risk of disease because of the substances to which they are exposed at work. According to the proposal, these workers would be notified of the risks and encouraged to enter a medical surveillance program (BI, May 26).

Employers and insurers say the bill duplicates several other federal efforts, especially those that took effect last month under the Occupational Safety and Health Administration's hazard communication standard.

They also believe portions of the bill will lead to lawsuits and additional workers compensation claims.

Trenwick to underwrite for X.L.

HAMILTON, Bermuda—Trenwick Services Ltd., a subsidiary of Westport, Conn.-based Trenwick Group Inc., has been named X.L. Insurance Co.'s "underwriting consultant."

X.L. is a wholly owned Barbados-incorporated subsidiary of EXEL Ltd., which was organized earlier this year by Marsh & McLennan Inc. and Morgan Guaranty Trust Co. (BI, March 17). EXEL, domiciled in the Cayman Islands, was created to provide excess liability and directors and officers liability insurance through X.L. It is capitalized by 67 U.S. and foreign companies and has assets of more than \$400 million.

According to a sticker affixed to Trenwick's recent prospectus, Trenwick Services Ltd. will provide underwriting and related services to X.L. for 12 months and will receive a fee based on a percentage of premiums written in that period and on a percentage of premiums renewed at the first renewal. The minimum fee Trenwick Services will receive is \$2 million.

The underwriting will be conducted in Bermuda by Trenwick underwriting officers.

Tobacco case may be appealed

OKLAHOMA CITY—The attorney for Betty Ann Marsee, who lost her suit against U.S. Tobacco Co. for \$147.5 million in damages for the death of her son, says he may appeal the decision to the 10th U.S. Circuit Court of Appeals in Denver.

George Braly, with the Ada, Okla., law firm of Braly & Braly, said he would cite the trial court judge's ruling that excluded evidence that Mr. Braly said shows other young users of smokeless tobacco developed oral cancer.

A jury found on June 20 that the Greenwich, Conn.-based tobacco maker was not responsible for 19-year-old Sean Marsee's death from cancer (BI, June 23).

Roy Burry, a tobacco industry analyst with Kidder, Peabody & Co. in New York, said U.S. Tobacco probably spent about \$15 million to defend the suit. A smaller, but similar, suit against the company also is pending in Texas, he said.

U.S. Tobacco, however, would not disclose the amount spent on defense costs or any insurance information.

Briefly noted

U.S. Bankruptcy Court Judge Burton R. Lifland in New York has approved **Manville Corp.'s** amended disclosure statement, paving the way for the company's creditor groups to begin voting on a proposed reorganization plan in August. . . . The California Supreme Court has upheld existing law that employers can be held liable for injuries sustained by unauthorized, non-employee passengers in **company vehicles**, if the injury occurs while the driver is carrying out his business. . . . The Self-Insurance Institute of America Inc. has filed suit in the U.S. District Court for the Southern District of Florida to block implementation of a Florida law that regulates **self-insured health and welfare benefit plans** because it violates the pre-emption provision of ERISA.

index

Classifieds	28	weekly at 740 Rush St., Chicago, Ill. 60611. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to <i>Business Insurance</i> , Circulation Department, 965 E. Jefferson Ave., Detroit, Mich., 48207; 313-446-1611. Copyright 1986 by Crain Communications Inc.
Legal briefs	20	
Letters	8	
Opinions	8	
Perspectives	19	
Speaking out	19	
Ticker	31	
Washington	24	
Vol. 20, No. 26— <i>Business Insurance</i> (ISSN 0007-6864) is published		

New York OKs tort reform, new regulations for insurers

By JUDY GREENWALD

ALBANY, N.Y.—Legislation approved by the state Legislature last week would reform New York tort law while tightening the regulation of property/casualty insurers.

Although the legislation includes several tort reforms supported by the insurance industry, at least one insurer last week criticized the bill as a "stop-gap approach" that "laid liability insurance problems at the feet of the insurance industry."

Another insurer said it was too early to tell if the tort reforms would reduce commercial insurance rates.

Most of the provisions in the legislation would go into effect immediately after the bills are signed by Gov. Mario Cuomo, who has said he supports the legislation.

Among the tort reforms included in the package are:

- The application of joint and several liability for non-economic damages will be modified so that only defendants who are more than 51% responsible for an accident would be held joint and severally liable.

- Structured settlements will be mandated for future damages that exceed \$250,000.

- The state's appellate court system can rule that an award is excessive or inadequate if it "deviates materially" from what the courts consider reasonable compensation.

- Directors and officers of non-profit corporations who are not compensated are exempt from liability except in cases of "gross negligence" or "intentional harm."

- Parties who file frivolous claims and counter-claims must pay the opposition's costs and reasonable

attorneys' fees of up to \$10,000.

- Awards can be reduced by the amount provided by certain collateral sources, such as insurance proceeds and Social Security benefits.

Changes in state insurance regulation promulgated by the legislation include:

- The creation of a "flex" rating system, under which the state insurance superintendent will tell insurers by how much they can increase or decrease filed rates for most commercial property/casualty lines without prior approval.

Currently, insurers do not need prior approval to modify filed rates on a per-policy basis.

Certain lines may be exempted from the flex rating system after the superintendent holds a hearing.

- The establishment of joint underwriting associations if the superintendent decides, after a hearing, that a JUA is necessary "due to the unavailability of meaningful coverage." The JUAs would be suspended once coverage availability is restored.

The bill also calls for the creation of a JUA for public entity risks by Oct. 1.

- Allowing groups of 25 or more public entities to form reciprocal insurers.

- Prohibiting the midterm cancellation of commercial property/casualty policies except for reasons specified in the bill, including non-payment of premium, the discovery of fraud or "material misrepresentation" or a decision by the superintendent that the continuation of the coverage would jeopardize the insurer's solvency.

- Mandating that insurers notify policyholders 60 to 120 days before policy expiration that either coverage

Continued on page 30

Two listings to spotlight surplus lines

Business Insurance will publish two directories in the Aug. 11 issue, which will contain a spotlight report on the excess/surplus lines market.

One directory will list surplus lines underwriting managers, managing general agents and brokers; the other will list surplus lines insurers.

There is no charge to be included in either directory. However, companies that wish to be listed must fill out and return a questionnaire provided by BI.

Underwriting managers, managing general agents, surplus lines brokers and insurers that have not received a questionnaire should contact Marilou Jones, Directory Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill., 60611; 312-649-5279.

The deadline for returning completed questionnaires to BI to be listed in the issue is July 14.

Excess, umbrella insurers study 'advisory' ISO form

By ROBERT A. FINLAYSON

NEW YORK—Excess and umbrella insurers are reviewing language issued by the Insurance Services Office designed to help them develop policies that can be written over ISO's new primary claims-made and occurrence general liability policies.

The policy language was issued on an "advisory basis," meaning that ISO does not intend to file it with state insurance departments, said Daniel J. McNamara, president of the insurer trade group.

Most of the major U.S. excess and umbrella insurers contacted by *Business Insurance* last week said they were just beginning to review the language and had not yet decided whether to use it. However, two insurers—Fireman's Fund Insurance Cos. and St. Paul Insurance Cos.—say they will not use the ISO language because they are satisfied with the excess policy forms they have developed.

The ISO package includes three separate policy formats:

- A commercial excess liability policy that provides only excess liability coverage over an underlying occurrence or claims-made CGL policy. This form uses a "follow form" approach that ISO says is intended to automatically parallel the type of coverage in the underlying policy. However, the policy includes legal defense costs within aggregate limits, unlike the current primary CGL policy forms.

- A commercial extended liability policy that provides coverage on an "all other perils" approach for liability exposures not covered in the underlying policy. These exposures are covered on a claims-made basis, regardless of the coverage trigger in the underlying policy. The coverage is subject to an optional deductible and includes defense costs within policy limits.

- A commercial umbrella liability policy that combines both the ex-

Continued on page 6

Judge to rule on Posgate appeal

By STACY SHAPIRO

LONDON—A former House of Lords judge is expected to decide soon whether Ian R. Posgate, once considered Lloyd's of London's most successful underwriter, will be allowed to resume his career at Lloyd's.

Mr. Posgate is appealing a February decision by the Council of Lloyd's to reject R.L. Glover & Co. (Underwriting Agencies) Ltd.'s application as a managing and member's agent for marine and non-marine syndicates. Glover had proposed that Mr. Posgate be named a director of the company and the active underwriter of Syndicates 162/80.

The council refused the application on the grounds that Mr. Posgate was "unsuitable" to be a Lloyd's underwriter, said Robert Alexander, Mr. Posgate's attorney with the law firm of Stephenson Harwood.

"In fact, Glover has made a new application which has been granted, I think, with a different underwriter," said Mr. Alexander. But that does not preclude this appeal being brought, which would—if successful—enable Mr. Posgate to become the underwriter.

Lloyd's confirmed Glover had filed a new application.

The council has banned Mr. Posgate from underwriting on the grounds that his honesty and integrity

are questionable, said Andrew Morritt, the attorney representing Lloyd's at the hearing on Mr. Posgate's appeal.

According to testimony submitted at the appellate hearing, Lloyd's said Mr. Posgate's conduct had been under scrutiny by Lloyd's since 1970, at which time Lloyd's put Mr. Posgate's syndicates under the management of broker Alexander Howden Group P.L.C. because Mr. Posgate overwrote premium limits.

Continued on page 28

errors & omissions

- The four insurers being sued by Greyhound Corp. and Greyhound Financial & Leasing A.G., a Swiss subsidiary, wrote excess fidelity coverage, not directors and officers liability insurance, as *Business Insurance* reported June 16. The incorrect information was provided by a Greyhound spokeswoman.

- Andrew Potash, president and chief executive officer of Davis, Dorland & Co., was incorrectly identified on page 90 of the June 23 issue of *Business Insurance*.

NAIC meeting

Federal regulation necessary, Massachusetts official says

By CAROL CAIN

BOSTON—Federal regulation of insurance is needed to solve the current availability and affordability problems in the liability insurance market, according to Massachusetts' director of business regulation.

"The more we look at insurance problems, the harder it is to avoid concluding that 50 states, acting independently, may not be able to resolve some of the underlying difficulties in the industry," said Paula W. Gold, who also is the state's consumer affairs secretary and chairwoman of Gov. Michael S. Dukakis' task force on liability insurance issues.

Ms. Gold was one of several speakers who addressed the current state of the liability insurance market and the possibility of federal regulation of insurance during the annual summer meeting of the National Assn. of Insurance Commissioners, held June 8-12 in Boston.

But, she was the only advocate of federal regulation. A few speakers called for more

cooperation between the states and the federal government. But the majority, including the insurance commissioner from Massachusetts and other state regulators, countered that federal regulation is not needed.

"This meeting of the NAIC comes at one of the most turbulent times in the history of the insurance industry," Ms. Gold advised, in a keynote address that opened the NAIC meeting.

Ms. Gold pointed out that Massachusetts and the other states have developed a number of insurance mechanisms to make coverage available in such lines as liquor liability, hazardous waste disposal and medical malpractice.

However, Ms. Gold said, these types of solutions just illustrate that:

- A combination of state and federal action is necessary.

Continued on page 10

Regulators consider proposal to control PPOs' operations

By CAROL CAIN

BOSTON—The regulation and operation of preferred provider organizations is the subject of new model legislation under consideration by the National Assn. of Insurance Commissioners.

"I think you have a growing number of entities around the country offering services through unregulated mechanisms, like PPOs," said George F. Grode, Pennsylvania's insurance commissioner. Mr. Grode chairs a subcommittee on PPOs that is part of the NAIC's State and Federal Health Insurance Legislative Policy Task Force.

Because PPOs provide health care, regulators need to oversee such operations, paying particular attention to PPOs' financial solvency and to the adequacy of care delivered, Mr. Grode said.

A draft of the model law applies to all PPOs except those "established and maintained solely by an employer for the exclusive benefit of its employees and their dependents."

However, those PPOs that assume financial risk would have to obtain a license and be subject to a full array of consumer protection regulations, Mr. Grode said.

PPOs that do not accept financial risk of loss would simply have to file with the state insurance commissioner a sworn affirmation that they have complied with the requirements in the law, in addition to filing a concise description of their operations.

The lack of uniform regulation throughout the country was another reason for drafting the model law, which was introduced during the NAIC summer meeting, June 8-12 in Boston.

Current state laws regulating or overseeing PPOs do so to varying degrees. Other states have no regulation, noted Henry Mandro,

Continued on page 12



Major provisions of tax overhaul bills

	IRAs/ 401(k)s	Pension vesting/ maximums	Pension asset reversions	Education/ legal benefits	Reinsurance excise tax	Insurer taxation
Senate-approved bill	IRA: No pretax contributions for members of employer-sponsored pension plans. 401(k): \$7,000 maximum annual deferral, with indexing.	Vesting: Full vesting after 5 years or 20% vesting after 3 years and 20% annually for next 4 years. Maximums: \$90,000 for defined benefit; \$30,000 for defined contribution, which is frozen until defined benefit reaches \$120,000.	10% excise tax, except on amounts transferred to an ESOP.	Education: Tax-free to one-eighth of Social Security wage base: \$5,250 in 1986. Legal: No tax.	1% on premiums paid to foreign insurers.	Property/casualty: Discounts loss reserves; taxes a portion of unearned premium. BC/BS: No provision.
House-approved bill	IRA: Reduces IRA contribution by any amount contributed to a 401(k) plan. 401(k): \$7,000 maximum annual deferral, no indexing.	Vesting: No provision. Maximums: \$77,000 for defined benefit; \$25,000 for defined contribution, which is frozen until defined benefit reaches \$100,000.	10% excise tax on pension plan reversions.	Education: Tax-free to \$5,000 through 1987. Legal: No tax through 1987.	4% on premiums paid to foreign insurers.	Property/casualty: New minimum tax; taxes portion of tax-exempt income. BC/BS: Removes tax-exempt status.
Current law	IRA: Permits an annual \$2,000 tax deduction for contributions. 401(k): \$30,000 maximum annual deferral.	Vesting: Multiple schedules; generally after 10 years. Benefits: \$90,000 for defined benefit; \$30,000 for defined contribution.	No excise tax on pension plan reversions.	Education: Tax exclusion expired Dec. 31, 1985. Legal: Tax exclusion expired on Dec. 31, 1985.	1% on premiums paid to foreign insurers.	Property/casualty: No discounting of loss reserves; no tax on unearned premium. BC/BS: Tax-exempt.

Major benefit tax changes only a step away

By JERRY GEISEL

WASHINGTON—House-Senate conferees will begin in mid-July to draft a final tax bill that will have a greater impact on employee benefit plans than any legislation passed by Congress since the Employee Retirement Income Security Act of 1974, experts say.

Benefit provisions in the tax bills passed by the Senate last week and by the House late last year affect a gamut of current benefit regulations and practices.

"The conferees' decisions will produce a massive change in benefit rules," said Frederick Rumack, director of taxes and legal services for Buck Consultants Inc. in New York.

"The limits and parameters of employee benefit plans will be defined" by the tax bill, said Stuart J. Brahs, executive director of the Assn. of Private Pension and Welfare Plans in Washington.

The benefit-related decisions the conferees will make could affect:

- How rapidly employees can vest.
- How pension benefits can be integrated with Social Security benefits.
- Maximum pension benefits and contributions.

- Non-discrimination rules and maximum limits for 401(k) salary reduction plans.

- Whether employees covered by corporate pension plans will be able to make contributions to Individual Retirement Accounts.

- Whether employers again will be able to offer tax-free educational assistance and group legal benefits.

- The amount of tax employers must pay on reversions from overfunded pension plans.

In addition, the conferees will work out differences in the bills that affect the taxation of property/casualty insurers. The conference committee will decide whether to accept provisions in the House bill that are absent from the Senate bill, including:

- A special minimum or alternative tax on insurers.
- A tax on insurer income that previously has been tax-exempt.

- Restrictions on how underwriting losses from property/casualty insurance affiliates can be used to offset parent company profits.

- An increase in the federal excise tax on casualty reinsurance premiums paid to foreign insurers to 4% from 1%.

Conferees will also decide whether to accept a Senate provision that would require insurers to discount their loss

reserves for tax purposes.

Finally, the committee will decide whether Blue Cross/Blue Shield plans should remain tax-exempt.

Employee benefit experts point out that some of the major benefit provision in the two bills may already have been informally decided.

For instance, the new rapid pension vesting schedules contained in the Senate bill will be accepted by House conferees, observers say.

"My feeling is stronger than ever that no one in the House will object to the Senate's vesting schedules. I can't think of a single House conferee that would object," said Buck's Mr. Rumack.

Under the Senate bill, single-employer pension plans, starting in 1989, would have to offer one of two vesting schedules:

- 100% vesting after five years of service.
- 20% vesting after three years, with full vesting after seven years.

The House bill does not propose new vesting rules.

Similarly, as previously reported, House conferees are likely to accept Senate provisions establishing new, expensive pension integration rules. These rules—also to go into

Continued on next page

Tax bill

Continued from previous page
effect on Jan. 1, 1989—will reduce an employer's ability to offset retirees' pension benefits by the Social Security benefits they receive (BI, April 28; May 19).

Other benefit provisions in the Senate bill that House conferees are most likely to accept, observers say, include permanent extensions of currently expired tax code sections that allow employers to provide tax-free educational assistance and group legal benefits to employees. The House bill only calls for an extension through 1987 of the tax-favored status of these benefits.

In addition, conferees almost certainly will agree to impose—retroactive to Dec. 31, 1985—an excise tax on asset reversions employers recover from terminated overfunded defined benefit plans, experts say. However, it isn't clear which provision will be adopted.

While both bills call for a 10% ex-

cise tax on asset reversions, the Senate measure excludes from the excise tax any reversions that are contributed to Employee Stock Ownership Plans. Mr. Brahs noted that since the excise tax is in both bills, it almost assuredly will be included in the final version.

