MAY 18, 1987

business insurance®

Reporting weekly for corporate risk, employee benefit and financial executives / $1.75 a copy; $68 a year

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update

California department seizes Homeland Insurance Co.

SAN JOSE, Calif.—The California Insurance Department has taken over Homeland Insurance Co. following a year's search by the workers compensation insurer for a white knight.

A Santa Clara County Superior Court judge on May 6 appointed California Insurance Commissioner Roxani Gillespie conservator of Homeland.

Continued on next page

Pillsbury creates retiree flex plan

By DONNA DiBLASE

MINNEAPOLIS—A new retiree benefit program at Pillsbury Co. gives retirees benefit flexibility while allowing Pillsbury to predict and control its retiree health care costs.

The Pillsbury program is thought to be the first flexible plan to be implemented specifically for retiree welfare benefits. And, it allows the company to determine in advance exactly how much it will contribute to pay for each retiree's health care benefits over his or her lifetime.

Under the plan, each retiree is provided with a specific amount of benefit credits at retirement with which to purchase medical, dental and life insurance coverage for the remainder of his or her life.

The number of credits provided to each retiree is based on the employee's length of service with the company, like pension benefits. Thus, retirees who have worked for Pillsbury for 30 years would be able to opt for richer benefits than those who have worked at Pillsbury for only 15 years.

And, because the company determines in advance the amount of credits that can be used by each retiree and his or her spouse, Pillsbury believes it will be able to better predict and control its future liabilities for retiree benefits.

"By saying up front this is what the credits are, that's where we feel we can really limit the future medical liabilities," explained Katherine McArdle, manager of retirement programs for the Minneapolis-based food and restaurant company.

"The whole idea is that we're trying to manage future retiree health care liabilities," she explained.

The plan is unique in that "it is a flex plan for retirees but also because it recognizes service, similar to other retirement plans," said Thomas Kuhlman, a principal in the Minneapolis office of

Continued on page 11

Carpenter seeks funds to form new reinsurers

By DOUGLAS McLEOD

NEW YORK—Guy Carpenter & Co. Inc. and Morgan Guaranty Trust Co. are trying raise $450 million through a private placement to capitalize a new group of reinsurance companies.

Centre Reinsurance Holdings Ltd., a Bermuda-based corporation, would act as the holding company for three reinsurance units offering a variety of financial reinsurance products.

Private placement memoranda recently were sent to a group of potential insurance company investors, and additional offering memoranda will be sent to prospective non-insurance investors shortly, confirmed Steven M. Gluckstern, president of Centre Re.

A minimum of $250 million must be raised for Centre Re to get off the ground, says Mr. Gluckstern.

Several large stock insurers—including United States Fidelity & Guaranty Co. in Baltimore and Aetna Casualty & Surety Co. in Hartford, Conn.—have received offering memoranda and are reviewing them.

The offering will have to raise a minimum of $250 million for Centre Re to get off the ground, according to Mr. Gluckstern, who said the organizers are hoping to close the deal by July 31.

Centre Re's reinsurance units—domiciled in Bermuda, Barbados and New York—would offer, among other products, working-layer casualty treaty reinsurance with aggregate caps and provisions for paying profit commissions to ceding companies.

Centre Re units—operating as broker markets open to all intermediaries—would be trying to attract working-layer casualty business that was lost to commercial reinsurers and brokers when ceding companies increased their net retentions during the tight reinsurance market.

Guy Carpenter, the reinsurance brokerage arm of Marsh & McLennan Cos. Inc., will not be a shareholder in Centre Re, though it will receive a fee equal to 1% of gross premiums written during the reinsurers' first five years of operation, along with a 10-year option to purchase 4.9% of Centre Re's common shares, Mr. Gluckstern said.

Some reinsurance company executives are uncertain about the Centre Re placement's chances for success, questioning Centre Re's attractiveness as an investment for insurance companies as well as the timing of the reinsurance stock offering.

However, Centre Re's products could be in greater demand as insurance companies seek ways to cope with the Tax Reform Act of 1986. Insurance companies ceding reserves to Centre Re would be able to take a 100% tax deduction for those reserves rather than discount them as required by the Tax Reform Act.

The three reinsurance subsidiaries of Centre Re will be:

- Centre Reinsurance (Bermuda) Ltd., which will write worldwide reinsurance business excluding U.S. risks.
- Centre Reinsurance (Barbados) Ltd., which will write predominantly U.S. business.
- Centre Reinsurance Co., which will be domiciled in New York and will write U.S. business as an ad-

Continued on page 46

Market stability slows brokers' growth

By LINDA J. COLLINS

A new stability in property/casualty insurance rates is slowing revenue growth for publicly held brokers.

Although all six public insurance brokers reported first-quarter revenue gains, their rate of growth diminished in the first quarter of 1987 from rapid gains experienced throughout 1986, when property/casualty rates—and thus commission income—rose significantly.

In addition, four of the six brokers reported net income declines in the first quarter, though the decreases in profitability at two of the brokers were not solely related to insurance operations.

Rate stagnation—including rate decreases in some lines—will continue "throughout 1987 and well into 1988. I think revenue growth will also slow," said financial analyst Harvey H. Bundy III, a partner with William Blair & Co. in Chicago.

And because "the softening of rates will persist" in 1987, brokerages will have to pay "more attention to expenses than they have over the past two years," said analyst Leonard M. Wilson, a principal with L.F. Rothschild Unterberg & Towbin in New York.

Analyst Samuel J. Weinhoff, first vp of Shearson Lehman Brothers in New York, says that brokerages that respond wisely to market changes will "slow their head-count growth, open fewer offices and act more selectively on bonuses."

First-quarter 1987 broker results
(In thousands of dollars)

Broker	Gross revenues	% change	Net income	% change
Marsh & McLennan	$560,000	26.1%	$92,900	42.7%
Alexander & Alexander	269,500	7.9	14,400	–34.8
Frank B. Hall	105,577	5.0	7,784	–14.5
Corroon & Black	97,178	15.4	9,288	–17.0
Arthur J. Gallagher	31,610	9.2	3,445	–23.0
Poe & Associates	8,439	2.8	1,203	0.5

Chart: Amy Palmer

"What continues to make a big difference in brokerage results is the quality of their management, their attention to expense control and their ability to focus their attention on the changing insurance marketplace" and adapt to those changes, stated Thomas G. Rosencrants, senior vp at Johnson Lane Space Smith & Co. Inc. in Atlanta.

Mr. Rosencrants said he categorizes the publicly held brokers in three-tiers, with Marsh & McLennan Cos. Inc. and Corroon & Black Corp. in the top tier; Arthur J. Gallagher & Co. alone in the second tier; and Alexander & Alexander Services Inc. and Frank B. Hall & Co. Inc. in the bottom tier.

Marsh & McLennan is "very good" at adapting to market changes and controlling expenses, and Corroon & Black is "making good progress," Mr. Rosencrants said. However, "Gallagher is struggling somewhat and needs to get its expenses better under control."

On the other end of the spectrum, "Alexander & Alexander and Hall are experiencing subpar revenue growth and above-average expense growth, and I don't see this changing in the foreseeable future," Mr. Rosencrants said.

While revenue growth slowed for publicly held brokers in the first quarter, New York-based Marsh & McLennan—the world's largest brokerage—continued to outperform the pack.

M&M's gross revenues rose 26.1% in the first quarter to $560 million from $444.2 million in the first quarter of 1986. M&M's net income for the same period rose 42.7% to $92.9 million from $65.1 million.

An M&M spokesman said the brokerage's first-quarter growth stemmed primarily from "new business development in insurance brokering, particularly in the U.S." While rates

Continued on page 33

Insurer officials worry that opponents will capitalize on ISO tort reform study
Page 2

Emergency medical helicopter services buffeted by spiraling insurance costs
Page 3

update

Homeland seized by California

Continued from previous page

The California department reported that Homeland had $27.7 million in liabilities and $24.2 million in assets on Dec. 31, 1986, creating a $3.5 million insolvency.

Even without the state action, Homeland would have lost its ability to write insurance in July. Employers Reinsurance Corp. canceled Homelands's reinsurance effective July 29, said W. Mick Taylor, resident vp in the San Francisco office of Employers Re. Employers Re will consider renewing the contract if Homeland obtains a needed $6 million boost, he said.

Most of Homeland's policies require a 30-day cancellation notice. Thus, without reinsurance, it must cancel all policies by July 1.

"After that, it will be futile to proceed with the conservatorship," Mr. Rosen said. "If Homeland doesn't have the money by July 1, I will apply to the court to appoint a liquidator."

Homeland's troubles stem from business it wrote in Texas and Oklahoma in the early 1980s. Adverse claims experience forced Homeland to set aside $2.2 million in reserves, sapping its surplus.

Homeland lost $914,600 in 1984, and $1.8 million in 1985.

Hotel fined for safety violations

SAN JUAN, Puerto Rico—The Puerto Rican Occupational Safety and Health Office has cited the Dupont Plaza Hotel for 28 violations of the commonwealth's safety and health standards and proposed fines totaling $527,400 stemming from the New Year's Eve fire that killed 97 persons and injured 147 others.

The penalties are the largest ever proposed by a state- or territory-run occupational safety and health agency, said John A. Prendergrass, who heads the federal Occupational Safety and Health Administration in Washington.

The Puerto Rican investigation, aided by federal OSHA experts, found the apparent violations contributed to the magnitude of the disaster, Mr. Prendergrass added. Among the violations were inadequate and locked exits and completely blocked passageways.

An attorney for the hotel declined to comment.

The Dupont Plaza is believed to have had only $1 million in liability insurance at the time of the fire, written by an American International Group Inc. unit (*BI*, Jan. 12).

Panels to vote on disease bill

WASHINGTON—The House and Senate Labor committees are expected to approve separate versions of the controversial High Risk Occupational Disease Notification and Prevention Act this week.

The legislation, S.R. 79 in the Senate and H.R. 162 in the House, cleared the Labor subcommittees of both chambers late last month.

The proposal, among other things, would require employers to notify current as well as past employees who are or have been exposed to hazardous workplace substances that they should seek medical testing. Further, it would force employers to pay for the testing.

Employers contend the proposal would create billions of dollars of losses in tort and workers compensation actions (*BI*, April 27).

President Reagan has not yet taken a position on the legislation, but three Cabinet members—Attorney General Edwin Meese, Secretary of Labor William E. Brock and Secretary of Health and Human Services Otis R. Bowen—have advised him to veto it.

Firms fined in mine disaster

WASHINGTON—The Department of Labor's Mine Safety and Health Administration last week levied fines totaling $111,470 against the owner and operator of the Wilberg coal mine near Orangeville, Utah, where 27 employees died in a 1984 fire.

The civil penalties, which are the largest assessed in the past decade, are being appealed by Utah Power & Light Co., the Salt Lake City-based mine owner, and are expected to be appealed by Emery Mining Corp. of Provo, Utah, the former operator of the mine.

Federal officials levied the fines jointly against both companies for 34 violations. Emery agrees that it should be solely liable for any fines, a Utah P&L spokesman said.

Federal authorities are investigating whether criminal sanctions should be brought against officials of the companies. The fire occurred while supervisory personnel worked with miners to set a record for the amount of coal mined using a particular process.

Survivors' lawsuits against the companies in Utah district courts were settled in March for $22 million. But the settlement left in its wake an insurance coverage dispute in U.S. District Court in Salt Lake City between Utah P&L, which was an additional named insured on Emery's liability policy, and some of Emery's liability insurers. (Emery was protected from liability for the settlement by workers compensation law.)

International Insurance Co. of Chicago, which paid $10 million under a first-layer excess liability insurance policy, is seeking to recover its contribution by alleging, among other things, that it was misinformed about the extent of its risk.

Meanwhile, Utah P&L will amend a complaint it has filed to allege that Emery's excess insurers—Twin City Fire Insurance Co. of Minneapolis and First State Insurance Co. of Boston—which equally shared the next $20 million layer of coverage, have responded in bad faith by failing to contribute the remaining $11.5 million needed for the settlement, said David Westerby, Utah P&L staff attorney.

In addition, Utah P&L sued all its 34 liability insurers seeking clarification about its coverage.

And, Federal Insurance Co., which provided $500,000 in primary liability coverage, is seeking to recover from other Emery insurers some of the more than $700,000 spent on defense.

Continued on page 46

Insurers fear reform foes to capitalize on ISO study

By ROBERT A. FINLAYSON

The tort reform study released this month by the Insurance Services Office gives ammunition to groups seeking to block proposed tort reforms or to link those reforms to mandated reductions in liability insurance rates, insurance industry officials say.

In fact, officials of several insurance trade associations pressured ISO not to release the study for fear it would be "misused" by the Assn. of Trial Lawyers of America and other tort reform opponents to derail tort reform efforts, *Business Insurance* has learned.

"Politically, the full ramifications of this thing weren't discussed," commented one insurance industry official who asked not to be identified.

"Some state legislators are going to be shaking their heads after hearing us tell them for months how important tort reform is, and now we come out with a study that says the legislation they passed was meaningless," the official said.

But, ISO officials rejected suggestions that the study be buried, saying that it had launched the study with such fanfare that it would be impossible to conceal its results, industry sources say.

ISO officials declined to respond to repeated requests for an interview about the study.

The study is an analysis by 1,262 insurance claims professionals of the impact of current and proposed state tort law changes on six hypothetical claims files (*BI*, May 11).

The "Claim Evaluation Project" concluded that tort law changes made in 15 states last year would hardly reduce most liability claim indemnity costs.

However, the study also concluded that enactment of a package of three key tort reforms—elimination of joint and several liability, relaxation of the collateral source rule and a $250,000 cap on non-economic damages—would reduce indemnity payments substantially in the 24 states studied.

And, in a series of questions and answers about the study issued by ISO, the organization says: "It is clear from the study that meaningful tort reform will have a favorable, prospective impact on loss costs, which in time will be reflected in a state's and individual insurer's loss experience."

But, in releasing the study, ISO President Daniel J. McNamara repeatedly stated the indemnity payment reductions reported in the study could not be used as a basis for mandated insurance rate reductions.

"Although the project is based upon the best and most comprehensive information that could be collected and evaluated immediately, neither the design of the study nor its results are directly relevant to the issue of insurance pricing," Mr. McNamara said in a statement accompanying the study.

Despite this disclaimer, officials with insurance industry trade groups and state tort reform coalitions, along with several state regulators, contend the study will focus state legislators' attention on the impact tort reform could have on insurance rates.

"The study has a real potential for misuse," said Franklin W. Nutter, president of the Alliance of American Insurers. "It's an opinion survey of admit-

Continued on page 45

$30 million reserve set for Polish crash

By STACY SHAPIRO

LONDON—Aviation underwriters plan to establish a liability claim reserve of $30 million to $33 million to pay damages to relatives of the 183 people killed in this year's worst air crash, sources in London say.

Observers believe the liability reserve is high, considering that compensation for the 172 passengers on board the ill-fated Soviet-built Ilyushin 62M jet, operated by Polskie Linie Lotnicze airlines, would be restricted to liability limits for international flights under the Warsaw Convention and Montreal Agreement.

Under the agreements, an airline's liability is capped at $75,000 per passenger or, in this instance, a total of $12.9 million.

However, because the LOT airline flight was bound for New York from Warsaw when it crashed and carried 22 American citizens, liability costs may increase, some sources in London say.

"The liability limit is $75,000 per passenger under the Warsaw Convention unless there is a products (liability) involvement," said one London source who asked not to be identified.

"There is always a way to get around (the limit) in the U.S. by bringing in aviation products manufacturers who are not bound under the convention. But, we don't know who is involved yet or what caused the loss. And, there are no lawsuits yet."

LOT's hull insurance and liability insurance is placed with WARTA, the Polish state-owned insurance company in

Continued on page 38

Groups fight 'window' plan court decision

By STEPHEN TARNOFF

NEW YORK—Groups representing employers and workers approaching retirement age are squaring off over a court ruling that says employers offering early retirement—"window"—plans must prove the plans are voluntary and non-discriminatory.

Dallas-based Dresser Industries Inc. and the New York Chamber of Commerce & Industry are seeking a rehearing of the 2nd U.S. Circuit Court of Appeals decision in *Paolillo vs. Dresser Industries Inc.* In the March 10 decision, the court ruled that three former employees of a defunct Dresser subsidiary could sue Dresser for forcing them into a company "elective termination" program.

Opposing them are the three former Dresser employees that opted for the early retirement plan but subsequently sued the company; the National Council of Senior Citizens; and the American Assn. of Retired Persons.

In addition, the Equal Employment Opportunity Commission has filed an

Continued on page 4

inside

- The recently released "Claims Evaluation Project" sponsored by the Insurance Services Office is so bogged down by caveats it is of little value to either side of the tort reform debate, says this week's editorial. **PAGE 8**
- The liquidators of Oceanus Mutual Underwriting Assn. (Bermuda) Ltd. are appealing to creditors for funds to pursue claims against European reinsurers. **PAGE 15**
- At the Assn. of Private Pension & Welfare Plans' annual meeting, speakers advance ideas for reform of the U.S. health care system. **PAGE 19**
- Kathleen Utgoff, executive director of the Pension Benefit Guaranty Corp., predicts a new system for funding the PBGC is inevitable. **PAGE 20**
- Ontario's proposal to index pension benefits to increases in the cost of living has employers, including General Motors of Canada Ltd., crying foul. **PAGE 24**
- In Ask a Benefit Manager, Joseph Duva, director of employee benefits at Allied Signal Inc. in Morristown, N.J., reports the reasons behind the recent surge in health care costs. **PAGE 27**
- The House Ways and Means Committee approved legislation to cap out-of-pocket expenses for Medicare-covered services at $1,600 per year. **PAGE 29**

departments

Around the states 18
Ask a benefit manager 27
Books & ideas 28
Classifieds 42
Comings & goings: industry 14
Insurance services guide 46
Legal briefs 28
Letters 8
London 35
Markets 25
Opinions 8
Perspectives 27
Ticker 47
Washington 29
Worldwide 37

Vol.21, No.20—*Business Insurance* (ISSN 0007-6864) is published weekly at 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 313-446-1611. Copyright 1987 by Crain Communications Inc.

Overburdened

Guaranty funds in need of repair, experts contend

By KATHRYN J. McINTYRE

QUEBEC—The 18-year-old state guaranty fund system needs to be overhauled or replaced because the number and magnitude of insurer insolvencies have surged, two guaranty fund experts advise.

Assessments levied against insurers by guaranty funds "have increased dramatically and this raises questions concerning the capacity of the guaranty funds and the ability of the industry to continue to shoulder this burden," according to Kenneth H. Nails, senior vp of the Alliance of American Insurers.

In the last three years, guaranty funds have assessed insurers $948 million, compared with only $454 million during the preceding 14 years between 1969 and 1983, Mr. Nails reported.

The alternatives available to cope with the problem: Amend the state fund system or replace it with a federal guaranty fund, says Thomas W. Jenkins, a partner with the law firm of Lord, Bissell & Brook in Chicago.

Among the amendments to the state system Mr. Jenkins advocates is eliminating coverage for large corporations, which was proposed two years ago but rejected by the National Assn. of Insurance Commissioners (*BI*, Dec. 16, 1985).

Mr. Nails and Mr. Jenkins discussed the drain on guaranty funds and the resulting strain on insurers during the 65th annual meeting of the Alliance of American Insurers held last week in Quebec.

"If there is any one mechanism which personifies the fulfillment of a social purpose by the insurance industry, it surely is the guaranty funds," Mr. Nails observed.

State guaranty funds, which pay claims

Continued on page 40

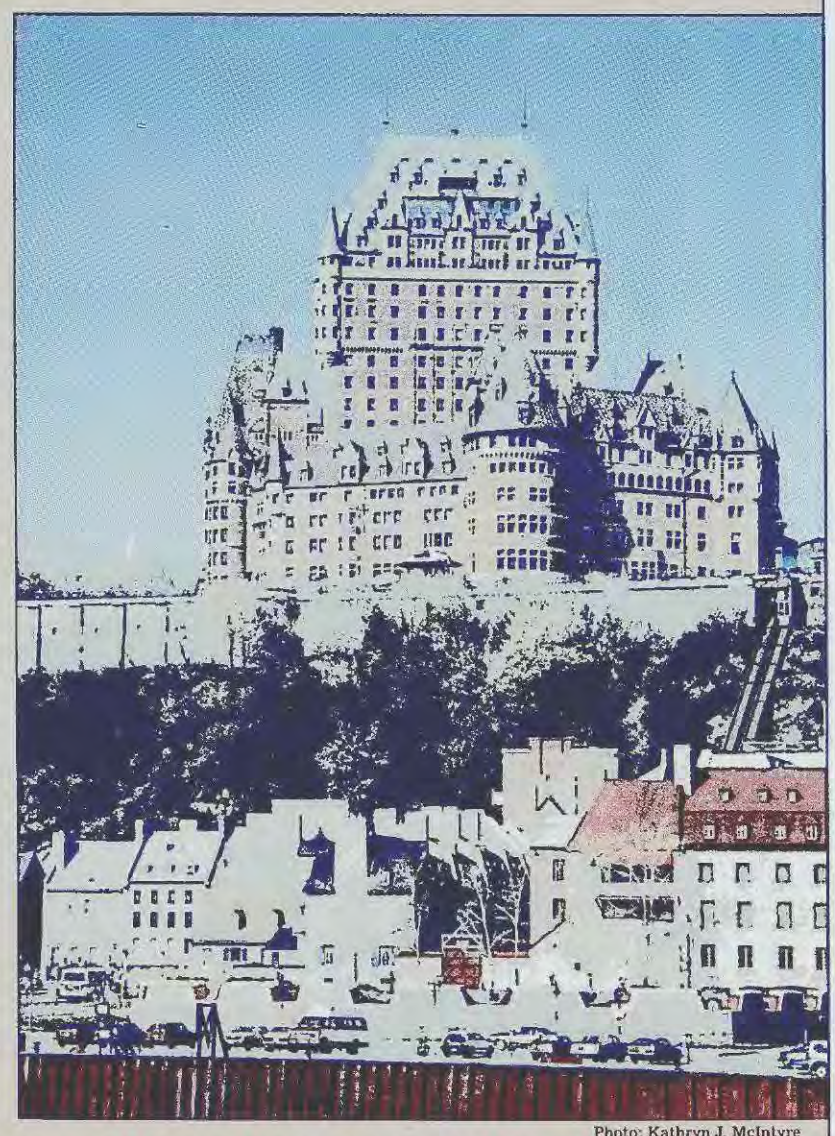


Photo: Kathryn J. McIntyre

The Alliance of American Insurers' 65th annual meeting was held at Le Chateau Frontenac Hotel, which dominates the skyline of the historic city of Quebec.

Exposure triggers liability coverage, federal court rules

By STEPHEN TARNOFF

SAN FRANCISCO—The first court decision interpreting California law on the trigger of coverage for long-latent disease claims says insurers on the risk when disease victims are exposed to a hazardous substance are liable.

In *Clemco Industries vs. Commercial Union Insurance Co.*, U.S. District Court Judge William H. Orrick ruled that Commercial Union must defend and indemnify Clemco for claims filed by individuals exposed to silica dust from 1970 until 1976, the time during which CU was Clemco's general liability insurer.

The court rejected CU's argument that it was only required to provide coverage for Clemco in cases where silicosis was manifested during the policy period. Silicosis is a scarring disease of the lung that results from inhaling silica particles.

In addition, Judge Orrick ruled that Clemco did not "expect or intend" silicosis to develop among individuals and, thus, coverage was not to be precluded on that basis.

He also ruled that CU was not liable for bad faith in refusing to defend or indemnify Clemco under the exposure theory.

Clemco currently faces more than 250 silicosis cases arising from its manufacture of sandblasting protection equipment, according to Clemco attorney Reuben J. Becker, with the Sausalito, Calif., firm of Silberman & Becker.

The suits allege that Clemco's equipment and a lack of adequate warnings contributed to the silicosis contracted by sandblasters using the equipment.

Clemco, which sought a ruling based on the exposure theory, was "very pleased" with Judge Orrick's decision, Mr. Becker said.

An attorney for CU could not be reached for comment.

The April 23 decision is the first to interpret how California law approaches the trigger of coverage in a long-latent disease case.

However, the ruling comes at a time when four asbestos producers and dozens of their liability insurers are litigating in San Francisco Superior Court over very similar coverage issues involving asbestos-related diseases. That litigation is the biggest insurance coverage case ever (*BI*, March 16).

Judge Ira A. Brown Jr., who is presiding over the San Francisco litigation, is expected to announce his decision on the trigger and scope of coverage for the asbestos

Continued on page 6

RIMSNET may feature S&P insurer ratings

By MEG FLETCHER

NEW YORK—Risk managers soon may be able to use their personal computers to call up insurance company ratings through the information and communication network service recently introduced by the Risk & Insurance Management Society Inc.

The ratings, from New York-based Standard & Poor's Corp., would complement the daily news, information and communication features already available to subscribers of the RIMSNET service, which was introduced by RIMS in March.

S&P representatives hope to work out an agreement with RIMS officials at a meeting on Wednesday, said Bill O'Neill, S&P's director of marketing.

"It is very close," he said, noting that the reports are expected to be available through RIMSNET in early June. "We are all set up to go," Mr. O'Neill added.

S&P rates insurers' claims paying ability, assigning ratings from AAA to D—for a company in default (*BI*, March 17, 1986). S&P performs a qualitative review of an insurer's managers and their abilities to perform, Mr. O'Neill said, noting that S&P reviews those insurers that request a rating.

The addition of S&P's ratings would make "a big difference" to some current and potential RIMSNET users, according to William L. Mather, administrator-risk management at The Gillette Co. in Boston and RIMS' most recent past president.

Mr. Mather noted that besides expanding the RIMSNET service, the ratings may make the service more cost-effective for risk managers if they currently are paying for S&P's ratings alone.

S&P's proposed services will be provided to RIMSNET free of charge, Mr. O'Neill said.

S&P also plans to market a more comprehensive insurance rating publication, which will cost between $1,000 and $1,200 annually. It will include a list of the insurers that have requested S&P to rate them, an explanation of how they are rated and more detailed individual company reports, Mr. O'Neill said.

Thus far, more than 100 persons are participating in RIMSNET, and more requests are being received daily, according to Brynell Somerville, RIMS' network manager.

"Overall interest in RIMSNET has already exceeded our expectations," said Ron Judd, RIMS executive director. However, Mr. Judd said he would like to see more people participate in the network.

RIMSNET reports and data base include information about employee benefit topics as well as property/casualty topics, Mr. Judd noted.

RIMS officials credit Henry Peterson, assistant vp-risk management for Chicago-based Budget Rent a Car Corp., as the program's originator and prime mover.

Continued on page 38

Helicopter services buffeted by spiraling insurance costs

By MEG FLETCHER

Some emergency medical service helicopter operators are facing perhaps their greatest challenge: rescuing their own operations from insurance market turbulence.

Poor loss experience is hovering over operators of rescue choppers, and some underwriters of helicopter liability and hull coverage have responded by increasing rates as much as 300% to 900% while tightening underwriting guidelines.

The liability experience of some helicopters used in high-risk work, such as in EMS operations, "has been extremely poor for all markets," noted a major aviation underwriter who asked not to be identified.

Insurers have been paying out about $2 in claims for every $1 in premium collected, the underwriter pointed out.

As a result, "prices are definitely going up" for helicopter liability and hull coverage, the aviation underwriter said.

Major U.S. markets writing helicopter coverage include U.S. Aircraft Insurance Group in New York; Associated Aviation Underwriters in New York; Southern Marine & Aviation Underwriters Inc. in New Orleans, which writes on behalf of Transamerica Insurance Co., Americas Insurance Co. and Lloyd's of London syndicate underwriters; and Aviation Office of America Inc., which writes on behalf of U.S. Fire Insurance Co. and American Eagle Insurance Co.

Rate increases are stabilizing, some say, but underwriters still are compounding operators' insurance troubles by limiting liability coverage for passenger injuries or deaths.

Because of insurance market conditions, several EMS helicopter operations have "just closed their doors," said Kenneth K. Woolnough, director of safety and

Continued on page 31



Photo: Bell Helicopter Textron Inc.

A turbulent insurance market and poor loss experience are forcing EMS helicopter operators to improve their risk management programs.

Window plans

Continued from page 2

amicus curiae brief with the appellate court questioning parts of the decision.

According to Dresser and the New York Chamber, particularly onerous findings by the court include that:

- Employees can pursue discrimination claims under the federal Age Discrimination in Employment Act merely by showing they were between 40 and 70 years old and employment ended because of an early retirement plan.
- The burden of proving the employees entered the plan voluntarily is on the employer rather than the employee.
- The employer cannot use economic hardship to justify the plan; it must show "age-related cost justifications" for restricting eligibility for the plan to a certain age group—in this case 60 or older.

