

business insurance

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Shell, U.S. to share costs of waste site cleanup: Judge

DENVER—Shell Oil Co. and the U.S. government are both liable for up to \$1.9 billion in costs for cleaning up the Rocky Mountain Arsenal, a federal judge has ruled.

U.S. District Judge Jim R. Carrigan's ruling on Nov. 15 followed Shell's admission that it was a generator of hazardous waste at the site. Under the Comprehensive Environmental Response, Compensation and

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Big firms could lose guaranty fund cover

By STEVE TARAVELLA

LOS ANGELES—Any business with a net worth of more than \$10 million would not be entitled to payments for first-party claims from state guaranty funds under proposed amendments to state guaranty fund legislation.

The amendments, suggested by a National Assn. of Insurance Commissioners task force, would only permit companies with a net worth of less than \$10 million to access guaranty funds for first-party claims payments if their insurers go broke and can't pay claims.

While the coverage exclusion applies to only first-party claims—such as property damage or business interruption—the amendments also would permit a state guaranty fund to subrogate against a policyholder whose net worth exceeds \$50 million to recover funds paid to a third-party claimant on its behalf.

These third-party claimants would include people injured by a policyholder's product, those injured in auto accidents caused by the policyholder and workers compensation claimants.

The task force is also proposing that guaranty funds eliminate coverage for claims filed against certain types of policies, including errors and omissions and directors and officers liability insurance as well as financial guarantee insurance. And, the net worth limit would apply to individual as well as commercial policyholders.

The amendments to the Post-Assessment Property & Liability Insurance Guaranty Assn. Model Act will be presented at the NAIC's year-end meeting Dec. 8-12 in Reno, Nev.

If adopted by the NAIC, the revised model law would then be available for passage by individual state legislatures.

Insurers are pushing for more limits on guaranty fund protection to limit their liability for guaranty fund assessments. In all but New York state, admitted insurers are assessed charges when a guaranty fund must pay claims on behalf of an insolvent admitted insurer. New York prefunts its guaranty fund with premium assessments.

Only New Jersey also maintains a guaranty fund for surplus lines insurers.

How many commercial insurance policyholders would be affected

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Lloyd's claims-made form drastically restricts cover

By STACY SHAPIRO

LONDON—Effective immediately, the leading underwriters of North American casualty risks at Lloyd's of London are significantly restricting coverage for long-latent injury claims and will not provide any coverage for punitive damages.

In addition, defense costs are included within policy limits and policyholders must cover their own defense costs while exhausting their underlying self-insured retentions with indemnity payments.

The Lloyd's underwriters earlier this month unveiled their draft of a new claims-made form for excess liability coverage; brokers are already communicating it to buyers that must renew coverage as early as Dec. 1.

Lloyd's underwriters generally lead liability risks placed in the London market on layers above \$5 million and up to \$50 million. Most often, their policyholders are larger U.S. corporations.

The introduction of the new claims-made form by Lloyd's underwriters at Merret Syndicates Ltd., Janson Green Ltd. and the F.R. White syndicate follows by almost 2½ months the introduction of a claims-made excess liability form by H.S. Weavers (Underwriting) Agencies Ltd., the other leading London underwriter of North American casualty risks (BI, Sept. 23)

Similarly, the Insurance Services Office has intro-

duced a new claims-made commercial general liability form for primary coverage.

All these forms are an attempt by insurers to better define the risks they are assuming and to help them price the coverage they are selling. They want to avoid paying claims years after a policy has expired for losses they never contemplated, nor charged a premium to insure, when underwriting the insurance.

Under a claims-made form, coverage is triggered when a claim is first made against the policyholder during the policy period. If the form includes a retroactive date, the incident that triggers the claim must have occurred after the retroactive date.

Currently, most liability coverage is written on an occurrence form. Under an occurrence form, the policy in force when an injury occurs responds, regardless of when the claim is filed.

However, the Lloyd's claims-made form is more restrictive than the Weavers form or the ISO form. And, the Lloyd's policy stresses on the first page in capital letters that the form is not subject to the terms and conditions of any other insurance.

Most significantly, a policyholder that purchases the new Lloyd's claims-made form will have less coverage for long-latent injury claims than for other liability claims and will have no coverage for punitive damages.

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Panel proposes boost in insurer taxes

By JERRY GEISEL

WASHINGTON—Stop-gap tax-revision proposals adopted by the House Ways and Means Committee probably will boost the cost of property/casualty insurance and make it more difficult for small employers to buy health insurance from Blue Cross/Blue Shield plans.

Digging into insurance issues for the first time in its effort to draft a tax-revision bill, the Ways and Means Committee on Nov. 15 cleared a series of proposals that would force the property/casualty industry to pay an additional \$4.8 billion in taxes over the next five years.

While lobbyists say the proposal would mean higher costs for buyers, the effect will be far less severe than if the committee had accepted a series of recommendations—including barring insurers from taking immediate tax deductions on reserves—earlier proposed by congressional staffers (BI, Oct. 7).

The proposals "mean marginally higher costs...but our general attitude is that the proposals are not as bad as they could have been," said Steve Broadie, counsel for the Alliance of American Insurers in Washington.

However, a separate proposal approved by the committee that strips away the tax-exempt status of the nation's Blue Cross/Blue Shield plans will force the Blues to toughen their underwriting rules for small employers, their lobbyists say.

"There is no question that we will have to be more selective in the risks we take," said Mary Nell Lenhard, vp in the BC/BS office in Washington. "Tax-exempt status allowed us a cushion to be more liberal in our underwriting. That cushion is now being taken away."

Under the new property/casualty proposals adopted by the committee:

- All insurers would be liable for a new

minimum tax, or "alternative tax," that would be equal to 20% of the company's "net gain." The net gain would be taken from Line 18(b) of Page 4 of the annual statement an insurer files with state regulators.

Line 18(b) includes tax-exempt income, like income from municipal bonds.

The alternative tax would be imposed if it is greater than the taxes the insurer would otherwise pay.

In addition, the alternative tax could not be offset by carryforwards created by tax losses in previous years.

This new alternative tax would go into effect in the 1988 tax year.

- A company that files a consolidated tax return that reports a negative number on Line 18(b) of an insurance unit's annual statement would not be allowed to use losses from the property/casualty unit to offset

profits generated by other affiliates. Industry lobbyists say that this provision will affect relatively few companies.

However, companies that report a positive number on Line 18(b) still will be able to offset affiliated company profits with tax losses from the property/casualty unit.

- Insurers would be taxed on tax-exempt income generated by investments acquired on or after Nov. 15, the date of the Ways and Means Committee action.

In 1986, an insurer would be required to reduce its deductions for loss reserves by an amount equal to 10% of the tax-exempt income generated from investments acquired after the date of the committee action.

For example, if an insurer set up a \$200 million loss reserve and earned \$100 million in tax-exempt income from investments made on or after Nov. 15, the company could deduct only \$190 million of those reserves from its federal taxes.

And, starting in 1988, the insurer would be

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Florida, several other states proposing new measures to ensure affordable coverage
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Insurers, reinsurance brokers discuss renewal worries at NAII annual meeting
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NEWSPAPER

update

Shell ruled liable for cleanup

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Liability Act of 1980, hazardous-waste generators may be held liable for cleanup costs and for damages to natural resources.

The Rocky Mountain Arsenal, a 27-square-mile Army installation northeast of Denver, is considered one of the most polluted sites in the country. The installation was used to manufacture and store chemical weapons, including nerve gas, starting in 1942. From 1947 until 1982, Shell and a predecessor company, Julius Hyman & Co., leased buildings at the arsenal to produce pesticides.

Army estimates of the cleanup costs have ranged from \$357 million to \$1.9 billion, and the federal government has already spent more than \$43 million to study the site and contain pollution there.

The Army filed a claim against Shell under CERCLA in 1983 to recover past and future costs of cleaning up the arsenal. This suit was combined with a suit the state of Colorado filed against the federal government and Shell seeking to force a cleanup.

Judge Carrigan's ruling does not specify how the costs will be divided between Shell and the government. The division of liability is being discussed by the two sides, a Shell spokesman said.

Meanwhile, Shell is continuing to press its 1983 lawsuit against about 270 primary and excess liability insurers filed in Superior Court for the County of San Mateo, Calif. (BI, Nov. 7, 1983).

Shell's suit seeks a declaratory judgment that the insurers—which provided liability coverage to Shell from 1947 to 1983—must indemnify Shell for cleanup liabilities related to the Rocky Mountain Arsenal and a California site in California.

Shell has not settled with any of the insurers, the spokesman said.

Lawsuit filed in ship hijacking

NEW YORK—A travel agency, a cruise line and three foreign corporations that operate the Achille Lauro cruise ship are defendants in a \$400 million lawsuit brought by two passengers aboard the ship when it was hijacked in October.

The suit, filed in New York Supreme Court in Manhattan, charges that Sophie Chasser and Anna Schneider of Hollywood, Fla., "were rendered sick, sore, lame and disabled and sustained severe nervous shock, mental anguish and great physical pain" during the seizure of the ship by terrorists near Egypt.

The suit seeks \$100 million in compensatory damages and \$100 million in punitive damages for each plaintiff.

The defendants in the suit include Achille Lauro Lines, The Lauro Lines and Flotta Achille, all foreign corporations with New York offices. The companies all "maintained and controlled" the Achille Lauro, according to court papers.

The suit also names as defendants Chandris Cruise Lines of New York and ABC Tours Travel Club of Union, N.J. According to a company spokesman, Chandris chartered the boat for the cruise. ABC Tours had booked the tour for the plaintiffs.

The suit charges the defendants were negligent and showed a "willful and wanton disregard for the life, safety, and well-being of the plaintiffs."

Marine insurers believe the Achille Lauro's protection and indemnity cover is spread throughout the London market. Steamship Mutual Protection & Indemnity Club in London is believed to have written part of the P&I cover, but no one at the club was available for comment.

Sources indicate that P&I coverage might not apply to any settlement awarded as a result of the hijacking. A P&I underwriter in London noted the hijacking might be considered an act of war and thus excluded from any P&I coverage.

Progress on Manville settlement

NEW YORK—At a hearing in Manville Corp.'s reorganization proceedings last Wednesday, progress was reported on a plan for settling asbestos property damage claims against Manville.

Manville and property damage claimants' representatives agreed to submit some issues, such as guidelines under which property damage claims will be paid, to arbitration if they could not resolve them within 45 days from last Wednesday's hearing, according to an attorney for property damage claimants.

However, the issue of how much Manville will contribute for property claims in the reorganization proceedings probably won't be arbitrated. In the proposed reorganization plan, Manville originally set a maximum of \$50 million for property damage claims, which was opposed by property damage representatives. (BI, Oct. 21).

Property damage claimants subsequently said they would settle for \$125 million, and the amount is being negotiated.

Mentor committee to meet

HAMILTON, Bermuda—After being appointed by Bermuda's Su-
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Judge rules Hyatt engineers guilty of gross negligence

By DOUGLAS McLEOD

JEFFERSON CITY, Mo.—Two engineers involved in the design of the Hyatt Regency Hotel in Kansas City, Mo., face possible suspension or revocation of their Missouri licenses after a state judge's finding that they were grossly negligent in their work on the hotel's skywalks.