The outcome of provisions affecting 401(k) plans is less certain. Both the House and Senate bills propose a \$7,000 maximum annual individual salary deferral limit to 401(k) plans, compared with \$30,000 under current law. However, the House bill freezes the \$7,000 limit, while the Senate measure indexes the maximum limit to future increases in the Social Security wage base.

In addition, the two bills propose different non-discrimination tests for 401(k) plans. In general, the House provisions are much more restrictive than the Senate's, but both are tougher than current law.

The \$7,000 limit most likely will be in the final bill, Mr. Brahs said,

though he could not predict whether the conferees will allow this maximum to increase in future years.

Conferees will be "more sympathetic" to the Senate 401(k) non-discrimination rules because they were drafted after employers complained that the House provisions were too restrictive, says Edward J. Davey, vp and manager of national benefits research at Johnson & Higgins in New York.

On another retirement income issue, observers say that some form of deductions for IRA contributions made by all taxpayers will be retained by the conferees.

The Senate bill bars individuals covered under corporate pension plans from taking tax deductions for IRA contributions. The House bill does not have such a provision, though it would reduce the deduction for IRA contributions by any amount deferred into a 401(k) plan.

"My guess is that there will be some restoration of the IRA deduc-

tion to quiet the disgruntlement of IRA owners who feel they would lose out if the current IRA provision were changed," said Frank McArdle, director of education and communications at the Employee Benefit Research Institute, a Washington-based benefits think tank.

Mr. McArdle says about 18 million people contribute to IRAs and legislators in an election year might be reluctant to antagonize such a large group of voters.

Some of the options that conferees might consider in lieu of the Senate proposal would be allowing smaller tax deductions for IRA contributions than the current \$2,000 maximum or allowing individuals covered by pension plans—but not vested—to deduct IRA contributions.

However, observers say the conferees could be far from any agreement on some other benefit issues.

For example, it's not clear whether the conference committee will adopt the House or Senate ap-

proach to maximum pension benefits and contributions.

The House bill calls for cutting the maximum annual benefit payable by a defined benefit plan to \$77,000 from the current \$90,000, and the maximum annual contribution an employer can make to a defined contribution plan to \$25,000 from \$30,000 per participant. The House bill also would cap the defined contribution limit until the defined benefit limit rises to \$100,000. Increases in both limits would be tied to changes in the Consumer Price Index.

The Senate bill would retain the current defined benefit and contribution limits, but it would not allow the defined contribution limit to increase until the defined benefit limit reaches \$120,000.

Observers are reluctant to predict how the final bill will affect insurers.

Steve Broadie, Washington tax counsel for the Alliance of American Insurers, says he cannot predict how the conferees will reconcile insurers' tax provisions in the House and Senate bills.

Mr. Broadie says he anticipates that Rep. Fortney (Pete) Stark, D-Calif., who likely will be a conferee, will oppose the Senate property/casualty tax provisions.

Walter Vinyard, a partner with the Washington law firm of Zuckert, Scoutt, Rasenberger & Johnson, explains that it's difficult to predict how the conferees will act "because insurance taxation is so complicated." The legislators' staff will play a big role in drafting the final legislation, he notes.

However, both Mr. Broadie and Mr. Vinyard agree that the property/casualty insurance industry generally prefers the Senate bill over the House version.

The industry is opposed to a provision in the House bill that imposes a special minimum or alternative tax on property/casualty insurers, Mr. Broadie explains. This tax would be equal to 20% of the company's "net gain" taken from Line 18(b) of Page 4 of an insurer's annual convention statement (BI, Nov. 25, 1985).

"We think this is a very harsh provision," Mr. Broadie said, noting the House bill doesn't target other industries for specific minimum tax provisions. The Senate bill does not contain a specific minimum tax provision for property/casualty insurers, though it does contain such provisions that affect all businesses.

In addition, the House bill would tax a portion of insurers' tax-exempt income, like interest received from municipal bonds, a provision not included in the Senate bill.

The House bill also would restrict owners of property/casualty insurers from using tax losses from a property/casualty affiliate to offset affiliates' profits, another provision not in the Senate bill.

Both bills contain similar provisions to tax unearned premium income, while the Senate plan contains complex rules on discounting reserves for tax purposes.

Earlier this year, major property/casualty trade organizations agreed to support a modified reserve discounting requirement if other property/casualty tax proposals were dropped (BI, Feb. 24).

Conferees also must reconcile differences concerning the federal excise tax on casualty reinsurance premiums paid to foreign insurers. The Senate bill proposes keeping the excise tax at the current 1%, while the House measure would raise the tax to 4%.

Jon Harkavy, director of governmental affairs and general counsel at the Risk & Insurance Management Society Inc. in New York, says conferees are more likely to accept the Senate's recommendation to keep the tax at 1% because administration and House support for an increase may have eroded.

Still, he notes: "Anything is possible in a conference committee."

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ISO policy form

Continued from page 2

tended liability and excess liability policies.

Excess and umbrella insurers have been struggling for months to develop policy forms that can be used over ISO's new CGL policies, particularly the claims-made form. Underwriters, consultants and brokers say writing such policies is difficult because of the potential for gaps and inconsistencies in coverage.

At least 16 major insurers already have developed their own excess and umbrella policies for use with the new claims-made CGL, brokers and consultants say. As a result, they don't expect these insurers to switch to the ISO policy language that was issued June 18.

"It's not likely that they will junk a form they've been using for six months to adopt the ISO form," said W. Lee Carter III, vp of research and development for Alexander & Alexander Inc. in Dallas.

But Pete Ligeros, an expert on umbrella and excess coverage with consultant Warren, McVeigh & Griffin Inc. in Newport Beach, Calif., said many other insurers have yet to develop their own policy forms. Thus, he sees the poten-

tial for widespread adoption of the ISO language by these insurers.

About 70% of the umbrella market is still drafting a policy form, and "those are the people that this new form may have an impact on," Mr. Ligeros said.

While excess and umbrella insurers in general "have a tendency to do their own thing, it's very likely they will take a look at it and extract some of the wording," he said.

Because this is the first time ISO has issued any excess or umbrella policy language, "there is no precedent that can be used to answer the question of how many insurers will adopt this form," said Lawrence J. Drake, managing director of Marsh & McLennan Cos. Inc. in New York.

However, Mr. Drake said the ISO language could be used to help brokers get better excess and umbrella policies for their clients.

"If the ISO form is a good one, which I'm sure it is, it could be used by brokers to improve the quality of excess coverage by setting a minimum standard in the market for such coverage," he said.

Fred Themmes, a vp with St. Paul, agreed.

"I see the value of the ISO form as a yardstick for comparison," he said. Companies often will compare

their primary policy to the ISO form when reviewing coverage, and the same is likely to happen with the ISO advisory form, Mr. Themmes said.

Except for Fireman's Fund and St. Paul, major excess and umbrella insurers contacted by *BI* were mostly noncommittal about whether they would use the ISO language.

For example, a spokeswoman for The Hartford Insurance Group said the insurer is developing its own form, which should be out in about a month. She said Hartford is reviewing the ISO language, but likely would stick with its own policy.

ISO presented the new policy language in a cut-and-paste format, allowing insurers to choose among various coverage provisions and endorsements to assemble their own form.

Under the advisory language, when the excess policy is written over a claims-made policy, a retroactive date provision, similar to the one in the primary CGL policy, is used. The policy also contains an optional minimum retention that acts "like a 'per-occurrence' deductible," according to ISO's summary of the policy. This retention does not apply to the excess insurers' defense obligation.

In addition to incorporating all of

the underlying exclusions by reference, the policy form also adds exclusions for fire legal liability, medical payments, liability under the federal motor carrier act and first-party liability statutes such as workers compensation.

The extended liability policy "is very broad," according to ISO. It extends coverage on a worldwide basis to all injury that is not covered by the underlying insurance, subject to applicable exclusions.

The policy excludes coverage for intentional injury; contractual liability; workers compensation; pollution; liquor liability; damage to property in the policyholder's care, custody or control or alienated premises; product recall; ERISA; first-party liability; professional liability; and war, motor carrier and nuclear liability.

Two optional deductibles are included in the extended liability policy: one on a per-claim basis and the other on an incident basis. The limits of the policy apply excess of the deductible.

There are three extended reporting period or tail coverage options: two for the excess liability policy and one for the extended liability policy.

The two excess policies differ in that one extends tail coverage whenever the policy is canceled or not renewed, while the other limits tail coverage to cases where the insurer cancels or does not renew the policy.

The primary claims-made CGL policy does not have this option, and the insurer must provide tail coverage regardless of whether the insurer or policyholder cancels or does not renew the policy.

Further, there is not automatic reinstatement of the aggregate limit for tail coverage, unlike the primary claims-made CGL policy. However, there is an optional endorsement to reinstate limits for tail coverage.

Mr. Ligeros, who has studied the ISO policy language, said it tracks closely with several other claims-made umbrella policies already in the market, and that it tracks "fairly well" with ISO's primary CGL policies.

He stressed that while he has not yet analyzed all the coverage features of the policy language, he noted several important differ-

ences from the primary CGL policy. One of the most important, he said, is that defense costs are included in policy limits.

"That's not the case with the CGL and most of the other claims-made umbrella policies, the mainstream umbrellas," he said.

However, like the new CGL policies and about half of the umbrella policies currently in the market, the defense coverage does not extend to "groundless, false or fraudulent claims," he said.

Such coverage, which up until recently was included in most CGL and umbrella policies, is important because attorneys will typically include a wide range of allegations in most legal actions "just to cover all the bases," according to Mr. Ligeros. If any of these allegations later turn out to be false, the insurer could deny a portion of the defense costs, he added.

Donald S. Malecki, an insurance and risk management consultant based in Fort Thomas, Ky., noted that ISO resurrected in its umbrella language a provision in the tail coverage that proved very controversial during the debate over the primary CGL policy, which "could present a problem." That provision allows the insurer to cancel or non-renew a policy without offering the policyholder tail coverage.

Overall, Messrs. Malecki and Ligeros, who work together on umbrella and excess coverage, said they do not "see anything really ugly that jumps out."

"I've seen a lot worse," Mr. Ligeros said. "You look at the Weavers' and the Lloyd's form, and these new forms that we're looking at are great in comparison."

Both the Weavers' and the Lloyd's forms are extremely restrictive and "aren't going to see any major use here," Mr. Ligeros said.

But, Mr. Ligeros said that while many insurers may pick up the ISO wording in their excess and umbrella policies, that will not solve all the consistency problems in the excess and umbrella markets.

"Not all of the people who are putting out a primary form are following the ISO," he noted. "Even if you get a good umbrella that's built to track over the ISO policies, it may not track over some of these mutations."



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PIA of Iowa to handle gripes for insurance department

DES MOINES—Members of the Professional Insurance Agents of Iowa will handle hundreds of property/casualty insurance-related complaints and questions directed to the Iowa Insurance Department under a new statewide program.

Under the Professional Insurance Agents Consumer Assistance Program, scheduled to be implemented July 1, PIA of Iowa directors will attempt to mediate policyholders' complaints and questions.

"Generally, insurance agents such as the PIA of Iowa board members could very well answer these types of questions because of their expert knowledge of insurance," Tony Schrader, deputy Iowa insurance commissioner, noted in a statement.

"We don't consider this 'self-policing' by any means, because most of the problem areas only require professional and expert insurance knowledge and advice—not remedial action," said Mark E. Gabrielson, PIA president. "That's up to the Market Conduct Bureau of the Iowa Insurance Department."

PIACAP will handle approximately 200 of the 1,500 complaints concerning property/casualty insurance that the Insurance Department receives annually, Mr. Schrader estimated.

The program was developed to facilitate the handling of com-

around the states

plaints following personnel reductions due to Insurance Department budget cuts, explained Donald Krist, executive director of PIA of Iowa.

Reinsurance rules

NEW YORK—Insurance Superintendent James P. Corcoran has tightened the conditions under which insurers may take credit in their financial statements for reinsurance recoverable from unlicensed reinsurers.

An amendment to New York insurance regulation No. 20 raises to \$20 million from \$10 million the minimum trusted surplus required for an unlicensed reinsurer to obtain a certificate of recognition from the Insurance Department.

The trust fund, maintained at a New York bank, must be in cash or marketable securities and is in addition to any other trust funds required by the department.

A ceding insurer may take credit for reinsurance recoverable from a reinsurer that meets the new trust fund and other requirements.

opinions



Missed opportunity

WHO WOULD TURN down a chance to be part of the anniversary celebration for the Statue of Liberty and the founding of our country?

Plenty of U.S. liability insurers, it appears.

The New York office of insurance broker Fred S. James & Co. Inc., from what we can gather, has had to scour the insurance marketplace for coverage and may yet be trying to fill out the insurance program for the Liberty Weekend organization, the producer of many of the events during next weekend's extravaganza celebrating the 100th anniversary of the Statue of Liberty (see story, page 1).

And, the Liberty Weekend organization is so nervous about holding its liability insurance together it won't talk about it. Apparently, officials fear publicity could cost them some committed insurers.

At least one other event sponsor is still looking for more insurance.

We don't underestimate the magnitude of the risks involved in this weekend of concerts, street fairs and fireworks that are expected to attract some 13 million people. But, the safety and security programs developed reflect top-quality risk management that certainly make the risk insurable.

And, we recognize that in the midst of a liability insurance crisis such a gigantic celebration naturally would face insurance problems.

Nonetheless, we think insurance companies should have exhibited more imagination and patriotism when offered this risk and seized the opportunity for some good publicity—especially at a time when insurers are much maligned.

Other corporations have spent millions of dollars to become official sponsors of the Statue of Liberty-Ellis Island Foundation and have spent millions more to capitalize on their official sponsorship.

U.S. insurance companies should have been eager to sign up for participation in the liability insurance for Liberty Weekend, however small. And, they should be boasting about their participation in such a gala event.

But, unfortunately, too many insurers apparently consider Liberty Weekend too big and too uncontrolled an event to insure. Even Transamerica Corp., which insured the Los Angeles Olympic Organizing Committee, providing \$200 million of liability insurance for the 1984 Summer Olympics, refused an opportunity to insure Liberty Weekend.

We don't know how much more insurance is needed for next weekend's events, but we urge all insurers to reconsider some participation and provide what they can to those groups still seeking coverage.

And to those insurers that have had the imagination and patriotism to participate in the insurance for Liberty Weekend, step forward. You deserve recognition.

letters

Insurers shouldn't look a gift horse in the mouth

To the editor: Me thinks the insurance industry doth protest too much! ("Bill Freezes Seven Insurers' Underwriting in Florida," *BI*, June 16).

I applaud the Florida Legislature's tort reform measures, particularly the provisions related to punitive damages. The insurers are not expressing any appreciation for these benefits, but they are quick to cry about parts of the legislation that inconvenience them.

As I read the article, they can charge more than 1984 rates if they can show them to be "clearly inadequate." Their reaction indicates to me that they see it will be difficult to justify their present ex-

ortionary rating.

As to the regulators in other states fearing that the move could spread to their states, I hope much of it does. While the Florida legislation is certain to influence legislators in other states, I've yet to see any state copycat blindly.

The real danger to the insurance industry in the law is the new freedom to self-insure.

In the long run, this could be the most costly. Those that take advantage of the alternatives the new law allows—after having been shoved out in the cold by their insurers—might just find they like it better out there.

Lawrence J. Bell

Assistant Vp-Risk Management
Revco D.S. Inc.
Twinsburg, Ohio

Current IRA tax treatment creates inequity

To the editor: The current tax treatment of Individual Retirement Account contributions creates a huge "tax expenditure" and a serious inequity: Some Americans have three tax-favored retirement plans (employer-sponsored pension and profit-sharing plans, plus their IRAs), while others have only one—an IRA.

The Senate tax bill, on the other hand, would restore an old inequity by making pretax IRA contributions available to only persons who do not participate in a tax-favored, employer-sponsored retirement plan. This approach ignores the fact that participation in a retirement plan is

of little value unless:

- The participant is *fully vested* in his or her plan benefits.

- The employer chooses to make a *contribution* to the plan in a particular year.

So here's a reasonable compromise for the conference committee: retain full IRA availability for non-participants, for participants who are not fully vested and for fully vested participants in plans to which sponsor/employers contribute less than 2% of payroll in any given year. It's fairer; it's logical; it could even work!

Mary A. Carroll
Chicago

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Federal regulation

Continued from page 3

Both the insurance regulatory system and the tort system must be re-examined.

Those involved must be wary of across-the-board solutions.

"Traditionally the states have been best at regulating local activities... In such areas as consumer protection, claims abuses and community responsiveness, the states have shown both the willingness and the ability to respond to local needs and concerns and to provide consumers with meaningful access to regulatory remedies," Ms. Gold pointed out.

"However, there are other areas where our regulation has sometimes fallen short. There is virtually no meaningful regulation of the international, and even national, reinsurance markets. This problem has been highlighted by the abrupt withdrawal of reinsurers from many critical liability areas with profoundly disruptive effects on our economy," she said.

While many states probably have the resources necessary to monitor their domestic insurers effectively,

"there are insurers that can slip through the cracks, and with increasingly complex national and international investments and products, even the job of examining major domestic insurers may prove beyond the resources of the most capable state insurance department," she said.

Threats by insurers to pull out of certain markets in some states also demand a federal regulatory response, Ms. Gold said.

"Few states, standing alone, have the leverage or economic clout to overcome such a threat," Ms. Gold said.

"In contrast with this fractionated regulatory environment, the insurance industry is national in character. With its antitrust exemption, not only can it share information, it can allocate markets, share risks, set prices and generally act in concert in ways that manufacturers, and even other competing financial institutions, cannot," she said.