"The panel's decision is certain to have a chilling effect on any employer's decision to reduce its workforce and corresponding labor costs through the medium of voluntary attrition rather than wholesale involuntary layoffs," says Dresser's petition for rehearing.

Representatives of employers and employee benefit consultants said the decision as it stands will put a greater burden on employers.

"Sweeping assertions in this court's panel opinion undermine the presumptive lawfulness. . .of the thousands of voluntary age-based 'window period' early retirement and incentive retirement plans—and by logical extension all retirement plans in which age is a criterion," says the New York Chamber's amicus curiae brief in support of a rehearing.

"The onerous and unprecedented evidentiary burdens imposed by the court on employers to justify 'window period' plans will make it virtually impossible to sustain them and thus will precipitate a flood of unwarranted ADEA litigation," the Chamber's brief asserts.

"It's bad news for employers, but the question is how bad?" said Henry von Wodtke, a benefits consultant with Buck Consultants Inc. in New York.

However, the employees and groups representing older employees argue that employers are exaggerating the potential consequences of the ruling and that reversing the ruling could hurt older employees.

"The National Council of Senior Citizens submits that the court correctly decided the appeal on a narrow issue, unique to the case before it, and rendered a decision which, in fact, was in keeping with established case law," it said in its brief to the appellate court.

"If the court were to repudiate either the reasoning or the outcome of its prior decision, this case could have devastating consequences for older Americans who may find themselves targets of discrimination by employers attempting to secure their involuntary separation from employment," says the brief filed by the American Assn. of Retired Persons.

The three employees in the case, who worked for Dresser's now-defunct Whitney Chain division, retired in 1982 under an "elective retirement program" that was offered to all employees aged 60 and older.

Whitney Chain first announced the program on Oct. 12, 1982, at a meeting between the division's operations manager and all eligible employees.

A letter given employees at the meeting said Whitney Chain was instituting an overall cost reduction plan because of economic problems. The letter stated that participation in the program was "totally voluntary," but that employees were required to return the election form by Oct. 18—six days after they were first informed of the plan.

Because a description of the plan benefits was not included with the announcement, two of the three plaintiffs met with company representatives on Oct. 15 to discuss the program.

All three signed program enrollment papers by Oct. 18, and their employment ended on Oct. 31, 1982. The three employees subsequently filed age discrimination complaints with the state fair employment practices agency and the EEOC. They also sued Dresser in U.S. District Court in New Haven.

A major issue was whether Dresser had forced the employees to enter the retirement plan in violation of ADEA, which protects persons 40 to 70 years old from discharge because of their age.

Section 623 (f)(2) of the act allows an employer to maintain a bona fide seniority system or employee benefit plan that is not a subterfuge to evade the purposes of the act. But it dictates that "no such plan shall require or permit the involuntary retirement of any individual. . .because of the age of such individual."

U.S. District Court Judge Peter C. Dorsey granted Dresser's motion for summary judgment, noting that the employees had failed to establish the elements necessary to proceed with their case and that the burden of proof was on the employees to show that they left Whitney Chain's involuntarily.

Judge Dorsey ruled evidence showed the employees acted voluntarily, because they:

- Did not request additional time to decide whether to take early retirement.
- Did not make it known that they felt great pressure from the deadline.
- Each signed an acknowledgment stating that the choice was freely made.

The appellate court, however, reversed the ruling.

"We conclude instead that appellants in this case established a prima facie case by showing that they were between 40 and 70 years old, and that their employment at Whitney Chain ended pursuant to an early retirement plan," the appellate court said.

"The burden is then on the employer to show that appellants voluntarily chose early retirement."

The court also found that Judge Dorsey erred in finding that the employees had acted voluntarily.

"Together with Whitney Chain's duty to insure that appellants were actually making voluntary decisions, the shortness of time given to appellants to make a decision, the reason for the compressed time period, the length of service of appellants with Whitney Chain and the apparent complexity of the options opened to them certainly raised a material issue as to whether appellants were given sufficient time to make a considered choice," the appellate court said.

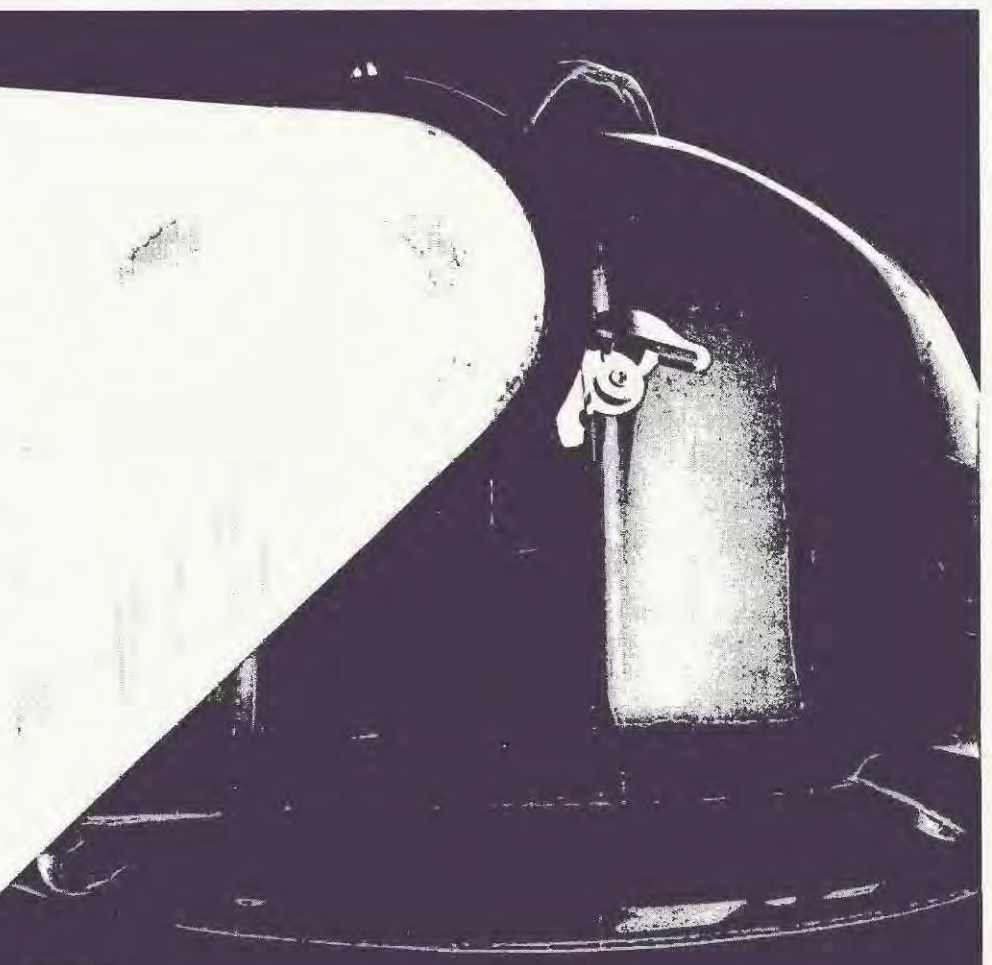
The court also ruled that Whitney Chain did not show there were "age-related cost justifications" in making only employees aged 60 and over eligible for the plan.

"Whitney Chain may not use economic hardship as an excuse to reduce, in an arbitrary and discriminatory manner, the number of older employees in its work force," the appellate court ruled.

"Whitney Chain must show not only that economic problems forced it to institute a voluntary early retirement plan to reduce labor costs, but also that a plan confined to employees aged 60 and over produces greater economic benefits than a plan available as well to employees under 60," the court added.

Both issues of whether the employees acted voluntarily and whether there was a subterfuge because there were no "age-based cost justification" are to be considered by the district court at trial, the court said. ■

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Exposure theory

Continued from page 3

producers and on the insurers' duty to defend on May 29. It is uncertain what impact the Clemco decision may have on Judge Brown, although a copy of the decision has been submitted to him.

According to Judge Orrick's decision in the Clemco case, Clemco's primary general liability insurance was written by five different insurers during the period it manufactured the sandblasting equipment. Clemco requested that all five defend and indemnify it against the lawsuits under the exposure theory, and only CU refused to do so.

CU wrote coverage for Clemco from August 1970 to October 1976 under three consecutive comprehensive general liability policies.

Clemco's other primary insurers include Zurich American Insurance Co., which wrote coverage for Clemco from January 1956 until January 1961; Transamerica Insurance Co. from February 1961 until July 1970; Central National Insurance Co. from October 1976 until October 1979; and American Universal Insurance Co. from October 1979 until October 1980.

The major issue in the decision was determination of when "bodily injury" in the form of silicosis occurred based on the language of the policies: at the time the victim is exposed to silica dust; when the disease manifests itself, which is often many years after exposure; or at some other time.

So far, various state and federal courts have ruled in various ways on the issue, mostly in the context of asbestos cases. The major theories include:

- Coverage is triggered upon inhalation or exposure of the substance. This is known as the exposure theory.
- Coverage is triggered when the disease is manifested in the victim, such as by symptoms of the disease. This is known as the manifestation theory.
- Coverage is triggered during exposure, manifestation and the intermittent latency period. This is the broadest theory of coverage, known as the triple-trigger or continuous trigger theory of coverage.
- Coverage is triggered when there is determined to be an "injury-in-fact" in the victim.

Although most policyholders seek to have the triple-trigger approach applied, Clemco sought the exposure theory.

Clemco argued that silicosis, similar to asbestosis, begins shortly after initial exposure to the silica dust particles. Even though the victim may not be diagnosed as having contracted silicosis until many years after exposure, Clemco argued the disease "occurred" upon initial exposure for purposes of triggering the policy.

CU argued, however, that the victim and the entire medical profession are unable to pinpoint precisely when the inhalation of silica becomes a disease. The insurer contended that the only time there is certainty when silicosis occurs is at the time of manifestation, which in most cases is the time of medical diagnosis.

In his decision, Judge Orrick noted that although there has been a split among federal judicial circuits concerning the trigger of coverage in asbestos cases, the majority have found that the exposure theory applies.

"Indeed, the exposure theory appears to be the 'trigger theory' that is the most reasonable, administratively workable and consistent with the intent of parties entering into CGL policies," Judge Orrick said.

In finding for the exposure theory, Judge Orrick relied on federal appellate court decisions in *Hancock Laboratories Inc. vs. Admiral Insurance Co.* and *Forty-Eight Insulations Inc. vs. Insurance Co. of North America.* He also looked to the medical evidence presented at trial concerning silicosis and its similarity to asbestosis.

The Hancock Laboratories case involved a dispute over coverage for liability arising from the implantation of a faulty heart valve. In the decision, the 9th U.S. Circuit Court of Appeals, which includes California, compared the spread of bacterial infection resulting from the faulty valve to asbestosis.

The 9th Circuit said that the California Supreme Court probably would adopt the decision by the 6th U.S. Circuit Court of Appeals in the Forty-Eight Insulations case, which found that the exposure theory applied in an asbestos coverage dispute.

As a result of these decisions, Judge Orrick said the California Supreme Court would adopt the exposure theory. Judge Orrick also found that the medical evidence of silicosis presented at trial backed the exposure theory.

"In an individual who is exposed to heavy doses of silica particles and who is later diagnosed as (having) silicosis, it is clear that the individual suffered permanent and irreversible injury to his lungs in the form of fibrosis within the first few weeks of exposure," he said. "It is also clear that, for that individual, the disease of silicosis has 'occurred' within the first few weeks of exposure."

Judge Orrick rejected CU's argument that there could be no certainty that the disease was present in the individual and thus there could be no occurrence until the individual was diagnosed as having silicosis.

"The disease must have 'occurred' well before the actual diagnosis if the impetus for the visit to the physician was the fact that the individual suffered from serious health deficiencies as a result of the disease," he said.

Judge Orrick also found that the pathogenesis of silicosis is similar to that of asbestosis in all relevant respects for determining the trigger of coverage under the policies.

"Although silicosis differs from asbestosis in some respects. . .the similarities between the two diseases are overwhelming," he said.

"The court finds that the pathogenesis of silicosis and asbestosis are sufficiently similar to justify similar treatment in choosing the proper trigger for insurance coverage under the policies at issue," Judge Orrick summarized.

"Therefore, the court adopts the reasoning of the 9th Circuit in *Hancock Laboratories* and the 6th Circuit in *Forty-Eight Insulations*, and finds that under the policies at issue, the exposure theory will be the proper trigger of coverage."

Judge Orrick next found that CU failed to show that Clemco "expected or intended" the losses for which it seeks coverage, which would have precluded coverage under the CU policies.

"Clemco did not expect or intend that the users of its products would contract silicosis, or that these users would file suits against Clemco alleging that its products failed to protect against silicosis," the judge said.

Finally, Judge Orrick ruled that CU did not act in bad faith by refusing to defend and indemnify Clemco under the exposure theory.

"Commercial did not act in bad faith merely by refusing to embrace the exposure theory when the trend of authority appeared to be heading in that direction. There was ample room for intelligent disagreement on the choice between the exposure theory and the manifestation theory as concerns the policy at issue," the judge said.

"Commercial should not be held liable for a difference of opinion. It did not act unreasonably, with intent to avoid clear obligation, or with any intent to deny Clemco coverage under the policies without justification," Judge Orrick added. ■



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opinions

Unconvincing evidence

UNPRODUCTIVE DEBATE is bound to erupt over the recently released "Claims Evaluation Project" sponsored by the Insurance Services Offices (see story, page 2 and *BI*, May 11).

The project, which was a survey of claims adjusters' opinions on how certain tort law changes would affect the cost of indemnity payments for six hypothetical claims, is going to be used by both sides in the tort reform debate to promote their own causes.

The problem: The study is so bogged down by caveats it has little value to either side.

Nonetheless, we expect to hear the results of this study quoted—and misquoted—ad nauseam in the coming months when the subject of tort reform is debated.

Those arguing for linking mandated insurance rate cuts to tort law changes will say the study shows that there are expected reductions in claims costs when certain tort law changes are implemented, so there is no reason not to link the two. We can envision legislators waving about charts from the study while demanding specific and immediate reductions in insurance rates if tort reforms are passed. We can just hear a legislator arguing that if joint and several liability is abolished, liability insurance rates should be cut in half.

That, of course, would be absurd, based simply on the opinion of the claims adjusters that the indemnity value of a certain mythical claim involving multiple defendants would drop more than half in most of the 24 studied states if there were no joint and several liability. In three other mythical claim situations, the expected decrease in indemnity value was much less, while joint and several liability is not a factor in single-defendant claims.

We also expect those opposing any tort law changes to cite the findings that tort changes passed by 15 states in the study generally will have little impact on the indemnity value of most liability claims and to argue that if claim costs aren't going to go down, why restrict citizens' rights to recover damages in tort cases.

Meanwhile, those promoting tort reform will say the study shows that tort reforms enacted so far were too watered-down to be effective. They will promote the findings that significant indemnity claim payment savings could be expected when three specific tort reforms are enacted together: abolition of joint and several liability, substantial relaxation of the collateral-source rule and a cap of $250,000 on non-economic damages.

Never mind on all counts that on every single page of the study that reports the claims adjusters' opinions there is printed in bold type: "Note: The estimates obtained in these standardized claim contexts cannot be generalized to the full claim portfolio of any insurer or to that of the insurance industry as a whole. Therefore, the results are not directly relevant to issues of insurance pricing or rate regulation."

Most readers of this study will be as persuaded by this disclaimer as smokers are by the surgeon general's warnings on packs of cigarettes.

We have called on the insurance industry in the past to provide statistics that will contribute meaningful information to the public debate on tort law changes. We are sorry to say this study falls short of the credible information that the public needs in analyzing the cost of current tort laws and the effect that tort law changes could have on future claims costs.

We hope the "ISO Claim File Analysis," due in late 1988, will be more useful.

letters

Michigan proposal would beef up pool regulation

To the editor: The Michigan House of Representatives is considering a bill that would give the Michigan Bureau of Insurance jurisdiction over municipal pool programs, which heretofore have been essentially unregulated in the state of Michigan (*BI*, March 9).

The act that enabled municipalities to form self-insurance pools assigns all regulatory authority to the Department of the Treasury, which has not been able to perform any true regulatory functions because the department is not staffed by persons with either the necessary training or experience. Hence, legislation has been proposed to bring the pools under the jurisdiction of the Insurance Department and to provide for minimum reserving, actuarial review, etc.

It is interesting to note that Wade Waterman, the risk manager for the Michigan Municipal Risk Management Authority, in his April 1987 newsletter to the membership states: "Currently, it is the risk manager's opinion that substantial additional funding will be necessary to have each member's loss fund meet statutory requirements as if this were a casualty insurance carrier."

This raises the question: Are the substantially lower costs that MMRMA has developed for its members a function of efficiency and better claims handling—as has been maintained by the risk manager and insurance agents selling the program—or are the lower costs really a function of a poorly funded program that could not withstand the financial impact of adverse loss experience?

One of the real weaknesses of any pool involving a homogenous group is pointed out rather succinctly by Frederick W. Beck, executive vp and general counsel for the Alliance of American Insurers (*BI*, April 27):

"The insurance mechanism is based upon the spread of risks among a number of different industries, while risk retention groups are not. 'Any major court decision or any new break in technology to discover new carcinogens or pollutants strikes all of them equally across the board. There is no diversity in a membership of a risk retention group. To me, it seems an awful lot like sending the sister ship of the Titanic into the ice floes to pick up survivors.' "

Municipal pools are much like a risk retention group in that they are made up of a homogenous group of municipal entities that are subject to very similar potential for loss. Not only are these groups not diverse in the type of exposures that they face, but are even less diverse in that they are all located within the confines of one state making them, as a group, very susceptible to any change in legislation or court decisions.

The reserving requirements laid out by the proposed House bill are set up as the *minimum* requirements for a casualty company operating in the state of Michigan. These minimum standards have proven, particularly over the past two or three years, to be in many cases inadequate and certainly should not be characterized as being guilty of overkill in the establishment of reserve requirements. Certainly the experience of Transit Casualty, Mission Insurance and Ideal Mutual, to mention just a few, are prime examples of the reasons that minimum requirements are absolutely necessary to protect the policyholders utilizing these pools.

Further, municipalities are public institutions in which decisions are made by persons who manage these pools on behalf of hundreds of thousands of taxpayers, who are ultimately the persons who will be injured should the funding and reinsurance arrangements of these pools prove inadequate.

If Mr. Waterman is correct in his forecast that considerable additional cost will be involved in funding this pool per the requirements of this bill, it would appear that the MMRMA is not as efficient as it has been represented to its membership. Rather, perhaps, this pool has operated as an insurance mechanism that has enabled its members to spend less money in exchange for far less security.

Dale K. Larson
Senior Vp
Corroon & Black of Michigan Inc.
Livonia, Mich.

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Facts not correct in RTD audit story

Two facts as alleged in the story, "Audit Rips RTD Claims Manager," (*BI*, April 27) are incorrect.

You state the mismanagement of accident and insurance claims cost the Southern California Rapid Transit District between $16 million and $24 million over the past two years. The article also claims that "the Southern California Rapid Transit District board voted Thursday to fire Leonard J. Russo Insurance Services Inc. . . ."

The board did not fire its claims ad-

Continued on page 10

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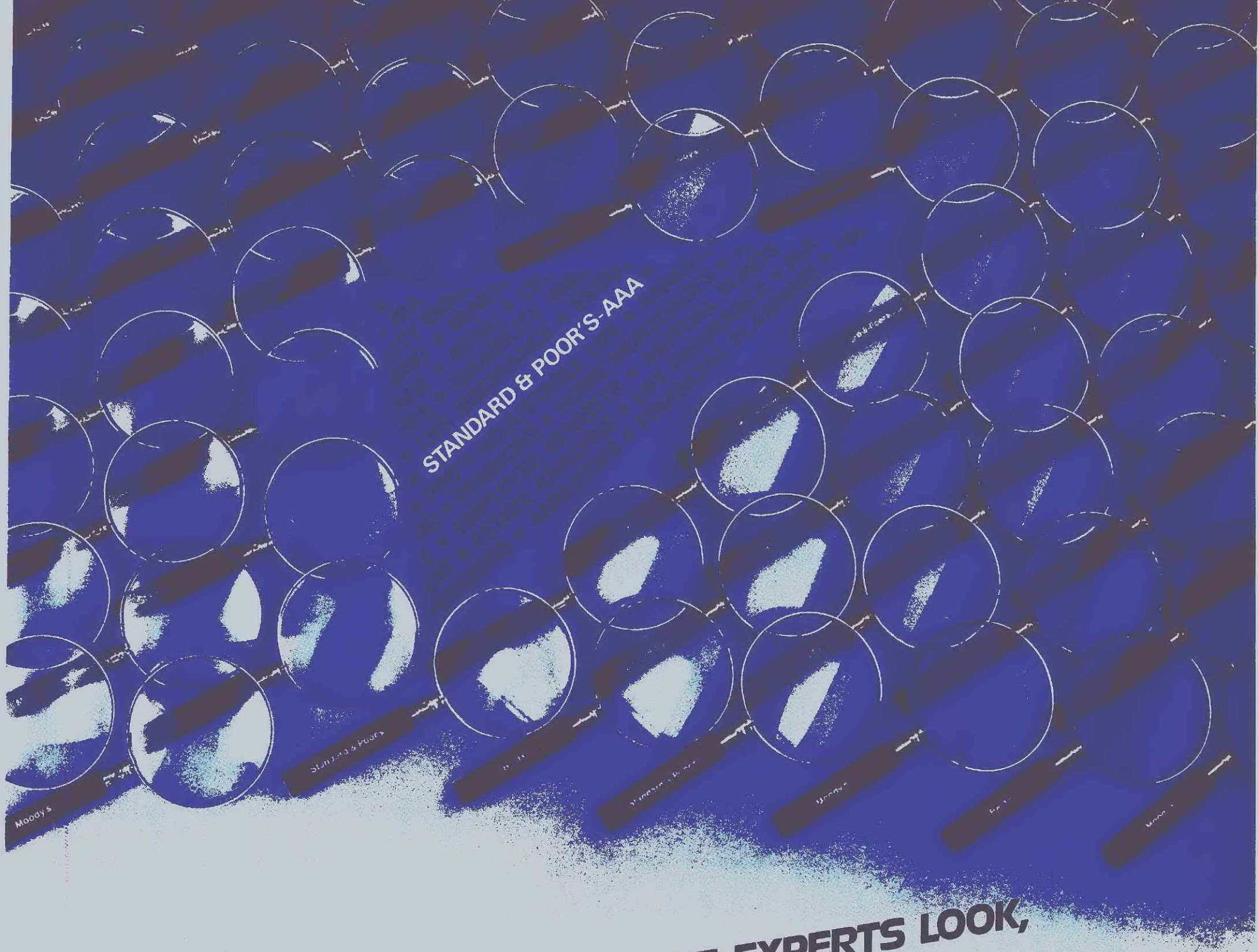
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letters

Continued from page 8

ministrator, LJR Insurance Services Inc. The board extended its contract six months, and simultaneously gave notice that it intended to issue an RFP (request for proposals) and go out to bid. This action was not necessarily to obtain a new claims administrator, but instead to issue a new contract, because the old contract is not sufficient to cover the operation as it exists today.

In addition, your dollar figure is incorrect in that the cost of the entire claims program for one year is only slightly greater than that dollar amount.

It is unclear from your story exactly were your figures were obtained. They were not set forth in the executive summary of the Fisher & Associates audit report.

Richard D. Hughes
Hughes & Crandall
Studio City, Calif.

■ *Business Insurance intended to state that the claims totaled $16 million to $24 million and regrets that the sentence structure used could have misled readers. The other facts as stated by Mr. Hughes, an attorney for Leonard J. Russo Inc., were stated in the original story.*

RIMS successful in spite of Vegas

To the editor: Having been deeply involved in the effort to make the 1987 Risk & Insurance Management Society conference in Las Vegas the success that it was, I take great exception to S.J. Davidian's letter (*BI*, April 27).

The 1987 Conference Committee voiced deep internal concern as early as April 1986 (our first meeting) as to the difficulties associated with running a convention in Las Vegas, and the associated problems of overcoming the Las Vegas stigma. Most people don't understand that there are a limited number of cities within North America that can provide facilities for such a large gathering. Furthermore, RIMS conference sites must be selected years in advance to guarantee space. Locations are already being considered for the year 2000.

In spite of the negative connotations associated with Las Vegas, the 1987 conference was the best-attended, best-exhibited conference in the history of RIMS.

As to the matter of the need to gamble—due to conference responsibilities, I was required to spend almost two weeks on-site—I may have spent an hour or two in the casinos. Never once was I made to feel uncomfortable by hotel personnel, nor did I find them to be rude or abusive. I don't remember being branded as a social outcast for not participating in Las Vegas' chief attraction.

Craig N. Gass
Manager
Peat Marwick Main & Co.
New York

Carefully choose investment adviser

To the editor: I would like to endorse the points made in the article "Picking Investment Manager is not Easy" (*BI*, March 30). As the chief marketing officer of Washington Square Advisers, a firm specializing in portfolio management for insurance companies, I can say from experience that Mr. Hardy and Mr. Geniser were on target with their comments. The selection of an appropriate investment manager is worth careful deliberation.

I would like to offer one additional observation that the article did not bring out. In choosing an investment manager, captive reinsurance companies—in fact, insurance companies of all kinds—should consider the degree of understanding of their business that an investment manager has. The vast majority of investment managers today are oriented toward a non-taxable client base such as pension and endowment funds. Captive reinsurers face a variety of issues that affect their investment strategy—not only taxes but also the nature of their liabilities, laws and regulations, etc. An investment manager that does not understand these issues or appreciate their impact on investment performance will not do the best job for the insurer.

Another point to remember is that the personal chemistry between an insurer or reinsurer and its investment adviser is also an important factor. The chemistry is much more likely to be good if the adviser understands the client's business and the two can speak the same language. The better the two communicate, the more successful the investment strategy will be in achieving the company's goals.

John A. Maschoff
Senior Vp-Investment Services
Washington Square Advisers
Minneapolis

Pollution decision is poor justice

To the editor: Your article on Middlesex County Superior Court Judge Joseph Sadofski's ruling that developer Summit Associates Inc. could recover for pollution to its own land, despite a specific policy exclusion, proves that justice is not only blind but political as well (*BI*, April 27).

Just when we thought the judicial and legislative pendulum was finally swinging back to middle ground, we get Judge Sadofski reaching deep into the pockets of Liberty Mutual Fire Insurance Co. Edison Township sells polluted land, orders the buyer to clean it up and pulls it off with the help of the Superior Court.

This ruling attacks our free enterprise system. Liberty Mutual is being told that it is no longer allowed to decide what risks it wants to insure. Soon all insurers will be forced to use the absolute pollution exclusion. Is that against public policy Judge Sadofski?

Thank you, Judge Sadofski, for taking us one step closer to federal intervention and regulation. Think what a wonderful world it would be if attorneys were banned from legislative and judicial appointments.

Anthony J. D'Asaro
Jackson & D'Asaro Insurance Brokers Inc.
Huntington Beach, Calif.

Transportation suits costly

SOLON, Ohio—One-quarter of all transportation product liability lawsuits resulted in verdicts of $1 million or more, according to Jury Verdict Research Inc.

The research firm analyzed product liability suits involving transportation products, including autos, aircraft, trucks, buses, motorcycles and boats.

The firm also found that plaintiffs recovered an award in 70% of cases brought against aircraft manufacturers.

Of the transportation products surveyed, the largest number of $1 million awards occurred in suits against commercial airliner manufacturers, as well as the manufacturers of helicopters, small planes, ultralight aircraft and gliders.



JUDGMEN

Retiree flex plan

Continued from page 1

benefit consultant Towers, Perrin, Forster & Crosby, which helped Pillsbury design the plan.

Pillsbury had several objectives in mind when it decided to design and implement the plan, noted Ms. McArdle and Mr. Kuhlman:

- The plan had to help control and manage the future costs of retiree health plans.
- Pillsbury wanted a plan that would enable it to provide these benefits in a competitive manner based on an equitable measure, such as benefits based on years of service.
- And, Pillsbury wanted to try to "position ourself better for future retiree medical liabilities," Ms. McArdle said, referring to the Financial Accounting Standards Board's proposed accrual accounting standards for future retiree health care liabilities.

The plan, which was implemented on Jan. 1, is available to all salaried and non-union hourly future retirees at Pillsbury's three divisions: Pillsbury Co.; Burger King restaurants; and Steak & Ale restaurants.

The plan was concurrently implemented with flexible benefits for Pillsbury's active employees.

Workers retiring this year receive 1,400 benefit credits for each year of service with the company, up to a maximum of 30 years.

Retirees each year decide how many credits they wish to spend to buy health care, dental and life insurance benefits for themselves and their spouses.