Judge James B. Deutsch of the Missouri Administrative Hearing Commission ruled Nov. 15 that engineers Daniel M. Duncan, Jack D. Gillum and their former company, G.C.E. International Inc., were guilty of gross negligence and misconduct in the practice of engineering in the Hyatt case.

Two skywalks at the Kansas City Hyatt collapsed during a tea dance on July 17, 1981, killing 114 people and injuring at least 200 others.

Judge Deutsch's findings will be reviewed by the Missouri Board for Architects, Professional Engineers and Land Surveyors, which will then decide on the type of disciplinary action to be taken against Mr. Duncan, Mr. Gillum and G.C.E.

Disciplinary action may include suspension or revocation of the two engineers' licenses in Missouri and G.C.E.'s certificate of authority, according to Larry Grebel, a lawyer with Brown, James & Rabbitt in St. Louis, which represented Mr. Duncan before Judge Deutsch.

G.C.E. is now "winding down" its operations, though

it is still incorporated in Missouri, according to Mr. Grebel.

The Missouri Board has until Dec. 15 to call a hearing on the case. Any disciplinary action taken by the board may be appealed in Missouri state court, Mr. Grebel said.

Meanwhile, Mr. Duncan and Mr. Gillum submitted letters of resignation to KKBNA, a Denver-based engineering firm that hired them and a number of other G.C.E. employees last June, according to Michael Barrett, KKBNA's chairman.

KKBNA has not accepted either of the resignations pending the outcome of the Missouri Board hearing, Mr. Barrett said.

Continental Casualty Co., a unit of CNA Insurance Cos., wrote professional liability coverage for G.C.E. and Mr. Duncan and Mr. Gillum.

The insurer paid its full \$2 million limit in 1983 into a

fund for the defense of Hyatt claims, according to Mr. Grebel.

The Missouri state attorney general filed its complaint against the two engineers and G.C.E. last year on behalf of the Missouri Board (BI, Feb. 13, 1984.)

The complaint charged that the engineers failed to properly review the design of a system of bridge rods and connectors used to support the skywalks that spanned the Hyatt's atrium lobby. The support system would have been found to be "grossly inadequate" had

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Mr. Gillum was negligent for not discovering that 'no design work had been done for the box beam hanger rod connections,' the judge says.

House weighs bill to extend EIL deadline for waste firms

By ROBERT A. FINLAYSON

WASHINGTON—Owners or operators of hazardous-waste disposal facilities would have up to two years to obtain environmental impairment liability insurance or otherwise meet federal financial responsibility requirements, under a bill being considered in the House.

The current deadline for businesses to meet the federal requirements was Nov. 8. However, the Environmental Protection Agency is not enforcing that deadline, pending congressional action on an extension.

H.R. 3692, which would extend the deadline two years, was introduced Nov. 8 by Rep. James T. Broyhill, R-N.C. Rep Broyhill is the ranking minority member of the House Energy and Commerce Committee.

The EPA told Congress in October that as many as 100 businesses would be forced to close their hazardous-waste disposal facilities on Nov. 8 because they would not be able to meet the deadline for compliance with the financial responsibility rules (BI, Nov. 4).

Those rules require companies that operate or manage hazardous-waste disposal facilities to purchase EIL insurance with limits of \$3 million per occurrence and \$6 million aggregate or, alternatively, pass a stringent test to demonstrate that they have the financial strength to self-insure their EIL exposures.

The business community has argued that when Congress set the Nov. 8 deadline for complying with the financial responsibility rules, lawmakers had no way of knowing how tight the insurance market

would be this year.

As a result, many companies that had planned to purchase EIL insurance to satisfy the EPA requirements cannot find coverage.

Most of the businesses that are being affected by the EPA deadline are small to midsized manufacturing firms and small chemical companies and petroleum refineries.

Most larger companies that operate hazardous-waste disposal facilities are able to meet the self-insurance test.

Rep. Broyhill's bill currently is awaiting action by the Commerce, Transportation and Tourism Subcommittee of the Energy and Commerce Committee.

Committee staffers expect some extension measure to pass because there is widespread agreement about the need to give companies more time to obtain EIL coverage and give the EPA time to issue changes to the financial responsibility rules that may help some companies meet the self-insurance test.

Meanwhile, EPA is not actively trying to close companies that are not in compliance with the financial responsibility rules, according to one EPA enforcement staffer.

"What happens next depends on Congress," the staffer said. "The agency's policy is: 'Let's wait and see awhile.'"

EPA officials are working with Energy and Commerce Committee members to develop legislation that is acceptable to the agency.

The EPA would like to see a one-year rather than a two-year extension of the federal deadline, according to the staffer.

Groups push changes in PBGC bills

By JERRY GEISEL

WASHINGTON—Three employer trade groups are making a last-ditch effort to persuade a congressional conference committee to alter legislation that increases the cost to employers of terminating an underfunded pension plan.

The three groups—the U.S. Chamber of Commerce, the National Assn. of Manufacturers and the National Assn. of Wholesaler-Distributors—say they support legislation that increases termination insurance premiums charged by the Pension Benefit Guaranty Corp.

And, they also say they support efforts to close loopholes that make it relatively easy for companies to shift unfunded pension liabilities onto the PBGC.

However, the groups specifically oppose provisions in two of the three recently approved bills that require

employers that want to terminate a pension plan to fund benefits beyond the levels guaranteed by the PBGC.

The groups contend these provisions have nothing to do with shoring up the PBGC, since they require employers to contribute more money to their plans than would be needed by the PBGC to pay benefits.

"Items unrelated to addressing the root of the problem—i.e., the already large and rapidly growing PBGC deficit—are inappropriate for Title IV reform legislation and contrary to an important policy objective: the maintenance and growth of single-employer defined benefit plans," the groups said in a joint letter sent to the Senate Labor and Human Resources Committee and the House Ways and Means and Education and Labor committees.

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Florida legislation would allow state to regulate all rates

By DAVE LENCKUS
and CAROL CAIN

The Florida Insurance Department is proposing legislation that would allow it to regulate all commercial property/casualty insurance rates.

Currently, only workers compensation and automobile insurance rates are regulated by the Florida department.

The Florida legislation, which also would create a joint underwriting pool and ease prohibitions on group self-insurance, is among a number of actions taken by a variety of states to ensure the affordability and availability of commercial coverage.

Among other developments:

- The Ohio Insurance Department has authorized a voluntary market assistance program to make property/casualty coverages available to all businesses in the state.

- The Pennsylvania Insurance Department is fine-tuning the final details of its voluntary MAP and expects to authorize it soon.

- Wisconsin Gov. Anthony S. Earl has signed special legislation that grants immunity from civil suits to establishments that sell, dispense or give alcoholic beverages to a person who subsequently injures another person while under the influence of alcohol.

- A coalition of the Maine medical, legal and insurance communities have drafted medical malpractice reform legislation.

- The California business community is gathering signatures for a ballot initiative that would limit a defendant's liability for an accident victim's non-economic damages.

- A special fact-finding task force appointed by Alaska Gov. Bill Sheffield reports that, contrary to perceptions by government and business leaders, insurance affordability and availability problems in Alaska are no worse than in other states.

In Florida, Insurance Commissioner Bill Gunter has vowed to push the rate regulatory bill, H.B. 138, through the Legislature when its next session begins April 8.

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Continental Illinois near deal with shareholders

By STEPHEN TARNOFF

CHICAGO—Continental Illinois Corp., which is battling with three insurers over its directors and officers liability coverage, may be close to a \$110 million settlement in the 3-year-old litigation filed by its shareholders, attorneys say.

An attorney for the shareholders said last week that the basic elements of a settlement with Continental Illinois had been worked out, although he noted the agreement could fall apart.

"There is the basic structure of a settlement in place," said Lawrence H. Eiger of the Chicago firm of Much, Shelist, Freed, Denenberg, Ament & Eiger.

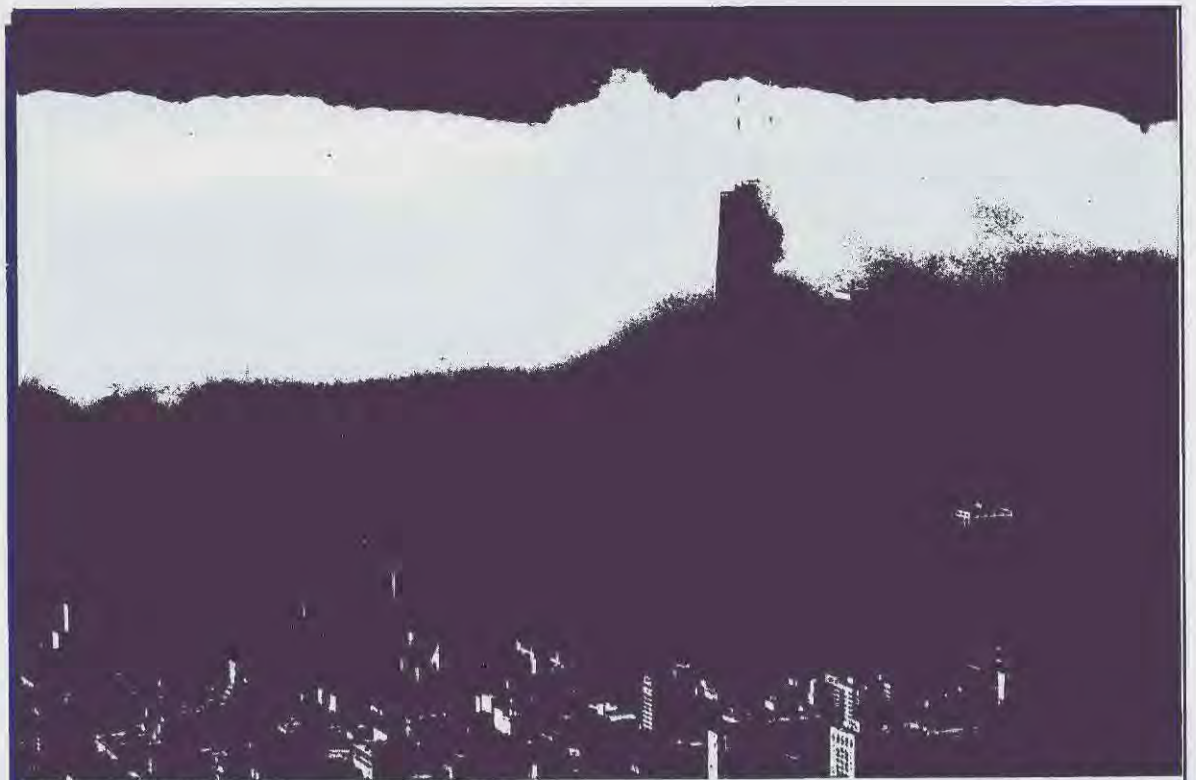
However, a complete settlement of the shareholder litigation would require Continental Illinois' D&O insurers, including the three underwriters disputing the coverage, to pay out \$85 million.

Continental Illinois on Nov. 14 filed counterclaims against the three insurers, which wrote \$65 million of Continental's \$100 million in D&O coverage that ran from August 1981 to August 1984.

The three insurers in August had filed two suits against Continental Illinois, seeking to rescind their policies (BI, Aug. 19).

Continental Illinois' counterclaims were filed against Harbor Insur-

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More than 1,500 insurance and reinsurance company executives and reinsurance brokers discussed problems with year-end renewals amid Chicago's blustery autumn weather.