Pointing to federal regulation of banking, Ms. Gold said it "has shown us the important role the federal government can play in giving our citizens assurance of the safety and soundness of their investments in financial intermediaries."

"Federal deposit insurance and federal regulation of the safety and soundness of our banking system may well be the keystone of our fi-

nancial markets," she said.

"Just as state and federal regulators and the Congress are closely examining the need for more cohesive banking regulation, we should look closely at the problems inherent in insurance regulation being diffused among 50 jurisdictions," she said.

"We must break out of the old ways of analyzing insurance problems," Ms. Gold said.

She urged a careful scrutiny of all alternatives and warned that little progress will be made if solutions hinge on either tort reform or increased regulation.

"The fundamental purposes of our tort system are to fairly compensate victims for wrongs suffered and to deter the commission of negligent or intentional wrongs," she said.

And, "the fundamental purposes of our insurance regulatory scheme are to protect the public by assuring the safety and soundness of their insurance policies and companies and to foster a fair marketplace," Ms. Gold added.

"Rather than looking at our tort and regulatory systems simply with an eye toward easing the current availability and affordability problems with liability lines, we should address the broader fundamental issues. We should be wary, in exploring the range of potential reforms, of broad-brush proposals purported to be across-the-board

panaceas," she said.

State insurance regulators did not respond directly to Ms. Gold's remarks.

After Ms. Gold concluded, NAIC President Josephine M. Driscoll approached the podium to introduce the next speaker and commented:

"That was refreshing."

The audience laughed—nervously.

Later, Ms. Driscoll, Oregon's insurance commissioner, said: "I still believe we do not

need federal intervention or regulation. The federal government is not any better equipped... The only place we feel we should get together with the administrator (of the Federal Insurance Administration) is on earthquake coverage or terrorism."

Throughout the weeklong NAIC meeting, others digressed from their topics to add comments on the issue of state vs. federal insurance regulation.

For instance, Lyndon Olson Jr., chairman of the Texas State Board of Insurance, said: "If you like the federal debt, you'll like federal reinsurance."

Harold T. Duryee, the Federal Insurance Administration's acting administrator, noted that his presence at the NAIC meeting illustrates how the federal and state governments can work together, but said each needs to recognize the other's scope and limits.

Such a limited role between federal and state governments also was acknowledged by Henry G. Parker, senior vp and director of Chubb & Son Inc. and chairman of the NAIC's International Insurance Advisory Council.

In a speech dealing with the protectionist policies by foreign nations that have inhibited the growth of the insurance market in the free world, Mr. Parker called upon the NAIC's members to "build a bridge between the state regulatory system and the federal trade negotiating system."

But in the shorter term, the NAIC must deal with a call by Rep. James Florio, D-N.J., asking for the association to tell his House Commerce, Transportation and Tourism Subcommittee by Jan. 15 what state regulators are doing about huge rate hikes, coverage unavailability and policy cancellations (BI, June 16).

"We are beginning to work on our response," Ms. Driscoll said, noting her surprise and pleasure that the deadline is several months away.

"Usually the demand is about two weeks," she said in reference to other requests from congressional committees for insurance regulatory information.

Ms. Driscoll added that states have responded to problems in the liability insurance market.

"There is some good coming out of all this... legislative committees and some members of the public have begun to recognize the need to support strong regulation at the state level. They also recognize support is needed for adequate funding and staffing (of state insurance departments) and appear to have a better understanding of regulatory problems," she said.

Another insurance commissioner urged his colleagues to continue to work through the NAIC.

"If we don't work through our national organization... we won't be perceived as being effective... and we invite pollution from other sources," said Peter Hiam, Massachusetts' insurance commissioner. "This may be our last opportunity to do so before we see national solutions being imposed on us."

"All of our meetings consider serious subjects. But this meeting is critical. As we are painfully aware, the problems of the property/casualty industry and the resulting disruption of the liability insurance markets have outraged the public," Mr. Hiam said.

"They have caught the attention of the media, and more important, they have caught the attention of Congress," he said.

"We cannot instantly solve the problems that have developed through the years... We have to realize we are individual states, but it's a national industry," he said.

NAIC Vp Edward J. Muhl, Maryland's insurance commissioner, agreed, saying that unless "appropriate voluntary solutions" are found that best meet consumers' needs, involuntary solutions will be found, many of which will be proposed by Congress.

"Voluntary solutions to our citizens' needs will do more to stop the flow of federal mandated solutions than anything we can otherwise say or do," Mr. Muhl said.



Ms. Gold



Ms. Driscoll

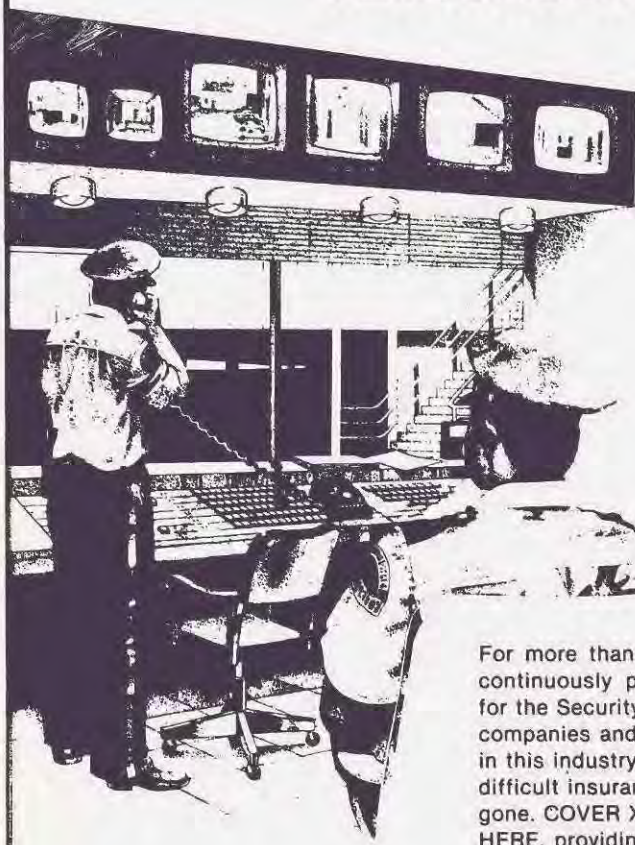


Mr. Hiam



Mr. Muhl

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1,300 attend NAIC meeting

BOSTON—More than 80 meetings of task forces, committees and subgroups were the focal point of some 1,300 registrants at the annual summer meeting of the National Assn. of Insurance Commissioners June 8-12 in Boston.

The 115-year-old organization gives state insurance commissioners and their staffs a chance to share ideas, problems and solutions in insurance industry regulation.

Assisting regulators with their task are advisory committees, most often comprised of insurance industry representatives. However, in recent years, consumer groups, such as the Risk & Insurance Management Society Inc., also have been invited to sit on these advisory panels.

This summer's meeting featured a forum on reinsurance, organized by Lyndon Olson Jr., chairman of the Texas State Board of Insurance.

It was held primarily to educate newly appointed insurance commissioners and their staffs about reinsurance, Mr. Olson said, adding that the forum could be subtitled: "An ongoing saga in the world of reinsurance and how it works."

Mr. Olson chairs the NAIC's Reinsurance and Anti-Fraud Task Force.

Besides reinsurance, regulators also spent several hours discussing how to respond to the continuing lack of affordable liability insurance. However, they did not come up with any specific action.

A smaller fall meeting of the NAIC—with fewer task forces, committees and subgroups meeting—will be held Sept. 7-9 in Des Moines, Iowa. The winter meeting—which includes all task forces, committees and subgroups—will be held Dec. 7-11 in Orlando, Fla.



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PPO model bill

Continued from page 3

director of licensure for PPO-sponsor Humana Inc. in Louisville, Ky.

He also chairs a subgroup of the task force's advisory committee, which will be meeting during the next few months to compile proposed amendments to the pending model law.

Additional discussion on the model law is planned for the fall NAIC meeting, Sept. 7-9, in Des Moines, Iowa, or the winter NAIC meeting, Dec. 7-11, in Orlando, Fla.

The advisory committee expects to have its amendments ready for the September NAIC meeting, Mr. Mandro said. And the task force itself is expected to take final action on the model law during the December meeting, Mr. Grode said.

Pollution liability

A partnership among policyholders, insurers and the government is needed to create a market for pollution liability insurance, according to an NAIC advisory committee.

"Whatever market existed in the past has virtually disappeared," noted George M. Mulligan, senior vp with the American Insurance Assn. in New York and chairman of the advisory committee to the NAIC's Environmental Liability Insurance Task Force.

Mr. Mulligan, in the preliminary report presented earlier this month, said the committee concluded through its surveys and deliberations of the past year that "certain legislative, regulatory and

other actions are necessary before market conditions can improve."

The committee emphasized that the viability of a market for pollution liability insurance depends "on financial conditions affecting individual insurers and on individual business decisions they are continually called upon to make about an appropriate mix of business, preservation of surplus and allocation of available capital."

The final report of the advisory committee is expected to be ready for the September meeting.

Its preliminary report contained 14 recommendations, including:

- Workable federal legislation should govern the cleanup of hazardous waste pollution. State statutes need not duplicate liabilities created under federal law.

- Federal and state environmental laws dealing with cleanup of hazardous waste and state laws dealing with bodily injury and property damage liability should be revised. The amendments should recognize defenses based on law, regulation and state-of-the-art standards existing at the time an activity took place rather than those that developed later; eliminate provisions allowing joint and several liability; and re-establish traditional tort principles of fault and causation as conditions for recovery of costs and damages.

- All retroactive liabilities at the federal and state levels should be repealed except for those entities guilty of intentional wrongdoing, with recognition that such action in effect shifts additional responsibility for financing cleanup to the public at large and will require adequate financial resources at the federal level.

- Federal environmental laws should be restructured so that hazardous waste sites are cleaned up on a cost-efficient basis and within a reasonable time.

- State-of-the-art standards should be adopted for contractors and others handling hazardous waste and other potential pollutants. Revisions of prior state-of-the-art standards should not apply retroactively.

- Regulatory restrictions on pricing and underwriting, which can have stifling effects on environmental insurance markets, should be structured carefully if they are considered to be necessary. Restrictions on cancellations and non-renewals can create additional disincentives to entering the pollution insurance market.

- Mandatory residual markets for pollution coverages should be opposed because they deplete insurance capacity needed in other insurance markets and threaten the solvency of insurers. Creation of pollution residual market mechanisms would guarantee coverage but also would ensure the continuation of practices that are harmful to the environment.

- The Environmental Protection Agency should be encouraged to meet with representatives from the insurance industry and other interested parties in an effort to determine how the hazardous waste facility endorsement provisions can be revised to make pollution insurance available to more businesses.

- Regulators should be receptive to proposals for alternative financing mechanisms and voluntary pooling arrangements to cover pollution exposures and to satisfy pollution-related financial responsibility requirements.

- They also should be receptive to legislative proposals permitting development of a partnership among private insurers, business and government to deal with pollution liabilities.

- The use of alternative dispute resolution procedures should be encouraged for settling pollution claims in an equitable and efficient manner.

- The voluntary exploration of the feasibility of new types of lim-

ited pollution coverages for specific markets should be permitted.

Insurance info sought

State legislators who chair insurance-related committees are trying to create their own resource base to rely on when drafting tort reform or insurance legislation.

But insurance commissioners believe the effort may not be worth it.

"We found there is no central clearinghouse that can tell us what legislation passed and, if so, whether it had a positive or negative impact," said Connecticut state Rep. Morag Vance, R-Trumbull.

Ms. Vance, a member of the Conference of Insurance Legislators, made her remarks during a joint session between COIL and the NAIC at the NAIC's summer meeting.

COIL is compiling a questionnaire that will be sent out soon to its members as well as to state insurance commissioners.

"We are attempting to form a central information bank," Ms. Vance said.

Information from the questionnaires will be compiled in a report. Some of the questions to be asked include: Does prior approval of rates work in this state? How long has it been an effective tool? Or, is it a disaster?

"We want resource information so we don't have to scrounge around," Ms. Vance said.

Several insurance regulators attending the session, including NAIC President Josephine M. Driscoll, Oregon's commissioner, told Ms. Vance the task would be hard.

"I think it will be difficult to gather all this information," Ms. Driscoll said. She also questioned the need for answers to these particular questions, noting "we all have a liability crisis, whether we're a prior approval state or not."

NAIC data available

The National Assn. of Insurance Commissioners reaffirmed that the financial data it gathers from insurers is available for sale, but the NAIC's analysis of that data is not.

That data includes the annual statements of 4,340 insurers submitted to the NAIC prior to April 17 that were processed through the NAIC's Insurance Regulatory Information System.

IRIS, which is referred to as the "early warning system," applies formulas to insurers' financial results that identify situations that may indicate an insurer is heading for financial trouble. State regulators use the results generated by IRIS tests to identify those troubled insurers and monitor them, said David A. Gates, Nevada's insurance commissioner and chairman of the NAIC Data/Systems Management Task Force.

Others—notably insurance agents—would like to obtain IRIS results so that they also will be warned early of troubled insurers.

However, the NAIC's position is not to give out IRIS ratio results and the contents of examiner team synopses, Mr. Gates said.

"We gathered all the numbers from all the insurers. We'll sell data tapes to anyone who wants them. But we want to keep confidential our work product," Mr. Gates said.

Recently, two separate lawsuits were filed in Montana and the District of Columbia seeking disclosure of IRIS ratios. The NAIC has intervened in both suits. The D.C. case has not been argued yet, and the Montana case is awaiting a ruling, Mr. Gates said.

The NAIC, however, also took steps to prepare for a legal decision that would force it to disclose IRIS results. It amended its IRIS Participation Model Act to add a section that classifies all financial analysis ratios and examination synopses as confidential and not to be disclosed.

And, it adopted a recommendation

Continued on next page

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Continued from previous page
tion that if a state is forced to disclose IRIS information, that state would, in the future, have access to the IRIS information only for its domiciliary insurers. It no longer would have access to IRIS information from the NAIC for other insurers.

"These (ratio results) are merely tools," Mr. Gates said. He explained that a number of insurers fall outside the acceptable financial ranges, but these "tools" only alert the state insurance department to look closer at the insurer, and in many instances, the insurer is not really financially troubled.

"These tests are not absolutes, just predictors," Mr. Gates said, adding that entities other than a state insurance department trying to use them might not go further in their examination of the data.

And, he noted, the NAIC continually examines the effectiveness of existing IRIS ratios and how the current system might be improved.

Wellness incentives

State insurance regulators declined to immediately support six recommendations contained in a report on wellness, one of which called for insurance premium reductions and/or financial rebates to people who participate in health promotion programs.

The Health Promotion and Chemical Abuse Task Force of the NAIC endorsed the report and its recommendations. However, its parent committee—the Accident and Health Insurance Committee—decided to further study the issue and deferred action until the September NAIC meeting.

The task force for the past 18 months has become increasingly involved in developing strategies to address health care cost-containment issues.

Two studies, one conducted by the Florida Insurance Department and the other by the Delaware Insurance Department, were combined to produce the final report.

The first recommendation calls for state insurance departments to enact regulations that would require incentives in the form of health care insurance premium reductions and/or direct financial rebates to persons who take part in certified health promotion programs. Those programs would involve regular exercise, no smoking, weight maintenance, blood pressure screening, stress control, non-abuse of drugs and moderate alcohol consumption.

Other recommendations in the report call for:

- State insurance departments to adopt regulations that would require disincentives in the form of increased deductibles and/or co-payments for subscribers who fraudulently certify participation in a health promotion program.

- State insurance departments to adopt regulations that would require coverage for a medical examination under existing health care plans. The examination should be limited to a set of specified preventive screening tests.

- State insurance departments to develop, in coordination with the state offices of public instruction, a comprehensive health/wellness educational program for school-age children. The program should emphasize regular exercise, seat belt usage, smoking cessation and an end to drug abuse.

- State insurance departments to adopt regulations that would require benefit incentives/disincentives in accident, life and disabilities policies to encourage individuals to wear seat belts.

- Legislation that would provide specific adult immunizations through state public health departments, which "is the most cost-effective manner." If such legislation is not passed, then state insurance departments should be allowed to adopt regulations that would re-

quire all health policies to cover specific immunizations.

Insurance survey

The NAIC Workers Compensation Task Force will survey state insurance departments to compile a list of issues to be tackled by the task force during the December meeting in Orlando, Fla.

The surveys are expected to be mailed this week, with responses analyzed in the next few months, said Gil McCarty, Kentucky's insurance commissioner and chairman of the task force.

State regulators will be given the opportunity to list as many "interesting" topics as they believe need NAIC discussion or action, Mr. McCarty said.

They also will be able to rank a number of already suggested agenda items, including a comparison of payroll base rates with alternatives, the use of trend factors in ratemaking and small risk problems.