"Retirees can either spread the credits over their lifetime or they can choose a 50% joint and survivor allotment," under which the retiree or spouse would receive 50% of the allotted credits upon the death of either person, noted Ms. McArdle.

Workers who retire before age 65 also can choose whether they want to spend all of their credits before age 65, when Medicare becomes the primary health care payer.

Under the plan, retirees have a choice of five medical plans, one dental plan and the opportunity to purchase up to $50,000 worth of term life insurance.

Retirees who retired prior to the Jan. 1 implementation date already were receiving non-contributory lifetime medical benefits and were not given benefit credits, Ms. McArdle said. However, they were offered the opportunity to opt for a less rich medical option and, in return, receive dental and life insurance coverage. Or, they could retain their current coverage and purchase dental or life insurance through deductions from their pension benefit checks, she said.

About 400 retirees who had retired before Jan. 1 decided to make benefit changes, she said.

Pillsbury each year can increase or decrease the amount of company-provided credits awarded to future retirees as needed to control retiree health costs.

"The cost control in the future comes in setting the credits. Obviously, the cost of the five (health plan) options will increase, but if the credits are kept level, more of that cost will be passed on to retirees" because if credits are not increased to match higher plan costs, retirees will not be able to "afford" more generous benefit options, explained Mr. Kuhlman of TPF&C.

Currently, the cost of the medical options ranges from 2,640 to 3,140 credits annually for a retiree and one dependent both under the age of 65, and from 414 to 858 annually for a retiree and one dependent over 65.

The cost in credits varies for the two age groups because at age 65 Medicare decreases Pillsbury's costs, Mr. Kuhlman said.

All of the medical options are self-insured, with claims administered by ALTA Health Strategies Inc. of Salt Lake City.

Retirees pay varying copayments under each option, depending on the division of the company in which they worked. Retirees do not contribute to the monthly premium under any of the options.

The options are:

- The richest option, which also costs the most credits, requires retirees to meet an annual $25 deductible.
- The "core" option, which is identical to Pillsbury's previous retiree health benefit plan, requires retirees to meet an annual deductible of $50, plus a varying copayment.
- A third option requires retirees to meet a $150 annual deductible.
- Under a fourth option, retirees must meet an annual deductible of $250, plus the copayment.
- The fifth option, which costs the fewest credits, requires retirees to meet an annual deductible of $500, plus the copayment.

There is a $500,000 lifetime coverage limit under all five medical options.

Retirees also can contract with any health maintenance organization, in which case Pillsbury will contribute up to $1 toward the HMO premium for each credit the retiree has available for health coverage.

In addition to the medical options, retirees also can purchase dental coverage with their credits. The company previously did not offer dental coverage to retirees.

The dental plan is self-insured, with claims administered by ALTA.

The plan covers preventive and major treatment, Mr. Kuhlman explained. Retirees must pay a $50 annual deductible and a 30% copayment for preventive services, like X-rays, and a 50% copayment for major services, like fillings and crowns.

There is a maximum annual coverage limit of $1,000.

Dental coverage costs 290 credits annually for a retiree and one dependent.

Retirees in the flex plan also can use their credits to purchase up to $50,000 in life insurance in $1,000 increments. These retirees also receive a $3,000 "burial benefit" from Pillsbury.

The company provides retirees who retired prior to Jan. 1 with half the life insurance benefit they received as an active employee until they reach age 65. The amount of coverage is then gradually reduced as the retiree ages.

The number of credits retirees covered under the flex plan must spend for life insurance coverage, which is underwritten by New York-based Equitable Life Assurance Society of the United States, varies depending on the age of the retiree and the amount of coverage they purchase.

Because the cost of the coverage increases with age, retirees can spend more credits each year to keep the same coverage or pay the same number of credits each year to purchase decreasing limits, Mr. Kuhlman said.

However, "if the retiree dies in the first year of coverage, the beneficiary receives the refunded premium as a death benefit," he added, to guard against retirees with only short life expectancies from opting for high levels of life insurance.

Any benefit credits not used in a given year are placed in a spending account, where the credits can be used in future years.

The Internal Revenue Service rules governing flexible spending accounts, to which employees defer pre-tax income, do not apply to the Pillsbury retiree credits because Pillsbury, not the employee, is funding the credits. In a typical spending account, amounts not used by the end of a plan year must be forfeited. ■



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British election spurs legislative flurry

By STACY SHAPIRO

LONDON—Three major pieces of legislation watched by the London insurance market and British risk managers are expected to be enacted following Prime Minister Margaret Thatcher's decision to call a general election June 11.

The bills, along with several others, were rushed through Parliament last week and were expected to receive royal assent.

Parliament will be dissolved today to make way for three weeks of campaigning before the election.

As a result of the speed in which the legislation was passed, the Conservative government's Finance Bill will exclude a clause that could increase Lloyd's of London members' taxes and potentially reduce Lloyd's membership, according to a Treasury department spokesman.

The government had inserted a clause in the Finance Bill that would treat for tax purposes the funds that Lloyd's syndicates set aside to cover future claims similarly to insurance companies' loss reserves. This meant that the funds, known as reinsurance-to-close premiums, would be subject to review by the Inland Revenue and would be tax-deductible only if based on adequate evidence or data.

This potentially could increase Lloyd's members' tax liability, which Lloyd's feared could lead to a reduction in membership and a decrease in market capacity (*BI*, May 4).

Lloyd's members and underwriting agents strongly lobbied in Parliament against the clause. The government was forced to delete the clause from the Finance Bill to push the legislation through Parliament before it is dissolved.

The Finance Bill will exclude a clause that could increase Lloyd's of London members' taxes.

However, the proposal will be included in new legislation submitted when Parliament reconvenes in July if the Mrs. Thatcher's Conservative Party wins next month's election.

"The chancellor of the exchequer has said that if the Conservative government returns, he will reintroduce those clauses which were taken out of the Finance Bill as soon as possible," noted a Treasury department spokesman.

And, the Lloyd's tax issue will not die if the Conservatives lose the election and either the Labor Party or the SDP/Liberal Alliance take control of the government, the spokesman noted.

"There is a bipartisan feeling on this," he said.

In addition, the Consumer Protection Bill, which will enact the European Community's product liability directive in Britain, was expected to be given royal assent late last week.

The bill, among other things, would make British manufacturers strictly liable for product liability lawsuits, with no limits on the amount of damages that can be recovered by a victim (*BI*, Dec. 1, 1986).

Because of the speed in which the bill was passed, there may be a compromise on the wording of the state-of-the-art defense that will be included in the bill, according to a spokeswoman at the Department of Trade and Industry.

The House of Commons wanted to include broader wording for the state-of-the-art defense that would allow manufacturers to compare their products to the products of other manufacturers at the time the products were sold.

The House of Commons version reads: "The state of scientific and technical knowledge at the relevant time (of sale) was not such that a producer of products of the same description as the product in question might be expected to have discovered the defect if it had existed in his product while they were under his control."

The House of Lords, however, wanted a stricter wording, along the lines of the original EC directive, which says that "the state of scientific and technical knowledge at the relevant time was not such as to enable the existence of the defect to be discovered."

In addition, a very shortened version of the Criminal Justice Bill, reduced to 12 clauses from the original 128 clauses, was expected to be passed by Parliament late last week.

However, the shortened version of the bill would set up a Serious Fraud Office and would include stronger measures to fight financial crime in London's financial district, which includes Lloyd's of London and the surrounding insurance market. ■



Tennessee House OKs JUA formation

NASHVILLE, Tenn—The Tennessee House passed two insurance reform bills earlier this month, one of which would provide for the creation of a mandatory joint underwriting association if a voluntary market assistance program fails.

S.B. 1041 gives the state commissioner of commerce and insurance the authority to form a voluntary MAP for lines of property/casualty coverage not readily available in the state.

If, however, if it is determined at a public hearing that the MAP isn't working, the commissioner is further authorized to establish a mandatory joint underwriting association to provide a market for those restricted lines of insurance.

Under the legislation, all licensed insurers in Tennessee writing that particular line of business would be required to participate in the JUA. Each insurer would be assessed an amount not more than 5% of its previous year's direct written premiums, in proportion to all other participating insurers.

The association would be governed by a seven-member board, of which two members would be licensed insurance agents or agent association representatives.

Under the companion measure, S.B. 1040, the commissioner will adopt the property/casualty insurer data disclosure requirements developed by the National Assn. of Insurance Commissioners. The bill also authorizes the commissioner to request additional data at his discretion to be used in considering rate adjustment requests. ■

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David Olsen named president at J&H

David A. Olsen will assume the post of president and chief operating officer at New York-based Johnson & Higgins this week.


Mr. Olsen

The position of president has been vacant since the retirement of **Edwin L. Knetzger Jr.** in 1985.

The promotion of Mr. Olsen, 49, previously an executive vp in New York, will take effect Wednesday.

Mr. Olsen joined J&H in San Francisco in 1966, as an account executive in the marine department. In 1971, he transferred to Chicago as vp and manager of the marine department, becoming executive vp in 1978. The following year, Mr. Olsen was named manager of the Houston office and executive vp of J&H in Texas.

Also, **Kenneth Hecken** will become vice chairman at Johnson & Higgins, a new position. Mr. Hecken is currently an executive vp in New York.


Mr. Hecken

Mr. Hecken joined J&H in 1961 as a senior account executive. He became vp in 1967 and named executive vp in 1986.

Mr. Hecken has held a number of positions within the company including: chairman of Willcox Inc., the New York-based J&H reinsurance brokerage, jointly owned with Willis Faber P.L.C.; director of the New York casualty department and managing director of the national sales and marketing department in New York.

In addition, the following J&H officials were promoted to executive vps:

Walter H. Clemens, currently director and manager of the San Francisco office; **Richard E. Meyer**, national casualty practice partner; and **Richard A. Nielsen**, director and manager of the Wilmington, Del., office.

In J&H's Detroit office, **John W. Gussenhoven** promoted to executive vp from senior vp. In addition, **Thomas M. Czarnecki** will move to Detroit as senior vp. Mr. Czarnecki had been property department manager in J&H's Philadelphia office.

Also at J&H, **Theodore J. Fuller**, currently branch manager of the Costa Mesa, Calif., office, will move to Philadelphia as an executive vp. **Richard E. Valliere** was promoted to senior vp and manager of J&H's Costa Mesa office, replacing Mr. Fuller. Mr. Valliere formerly was manager of the Los Angeles sales department.

Joseph P. Platt Jr., chairman of Johnson & Higgins National HealthGroup and senior vp in the Pittsburgh office, promoted to executive vp of J&H of Pennsylvania Inc.

Also at J&H, **Vivian R. Menna** has joined the Stamford, Conn., office as a vp and account executive.


Ms. Menna

In other broker changes:

Clark L. Fitzgibbons joined Rollins Burdick Hunter of Ohio Inc. in Cleveland as vp. Previously, Mr. Fitzgibbons was director of risk management for The Sherwin-Williams Co. in Cleveland.

Bayard Bigelow III promoted to vp-planning at the Orion Group in Farmington, Conn. Previously, Mr. Bigelow was an assistant vp.

comings & goings: industry

Insurers

At the North River Insurance Co. in Basking Ridge N.J., a subsidiary of Crum & Forster Commercial Insurance the following people were elected vps from assistant vps: **Elroy J. Dyksen,** responsible for inland marine products; **John J. Mueller Jr.,** responsible for claims handling in the northeast and Canada; **Richard A. Annese,** responsible for bond underwriting; and **William P. Kearney**, responsible for umbrella and excess liability underwriting.

Also at North River Insurance, **George P. Michaels** elected vp. Mr. Michaels previously was director of business accounts.


Mr. Dyksen

Thomas M. Collerain named president and chief executive officer of American Eagle Insurance Co. and American Meridian Insurance Co., both wholly owned subsidiaries of AOA Corp. in Dallas. Previously, Mr. Collerain was executive vp of Ranger Insurance Co. in Houston.

Robert H. Wall promoted to senior vp-actuary and **Paul E. Margus** named vp-actuary at US-LIFE Corp. in New York. Previously, Mr. Wall as vp-actuary and Mr. Margus was an actuary.


Ms. Muedder

At The Home Insurance Co. in New York, **Richard G. Lambert** promoted to senior vp and region head from division head. Mr. Lambert will oversee the newly created Greater New York Region.

Kathleen Muedder appointed vp at Zurich Insurance Co. She also was elected vp of subsidiary American Guarantee & Liability Insurance Co. in Schaumburg, Ill. Previously director of the product support area, Ms. Muedder is responsible for the development of new insurance products.

Joseph LaMonte joined the New York Insurance Exchange as a consultant on financial solvency and syndicate rehabilitation. Previously, Mr. LaMonte was deputy New York insurance superintendent in charge of the Insurance Department's liquidation bureau.

Reinsurance

Robert J. Seery joined American Intermediaries of New York Inc. as senior vp in the treaty department.

Robert G. Bailey appointed vp

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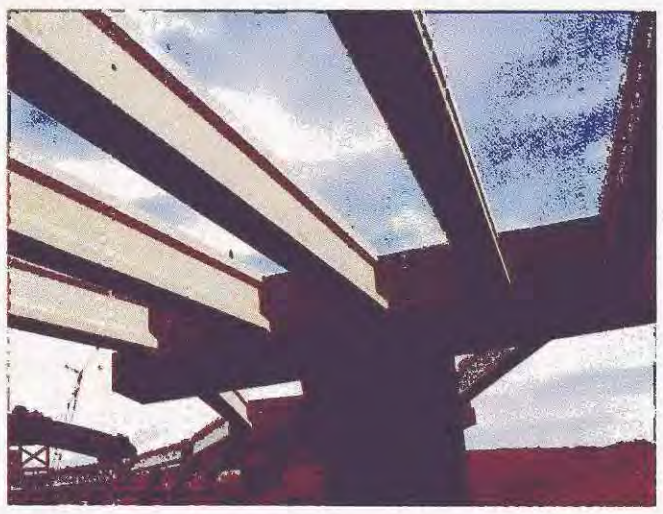
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Continued from previous page
at North Star Reinsurance Corp. in Parsippany, N.J.

Robert DeMichele elected president and chief executive officer of United Reinsurance Corp. of New York. Previously, Mr. DeMichele was president of The Reinsurance Corp. of New York, an affiliate company.

Excess/surplus

Ronald Gabor joined Horan, Goldman Cos. Inc. in Rosemont, Pa., as executive vp. Prior to this appointment, Mr. Gabor was president of Gabor & Co. Inc., a managing general agency in Miami. Horan, Goldman is a managing general agent/surplus lines broker operating throughout the northeastern United States. Also at Horan, Goldman, **Marcie McDevitt** promoted to vp from assistant vp.

Lisa Garn and **James C. Kilduff** joined American Marketing Center Inc. in New York as senior vps. Most recently, Ms. Garn and Mr. Kilduff were vps of Major Surplus Inc.

HMOs/PPOs

Jacob Getson named senior vp of U.S. Healthcare Inc. in Blue Bell, Pa. Previously, Mr. Getson was vp-health programs development for Blue Cross of Massachusetts Inc. with responsibility for managing all health maintenance organization lines.


Mr. Getson

Other suppliers

At the Actuarial, Benefits and Compensation Group of consultant Coopers & Lybrand in Detroit, **J. Larry Glass** appointed regional managing partner for the northeast region. Mr. Glass also will serve as managing partner of the Boston ABC office. In addition, **Ed Holohan** appointed manager and senior consultant of the ABC Albany office, a satellite of the Boston office.

At the ABC Los Angeles office: **Diana Cookmeyer** named western regional director of compensation services; **Linda Garcia** appointed western regional director of benefits administration services; and **Susan Duin** joined as senior consultant for benefit administration services. Previously, all three worked for consultant A.S. Hansen Inc.

Harry R. Hinkleman joined the New York office of insurance adjusters Toplis & Harding as a vp in the casualty department.

Richard Carris joined Stone & Webster Management Consultants Inc. in New York as a senior consultant. ■

Oceanus liquidators seek 'fighting fund'

By ROGER SCOTTON

HAMILTON, Bermuda—The liquidators of Oceanus Mutual Underwriting Assn. (Bermuda) Ltd., a Bermuda-based protection and indemnity club that put itself into liquidation in March 1984, are appealing to the P&I club's creditors for money to set up what they describe as a "fighting fund" to help pursue claims against European reinsurers.

Bermuda-based joint liquidator David Anfossi of the accounting and consulting firm of Touche Ross & Co. said last week he is seeking 1 million pounds ($1.68 million) from creditors to continue litigation in London against a Paris-based syndicate of French stop-loss reinsurance underwriters.

In a letter to Oceanus creditors, Mr. Anfossi says the club's stop-loss policies represent its major reinsurance coverage for the underwriting years 1977-1982. It says that based on notified claims at the date of liquidation, the reinsurance recovery had a book value of approximately $150 million.

The letter says some of the reinsurance underwriters have accused Oceanus of misrepresenting claims statistics and methods of rating risks. It says litigation now before another London court also alleges fraud on the part of Oceanus.

"The effect of this plan, if successful, is to deny Oceanus any entitlement to recover premiums paid (net of claims recoveries), which would be recoverable if misrepresentation alone was proved," the letter says.

It says the U.K. court in which Oceanus is pressing its claim has given Oceanus until June 1 to put up 700,000 pounds ($1.18 million) in security for legal costs if it intends to continue with the case.

The letter says that investigations conducted by Mr. Anfossi and his co-liquidator, Christropher Morris, a Touche Ross partner in London, indicate that the accusation of fraud is likely to fail and that Oceanus' claim against the reinsurance underwriters will result in a substantial recovery.

But, the letter adds that Lloyd's Bank in London, which is owed about $8.5 million by Oceanus and had been funding Oceanus' litigation costs, has "decided to withdraw its assistance, largely due to lack of contributions from the general body of unsecured creditors."

"Accordingly, we have written to all the creditors with claims in excess of $1 million requesting their assistance in raising a fighting fund of a million pounds in order to continue with the case. Whilst we consider that this case should be settled out of court at an early date, we are unable to talk sensibly with the underwriters until the security for the costs order is satisfied."

Mr. Anfossi said that Oceanus—which was managed by John Laing Management (Bermuda) and had 1,955 vessels on its books when it went into liquidation—faces claims of about $322 million. He said this figure includes the $8.5 million owed to Lloyd's Bank and a further $13.5 million claimed by John Laing, which initially refused to give the liquidators Oceanus' books and records.

Mr. Anfossi said he did not know how many creditors are involved in the Oceanus collapse, but that there are likely to be hundreds, including the Argentine, Brazilian and Indian governments. He said the liquidators have not established proofs of debt since this process would involve heavy expenditure and was pointless until it was established that funds could be recovered from stop-loss reinsurers.

He said that about 300,000 pounds ($504,000) so far had been pledged to the fighting fund by some of the larger creditors, but they were reluctant to contribute more until other creditors committed funds.

He said that the London law firm of Linklaiters & Paines had advised the liquidators they had good grounds on which to fight the action and that a full trial could be expected to take place in September if no settlement is reached.

"We have received an opinion from law professor Dr. John Beddington of the Imperial College, London, indicating that the fraud claim against us is without merit," said Mr. Anfossi. ■



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3 experts to discuss financing options at Hines symposium

CHICAGO—New ways to finance risk will be addressed by the third annual Harold J. Hines Jr. Memorial Symposium, to be held June 4 in Chicago.

The symposium, "Risk Management in the 1980s and Beyond—The Age of Uncertainty" will explore how underwriters are reacting to changes in the marketplace and the future status of traditional insurance markets as they face competition from non-traditional alternatives.

The annual event is sponsored by the Chicago Chapter of the Risk & Insurance Management Society and the Insurance School of Chicago.

Panelists will include: John Cox, chairman and chief executive officer of A.C.E. Insurance Co. Ltd. in Bermuda; Robert Nevins, executive vp of The Home Insurance Co. in New York; and Albert Beer, an actuary with the Tillinghast Division of Towers, Perrin, Forster & Crosby Inc. in New York.


Mr. Hines

Edwin S. Overman, president of the American Institute for Property and Liability Underwriters Inc. in Malvern, Pa., will serve as moderator.

The panelists will discuss the problems faced by companies sponsoring alternative risk financing mechanisms, including their ability to price their own product.

In addition, they will offer insight into the trend toward alternative financing mechanisms, which some estimates say will replace as much as one-third of commercial insurance by 1990.

Panelists will offer advice for financial executives and risk managers about the changing market.

Panelists also will debate the possibility of another soft insurance market as commercial insurers fight for market share.

Finally, they will offer advice about what plans financial executives and risk managers should make to cope with these uncertainties.

The symposium is held annually in memory of Mr. Hines, a 30-year veteran of the insurance industry.

At the time of his death in 1984, he was president and chief executive officer of Chicago-based Rollins Burdick Hunter Co.

Previously, Mr. Hines had been president and vice chairman of broker Marsh & McLennan Inc.

Mr. Hines was "one of the country's foremost thinkers in the subject of risk management economics," said Jack Cornelius, president of the Chicago Chapter of RIMS and chairman of the symposium.

The symposium will be held at the Union League Club in Chicago at 65 W. Jackson Blvd., beginning at 3 p.m. June 4.

Following the program, Patrick G. Ryan, president and chief executive officer of Aon Corp. (formerly Combined International Corp.), RBH's parent company, will host a reception in honor of moderator Dr. Overman, who is retiring after working in the insurance industry for 34 years.

There is no charge to attend the symposium, but space is limited. Invitations can be requested by calling the Insurance School of Chicago at 312-427-2520.

In addition, copies of last year's symposium presentations are available from the school.

Speakers at the last Harold J. Hines Jr. Memorial Symposium included executives from General Re Corp. in Stamford, Conn., and FMC Corp. in Chicago. ■

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Indiana governor vetoes tort reform bill

INDIANAPOLIS—Indiana Gov. Robert D. Orr vetoed one of four tort and insurance reform bills passed by the Legislature late last month.

Gov. Orr said S.B. 375, which would have established pre-judgment and post-judgment interest in civil suits, was "too broad in scope and lacks sufficient guidelines for predictable application."

In addition, the governor criticized a provision that would have permitted post-judgment interest to be applied to any portion of an existing judgment that remained unpaid by Dec. 31, 1987.

The governor had been expected to sign the measure, which was opposed by the Alliance of American Insurers and the Indiana Forum for Civil Justice.

If S.B. 375 had become law, it would have capped post-judgment interest in private-sector lawsuits at 10% from the date of verdict. The bill also would have limited to 8% post-judgment interest on settlements against the state or a state agency. The interest would begin accruing 45 days after a verdict is reached (*BI,* May 4). In addition, the measure would have set parameters for the permissible percentage range and length of payment for pre-judgment interest awards.

After vetoing S.B. 375, Gov. Orr went on to sign two other tort reform bills and a third bill dealing with insurer cancellation procedures and insurer reporting requirements.

H.B. 1273, which limits insurers' rights to cancel liability policies and increases reporting requirements for certain hard-to-place lines of business, including liquor liability and municipal liability coverage, takes effect Sept. 1.

S.B. 2, which went into effect immediately upon the governor's signature, specifies who is eligible to recover damages for the wrongful death of a child and for what reasons. The new law also caps awards for loss of love and companionship at $100,000, although this cap will be lifted by a sunset provision on Nov. 1, 1990.

The governor also signed a bill concerning tort claims against political subdivisions. H.B. 1098 stipulates that a public employee, as defined in the bill, acting within the scope of his employment is not liable for losses resulting from a number of causes, including:

- The natural condition of unimproved property.
- The condition of a reservoir, dam, canal, conduit, drain or similar structure used by someone for an unforeseeable purpose.
- Temporary weather conditions on a public thoroughfare.
- The condition of an unpaved road, trail or footpath designed to provide access to a recreation area.
- An act or omission of someone other than the governmental entity employee.
- Unintentional misrepresentation.
- Failure to make an inspection, or making an inadequate or negligent inspection, of property other than that of a government entity to determine if the property complied with or violates any law or contains a hazard to health or safety.
- Injury to a person or property of a person under supervision of a governmental agency when that person is on probation or assigned to an alcohol and drug services program, a minimum security release program or a community corrections program.
- The design of a public highway, if the claimed loss occurs at least 20 years after the highway was designed or substantially redesigned. This provision does not relieve a responsible government entity from duty to provide and maintain public highways in a reasonably safe condition.

In addition, H.B. 1098 states that, with a claimant's consent, a political subdivision may settle a claim or suit through a structured settlement. H.B. 1098 took effect immediately upon signature.

around the states

Mississippi JUA

JACKSON, Miss.—Mississippi Governor William A. Allain signed legislation last month authorizing the state's insurance commissioner to set up a temporary joint underwriting authority for medical malpractice insurance, if the commissioner finds that such a need exists.

The JUA would consist of all insurers authorized to write medical malpractice insurance. The law goes into effect on July 1 and contains a sunset provision that terminates the legislation on July 1, 1991.

Kentucky lawyers

LOUISVILLE, Ky.—Private attorneys in Kentucky are soliciting members and capital contributions for the proposed Lawyers Mutual Insurance Co., which hopes to write errors and omission coverage for lawyers in the state.

About 1,000 attorneys already have contributed more than $1 million to capitalize the proposed facility, but the mutual's organizers want $3.5 million before they will ask state regulators to approve the insurer, said C. Craig Bradley Jr., the organizers' general counsel. He is a partner in the firm of Stites & Harbison in Louisville.

However, the mutual's planners will consider establishing the facility if at least $3 million is collected by June 30, he added.

Organizers want enough capital to ensure financial stability, beyond the $1.25 million required by the state, Mr. Bradley said.

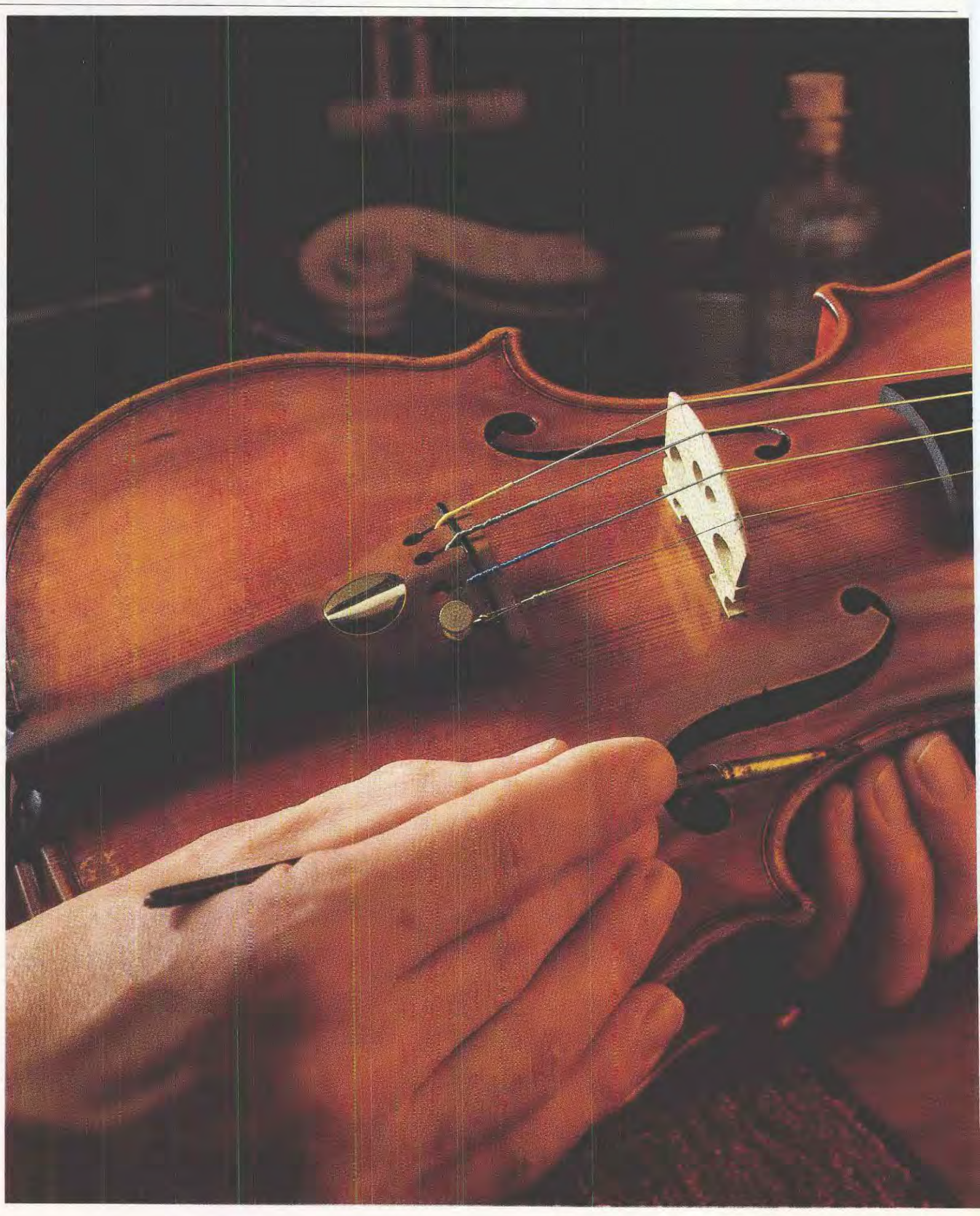
The program, which is endorsed by the state bar association, intends to offer $1 million in claims-made coverage to private attorneys in the state who meet the program's underwriting guidelines.