Renewal worries

Scramble for reinsurance shows at NAI

By KATHRYN J. MCINTYRE
and STACY SHAPIRO

CHICAGO—With less than two months until 1986 reinsurance contracts should be renewed, progress is running weeks behind last year's delayed renewal schedule.

Reinsurers are stalling renewals, partly because their own retrocessions have been held up by reluctant reinsurers and partly because no one seems to want to be among the first to commit to prices or policy wordings.

And, reinsurers that are quoting renewals are handing down terms and conditions that leave reinsurance brokers and ceding companies with their jaws hanging open.

For example, if a reinsurer isn't restricting its capacity for casualty business to only claims-made insurance policies, it well may be imposing new contract wordings that restrict its liability for long-tail claims.

And, there's no question that reinsurers are increasing excess-of-loss reinsurance rates and are demanding ceding companies hike rates in 1986 if they want quota-share reinsurance.

Reinsurers are taking a tough stand: If the business won't produce a profit, they don't want it.

The impact on commercial insurance buyers: Renewals in 1986 will be even more difficult than in 1985, with additional price hikes and lower limits.

These are the assessments of reinsurance brokers and underwriters attending the National Assn. of Independent Insurers annual meeting in Chicago earlier this month. Often referred to as the U.S. version of the Rendez-Vous de Septembre in Monte Carlo, the annual NAI meeting attracts U.S. and foreign reinsurance brokers and reinsurers who are searching for markets and information on current conditions in the U.S. marketplace.

The official meeting registration was 1,500, but uncounted hundreds also milled around hotel lobbies and worked in suites without officially registering.

"It's depressing," summed up P. Kenneth Nitz, senior vp of the national marketing division of specialty broker Swett & Crawford Group in Los Angeles.

"Some renewals are progressing, but capacity is dramatically reduced," he said. "And net retentions are substantially increased."

"It was a good skirmish—particularly in the retrocessional market," commented Charles B. Penruddocke, who is chief executive officer of reinsurance broker Greig Fester (North America) Inc. in New York.

When asked how he survived the skirmish, he demurred: "I'll tell you Feb. 1."

Generally, reinsurance brokers expect to pin down commitments at the NAI meeting, or at least go home with a better idea of available capacity for the coming year's reinsurance renewal season than they had eight weeks earlier after attending the Monte Carlo meeting.

But this year, commitments were far and few between. Only a few brokers said they had landed any firm quotes at the meeting.

The slow pace of reinsurance contract renewal in general most often is blamed on London reinsurers. "London has to make up its mind. They affect us and we affect ceding companies," said James Dowd,

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'Some renewals are progressing, but capacity is dramatically reduced,' Mr. Nitz said.

Lloyd's to pay most of \$51 million settlement

By STEVE TARAVELLA

HOUSTON—Lloyd's of London underwriters will pay the majority of a \$51.2 million settlement to families of 36 workers killed in the 1983 sinking of the Glomar Java Sea oil drilling ship.

Lloyd's underwriters will pay virtually all of Global Marine Inc.'s \$38.5 million portion of the settlement, according to a spokesman for Global Marine, which owned the ship.

In addition, Lloyd's will pay at least part of Atlantic Richfield Co.'s \$12.7 million portion of the settlement, plaintiffs' attorneys say. ARCO leased the ship at the time of the accident.

Lloyd's wrote excess liability coverage for both companies.

The arrangement is believed to be one of the largest liability settlements stemming

from a marine disaster involving U.S. companies. It settles all claims against Global, though relatives of 14 victims still are suing ARCO.

ARCO actually offered to settle for \$15.5 million, but some plaintiffs would not accept that offer and are pursuing litigation for additional funds.

The Glomar Java Sea sank off the coast of China in October 1983 after being struck by Typhoon Lex (BI, Nov. 7, 1983). All 81 people aboard, including 35 Americans, were killed.

Neither Global Marine nor ARCO admitted negligence or guilt in agreeing to the settlement.

Virtually all of Global Marine's portion of the settlement will be paid by Lloyd's underwriters, says a company spokesman, who added that a U.S. insurer, which he would not identify, will pay a small portion of the

settlement.

Global Marine's legal costs long ago exhausted its \$250,000 liability retention and its \$4.75 million primary liability policy written by Insurance Co. of Pennsylvania, adds Fred Hagans, a plaintiffs' attorney with O'Quinn & Hagans in Houston. That insurer is part of New York-based American International Group Inc.

Global had made about \$6 million in previous settlements related to the accident, Mr. Hagans reports.

Of ARCO's portion of the settlement, the Los Angeles-based oil concern will pay the first \$2 million, the amount of its liability retention, sources say.

The remaining \$10.7 million of ARCO's contribution will be paid by Lloyd's underwriters, at least one U.S. insurer and the People's Insurance Co. of China, attorneys

say.

The Chinese government required ARCO to purchase coverage from this insurer before drilling in that country's waters.

An ARCO spokesman acknowledged that the company settled the claims but would not comment further.

The agreement provides cash awards to families of 36 victims, most of whom were Americans.

The settlement was approved in concept last week by the U.S. District Court in Houston, but the court must formally approve each award on an individual basis once the funds are received by plaintiffs' attorneys, according to Robert B. Keaty of Keaty & Keaty in Lafayette, La., one of the plaintiffs' attorneys.

The money is expected to be paid in about

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NAII meeting

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president of Skandia America Group in New York.

U.S. reinsurers are waiting not only for reinsurance support, but also "to see what London will do," observed Jacques Tanguy, director of French reinsurer Transcontinentale de Reassurance in Paris.

London underwriters are trend-setters, he noted: "Last year I saw quotes from the U.S. and days later those quotes were changed by London—they were increased."

Also slowing renewals is confusion over the use of claims-made general liability forms.

More reinsurers expressed their determination to underwrite reinsurance for casualty business only on a claims-made basis.

Trenwick America Reinsurance Co., for example, a facultative reinsurance underwriter, will not reinsure U.S. casualty business written on an occurrence form beginning

The National Assn. of Independent Insurers, based in Des Plaines, Ill., represents about 500 property/casualty insurance companies.

About 1,500 people registered for the annual NAII meeting, held in Chicago Nov. 11-13.

Only 270 of the registrants were spouses—about half the number of spouses registered last year when the meeting was held in San Francisco.

No one knows whether it was the location, companies' budgets or the seriousness of the business to be conducted that kept the spouses at home.

Jan. 1 (BI, Nov. 18).

Other reinsurers, fully supporting claims-made forms, hesitate to restrict their capacity to reinsuring only claims-made forms. They point out the Insurance Services Office's claims-made form may not be approved in all states by Jan. 1.

"I don't think we are in a position to demand claims-made," concluded Mr. Dowd.

In lieu of strictly claims-made

coverage, some reinsurers are imposing new restrictions of their own on casualty contracts they will offer ceding companies.

They increasingly are imposing a commutation clause and even a sunset clause in their treaties.

A commutation clause provides for the estimation, payment and complete discharge of all obligations—including future obligations—between the parties, upon nego-

tiation at some predetermined point after inception of the treaty. Some involve only known losses and others include incurred but not reported losses.

A sunset clause, otherwise known as "sudden death," means that the reinsurer will not cover any new losses after a certain predetermined date.

Specific contracts, however, may apply different conditions.

And, North American Reinsurance Corp. has developed a new casualty reinsurance product dubbed ALEX, aggregate limit excess treaty, which uses a reinstatement provision as a way of limiting the reinsurer's ultimate liability. ALEX provides for reinstatement of limit after the first aggregate limit is exhausted. Currently, under traditional casualty reinsurance treaties written on an occurrence basis there is no aggregate limit.

The product is specifically designed for larger ceding companies underwriting long-tail lia-

bility risks.

These efforts by reinsurers were hailed by some as positive, because the reinsurers are trying to provide capacity rather than flat-out refusing to renew any treaties that aren't on a claims-made basis.

But, these restrictions will contribute to tighter markets for general liability insurance in 1986.

And, excess or umbrella liability insurance will be even more difficult to buy in 1986, observers agree.

Paul Ingrey, president of F&G Re Inc., the reinsurance underwriting manager for United States Fidelity & Guarantee Co., says the price for umbrella liability insurance "is right through the roof." A risk manager should expect to pay 150% of the underlying premium for \$4 million excess of \$1 million in coverage for tough risks, he says.

And, not only liability insurance will cause problems in 1986.

Many reinsurers and brokers warned that rates will rise and limits will shrink in 1986 for all-risk property insurance and difference-in-conditions policies.

"The DIC market has dried up," warned Mr. Ingrey. "Risk managers may have more trouble placing their all-risk property insurance and DIC than their D&O next year," he said. "No one wants it."

All-risk property insurance generally excludes flood and earthquake risks, although coverage for these perils was endorsed to all-risk policies, with separate limits and deductibles, when competition for policyholders was fierce. DIC policies cover floods and earthquakes, with separate limits and deductibles, as well as filling in gaps in underlying property policies.

All-risk losses piled up in 1985, Mr. Ingrey says. And, those writing earthquake cover have been scared by the loss potential calculated by the California Insurance Department (BI, Oct. 7).

Mr. Nitz of Swett & Crawford contends "you can buy all-risk, excluding earthquake and flood, at a price." Coverage for flood and earthquake are available, too, but at a higher price.

Property that doesn't qualify as a highly protected risk, like an office building, may have been paying only 3-4 cents per \$100 of value for all-risk insurance, including earthquake and flood, Mr. Nitz noted. Today, the same building could be quoted 10-15 cents for a named-perils policy excess of a \$100,000 deductible, he said.

And, available limits are down to \$25 million to \$50 million for all-risk with earthquake and flood, compared with \$100 million as recently as a year ago.

Insurers also are concerned courts will broaden coverage under commercial all-risk policies for excluded perils under the theory of concurrent causation—if both an insured and uninsured peril cause the damage, the loss is covered.

While current property insurance market conditions are difficult for buyers, it could have been worse, especially for catastrophe reinsurance, Mr. Ingrey observes.

"We would have seen a collapse of the worldwide market if Gloria had hit," he said, referring to the September hurricane that did not hit the East Coast as hard as feared.

While brokers and reinsurers complained that capacity is short, new reinsurance capital continues to be added to the market.

For example, Skandia America Reinsurance Co. will receive an additional \$50 million in surplus by year-end, said Mr. Dowd. Its capital and surplus today is \$70 million.

The new capital will improve Skandia America's market position and let it take advantage of new business opportunities, he said.

The company's facultative business probably will grow to about 30% from the current 20% of its business, because of rate increases, Mr. Dowd noted.

Continued on page 8

"The LTD specialist from CNA knew exactly how to get my Social Security benefits reinstated."



"Severe kidney disease forced me to leave my sales job some years ago. Two years later, Social Security terminated my benefits. My CNA claim representative learned about the termination and advised me to refile for my benefits. He said CNA would work directly with Social Security to get my benefits reinstated. I don't know what they did, but I'm getting my benefits again!"

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opinions

One more knee-jerk response

STATE INSURANCE COMMISSIONERS should not vote to restrict the scope of state property/casualty guaranty funds at their meeting next month.

To do so would be another knee-jerk reaction to the difficult problems presented by current conditions in the commercial insurance market.

The commissioners will be asked to kick away at property/casualty guaranty funds when they meet in Reno, Nev., next month for the year-end meeting of the National Assn. of Insurance Commissioners.