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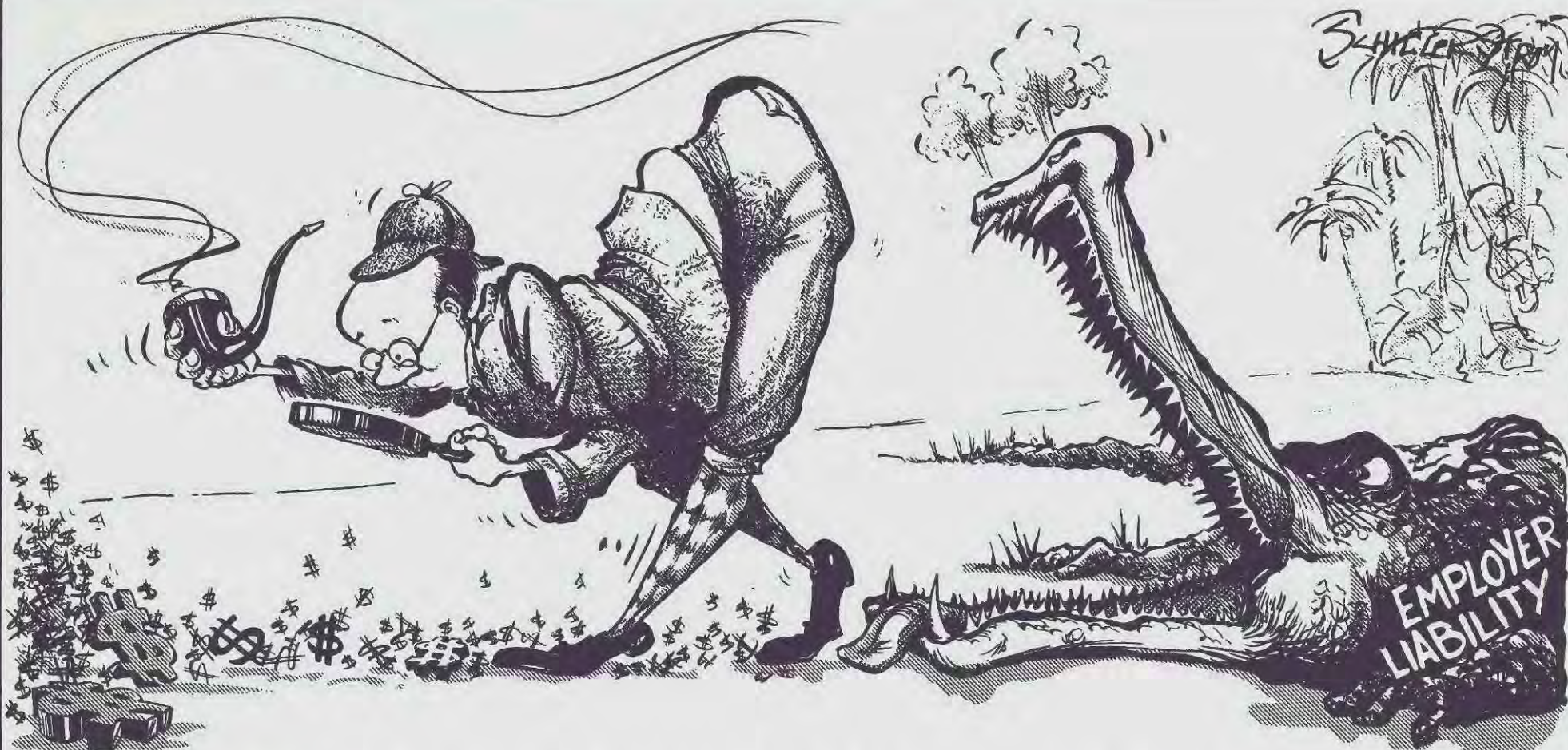
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QUALITY VS. COST

Employers must evaluate HMOs and PPOs for competency as well as savings

By Samuel X. Kaplan

A FEW YEARS AGO, initial attempts to manage the spiraling cost of health care in the United States were greeted with skepticism and suspicion. The concept of cost management was foreign to an industry that purported to focus on the quality of care.

Quality was actually construed to be quantity—the more procedures performed and the higher the cost, the better the quality.

Today, it is no longer a question of whether cost could or should be controlled; it is a matter of finding ways to effectively manage the utilization of health care services and dollars.

However, most employers have chosen to address high health care costs by treating only the symptoms rather than the disease. They have shifted more of the burden to their employees by introducing or raising employee contributions in addition to introducing or raising deductibles.

In the quest to develop an effective cost management system that addresses the utilization of health services, many corporations and even some provider organizations have come full circle in their approach to health care provider selection.

They have lost the all-consuming interest in quality, which supposedly dictated health care delivery decisions only a short time ago, and are now focusing on the bottom line: cost.

This view of effective health care management is as myopic and unbalanced as the quality-at-any-cost approach to health care that dominated the industry earlier.

As is the case in most matters, the truth is somewhere in between these approaches. And, the truth is that employers can and should ensure cost-effective

speaking out

services for employees without forsaking quality of care.

In fact, the right cost management techniques can assist employers in evaluating the efficacy of certain providers and provider organizations. Unfortunately, this realization is often lost in the pursuit of reduced health care expenditures.

Employers perceive health maintenance organizations and preferred provider organizations as cost-efficient providers and exert considerable effort toward channeling their employees to participate in HMOs and PPOs. However, few employers are receiving medical encounter data from HMOs and PPOs that will enable them to determine the quality of service through yardsticks such as rates of service or mix and frequency of services. Nor do employers receive utilization reports, which also would enable an employer to evaluate the provider.

Corporate America's belief that these alternative delivery systems are cost-effective is often based on a comparison of the previous cost per employee under an indemnity program that generated little pertinent data. Since employers do not have the necessary data to track the medical history of each individual before and after the transition to an alternate delivery system, they lack the information to make a valid comparison.

Thus, fees alone become the deciding factor. This is an unfortunate and possibly dangerous trend.

Quality always has been and must remain the crucial factor in health care decisions. HMOs and PPOs may well be the most cost-effective options available to some employers; they also may provide the highest quality of care.

But, employers have no way of ascertaining this unless they examine the credentials and practice patterns of the individual physicians who comprise these health care organizations. This is necessary for both the well-being of the individual employee/patient and the continued good health of the corporation itself.

While employers are checking costs, in most cases they are not checking the credentials of health care providers. Providers are selected on the basis of their charges for services or on their willingness to accept

specified fees.

Rarely do companies demand evidence of the credentialing process that HMOs and PPOs use to ensure the competency of the individual provider within their organization. They neither investigate the criteria used to determine practice style nor evaluate the quality of care delivered through an analysis of individual cases.

Employers usually assume that the sponsors of these organizations are assuring quality and investigating the credentials of individual providers.

Neither the employers that contract with these organizations nor the sponsors of these HMOs and PPOs can afford to make physician fees the determining factor in health care management decisions. Competency and quality must be weighed equally with cost.

What are the liabilities of the HMO or PPO sponsor, which may be an insurance company, and of the employer in the event of unsatisfactory care? Both are deep-pocket organizations, and both are very likely to be drawn into a lawsuit arising from this unsatisfactory care rendered by an individual provider within an HMO or PPO.

In the past, employers simply paid for medical benefits; they did not know nor care who delivered the services. Now, employers are becoming directly involved in contracting with providers or indirectly contracting with them by channeling employees toward what they consider to be the most cost-effective providers.

Since the employer is offering incentives and directing employees to less costly or more cost-efficient providers, the employer as well as the sponsor may be liable.

In cases where providers were selected solely on the basis of their fees, as most are, and the employer or sponsor can neither demonstrate nor document any attempts to ascertain the credentialing process of HMOs or PPOs, which few can, the employer may be required to pay a significant cost for this oversight. Thus, the employer may be liable for the quality of care the HMOs and PPOs deliver to employees.

There are no reported legal cases that currently impose this kind of legal obligation on employers.

Continued on next page



Samuel X. Kaplan is president of U.S. Administrators Inc., a health care claims management company based in Los Angeles.

Suicide compensable if work-related

Suicide may be compensable under the Pennsylvania Worker's Compensation Act if the suicide is a direct result of a work-related mental illness, a state appellate court ruled.

Somerton Fisher died in July 1975 as a result of a self-inflicted gunshot wound. He was a clerk at Allegheny Ludlum Steel Corp., preparing documents to accompany materials ready for shipment to customers. It was established that Mr. Fisher was having difficulty coping with the force and pressure of his job. His widow filed for benefits but was denied.

At the hearing, psychiatrists for both the widow and the employer agreed that he suffered from an obsessional personality. The board allowed benefits.

On appeal, the employer argued that while it was uncontested that Mr. Fisher was mentally ill, his death was not work-related.

The court said that psychiatric disorders are compensable only when they are the result of something other than normal working conditions. According to the court, he was concerned that vacations were a penalty because his work accumulated during his absence; he no longer had an assistant; and, there had been a changeover to computerization which increased the volume of his paper work—all of which produced an abnormal working environment for Mr. Fisher. The award was affirmed. *Allegheny Ludlum Steel Corp. vs. W.C.A.B., Commonwealth Court of Pennsylvania, Sept. 4, 1985 (BI/05/Au.-\$5).*

Work comp death benefits

In a case of first impression, the Court of Appeals of North Carolina ruled that allowing non-legally dependent stepchildren to recover death benefits under the Workers Compensation Act did not violate the equal protection clause of the U.S. Constitution or a fundamental state law.

Kenneth Winstead died in an accident arising out of and in the course of his employment. At the time of his death, Mr. Winstead had two stepchildren, both under 18, who lived with him and his wife. He also had a child from a previous marriage, Melanie, who lived with them.

Both Mr. Winstead and his wife were employed and contributed to the support of the children. However, the

stepchildren also received monthly support from their natural father, and Melanie received some support from her natural mother.

The industrial commissioner upheld an award of death benefits to the stepchildren, concluding that they were presumed to be wholly dependent upon Mr. Winstead at the time of his death. Melanie appealed the award of benefits to the two stepchildren.

The appellate court held that stepchildren are not conclusively presumed to be wholly dependent upon a supporting stepparent, but they are entitled to death benefits if they are substantially dependent upon the stepparent.

"Under our holding, a stepchild could receive death benefits from the stepparent based on substantial factual dependence and from the estranged natural parent under the conclusive presumption of total dependency for a natural child," the court said. *Winstead vs. Derreberry, Court of Appeals of North Carolina, Feb. 19, 1985 (BI/03/M.-\$5)*

Group life insurance

An employee on sick leave due to illness that resulted in his death was not entitled to benefits under a group life insurance policy that became effective after he ceased working, a Georgia appellate court ruled.

George E. Smith worked for the county water authority but was forced to cease work on March 24, 1983, because of his illness. At that time, he was considered by the authority to be on sick leave.

Mr. Smith had been covered under a group insurance policy issued by Prudential Insurance Co. that expired on June 1, 1983. That policy was replaced by a policy issued by Founders Life Assurance Co. The Founders policy covered employees "actively employed" 30 or more hours per week on the date of issuance. Employees not actively at work on the date of issuance would not be insured, according to the policy terms, until the next following day on which the employee was actively at work.

Mrs. Smith filed a death benefit claim,

which was denied by Founders. She sued but lost in the trial court.

The appellate court said that it was undisputed that he had not been "actively at work" at any time between the date of his death and the policy's issue date. Thus, the court said that coverage never took effect as to Mr. Smith. *Smith vs. Founders Life Assurance Co., Court of Appeals of Georgia, June 10, 1985, rehearing denied June 28, 1985 (BI/03/My.-\$5).*

Fraudulent/dishonest act

The fact that an employee did not gain anything except his regular salary and expenses from his fraudulent acts of submitting false orders to a company precluded the policyholder's indemnification under a commercial blanket bond, according to a Minnesota appellate court.

Benchmark Crafters Inc., a toy manufacturer, was covered under a fiduciary bond issued by Northwestern National Insurance Co. The contract provided coverage up to \$25,000 for any loss directly resulting from the fraudulent or dishonest acts of an employee.

Benchmark hired Timothy Mohr as its national marketing and sales manager. Within four months, Mr. Mohr submitted nearly \$350,000 worth of false orders for a new line of toys. Upon being confronted, Mr. Mohr resigned.

Benchmark filed a proof-of-loss statement seeking \$25,000 in damages. Northwestern National denied the claim, and Benchmark sued. At the trial, the company claimed losses of \$62,000. However, no proof was introduced that Mr. Mohr had intended to harm the company.

On appeal, the court said that the policy required proof of a manifest intent, first, to harm Benchmark and, second, to obtain financial benefit for the employee other than the benefits earned in the normal course of employment. According to the court, Mr. Mohr did not gain anything except his regular salary and expenses from the fraudulent acts. Thus, the court reversed the trial court judgment. *Benchmark Crafters vs. Northwestern National Insurance Co.,*

Court of Appeals of Minnesota, Feb. 19 1985 (BI/01/M.-\$5)

Cancellation notice

When a policyholder did not renew his fire insurance policy, an insurer was not required to notify him of cancellation, a Minnesota appellate court ruled.

Floyd Byman operated a retail business. He carried two fire insurance policies on his inventory—one with Auto-Owners Insurance Co. and one with Milbank Insurance Co. Each policy was for \$25,000 and covered 50% of loss from a fire.

Mr. Byman had purchased the policies through Ringdahl & Terhaar Insurance Agency.

In December 1981, Auto-Owners mailed Ringdahl a copy of the 1982 renewal policy for Mr. Byman's fire insurance and billed Ringdahl \$315 for the renewal premium.

After discussion with Mr. Byman, Ringdahl returned the policy to Auto-Owners for cancellation.

Mr. Byman's place of business burned on March 3, 1982, and his inventory was destroyed.

He filed a proof of claim with Auto-Owners, which was denied. Mr. Byman then sued the insurance company, but lost in the trial court.

The appellate court noted that under Minnesota law, every fire insurance policy required a provision that the policy may be canceled at any time by the company by giving the insured 10 days' written notice of cancellation. Mr. Byman argued that because Auto-Owners failed to comply with that notice requirement, its "cancellation" was ineffective.

But, the court said that before an insurance policy can be renewed, the insured must consent to the renewal. Thus, the court said that Mr. Byman had not accepted the renewal and the policy never was in effect. *Byman vs. Auto-Owners Insurance Co., Court of Appeals of Minnesota, March 19, 1985 (BI/05/M.-\$5)*

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

Employer liability may exist in provider selection

Continued from previous page

However, existing cases dealing with general principles of negligence—particularly as they apply to other health care provider relationships—enunciate legal principles and indicate trends that lead one to believe employer liability does exist in these situations.

It is only a matter of time until legal decisions formally imposing this liability on employers begin to appear.

Once an employer accepts the responsibility of designating preferred health care providers for employees, it is implied—if not expressly stated—that these designated providers are competent. The employees reasonably rely on that implicit representation.

Further, since the providers were selected by their employer, employees may justifiably conclude that the providers are in some way agents of the employer. Once this apparent agency is established, the employer is liable for the conduct of the providers within the scope

ERISA creates a fiduciary duty for anyone who has discretionary authority or responsibility to administer a benefit plan under the act.

of that relationship.

In addition, a legal duty to exercise reasonable care may be imposed by statute.

The Employee Retirement Income Security Act creates a fiduciary duty for anyone who has discretionary authority or responsibility to administer a benefit plan under the act. ERISA provides that the fiduciary shall carry out its duties in accordance with the "prudent man" standard.

Using this standard, one can argue that a reasonably prudent person establishing a provider network and

administering a health benefit plan would employ appropriate methods to assure the quality of the services under the plan.

This quality assurance applies to both initial selection and continued supervision.

Today's enlightened, intelligent buyers of health care services must be concerned with their exposure in such cases. Employers should balance cost with the quality of care if it is to achieve any real progress in the ongoing effort to manage costs. Also, checking the credentials of individual providers within alternative delivery systems should be part of the selection process.

If rejection rates on providers indicate that fees were the only criteria used in selecting a health care provider, both the employer and the sponsor are at risk and may well become party to a lawsuit in the event of an unsatisfactory outcome.

It is time to balance the ever-shifting scale of health care delivery in favor of both cost and quality management.

Regulators seek more information

By CAROL GAIN
and STEVE TARAVELLA

BOSTON—Insurance regulators want more statistical data from insurers, partly so regulators can judge the effectiveness of state tort reforms.

To obtain additional data, the National Assn. of Insurance Commissioners earlier this month passed a resolution to establish a program to coordinate the reporting of statistical data "that will more clearly reveal the actual costs of individual insurance transactions."

"We have a tremendous amount of data available to insurance regulators...but some is not now available to us... (like) claims information in counsels' files," said Edward J. Muhl, Maryland's insurance commissioner and the vp of the National Assn. of Insurance Commissioners.

"This organization will attempt a degree of uniformity. With this system we can compare states with one another," Mr. Muhl said.

"This recent crisis...demonstrated the questions asked," Mr. Muhl said, adding that the answers rely on "capturing additional data."

The reporting requirements will allow state insurance regulators to double-check statements made by insurers "to see if what they're saying about raising prices is true," he added.

Insurance regulators will need to receive more data from the insurance industry because they will be asked by the public and state legislatures to monitor the impact that state tort reform laws will have on the property/casualty insurance market, said NAIC President Josephine M. Driscoll, who is also Oregon's insurance commissioner.

"We will not be able to do that unless we have this new data," she said.

The NAIC's resolution takes this concern into consideration and notes that already-enacted state tort reform measures require "the development and implementation of a standardized procedure to monitor the impact on the insurance industry's underwriting and pricing behavior."

The data reporting program adopted by the NAIC at its summer meeting, held June 8-12 in Boston, "will not necessarily be confined to obtaining information from insurers specifically authorized to do business in the several states, but shall also address information from the non-admitted and reinsurance sectors," the resolution noted.

The new statistics that regulators are expected to seek include:

- Legal expenses incurred by insurers.
- Comparison of case reserves to the actual settlements or awards.
- Adjustments in insurer loss reserves.

In addition, the regulators are expected to ask insurers to further break down the lines of business for which they report data.

The NAIC's Legal Liability Insurance Task Force has been charged to develop the program for coordination of the reporting of statistical data. NAIC officials hope the task force will develop the program in time for its adoption at the NAIC's winter meeting, Dec. 7-11 in Orlando, Fla.

"Insurance regulators are literally inundated with numbers, but current information is directed solely toward ratemaking or solvency concerns," pointed out Kansas Insurance Commissioner Fletcher Bell, the task force's chairman.

"The current liability crisis has demonstrated a very real and a very serious need for information



that is of more practical benefit to consumers," he said.

The new data will focus on individual claims, Mr. Bell said.