Policyholders would not be assessed if claims exceed established reserves, he added.

No decisions have been made about whether the policies will include an aggregate limit or whether public sector attorneys in the state will be included, Mr. Bradley said.

The mutual was proposed after a survey indicated that professional liability insurance rates for some Kentucky attorneys have risen 200% to 500%. In addition, some attorneys in high-risk specialties like securities and plaintiffs' personal injury practices could not find coverage, Mr. Bradley said.

The proposed mutual is being established with the help of McNeary Insurance Consulting Services Inc., a risk management consulting firm based in Charlotte, N.C. ■



20th annual APPWP meeting

Health policymakers see need for reform

By DEBORAH SHALOWITZ

WASHINGTON—Although business support for mandated employer-provided health care benefits remains weak, a consensus is growing among those involved in health policy issues that some kind of reform is necessary to deal with the problems of the uninsured.

Speakers at the 20th annual Assn. of Private Pension & Welfare Plans meeting earlier this month in Washington, D.C., presented varying viewpoints on how the U.S. health care system should be changed.

Ideas ranged from simply expanding Medicare to cover the costs of catastrophic health care for the elderly to requiring all employers to offer at least a minimal level of health benefits.

But any discussion of health care coverage reform is complicated by the often conflicting goals of business, labor and government.

For example, while there are numerous initiatives in Congress to expand and improve the Medicare program, the Reagan administration is concentrating on restructuring the existing program rather than devising new programs.

And, while some on Capitol Hill think that it is the responsibility of both business and the government to ensure that the uninsured have adequate health care coverage, most in private industry resist those notions.

According to one congressional expert, there is "a sense of urgency" on Capitol Hill to come up with solutions to the problem of those without health insurance.

David Nexon, a senior health policy adviser to the Senate Labor and Human Resources Committee, noted that companies and their insurers are "almost exclusively" picking up the cost of charity care provided by hospitals to uninsured individuals through cost shifting.

Therefore, mandating employers to provide a "minimum package of benefits" would "put the cost (of health care) where it belongs. . .on the minority of employers that don't provide health care coverage," said Mr. Nexon.

A proposal to be introduced "sometime soon" by Sen. Edward Kennedy, D-Mass., that would require employers to offer group health insurance plans would not require employers currently providing health insurance to absorb many additional costs, Mr. Nexon assured (*BI*, April 27).

However, he added, "there's a desire not to load lots of costs on small business," so the proposal will restructure the way in which small businesses can purchase group health insurance to help lower their costs. Mr. Nexon declined to give further details.

A representative of organized labor also supports mandated benefits and agreed with Mr. Nexon that the financial burden for providing health care services for the uninsured falls with employers.

Karen Ignagni, assistant director of the department of occupational safety, health and social security of the AFL-CIO, pointed out that companies providing health insurance for their workers are being taken advantage of by those employers not providing health plans.

The added injustice is that the companies now providing health insurance are paying for care for the uninsured through cost shifting, which further increases their health care costs, she explained.

The AFL-CIO, which represents approximately 13 million workers, or 70% of the organized labor force, has developed a set of principles regarding mandated benefits. These principles include:

- All companies should be required to provide a minimum benefit package analogous to a minimum wage. This would be "just a floor," emphasized Ms. Ignagni.
- Employers currently offering benefits could be deemed "actuarially equivalent" to the minimum benefit package. So employers already providing some health insurance benefits would not necessarily have to comply with the exact requirements of a mandated benefits package, provided the benefits they offer are roughly equivalent in value to those required in the minimum package.
- This minimum benefit package would pre-empt existing state mandates, which vary across the country.
- A "window" of time would be allowed for companies that don't already provide health insurance to establish health care plans.
- Companies would be allowed to join regional health insurance purchasing groups.
- Health insurance plans offered by employers must require pre-certification reviews and second opinions, but companies could choose between indemnity and managed care options.

Ms. Ignagni emphasized that businesses now offering health insurance to their workers will profit, not lose, from mandated benefits. She advised employers to "look at mandated benefits for what it is. It's about fairness, it's about equity."

Employers, however, express a different perspective.

Robert S. Duff, director of benefits and human resources at Avon Products Inc. in New York, said the long-term implications of mandated benefits are serious and not quantifiable, and he opined that employers will pay more if required to offer health benefits.

The Reagan administration's basic health care goals are to increase competition in the health care marketplace and sharpen incentives to bring down health care costs, said Dr. William Roper, administrator of the Health Care Financing Administration.

Dr. Roper explained, though, that while the administration wants to decrease the role of government in health care policy, achieving that goal may require a basic restructuring of Medicare.

While the Reagan administration is looking for ways to make Medicare more manageable, Congress is moving ahead with an expansion of the system. The House Ways and Means Committee approved legislation to expand Medicare to cover the costs of catastrophic health care through an increased premium (see story, page 29).

This could "relieve the liability that many companies have for retiree health care beyond Medicare," said Rep. Rod Chandler, R-Wash. "Then companies can look to providing other benefits for retirees." ■



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PBGC director predicts new funding method

By DEBORAH SHALOWITZ

WASHINGTON—A new system for funding the Pension Benefit Guaranty Corp.'s massive deficit will be enacted, predicts the agency's executive director.

"There will undoubtedly be some kind of revenue measure" to raise funds for the PBGC said Kathleen Utgoff, adding that while the Reagan administration's proposed variable rate premium may not be the perfect solution to the agency's financial distress, it is certainly the best solution.

While support exists for a variable rate premium from administration officials and on Capitol Hill, some employers are not satisfied with the proposal.

"This proposal doesn't make any group happy," admitted Ms. Utgoff to those who attended the 20th annual meeting of the Assn. of Private Pension & Welfare Plans earlier this month in Washington, D.C. "I'm sympathetic to all the 'buts' " and objections that people have to the proposal.

However, "now, we have a system that makes people responsible for what they've funded," she explained. "This proposal makes people responsible for what they've promised."

The variable rate premium mechanism proposed by the Reagan administration would force employers with underfunded defined benefit pension plans to pay an additional premium to the PBGC based on the amount of the plans' unfunded vested benefits (*BI*, April 13). A plan would be considered underfunded if its assets did not exceed vested benefit obligations by at least 25%.

These underfunded plans would pay, in addition to the basic $8.50 premium per plan participant, a funding charge of $6 per $1,000 of underfunding per plan participant. However, an employer's annual PBGC premium would be capped at $100 per plan participant.

Employers whose vested pension benefit obligations are overfunded by at least 25% initially would pay the current annual premium of $8.50 per plan participant. But later, this premium would be indexed to the annual average increase in national wages.

In addition, the PBGC would be authorized to adjust the funding charge by as much as 50%—up or down—every three years if its claims experience proved better or worse than expected.

Ms. Utgoff assured the audience that 92% of employers remitting premiums to the PBGC would continue to pay only the basic $8.50 premium per plan participant. And only 5% of employers would pay the maximum annual premium of $100 per plan participant.

Although the proposal isn't fair to each and every employer with a defined benefit pension plan, Ms. Utgoff acknowledged, employers must "realize that some compromises are going to have to be made" to accomplish the goal of increasing PBGC revenues while keeping the proposal politically acceptable.

"Everyone thinks they should pay less, but who will pay more?" she asked.

Rep. Rod Chandler, R-Wash., during a separate speech the following day before the group, commented that a variable rate premium is the "most justifiable" and "least destructive" means of raising the necessary revenue for the PBGC. Rep. Chandler noted that the administration's variable rate premium proposal is before the Oversight Subcommittee of the House Ways and Means Committee.

Following Ms. Utgoff's speech, members of the audience heatedly objected to some specific provisions of the variable rate premium proposal, such as automatically indexing premium increases to the average increase in national wages.

"People think there's something nefarious" about indexing, Ms. Utgoff remarked. But that's not true, she said, and proceeded to explain and defend the idea.

An annual non-indexed premium of $8.50 per plan participant would not raise enough revenue to amortize the PBGC's existing debt, Ms. Utgoff pointed out.

She also said that an average

Continued on page 22

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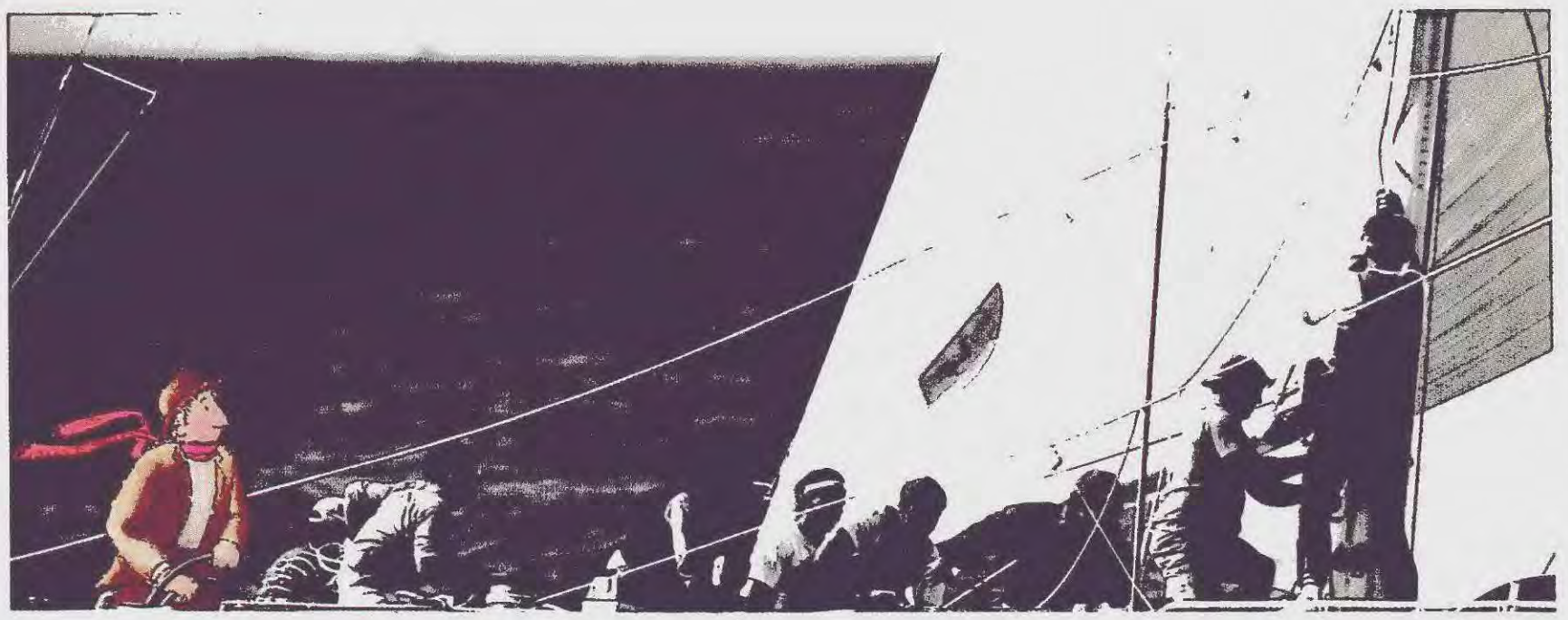
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Ontario proposal may raise pension costs

By TONY THOMPSON

TORONTO—Employers in Ontario fear their pension costs would more than double and their plans could be endangered if they are forced to index pension benefits to increases in the cost of living.

If legislators adopt an indexing provision as they overhaul Canada's current pension law, some employers would be forced out of business and others would terminate their plans, employers and consultants say.

"We feel many employers would wind up their plans if this goes through," observed Guy Jobin, senior vp-employee benefits with Johnson & Higgins Willis Faber Ltd. in Toronto.

A task force for the Ontario government currently is studying the ramifications of indexing private pension plans to the cost of living index and is expected to report its findings within a year. At that time, the government is expected to amend the pension legislation, which the Legislature is scheduled to consider later this session.

The otherwise employer-backed legislation, Bill 170, is an omnibus legislative move to update existing laws relating to private pension plans in the province. While the bill applies to only the pension plans of employers based in Ontario, observers point out that 70% of all employers with pension plans in Canada are based in Ontario.

But the bill eventually could affect the remaining 30%, observers contend, as they expect other provinces to follow Ontario's lead if the bill is enacted in its current form.

Quebec and Manitoba already are considering legislation similar to the bill; however, those measures do not include the controversial indexing provision.

Employers and benefit consultants in Ontario contend indexing pension benefits to the cost of living would be financially devastating to employers.

Even if pension benefits were indexed at 60% of the inflation rate and the cost of living index increased only 3%, actuaries have estimated pension indexing would cost employers between 16% and 43% more to maintain their current pension plans, according to Judith Andrew, the Canadian Federation of Independent Business' director of provincial affairs for Ontario. The CFIB represents small to medium-sized businesses.

If inflation hit 12%, indexing would increase pension costs by 60% to 160%, Ms. Andrew noted.

A spokesman for General Motors of Canada Ltd. in Oshawa, Ontario, claimed that if employers are forced to index, the resulting competitive advantage for offshore manufactures currently setting up assembly plants in Canada would force GMC to close its doors and lay off its 46,000 employees.

"It would become uncompetitive for GM to make cars here," the spokesman said.

"If the indexing were 100%, it would add $321 million Canadian ($240 million) to our salary and wages bill, an increase of 19.5%," said the spokesman, noting that the figures are based on actuarial tables the company prepared on the cost of indexing benefits paid by GMC's non-contributory defined benefit pension plan. "This would translate into an extra $444 Canadian ($333) for each car we make, before federal and provincial taxes, which add a further $90 Canadian ($67)."

Even a "watered-down" 60% indexing rate would cost GMC $139.5 million Canadian ($104.5 million) in additional pension benefits, said the spokesman, noting that the automaker has 11,000 retirees currently receiving pension benefits and an aging workforce.

Mr. Jobin hopes the proposal will be amended to offer employees the option of paying for increased pension benefits rather than putting the burden on employers.

'I don't think we should force employees to take an indexed pension if they have other ways of protecting against inflation, such as real estate investments," he said. "The Canada Pension Plan (the government's Social Security system) is already indexed. Employees may feel they have adequate protection against inflation," he noted.

Apart from the indexing proposal, employers generally support the proposed Ottawa pension law overhaul, which has been under study by various government committees over the past 10 years.

Loopholes in the province's pension law were brought to a head during the past two years when financier Conrad Black claimed $62 million Canadian ($44.3 million) from Toronto-based Dominion Stores' employee pension plan in December 1985 following the sale of his controlling interest in the supermarket chain.

Mr. Black claimed that because many employees whose pension benefits were not fully vested lost their jobs when the business was sold to The Great Atlantic & Pacific Tea Co. Inc.'s Canadian subsidiary, that money reverted to his company. Under current law, employees must be age 45 or older and a member of their pension plans for 10 years before they are vested.

The store workers' union obtained a court order that the funds be returned, but Mr. Black is appealing that decision.

During all of 1985, 70 companies in Ontario were permitted by the Pensions Commission of Ontario to withdraw $176 million Canadian ($125.9 million) from pension plans. The government has since placed a moratorium on the withdrawal of pension fund surpluses.

Under the proposed pension bill:

- Employees would be entitled to their pension benefits after two years of service, and there would be no age requirement.
- Employees could transfer their entitlement to other employers' plans if they change jobs.
- Part-time employees who draw a minimum annual wage of $7,280 ($5,453) would be eligible to join plans after two years with an employer.
- Private plans would have to contain a procedure allowing early retirement if the plan member retires within 10 years of the normal retirement age of 65.
- Minimum survivor benefits would be determined by the government and probably would be set at around 60% of benefits, according to some political observers.
- More complete disclosures of the financial conditions of plans would be required by the government watchdog, the Pensions Commission of Ontario, which itself is expected to be the subject of a major shake-up because of the amount of funds it has allowed withdrawn from pension plans.
- Plans would not be allowed to discriminate on the basis of sex. ■

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Provident buys Transamerica group business

Provident Life & Accident Insurance Co. of Chattanooga, Tenn., has acquired the group life and group health insurance business of Transamerica Occidental Life Insurance Co. of Los Angeles for $180 million.

Provident posted more than $2.3 billion in group premiums and premium equivalents in 1986, while Transamerica earned 1986 premiums of $850 million on group business.

"Transamerica Occidental will recognize a gain of approximately $75 million aftertax from the transaction," said David R. Carpenter, chairman and chief executive officer of Transamerica Occidental.

Provident's group life/health operation employs more than 2,500 people, while about 1,100 were employed by Transamerica's group operation.

"We are excited about the opportunities for major national growth that are now available to us as we assume this additional business and staff," said Carey Hanlin, Provident's president and chief executive officer.

"Supported by our over $7 billion in total corporate assets, the new magnitude of our group and managed health care business now identifies us as a major national force in the highly competitive group life and health industry."

Provident's purchase includes Transamerica Occidental's partnership in a national health care joint venture with American Healthcare Plans to operate a national preferred provider organization network. American Healthcare Plans is an affiliate of American Healthcare Systems, operators of a network of not-for-profit hospitals.

markets

New umbrella facility

RISC Inc. of Dallas, a specialty risk brokerage, has spun off a new facility to offer umbrella liability coverage.

Fort Worth, Texas-based International Lloyds Insurance Co. is providing $1 million limits over primary automobile and general liability limits of $500,000, says Paul E. Warmingham, RISC vp.

The company has accumulated $2 million in capital and surplus, said President David Geary.

The coverage is written on an occurrence form. Telephone submissions will be accepted, Mr. Warmingham said, and, to eliminate unnecessary delays, in-house binding is offered.

In addition to umbrella coverages, RISC offers more than 20 years' experience in oil and gas risks, trucking, aviation, marine, primary and excess property and casualty coverages.

For more information about International Lloyds Insurance Co., contact Paul E. Warmingham, RISC Inc., 750 N. St. Paul, Suite 990, Dallas, Texas 75201; 214-922-9898; 800-442-7103 within Texas.

Name change

Progressive Transportation Co. Inc. has changed its name to **NCI Transportation Inc.** The company can be reached at P.O. Box 51148, Knoxville, Tenn. 37950; 615-584-3655.

Mergers/acquisitions

Independent claims administrator **ALTA Administrators** in Salt Lake City, a division of ALTA Health Strategies Inc., acquired **Reed Stenhouse Associates Inc. of Texas**, a third-party administrator subsidiary of Alexander & Alexander of Texas Inc.

Alexander Howden North America Inc., an Atlanta-based surplus lines broker, acquired **J.J. Francis & Associates** of Cherry Hill, N.J. J.J. Francis specializes in the placement of primary product liability insurance nationwide and excess/surplus lines insurance in the Northeast.

Wolper Ross & Co. Ltd., a Miami-based insurance and pension consultant, through its affiliate, Ingham Liedman & Co., has acquired **Axelrod Associates** of Hollywood, Fla., and **Downey & Schlageter Inc.** of Fort Lauderdale, Fla.

Kevin Quinn and **Fritz Bodenheimer** have acquired **Corbett Quinn Bodenheimer Insurance Services** in San Jose, Calif., and have changed the name of the company to **CQB Insurance Services Inc.** The company is located at 1485 Park Ave., Suite 200, San Jose, Calif. 95126; 408-293-9800.

Burns & Wilcox acquired the Baltimore branch office of **Alexander Howden North America**.

Associated Agencies Inc. of Chicago acquired **Milum & Associates Insurance Brokers Inc.** of Irvine, Calif.

Capital Enterprise Insurance Co. of Louisville, Ky., has merged with **Worldwide Underwriters Insurance Co.** of Wausau, Wis., a subsidiary of the Nationwide Group. Capital's operations will be merged into Worldwide's offices at 11975 Westline Drive, St. Louis, Mo. 63146; 314-878-1800.

New offices

Resource Information Management Systems Inc., an employee benefit information system software vendor, has moved to Millbrook Executive Place, 500 Technology Drive, Naperville, Ill. 60540-2599; 312-369-5300.

Burns & Wilcox Ltd. has opened a new office at 5950 Fairview Road, Suite 510, 1 Fairview Plaza, Charlotte, N.C. 28210; 704-553-8984.

KL&K Associates Inc. has opened a new office at 2122 S.E. 82nd Ave., P.O. Box 06030, Portland, Ore. 97206; 503-774-2002.

A.J. Renner & Associates Inc. has relocated its offices in Chicago and Los Angeles. The Chicago office is located at 200 W. Adams St., Suite 2121, Chicago, Ill. 60606; 312-781-0600. The Los Angeles office has moved to to 3435 Wilshire Blvd., Suite 2018, Los Angeles, Calif. 90010; 213-389-1726.

Alliance Insurance Group Inc. also has relocated its Chicago and Los Angeles offices. The Chicago office is located at 200 W. Adams St., Suite 2100, Chicago, Ill. 60606; 312-269-0099. The Los Angeles office is now at 3435 Wilshire Blvd., Suite 2024, Los Angeles, Calif. 90010; 213-386-8747.

Douglass Financial Group has moved into new headquarters at 6010 Cornerstone Court W., Suite 110, San Diego, Calif. 92121-3712; 619-455-6555. ■



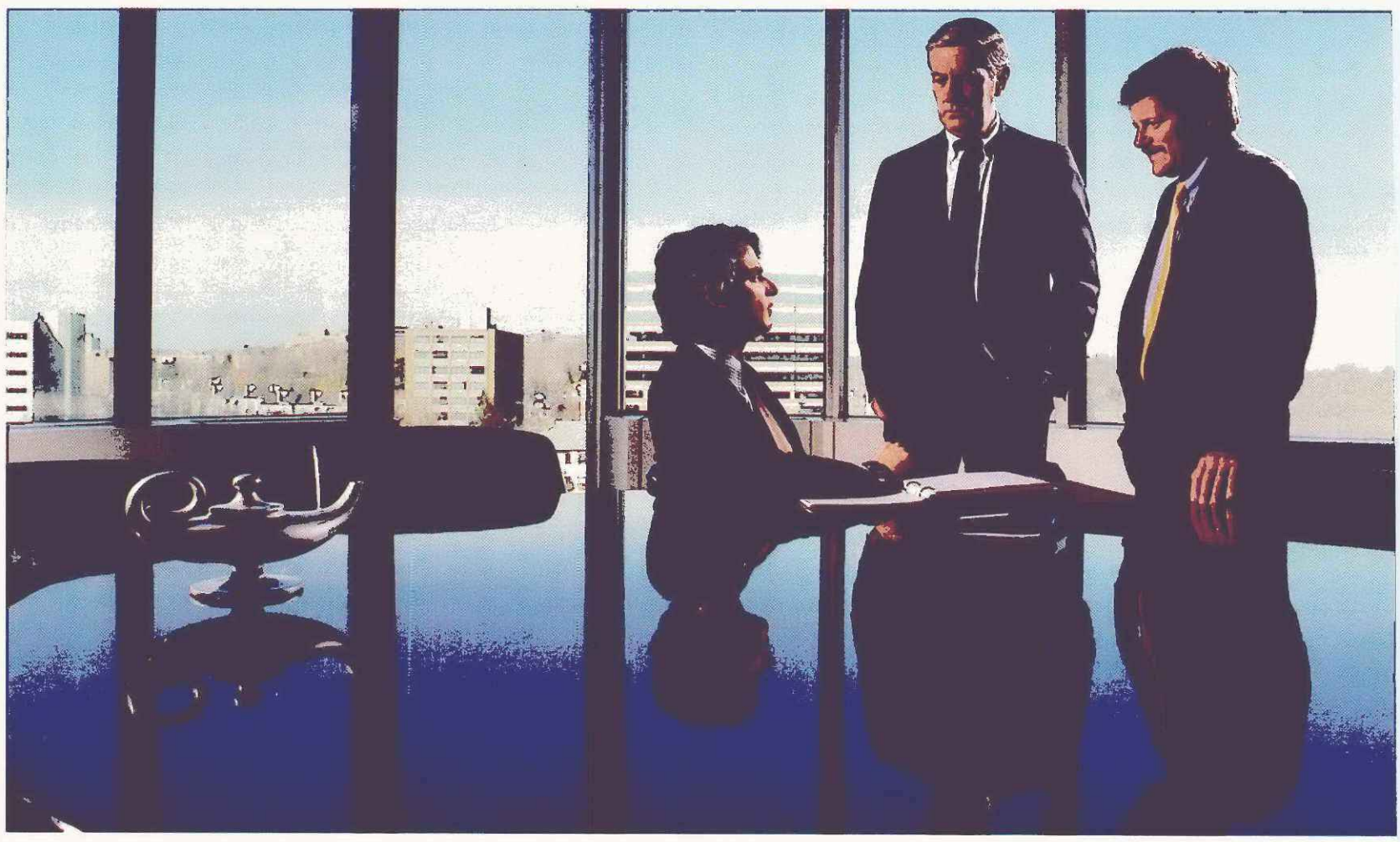
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ASK A BENEFIT MANAGER

Battle to control costs continues to be fought

Q **I have read a number of articles indicating that health care costs are again increasing at the rate we experienced in the early 1980s. What are the causes of this increase and what does the future look like?**

A The battle to control health care cost is continuing and will be even more difficult. We will have to deal with the problems of the early 1980s and newer ones that need our attention.

Some of the problems of the early 1980s—inflation, utilization and cost shifting—continue:

✔ Inflation. Health care costs continue to rise despite changes in the delivery system and cost-cutting measures. The medical care component of the Consumer Price Index rose at an average rate of 7.7% during 1986. This increase is higher than the 6.2% increase for 1985, and is again approaching the medical care inflation rate of the early 1980s, when the medical component rose 8.7%. In contrast, the rate of increase in the overall CPI for 1985 was 1.1%, and for 1985 it was 3.6%.

Medical inflation has been running at seven times the average inflation rate, even though the rate of increase has slowed for both. For more than 20 years, the health care inflation rate has been substantially higher than the overall CPI.

New technology in health care escalates, rather than reduces, cost. Each new piece of equipment bumps the cost of health care units higher as "quality" improves. Also, the health care system is overbuilt. There are too many hospital beds, doctors, nurses, etc. We currently are operating at a collective capacity rate of about 60%. The cost of that over-capacity is higher unit cost.

Lastly, and unfortunately, the cost of medical malpractice insurance, which is passed along to consumers, seems to have no ceiling.

People in the health care industry have indicated that we are now in the beginning phases of another price escalation—not as bad as what we saw in the early 1980s, but more than we've seen in recent years. Many group health insurers have increased rates between 8% and 15% in 1987.

✔ Utilization. One way to control health care costs is to control the number of units used. Health care is used for many reasons; unfortunately, many are inappropriate. The demand is driven by the industry: A hospital with low occupancy has an incentive to stimulate revenue; a physician, worried about malpractice will over-treat; a hospital, worried about the millions spent on a new CAT scanner will use the machine on as many people as possible.

Finally, and unavoidably, we are an aging population. We will use many services as we continue to grow old. We must continue to monitor utilization of medical services to be sure that changes in treatment and shorter hospital stays don't result in over-utilization of other medical services that are even more costly.

✔ Cost shifting. Cost shifting has been a problem for years. It stems from the government shifting health care costs to employers. Managing a prescribed level of benefits is one approach, requiring employers to offer health maintenance organizations is another, and a third is reducing Medicare reimbursements.

Cost shifting will continue in the years ahead as both federal and state governments try to pass on to employers increasing responsibility for health care costs.

These three areas have been and continue to be very important in controlling and minimizing overall health care cost.

The newer, and maybe even more significant issues are retiree medical benefits, alternative delivery systems and special medical conditioning.

One of the hottest issues in the employee benefit area in 1987 is retiree medical benefits. Until the last few years, the cost of continuing medical benefits after retirement had received little attention. However, several developments are bringing this issue into sharper focus.

Companies began by offering post-retirement medical coverage as a supplement to Medicare, then started to provide coverage to employees who retired prior to age 65 to make early retirement options more attractive. Companies expected that Medicare would continue to cover a substantial portion of the medical costs incurred by retirees over age 65. In addition, the early retiree rolls have grown substantially due to corporate restructuring and early retirement incentive plans.