An NAIC task force is expected to recommend that the commissioners amend the 1971 model law governing guaranty funds to deny fund protection for first party claims filed by any business or individual whose net worth exceeds \$10 million. In addition, certain policies now enjoying guaranty fund protection would be excluded, such as directors and officers liability insurance and errors and omissions insurance.

The reason: Insurance companies are adamant that the institutional structure of the insurance industry cannot afford the assessments they expect in the coming years to cover the flood of claims that will be filed against guaranty funds because of recent, not to mention future, insurance company insolvencies.

We agree that the pending crunch on guaranty funds calls for assessing the ability of these funds to meet demands.

We're not worried about the solvency of the surviving insurers, as the insurers imply we should be, because the cost of guaranty fund assessments ultimately is passed onto the buyer of insurance. What concerns us is whether the buyers of insurance can afford to pay the cost of guaranty fund assessments.

If it is determined that there are not enough resources to meet demands on guaranty funds, then the structure as well as the scope of guaranty fund protection should be reassessed.

In analyzing the structure of guaranty funds, the first question must be: Is the current system of assessing insurers after an insolvency the best way to fund these mechanisms? Or, does New York state have the better method, which is prefunding with premium assessments to maintain a minimum amount of money in its fund. This permits socking away money in good times that can cover losses in bad times.

In analyzing the scope of guaranty fund protection, we have to defend larger policyholders against unfair discrimination. We find fault in the argument that just because a policyholder is wealthier—whether an individual or business—that policyholder should be sophisticated enough not to buy insurance from a company heading for insolvency.

What risk manager could have known that Mission Insurance Co., for example, was bleeding to death from its reinsurance underwriting? What risk manager could have known that Ideal Mutual Insurance Co. had foolishly handed out underwriting authority to managing general agents who were writing policies that would drain the company's resources?

Financial might does not give an insurance buyer a

shield against insurer insolvency.

We can, however, accept that if the scope of guaranty funds must be limited, then the financially weak should be entitled to relatively more recovery than the financially strong from such a social mechanism.

But, we maintain that the drafters of guaranty fund legislation in the late 1960s and early 1970s had the best approach to protecting individuals and small businesses against the financial ruin that could be caused by unrecoverable insurance claims. They imposed caps upon the amount of each claim paid by guaranty funds, providing more relative protection to financially smaller insurance buyers.

While analyzing these caps, the commissioners should take the opportunity to recommend minimum and maximum caps. The wide range of recoveries under guaranty funds—from a low of \$50,000 in Missouri to unlimited recovery in Maryland—is absurd.

If it is determined that the scope of guaranty funds must be limited because there are not enough resources to cover all the potential claims, then further reducing the limits of claims that will be paid by guaranty funds is a better option than denying all policyholders a certain net worth protection. The claim payment caps could be reduced, or payments could be restricted to a percentage of the unpaid claim, up to a ceiling.

While we endorse the decision to exclude financial guarantee insurance products from property/casualty guaranty fund protection, we object to the deletion of errors and omissions insurance and directors and officers liability insurance from fund protection.

If, however, the commissioners and state legislatures are determined that businesses of a certain net worth should not be covered by guaranty funds for first-party claims, then we maintain that the net worth limit should be increased from the current proposal. The limit of \$10 million in net worth is far too low. Guaranty fund protection for one or two uncovered claims would not be significant, but recovery for a large number of claims could be very significant to a business with only \$10 million in net worth.

And, those who are shut out of guaranty fund protection either by virtue of their size or the type of insurance purchased also should not be forced to purchase that insurance from licensed insurers. Currently, in most states, insurance buyers must prove they cannot buy insurance from admitted insurers before they can use surplus lines insurers. While laws requiring buyers to use licensed companies predate guaranty funds, the coverage afforded by guaranty funds is often used today as a justification for this restriction on a buyer's freedom of choice.

But, if certain buyers are denied guaranty fund protection, why should they contribute to the cost of guaranty funds within their premiums paid to admitted insurers?

As the Risk & Insurance Management Society argues: "To do otherwise would be to confer an illegitimate regulatory advantage on licensed carriers with no corresponding benefit to the insurance consumer."

letters

Claims-made CGL form is a matter of economics

To the editor: The comments of S.H. Staubitz in the Nov. 11 letter ignore an important aspect of the claims-made debate: economics.

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.

Although not all reinsurers insist upon claims-made forms, much of the pressure appears to come from that market. It is a simple economic truth that if an insurer cannot get sufficient reinsurance for an occurrence form, it cannot offer that form.

Likewise, a reinsurer with finite resources will invest those resources where it can reap the largest return. If the general liability occurrence form is regarded as a poor investment, it will not attract the appropriate reinsurance.

We can refuse to buy the claims-made form and we can even jail all insurance company executives who offer claims-made policies. But that will not change

the economic situation. A domestic policy, such as taxation or antitrust legislation, cannot control an international economy.

It is unclear if S.H. Staubitz condemns the claims-made form because it is claims-made or because of its restrictive nature. Is claims-made medical malpractice insurance equally bad? Remember when \$200,000/\$600,000 hospital professional liability limits were the general rule and they had to respond to a claim, many years later, resulting in much higher damages? Claims-made applies today's limits to today's claims.

Stephen Michaels
Indianapolis

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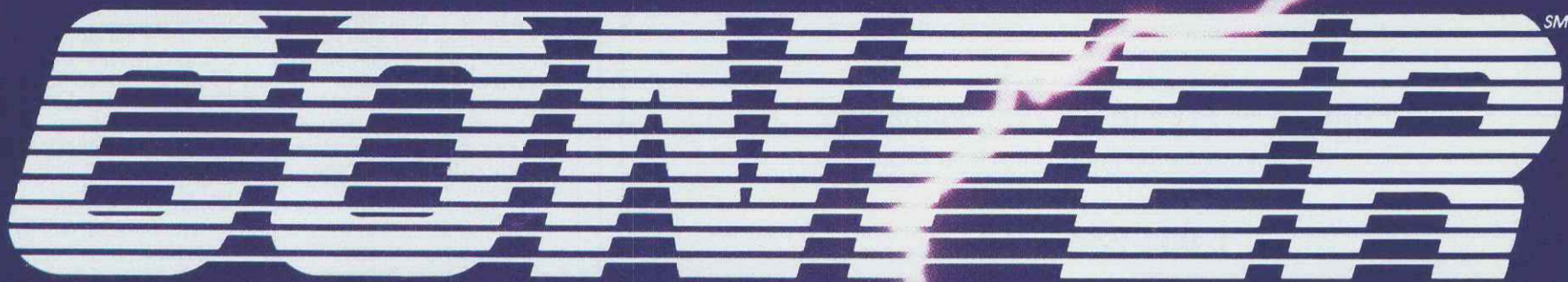
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NAII meeting

Continued from page 4

On a smaller, but yet significant, scale, Abeille-Paix Management Inc. will expand its U.S. underwriting as a licensed U.S. branch of Abeille-Paix Reassurances, the second-largest French reinsurer.

"It's the Marshall Plan—in the reverse way," says Senior Vp Jacques Dard, commenting on his company's commitment to U.S. risks at a time that many European reinsurers are abandoning them.

Currently, the parent company writes about \$22 million in reinsurance premiums as a non-admitted insurer. Eventually, the U.S. branch will assume renewals of that business on an admitted basis.

And, the U.S. branch may write as much as \$5 million in new premiums in 1986.

Abeille-Paix is better known for property treaty underwriting, but Mr. Dard said the U.S. branch will accept submissions for general lia-

bility reinsurance, if the ceding company is committed to claims-made writing and the business meets underwriting standards. For example, the reinsurer is not interested in business underwritten by managing general agents.

While no reinsurance executive wants to see the business of underwriting grind to a halt, few at NAII complained about higher prices.

"This is the market we've been waiting for," asserted Mr. Ingrey.

He allowed that "maybe there is some price gouging," but he quickly added that after reinsurers have lost so much money the right price is "whatever it takes to get the players interested."

Reinsurance brokers and underwriters also speculated about reinsurance results in 1985, which will be affected by ceding companies' decisions on additions to loss reserves in the fourth quarter.

Some predicted insurers will delay strengthening their reserves until 1986, when better results on current underwriting will help offset the impact of increasing loss reserves. Others are holding their breath against another wave of reserve increases this year that will in turn force reinsurers to increase their loss reserves this year and worsen their underwriting results.

While difficult contracts were negotiated in private, the public sessions were equally ominous.

Welcoming the NAII to Chicago, Illinois Director of Insurance John E. Washburn warned that price hikes and capacity shortages are a "serious threat to the open marketplace in Illinois."

He charged that "some insurers are taking advantage" of current conditions in the marketplace, which has attracted the attention of the Illinois General Assembly.

The result may be an end to open rate competition in Illinois, he said.

And NAII officials cited state regulatory efforts to curtail insurers' rights to cancel or not renew insurance policies and the problems created by the tort system, while others advised that state regulation of insurance could be in jeopardy (see stories, pages 9-14).

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Buyers split on increases

There are different readings on how well commercial insurance buyers are accepting rising prices and shrinking capacity in today's marketplace.

"There seems to be a higher level of understanding and almost tolerance that didn't exist a year ago," according to James Dowd, president of Skandia America Group, a leading reinsurer in New York.

"Brokers are doing a good job working with risk managers explaining market conditions," he says.

But P. Kenneth Nitz, senior vp of the national marketing division of specialty broker Swett & Crawford Group in Los Angeles, suggests brokers need to do an even better job of explaining the tight market to buyers.

"Buyers do not understand the problem," Mr. Nitz maintains.

"We've got to educate the public to our problems," he contends.

"If 1983 had continued, there would be no insurance. First we need to explain to our people, and then they can educate the buyer."

Mr. Nitz recommends that buyers check what they paid for insurance eight years ago and compare those prices with today's rates to put rate hikes into perspective.

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State regulation threatened, experts say

CHICAGO—Don't take state regulation of insurance for granted.

The McCarran-Ferguson Act, passed by Congress 40 years ago, exempts the business of insurance from federal regulation when its activities are state regulated. But, the law could be amended or repealed, according to two insurance industry experts.

"It is a conditional grant of authority," warns Frank J. Barrett, president of Central National Insurance Co. and formerly director of insurance in Nebraska.



Mr. Barrett

Continued state regulation of insurance companies "depends upon the vitality of state regulation," advises Bruce W. Foudree, the president of the National Assn. of Insurance Commissioners and Iowa's commissioner of insurance.

Both issued their warnings in speeches at the annual meeting of the National Assn. of Independent Insurers held earlier this month in Chicago.

Also on the panel was Sen. Alan K. Simpson, R-Wyoming.

Mr. Barrett stressed that the McCarran-Ferguson Act is subject to periodic review by Congress and by federal agencies.

These reviews are welcome, he said, except when they are "politically motivated and conducted in an unfair atmosphere."

Referring to consumer advocates Ralph Nader and J. Robert Hunter, Mr. Barrett charged, "The Naders and Hunters of the world are not interested in improving state regulation so it will work but in moving it to the federal level."

While advocating state regulation of insurance, Mr. Barrett suggested that state regulators failed to properly enforce their rating laws requiring that insurance rates not be "excessive, inadequate or unfairly discriminatory."

"No one disapproved rates because they were too low," he said.