This data will allow regulators to quantify the legal costs involved in resolving liability claims.

While some of the information that regulators want may not be relevant to pricing and insurer solvency problems, which has traditionally been regulators' major concern, the additional information can be used by regulators to help make coverage more available and affordable, Mr. Bell said.

Reports of other actions taken by the NAIC at the annual summer meeting earlier this month follow.

Financial guarantees

Hoping to ward off insurer insolvencies caused by losses on financial guarantee insurance, the NAIC is advising state regulators to permit only monoline companies to write these policies.

According to a newly adopted NAIC model law, multiline companies would have to set up a separate subsidiary to write financial guarantee coverage.

That model, which will be offered to various state legislatures, was adopted at the NAIC summer meeting after a study group unanimously rejected a proposal that would permit multiline companies to continue writing financial guarantees.

The adoption of the model act culminates about a year and a half of work by the NAIC.

Many fear financial guarantee insurance, which the NAIC likens to "a hybrid of insurance and investment banking," has the poten-

tial to create more severe losses than most other types of commercial property/casualty coverage (BI, May 27, 1985).

"We want to make sure companies that write these hazardous lines are around to pay claims," Ms. Driscoll said at a joint meeting between the NAIC and the Conference of Insurance Legislators.

According to the model law, insurers that write financial guarantees may also write surety coverage, residual value insurance and certain types of credit insurance, but cannot write other property/casualty lines, including fidelity coverage.

Some of the reasons the NAIC cites for restricting financial guarantee underwriting to monoline companies are:

- Regulators can better identify the available capital and exposures of a monoline company.
- Since multiline insurers do not always report financial guarantee business in the same category, premium, exposure and underwriting experience related to financial guarantee underwriting often is not ascertainable.

Insurance departments can better use some of the regulatory resources they must now earmark for multiline companies writing financial guarantees.

Multiline insurers are wasting already limited capacity for other property/casualty lines by using their capital and surplus to write financial guarantees.

Few multiline insurers have the experience to write financial guarantee insurance successfully.

If financial guarantee writing caused a multiline insurer to become insolvent, state guaranty funds would become responsible for paying claims for non-financial guarantee coverages.

According to the model law, a company that wants to be licensed as a monoline financial guarantee insurer must submit to regulators a plan detailing the specific types of insurance to be written, the underwriting procedures it will employ,

the insurer's managerial supervisory methods and its investment policies.

Such companies must have paid-in capital of at least \$10 million, contributed surplus of at least \$40 million and policyholder surplus of at least \$35 million. In addition, financial guarantee insurers cannot invest more than 1% of their admitted assets in any entity for which they write coverage.

The model law requires financial guarantee insurers to maintain capital, surplus and contingency reserves in the aggregate of at least 0.29% of all outstanding liabilities for municipal bonds, 0.57% for special revenue bonds, 1% for industrial development bonds, 4% for consumer debt and investment grade obligations and 10% for all other obligations not of investment grade other than consumer debt.

These ratios, in particular, "would certainly discourage" insurers from writing financial guarantee coverage, maintains Bob Mackin, executive vp of the Assn. of Financial Guarantee Insurers in Albany, N.Y., a trade group of nine companies writing financial guarantee insurance. The 3-month-old group opposes the model law.

The NAIC's financial condition subcommittee will continue to monitor financial guarantee insurance to consider any changes in the model language that might be needed in the future.

Because of this, Mr. Mackin points out that the subject is open to further discussion. "The model is by no means locked in stone," he says.

Regulators plan to draft certain "clean-up" amendments—one of which would facilitate re-licensing of monoline companies already writing financial guarantees—for final approval at the NAIC's year-end meeting in December.

Advisory committees

Members of NAIC advisory committees may speak for themselves but not for the NAIC as a whole, according to a resolution following

the announcement by insurance industry members of one committee that the liability insurance crisis is not widespread.

The resolution points out the function of its advisory committees is "limited to the advising and assisting of the workings of the NAIC."

Advisory committees primarily are composed of representatives from the insurance industry, though a few panels have consumer representatives, from groups such as the Risk & Insurance Management Society.

"No individuals who are members of an advisory committee appointed by this body may, either individually or collectively, make any statement, issue any release or allow for public dissemination of any information relating to its charge from the NAIC that implies in any way that the position, workings or conclusions of the advisory committee are that of the NAIC," the resolution says.

The action was taken after representatives from the National Assn. of Independent Insurers, the Alliance of American Insurers and the American Insurance Assn.—all members of the Advisory Committee on Availability—went public earlier this month with their views on a committee report that still had not been presented to the NAIC (BI, June 16).

The committee report focused on a six-month survey of the use of market assistance plans throughout the country.

The three insurer trade associations told a press conference that data within the report shows that MAPs are working and that the liability crisis is exaggerated.

"We felt they were a little premature" in their conclusions, said Ms. Driscoll, the NAIC's president.

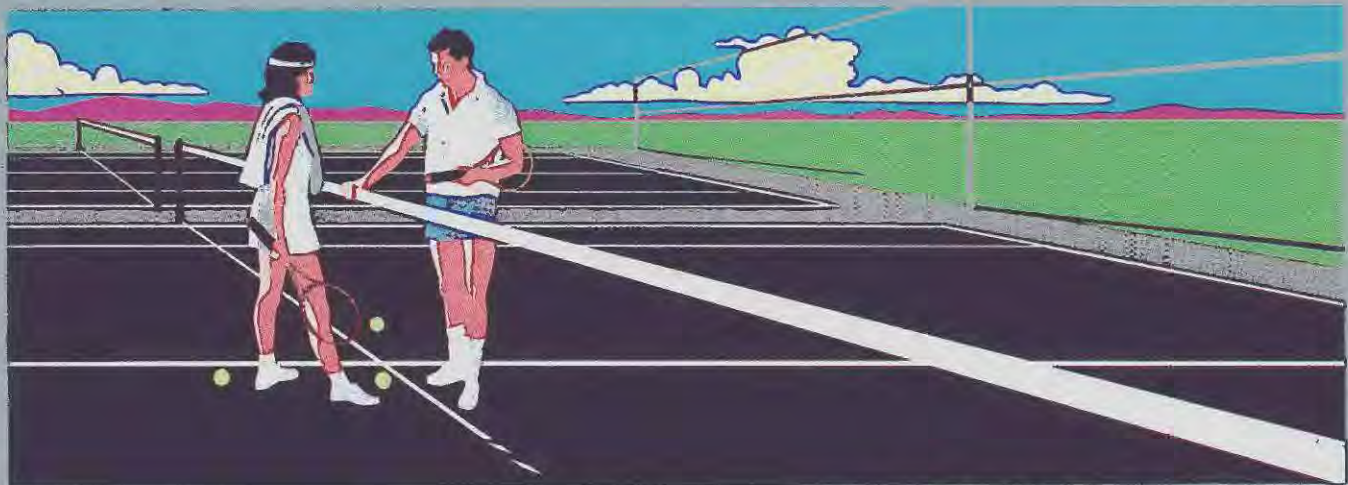
"We are not convinced of certain of the conclusions drawn," said Mr. Muhl, the NAIC's vp and the Maryland insurance commissioner.

State regulators strongly criticized the three trade associations

Continued on page 24

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Mario B. Caldarone
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HUMANA INC., Group Health Division
Panelist, *Communicating Healthcare Alternatives: The PPO*

Kathryn Collura
Communications Consultant,
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Case Study: Computer Communications
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VP, Sales & Marketing
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Panelist, *Communicating Healthcare Alternatives: The HMO*

Eileen Nash
Director, External Communications
EQUITABLE GROUP & HEALTH INSURANCE COMPANY
Panelist, *Communicating Healthcare Alternatives: The Indemnity Plan*

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Keynote Address

Mr. Moynahan's dynamic address will set the tone for the *Business Insurance* 1986 Conference, as he describes today's changing healthcare environment and the developing trends in the marketplace.

Panel: Communicating Healthcare Alternatives

This three part panel will discuss how to best communicate the unique features of a particular type of healthcare plan so that employees can make informed choices. Speakers will point out weaknesses in how employers communicate alternative plans and how alternatives can be effectively communicated.

The Indemnity Plan: The changing healthcare environment has transformed the traditional plan to include innovative cost containment programs. *Equitable* suggests that as employees become active healthcare consumers, employers must develop comprehensive communication programs that motivate employees to get involved with their healthcare choices.

The PPO: The entry of preferred insurance into the marketplace requires the employee to have a greater understanding of the services provided. *Humana* stresses that while effective communications are essential for the total understanding of the plan, the employer must also assure employees that the quality of services has not been sacrificed for a lower cost plan.

The HMO: Healthcare management in the form of HMOs is in an evolutionary stage, suggests *US Healthcare*. The widening range of benefits — health programs such as health check and dental plans — point toward the need for increased communication by employers so that employees can make educated choices.

Panel: Computer Communications

This panel consists of employee benefit specialists whose companies are on the cutting edge of communications technology. Discussions will focus on why their companies opted for computer communications and how they combined market trends with technological innovations to implement state-of-the-art interactive communication vehicles.

Metropolitan Life blended the skills of benefits, technological and communication experts to develop an employee communications program called "SHOWCASE." Employees can directly access information about their benefits from interactive computer terminals housed in kiosks in the company lunchroom and lobby.

NCR Corporation is using NCR pc's as communication vehicles and interactive decision aids in employee retirement planning. NCR developed "EstiMATE," a software package that enables employees to do long-range forecasting of their future retirement income.

RCA Corporation's interactive communication system is tapped by employees for benefits data approximately 7,000 times a month. The system is designed to expand the applications to include interactive video, job postings, local health provider information and more.

Hanes Group, a subsidiary of Sara Lee Corp., developed a program using microcomputer disks to introduce a new 401(k) feature to their Retirement Savings Plan. In one-on-one meetings, employees were able to experiment with the percent of deferred pay and immediately see the impact of their decisions on take-home pay and benefit projections.

EBC Awards Luncheon

Recognizing outstanding communications programs, Alfred Malecki, Publisher, Business Insurance, presents the EBC Awards on August 4th.

Case Study Sessions

Informal workshops will be presented as concurrents giving you the opportunity to attend all sessions.

Total Benefits Communication

Bell Atlantic Enterprises' communication program, "A Wave in Benefits," is a 1985 award winning example of a total communication effort, effectively communicating the full range of benefits. Mr. Olsen will review the program, including such aspects as management objectives, budgetary considerations and strategies.

Print & AV Go Hand In Hand

This session will focus on how *Colgate-Palmolive* combined audio-visual and unique print to build a 1985 EBC award winning communications program, "More Financial Power." They chose a marketing approach to introduce a new 401(k) feature to their employee savings plan, by using identifiable packaging and slogans. Mr. DiStefano and Ms. Kekich will explain why Colgate chose this approach and will give an overview of the components of the program.

Computer Communications Workshops

The Computer Communications panelists, along with their consultant or marketing firm, will provide personal computers so that attendees may have an unprecedented opportunity to experiment with these communications vehicles.

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Liberty Weekend

Continued from page 1
discuss the coverage it had placed or reports that it is still seeking additional liability insurance. Liberty Weekend also refused to discuss specifics of its insurance.

New York City, which self-insures its exposures, is not buying any special insurance for the weekend celebration.

Elaborate security and safety measures have been planned by the New York Police Department and other agencies to try to prevent any injuries or damage during the celebration—from someone bruising a toe in the crush of a crowd at a downtown street fair, to a fire set off by some of the official—or unofficial—fireworks, to a terrorist bomb destroying property and hurting or killing hundreds.

The massive celebration, orchestrated by the 1984 Summer Olympics producer David Wolper, will begin when the first of 100 sailing ships starts down the East River at 8 a.m., July 3. The opening ceremonies, including the unveiling of the renovated Statue of Liberty and the lighting of her torch by President Reagan, will be held at 8:30 p.m. that evening.

July 4 activities will begin at 9 a.m. when President Reagan boards the battleship USS Iowa to preside over the International Naval Review, a parade of 33 vessels from 14 countries.

At 10 a.m., Operation Sail 1986, a procession of 280 ships, will begin traveling up the Hudson River to the George Washington Bridge and back down the Hudson.

Simultaneously, celebration of

the holiday will begin in lower Manhattan with the 10th annual Harbor Festival street fair, which runs through July 6.

On the evening of the Fourth, New Jersey's Liberty State Park will host a concert starting at 8:30.

At 9:45, President Reagan will give a speech, to be followed by a fireworks display, which is being billed as the largest pyrotechnical show in American history.

The renovated Statue of Liberty will be opened to the public July 5, along with many of the tall ships and naval vessels.

On the same day, the New York Philharmonic will perform on Central Park's Great Lawn in Manhattan at 8 p.m.

Two events are scheduled for the night of July 6 at the Meadowlands Sports Complex in New Jersey: a sports salute, at 6:30 p.m. at the Brendan Byrne Arena, and the Liberty Weekend closing ceremony, at 8 p.m. at Giants Stadium.

Responsibility for the weekend falls to several private and public organizations. Chief among them is the Statue of Liberty-Ellis Island Foundation, the group also responsible for the restoration of those landmarks.

A spokesman for the foundation said that while "we don't expect any problems insuring the celebrations," he was unsure if coverage had been obtained yet. "We are working with the insurance industry," was all he would say.

The Liberty Weekend company would not give out any insurance information. "That's a personal matter," a spokeswoman replied. "It's none of your business."

Activities organized by Liberty Weekend include the unveiling of the renovated Statue of Liberty, both concerts and the events at the Meadowlands on the closing night of the weekend.

Abraham & Strauss department store, which, along with Bloomingdale's is sponsoring the various fireworks displays throughout the weekend, referred inquiries about insurance to Liberty Weekend.

A separate group, Harborfest, responsible for the three-day street fair in lower Manhattan, said it had obtained some coverage and was trying to get more. A spokeswoman declined to say what the limits were, adding "We're still in the process of calling companies."

OpSail, which organized the parade of tall ships, would not disclose any information about insurance for the event. A spokesman said, "It's not something we want the media to concentrate on."

Insurers that covered the foundation for the restoration of the Statue of Liberty and Ellis Island sought publicity for their involvement. James also brokered that insurance (BI, Sept. 10, 1984).

But, of those insurers, only CIGNA Corp. says it is involved for

'We don't expect problems insuring the celebrations,' said a foundation spokesman.

a small part of the weekend coverage.

Aetna Life & Casualty Corp. and Scor Reinsurance Co., which also provided some of the coverage for the statue renovations, said they are not involved in the coverage for the weekend activities.

Fireman's Fund Insurance Cos., which also provided part of the restoration insurance, would not say if it is involved in the special events coverage.

However, a subsidiary of New York based-Continental Insurance Co., Marine Office of America Co., is leading a \$500,000 primary policy to insure the barges that will be used to store and transport the fireworks and from which the fireworks will be set off. MOAC has a 15% participation in the coverage, which excludes damage caused by the fireworks.

Other participants in the coverage include Motors Insurance Co., William H. McGee in New York and Underwriters Marine Services in New Orleans, said Fred Roberti, assistant vp at MOAC.

Even though special risks like this are not "terribly attractive" to Continental, the insurer felt it was not appropriate to have the coverage all written in London with the Statue of Liberty Foundation as the named insured, Mr. Roberti said.

Continental also had written inland marine insurance for the old torch when it was transported around the country.

American International Group Inc., a New York-based holding company whose insurers are known for underwriting special risk coverages, including insurance for the fund-raising Hands Across America event in May, said it is not in any way involved in covering the Liberty Weekend events.

Perhaps the most elaborate security precautions are those surrounding the handling of the fireworks to be used in the gigantic display on July Fourth.

The city of Hoboken, through which the fireworks will pass on the way to the barges on the Hudson River, is working with the state police, Coast Guard, NYPD, New York City Fire Department, New York City Harbor Patrol and its own fire department to insure the safe passage of the explosives.

"I've never seen anything like it," said Capt. John Lewis, a senior inspector with the Hoboken Fire Prevention Bureau. He noted that, according to standard practice, the

fireworks will not be allowed to pass through the city without proof of insurance.

Capt. Lewis said that, to his knowledge, Liberty Weekend had secured coverage for the fireworks and was trying to place more.

An umbrella policy covering the six fireworks manufacturers taking part in the various displays throughout the weekend has been obtained by Liberty Weekend, according to Auguste Santore, a partner in Garden State Fireworks of Millington, N.J., to cover all liability connected with the holiday events. In addition, each fireworks company has individual coverage.

Along with Garden State, fireworks for the displays are being supplied by Austin Fireworks of Wichita, Kan.; Fireworks by Grucci of Belpoint, N.Y.; Pyro Spectaculars of Rialto, Calif.; Rozzi's Famous Fireworks of Loveland, Ohio; and Zambelli Internationale of New Castle, Pa.

The fireworks will be transported by truck to Hoboken under state police protection at different times from different locations, which will not be revealed, Capt. Lewis said.

He would say only that it would be a matter of just a few days between the time the fireworks arrived and the July Fourth spectacular.

The fireworks, stored "in containers in containers," according to Capt. Lewis, will be unloaded onto barges at the end of a 900-foot-long pier that is 1,500 feet from the closest building. That building is unoccupied, the captain noted. The transfer of the explosives will be done in the presence of the fire department and Coast Guard, he said.

A spokesman for the New York City Fire Department said the department is concerned about possible problems associated with the massive fireworks display schedule for July 4.

"There's always a danger where explosives, such as fireworks, are used," he commented. "We only give permits to professionals who know how to handle them and we require them to have insurance."

Forty-two steel barges will be required for storing and moving the fireworks, according to William Cunnius, who runs Creek Towing Co. on Long Island and is responsible for coordinating the transport of the explosives and their unloading for use in the display. About half of the barges, which are insured under the MOAC policy, were donated and the other half chartered, Mr. Cunnius said.