The major retiree medical issues are:

- Costs for retirees are increasing 10% to 15% annually. The *present value* of the accrued liability for retiree health benefits in the United States in 1983 was estimated to have been $98.1 billion, even though I have seen estimates as high as $2 trillion and $3 trillion.
- Increased cost shifting to employer plans.
- Ability to modify or terminate benefits. As a result of the rising cost of providing retirees with health insurance, many companies have attempted to reduce or discontinue retiree health benefits. Retirees have brought suit under the Employee Retirement Income Security Act of 1974 and for breach of contract against their former employers. The courts have acknowledged the power of an employer to reserve the right to modify or terminate these benefits. However, the courts have imposed stringent standards on companies.

Both written descriptions and oral representations must clearly and unambiguously establish the employer's unqualified right to alter the plan. When the court has been called upon to interpret ambiguous contractual language, retiree benefits are generally presumed to be provided for life.

- The Financial Accounting Standards Board's position on retiree liabilities. FASB will be a major influence and has addressed the issue of retiree welfare benefits several times in the past few years. In its 1982 preliminary views on pension accounting, it expressed a preference for expensing retiree welfare benefits during the active careers of employees expected to receive such benefits. It considered requiring employers to determine retiree welfare costs in much the same way pension costs are calculated and treat these actuarially measured costs as a current compensation expense. In subsequent discussion memorandums, FASB softened its initial position, requiring only footnote disclosure of the types of retirement benefits employers provide to specific employee groups, their current accounting and funding policies and the cost of their benefits recognized for each accounting period.

Nevertheless, the FASB decision to move slowly in this area does not mean that it will not act. On the basis of its findings, FASB may well conclude that retiree welfare costs should be charged to the same accounting period for which revenue is recognized. The question is not whether FASB will act—only when. Based on information I received, FASB is planning for a 1990 effective date on the specific accounting treatment for retiree medical benefits.

Second only to new accounting requirements in its potential cost impact—and perhaps even more dangerous—is the Treasury Department study of minimum participation, vesting, accrual and funding standards for retiree health benefits. Such legislation could make it difficult, if not impossible, for firms to terminate existing plans, to say nothing of its effect on a company's profits.

Will "ERISA II" become a reality? To a Congress searching for creative ways to reduce Medicare costs, shifting more of the burden to the private sector through mandatory private retiree health coverage looks mighty appealing.

Another major cost issue facing us deals with changes being made in the health care delivery system.

Managed care is clearly the wave of the future. Growth of health maintenance organizations and preferred provider organizations will continue to accelerate as more people seek low-cost, quality options. Some studies I have seen estimate 30% to 50% of Americans will belong to HMOs by the mid-1990s. And, PPOs that manage care effectively will become a major force in the medical care market.

Based on this significant change in health care delivery, which is expected to incorporate the advantages of all the present arrangements and accordingly be more efficient and cost-effective to employers, we must be prepared to grasp the opportunities for lower health care cost.

We have been able to determine that the HMO concept is cost-effective. However, the federal HMO Act and regulations in many cases have made HMOs more costly to employers since they attract the younger, healthier employees while the traditional indemnity plan is left with older employees and, in most cases, the workers that have more and larger claims.

As you know, the HMO Act and other regulations require employers to calculate the cost of the indemnity plan as the basis for determining how much is required to transfer to the HMO for employees who enrolled for HMO coverage. It is now clear that this method of calculations resulted in many employers reimbursing too much to the HMO for the risk they were assuming.

With regard to HMO regulations, there appears to be relief in sight since the Health Care Financing Administration proposed in January to rescind the regulation controlling the amount employers must contribute to federally qualified HMOs.

The proposal would rescind the current "equal contribution" requirement. It may be that the greatest opportunity in controlling health care cost in the future is having employees and retirees in a managed care program.

Having a higher percentage of employees in HMOs gives employers increased leverage. This leverage

Continued on next page

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



Mr. Duva

This month's column, on employee benefits issues is written by Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J. Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco answers risk management questions. And, William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actaurial questions in the casualty field. Mr. Duva's and Mr. Perry's columns appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Duva's next column will appear in July.

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

Health care cost-control battle goes on

Continued from previous page
can be used to negotiate tailor-made benefit plans as seen in the relatively new triple-option plans now available from some of the largest insurers. Triple-option plans essentially allow an employer to administer three plans under one master plan, reduce both adverse selection and administrative costs and have control over expenditures with an overall experience-rated plan.

Another area of cost that presents cost-containment opportunities is the broad area of mental and nervous disorders, including substance abuse. Until lately, companies have not been aggressive in attempting to control this cost because of its sensitive nature and lack of good data. However, many companies have determined that they can't wait any longer and that it is important to begin controlling these costs.

One newer approach to the reimbursement and management of mental health services is the case management approach. The firms offering a case management approach guarantee savings of up to 10%, which may be an indication of the waste and unnecessary services presently being provided.

Two other costly health care areas are substance abuse and acquired immune deficiency syndrome.

There is agreement between both public and private sector experts that drug abuse may well be the most common health hazard in the American workplace today. In a broad-based study on substance abuse, North Carolina's Research Triangle estimated that alcohol abuse caused $65 billion in productivity losses, and drug abuse caused an additional $33 billion.

Drug testing is now being used by hundreds, if not thousands, of employers. According to surveys, the percentage of Fortune 500 companies screening employees or job applicants for drug abuse rose to almost 30% from 3% between 1982 and 1985.

Another very scary and costly area is the emerging AIDS epidemic. An AIDS patient is expected to incur an average of $140,000 in medical bills between the time the patient is diagnosed with the illness and his or her death, which usually comes within two years of diagnosis. And, when disability and group life insurance benefits are added, corporate costs for employees with AIDS increase even more. As a result of this cost, alternative forms of health care, such as home health care, hospice care and case management programs, must be considered to hold down AIDS treatment costs.

To be successful in managing health care costs in the future, we will need the assistance and cooperation of management, our employees and the providers of health care. The necessary actions needed to meet the future challenges will be even more difficult than we have experienced in the past—because, in most cases, we will be dealing with more sensitive areas and specific groupings of employees, including former employees.

Book takes comprehensive look at D&O cover

"Directors' and Officers' Liability Insurance"
Compiled by the Insurance Institute of London
20 Aldermanbury, London EC2V 7HY, England
184 pages, softcover. 10 pounds ($16.80) for institute members; 12 pounds ($20.16) for non-members

By Stephen Tarnoff

WITH THE RECENT publication of "Directors' and Officers' Liability Insurance," the Insurance Institute of London gives a welcome overview of the legal and insurance considerations governing a growing problem in the United States, United Kingdom and Europe.

Although D&O claims have been a problem in the United States for years, the increase of directors and officers liability claims is only beginning to have a major impact elsewhere, and this book will help anyone who is concerned with the problem.

". . .There is a growing interest in the United Kingdom in directors' and officers' liability insurance," the book notes in its introduction. "In the following pages, we examine the current situation, but what does the future hold? We would be brave indeed to predict a final position except to say that in 10 years' time the class will be a major premium earner."

Stephen Tarnoff is an associate editor at Business Insurance.

books & ideas

In 184 pages, the book succeeds in detailing the principles governing the duties and liabilities of directors and officers, the underwriting of the exposures and the coverage provided.

The book is of value not only to those in the United Kingdom, but to those in the United States and Europe as well.

Included in the book are summaries of the laws governing corporate officers and directors in the United Kingdom and the United States and also more limited discussions of the laws in 14 other countries.

In less than 20 pages, for example, the section on U.K. law includes a discussion of the duties of officers and directors, their potential statutory liability and the nature of criminal, civil and derivative actions that can be filed against them.

The section on the United States also discusses duties, responsibilities and loyalties of officers and directors and their liabilities under state corporation laws and state and federal securities laws.

This section also discusses directors and officers' liability for federal antitrust, tax and pension law violations and claims under the federal Racketeer Influenced & Corrupt Organizations Act.

Following the legal summaries for the United Kingdom and the United States is a catalog of cases and statutes cited in the chapters, along with suggestions for further reading.

The 14 additional countries for which the book gives a brief outline of directors and officers liability law are Australia, Canada, New Zealand, South Africa, Denmark, Finland, France, Germany, Japan, the Netherlands, Poland, Sweden, Czechoslovakia and Belgium.

The laws covering directors and officers and the insurance these executives purchase often differ considerably in those countries. For example, the section on Japan notes that although various types of professional liability insurance for Japanese physicians, accountants and architects are written, D&O cover and legal expense insurance are not yet available because of little demand for such coverage.

The book's sections on insurance coverage include discussions on the wordings in D&O policies, who is covered, in what circumstances coverage applies and what is meant by such terms as "wrongful act," "subsidiary" and "loss." There also is a discussion of exclusions along with various other details of D&O policies.

The final section of text addresses the underwriting considerations insurers take into account when writing D&O policies.

The book notes that, broadly speaking, the most important rating factors appear to be the size of the compa y, its business, the number of directors and officers to be covered and the company's locale.

More specifically, the book discusses the completion of a proposal form, accounts and financial statements and other sources of information that underwriters will require.

The book adds that insurers also attach importance to underwriting facts such as who the shareholders are, the company's business, its age and its financial health. "Probably more attention is paid to financial information than to anything else," the book notes.

Other important factors insurers consider when evaluating D&O risks are auditors' reports, overseas exposure, subsidiaries and past or pending legal actions, the book explains.

The final section of the book includes specimen D&O insurance policies in the United States and United Kingdom and copies of proposal forms. Also included is a list of offenses, modes of prosecution, punishment and daily default fines for not complying with the U.K.'s Companies Act.

Among those working on the report was John W. Morrison, a partner at the Chicago-based firm of Karon, Morrison & Savikas. Mr. Morrison is the first non-British member to participate in an advanced study group in the history of the Insurance Institute of London.

Sterilization covered if health risks present: Court

Does a sterilization procedure fall within the coverage for "bodily injury or illness" in a group medical insurance policy? A Louisiana appellate court ruled that where a woman was subject to a health hazard associated with three prior pregnancies coverage would be awarded.

Kim Poche was covered under a group health policy issued by The Travelers Insurance Co. The policy provided coverage for bodily injury or sickness.

Ms. Poche had a history of problem pregnancies. When she became pregnant with her fourth child she, along with her husband and their doctor,

legal briefs

decided to have a surgical sterilization procedure performed. Two days after the fourth child's birth, the doctor performed a sterilization procedure to prevent future pregnancies.

Although Travelers paid for the maternity hospitalization and doctor bills, it refused to pay the $350 charge associated with the sterilization procedure. Mrs. Poche sued. The trial court ruled against Travelers.

The appellate court said that, under the facts and circumstances of this case, the sterilization came within the scope of the "bodily injury or sickness" coverage of the policy because of the health hazard to Mrs. Poche associated with pregnancies.

Poche vs. Travelers Insurance Co., Court of Appeals of Louisiana, June 30, 1986, *rehearing denied* Aug. 4, 1986 (*BI*/05/A./$10).

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

Ways and Means Committee OKs Medicare expansion bill

By DEBORAH SHALOWITZ

washington

WASHINGTON—Legislation that caps out-of-pocket expenses for Medicare-covered services at about $1,600 per year is heading toward the House floor.

The proposal, approved by the House Ways and Means Committee earlier this month, would be financed by a new, income-related supplemental Medicare premium and an increase in the Part B monthly Medicare premium.

The legislation, H.R. 1280 and H.R. 1281, introduced by Ways and Means Health Subcommittee Chairman Fortney "Pete" Stark, D-Calif., originally would have been financed by taxing beneficiaries on a portion of the actuarial value of the benefits for which they are eligible (*BI*, April 13).

However, during markup of the legislation before the full Ways and Means Committee, many members said they were confused by that financing proposal and opposed to increasing the tax liability of Medicare beneficiaries.

Rep. Stark and the bill's cosponsor, subcommittee ranking minority member Rep. Willis Gradison, R-Ohio, offered an amendment to substitute a mandatory supplemental premium.

The committee rejected a catastrophic health insurance plan proposed by Health and Human Services Secretary Otis Bowen that would have been financed solely by raising the Part B premium (*BI*, March 23).

Under the legislation approved by the committee, the Part B monthly premium, currently $17.90, would not increase until 1990, when it would rise by $1. In 1991 and 1992, it would rise by $1.50 each year.

The annual supplemental premium under the proposal would vary with family income. For instance, families with annual incomes of less than $10,000 would not have to pay any supplemental premiums, while beneficiaries with annual incomes of between $10,000 and $15,000 would pay $38.04 annually, and those with incomes between $20,000 and $30,000 would pay $149.04.

The highest additional annual payment in 1988 would be $532 for families that make between $75,000 and $200,000, according to preliminary estimates by subcommittee staff members..

Under the legislation passed by the full committee, the maximum annual out-of-pocket expense for hospital-covered services for a beneficiary next year would be $541, while the maximum out-of-pocket expense for physician services would be $1,000.

A legislative aide to Rep. Stark said that Ways and Means Committee Chairman Dan Rostenkowski, D-Ill., has asked the health subcommittee to quickly report out legislation that would provide Medicare benefits for outpatient prescription drug expenses. That legislation then could be attached to the Medicare bill already passed by the panel.

Health care reform

Comprehensive, market-oriented health care reforms are necessary to control health care costs while maintaining the quality of care, says a report issued recently by the Committee for Economic Development.

The report, "Reforming Health Care: A Market Prescription," describes some innovative employer-provided health care plans and suggests several techniques that businesses can employ to lower their health care costs and respond to a changing health care environment.

The study was summarized at a press conference by William Woodside, chairman of the executive committee of Primerica Corp. in Greenwich, Conn., and chairman of the CED subcommittee that prepared the report.

One major step, according to the CED, is for all employer-based health care plans to include some degree of cost sharing, such as requiring employees to pay coinsurance or deductibles.

Also, employers should offer a choice of health care plans with

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washington

Continued from previous page
differing levels of benefits and allow employees to choose the most efficient provider, the CED says.

However, the CED recommends that employers contribute to any health care plan a fixed amount for each employee so that employees who choose more expensive plans will have to pay the difference.

Companies also can improve the management of their health care programs by supplying improved information on costs of services and requiring a variety of checks, including utilization review, on whether health care procedures are necessary, said the report.

An effective safety program for prevention of accidents and exposure to workplace hazards has an "extremely high payoff in terms of lower health care costs," according to the report. The CED also urged corporations to establish employee wellness programs that encourage health care prevention and fitness.

To combat the problem of uninsured workers, the CED suggested that employer groups, such as local chambers of commerce or business health care coalitions, working with insurers, can organize health insurance groups for small employers and individuals who do not have access to group insurance.

The CED also suggested several ways employers could include insurance for long-term care in employee benefit packages.

For example, an employer could offer to phase down his contribution to life insurance at some point in an employee's career and substitute long-term care insurance.

The CED also recommended that business provide coverage for high-cost medical innovations by adding optional riders to basic plans to cover the additional costs.

The report will be available June 10 for $9.50 plus 95 cents postage from the Committee for Economic Development at 477 Madison Ave., New York, N.Y. 10022; 212-688-2063.

OSHA penalty

USX Corp. will pay $65,000 in penalties and correct its injury and illness records dating back to January 1985 under a settlement reached with the Occupational Safety and Health Administration on a major record-keeping case brought against USX last year.

The agreement resolves federal citations issued in December 1986 against a USX coke plant in Clairton, Pa., but requires the conglomerate to correct its records at all of its facilities across the country over the next six months. USX, formerly U.S. Steel Corp., employs about 75,000 people nationwide.

OSHA had cited the Clairton plant for 98 alleged instances of willfully violating federal record-keeping requirements and proposed penalties totaling $130,000. USX did not admit any wrongdoing in the settlement agreement.

In other terms of the settlement, USX agreed to modify its corporatewide record-keeping practices to comply with Bureau of Labor Statistics guidelines and provide a report to the secretary of labor by July 1, 1987, confirming that this has been done.

OSHA reduced the number of instances listed on the Clairton citation to 88, but retained the characterization of the incidents as willful.

"The significance of the settlement goes far beyond the outcome of these citations," said OSHA Assistant Secretary John A. Pendergrass. "We have achieved companywide abatement of a safety and health problem without having to inspect, cite, negotiate or litigate at every USX plant."

Retiree benefits

Legislation passed last year that protects health and life insurance benefits for retirees whose former employer has filed for bankruptcy has been extended by Congress beyond its May 15 expiration.

The law will now expire Sept. 15.

The legislation, S. 903, originally was approved only as a stop-gap measure when Dallas-based LTV Corp. tried to cut off retirees' health and life insurance benefits after it filed for bankruptcy last summer (*BI*, Aug. 4, 1986).

Two bills introduced earlier this year, S. 548 and H.R. 1186, which would permanently prohibit companies filing for bankruptcy from unilaterally suspending health and life insurance benefits for union and non-union retirees, are in subcommittee (*BI*, March 16).

Tax reform guide

The congressional Joint Committee on Taxation has released a 1,379-page document explaining the Tax Reform Act of 1986.

The "blue book," so named because of its blue cover, traces the legislative background of the act, details the act's provisions and provides estimated revenue effects of the new law.

The book also includes many references to congressional intent in drafting the major tax overhaul program and has footnotes indicating where technical corrections are necessary.

The document was prepared by the JCT staff and staff members of the Senate Finance and House Ways and Means committees.

The document, titled "General Explanation of the Tax Reform Act of 1986," (Stock No. 052-070-06311-4) is available for $31 from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402-9325; 202-275-3030. ■

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EMS helicopters

Continued from page 3

technical programs for Alexandria, Va.-based Helicopter Assn. International, a trade organization.

Still, the field is growing and other EMS helicopter operators are turning to what they hope will be a life-saving tool for their operations—better risk management.

In an attempt to minimize their losses, some EMS helicopter operators are instituting more stringent risk management procedures, including:

- Increasing pilot training and adding more pilots to reduce fatigue and stress.
- Establishing safer nighttime flying procedures.
- Requiring that helicopters operate safely under more adverse weather conditions than in the past.
- Establishing minimum weather conditions in which helicopters will fly.
- Using new weather forecasting services designed to provide forecasts of more specific areas.

However, the insurance industry's role as informal regulator of most operational policies and procedures may end soon.

The Federal Aviation Administration, which licenses EMS helicopters primarily under the same rules air taxi businesses must follow, is reviewing EMS helicopter operations and may impose federal safety guidelines.

EMS helicopters now go far beyond the "grab and run" air ambulance service developed by the Army during the Korean War and depicted in "M*A*S*H," said Howard Collett, editor and publisher of Hospital Aviation magazine.

Since their inception in the early 1970s, EMS helicopters have become more like portable intensive care units that fly highly trained medical personnel and emergency room services to the side of an often critically ill patient.

As a result, more lives have been saved, said Nina Merrill, executive director of ASHBEAMS, a San Diego, Calif.-based professional organization for both helicopter and fixed wing aircraft that transport injured persons.

In addition, the quality of the lives of many accident victims has been improved by the use of EMS helicopters, she said. For example, quick transport of a worker whose arm has been severed by a machine can mean the difference between saving or losing the arm, Ms. Merrill explained.

Hospital-sponsored EMS programs transported 75,000 patients last year, in addition to the 10,000 patients who were transported by non-hospital sponsored programs operated primarily by public entities, according to Mr. Collett. Transports include not only emergency cases, but transferring stabilized patients between hospitals.

And the number of EMS helicopter operations and patients they transport is growing. EMS helicopters are expected to transport nearly 100,000 patients this year, an increase of 17.6%. And about 20 to 25 new programs are expected to join the 140 hospital-based EMS programs nationwide, Mr. Collett said.

The existing hospital programs contract with about 36 helicopter operating companies, which utilize 170 helicopters, he said.

Hospitals are expanding their sponsorship of EMS services for several reasons, including the fact that "helicopters are great bed fillers," because they expand a hospital's service area, Ms. Merrill observed.

EMS helicopter services also provide hospitals "good publicity" and become a "visibility catalyst" for a hospital, Mr. Collett said. "It really puts them on the map."

But loss experience numbers tell the story why all commercial helicopter operations, especially EMS operations, are struggling for their survival.

Although there was a five-year low of 212 accidents in 1986 involving all types of civilian helicopters, a four-year high of 77 people died in those accidents, according to statistics provided by the National Transportation and Safety Board.

Civilian operations include EMS helicopters as well as charters, offshore work and helicopters used as "flying cranes" for jobs like hauling air conditioning units to the top of skyscrapers, explained a major aviation underwriter.

About 60%, or 4,800, of the 8,000 helicopters the FAA considers active in the United States today are flown for commercial purposes, according to Mr. Woolnough.

EMS helicopter operations have a worse accident rate than other helicopters, observers say.

Generally, the number of EMS accidents in recent years is two or three times higher than the number of accidents for all helicopters, Mr. Collett noted.

A four-year high of 77 people died in civilian helicopter accidents in 1986, says the NTSB.

John Galipault, president of the Aviation Safety Institute in Worthington, Ohio, said an EMS helicopter "is three times as likely to have an accident as a corporate helicopter."

In the 1980s, there were about eight accidents per 100,000 flight hours for all commercial helicopters, according to Mr. Woolnough of the HAI. However, that accident rate is considerably lower than the 30 accidents per 100,000 flight hours recorded in the 1970s, he pointed out.

Mr. Collett said there were 15 accidents last year involving hospital-based EMS helicopter programs. Those accidents resulted in 15 deaths, according to Ms. Merrill of ASHBEAMS.

However, spokesmen for the National EMS Pilots Assn. in Houston, say the number of accidents involving all types of helicopters on EMS-type missions is closer to 28. They noted, though, that some of those accidents may have been downgraded to less-serious "incidents."

In addition to the number and severity of helicopter accidents, insurers are concerned about the increasing cost of both liability claims and repairing the increasingly sophisticated machines, Mr. Woolnough of the HAI said.

Whether a case goes to court or is settled has a big effect on liability claims.

A review of 20 general helicopter-related lawsuits from 1980 to 1984 shows that a death claim results in an average $700,000 payout if settled out of court. If the case goes to court, the average jury verdict is $1.2 million, according to Don Marshall, director of research services for the Solon, Ohio-based Jury Verdict Research Inc.

The result has been rate increases as high as 900% for some operators of high-risk helicopter services, according to ASHBEAMS' Ms. Merrill.

For example, Woody Stamer, who operated Executive Helicopter Inc., an EMS helicopter service at Chicago's Midway Airport for 13 years, shut down his operation at year-end 1986 because insurance rates rocketed despite the company's good safety record.

Mr. Stamer received a $22,800 renewal quote for $20 million in combined single limit insurance for each of his eight helicopters

Continued on next page

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EMS Helicopters

Continued from previous page
last year, an increase from $6,000 per helicopter, according to Robert W. Bryan, Mr. Stamer's insurance agent.

Mr. Stamer and Mr. Bryan subsequently formed Schaumburg, Ill.-based Rotorcraft Assn. of North America, a combination trade association and insurance brokerage, to help helicopter owner-operators with up to 20 helicopters find affordable insurance coverage.

But, for the first time in several years, some helicopter operators are finding rates stabilizing. Some have had no premium increases this year.

Stephen Dinsdale, vp with Southern Maine & Aviation Underwriters in New Orleans, said that rates are now "fairly stable" following price increases last year.

While some underwriters may be holding rates steady, some insurers are imposing sublimits in policies for passenger liability.

Helicopter insurance typically consists of liability coverage—for bodily injury, third-party property damage and passenger liability coverage—up to a combined single limit that typically ranges from $1 million to $50 million or more.

But some insurers now are including a sub-limit in policies for passenger liability. Typical sublimits could limit payout on a passenger's liability claim to $100,000, $200,000 or $250,000, one aviation underwriter said.

EMS helicopter operators fighting to stay in business now are stressing risk management techniques that underwriters and industry professional organizations —through the use of peer review and pressure—have taken the lead in urging.

In response to accident cause data, the aviation underwriter said, "we are trying to be a bit more selective and are setting up

Rates are now 'fairly stable' following price increases last year, according to Stephen Dinsdale.

stiffer requirements for a risk to be acceptable."

Those requirements may include stipulating or raising the minimum numbers of hours pilots must have in general flight experience, flying the type of helicopter being insured and in training and recent retesting.

An underwriter also may specify the maximum number of hours a pilot can be on call and the minimum number of pilots an EMS operation must use, the underwriter said.

Spokesmen for the National EMS Pilots Assn. agreed that a primary cause of accidents is pilot stress and fatigue resulting from programs operating around the clock with three, rather than four pilots.

And Mr. Collett said that preliminary results of recent accident data appear to show that some EMS pilots are not appropriately trained.

Weather-related problems and night flying also are major causes of EMS accidents, according to observers.

However, nighttime accidents can be minimized by flying only to pre-surveyed heliports rather than directly to an accident scene, noted a spokesman for Vanderbilt University Medical Center in Nashville, Tenn.

For some EMS pilots, the problem of bad weather is coupled with a lack of instrument-flight equipment on some EMS helicopters, the pilots' spokesmen say.

In those helicopters lacking instrument-flight equipment, a pilot who runs into bad weather has great difficulty flying safely through cloud cover and finding a safe landing site.

ASHBEAMS and the pilots' association, which are among EMS-related groups that are promulgating their own industry standards, recommend that EMS helicopter operators use additional helicopter equipment to cope with poor weather conditions, as well as establish the minimum weather conditions that must exist before rescues will be attempted.

Saying "no" can be difficult when an injured person needs help, so hospital administrators and the EMS flight team must work together to balance a zeal to serve with the dictates of safety, agreed Karl B. Gills, senior vp of hospital operations at North Colorado Medical Center in Greeley, Colo.

In bad weather, "sometimes saying 'no' is the right thing to say," Mr. Gills said.

One risk management tool to help EMS helicopter operators steer clear of bad weather may be a computerized weather forecasting service that provides timely localized forecasts to pilots or dispatchers. The pilots or dispatchers either log onto a data base for a weather report with maps or view a constantly updated color monitor that depicts storms in different colors that reflect the storm's intensity, explained Greg Slater, national sales manager of Kavouras Inc.

Although some sources emphasized how quickly weather patterns change, a spokesman for Vanderbilt University Medical Center found the computer service helpful in determining the location of changing weather patterns and the speed in which they are moving.

Only "about 20% of all EMS accidents are due to mechanical failure," said Mr. Galipault of the ASI.

In addition, hospitals must educate themselves about EMS services and realize that the lowest-priced EMS service may not be the best, unless it also includes important safeguards.

Many operators are finding that they can have their insurance renewed by explaining to insurers what they are doing about using available safeguards to manage risk, Mr. Woolnough of the Helicopter Association International said.

Despite attempts by helicopter operators to reduce their losses, more federal regulation may be on the way.

The Federal Aviation Administration in March ordered its field representatives to inspect EMS operations during a 60-day period and forward data about these operations to officials in Washington, D.C., according to an aviation administration spokesman said.

That information is being compiled and a report is expected to be released in a month or so in an effort to determine if additional regulation in needed, the FAA spokesmen said.

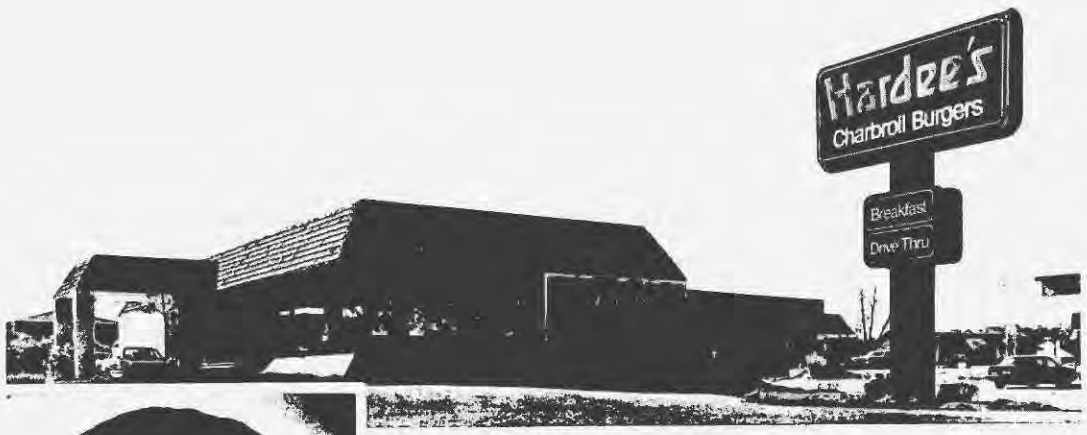
The FAA currently regulates EMS helicopters flight under rules established for air taxi businesses, although pilots are allowed to work longer hours than commercial pilots if they have separate quarters where they can rest when not airborne.

Other FAA regulations include pilot licensing and medical examinations as well aircraft design, equipment and maintenance, an FAA spokeswoman said.