However, Mr. Barrett also criticized insurance company managements for engaging in prolonged price wars, policyholders for buying insurance based only on price and stockholders for allowing insurance company managements to nearly destroy their companies.

Weaknesses in state regulation aside, Mr. Barrett declared "buyers and insurers are entitled to fair and reasonable regulation, and that is best accomplished by local regulation."

State regulation is "more competent and more responsive now than ever in history," he said.

Mr. Foudree stressed in his remarks that the McCarran-Ferguson Act has been narrowed by the courts, which often have focused on the "scope and adequacy of state regulation" in determining whether state regulation is to be preserved.

It's not the structure of insurance that troubles those ad-

vocating federal regulation, Mr. Foudree observed. "The government's principal objection is that the insurance industry is not sufficiently accountable to the public or the product is not available."

State regulators recognize that

their regulations must pass the test of scope and adequacy to survive federal intervention, Mr. Foudree suggested. "We are trying to be more effective and efficient with the limited resources we have."

Regulators' efforts include adopt-

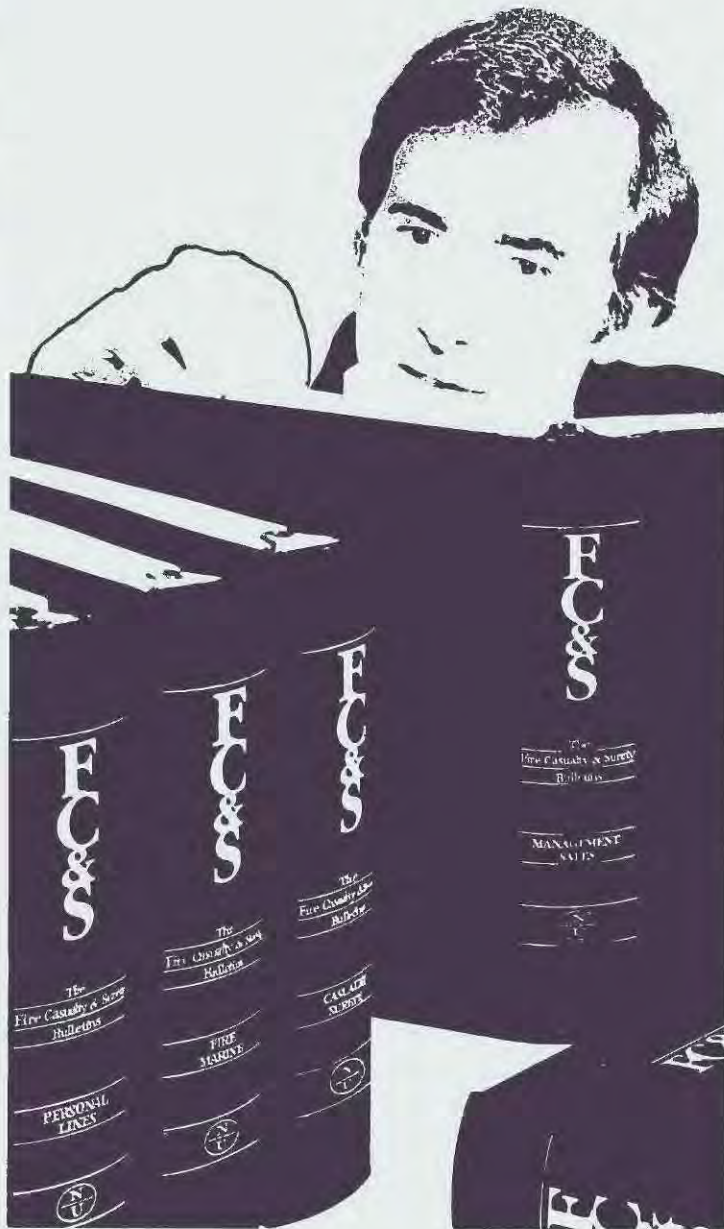
ing new model laws, regulations and guidelines and amending others, he said. New models adopted in June include those governing the uniform application for resident/non-resident licenses for agents and brokers, managing gen-

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update

EMPLOYEE BENEFITS: IN RETROSPECT

Issue Date: December 23

Ad Closing: December 10

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**business
insurance**

State regulation

Continued from previous page
tion of benefits, insurance holding companies and surplus lines.

"We are also studying the guaranty fund act," Mr. Foudree reported.



Mr. Foudree

That study includes how to amend the property/casualty guaranty fund laws to limit coverage for claims filed by large corporate policyholders.

And, the NAIC is working to improve its early warning system to detect insurers heading for financial trouble.

"Regulators are rethinking rate regulation," Mr. Foudree also said, noting that there was a 73% increase in the last year in the number of property/casualty insurers

targeted for immediate regulatory review. Today, 215 are targeted, compared with 124 in 1984.

"Financial information given us can't be trusted," he said. "Too often it doesn't reflect the true financial status of insurers."

Mr. Foudree noted, "The public has to make choices about how much protection it wants." If it wants open competition, "then it must pay with insolvencies."

He acknowledged adding federal regulation of insurance to state regulation has been floated as an alternative to the current system.

He cautioned that the "federal-level regulation of banks has not been very stellar."

And, he said, the federal proposal to mandate the discounting of loss reserves for tax purposes "would be a serious disincentive to maintaining proper reserves."

Sen. Simpson offered only one comment on McCarran-Ferguson: "I believe the regulation of your industry is best done at the state level."

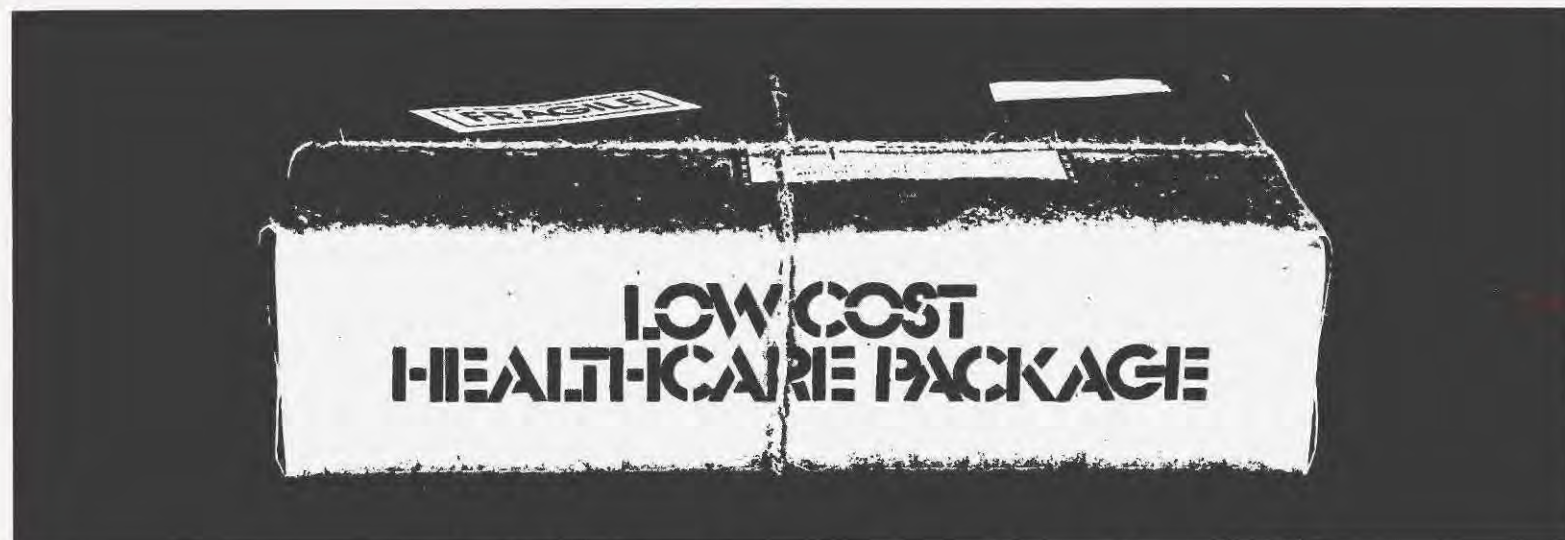
But, he noted that Congress is involved in insurance issues not only in reviewing tax proposals but also in its analysis of the Price Anderson Act governing liability for nuclear accidents and Superfund legislation.

He predicted tax reform will not be passed this year because Congress will run of time, but it will be passed next year. But, he said, "I don't know what form it will take."



Sen. Simpson

—By Kathryn J. McIntyre



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NAII supports state control

CHICAGO—Despite some problems with state regulation, the National Assn. of Independent Insurers staunchly opposes federal regulation of insurance, its president says.

"State regulation has its problems," concedes NAII President Lowell R. Beck. "It's duplicative and wasteful at times, and it's struggling to apply modern technology to its many tasks," he said in an address at the annual NAII meeting held in Chicago earlier this month.

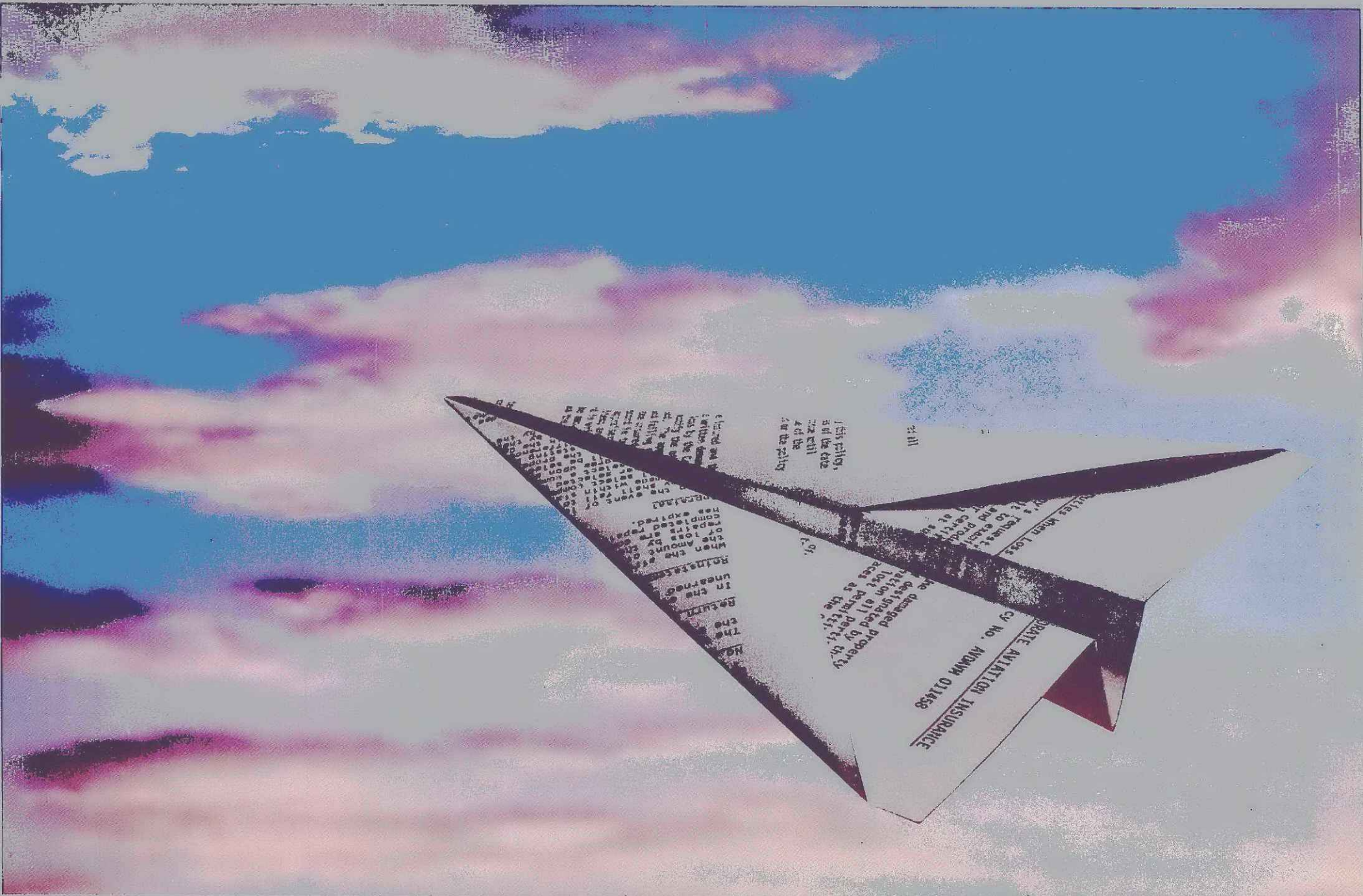
"But, it has proven over and over that it gets the job done. And it admirably has protected the insurance consumer while, with some notable exceptions, it has understood the legitimate needs of the insurance companies."