New York City has not obtained any extra insurance coverage for the long weekend, according to Alex Carrozelli, the city's new risk, finance and insurance manager. "The city is essentially self-insured," he said.

He does anticipate that the July Fourth festivities will mean some "out-of-pocket expenses" resulting from "third-party exposures," but he declined to estimate what the cost to the city might be. "There will be all kinds of stuff," he said, speaking of the potential claims. "It's hard to measure."

In 1985, he noted, the city paid out \$94 million in third-party claims.

Security precautions are primarily the jurisdiction of the NYPD, which has coordinated its efforts with those of 51 other agencies, including the transit police, Governor's Island security force, U.S. Coast Guard, Federal Bureau of Investigation, Secret Service, National Park Service, New York City Fire Department and Port Authority of New York and New Jersey.

Approximately 34,000 police will be on hand during the weekend to protect the crowds expected to gather at various sites around the city to view the fireworks and the several parades of ships scheduled to go up the Hudson and East

ivers, and to attend the fair and concerts.

To contain the upward of 13 million people expected to attend the activities during the four-day celebration, the police will use 5,778 wooden barriers.

There will be five NYPD and three Navy helicopters patrolling the town; 21 NYPD, six Navy and four Customs Service boats in addition to Coast Guard vessels; and two NYPD and two FBI bomb trucks on call. In addition, the police and Parks Department are responsible for maintaining safety at campsites in Queens and Staten Island, which will be open to approximately 10,000 out-of-town visitors.

A fire department spokesman said the department expects the Harbor Festival to cause problems in the lower Manhattan area. "We're expecting 13 million people to visit New York City during the four-day weekend," he said. "Our units won't be able to move through the crowds; in the event of a fire that will be a dangerous situation."

Because of the crowds, there will be strict enforcement of restrictions on the number of vendors supplying cooked food, according to the spokesman. "The propane gas in vending machines is highly explosive. We want to decrease the chances of having an explosion, or in the event of one exploding, the chances of it setting off another."

New York City would be responsible for any occurrences on land, Mr. Carrozelli noted, with the exception of federal property: Liberty, Governor's and Ellis islands, Castle Clinton in Battery Park and Federal Hall.

These areas will be protected by a combination of federal and local forces, according to a NYPD spokesman. Certain incidents would be the primary responsibility of the local police, the spokesman added, for instance a "suspected device." The spokesman declined to comment on whether bombs will be a particular concern of law enforcement agencies during Liberty Weekend.

Security on the water surrounding the host islands will be handled primarily by the U.S. Coast Guard and the Auxiliary Guard. The Coast Guard will work in conjunction with the FBI, NYPD and Secret Service forces.

"This will be the largest Coast Guard operation since World War II," said a Coast Guard spokesman. "Federal and local forces will work together to secure the area."

According to the spokesman, the area's 20 patrol vessels will be joined on the holiday weekend by 80 additional active-duty Coast Guard vessels and 200 auxiliary vessels. "Auxiliary vessels are privately owned and manned by volunteers," he said. "Each will have a Coast Guard officer on board."

Coast Guard officers posted on Governor's Island will organize security for President Reagan's July 3 and July 4 appearances, the spokesman added.

The Navy will be responsible for the security of the 33 ships—12 U.S. and 21 foreign—participating in the International Naval Review and for the safety of the 17,000 sailors aboard them, said a Navy spokesman.

"On July 4, President Reagan will be visiting two of the U.S. ships, the battleship Iowa and the aircraft carrier John F. Kennedy," he said. "For those visits, Navy security will be working with the FBI and White House Secret Service."

At the Meadowlands, a spokesman said the complex does not foresee a security problem. "From the crowd and traffic aspect, the closing ceremony and sports salute are not unusual events for the Meadowlands. We deal with large crowds on a year-round basis and are very conscious of security needs."

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Posgate appeal

Continued from page 2

In September 1982, Lloyd's suspended Mr. Posgate for his alleged involvement in the misappropriation of \$55 million from syndicates managed by Alexander Howden Underwriting Ltd.

Last year, Lloyd's found Mr. Posgate guilty of two of eight charges brought against him by Lloyd's:

- Secretly owning shares in a Swiss bank without informing the Howden board. Lloyd's alleges that several former Howden officials—but not Mr. Posgate—secretly purchased the bank using funds misappropriated from underwriting operations managed by Howden, including Lloyd's syndicates.

- Accepting a Pissarro painting from two former Howden officials who allegedly tried to influence his underwriting decisions.

Lloyd's had recommended that Mr. Posgate be expelled from Lloyd's on the charge related to the ownership of the bank.

But, on appeal, Lord Wilberforce, who is also hearing Mr.

Posgate's current appeal, reduced the sentence to two six-month suspensions to be served concurrently.

The suspensions expired Jan. 8 (BI, July 22, 1985; Jan. 20, 1986).

"The overall picture which emerged was of a man who could not be trusted and was prepared to involve himself in dubious transactions," said Mr. Morritt, who urged Lord Wilberforce to dismiss Mr. Posgate's appeal.

However, Mr. Alexander, Mr. Posgate's attorney, argued that the Council's decision to bar Mr. Posgate from underwriting for the Glover syndicates should be overturned for several reasons.

Mr. Alexander said it is "disturbing" that the Council of Lloyd's has the right to deprive Mr. Posgate of his "livelihood" in the Lloyd's market when a Lloyd's disciplinary committee could only suspend Mr. Posgate for the charges brought against him.

Mr. Alexander added that it would be wrong to allow the council to "bypass the safeguards" in Lloyd's regulations and allow it to expel an underwriter and revoke his licence without judicial proceedings. Such an action amounts to "expul-

sion from the market without a disciplinary hearing," he said.

Also, the council did not "weigh in the balance the quality of Mr. Posgate as an underwriter" when it reached its February decision, said Mr. Alexander.

"It is not mentioned that he was a dynamic underwriter or very successful and indeed takes no account that he was probably the most successful underwriter for his names in the history of Lloyd's," Mr. Alexander said. "This would have been well-known to the council who include men of market experience, indeed, including several of his competitors."

Also, any errors committed by Mr. Posgate before 1982, when the new Lloyd's Act was passed by Parliament, occurred at a time when "Lloyd's standards were, with hindsight, sadly lax in numerous ways and unclear in others," said Mr. Alexander. Indiscretions committed before 1982 may have actually been considered satisfactory practice at the time, the attorney said.

Mr. Alexander pointed out that times have changed in the four years since Mr. Posgate was first suspended and said there is no doubt that Mr. Posgate would abide by today's rules if he returns to Lloyd's.

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Administrative:
CEO's presidents and owners...2,983
Vice-presidents, general managers and other administrative personnel...2,758

Financial:
Chief financial officers and vice-presidents of finance...2,018
Secretaries, treasurers, controllers and other financial personnel...6,484

Risk/employee benefits:
Vice-presidents, directors, managers, and other related department personnel of insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations...8,111
Sub-total...22,354

Associations...483
Government, unions and educational institutions...1,252

Commercial Consumers
Sub-total...20,089

Insurance agents and brokers 10,285
Insurance companies 6,739

Financial institutions 748
Attorneys, accountants, appraisers and consultants 3,808

Others allied to the field 1,308
TOTAL 46,977

* Source: Business/Occupational breakdown of qualified circulation, Nov. 25, 1985 issue, as submitted to BPA for December 1985 BPA Publisher's Statement.

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SUBARU

Pine Top

Continued from page 1

Gross written premiums in 1985 totaled \$41.9 million.

Due to continuing losses on its reinsurance business, Pine Top's policyholder surplus at March 31 was only \$346,170, nearly \$954,000 short of Illinois' minimum capital and surplus requirement of \$1.3 million for any property/casualty insurance company.

The company reported losses of more than \$2.5 million incurred in the first quarter and nearly \$6 million including loss development from previous periods.

At year-end 1985, Pine Top reported policyholder surplus of \$1.8 million, a decrease of \$10.9 million from the \$12.7 million at year-end 1984. The company incurred nearly \$37.8 million in losses during 1985.

In March, the Arizona Insurance Department suspended Pine Top's certificate of authority because the company's surplus did not meet state requirements. The state—where Pine Top was licensed to write property, casualty, surety, vehicle, marine and transportation business—requires a minimum of \$1 million in capital and \$250,000 in surplus. Pine Top wrote \$1.4 million in direct premiums in Arizona in 1985.

And, last week, the Arizona department obtained an oral agreement from Greyhound executives that the parent company will keep the management of Pine Top and Pine Top Life Insurance Co., another Greyhound subsidiary, separate and not transfer any capital from Pine Top Life to Pine Top, according to David Ward, deputy director of the Arizona Insurance Department.

Pine Top Life is not financially troubled, Mr. Ward noted.

Montana has not taken any action against Pine Top. Jim Borchardt, chief examiner of the Montana Insurance Department, said he has not received formal notification of Pine Top's financial status.

If the state finds that Pine Top does not meet the state's minimum capital requirement of \$800,000, "you can bet we will do

something," he noted. "Typically, we suspend in these cases."

The bulk of Pine Top's financial woes stem from losses on the reinsurance it assumed and from uncollectable reinsurance, said Illinois Insurance Department officials.

Ken Smith, a deputy director at the department, believes the bulk of Pine Top's problems were caused by the reinsurance it assumed. According to Part 1A—Section 2 of Schedule F in Pine Top's 1985 convention statement, reinsurance payable on unpaid losses totals \$68.7 million, with several companies owed more than \$1 million each for reinsurance on unpaid losses.

Those companies and the amount of reinsurance on unpaid losses Pine Top owes are:

- Republic Western Insurance Co. of Phoenix, a unit of Amerco Group, \$4.4 million.
- British National Insurance Co. Ltd. of London, a subsidiary of Armco Insurance Group Inc., \$3.1 million. British National is no longer writing insurance.
- Puritan Insurance Co., domiciled in Stamford, Conn., but based in Johnston, R.I., a unit of General Electric Credit Corp., \$2.9 million.
- National Reinsurance Co. of America in Montreal, \$2.7 million.
- Universal Reinsurance Corp. of Holland Township, N.J., another Armco subsidiary, \$2.6 million. Universal Re is running off its book of business.
- Fremont Indemnity Co. of Los Angeles, a subsidiary of Fremont Insurance Group Inc., \$2.4 million.
- National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc., \$2.2 million.
- American Home Assurance Co. of New York, another AIG subsidiary, \$1.9 million.
- Cravens Dargen & Co., Pacific Coast, of San Francisco, a managing general agency subsidiary of CIGNA Corp., \$1.9 million.
- American Centennial Insurance Co. of Peapack, N.J., a subsidiary of Beneficial Insurance Group Holding Co., \$1.9 million.
- Central National Insurance Co. of

At year-end 1985, Pine Top reported policyholder surplus of \$1.8 million, down from the \$12.7 million at year-end 1984.

Omaha, Neb., a subsidiary of Champion International Corp., \$1.8 million.

• Philadelphia Reinsurance Corp., a subsidiary of Nationale-Nederlanden U.S. Group, \$1.2 million.

• Protective National Insurance Co. of Omaha, Neb., another Champion unit, \$1.2 million.

• New England Reinsurance Corp. of Boston, a subsidiary of Hartford Fire Insurance Co., \$1 million.

Another "significant" problem for Pine Top is the amount of reinsurance it ceded that now appears uncollectible, according to Mr. Traylor of the Illinois department.

Mr. Traylor would not identify the companies to which Pine Top ceded business and now cannot collect from, but Part 1A in Section 1 of Schedule F in Pine Top's 1985 convention statement lists several reinsurers either under supervision, in rehabilitation or in liquidation. Together, these companies owe Pine Top millions of dollars in reinsurance recoverables on paid and unpaid losses.

Topping the list of troubled reinsurers that owe Pine Top recoverables in paid and unpaid losses is Philadelphia-based Mutual Fire, Marine & Inland Insurance Co., which placed itself under voluntary supervision in Pennsylvania on June 13 (see story, page 1). The convention statement says Mutual Fire, Marine is liable to Pine Top for reinsurance recoverables of \$81,000 on paid losses and nearly \$1.5 million on unpaid losses.

The other financially troubled reinsurers to which Pine Top ceded business and their liabilities include:

- Cherokee Insurance Co. of Nashville,

Tenn., a subsidiary of Dana Corp. that is in voluntary rehabilitation in Tennessee; \$820,000 on paid losses and \$544,000 on unpaid losses, of which \$128,438 is secured by deposit and funds withheld.

• Mission Insurance Co. of Los Angeles, a Mission Insurance Group Inc. unit that is in rehabilitation in California; \$24,700 on paid losses and \$1.2 million on unpaid losses.

• Transit Casualty Co., which is in liquidation in Missouri; \$97,419 on paid losses and \$622,508 on unpaid losses.

• Union Indemnity Insurance Co. of New York, a Frank B. Hall & Co. Inc. subsidiary that is in liquidation in New York; \$364,000 in paid losses and \$340,000 on unpaid losses.

• Beacon Insurance Co. of Winston-Salem, N.C., which is in voluntary rehabilitation in North Carolina; \$19,000 on paid losses and \$145,000 on unpaid losses, of which \$37,509 is secured.

• Aspen Indemnity Corp. of Englewood, Colo., an Aspen Holding Co. subsidiary that is in liquidation; \$694,889 on paid losses and \$1.1 million on unpaid losses, of which \$338,000 is secured.

• Mentor Insurance Co. Ltd., a subsidiary of Ocean Drilling & Exploration Co. that is in liquidation in Bermuda; all \$112,000 secured.

Pine Top also has on deposit \$812,000 of the \$894,000 in reinsurance that British-based Pine Top Ltd., another Greyhound subsidiary, owes the company. British-based Pine Top stopped writing new business in 1983.

Pine Top's rehabilitation comes a little more than a year after Greyhound thought it had sold the subsidiary.

After searching for a buyer for more than two years, Greyhound announced last April it had sold Pine Top and Pine Top Life to Phoenix-based Whitney Financial Group for about \$20 million (BI, April 8, 1985). However, Greyhound reassumed control of the insurers in December because Whitney did not fulfill certain obligations, a Pine Top official said last year (BI, Dec. 23, 1985).

A.M. Best Co. assigned Pine Top an omitted rating after the insurer was reacquired by Greyhound.

Mutual Fire

Continued from page 1

premiums of only \$60.6 million. Net premiums totaled \$42.7 million.

Of the four jurisdictions where Mutual Fire, Marine is admitted to write insurance, it wrote direct premiums of \$15 million in New York, \$6 million in Pennsylvania, only \$304,761 in Delaware and none in Puerto Rico.

At March 31, the insurer reported on a preliminary basis \$10 million in policyholder surplus after discounting loss reserves. The insurer lost \$13 million in the first quarter after a \$9 million underwriting loss and a \$4 million investment loss from the liquidation of a bond portfolio.

At year-end 1985, the insurer reported capital and surplus of \$23.7 million, compared with \$33.5 million at year-end 1984.

In 1985, Mutual Fire, Marine recorded a net loss of \$12.8 million, significantly higher than the \$1.2 million loss the year before.

The insurer strengthened its reserves last year by \$22 million, primarily because of losses under assumed reinsurance treaties, after adding only \$2.5 million to reserves in 1984. Of the \$22 million addition to reserves in 1985, \$11.6 million was related to assumed treaty reinsurance business, \$3.8 million was related to the financial guarantee losses and \$7 million was related to business underwritten by MGAs for the insurer.

Mutual Fire, Marine is now implementing a plan that will involve the company's cedents, lenders, reinsurers and MGAs to "significantly improve the financial condition of the mutual."

While Richard J. Guilfoyle, Mutual Fire, Marine's president, wouldn't release details of the company's plan because the parties involved hadn't seen it last week, he did say it included selling some assets.

Mutual Fire, Marine plans to sell its UMI Reinsurance Co. and the half interest it holds in its home office building. Sale of the reinsurance company should generate around \$7.5 million and the sale of its ownership in its building should generate about \$3.5 million.

Operating under voluntary supervision by the state insurance means the department "is in support of the program" the company has developed to strengthen its financial position, Mr. Guilfoyle said. "They are working with us to lend support to see the successful implementation of the program," he added.

"We structured the program, they approved it," Mr. Guilfoyle explained. "Their participation will be in terms of helping with some of the issues that involve retrocessionaire agreements and the collection of funds on reinsurance."

"At the end of 90 days, a decision will be made to determine if it is prudent to continue the supervision or if other action needs to be taken," a spokesman for the Pennsylvania Insurance Department said.

Mutual Fire, Marine's assumed and ceded treaty reinsurance during 1982 through 1984 involved mostly pro-rata casualty insurance contracts.

Losses under the assumed reinsurance business increased, requiring "reserve strengthening," Mr. Guilfoyle said.

Mutual Fire, Marine did not receive sufficient premiums under the reinsurance contracts written during the competitive market cycle, Mr. Guilfoyle said. "We're talking about a period of time where the industry was significantly underpriced," he said.

In addition, Mr. Guilfoyle says incurred-but-not-reported losses could present substantial claims for Mutual Fire, Marine. "There could still be some reserve strengthening that hasn't been recognized by the carriers we are reinsuring and that reserve strengthening could be significant. There might be some additional IBNR development not contained in IBNR reported to us."

Mr. Guilfoyle pointed out Mutual Fire, Marine is operating under new management put in place when he became president in 1984.

Among ceding companies with the largest reinsurance recoverables from Mutual Fire, Marine—including paid and unpaid losses—are:

- Mutual Marine Office Inc., \$10.3 million.
- Lloyd's of London underwriters, \$6 million.
- Colonial Penn Insurance Co., \$5.5 million.
- Home Insurance Co., \$3.6 million.
- American International Group Inc., \$2.5 million.