However, Mr. Galipault of the ASI does not agree additional federal regulation is necessary.

"I think the insurance industry is pretty well specifying to EMS activities how they should operate.

"I don't think that more regulation is needed," he said. "Everything is in place and all we need now is for people to use them." ■





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Susan Werner, Director of Risk Management, Hardee's Food Systems, Inc.

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RISK MANAGEMENT SERVICES

Broker results

Continued from page 1

did not play much of a factor in M&M's first quarter, he added that "if a particular broker handled a predominance of property accounts, that could have made a difference" in their revenues.

However, Mr. Bundy attributed M&M's strong performance partly to its focus on insuring the needs of very large corporate clients. Brokers with "a lot of jumbo business had a much better quarter."

He explained brokers that handle small to medium-sized accounts are not seeing the commission increases of previous quarters because of stabilizing rates.

On the other hand, brokers with a predominance of jumbo business found that many of their clients, which were unable to purchase huge limits of coverage during the past two years, are filling out their programs with new-found capacity, thus generating higher commissions for the brokers.

In addition, M&M's "ability to distinguish itself from the pack" and the talents of its management team have boosted the brokerage's results, Mr. Bundy added.

While Marsh & McLennan will "not be immune to the soft market," it will be better positioned than the other brokers because of its diversity and size of operations and will continue to grow, predicts Mr. Wilson.

M&M's "pre-eminence in the reinsurance market and its ability to create markets when none are available differentiates it from the rest of the pack," agreed Shearson's Mr. Weinhoff. He sees continued revenue growth for M&M throughout 1987, both in its property/casualty and employee benefits business.

Marsh & McLennan's benefits business was boosted in the first quarter by the brokerage's acquisition of Deerfield, Ill.-based benefit consultant A.S. Hansen Inc. in late February (*BI*, Dec. 15, 1986). M&M gained 700 employees through the acquisition and significantly boosted the client base of M&M subsidiary William M. Mercer-Meidinger Inc., the world's largest benefit consulting firm.

Results for Alexander & Alexander, the second-largest U.S. broker, were less positive.

A&A reported a 7.9% first-quarter gain in gross revenues to $269.5 million from $249.8 million in the first quarter of 1986. However, A&A's net income dropped 34.8% in the quarter to $14.4 million from $22.1 million in 1986.

Included in A&A's profits for the first quarter is a gain of $6.1 million from the sale of an office building in Paris by a 50%-owned subsidiary.

"The problems are not behind A&A," said Mr. Rosencrants, pointing out that profits from the sale of the Paris office building inflated the brokerage's first-quarter net income.

A&A's first quarter "fell short of most analyst expectations. A&A needs a few good earnings quarters to re-establish the confidence of investors," said Mr. Wilson.

"Our first-quarter revenues were slightly less than we had forecast," said Tinsley H. Irvin, A&A's president and chief operating officer.

"Certain segments of the market are softening quicker than we had anticipated," said Mr. Irvin. "Property business has become very competitive, and traditional owners, landlords and tenants liability-type business is becoming more competitive," he commented.

In addition, weakness in the amount of professional liability business written by Evanston Insurance Co., of Evanston, Ill., which A&A holds a 52% interest, negatively impacted the brokerage's results by approximately $4.5 million, explained Mr. Irvin.

"We feel this is a first-quarter situation," Mr. Irvin stressed. "Evanston's volume was down because of the change in the insurance marketplace. Evanston is changing its strategy to redirect business efforts in other areas to bring its premium volume back up," he added.

Mr. Irvin said A&A has instigated expense controls that should reduce expenses in 1987. He explained that part of the reason expenses were so high in the quarter is because the brokerage added about 1,000 employees during 1986 and those expenses were fully realized in the first quarter of 1987.

However, Mr. Bundy is not convinced that A&A will be able to recover that rapidly from its current problems.

A&A "management has shown the ability to make mistake upon mistake" in the past and there are "still potential risks left," Mr. Bundy said. Risky areas, he said, include Evanston Insurance Co.

Continued on next page

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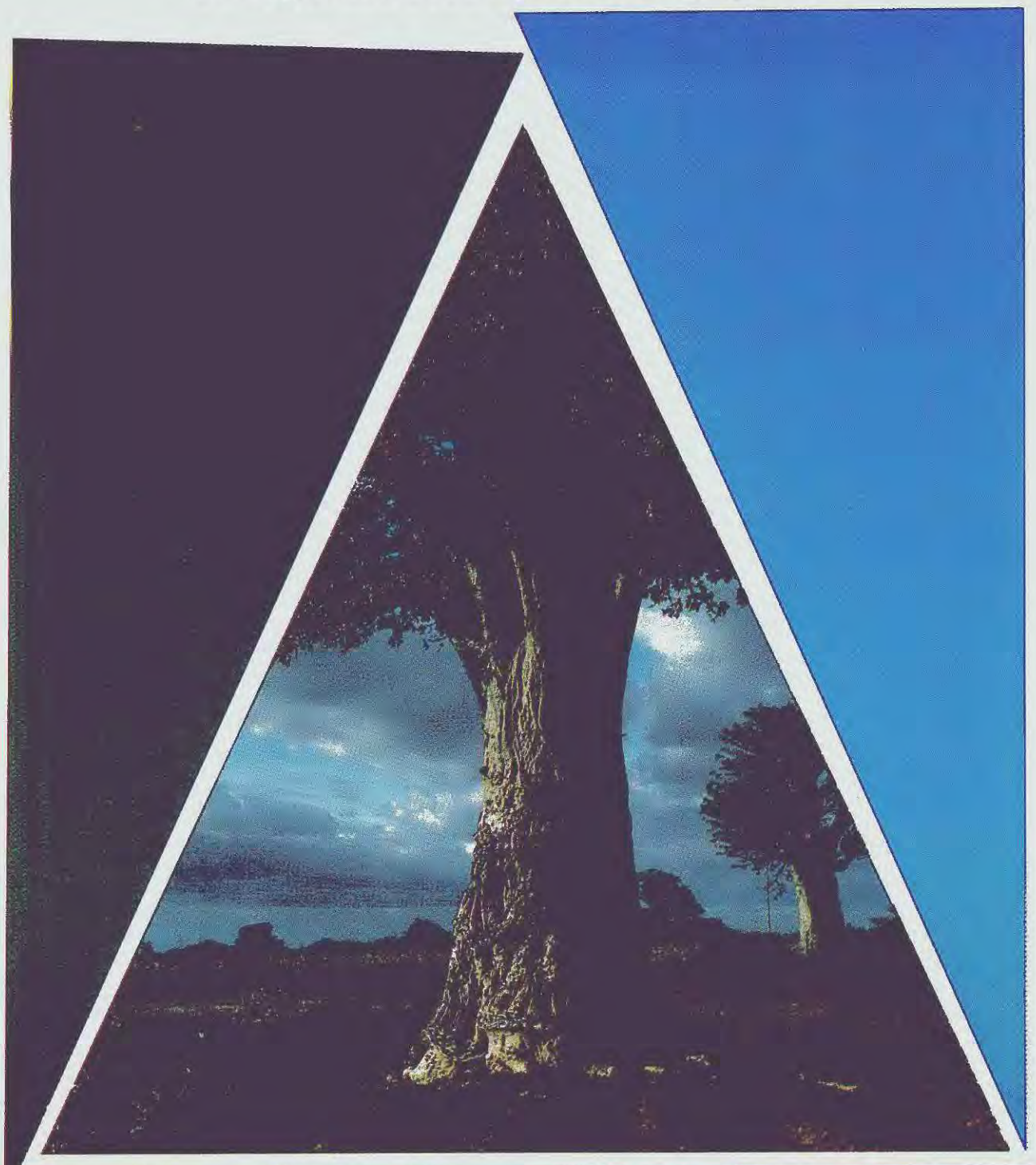
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Broker results

Continued from previous page
and underwriting manager Shand, Morahan & Co. Inc., also of Evanston, Ill., both of which A&A is currently trying to sell.

Briarcliff Manor, N.Y.-based Frank B. Hall reported first-quarter gross revenues of $105.6 million, a 5% increase over a restated $100.6 million in the first quarter of 1986. Hall restated its 1986 results following its decision to treat subsidiaries Adjustco Inc. and Frank B. Hall of California's Stockton division as discontinued operations (*BI*, March 23).

Hall's net income for the first quarter decreased 14.5% over the first quarter of 1986, falling to $7.8 million from $9.1 million.

Net incomes for brokers "have dropped off across-the-board" due to rate stabilization in 1987, said Hall Senior Vp John A. Addeo.

While Hall has "obviously" lost some market share, "we have seen no significant deterioration," he said.

"New business development is first and foremost in the minds of our profit center and senior corporate managers," Mr. Addeo added.

But Mr. Wilson noted that while Hall is "making a strong effort" to improve Hall's performance, "turnarounds take time."

Mr. Weinhoff agreed. "With its new management in place, each quarter will be a little better," he predicted.

However, Mr. Bundy and Mr. Rosencrants are not so optimistic. Both are recommending investors sell A&A and Hall stock because of continuing problems.

Mr. Rosencrants explained that both brokers find themselves in a Catch-22 situation: While they need to reduce expenses to improve results, "they must pay competitive wages to keep producers" and generate new business.

New York-based Corroon & Black announced a 15.4% increase in gross revenues in the quarter to $97.2 million from $84.2 million in the first quarter of 1986. The brokerage also reported a 24.7% gain in income from continuing operations for the quarter to $14 million from $11.2 million in the first quarter of 1986.

However, due to a $4.7 million charge for discontinued operations in the quarter, Corroon & Black's net income dropped 17% to $9.3 million from $11.2 million in the first quarter of 1986.

The charge stems from a settlement offer made by Lloyd's of London to members of loss-riddled Lloyd's syndicates formerly managed by PCW Underwriting Agencies Ltd., a now-defunct subsidiary of Minet Holdings P.L.C. Corroon & Black holds a 25% equity interest in Minet.

Under the settlement offer, 37 organizations—including Minet—will contribute 55 million pounds ($92.4 million) to help pay PCW syndicate losses (*BI*, April 13).

Minet has not yet announced how much it will contribute toward the proposed settlement, but has reserved 12.9 million pounds ($21.7 million) from its 1986 earnings to cover PCW liabilities.

"The provision made in our financials consisted of more than our proposed contribution to the settlement," said Stephen Crane, Corroon & Black's senior vp and chief financial officer.

Analysts did not seem to be troubled by the Minet charge and were generally positive about Corroon & Black's performance.

"In terms of the first quarter, we view Corroon & Black's results pretty positively," said Mr. Weinhoff.

Mr. Wilson said Rothschild is recommending accumulation of Corroon & Black stock for long-term investment and says it appears "promising" that Minet's problems may soon be behind it.

According to Mr. Crane, Corroon & Black's revenue growth in the quarter was attributable to "continued strength in its Brokerage Services Group, helped by contingent commissions and continued high growth in the professional liability operations" of its Specialty Services Group. "Minet's contribution to Corroon & Black's results was very substantial from an ongoing operations standpoint," he added.

Rolling Meadows, Ill.-based Arthur J. Gallagher reported a 9.2% gain in gross revenues in the first quarter to $31.6 million from $28.9 million in the first quarter of 1986. But, net income dropped 23% to $3.4 million from $4.5 million.

Three factors affected the brokerage's results for the quarter, explained Michael J. Cloherty, vp of finance.

"First, we are seeing competition, although it is still sporadic, geographic and by line and by company. We experienced about $750,000 of renewal rate decreases in the quarter overall."

Secondly, "We still experienced some lost business in the quarter by clients who decided to assume their own risks or to not buy levels of excess coverage, which had about a $1.5 million effect on our results," Mr. Cloherty added.

Thirdly, the brokerage made a one-time decision, due to the continuing difficulty in placing primary levels of brokers errors and omissions coverage, to reserve about $1.1 million to fund losses within the deductible under its own E&O policy, he explained.

All in all, Gallagher's results "were in line with our budget forecasts," Mr. Cloherty said, adding that the brokerage is "optimistic" about the rest of 1987.

Mr. Rosencrants is recommending that investors hold onto Gallagher stock right now, as are Mr. Wilson and Mr. Bundy. Mr. Weinhoff does not track the brokerage's results.

Tampa, Fla.-based Poe & Associates reported a 2.8% gain in gross revenues in the first quarter of 1987 to $8.4 million from $8.2 million in the first quarter of 1986. For the same period, Poe's net income increased 0.5% to slightly more than $1.2 million from slightly under $1.2 million.

Chairman William F. Poe attributed the brokerage's flat first quarter to the tort and insurance reform legislation enacted by Florida in 1986 that prompted many insurers to stop writing new business in Florida (*BI*, Dec. 15, 1986; July 7, 1986; June 16, 1986). Approximately 70% of Poe's retail business is written in the state.

Mr. Poe explained that while capacity and the insurance climate in general are showing signs of improvement in Florida, it will take time to catch up and generate substantial new business growth.

"You can slam the door in eight hours and stop business, but you can't start it up again that fast," he said.

"Because of the substantial weight of business we write in Florida, we are going to be aggressive in new business efforts. We've maintained our expenses closely, and now we plan to add new salespeople to our force," Mr. Poe explained. He anticipates some revenue growth in the second quarter and more substantial growth in the second half of 1987.

None of the analysts contacted tracks Poe's results. ■

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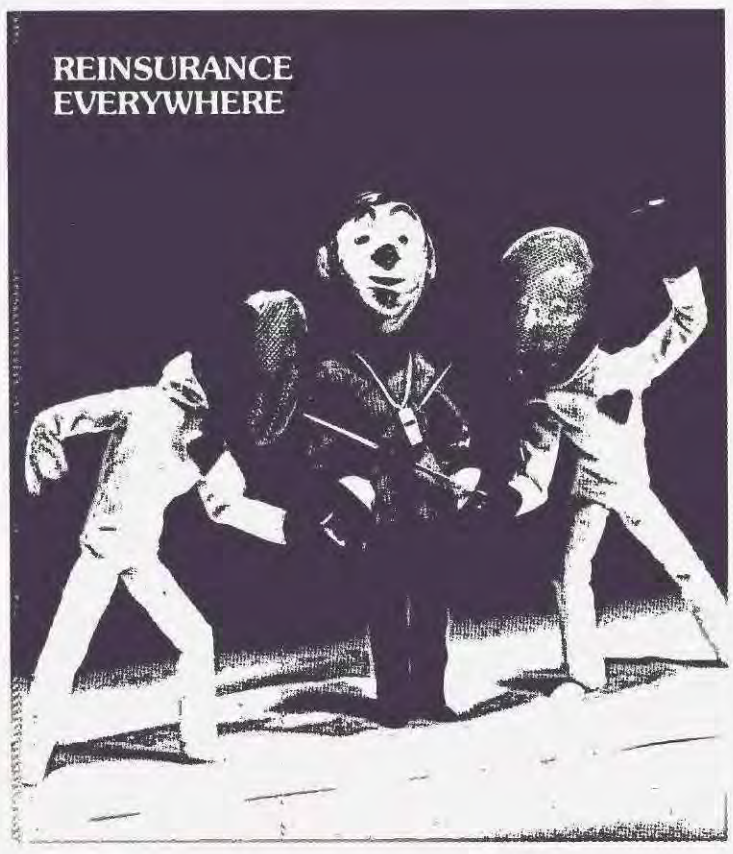
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Valentine gives profits from Imperial to charity

By CAROLYN ALDRED and STACY SHAPIRO

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LONDON—The managing director of Janson Green Holdings Ltd., found guilty of detrimental conduct by Lloyd's of London earlier this month, is donating the proceeds from his small interest in Imperial Insurance Co. (Cayman Islands) Ltd. to Lloyd's Charities Trust.

Lloyd's recently found that Peter Valentine had committed two breaches of Lloyd's bylaws falling into the category of "detrimental conduct" in relation to his and former Lloyd's Chairman Sir Peter Green's interest in Imperial.

Sir Peter was censured after being charged with discreditable conduct and fined 32,500 pounds ($54,275) by Lloyd's, while Mr. Valentine was fined 5,000 pounds ($8,400) for his failure to disclose his 0.5% share of Imperial and for distributing a letter by Sir Peter in 1983 that contained an error regarding Imperial (*BI*, May 11).

Mr. Valentine's attorney is currently negotiating with Lloyd's regarding how much Mr. Valentine must pay Lloyd's in legal costs, according to a Lloyd's spokesman.

Lloyd's found that Mr. Valentine had a "fiduciary duty," which he had not performed, to tell members of a Janson Green syndicate of the small profit he made from Imperial on two reinsurance policies placed by the syndicate with Imperial.

Lloyd's calculated that Mr. Valentine's share of the profit from the reinsurance policies between 1974 and 1982 totaled $13,015.

"It seems that this (calculation) alone occupied about 70,000 pounds ($116,900) of time of the accountants engaged by Lloyd's," said Mr. Valentine in a letter to Janson Green syndicate members.

Mr. Valentine calculates that each member that had a constant premium limit of 50,000 pounds on the syndicate between 1974 and 1982 is owed 6.36 pounds ($10.62). "Should you wish it, your precise share will be calculated and remitted to you," he said.

However, since the sums are very small, "this may appear a rather hollow offer," he said. "Therefore, I intend to donate $13,015 or the sterling equivalent to Lloyd's Charities Trust.

"I need hardly tell you that it is a matter of keen personal regret to me that any action or omission on my part should have constituted detrimental conduct within the meaning of Lloyd's rules."

Lloyd's disciplinary committee and Lloyd's appeal tribunal led by Lord Wilberforce pointed out that there was "no question of dishonesty" involved, added Mr. Valentine. "My intent in all that I have done has always been to benefit the names and I believe that I have consistently achieved that over a period of many years."

Outhwaite syndicates

Lloyd's of London underwriting agency R.H.M. Outhwaite (Underwriting Agencies) Ltd. is expected to shed more light on the deterioration of its syndicates' 1982 account when it publishes its 1986 annual report at the end of May.

So far, approximately 1,600 members of Outhwaite's marine syndicate 317 and incidental non-marine syndicate 661 have been asked to pay 10.3 million pounds ($17.3 million) in cash by the end of July to respond to asbestos-related claims on mostly runoff reinsurance policies for the 1982 accounting year (*BI*, May 11).

Altogether, about 50 runoff policies were placed with the Outhwaite syndicates between 1981 and 1982, although not all of those are being disputed by the Outhwaite agency, said Maurice Hussey, chairman of the Outhwaite agency.

At least six other underwriting agencies have told Lloyd's members they are having trouble collecting claims on runoff reinsurance policies placed with non-marine syndicate 661. At least 10 syndicates and two insurance companies may be affected by the Outhwaite syndicates' refusal to pay asbestos- and pollution-related claims (*BI*, May 4).

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Update

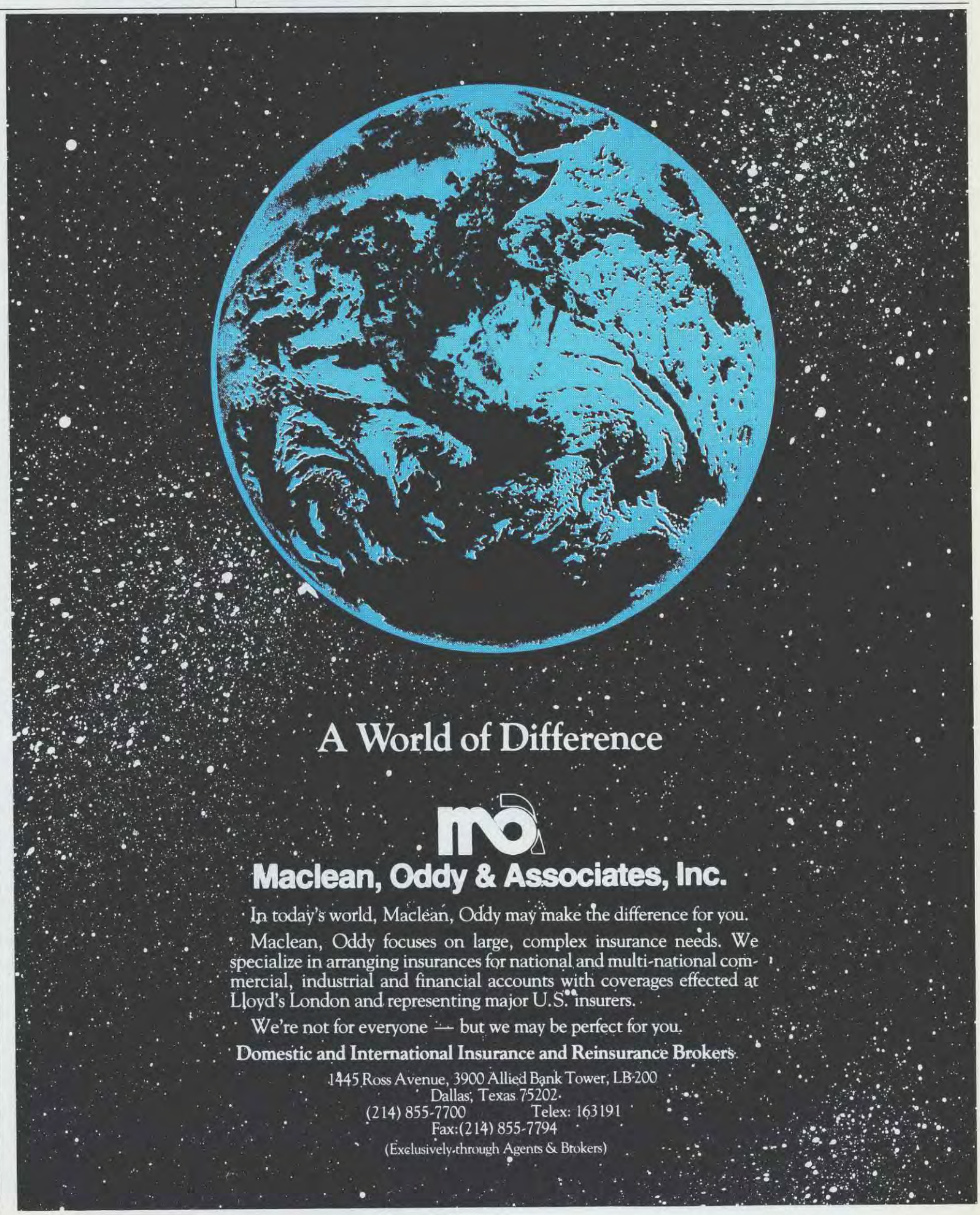
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london

Continued from previous page

In the 1986 annual report, the Outhwaite agency is expected to explain to Lloyd's members why they are being asked to pay a cash call this year and the impact of the disputes with other syndicates on the Outhwaite syndicates.

Updated figures for the 1982 Outhwaite syndicates' account are expected to show that total losses before reinsurance have surged to around 243 million pounds ($407.4 million) from 201 million pounds ($337 million). Losses from the runoff policies have increased to 150.6 million pounds ($252.5 million) from 127.1 million pounds ($213.1 million), and incurred-but-not reported losses have jumped to 67 million pounds ($112.3 million) from 50.4 million pounds ($84.5 million).

The report also will explain in more detail the "time and distance" reinsurance policies that the Outhwaite syndicates have to cover losses on the runoff policies.

A "substantial amount" of the time and distance policies are retroceded to Pinnacle Reinsurance Co. Ltd., Mr. Hussey said.

The Outhwaite syndicates are having no trouble collecting from Pinnacle, according to Mr. Hussey.

London observers have claimed that the Outhwaite agency is stalling payment of claims until its time and distance reinsurance contracts are triggered, but Mr. Hussey denies that allegation.

The ceding syndicates placed the runoff policies—most of which have no limits—to cover losses during prior accounting years when the market began to realize that long-latent disease losses, especially asbestos losses, could be filed for those years, he said.

However, the ceding syndicates didn't give the Outhwaite syndicates sufficient information about the outstanding asbestos losses when the runoff policies were placed, he said. "We consider that the information available to the market on outstanding asbestos liabilities (at the time) was sufficiently well known that syndicates could have made better estimates than they did."

Legally, the ceding syndicates had an obligation to give all the known facts that were available to Lloyd's underwriter Richard Outhwaite, regardless of what was known by Mr. Outhwaite, at the time the runoff policies were placed, contends Mr. Hussey.

Also, "though we were aware of the likely development of asbestos (claims), it was impossible to predict what the effect would be on each of the syndicates' accounts. Only the (ceding company) knew what was in its years of account."

So far, Outhwaite syndicate 661 is only in litigation with Lloyd's marine syndicate 764/763, underwritten by Norman P. Compton and managed by Philip N. Christie & Co. Ltd. Christie filed a lawsuit in High Court against Outhwaite in January, Mr. Hussey confirmed.

Both Mr. Compton and the Outhwaite syndicates are appealing a summary judgment denying Mr. Compton the receipt of $627,094 that Mr. Compton claims the Outhwaite syndicate owes on a $5 million runoff policy, said Mr. Hussey.

Other syndicates have said that they will start arbitration proceedings against the Outhwaite syndicates, said Mr. Hussey, who added "we are prepared to go to arbitration on them."

The Outhwaite agency has a duty to its syndicates' members to dispute the asbestos-related losses on runoff policies, Mr. Hussey said.

"It has been made plain to us that we would be in breach of duty to our names if we did not question these policies," he explained.

Lloyd's authorities are aware of the problems at the Outhwaite syndicates and will probably encourage some kind of compromise "if they can," said Mr. Hussey.

But, the Outhwaite syndicates' members should not be worried about the outcome of these disputes, said Mr. Hussey. "We are not stalling for lack of cash."

Already, Outhwaite has reserved 75.9 million pounds to pay for the disputed losses. "If you look at the accounts you will see that we have the cash." In the meantime, the 1986 results will also show that for 1984, members of the Outhwaite syndicates earned a 15% profit for every 10,000 pounds of premiums underwritten, said Mr. Hussey.

This year, Outhwaite syndicates 317/661 have a total of 4,000 members with a premium capacity of 115 million pounds ($192.0 million).

Ferry disaster

A full-scale reconstruction of the events leading up to the March ferry disaster in Zeebrugge, Belgium, was conducted earlier this month using a sister ship of the Herald of Free Enterprise, which capsized March 6, killing at least 182 people.

The ship, owned by British ferry operator Townsend Thoresen, sank after sea water entered through open bow doors, causing the roll-on/roll-off ferry to tilt to one side and capsize (*BI*, March 16).

Although the bow doors of the The Pride of Free Enterprise, a sister ship also owned by Townsend Thoresen that was used in the reconstruction, were kept closed, investigators from the British Department of Transport and British Maritime Technology used video equipment to monitor the movement of the bow as the ferry left Belgium.

Cargo distribution on the passenger vessel was recreated as closely as possible to that of the Herald on the night of March 6.

Results of the experiment will be part of the official British public investigation of the disaster, said a spokesman for the Department of Transport.

Meanwhile, the head of the investigation, Mr. Justice Sheen, has condemned safety instructions issued by Townsend Thoresen after the ferry disaster.

The company's latest safety guidelines regarding the closure of bow doors are unsatisfactory and need immediate review, he said at an official public hearing.

Payments to disaster victims and survivors from the Channel Ferry Disaster Fund, a charitable disaster fund set up by the Dover District Council, an English public entity, have exceeded 1 million pounds ($1.68 million), said a spokesman. Contributions to the fund surpassed 4 million pounds ($6.72 million) last week.

Comings & goings

Mike Jones has become the chief executive of the Assn. of British Insurers, the principal trade association for more than 420 insurance companies in Britain. After working for The Life Offices' Assn. since 1968, Mr. Jones was appointed manager of the legislation department of the ABI when the ABI was established in 1985.

Eamonn O'Sullivan appointed resident engineer for Factory Mutual International in Dublin, Ireland, after working for FMI in London for the last four years.

Peter H. Purchon, chairman of Stewart Wrightson Management Services Ltd., has been elected president of the Insurance Institute of London. John Lock, general manager and director of Mercantile & General Reinsurance Company P.L.C., was elected deputy president. ■



Insurers facing regulatory pressures: Panel

By KATHRYN J. McINTYRE

QUEBEC—Regulation of the insurance industry is a growth issue, a state legislator and a former insurance commissioner agree.

And, the state system of insurance regulation should be defended against federal intrusion, they advise.

"You cannot assume renewed interest by Congress in your business is just a passing fad," John R. Dunne, a New York state senator, told insurers attending the 65th annual meeting of the Alliance of American Insurers in Quebec last week.


Sen. Dunne

"The only alternative to professional state regulation is amateurish regulation," noted Philip R. O'Connor, former director of insurance in Illinois and now chairman and chief executive officer of Palmer Bellevue Corp. in Chicago.


Mr. O'Connor

Both spoke on the "Politicization of the Regulatory Process" during the Alliance meeting. A panel including a consumer advocate, an insurance company executive and a current state insurance regulator added their observations on the issue.