Acknowledging that the problems of high insurance prices and limited availability of insurance products following insurance company insolvencies has promoted calls for federal regulation of the insurance business, Mr. Beck countered that, "The difficulties and changes in the insurance industry do not, in even the slightest way, require federal regulation. Not is it even just a little bit desirable."

Competition in the insurance industry is much greater than competition in other industries fully subject to antitrust laws, Mr. Beck asserted.

And, noting that more than 100 commercial banks will fail this year, the most since 1930, Mr. Beck suggested that "federal oversight does not guarantee solvency."

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Civil justice reform essential: Mitchell

By STACY SHAPIRO

CHICAGO—Problems with the U.S. civil justice system could destroy the property/casualty insurance industry, says the chairman of the National Assn. of Independent Insurers.

"For months now, we've been telling each other and everyone else who will listen that the industry faces almost certain ruin at the hands of rapacious lawyers, overly generous courts and judges that rewrite liability laws," said NAII

Chairman Bradford W. Mitchell at the group's annual meeting earlier this month in Chicago.

"Our overburdened civil justice system is the real cause for our ills, and its abuses are spreading faster than any cancer," added Mr. Mitchell, who is chairman, president and chief executive officer of Harleysville Mutual Insurance Co. in Harleysville, Pa.

He said that, as a result of problems with the civil justice system, insurers either have increased rates or have stopped writing certain

lines of coverage altogether.

"It's getting so bad that some obstetricians have stopped delivering babies. . . drug companies have cut back on research to pay for insurance. . . day-care centers are closing up because a few child-abuse incidents scared the daylights out of us."

Despite this fallout, many legislators think the insurance industry's problems are over because it has reported increased profits this year, he said.

While the industry's aftertax net

income increased to \$1.1 billion in the first half of 1985 from \$562 million in the first six months of 1984, he noted that underwriting losses rose by \$1.3 billion in the first half of 1985.

"At the rate we're going, we will see yet another dismal record in 1985, with an underwriting loss which will probably exceed \$22 billion," he said, attributing profits to realized capital gains and tax credits resulting from years of losses.

Mr. Mitchell also pointed out the

industry lost \$2 billion in surplus in 1984 solely through poor underwriting experience at a time when the stock market was stable and investment income was growing. He also cited estimates that the industry is at least 10% underreserved.

"When you add those two factors—inadequate reserves and surplus erosion—to a combined ratio of 118%, you have met all the conditions for a drum-tight availability crisis. . ." he said.



Mr. Mitchell

While insurers' problems can be blamed on the "usual explanations," like cash-flow underwriting, the recessions of the mid-1970s and early 1980s and inflation, "none of these are completely convincing," Mr. Mitchell said.

"Something is pulling us deeper under water and holding us there. That something is the civil justice system," Mr. Mitchell said.

He noted that courts often issue "outrageous" verdicts.

"Yet, it's not the case that goes to trial and results in a multimillion-dollar verdict that should overly concern us. It's the thousands of routine cases that are settled because the courts' inconsistencies and their eagerness to find ways to help the claimant hit the jackpot have destroyed insurers' faith in the legal process. . ."

"What's happened to the civil justice system is what workers comp lawyers call cumulative trauma," he explained.

"The damage has been done over years by countless judges, juries and plaintiffs' lawyers. But, they're not the kind of events that make the 6 o'clock news or page one of your local newspaper."

For instance, Mr. Mitchell said, courts gradually have expanded insurers' obligation to defend.

"Who can trust the courts when they change the rules in the middle of the game or rewrite contracts from the bench? What it all adds up to is not only more and larger claims payments, but higher administrative costs as well. . ."

Mr. Mitchell explained that from 1956 to 1983, the industry's loss adjustment expenses for general liability lines increased three times faster than its losses.

"Deplorable conditions like these can be papered over with rate increases and more selective underwriting, but they will not be corrected until the tort system is reformed," he said.

"Our industry has to take the lead because we are the first victims in line."

Mr. Mitchell said the industry can take three steps to help reform the civil justice system.

"First, we need more and better research to present a clear and convincing case that the civil justice system needs changing," he said.

Second, he said, more coalitions must be formed on the state level to promote civil justice reform. These coalitions include not only insurers but manufacturers, physicians and hospitals, railroads, small businesses and other employers interested in civil justice reform.

Finally, he urged NAII members to lend support and expertise to coalitions in individual states and to support reform legislation.

"A window of opportunity is open for us, and we must move through before it closes," Mr. Mitchell concluded. "Our only hope of sustained profitability is tort reform, but any attempt at reform is like a wheelbarrow. It just sits there until someone pushes it."

"The time to push has arrived." ■

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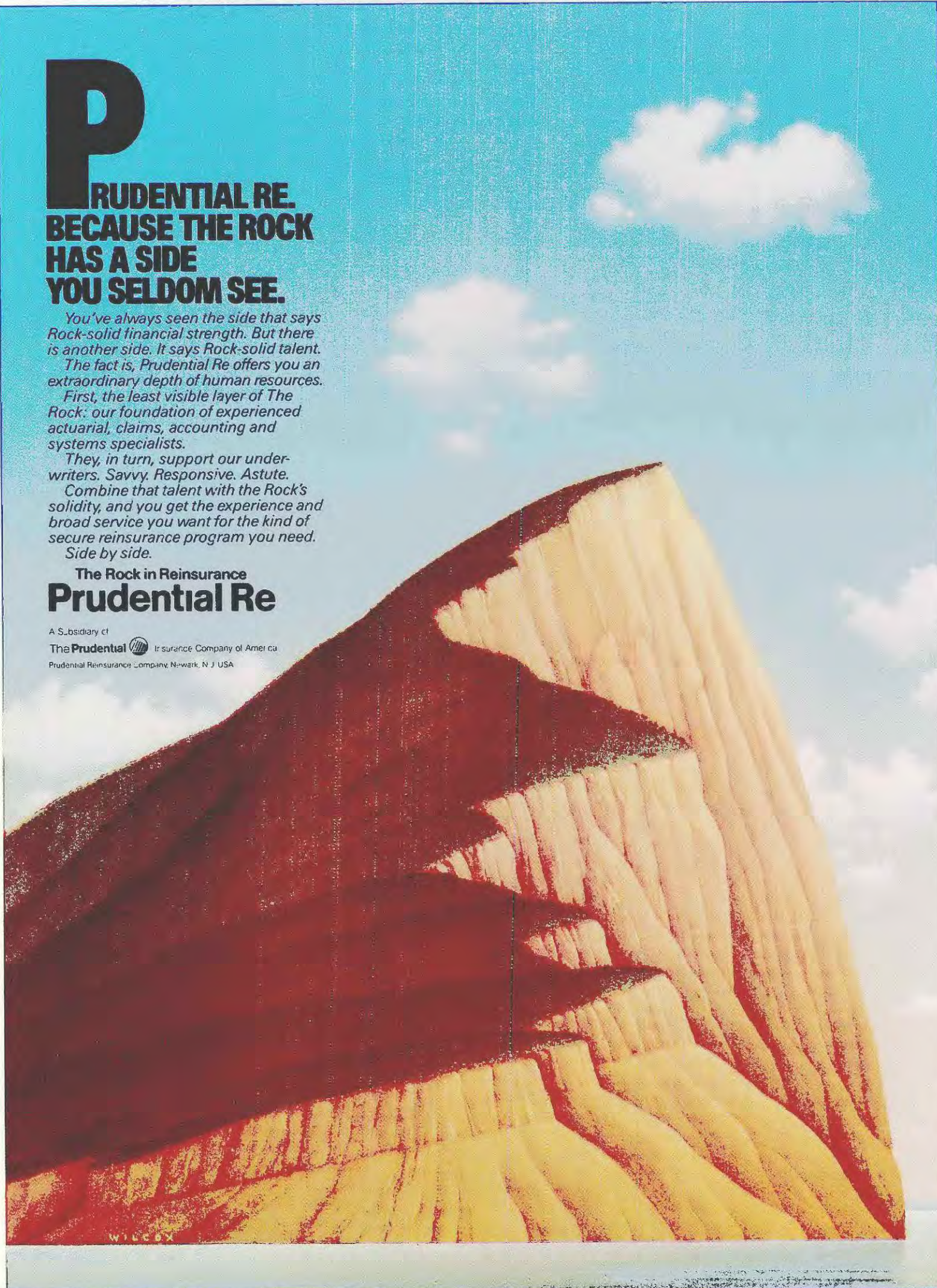
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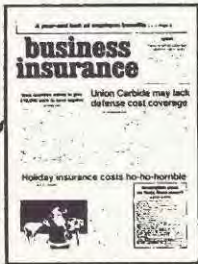
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HAS

Insurers can meet challenges of current market: NAII head

By KATHRYN J. McINTYRE

CHICAGO—Property/casualty insurance companies should "use the scalpel, not the ax" when pruning their books of bad and marginal business, the president of the National Assn. of Independent Insurers advises.

"Individual companies must show great care, judgment and diplomacy in making their decisions to cancel or non-renew, and in their consideration of rates," according to NAII President Lowell R. Beck.

In his annual address to his membership at the NAII annual meeting in Chicago, Mr. Beck advised both insurers and policymakers on how to cope with the current insurance marketplace.

"Selective pruning of bad and marginal business is necessary if companies are to remain solid, healthy and solvent," Mr. Beck said, for the benefit of both insurers and policymakers.

But, insurers, he said, "have a responsibility to look carefully at their own underwriting and claims practices."

He advised insurers to adopt "thoughtful underwriting, new market plans, and constructive recommendations, such as the redesign of insurance contracts, so that costs can be predicted more accurately."



Mr. Beck

And, he suggested that insurers also improve efforts to educate the public, "to whom many of the recent price hikes appear drastic."

Insurers can show how price changes expressed in percentages influence perceptions, he said.