Also contributing to Mutual Fire, Marine's problems are the loss of some of its reinsurers. "Some of the retrocessionaires are no longer with us. They became bankrupt, and we had to pick up their part of the book as well," Mr. Guilfoyle said.

He specifically named Mentor Insurance Co. Ltd. in Bermuda, which was placed into liquidation last year by the Bermuda court.

Mutual Fire, Marine is carrying a recoverable of \$1.6 million from Mentor, which is half the amount actually owed Mutual Fire, Marine, says Mr. Guilfoyle, after recoveries from letters of credit and premium payment credits.

In 1985, A.M. Best Co. gave Mutual Fire, Marine a non-assigned rating due to the amount of reinsurance ceded to foreign reinsurers.

However, the insurer is also having difficulty collecting from some authorized reinsurers, according to treasurer Robert Quigley, who declined to name the reinsurers.

In connection with the financial guarantee programs written for oil and gas and real estate partnerships, Mutual Fire & Marine has sued Worldsurance Inc. and its parent company, Financial Guardian Group Inc. in the 3rd District Court of Philadelphia.

The suit charges the agency did not exercise the due diligence required to assess the financial status of the partnerships it insured. Worldsurance wrote guarantees mostly for oil and gas partnerships.

Mutual Fire, Marine is seeking "the full extent of the amount of the losses" generated by the partnerships insured by the MGA named in the suit, Mr. Guilfoyle said.

Mr. Quigley said Worldsurance has \$10 million of errors and omissions insurance underwritten by International Surplus Lines Insurance Co., a Crum & Forster unit.

Financial Guardian referred questions to its attorney, who did not return phone calls by press time.

ISLIC could not be reached for comment because its

Chicago office was closed last Thursday while the company moved to a new location.

The other MGA writing financial guarantees for Mutual Fire, Marine was Surety Intermediaries of New York, which underwrote insurance mostly for the real estate partnerships. Losses under the real estate partnership bonds were not as large as the oil and gas partnership losses, Mr. Quigley said. However, he said, the insurer probably will seek arbitration of disputes with Surety Intermediaries. Surety had \$3 million of E&O insurance underwritten by Employers Reinsurance Corp., he said.

Surety Intermediaries' telephone was not working last week and a messenger seeking to deliver a written request for comment found that the company was no longer located at the last available address.

Employers Re said it has no record of coverage for Surety Intermediaries.

Altogether, the defaults have resulted in gross losses of about \$60 million, according to Mr. Quigley.

In addition to litigation filed against Worldsurance, the insurer is also suing all 620 of the partnerships that defaulted. Litigation has already been filed against more than half of the partnerships and eventually all of them will be accused of failure to comply with the terms of their agreements "and pay the balances due the banks," said Mr. Guilfoyle.

The financial guarantees were written to cover promissory notes issued by the limited partnerships to banks and financial institutions that had loaned money to the operations, he said.

Premiums totaled \$13.4 million to cover bonded exposures of \$335 million in principal and \$100 million in interest for 7,500 partnerships in 1983 and 1984. The coverage was written to limits of \$150,000 for individual investors and to \$7.2 million for the partnerships.

Mr. Guilfoyle said Mutual Fire, Marine ceded around 70% of the exposure to domestic and Bermuda reinsurers, while retaining 30% of risk.

The insurer's current financial guarantee exposure is around \$180 million, Mr. Quigley said.

Among MGAs that have written business for Mutual Fire, Marine is Shand, Morahan & Co. Inc. in Evanston, Ill., which wrote professional liability insurance for the insurer.

Shand, Morahan says the move by the insurer to place itself under supervision should not greatly affect the the underwriting manager.

Robert Libby, executive vp at Shand, said, "We have notified our clients of the voluntary supervision," adding that Shand informed clients that claims payments are suspended until approved by the Pennsylvania Insurance Department.

Although he did not have figures as to how much professional liability coverage Shand wrote for Mutual Fire, Marine, Mr. Libby did say that the underwriting manager had scaled back the business during the soft market that saw surplus lines business jump to the admitted market.

Mr. Libby said that much of the professional liability, which was predominantly medical malpractice, that had been written by Shand on behalf of Mutual Fire, Marine, is now written for the General Accident Insurance Group in Philadelphia.

New York tort reform bill

Continued from page 2

will not be renewed or terms will be changed.

The superintendent also is required to submit to the governor and Legislature an annual report on the commercial property/casualty insurance market in the state, including loss and expense experience.

Under a separate bill passed by the Legislature applying to medical malpractice insurance and lawsuits:

- The insurance superintendent will have authority to set and review medical malpractice rates without holding hearings. This authority will run through 1988.

A spokesman for the New York Insurance Department said Superintendent James P. Corcoran plans to authorize a retroactive increase of about 14% to cover the 12 months beginning July 1, 1985. The spokesman added that rate increases of about 9% would be authorized for the next two 12-month periods.

The latest legislation provides for an additional surcharge of 8% beginning in 1989 if these rate hikes are inadequate, the spokesman said.

New York medical malpractice rates increased 29% to 32% last year under a bill passed by the Legislature last summer (BI, July 8, 1985).

That law reduced a 52% rate hike that was previously approved by the Legislature.

That law also included several tort reforms, including limits on attorneys' contingency fees in medical malpractice cases.

- Medical malpractice insurers must furnish records to better enable the insurance superintendent to monitor the need for rate increases.

- Doctors new to the state, or those who are just beginning to practice medicine, would be required to purchase claims-made medical malpractice coverage. Other doctors would still be permitted to buy occurrence policies.

- Arbitration will be permitted in cases in which defendant physicians admit liability.

- Verdicts for loss of earnings will be reduced by the amount of taxes the victim would have paid if that amount was part of normal earnings.

- Attorneys filing medical malpractice suits will be required to submit affidavits stating that at least one doctor believes there is a reasonable basis for the suit.

While attempting to reduce litigation, the package of bills also expands some plaintiffs' rights. The bills give persons allegedly exposed to certain toxic substances more time to file suit.

Currently, state law mandates that legal action must be started within three years from the date of last exposure to a toxic or harmful substance.

Under the legislative package, victims who have been exposed to one of five substances—DES, tungsten carbide, asbestos, chlordane or polyvinyl chloride—who had been previously barred from filing suits because statutes of limitation had expired will have one year from the date the bill is signed to file suit.

In addition, the legislation amends state law so that plaintiffs alleging they have contracted a long-latent disease can initiate legal action within three years from the discovery of injury, or within three years from the date "when through the exercise of reasonable diligence such injury should have been discovered," whichever is earlier.

Last week, at least one insurance company official said the legislative package was unsatisfactory.

Jack B. Riffle, chairman and chief executive officer of the Utica National Insurance Group in New Hartford, N.Y., said in a statement that he has a "sense of deep disappointment that the Legislature has apparently failed to come to grips with a fundamental societal problem."

"Legislators have instead laid liability insurance problems at the feet of the insurance industry where they do not belong. The problems should be directed, in large measure, toward the attorneys who profit from the current system of civil justice in New York," Mr. Riffle said.

"What we will end up with is a Band-aid, stop-gap approach to a liability problem that will probably worsen over time."

Mr. Riffle also said he was displeased that the Legislature did not adopt all the recommendations contained in an April report by a gubernatorial advisory commission (BI, April 21).

The report recommended that joint and several liability be totally eliminated for pain-and-suffering and other non-economic awards and recommended a \$250,000 cap on non-economic awards against public entities.

"It is unfortunate, indeed, that after all the time, money and energy spent by the governor's commission, the proposed legislation adopts virtually all of the regulatory proposals, but fails to include the important substantive tort reforms sug-

gested by the commission."

Orin S. Kramer, vice chairman and executive director of the commission, said: "I think that the package is a significant evolutionary step forward, but it would be a mistake to assume that the agenda's complete."

The commission is scheduled to release another report this week dealing with product liability and a "variety of other tort issues," he added.

Utica Mutual, which had been a major insurer of municipalities in New York, refused to renew coverage for 229 public entities in the state last year.

A Utica Mutual spokesman said last week, "There is nothing in the legislation that will induce us to go back into the municipality market."

Charles Hunt, counsel in the government affairs office of the Travelers Corp., said it is difficult to estimate the impact of the legislation's joint and several liability reform provision. But he added, "It's an improvement over the existing joint and several liability doctrine."

"I don't know that it will have a dramatic effect on the cost of insurance," Mr. Hunt noted.

Insurers will "just have to wait and see" the impact of the various insurance regulatory reforms, including provisions authorizing flex rating and JUAs, he added.

"Flex rating is new. Nobody's had any experience under it. But I'm sure it can work," he said, adding that if the new rates prove inadequate, insurers can apply for modifications.

"I'm confident the flex rating can work. But the proof will be in the pudding sometime down the road," he said.

Mr. Hunt described JUAs as short-term solutions that permit high risks to purchase coverage at favorable rates under state mandate. He added that the threat of JUAs could serve as an incentive for insurers to offer buyers adequate capacity.

A spokesman for the Medical Society of the State of New York, which represents 27,000 of the state's 46,000 practicing doctors, said the group opposes the medical malpractice legislation. "Basically, because in our view, the bill does not really solve the problem."

He said the bill lacked three necessary elements:

- A \$250,000 cap on non-economic damages.
- Limiting physicians' liability to \$1 million per occurrence and \$3 million aggregate.
- A rollback of medical malpractice rates to the rates that were in effect June 30, 1984.

Product liability bill

Continued from page 1

turer found liable.

- Eliminate most punitive damage awards against pharmaceutical and aircraft manufacturers whose products were approved by the Federal Drug Administration or the Federal Aviation Administration.

Punitive damages still could be awarded if drug or aircraft manufacturers withheld relevant information from the FDA or FAA.

- Allow punitive damages only if a plaintiff could prove by "clear and convincing evidence" that a defendant exhibited a "conscious, flagrant indifference to the safety of those persons who might be harmed by a product."

- Require product liability suits to be filed within two years of injury or within two years of the time a plaintiff discovered or should have discovered his or her injury.

- Eliminate liability for wholesalers and retailers except in cases in which they are proven to be negligent or in which the product manufacturer is bankrupt.

- Make it more difficult for U.S. manufacturers to be sued in U.S. courts for accidents that occur in other countries. Under the bill, it would be presumed that such suits should proceed in a foreign jurisdiction.

- Bar recovery if a plaintiff was under the influence of an intoxicating liquor or drug and his or her impaired condition was more than 50% responsible for the accident or injury.

- Punish attorneys who file frivolous lawsuits or frivolously delay cases by making them liable for other parties' legal fees and for court costs.

In addition, the measure will require the secretary of commerce to collect from insurers statistics on product liability coverage and litigation.

Under this amendment, made by Sens. John Rockefeller IV, D-W.Va., and Wendell Ford, D-Ky., this information would "to the maximum extent practicable" be obtained from existing sources, including state insurance commis-

sioners, recognized insurance statistical agencies, the Administrative Office of the United States

'Joint and several liability has been a serious impediment to being able to predict a policyholder's exposure. The . . . proposal would substantially stop the drift toward the deep-pocket syndrome,' said Mr. Cheek.

Courts and the National Center for State Courts.

While the Commerce Committee vote clears the way for consideration of the product liability bill by the full Senate, the bill still must clear several obstacles before it comes to a vote.

For example, the Senate Judiciary Committee could ask that the product liability bill be referred to it for review before a Senate vote, observers say. That could delay the bill long enough to prevent the Senate from voting on the proposal this year.

When the bill reaches the Senate floor, Sen. Ernest Hollings, D-S.C., who made no secret of his dislike for the concept of a federal product liability bill during the months of committee debate, is likely to filibuster.

But the Commerce Committee approval will, at the least, propel the Senate to consider product liability legislation next year if time runs out during the current session, Sen. Danforth said.

"We have, at the very least, a very good head of steam for next year," Sen. Danforth said.

Observers do not expect the House to consider product liability legislation this year, even if it is approved by the Senate.

The committee's approval of legislation comes a little more than one year after members rejected a sweeping product liability bill introduced by Sen. Robert Kasten, R-Wis. (BI, May 27, 1985). The committee had approved a similar bill the previous year (BI, April 2, 1984).

Sen. Danforth said the committee's stance on product liability legislation changed this year because it began to consider a more balanced approach.

He also noted that the liability insurance crisis and greater public

awareness triggered the committee action.

"Clearly, Congress reacts to public pressure. A lot of people know the civil justice system has broken down," he said.

"The liability insurance crisis gave the committee an incentive to act," agreed the Alliance's Mr. O'Day.

One provision—the elimination of joint and several liability for non-economic damages in product liability cases—was added in response to public opinion. The committee adopted the provision in response to California voters' approval last month of Proposition 51, which eliminated joint and several liability for non-economic damages in all personal injury cases, Sen. Kasten said (BI, June 9).

Insurers say the repeal of joint and several liability for non-economic damages, proposed by Sen. Larry Pressler, R-S.D., will make it easier for insurers to provide product liability coverage.

"Joint and several liability has been a serious impediment to being able to predict a policyholder's exposure," said Leslie Cheek, vp-federal affairs in the Washington office of Crum & Forster. "The Commerce Committee proposal would substantially stop the drift toward the deep-pocket syndrome."

Other provisions were added to the bill because of recent product liability suits.

For example, the provision to make it more difficult to sue U.S. manufacturers in American courts for accidents abroad—which was proposed by Sen. Slade Gorton, R-Wash.—was offered in reaction to the attempts of plaintiffs' attorneys to sue Union Carbide Corp. in U.S. courts on behalf of victims of the December 1984 gas leak at the Carbide plant in Bhopal, India.

Some amendments were made

by senators representing constituents with particular product liability problems.

For example, the amendment to eliminate most punitive damage awards against pharmaceutical and aircraft manufacturers was proposed by Sen. Nancy Kassebaum, R-Kan. Several aircraft manufacturers are based in Kansas.

The most controversial provision in the bill approved by the committee is the so-called expedited claims settlement procedure.

This proposal, introduced by Sen. Danforth, is aimed at giving both plaintiffs and manufacturers incentives to settle cases before they go to trial.

For example, if a plaintiff rejected a manufacturer's offer to pay all economic losses and up to \$100,000 for a "serious dignitary loss," the manufacturer's maximum liability for non-economic damages—excluding punitive damages—would be \$250,000.

On the other hand, if the plaintiff made a settlement offer and the defendant rejected it, the defendant would be liable for the plaintiffs' attorney fees, up to \$100,000, if the plaintiff won.

Sen. Danforth said his proposal would give both sides incentives to settle before heavy litigation costs were incurred.

However, Sen. Gorton labeled the proposal as unjust, and other senators vowed to oppose the provision when the bill reaches the Senate floor.

"The amendment does not advance the cause of justice. It manifests injustice. There has not been a word of justification for this provision," Sen. Gorton said.

"Who in the hell are we to say that \$250,000 is enough?" asked Sen. Albert Gore, D-Tenn.

"I'll do whatever I can to remove those caps," said Sen. Inouye. "It is easy for those who are not victims to be setting caps."

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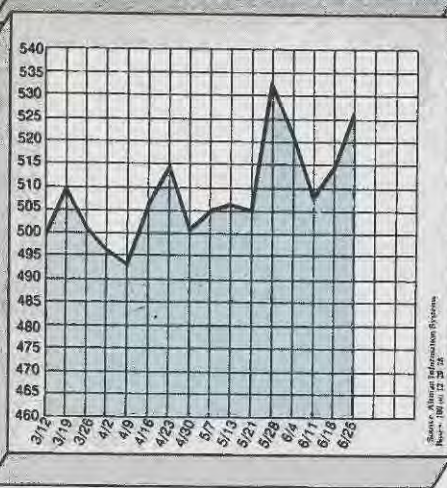
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BI Insurance Index



Insurance industry stocks posted a strong advance last week as the *Business Insurance* stock index increased 11.3 points to 525.6 on June 25, up from 514.3 on June 18. However, the index fell short of its record high of 533.1 set on May 28. Thirty-seven issues advanced during the five-day trading period, 15 stocks declined and eight stocks were unchanged. The largest gains were posted by: Aneco Reinsurance Co. Ltd., up 27.8%; Great West Life Assurance Co., up 20.0%; Crown Life Insurance Co., up 9.4%; CNA Financial Corp., up 8.5%; and Torchmark Corp., up 8.4%. The biggest declines were reported by: Frank B. Hall & Co. Inc., down 6.2%; Trenwick Group Inc., down 3.9% during the first week it was included in the index; Avemco Corp., down 3.5%; Poe & Associates Inc., down 2.3%; and United Fire & Casualty Co., down 1.8%. The 5.8% increase in the *Business Insurance* index outperformed the major market averages. The Standard & Poor's 500 index rose 1.6%, the New York Stock Exchange Composite rose 1.5% and the Dow Jones 30 Industrials advanced 0.8% during the same period.

British Issues

25 June	Price	P/E	Div.	Yield	1 Week
Companies	pence		pence	%	High-Low
Comml Union	304	27.6	16.9	5.5	308-303
Genl Accident	804	14.6	31.4	3.9	812-800
Gdn Royal Exch	853	16.4	40.7	4.7	860-849
Royal	857	14.3	36.7	4.2	867-842
Sun Alliance	675	22.5	23.6	3.7	683-675
Brokers					
CE Heath	525	8.0	34.5	6.5	593-525
Hogg Robinson	290	9.7	13.4	4.6	300-290
JH Minet	241	9.3	11.3	4.7	245-231
Sedg Grp	333	12.8	15.7	4.7	350-333
Stew Wrightson	393	12.5	15.7	3.9	397-390
Willis Faber	415	15.4	12.5	3.0	417-415

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Insurers and investors: Wary of Florida reforms

By MYRON M. PICOULT

Special to Business Insurance

THE TORT REFORM legislation passed in Florida earlier this month—which would also freeze commercial property/casualty insurance rates and authorize that 1987 rates be rolled back to 1984 levels—is clearly a negative for the insurance industry.