Sen. Dunne, the Republican deputy majority leader of the New York state Senate, warned that "never before have conditions been so ripe for fundamental change in the way your industry is perceived and, in turn, regulated."

Members of state legislatures and Congress are more interested in the insurance business now than they ever have been, Sen. Dunne reported, citing the "continuing crisis in the availability and affordability of liability insurance."

Noting that the current insurance crisis strikes at all types of consumers from small businesses to municipalities, Sen. Dunne said that "the present crisis is different" from past insurance market problems that struck doctors and hospitals in the mid-1970s.

While the former insurance market problems were isolated to specific types of policyholders, in the current market, "Little Leagues, civic groups, physicians, manufacturers and small business owners besieged my office and those of my colleagues with horror stories of unavailability and of drastically increased costs for liability insurance," Sen. Dunne said.

"Our constituents did not distinguish between their state and federal representatives," Sen. Dunne stressed. "They demanded action and they couldn't care less that the McCarran-Ferguson Act existed," he said, referring to the federal law that delegates regulation of insurance to the states.

As a result of consumers' demand for action, insurers now "must defend your industry before multiple state and federal agencies and the Congress," he observed.

Sen. Dunne advocated that the state system of insurance regulation be improved to "demonstrate that the states are up to the task that they have been delegated by Congress."

Insurance companies can assist that effort by supporting increased funding for state insurance departments and by demanding effective and fair state regulation, he said.

Mr. O'Connor also advocated insurance industry support for "quality state regulation."

"The idea that a weak regulator will stay out of your hair is misplaced," because in times of crisis, the governor will get "weak advice" from a weak regulator, Mr. O'Connor advised.

While Congress is more interested than ever in the insurance business, Sen. Dunne predicted that "for the immediate future, significant change will likely continue to come from within the states."

And, there will likely be little tort reform for insurers without insurance reform, Sen. Dunne advised. "In return for tort reform, the states have increasingly abandoned the 20-year trend toward open competitive rating and moved in the direction of some form of prior approval and, in some cases, mandating outright rate reductions."

Mr. O'Connor pointed out that tighter rate regulation, such as regulating the insurance industry as a utility, "would drive prices up."

Mr. O'Connor, who also has served as Illinois' chief public utility regulator, said utility ratemaking principles would "support weak players" by keeping rates at a high enough level to keep companies solvent. "More money would come out of consumers' pockets."

This is the "contradiction" in consumers advocating tighter regulation of insurers, he observed.

"The battle lines are drawn" over repeal of the McCarran-Ferguson Act, Mr. O'Connor also pointed out. The coalition in favor of repealing the law, which gives insurers limited exemption from antitrust laws as well as delegating the regulation of insurance to the states, includes the Reagan administration and consumer advocates, he said.

Insurers' efforts to negotiate on regulation have been made even more difficult because the "era in which far-reaching regulatory laws were worked out by politicians with a long-term view in conjunction with the experts is gone," Mr. O'Connor observed. Special interest groups are vying for influence over the industry, and regulations now are "worked out in compromise," he said.

The interest groups include trial attorneys and slices of the insurance market, such as day care center operators, medical professionals and municipalities.

"Many of the new players have legitimate interests to protect. Others are institutionalized advocates," Mr. O'Connor said, which subject the industry to far more scrutiny than in the past.

At the same time, the insurance industry has lost its credibility, he added. "The aggregate size of the industry, the fact that insurance is basically an unsatisfying sort of product, and everybody's ability to have had one bad claims experience, and the inexplicable nature of the industry's pricing and underwriting are not designed to inspire love and affection," he observed.

In addition, the insurance business is fragmented, with several insurance trade associations, he said.

And, insurers do not maintain consistent positions, Mr. O'Connor observed. "It's a little difficult for a legislator to hear that it's very bad to consider prior approval of rates for commercial liability but don't touch workers comp," he said.

"Today, one cannot even get industry unanimity on the question of federal regulation of insurance," he said.

In the face of this growing demand for tighter insurance regulation, Mr. O'Connor advised insurers to "tell a consistent story" and "develop a new paradigm" for the industry, as well as conduct the research necessary to support their arguments and to lobby for their opinions at the grassroots level.

There is no "commonly subscribed-to paradigm setting out the mission of the insurance industry and the context in which and purposes for which it should be regulated," Mr. O'Connor observed.

After listening to Sen. Dunne and Mr. O'Connor, panelist C.I. Buxton II, chairman and chief executive officer of Federated Mutual Insurance Co. in Owatonna, Minn., said: "I don't know if we should throw in the towel or not. It's an awesome challenge."

Responding to criticism of insurers pulling out of markets, Mr. Buxton noted that "there are markets that we are breaking away from because the long-term immeasurable risks aren't fair to the balance of our policyholders."

Panelist Linda F. Golodner, executive director of the National Consumers League in Washington, D.C., advised insurers to "provide access to the industry for consumers, legislators and the media. We are cut out of the process that we don't understand.

"The industry must shift from a mentality that focuses narrowly on next quarter's profits to moving closer to the customers' and their insurance needs."

Insurers must be "open and providing information," she continued. "Unless consumers understand how insurance works and why, you cannot expect them to be sympathetic when you ask them to defend the industry decisions before legislators."

However, Ms. Golodner also observed that lobbying for caps on damage awards is "anti-consumer."

Illinois Director of Insurance John E. Washburn observed that most state legislators operate under what he calls the "squeal-feel" theory: "They hear the squeal on one side so they take some action until they hear a corresponding squeal on the other side and then they know they have gone too far."

Mr. Washburn also observed that insurers alienated agents and brokers during the tight commercial insurance market, so agents and brokers did not attempt to explain to the consumer why premiums were going up.

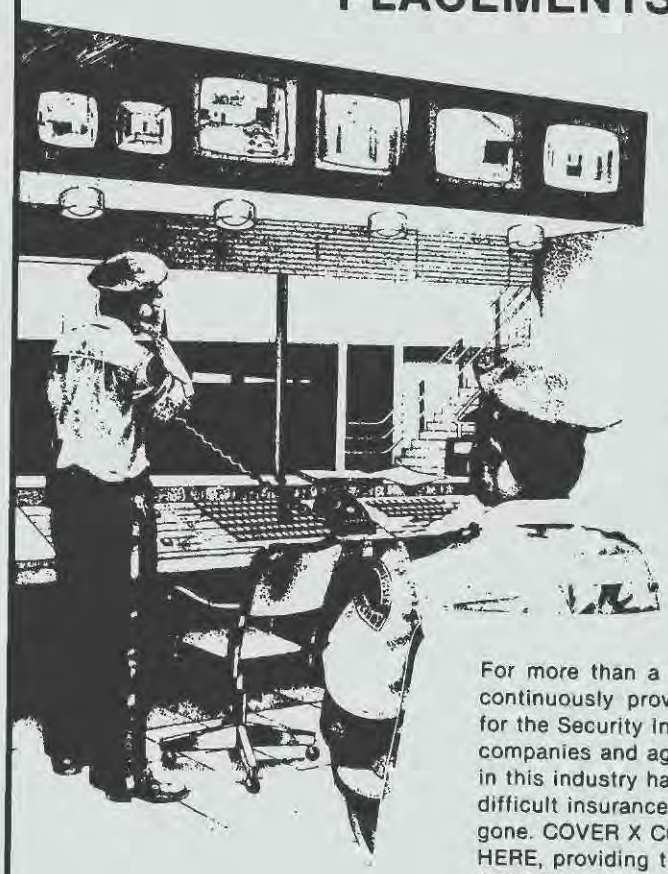
Mr. Washburn predicted that that government will demand more data from insurers, which will be expensive. "You are going to be asked to do a lot more reporting an individual basis," he warned. ■

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Insurers must seek 'balance': Nutter

By KATHRYN J. McINTYRE

QUEBEC—The insurance debate today pits insurers' need for an adequate return on capital against the public's need for the security of the insurance product, says the president of a major property/casualty insurance association.

"Like all for-profit business, insurers are motivated by economic self-interest," observes Franklin W. Nutter, president of the Alliance of American Insurers.

"That is nothing to be ashamed of," he says.



Mr. Nutter

However, "the pursuit of economic self-interest" brings the industry into conflict with the public interest, Mr. Nutter said in remarks opening the 65th annual meeting of the Alliance, which was held in Quebec last week.

Noting that the "failures of fully achieving the public interest result from the impossibility of defining it or agreeing upon what it is," Mr. Nutter advised: "We must accept the fact that property/casualty insurance is an instrument of social policy in pursuit of the public interest."

And, citing the predictions of historian Arthur Schlesinger Jr. that the United States is entering a new period of liberalism, Mr. Nutter observed that the property/casualty insurance industry has entered an era in which public officials will seek ways to use government to solve social problems.

"The next cycle of American history probably has begun for this industry," Mr. Nutter said. "Clearly, the legislative agenda is not business as usual.

"The challenge," Mr. Nutter said, is "to find the appropriate balance between entrepreneurship and responsible social policy."

'The challenge,' according to the Alliance's Mr. Nutter, is 'to find the appropriate balance between entrepreneurship and responsible social policy.'

Solutions routinely proposed present only a choice of the subsidy required to make insurance available and affordable, Mr. Nutter suggested, citing proposals for greater rate regulation and involuntary underwriting mechanisms, such as joint underwriting associations and assigned risk plans.

"Is it our policyholders, government or insurers themselves which must subsidize difficult and increasingly costly societal problems?"

In choosing to subsidize insurance, "lawmakers too often defeat or do nothing to achieve the consumer's goal for insurance—that is, greater safety in products and services which the pricing of insurance commands," Mr. Nutter explained.

"Regulating insurance to achieve social objectives often compromises the underwriting and risk evaluation function of insurance," Mr. Nutter said.

"Mandated subsidies defeat the insurance goal, that of reallocating cost and spreading risk, and preclude the pass-through aspect of the insurance function," he pointed out.

At the close of the meeting, Mr. Nutter offered advice on how a balance can be struck between responsible social policy and private entrepreneurship. His suggestions include:

- Demanding that the government and the public address the underlying problems that create insurance availability and affordability concerns.
- Insurers working "to avoid government pre-emption of this business and creeping expropriation of this business to solve those problems with solutions limited to insurance."
- Insurance companies finding the ways and the capacity to underwrite the more difficult risks as well as the routine risks.

"We must resist temptation to take action that benefits your individual company to the detriment of the industry as a whole," he advised.

- Educating the public so it does not consider insurance to be a utility.
- Working "with our employees and policyholders to see they understand the function of insurance."

The public needs to understand that the functions of insurance are threefold: to spread risk and reallocate costs, allowing individuals and businesses to survive losses and enter new ventures; to maintain and control costs and losses; and to evaluate risk.

- Not deferring to the government the determination of what the public interest is.

Government has the tendency to define the public interest "at our expense," Mr. Nutter pointed out.

- Insurers making "responsiveness to our role as a tool of social policy a role in each company's strategic plan."

"We must recognize that property/casualty insurance is an instrument of social policy in the pursuit of the public interest. It is not imposed upon us, but is inherent in the nature of the product."

Mr. Nutter interjected some good news for insurers in his remarks.

"The arguments about the regulation of this industry and its role in society would not be so strident if the industry were not so important," Mr. Nutter observed.

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Residual market costs to exceed $1 billion

By KATHRYN J. McINTYRE

QUEBEC—The residual insurance markets will cost insurers in excess of $1 billion this year.

The lion's share of that cost is for workers compensation assigned risk plans, but the residual markets for automobile insurance and property insurance also have reported losses in recent years.

Furthermore, state medical malpractice joint underwriting associations are woefully under-reserved for losses, threatening massive assessments of insurers, according to research by the Alliance of American Insurers.

The residual markets and their impact on insurers bottom lines were discussed during the 65th annual meeting of the Alliance of American Insurers held last week in Quebec.

While insurers theoretically can pass the cost of residual market losses onto other policyholders in the form of higher premiums, the insurers say that competition for good accounts prevents them from setting premiums high enough to fully cover their residual market losses.

Workers compensation coverage underwritten by commercial insurers through assigned risk plans will cost insurers about $1 billion this year, according to Kevin M. Ryan, president of the National Council on Compensation Insurance in New York.

In 1986, the assessment for these plans totaled $868 million.

The assigned risk plans provide workers compensation insurance to employers that cannot purchase it in the commercial insurance market; the premiums and losses are redistributed to workers compensation insurers.

Workers compensation insurance rates are based on insurers' total underwriting experience, including assigned risk plans, and therefore, the total premiums are expected to be adequate to cover all losses, including assigned risk plan losses, Mr. Ryan said. An insurer writing "a reasonable mix of business" has an adequate rate to handle the assigned risk plans, he said.

However, Mr. Ryan expects workers compensation insurance will not be profitable the next two to three years because loss reserves are understated about 10%, which translates into 20 points in the combined ratio.

And, until workers compensation insurance appears profitable, more insurers will not enter the line and the assigned risk plans will continue to be needed, he added.

Total premiums written by workers compensation residual markets now total $2 billion, Mr. Ryan reported.

Assigned risk plans wrote 16% of the premium volume for workers compensation in 1986, compared with 10% in 1985 and 5% in 1984, he noted.

In addition to the underwriting losses these plans create, the growing market share of these plans "is a problem because it detracts from the operations of the workers compensation system," Mr. Ryan said. "It mitigates efforts for pricing equity and adequacy."

Because these plans remove the problem of insurance availability, regulators do not have an incentive to grant adequate rates, Mr. Ryan said. "If you cannot find a market, pressure to return to pricing appropriateness is much stronger than if you always have a market," he explained.

And, once an employer is in an assigned risk plan for workers compensation insurance, "the employer is freed from the need to develop and improve his own workplace," Mr. Ryan said.

Efforts are underway to change the rating used by assigned risk plans. Insurers want permission to place a surcharge on premiums charged based on the experience of the assigned risk plan. They also want to withdraw premium discounts that are afforded larger risks. And, they want to offer retrospectively rated programs to encourage employers to adopt safety programs.

Employers buying workers compensation insurance from assigned risk plans are mostly smaller employers: 95% of the risks pay less than $5,000 annually in premium and 60% pay less than $1,000.

In the residual market for automobile insurance, the combined loss and expense ratio for commercial auto insurance in 1985 totaled 116%, while private passenger automobile insurance written by residual plans produced a 118% combined ratio, according to John H. Corbley, president of the Automobile Insurance Plans Service Office.

In 1986, premium volume written by plans in the 46 jurisdictions represented by his office totaled $4 billion, Mr. Corbley said. (Excluded are Massachusetts, Texas, New Jersey and North and South Carolina.)

"The biggest problem area is commercial automobile," Mr. Corbley said, under which all premiums and losses are equitably distributed to all companies that participate in the program. This is different from the underwriting of private passenger auto insurance policies. These policies are equitably distributed by the amount of business an insurer writes in a state.

The problem in the commercial auto residual plan is due to dramatically increased premium volume created by the requirements of the Motor Carrier Act of 1980. That federal law requires haulers of hazardous waste to obtain higher insurance limits than ever required before, Mr. Corbley explained.

The hauler of the most hazardous waste needs $5 million in liability insurance limits per vehicle, he noted.

Due to these requirements, commercial auto insurance premiums

Continued on next page

Rate changes needed: Economist

QUEBEC—Residual insurance markets should charge policyholders what it costs to underwrite their insurance, according to economist Richard E. Stewart.

Instead, current residual markets are subsidized by consumers who buy their insurance in the voluntary market.



Mr. Stewart

"These facilities should carry their own weight," he said. It is the best way to get the most productivity and stable behavior from the insurance business, explained Mr. Stewart, chairman of New York-based Stewart Economics Inc., in remarks at the annual meeting of the Alliance of American Insurers last week.

Residual markets are expensive for the insurance industry, Mr. Stewart said. In addition to the direct costs to insurers of underwriting the unwanted risks (see related story), there is a "never quantified" cost: the disruption that the involuntary facility causes the voluntary market.

"It affects competition and it undermines pricing," Mr Stewart said.

The disruption residual markets cause the voluntary market is proportional to the suppression of underwriting and classification and the subsidy of insurance for those in the residual market, Mr. Stewart said.

"It is not too early to balance, help wind down or at least make less disruptive the facilities we have," Mr. Stewart advised.

Insurers should try to influence the mechanics of these markets, he continued. "There is nothing inherently impossible about a self-rating, self-supporting residual market," in contrast to the subsidized residual markets of today, Mr. Stewart said.

"The disruption would be reduced the more they stand on their own," he said.

Residual markets, Mr. Stewart noted, are created for three reasons:

- Social policy to provide needed insurance.
- As a punitive measure against insurers.
- At the behest of a very influential interest group, such as the wealthy homeowners in California who needed insurance against brush fires.

Given the choice between government funds underwriting insurance and insurers writing coverage under a government mandate, insurers' best interest is the latter, Mr. Stewart said.

And, he predicted that there will be new residual markets created in the future because there will be risks that the voluntary insurance market will not know how to price and therefore not underwrite.

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Continued from previous page
written by the residual markets for auto insurance increased 158% to $644 million in 1986 from $250 million in 1985, Mr. Corbley reported.

"More companies have to volunteer as a servicing carrier," Mr. Corbley said. The 11 insurers now acting as servicing companies cannot absorb any more business, he said.

"Unless and until more companies agree to become servicing carriers, we may have to return to the assignment mechanism, which could affect the solvency and surplus of well-managed companies."

Mr. Corbley explained that a small insurer, by the luck-of-the-draw under the assignment mechanism, could be hit with several $5 million losses under the commercial auto program and its solvency could be in jeopardy.

"There are a half-dozen large companies that should come on board for the sake of the smaller companies that would suffer greatly if we had to go back to the assigned mechanism for commercial auto," Mr. Corbley said.

In the residual market for property insurance, 27 FAIR plans (Fair Access to Insurance Requirements) suffered nearly an $8 million statutory underwriting loss in 1986, reported Eugene L. Lecomte, president of the National Committee on Property Insurance. In the previous five years, these plans produced a $273 million underwriting loss.

The plans, which distribute premiums and losses to insurers writing property insurance, provide fire and extended peril insurance to businesses and individuals that cannot find property insurance in the commercial market.

About 55% of the $332.4 million in premiums written by these plans is for commercial property insurance and 45% is residential, although by policy count the percentages change dramatically: 20% commercial and 80% residential.

Most plans provide up to only $1.5 million in coverage on a building and its contents.

Over the three-year period 1984-1986, written premiums increased 223% and new applications increased 226%, but renewal applications fell 3%.

'These residual market facilities bear heavily on operating results,' says Francis P. Story of Holyoke Mutual Insurance Co.

In contrast to the other residual markets, windstorm insurance plans operated by property insurers in seven states along the Atlantic and Gulf Coasts produced a $12.8 million underwriting gain in 1986.

However, in the previous five years these plans, which provide insurance against damage from hurricanes and other windstorms, produced an aggregate underwriting loss of $165 million.

The 1986 gain reflects the fact there were no major hurricanes in 1986, Mr. Lecomte said.

These "excess funds," which are still in the plans, should be distributed to the participating insurers, said Mr. Lecomte, citing several reasons: to establish the "pass-through vehicle" concept and lessen the potential for a plan appearing to be an insurer; to permit plan members to invest their funds; and to alleviate the temptation by regulatory authorities to divest a plan of its members' money.

Premiums written by the wind plans increased 236% during the period 1984-1986, to $65.7 million in 1986, while new applications increased 142% and renewals policies increased 113%.

While the residual markets for workers compensation, automobile and property insurance are supported by insurers that write the coverages on a voluntary basis, all liability insurers operating in the 10 states with medical malpractice joint underwriting associations could be assessed to cover JUA operating deficits, warns Rodger S. Lawson, a senior vp of the Alliance.

Except for Kansas and Pennsylvania, JUA member companies are defined as all insurers authorized to write or writing personal liability insurance in the state.


Mr. Lawson

"This includes motor vehicle liability insurance and multiperil policies, which means that the majority of insurers operating in any state technically could be assessed to help fund these deficits," Mr. Lawson said.

While all states except Florida provide some mechanism for insurers to recoup their assessment, "this is not to suggest that JUA deficits pose a benign threat," Mr. Lawson stressed.

The ability and the timeliness of the recovery "may not be competitively neutral," Mr. Lawson observed later in an interview.

Many of the JUAs are underfunded, according to research by the Alliance.

"The medical malpractice JUAs in five states—Massachusetts, New Hampshire, New York, Rhode Island and South Carolina—are estimated to have insufficient funds to pay all existing claim liabilities even when these liabilities are discounted to their present value," Mr. Lawson said.

"The existing deficits in these states are of such a serious nature that they merit special attention by regulators, legislators and insureds, not to mention member companies," Mr. Lawson said.

The JUAs need to charge higher rates, he said, which not only would eliminate the deficits but also would reduce the number of policyholders in the JUA, "which is the ultimate solution to this financial threat."

Meanwhile, all-lines JUAs also are being developed, Mr. Lawson said.

Eighteen states have authority for creation of JUAs for various liability coverages—13 of which obtained their authority by legislation enacted in 1986.

Only two states, Maryland and Minnesota, have activated these JUAs, Mr. Lawson said.

Maryland denied coverage to the first class of policyholders seeking coverage: Baltimore landlords that wanted liability coverage for lead paint poisoning.

Minnesota, however, has received applications for coverage from more than 300 classes of business. "At last count, 29 classes had qualified, while five others had been approved but have not yet been activated," Mr. Lawson said.

"These proposals, like the large majority of medical malpractice JUAs, are designed to make the insurance community at large responsible for any shortfalls which may occur in the revenue necessary to pay incurred claim liabilities," Mr. Lawson explained.

The Alliance board last week authorized its staff to work with others in the insurance industry to create a coordinating group to oversee the activities of these new JUAs, he announced.

"Part of the committee's charge would be to monitor the financial performance of these facilities and to work with the managers to make sure that the JUAs operate in an efficient and effective manner," he explained.

A similar group exists to oversee medical malpractice JUAs.

"These residual market facilities bear heavily on operating results," commented Francis P. Story, president of Holyoke Mutual Insurance Co. in Salem, Mass.,who participated in a panel discussion on residual markets.

Mandatory plans created 93% of Holyoke's underwriting loss in 1986, he said.

But, New York State Sen. Donald M. Halperin, D-Brooklyn, also on the panel, told insurers: "We have to see where we can meet social needs for insurance without destroying the insurance industry. I do see a need for government to step in."

Lyndon L. Olson Jr., chairman of the Texas State Board of Insurance, observed that the all-lines liability JUAs "were created purely to punish you." ■

ISO tort reform study

Continued from page 2
tedly knowledgeable adjusters, but it is not an empirical study. Therefore, the link with rates is a tenuous link."

However, he said tort reform opponents will be able to turn the ISO study to their advantage.

"I think our critics can and probably will use the study to demand rate reductions in rate filings or legislation. And worse, the study may be misunderstood by objective readers because we have repeatedly been asked for rate-impact information," he explains.

Mr. Nutter's biggest concern is that the study will "reinforce, mistakenly, the idea that tort reform and immediate rate reductions are fully integrated."

Mr. Nutter, like most industry officials, believes that if tort reform results in lower claims costs, the inherent competition in the insurance industry will force insurers to pass those savings along to buyers.

Other insurance industry officials share Mr. Nutter's concerns about the study's impact.

"This is a losing report from the insurers' standpoint. From the beginning, we asked 'what the hell is this thing going to do? Is it going to be definitive?' No. It's going to be some estimates, and those estimates are always used against us in the worst possible way," said an industry official who asked not to be identified.

Another industry official fears the report could force insurers to reverse their position and oppose tort reform if state legislators tie tort reform efforts with mandated insurance rate reductions.

"The thing that bothers me about this report is that people are going to say: 'Aha! We do this and we're going to get this from the insurance industry,' " the official said.

"The Florida approach is the worst thing that can happen to tort reform. It will kill tort reform. The insurance industry will turn on tort reform," said the official, referring to Florida's Tort Reform and Insurance Act of 1986, which contained both tort reform and mandated liability insurance rate rollbacks.

Jon Harkavy, director of governmental affairs and general counsel for the Risk & Insurance Management Society Inc., said the study likely will provide "ammunition to both sides and certainty to neither."

And, while publicly praising the ISO study for its value in pointing out the impact of various tort law changes on insurance claims costs, officials with several state tort reform coalitions privately admitted they fear the study may be used against them.

"We see this study as giving our opponents a tool they can use to focus attention on the insurance question and rate reductions," said an official with one state tort reform coalition.

"We've been arguing that tort law should be changed to make the system fairer and that insurance is a secondary consideration. This is really going to set us back," the official added.

Cecil L. Pearce, director of state government affairs for the Independent Insurance Agents of America, says that while he thinks ISO deserves credit for the "first attempt to quantify tort reform," he is concerned that the study will be misinterpreted or misused.

"And I say that because one of the major pressures that's been on the small business community and been on the insurance community is to put forward absolute specific numbers that tell legislators if they pass a specific tort reform there will be a specific rate reduction."

The IIAA has been working for two years to convince legislators that they can't link tort reform to insurance rate reductions, Mr. Pearce said.

"But the natural instinct among public policy makers is that if they pass a piece of legislation, they want to know that rates will go down a certain amount," Mr. Pearce explains.

At least one industry opponent says he plans to make use of the ISO study.

J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va., which has opposed many tort reforms supported by insurers, said the ISO study will help him make his case before state legislatures considering tort reform legislation.

"It's so ridiculous for the insurance companies to be lobbying on the one hand for tort reform, but on the other hand saying if you do it, there won't be any savings," said Mr. Hunter.

"They don't understand even this late in the game the political suicide that they are engaging in here."

Mr. Hunter said that NICO consistently has maintained that the only way to guarantee that insurance consumers will benefit from tort reform is to tie it to insurance rate reductions, and he says the ISO study will help NICO do just that.

"I've never seen a report where they say this is a really good solid report, the first one that is really meaningful, but don't pay any attention to it. That's essentially the way it reads," Mr. Hunter says.

Officials of the Assn. of Trial Lawyers of America dismissed the study as not credible, both because it was sponsored by an insurance industry organization and because it is based on hypothetical, rather than actual, claims.

"It seems to me it would be difficult to give it any credence because they are basing it on hypotheticals and I don't think one can place much credence in hypotheticals," says a spokesman for ATLA.

ATLA is waiting for the results of ISO's "Claims File Analysis," a closed-claim study of the effect of tort reform measures currently under way. The results of that study are not expected to be available until 1988.

"ATLA has always been interested in what is in the insurance company files because I think the answer to a lot of the problems of the so-called insurance crisis and tort reform crisis rests in the insurance company files," the spokesman said. "It makes no sense at all to hypothesize to get responses when you can look at actual cases and figures and find out how much money really is changing hands."

The credibility of the study released by ISO can be questioned because the results are open to manipulation by the ISO, the ATLA spokesman contended. "In a closed-claim study, I would assume ISO's integrity is on the line because it could be checked."

At least one state insurance regulator also disputes the credibility of the ISO study.

Minnesota Insurance Commissioner Michael A. Hatch says "the credibility of anything ISO put out at this stage would be about the same credibility I would give" an ATLA study.

"There are two groups of people who I will not listen to any more: One is the lawyers and the other is insurance people. They have absolutely lost their credibility.

"Everything they come out with is so predictable," Mr. Hatch says. "If they say the claims are going to go down, but the rates can't come down, that's obviously a perfect world for the industry."

Another regulator said the study probably will not affect his department's stance on tort reform and rate reductions.

"We are still analyzing the report, but our preliminary evaluation hasn't substantially changed our opinion on tort reform," said Washington Insurance Commissioner Richard D. Marquardt.

"Although tort law changes, particularly in the area of joint and several liability, may have some long-term bearing on insurance rates, I do not believe a faulty tort system was the No. 1 cause of the insurance crisis. I still feel that short-sighted business practices, such as cash-flow underwriting, were at the heart of the problem," he added.

However, some tort reform proponents said the ISO study may aid tort reform efforts.

Blair Childs, executive director of the Washington-based American Tort Reform Assn., said the study will show state legislators "why it is important that we keep the tort reform packages comprehensive if we want it to have an impact on insurance rates."

Mr. Childs says that while he expects the opponents of tort reform to attempt to capitalize on the ISO study, he feels it will not really help them.

"This won't change what the opponents of tort reform are saying a bit. All this is going to do is give them one more thing to use to claim that these are the facts," Mr. Childs said. "But, I think the public is moving in the other direction."

Mr. Nutter of the Alliance said the study shows "the tort reforms we set out to achieve—pure tort reforms—have been compromised in the legislative process and the value of those tort reforms on claim costs has been emasculated. The study clearly shows that broad based and pure reforms would have a dramatically greater value than what we got."