"When a \$1,000 premium is cut by 50% to \$500, it takes a 100% increase to restore the premium to its previous level," Mr. Beck observed.

Mr. Beck also urged public policymakers to "realize that private capital cannot fund extravagant excesses arising out of theories of entitlement and punitive damages. If this industry is to continue serving the public by bearing risks that are indeed reasonably insurable, the law cannot consider it a cash bonanza for everybody with a complaint."

In addition to criticizing the effect of the tort system on insurers, Mr. Beck took the opportunity to point out that insurance availability problems also are created by statutory accounting rules and regulatory constraints designed to promote insurer solvency.

"Rate increases that lead to rapid growth of premium volume can abnormally affect a company's balance sheet," Mr. Beck commented. "Because of those rules, large rate increases actually limit a company's capacity to write more business as the net premium to surplus ratio gets stretched out beyond 2- or 3-to-1."

As of midyear 1985, Mr. Beck said, one out of six companies reporting to the NAII and the Insurance Services Office exceeded the 3-1 standard. "It's an ominous sign," he warned.

And, insurers can't count on reinsurers to "beef us up," he said, because "the capital in the reinsurance community has been so reduced."

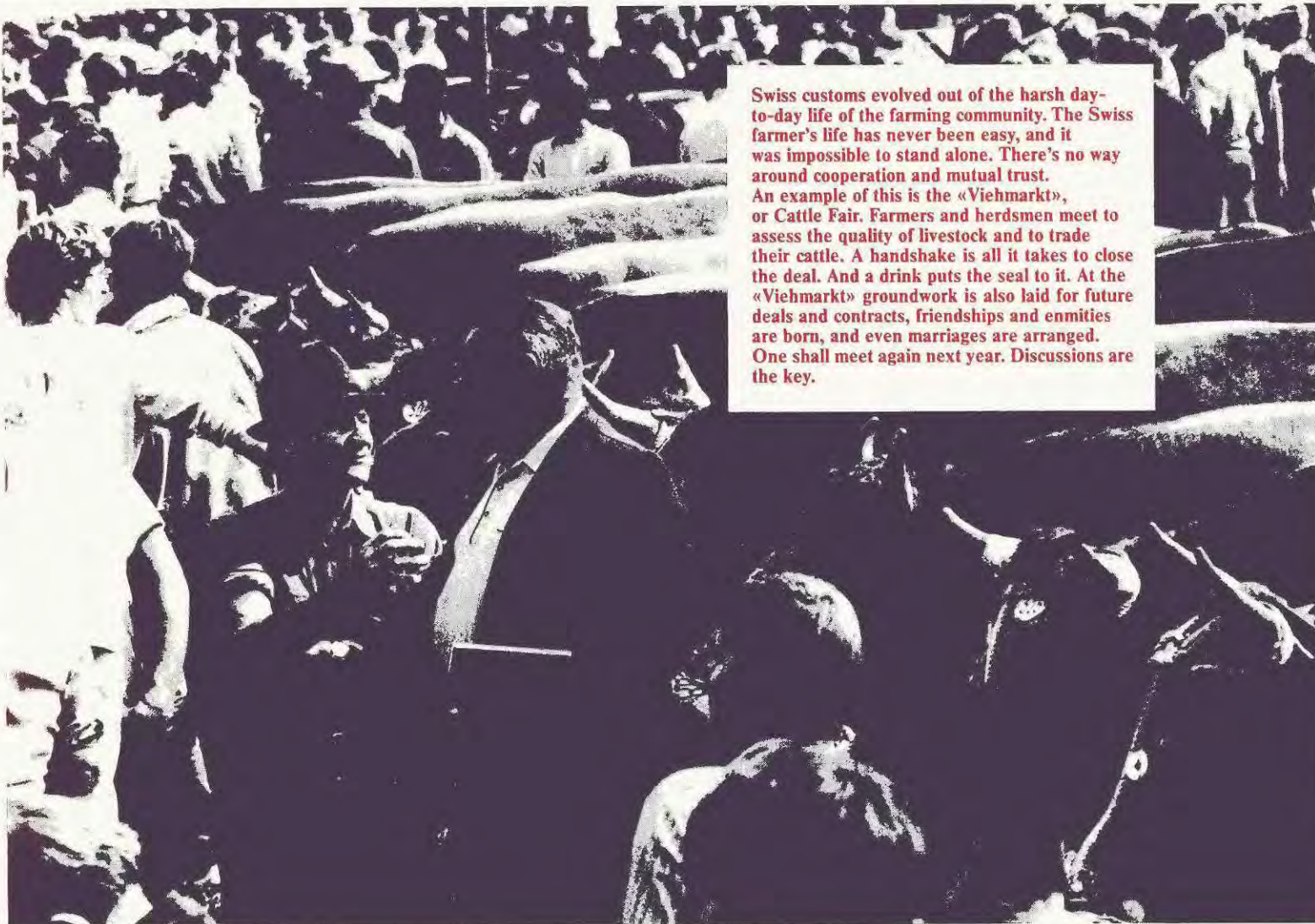
Regulators' and legislators' shock at current rate hikes and highly selective underwriting are leading to threats to repeal competitive rating laws and the adoption of mandated residual markets, he said.

In addition, "legislation and regulations to prohibit cancellations and non-renewals and needed rate increases are under consideration as a rule, not the exception," he said.

"In short, we face one of the most serious challenges that has ever confronted us," Mr. Beck warned.

"In the months ahead, working to develop and maintain a stable environment, without new laws and without regulations crashing in upon us, will be the major challenge for this association," he said.

But, Mr. Beck expressed optimism that "we will solve the problems of insolvency and availability. We are in a period of strong recovery which can mean a return to profitability for companies that have sufficient capital and are well and effectively managed."



Swiss customs evolved out of the harsh day-to-day life of the farming community. The Swiss farmer's life has never been easy, and it was impossible to stand alone. There's no way around cooperation and mutual trust. An example of this is the «Viehmarkt», or Cattle Fair. Farmers and herdsmen meet to assess the quality of livestock and to trade their cattle. A handshake is all it takes to close the deal. And a drink puts the seal to it. At the «Viehmarkt» groundwork is also laid for future deals and contracts, friendships and enmities are born, and even marriages are arranged. One shall meet again next year. Discussions are the key.

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'Reinvented' companies consider employee needs

By STACY SHAPIRO

CHICAGO—Today's successful companies are altering management techniques and tailoring benefits to individual employees' needs to create a more pleasant working environment for employees, say the authors of "Reinventing the Corporation."

John Naisbitt, who also wrote the highly successful "Megatrends," and Patricia Aburdene told a packed audience at the National Assn. of Independent Insurers' annual meeting that corporations are taking these steps because they recognize that employees are their most valuable assets.

Specifically, the authors say, "reinvented" corporations:

- Are abandoning the old pyramid structure of management. Instead, corporations are taking a "twisted knot" approach, a management technique in which there are no pre-established managers, only leaders who naturally take command of a project.

- Allow employees to establish their own working schedules.

- Provide profit-sharing or stock option plans, so employees feel that they have a greater stake in the organization.

"The new American work ethic holds that work should be fun, rewarding and productive, and the corporation a place where people and profits can flourish," Mr. Naisbitt and Ms. Aburdene say in their new book.

"Corporations that cling to the outdated philosophy and structure of the old industrial era will become extinct in the new information society," the authors say.

The authors explained that today's society depends on people's ideas, rather than on their physical strength as in the industrial age. And, corporations that provide the greatest potential for personal growth are attracting the most talented people, Mr. Naisbitt said.

"In the information society, where ideas are major resources, you cannot go to the bank and borrow ideas," he said.



Mr. Naisbitt

But, corporations will be facing a labor shortage within a few years, the authors warned. While 4 million new jobs were created last year and more will be added this year, there will not be enough workers to fill those positions, Mr. Naisbitt said.

"Starting in 1965 until 1980, women had fewer kids. Because of these baby-bust kids, we will take people into the workforce at half the rate that we have today. For the rest of the century, we will have terrific labor shortages," he said.

And, a greater percentage of those workers will be women.

"The white male has become a minority in the workforce," Ms. Aburdene said. Thirty years ago, men comprised 63% of the workforce, but today they comprise 49%, she said.



Ms. Aburdene

She also noted that women generally are the prime motivators behind corporations' moves toward employee benefit innovations like flexible work schedules and day-care facilities.

The authors believe that the new information society also will promote changes in the educational system. They say today's educa-

tional system was designed for an industrial economy, in which uniformity and discipline reigned.

But, in the information society, the educational system must teach students how to think, learn and create, Ms. Aburdene says. The result will be increasing respectability for courses like philosophy, literature, art and music.

Corporations also are taking on the role of educators. "Companies are on the leading edge of education," Mr. Naisbitt said.

Corporations are creating their

own education programs, and some give academic recognition for the training, Ms. Aburdene said. Others, like International Business Machines Corp., spend up to \$1 billion on training their employees.

Among the successful "reinvented" corporations mentioned by Mr. Naisbitt and Ms. Aburdene are:

- Scandinavian Airline System. In a single year, President Karl Johnson turned the company's losses to profits by turning the corporation upside down, the authors say.

Since a major portion of the company's operations involves dealing with the public. Mr. Johnson gave employees in charge of dealing with customers top posts in the company.

- W.L. Gore & Associates, established in 1958. The company does not have a managerial hierarchy, which means no bosses, the authors say.

The company's only objectives are "to make money and to have a good time," Mr. Naisbitt said.

- General Motors Corp. "GM's

strategy is a model for reinventing an established industrial company to survive and flourish in the new information society," they say.

GM purchased Electronic Data Systems for \$2.5 billion to provide the computer technology GM needed, but, instead of imposing GM's established management style on EDS, the automaker is learning from the computer firm how to be more entrepreneurial and to make decisions faster to create profit without paperwork, Mr. Naisbitt and Ms. Aburdene say. ■



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DEC. 5. Employee Illnesses conference in Chicago, sponsored by the Illinois State Chamber of Commerce; \$90 for members; \$135 for non-members. Carol Jensen, Illinois State Chamber of Commerce, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

DEC. 5. Fundamentals of Environmental Health seminar in Houston, sponsored by the International Safety Academy; \$185. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147, 215-241-5800 in Pennsylvania.

DEC. 5-6. Health Care: Legal Responses to New Economic Forces seminar in New York, sponsored by the Practising Law Institute; \$390. Practising Law Institute, Department 105-DK, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, Ext. 286.

DEC. 5-6. National Product Safety Symposium in Chicago, sponsored by the National Safety Council; \$180 for members and U.S. Government employees; \$225 for non-members. Russ Marhefka, National Safety Council, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800.

DEC. 5-6. Audio-Visual Media for Safety & Health: Developing and Producing Inexpensive Programs course in Los Angeles, sponsored by the University of Southern California Institute of Safety and Systems Management; \$400. Registrar, University of Southern California, Institute of Safety and Systems Management, Office of Ex-

tenation and In-Service Programs, Los Angeles, Calif. 90089-0021; 213-743-6523; 213-743-6524.

DEC. 6. Product Liability Avoidance for the Boat Manufacturing Industry seminar in Orlando, Fla., sponsored by Corroon & Black Corp.; free registration limited to members of boat manufacturing industry. Mary Jo Butts, Seminar Coordinator, Corroon & Black Corp., P.O. Box 1020, Nashville, Tenn. 37202; 615-367-9702.