The main problem is that the Florida statute could become a standard that other state legislatures might attempt to follow, rather than the possible economic impact if property/casualty insurance companies withdrew from the Florida market.

Other states have passed tort reform measures without onerous rate reductions. Some legislators have recognized that some tort reform measures involving limits on losses, for example, could lead to better loss experience. However, ceilings on damage awards soon become floors, and only time will tell if the measures are sufficient to stem the tide of irresponsible litigation and the concomitant impact on loss costs.

And, while the Florida proposals relate only to certain commercial lines, it would be fallacious to assume that the concept could not spread to the personal lines arena and/or other commercial lines.

Although numerous companies have indicated that they have put a hold on writing new business in Florida, only a few have issued veiled threats that they might consider more forceful measures, such as allocating their capital to other, more palatable, state environments or operate in the state on a non-admitted basis.

What a company does not write cannot hurt it. What a company is forced to write at deficient rates, together with a proportionate share of business written through a joint underwriting association, can be debilitating.

The industry's response to date has basi-

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Mr. Picoult

Although numerous companies have indicated that they have put a hold on writing new business in Florida, only a few have issued veiled threats that they might consider more forceful measures, such as allocating their capital to other, more palatable, state environments...

cally been a hollow protest. Most insurance company managements argue that longer-term implications force a more measured near-term response. However, there will be no long term if the industry gives away its pricing and policy format flexibility.

The industry is now reaping what it has sown. It must become more articulate with respect to the cause of the problems involving the availability and cost of liability insurance coverage and how it is seeking to remedy the situation.

The performance of industry stocks over the past few weeks has been buffeted both by the legislative events in Florida and misinterpretation of proposals or legislation in other states.

Every insurer that we have talked to has decried the stock market's reaction and feels that there has been an over-reaction. What managements have totally missed and have not addressed, however, is that investors fear the Florida virus may become an epidemic.

Furthermore, a portfolio manager with an overweighted position, sensing some material weakness, had no choice but to lighten up.

If the industry were to permit itself to be viewed as a utilitarian or charitable institution, capital flow into the business would be sharply curtailed and investor recognition would shrink.

There are several countervailing factors that will affect the near-term performance and prospects of the industry. There is obviously a good relative earnings story. However, offsetting this is a highly charged political environment and the fact that most investors still have big profits on the line.

Yet another factor to watch is the possibility that second-quarter earnings may fall somewhat short of expectations as insurance company managements cope with allegations of inflated profit levels. The opportunity has once again been presented to companies to address reserve deficiencies and questionable reinsurance recoverables.

What we may have for awhile is a Mexican standoff. If the Florida situation were to get out of hand, we could have a replay of Custer's last stand.

Pinnacle Reinsurance

Pinnacle Reinsurance, the Bermuda-based subsidiary of Lloyd's broker C.E. Heath P.L.C., increased its 1985 underwriting income 66% to \$9.2 million and its net income 53% to \$13 million.

The runoff reinsurance specialist increased net premium income 75% to \$126.1 million. Investment income grew to \$4.1 million from \$3.8 million previously, while claims paid dropped to \$18.9 million from \$33.2 million.

Pinnacle paid its British parent a dividend of \$6 million and strengthened its capital to \$40 million with a transfer of \$10 million from retained earnings. Pinnacle's shareholders equity now stands at \$49.6 million compared with \$42.6 million in 1984.

Pinnacle, which specializes in financial reinsurance, says that last year it reinsured on a funds withheld basis \$64.9 million of matched asset and liability business with its wholly owned Bermuda subsidiary, APEX Reinsurance, for a fee of \$656,000.

Pinnacle's investment in APEX is accounted for under the equity method and, in 1985, income from APEX was \$1.5 million.

Pinnacle is not providing for contingent liabilities that could arise out of a \$500 million legal action filed against it and 10 other defendants in March by liquidators of the failed Mentor Insurance Co.

The suit alleges that the defendants conspired to conceal Mentor's true financial condition through a series of reinsurance contracts (BI, March 24).

Pinnacle, which is named in the action for its role as a reinsurer of Mentor, has asked to be dismissed from the suit. The suit is pending in U.S. District Court for the Eastern Division of Louisiana (BI, June 16).

Pinnacle's 1985 annual report says "the company utterly refutes allegations made in the writ and, having taken legal advice, considers there is no case to answer and that no material liability will result from the action. Accordingly, no provision has been made in these accounts in respect of this matter."

USF&G Corp.

Baltimore-based USF&G Corp. has filed a registration statement with the Securities and Exchange Commission seeking permission to offer 4 million shares of convertible exchangeable preferred stock.

The stock's underwriters, Goldman Sachs & Co. and Alex. Brown & Sons, also have the option to purchase up to 600,000 additional shares to cover overallocations.

A USF&G spokesman said the sale's proceeds would be added to the surplus of USF&G's property/casualty subsidiary, U.S. Fidelity & Guaranty Co.

Trenwick Group

Trenwick Group Inc., parent of Trenwick American Reinsurance Corp., has completed its public offering of \$3.3 million shares.

Trenwick stock was traded over the counter at \$24.25 per share on June 25, compared with the June 18 offering price of \$23 per share. Based on the offering price, the 3.3 million-shares offered grossed about \$76 million.

According to the prospectus at least \$60 million of the proceeds of the offering will be contributed to Trenwick American's capital and surplus, increasing it to \$107.6 million from \$47.6 million at year-end 1985 (BI, May 19).

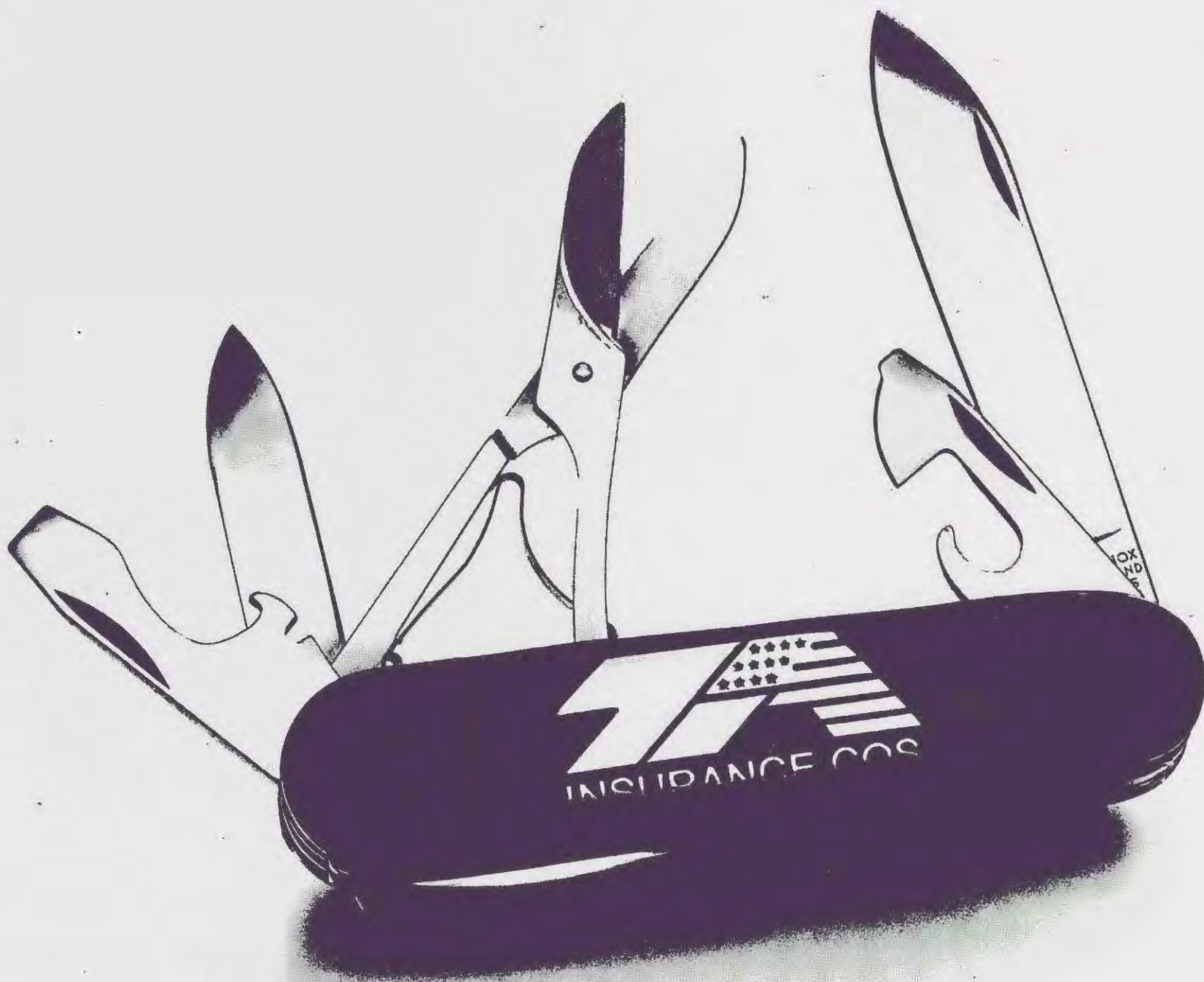
BI Industry Stock Report

June 25, 1986

6/19/86 thru 6/25/86

Brokers										Price % Chg. P/E \$ Div. % Yld. High Low Vol.(000)									
Alexander & Alexander Svcs	NYSE	38.38	2.3	0.4	1.00	2.6	38.38	36.88	176.2	Continental Corp	NYSE	47.25	4.4	0.0	2.60	5.5	47.25	45.63	703.4
Baldwin & Lyons Inc	OTC	23.00	0.0	57.5	0.16	0.7	23.00	20.00	0.4	Crown Life Ins Co	OTC	350.00	9.4	3.5	0.00	0.0	350.00*	320.00	0.4
Corroon & Black Corp	NYSE	39.88	2.2	21.3	0.65	1.6	39.88	39.00	80.6	Durham Corp	OTC	46.00	-1.3	12.4	1.36	3.0	47.00	46.00	6.5
Crump E H Cos Inc	OTC	27.50	0.9	23.3	0.25	0.9	27.50	26.75	193.9	Farmers Group Inc	OTC	42.00	0.0	15.1	1.00	2.4	42.25	41.00	1,259.8
Gallagher Arthur J & Co	OTC	49.00	-1.0	21.1	0.40	0.8	51.00	49.00	13.5	Farmount Finl Inc	AMEX	31.13	5.1	23.4	-0.00	0.0	31.13	29.88	129.5
Hall Frank B & Co Inc	NYSE	24.50	-6.2	0.0	0.00	0.0	26.13	24.50	398.2	Fireman Fd Corp	NYSE	35.00	0.7	0.4	0.30	0.9	35.00	33.50	1,270.2
Marsh & McLennan Cos Inc	NYSE	57.63	-0.6	22.9	1.50	2.6	58.38	57.38	466.9	Fremont Gen Corp	OTC	27.50	3.8	0.0	0.48	1.7	27.50	26.75	121.4
Poe & Assoc Inc	OTC	10.75	-2.3	0.0	0.53	5.0	10.75	10.75	10.0	Great West Life Assurn Co	OTC	840.00	20.0	8.4	18.00	2.1	890.00*	700.00	16.9
AGENTS/BROKERS										Home Group Inc	AMEX	26.38	3.9	57.3	0.00	0.0	27.38	25.13	654.9
AVERAGE										Hanover Ins Co	OTC	60.25	-1.6	32.2	0.56	0.9	61.00	59.50	43.8
2.8										1.7									
Conglomerates & Holding Cos.																			
African Express(Fireman's Fd)	NYSE	61.63	2.9	14.4	1.36	2.2	61.63	59.25	3,600.6	Hartford Steam Boiler Inspnt	OTC	93.50	-1.1	14.8	2.40	2.6	95.00	93.50	22.3
Anderson Clayton(Ranger/PanAm)	NYSE	55.88	-6.7	31.9	0.00	0.0	0.00	0.00	0.0	Kans City Life Ins	OTC	36.00	1.4	14.2	0.87	2.4	36.25	36.00	7.4
Ameco Inc	NYSE	9.63	0.0	0.0	0.00	0.0	9.88	9.63	2,145.8	Keeper Corp	OTC	31.50	5.3	100.0	0.60	1.9	31.50	30.08	840.9
Berkley W R Corp	OTC	37.75	4.9	29.3	0.24	0.6	37.75	36.25	269.4	Liberty Corp S C	NYSE	42.63	0.9	18.0	0.72	1.7	43.00	42.00	36.6
CIGNA Corp	NYSE	62.63	2.7	0.0	2.60	4.2	62.75	61.00	1,095.5	Lincoln Natl Corp Ind	NYSE	51.00	1.7	11.5	2.00	3.9	51.38	49.50*	845.7
CNA Finl Corp (CNA)	NYSE	62.13	8.5	19.6	0.00	0.0	62.13	57.00	322.6	Mission Ins Group Inc	PAC	3.00	0.0	0.0	0.00	0.0	4.38	2.88	300.0
General Re Corp	NYSE	61.75	4.7	38.1	0.88	1.4	61.75	58.50	1,328.0	Monumental Corp	OTC	54.38	0.2	19.4	1.40	2.6	54.38	54.25	17.9
ITT (Hartford Group)	NYSE	49.38	9.4	26.8	1.00	2.0	49.38	44.88	3,691.9	Nac Re Corp	OTC	35.88	-1.7	0.0	0.00	0.0	37.00	35.50	27.1
Sears Roebuck & Co. (Allstate)	NYSE	48.00	1.6	13.9	1.76	3.7	48.00	46.75	4,417.3	Nobel Ins Ltd	OTC	17.00	3.0	22.4	0.25	1.5	17.00	16.25	23.7
Teledyne Inc (Argonaut)	NYSE	336.75	0.7	8.1	0.00	0.0	336.75	330.00	162.4	Northwestern Natl Life Ins	OTC	28.88	2.2	12.7	0.86	3.0	28.88	28.13	420.3
Transamerica Corp (Occidental)	NYSE	36.00	3.6	17.2	1.68	4.7	36.00	34.63	1,037.0	Ohio Cas Corp	OTC	83.50	0.3	19.3	3.00	3.6	83.75	83.00	92.5
CONGLOMERATES/HOLDING COS.										Old Rep Intl Corp	OTC	37.38	-1.6	13.7	0.78	2.1	37.75	37.00	130.4
AVERAGE										Orion Cap Corp	NYSE	35.63	0.0	0.0	0.76	2.1	35.75	35.63	56.6
16.7										Protective Corp	OTC	24.50	2.1	13.4	0.70	2.9	24.75	24.00	89.0
1.2																			
Insurers																			
Aetna Life & Cas Co	NYSE	61.88	5.3	13.6	2.64	4.3	61.88	59.50	2,864.6	Provident Life & Acc Ins Co	OTC	28.25	0.0	9.8	0.84	3.0	28.75	28.25	243.1
American General Corp	NYSE	39.88	-0.3	12.1	1.12	2.8	40.00	38.88	1,084.8	St Paul Cos Inc	OTC	45.75	4.0	27.7	1.50	3.3	46.50	45.00	1,063.9
Amern Heritage Life Invnt Co	NYSE	42.25	0.3	15.5	1.32	3.1	42.25	42.13	3.6	SAFECO Corp	OTC	58.00	2.7	15.7	1.68	2.9	58.13	56.88	636.4
American Indty Finl Corp	OTC	18.50	-1.3	0.0	1.12	6.1	18.75	18.50*	17.0	Sri Corp	OTC	22.75	0.0	0.0	0.80	3.5	23.00	22.75	68.5
American Intl Group Inc	NYSE	126.75	-0.9	23.6	0.44	0.3	127.63	122.38	651.6	Seibels Bruce Group Inc	OTC	19.25	0.0	0.0	0.80	4.2	19.25	18.75	32.5
Aneco Reins Ltd	OTC	2.88	27.8	0.0	0.00	0.0	2.88	2.25	57.2	Statesman Group Inc	OTC	5.50	0.0	39.3	0.05	0.9	5.63	5.50	67.9
Avemco Corp	NYSE	27.25	-3.5	15.1	0.50	1.8	28.50	27.25	16.5	Tokio Marine & Fire Ins Co	OTC	411.50	4.4	77.5	1.05	0.3	413.75*	405.00	18.7
Business Mens Assurn Co Amer	OTC	29.00	1.3	17.5	1.10	3.8	29.25	28.75	84.9	Torchmark Corp	NYSE	37.13	8.4	16.1	0.60	1.6	37.13*	34.50	536.8
Chubb Corp	NYSE	68.25	2.8	133.8	1.56	2.3	68.25	66.13	493.2	Travelers Corp	NYSE	49.63	2.6	12.5	2.16	4.4	49.63	47.63	2,458.9
Combined Intl Corp	NYSE	60.75	2.7	12.2	2.24	3.7	60.75	59.13	174.4	Trenwick Group Inc	OTC	24.25	0.0	0.0	0.00	0.0	25.00	23.63	985.1
										United Fire & Cas Co	OTC	27.50	-1.8	21.8	0.80	2.9	27.75	27.50	26.3
										United States Fd & Gty Co	NYSE	39.50	3.3	0.0	2.32	5.9	39.50	38.38	1,730.0
										Ustlife Corp	NYSE	45.25	3.1	12.1	1.12	2.5	45.25	43.75	204.9
										Washington Natl Corp	NYSE	34.50	1.8	15.2	1.08	3.1	34.88	33.88	46.6
										Zenith Natl Ins Corp	OTC	28.75	0.0	143.8	0.80	2.8	29.50	28.75	292.6
										INSURANCE COMPANIES									
										AVERAGE									
										9.1									

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