"It can be helpful to substantiating our position that we need relief and we need substantive changes in the (tort) law," said Mark D. Davidson, chairman of the Ohio Alliance for Civil Justice and Ohio director for the National Federation of Independent Business.

Mr. Davidson says he does not think the ISO study can be used by tort reform opponents in Ohio to link tort reform with insurance rate reductions "because the Ohio process is so far along."

"I'm less concerned that the naysayers will capitalize on this to our detriment at this point simply because we have made a credible and fair case," Mr. Davidson says. ■

Centre Re

Continued from page 1

mitted reinsurer.

U.S. policyholders will be offered their choice of the Barbados company or the U.S. company, Mr. Gluckstern said, explaining that the Barbados unit will offer tax and regulatory advantages while the U.S. unit will provide admitted reinsurance.

Private placement memoranda will be sent to roughly 100 potential insurance and non-insurance company investors, from which organizers expect to draw 20 to 30 Centre Re shareholders.

The minimum investment for insurers will be $5 million, while non-insurance companies will have to invest a minimum of $10 million, said Mr. Gluckstern, who formerly was general manager of the reinsurance division of Berkshire Hathaway Inc. Overall, organizers intend to hold investment by insurance companies—which may also be Centre Re policyholders—to no more than 20% of the corporation's total equity, thus ensuring that Centre Re will be treated as a non-controlled foreign corporation by the Internal Revenue Service.

As a non-controlled foreign corporation, Centre Re would not be taxed currently on its income, but would pay tax only when income is repatriated to U.S. shareholders.

Shareholders investing $10 million will have the right to nominate one member to Centre Re's board of directors, according to Mr. Gluckstern, who said that insurance companies investing the minimum $5 million would not be represented on the board.

Centre Re is offering voting and non-voting common shares, he added, noting that the non-voting shares will be available to bank holding companies, which are generally barred from owning more than 4.9% of the voting stock of an insurance company.

Guy Carpenter and Morgan Guaranty hope to raise $450 million through the private placement, $360 million of which will be drawn on at the closing of the deal and $90 million of which will take the form of commitments that may be drawn on during Centre Re's first two years of operation.

Centre Re will contribute the capital to its reinsurance units based on each unit's needs, which will be known only when demand for coverage develops, Mr. Gluckstern said.

He expects most proceeds from the private placement—including the $90 million in commitments—will be paid into the reinsurance subsidiaries within 18 months of Centre Re's start-up.

The Centre Re units will write at a net premium-to-surplus ratio of between 2-to-1 and 3-to-1, but never exceeding 3-to-1, he said.

During Centre Re's first year of operation, the reinsurance units will be writing at less than a 1-1 ratio, he added.

The organizers hope to secure commitments from an initial group of insurer investors by June 22 and from non-insurance investors by July 22, he said.

Morgan Guaranty will receive a 10-year option to purchase 4.9% of Centre Re's shares, and will collect a placement fee of 2.5% of the first $250 million raised and 3% of any amounts raised exceeding $250 million.

The reinsurance units will accept business through intermediaries and will allow brokerage commissions of 1% to 5%, with commissions probably averaging 2.5%, Mr. Gluckstern said.

The Centre Re units will write only treaty reinsurance at the outset, and while the majority of this business will be working-layer casualty excess-of-loss reinsurance, the companies also will write some quota-share treaties, Mr. Gluckstern said.

Mr. Gluckstern described Centre Re's anticipated treaty business as being "finite risk" business, with contracts carrying aggregate caps on payouts to ceding insurers. For example, a Centre Re unit's liability on a particular treaty may be limited to 250% of premium collected for the coverage, he noted.

The reinsurer would create a "commutation account" to hold a portion of the premium paid. If no losses develop on a treaty after a given period, a portion of the premium would be returned to the ceding company.

Along with these "finite risk" treaties, the reinsurers will write loss portfolio transfers and financing quota-share treaties, under which a Center Re unit would assume a quota share of the ceding company's business and return profits on the business through a retrospective ceding commission.

The units also may write contracts covering ceding companies for reinsurance that is unrecoverable from other "distressed reinsurers," Mr. Gluckstern added.

The reinsurers also could handle self-insurance or captive insurance company reserve buy-outs, and could conceivably reinsure A.C.E. Insurance Co. Ltd. and X.L. Insurance Co. Ltd., two multiple-owner excess liability insurers organized by M&M and Morgan Guaranty.

The Centre Re companies will assume the timing risk on reinsurance contracts they write.

Each of the three Centre Re units will have its own underwriting staff, according to Mr. Gluckstern, who added that Guy Carpenter will have no role in the companies' underwriting management.

J.P. Morgan Investment Management Inc., a London-based affiliate of Morgan Guaranty, will provide investment management services, subject to review of the arrangement by Centre Re's board.

The New York law firm of Willkie, Farr & Gallagher has provided legal advice on Centre Re's development; accounting services are provided by Ernst & Whinney.

The Centre Re companies will begin underwriting "as soon as possible" after the expected July 31 closing of the private placement, Mr. Gluckstern said, noting that the reinsurers have to hire staff and develop computer systems for handling their business.

In addition to acting as president of Centre Re Holdings, Mr. Gluckstern will serve as president of Centre Re (Bermuda) and will live in Bermuda.

The only other executive hired so far is Michael D. Palm, former vp with National Indemnity Co., a Berkshire Hathaway unit. Mr. Palm will serve as president of Centre Re (Barbados) and executive vp of the holding company.

Some observers question Centre Re's prospects for success.

One reinsurance company executive noted that Centre Re plans to write its business at an underwriting loss, with investment income ultimately providing shareholders with a targeted 20% return on their investment.

The executive—who said he has not seen the private placement memorandum and who requested anonymity—questioned why a stock insurance company shareholder would "give away" a 20% return to Centre Re unless the reinsurer provided significant tax advantages to the ceding company.

While Centre Re may provide these tax advantages, the executive also predicted that its reinsurance products could face an IRS challenge. "I don't see the Treasury (Department) sitting still if they see a tax-avoidance type of thing."

A Centre Re spokesman, however, said that while tax advantages may be one benefit of ceding business to Centre Re, they will not be the motivating force behind insurers' use of the facility.

"The idea came from a reinsurance need, not from a tax need," the spokesman said.

However, another reinsurance company executive, who also requested anonymity, also questioned whether the reinsurance need exists.

The business Centre Re is trying to attract is business that ceding insurers have recently been forced by the tight reinsurance market to keep net, and many insurers "have gotten comfortable" with the increased net retentions, the official said.

"What Carpenter is trying to do is recapture that business back to the ceded marketplace when it does not need to go back to the ceded marketplace," he observed.

Demand for loss portfolio reinsurance also has slackened—in part because of the restrictions on such transactions imposed by the New York Insurance Department's Regulation 108—and this may not be a significant source of business for Centre Re, the executive said.

A Centre Re spokesman concurred that loss portfolio business is not expected to be a major line for the reinsurance units. ■

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update

Continued from page 2

Firm settles malpractice suit

BALTIMORE—The law firm of Venable, Baetjer & Howard has professional liability insurance to cover a $27 million settlement reached last week with the Maryland Deposit Insurance Fund.

General Accident Insurance Co. of America will pay the settlement under a $30 million claims-made policy issued in 1985, according to Maryland Assistant Attorney General Ralph S. Tyler.

Venable denied any wrongdoing in the settlement agreement.

MDIF sued Venable in the Circuit Court for Anne Arundel County in July 1986, seeking $450 million. MDIF is the successor to the Maryland Savings-Share Insurance Corp., which insured state savings and loans (*BI*, July 14, 1986).

Venable was general counsel to MSSIC for about 10 years prior to the May 1985 collapse of MSSIC-insured institutions and simultaneously represented various savings and loans. MDIF had charged the law firm with responsibility for causing the collapse of MSSIC and MSSIC-insured institutions.

New claims facility proposal

RICHMOND, Va.—A revised set of guidelines for a claims resolution facility for Dalkon Shield claimants is being considered as part of A.H. Robins Co.'s reorganization plan.

Under the proposals, drafted by a special master, independent trustees rather than Robins will set the value for categories of claims brought to the facility, a Robins spokesman said.

In addition, the U.S. Bankruptcy Court in Richmond will nominate the independent trustees, which will administer the facility. Also, if all the trust money is not used, the first $50 million remaining will be distributed to all claimants on a pro rata basis in lieu of punitive damages, the spokesman added.

Attorneys representing Dalkon Shield claimants are more favorably inclined toward the revised plan, which Robins has agreed to, than previous proposals for the claims facility, according to the spokesman.

Robins' plan calls for creation of a $1.75 billion trust fund for Dalkon Shield claimants (*BI*, April 20).

Bronx jury awards $28 million

NEW YORK—A State Supreme Court jury in the Bronx awarded nearly $28 million to a man who was severely brain-damaged as a result of the improper administration of an anesthetic after he entered a city hospital with a broken leg.

A spokesman for New York City's Health and Hospitals Corp., which runs North Central Bronx Hospital, said it plans to ask the trial judge to set aside the verdict, adding the award will be appealed if the judge refuses.

New York City is self-insured for the award.

The jury awarded Djon Pjetri, 29, $20 million for pain and suffering, slightly more than $4.5 million for lost earnings and medical care and $3 million for his wife.

Excess, educators liability RRG

WASHINGTON—A new risk retention group has been incorporated in Vermont to provide excess liability and educators legal liability coverages to non-profit independent schools, colleges and universities and education-related associations.

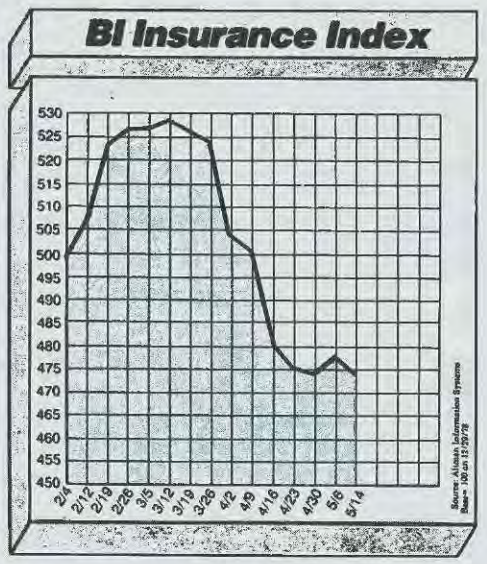
United Educators Insurance Risk Retention Group Inc. will write excess liability limits of up to $15 million excess of $1 million and educators legal liability limits of up to $5 million on a primary or excess basis.

United Educators will be reinsured by Schools, Colleges & Universities Underwriters Ltd., a Bermuda-based excess liability insurer (*BI*, Jan. 26, Dec. 8, 1986).

United Educators will retain $250,000 per occurrence on excess liability and $50,000 per claim on educators legal liability, ceding the balance to SCUUL, according to Douglas C. Dolan Jr., senior vp with Victor O. Schinnerer & Co. Inc. in Washington, United Educators' underwriting manager.

Briefly noted

Connecticut Gov. William O'Neill has not yet decided whether to sign a bill passed by the Legislature that would liberalize the state's rules governing **joint and several liability**, which had been modified by a major tort reform bill last year. The bill also repeals mandated structured settlements for portions of an award exceeding $200,000. . . .**Sen. Edward M. Kennedy**, D-Mass., is expected to introduce legislation early this week requiring employers to provide a minimum package of health insurance benefits for employees (*BI*, April 27). . . .The Southern California Rapid Transit District's claims administrator last week filed suit alleging that two Los Angeles law firms, two attorneys and a Hollywood, Calif., medical clinic conspired to defraud the transit agency by filing **phony accident claims.** The $17 million suit filed by Leonard J. Russo Insurance Services Inc. alleges that injury claims were filed on behalf of persons who were not involved in a two-bus collision or who do not exist. . . .A Leon County Circuit Court judge last week declared **International Medical Center Inc.** insolvent and placed it into receivership under the control of the Florida Insurance Department. The seizure was precipitated by creditors' complaints about lack of payment. Meanwhile, investment banker D.H. Blair & Co. of New York confirms it is negotiating to form a new company to acquire IMC. . . Tentative approval has been given to a settlement proposed by the **Pension Benefit Guaranty Corp.** in a 5-year-old class-action suit brought by workers who were denied PBGC guarantees of benefit improvements due to a phase-in provision of the Employee Retirement Income Security Act of 1974. The settlement will affect approximately 16,000 workers and will cost the PBGC between $20 million and $35 million (*BI*, April 6).



Insurance industry stocks declined last week as the *Business Insurance* stock index dropped 3.2 points to 474.0 points on May 14 from 477.2 points on May 6. Twenty-nine stocks lost ground during the trading period, while 23 issues posted gains and another 11 remained unchanged. The leading gains were posted by: Aneco Reinsurance Co. Ltd., up 38.9%; Business Mens Assurance Co. of America, up 9.9%; Unum Corp., up 8.9%; Arthur J. Gallagher & Co., up 7.8%; and Orion Capital Corp., up 3.9%. The largest declines were tallied by: Scor U.S. Corp., down 11.1%; Alexander & Alexander Services Inc., down 10.6%; Nobel Insurance Ltd., down 10.5%; Harleysville Group Inc., down 7.5%; and Marsh & McLennan Cos. Inc., down 6.6%. The *BI* index fell 0.7% during the period, which was equal to the decline in the Dow Jones 30 industrials, but greater than the declines in the broad-based market averages.

British Issues

May 12 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High	1 Week Low
Commi Union	333	16.6	18.3	5.3	333	319
Genl Accident	925	15.3	39.4	4.1	928	913
Gdn Royal Exch	908	14.3	46.5	5.1	925	903
Royal	899	8.5	43.7	4.7	900	870
Sun Alliance	873	13.6	30.3	3.7	885	840
Brokers						
CE Heath	481	15.0	34.5	6.9	488	475
Hogg Robinson	425	15.7	16.2	3.7	425	402
JH Minet	332	12.3	12.9	3.9	332	295
Sedg Grp	320	14.6	16.9	5.1	320	306
Stew Wrightson	448	16.0	18.3	4.0	448	421
Willis Faber	438	16.8	15.1	3.4	438	408

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

Annual reports provide insights to managements

By LEONARD M. WILSON

Special to Business Insurance

ANNUAL REPORT time has rolled around again for the publicly held insurance brokers. Managements have an opportunity to expound upon their view of the world and corporate developments. We have long advocated a close reading of annual reports as an insight into a company's direction.



Mr. Wilson

Despite a high degree of individuality, common threads run through the brokers' 1986 reports. Acquisitions continue to be a focus for all the public brokers. The industry is still moving toward increased concentration. Getting under the umbrella of an alphabet broker remains an inducement for many entrenched private brokers despite the improved operating environment of the past two years.

New business also is characterized as strong by most of the public brokers. This should come as no surprise since tight markets have always tended to favor the professional broker. Although the numbers are somewhat inconclusive, we believe that once again the publicly owned brokers as a group gained market share.

Candor is another common denominator of this year's crop of annual reports. Problems are discussed at least briefly, and not swept under the rug in a cloud of euphemisms.

More specifically, New York-based Marsh & McLennan Cos. Inc. notes three acquisitions consummated in the United States by its insurance brokerage subsidiary. Clearly, the company is still seeking to flesh out geographical presence wherever possible.

But, acquisitions were not limited to insurance brokerage. Marsh & McLennan's aggressive posture in benefit consulting was conveyed by completion of an acquisition in the United Kingdom and the acquisition of A.S. Hansen Inc. in the United States. Marsh & McLennan has the wherewithal and the corporate drive to persist in a program of broader representation.

In the realm of premium rates, Marsh & McLennan had little to offer on the subject of changing markets. The company's innovative contribution to insurance capacity was highlighted in a discussion of A.C.E. Insurance Co. Ltd. of the Cayman Islands, X.L. Insurance Co. Ltd. of Bermuda and American Excess Insurance Co. of New York. These new facilities reinforce the company's self-characterization as an organization seeking solutions for the client.

Alexander & Alexander Services Inc. of New York admitted to its operating shortfall in the second half of the year. But enough was accomplished during the full year to give the annual report discussion an upbeat tone.

The company describes itself as the world's leading retail broker, but development of wholesale brokerage was not neglected. Reinsurance brokerage, London brokerage through Alexander Howden Group Ltd. and U.S. surplus lines operations contribute significantly to A&A's overall results and mesh with retail brokerage.

The tempo of acquisitions was brisk, with 12 consummated during the year. The company also geared up for a global expansion in employee benefits consulting.

Premium rates were characterized by A&A as softening significantly.

Frank B. Hall & Co. Inc. of Briarcliff Manor, N.Y., is in a stage of recuperation, judging by the tone of its annual report. Clearly, most of the problems have been put behind the broker, and the current stance is one of marshaling professional capabilities. New business has become a principal focus.

The divestiture of Hall's claims adjusting operations goes along with the goal of slimming down to the core insurance brokerage business.

Acquisitions were apparently on the back burner for 1986 as resources were directed toward internal rationalization. The company also is placing greater emphasis on benefit consulting and cites a staff of 1,000 involved in benefits on a global scale.

Corroon & Black Corp. of New York completed five acquisitions in 1986 and early 1987. Growth through acquisition was complemented by internal initiatives that included a highly successful public entities program. Premium volume in this specialty has advanced to $146 million in 1986 from only $12 million in 1981.

In addition, a focus on health care, including a range of administrative services for health provider organizations, afforded significant gains.

Corroon & Black management alludes to a culture of production by way of citing a strong new business effort. As for premium rates, C&B envisages a two-tier market with competition in the middle market and continuing tightness for more specialized, difficult risks.

Arthur J. Gallagher & Co. of Rolling Meadows, Ill., focused its annual report on what is called an integrated approach. The firm's capabilities in self-insurance administrative services, along with insurance brokerage, are viewed as a particular strength. Self-insurance services have been marketed on an unbundled basis to clients with positive results, the brokerage reports.

Management is candid about the sizable amount of business lost due to clients going bare or resorting to higher deductibles.

Three important acquisitions broadened the company's scope. In particular, its presence in London was augmented significantly, positioning the company to increase its role in wholesale brokerage.

Notably absent from the annual reports was a discussion of the need to be careful in the face of an insurance market in transition. Perhaps the memory of the last soft market was too fresh. Anecdotal discussions of accomplishments in the tight market seemed a little dated in view of the evident shift in the commercial insurance environment.

We do not take this to mean that managements are resting on their laurels or will not be responsive to altered circumstances. Certainly, the aggressive posture toward new business augurs well for performance in a softening market.

Leonard M. Wilson, a principal at L.F. Rothschild, Unterberg, Towbin in New York, specializes in insurance brokerage stocks. He is a member of the New York Society of Security Analysts.

USF&G Corp.

Baltimore-based USF&G Corp.'s first-quarter operating income jumped 87.6% to $94.8 million from $50.5 million in the first quarter of 1986 due to improvement in the company's property/casualty business, but investment losses almost wiped it out.

The company raised average premiums for commercial property/casualty policies 17.2%, but raised the premium for personal lines policies only 5.3%.

President Jack Moseley said, "The primary reason for the industry's improvement is premium increases. The amount of these increases provides testimony to the underpricing in prior years."

Net income in the first quarter plummeted to $3.6 million from $143.5 million due to realized capital losses of $94.6 million as compared to capital gains of $50.3 million in the first quarter of 1986. The losses resulted from the repurchase of covered call options and index options. In addition, 1986 first-quarter net income was inflated by extraordinary tax credits totaling $42.8 million, compared with 1987 tax credits of $3.4 million.

USF&G's combined ratio improved to 103.8% in 1987 from 110.5% the first quarter of 1986.

Premium volume rose 15.7% to $971.1 million from $839.5 million, while net investment income rose 9.5% to $161.1 million from $147.1.

CNA Financial Corp.

Chicago-based CNA Financial Corp.'s first-quarter operating income increased 47.8% to $79.6 million from $53.9 million in the first quarter of 1986.

Most of this increase was due to positive performance in CNA's property/casualty division, whose operating income rose 73.2% to $67.2 million from $38.8 million. The life insurance division's operating income fell 26.9% to $9.5 million from $13.0 million.

First-quarter net income decreased 17% to $95.0 million from $114.5 million as a result of lower realized investment gains. Revenues increased 20.9% in the first quarter to $1.44 billion from $1.19 billion. ■

BI Industry Stock Report

May 14, 1987 5/7/87 thru 5/14/87

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	23.25	-10.6	27.7	1.00	4.3	24.25	22.63*	4,655.0
Baldwin & Lyons Inc	OTC	21.00	-4.5	8.8	0.20	1.0	22.00	21.00	0.1
Corroon & Black Corp	NYSE	28.00	-4.3	13.0	0.84	3.0	28.50	27.75*	338.7
Gallagher Arthur J & Co	OTC	20.75	7.8	16.0	0.40	1.9	20.75	19.00*	339.2
Hall Frank B & Co Inc	NYSE	13.63	2.8	0.0	0.00	0.0	14.00	13.63	86.3
Marsh & Mclennan Cos Inc	NYSE	58.75	-6.6	16.1	1.90	3.2	62.13	58.00	1,266.1
Poe & Assoc Inc	OTC	13.25	0.0	16.8	0.40	3.0	13.25	13.25	0.7
AGENTS/BROKERS	AVERAGE			14.8		2.9			
Conglomerates & Holding Cos.									
Anderson Clayton(Ranger/PanAm)	NYSE	65.63	0.0	18.8	0.00	0.0	0.00	0.00	0.0
Armco Inc	NYSE	12.25	2.1	0.0	0.00	0.0	12.50*	11.88	2,372.5
Berkley W R Corp	OTC	26.75	0.0	9.1	0.24	0.9	26.75	25.00	1,015.9
Berkshire Hathaway Inc Del	OTC	3470.00	2.1	237.3	0.00	0.0	3470.00	3420.00	1.0
CIGNA Corp	NYSE	60.38	-0.6	8.6	2.80	4.6	61.13	60.00	1,318.8
CNA Finl Corp (CNA)	NYSE	50.25	-4.1	11.5	0.00	0.0	52.38	49.88	324.5
General Re Corp	NYSE	51.00	-6.0	15.6	1.00	2.0	53.50	51.00	3,784.9
ITT (Hartford Group)	NYSE	53.38	-5.7	13.7	1.00	1.9	56.63	53.00	5,687.7
Sears Roebuck & Co, (Allstate)	NYSE	54.00	0.0	14.0	2.00	3.7	54.25	53.13	4,965.1
Transamerica Corp (Occidental)	NYSE	32.88	-1.1	7.4	1.76	5.4	33.75	32.88	567.7
CONGLOMERATES/HOLDING COS.	AVERAGE			80.7		0.2			
Insurers									
Aetna Life & Cas Co	NYSE	58.00	0.9	8.9	2.76	4.8	58.13	57.38	1,985.0
American General Corp	NYSE	37.25	-2.9	10.0	1.25	3.4	38.38	37.00	2,001.7
Amern Heritage Life Invt Co	NYSE	46.00	1.7	15.5	0.96	2.1	46.25*	45.25	2.7
American Indty Finl Corp	OTC	14.75	-6.3	0.0	1.12	7.6	16.00	14.75*	13.5
American Intl Group Inc	NYSE	64.00	-3.2	14.1	0.25	0.4	64.75	61.50	3,856.2
Aneco Reins Ltd	OTC	3.13	38.9	12.5	0.00	0.0	3.13	2.88	71.2
Avemco Corp	NYSE	45.88	3.7	16.6	0.56	1.2	46.00*	43.75	88.8
Business Mens Assurn Co Amer	OTC	27.75	9.9	0.0	1.10	4.0	28.00	25.75	248.0
Chubb Corp	NYSE	59.75	-1.8	9.4	1.68	2.8	60.38	59.13	964.1
Combined Intl Corp	NYSE	48.25	0.0	8.8	2.40	5.0	48.25	48.25*	49.7
Continental Corp	NYSE	42.75	-4.7	9.7	2.60	6.1	44.38	42.50*	1,649.7
Crown Life Ins Co	OTC	310.00	0.0	10.7	6.40	2.1	310.00	310.00	0.6
Durham Corp	OTC	48.25	-2.5	16.2	0.92	1.9	49.50	48.25	20.8
Farmers Group Inc	OTC	41.75	0.0	13.2	1.20	2.9	42.00	41.25	1,191.5
Fairmont Finl Inc	AMEX	18.00	-1.4	10.1	0.00	0.0	18.25	18.00	75.9
Fireman Fd Corp	NYSE	36.00	0.7	12.4	0.40	1.1	36.00	35.50	1,703.3
Fremont Gen Corp	OTC	16.38	3.1	0.0	0.48	2.9	16.38	15.75	292.5
Great West Life Assurn Co	OTC	700.00	0.0	14.4	18.00	2.6	0.00	0.00	0.0
Home Group Inc	AMEX	19.88	-3.6	5.1	0.20	1.0	21.38	19.63	367.7
Hanover Ins Co	OTC	31.00	-3.1	7.4	0.36	1.2	32.75	31.00*	208.3
Harleysville Group Inc	OTC	15.50	-7.5	4.8	0.40	2.6	16.50	15.50	35.3
Hartford Steam Boiler Insptn	OTC	28.75	-5.7	12.5	1.00	3.5	29.75	28.50*	318.7
Kans City Life Ins	OTC	27.50	1.9	10.6	0.96	3.5	27.50	27.00	114.1
Kemper Corp	OTC	30.00	-4.8	10.4	0.60	2.0	31.25	29.75	692.2
Liberty Corp S C	NYSE	38.38	-0.3	13.8	0.72	1.9	38.75	38.38	10.0
Lincoln Natl Corp Ind	NYSE	48.13	0.3	10.2	2.16	4.5	48.75	47.50	304.7
Mission Ins Group Inc	PAC	1.75	0.0	0.0	0.00	0.0	4.38	0.69	1.5
Monumental Corp	OTC	55.63	0.0	18.8	0.00	0.0	55.63	55.63	1.1
Nac Re Corp	OTC	25.25	-6.0	33.2	0.00	0.0	27.00	25.25*	173.0
Nobel Ins Ltd	OTC	12.75	-10.5	9.6	0.37	2.9	14.38	12.75	858.4
Northwestern Natl Life Ins	OTC	26.00	0.5	7.8	0.96	3.7	26.25	25.63	524.5
Ohio Cas Corp	OTC	41.50	-0.6	11.8	1.68	4.0	42.00	41.50	292.9
Old Rep Intl Corp	OTC	27.13	-1.8	9.7	0.80	2.9	27.25	27.00	196.4
Orion Cap Corp	NYSE	23.38	3.9	0.0	0.76	3.3	23.38	22.25*	125.8
Protective Corp	OTC	14.38	0.0	11.7	0.70	4.9	14.50	14.25	184.7
Provident Life & Acc Ins Co	OTC	21.75	-2.8	12.0	0.84	3.9	22.25	21.63	263.7
St Paul Cos Inc	OTC	43.75	-5.4	10.1	1.76	4.0	45.75	43.75	846.7
SAFECO Corp	OTC	56.25	0.4	10.4	1.70	3.0	56.25	54.75	629.9
Scor U S Corp	OTC	12.00	-11.1	19.0	0.00	0.0	13.25	12.00	59.6
Seibels Bruce Group Inc	OTC	15.25	0.0	95.3	0.80	5.2	15.75	15.00	215.9
Selective Ins Group Inc	OTC	26.00	2.0	10.0	0.92	3.5	26.50*	25.50	302.0
Statesman Group Inc	OTC	5.00	-2.4	0.0	0.06	1.1	5.13	5.00	105.9
Tokio Marine & Fire Ins Co	OTC	97.38	0.0	109.4	0.17	0.2	97.38	97.38	0.0
Torchmark Corp	NYSE	26.63	-3.2	9.5	1.20	4.5	27.13	26.50	472.0
Travelers Corp	NYSE	45.00	-0.8	9.6	2.28	5.1	45.75	44.88	1,718.0
Trenwick Group Inc	OTC	15.75	1.6	26.7	0.00	0.0	15.75	15.00	258.5
United Fire & Cas Co	OTC	28.25	3.7	10.9	0.80	2.8	29.00	28.00	62.7
United States Fid & Gty Co	NYSE	38.88	0.0	9.4	2.48	6.4	39.25	37.75	2,271.5
Unum Corp	NYSE	23.00	8.9	0.0	0.40	1.7	23.00	21.25	984.2
Uslife Corp	NYSE	36.75	-4.2	9.4	1.20	3.3	38.00	36.75	154.6
Washington Natl Corp	NYSE	25.00	-2.4	12.9	1.08	4.3	25.13	24.75	58.6
Zenith Natl Ins Corp	OTC	19.75	0.0	11.4	0.80	4.1	20.00	19.50	688.4
INSURANCE COMPANIES	AVERAGE			12.3		2.6			

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