DEC. 6-7. Fifth Annual Occupational Health Nursing Principles and Certification Review course in San Rafael, Calif., sponsored by the Occupational Health Consulting Division of Fireman's Fund Risk Management Services Inc.; \$225. Also Jan. 10-11 in Newark, N.J.; Jan. 24-25 in Cincinnati; Feb. 7-8 in Dallas; Feb. 21-22 in Schaumburg, Ill.; Feb. 23-March 1 in Torrance, Calif.; and March 14-15 in Arlington, Va. Annette B. Haag, Director, Occupational Health Consulting, Fireman's Fund Risk Management Services Inc., P.O. Box 3890, San Rafael, Calif. 94912; 415-492-7753.

DEC. 9-10. Banks and Insurance Joint Venture Marketing Strategies conference in West Palm

Beach, Fla., sponsored by The Banking Law Institute; \$750; \$650 for each additional registrant from the same organization. Make checks payable to Executive Enterprises Inc., #5CINS22/E5349, 33 W. 60th St., New York, N.Y. 10023-7988; 212-489-2680.

DEC. 9-10. Marketing Insurance Through Financial Institutions seminar in Newport Beach, Calif., sponsored by Inter-Financial Assn.; \$525 for members, \$465 for additional members from the same company; \$595 for non-members, \$535 for additional non-members from the same company. Diane Vonarb, The Bankers Institute, 21 Tamal Vista Blvd., Corte Madera, Calif., 94925; 415-924-1420.

DEC. 9-13. Managing Program Implementation course in Sacramento, Calif., sponsored by the International Loss Control Institute; \$695. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-554-6001; 404-466-2208 in Georgia.

DEC. 11. Purchasing Crash Protection in Auto Fleets seminar in Washington, sponsored by the

Insurance Institute for Highway Safety, the National Safety Council and the National Assn. of Governors' Highway Safety Representatives; free; John R. Cook, Insurance Institute for Highway Safety, Watergate 600, Washington, D.C. 20037; 202-333-0770.

DEC. 11. Health Improvement/Prevention Workshop in Chicago, sponsored by the Health Research Institute; \$195. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

DEC. 11. Advanced "Post-Graduate" Cost Containment workshop in Chicago, sponsored by the Health Research Institute; \$195. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

DEC. 11. Medical Directors workshop in Chicago, sponsored by the Health Research Institute; \$195. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

DEC. 11-13. Legal Operational Issues in HMOs, PPOs and CMPs program in Chicago, sponsored by the National Health Lawyers Assn.; \$350 for members; \$400 for non-members. Program Division, National Health Lawyers Assn. 522 21st St., N.W., Suite 120, Washington, D.C. 20006; 202-833-1100.

DEC. 11-13. Ocean Cargo Claims Handling seminar in New York, sponsored by The World Trade Institute; \$775; \$730 for each additional registrant from same organization. Registrar, The World Trade Institute, One World Trade Center, 55W, New York, N.Y. 10048; 212-466-4044.

DEC. 12-13. Labor/Management workshop in Chicago, sponsored by the Health Research Institute; \$195. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

DEC. 12-13. New Issues in Accounting, Legal and Reporting Aspects of Loss Reserves seminar in New York, sponsored by Executive Enterprises Inc.; \$750; \$650 for each additional registrant from same organization. Executive Enterprises Inc., Reference E5381, Session #5CINS23, 33 W. 60th St., New York, N.Y. 10023-7988; 800-223-0787; in New York, 212-489-2680.

DEC. 20. The Economy 1986 and Beyond luncheon program in Chicago, sponsored by the Assn. of Certified Employee Benefit Specialists; \$25. Tom Gaffigan, Assn. of Certified Employee Benefit Specialists, P.O. Box 600, Chicago, Ill. 60690; 312-732-3988.

JAN. 12-14. Paradox of the '80s: Regulating Health Care in a Deregulated Environment conference in Washington, sponsored by the Group Health Foundation; \$285 for members before Dec. 11, \$335 after Dec. 11; \$325 for non-members before Dec. 11, \$375 after Dec. 11. Conference Office, Group Health Foundation, 624 Ninth St., N.W., Suite 700, Washington, D.C. 20001.

JAN. 13-17. Modern Safety Management in Atlanta, sponsored by the International Loss Control Institute; \$695. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-554-6001; 404-466-2208 in Georgia.

JAN. 20-21. Developing and Managing an Employee Medical Monitoring Program course in Los Angeles, sponsored by the University of Southern California Institute of Safety and Systems Management; \$350. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, University Park, Los Angeles, Calif. 90089-0021; 213-743-6523/6524.

JAN. 29-31. Regulation of Chemicals in the Global Environment: Protecting the Public Against Hazards from Chemicals program in Brussels, Belgium, sponsored by The Bureau of National Affairs; \$420. International Chemicals Symposium Registrar, BNA Conferences, The Bureau of National Affairs Inc., 2550 M St., N.W., Suite 699, Washington, D.C. 20037; 800-424-9890, 202-452-4420 in Washington.

FEB. 12-13. London Market and its Future conference in London, sponsored by Risk Research Group Ltd.; 293.25 pounds (\$410.55); 517.50 pounds (\$724.50) for two registrants from same organization. Judith Hobday, Risk Research Group Ltd., Bridge House, 181 Queen Victoria St., London, EC4V 4DD; 01-441-236-2175.

FEB. 17-19. Fifth Annual Pension Seminar in Kissimmee, Fla., sponsored by Corbel & Co.; \$395. Brenda Chatham, Registrar, Corbel & Co., P.O. Box 17548, Jacksonville, Fla. 32245-7548; 904-731-4455.

MARCH 11. Captives in Brief workshop in Hamilton, Bermuda, sponsored by Tillinghast, Nelson & Warren Inc.; \$300. Micki Briskin, Tillinghast, Nelson & Warren Inc., 722 Post Road, Darien, Conn. 06820-4798; 203-655-9791.

MARCH 12-14. 10th International Captive Insurance & Reinsurance Forum in Hamilton, Bermuda, sponsored by Tillinghast, Nelson & Warren Inc.; \$750; \$675 for additional registrants from same organization. Micki Briskin, Tillinghast, Nelson & Warren Inc., 722 Post Road, Darien, Conn. 06820-4798; 203-655-9791.

MARCH 23-28. 13th Workers Compensation College at Duke University, Durham, N.C., sponsored by the International Assn. of Industrial Accident Boards & Commissions; \$300 for members; \$400 for non-members. IAIABC College, P.O. Box 79109, Jackson, Miss. 39236; 601-355-4582.

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EASING ASBESTOS RISK

Correct methods, tools can make it much safer to get rid of asbestos

By Jaswant Singh and Michael A. Coffman

ASBESTOS EXPOSURE may well be the No. 1 occupational and environmental health problem in the United States today.

Lawsuits and litigation regarding the consequences of exposure to asbestos have affected thousands of individuals and major corporations and have shaken the insurance industry.

For many years, industrial exposure to asbestos was considered the major problem; in recent years, however, there also has been increasing concern over the potential for asbestos exposure in public buildings, including schools and office buildings.

Sprayed-on asbestos fireproofing and insulation were used increasingly after World War II in steel-framed, multistory buildings. This use of asbestos, in addition to the more traditional uses such as pipe insulation and acoustical plaster, continued until the early to middle 1970s.

Worries over the release of fibers from asbestos products have led many building owners to initiate expensive removal programs. Ensuing litigation over liability for asbestos in buildings, as well as the more traditional exposures in shipyards and insulation applications, has resulted in many insurance companies severely limiting available coverages for asbestos-related work.

With increasing concerns about asbestos, many corporations and schools have undertaken extensive asbestos removal projects in their buildings and from equipment such as steam pipes, asbestos-insulated reactors, digestors, etc. Many schools are in the process of evaluating asbestos problems in their buildings and contracting for removal of asbestos from their buildings, and plan to begin asbestos removal during the summer recess this year.

The demand for asbestos removal has created a major new industry. Some estimates are that it could become a \$3 billion per year business.

This activity, however, is threatened by the difficulties that asbestos removal contractors are experiencing in obtaining liability insurance.

Liability insurance for asbestos removal has been disappearing so fast that many planned asbestos removal projects may never be implemented. Some recent cases have shown that the asbestos contractor was able to obtain coverage only after paying a high price.

And one of the nation's largest asbestos removal contractors, East Hartford, Conn.-based Acmat Corp., formed its own insurer to offer liability coverage to itself and other asbestos removal contractors (*BI*, June 3; Nov. 4).

From a technical standpoint, reluctance of the insurers to cover the risk posed during asbestos removal projects appears unfounded.

There is no doubt that exposures to high concentrations of asbestos have caused a variety of diseases such as asbestosis, mesothelioma and lung cancer.

The evidence, however, exists that there is dose-response relationship, meaning that if the exposure to asbestos is kept "low," the health risk can be minimized.

Over the past few years, procedures have been developed to keep asbestos exposures extremely low during asbestos removal projects. Clayton

Jaswant Singh is vp and technical director of Clayton Environmental Consultants Inc. in Southfield, Mich. Michael A. Coffman is manager-industrial hygiene services at Clayton Environmental Consultants.

Asbestos exposure (Mean concentration of fibers/cc)

	Worker exposure without respirator	Worker exposure with respirator
Removal of fireproofing and/or acoustical plaster	1.1	0.01
Removal of pipe and boiler insulation	0.46	0.005
Removal of insulation from industrial ovens	0.22	0.002
Removal of pre-formed pipe insulation from process piping at petroleum refineries	0.09	0.001

Chart: Amy Palmer

Environmental Consultants and others have written job specifications and monitored many such projects.

The data indicate that if a contractor adheres to the specified protocol and good work practice guidelines, the exposure to workers performing the removal and "incidental exposure" to other occupants of the building in the vicinity of the removal is low.

Many corporations and organizations have developed specific and detailed control programs to minimize exposure risks. These programs include:

- Respiratory protection.
- Disposable work clothing. To avoid prolonged exposure or exposure of family members after the workday, abatement workers should be provided with disposable coveralls and head coverings.
- Showers. After removing contaminated work clothing, workers should take a full body shower.
- Barriers, which generally consist of polyethylene sheeting used to seal off the work area from the rest of the building.
- Negative pressure ventilation. To ensure that airborne asbestos fibers from the removal zone do not escape into other work areas, portable HEPA (high-efficiency particulate air) ventilation systems should be used to place the removal zone under negative pressure.
- Medical monitoring. All workers should receive annual physical examinations.
- Air monitoring. Air monitoring should be performed before, during and after removal to determine escape of fibers, if any, from the work area and establish whether the area has been adequately cleaned at the completion of work.
- HEPA vacuums. Cleanup of asbestos debris is performed using vacuum cleaners equipped with special HEPA filters.
- Wet methods. Before removing asbestos and when cleaning up, water is sprayed on to prevent dust generation.

Industrial hygienists have studied fiber levels extensively during asbestos abatement projects. The accompanying chart summarizes the results of more than 1,000 such measurements.

This data represent the mean of asbestos exposure measured during asbestos abatement projects, without taking into account respiratory protection.

When respiratory protection—a full facepiece, type C supplied-air respirator—is used as recommended, the actual exposure to a worker will be far less, as shown in the chart.

Studies performed by the federal Occupational Safety and Health Administration and others have shown a clear dose-response relationship for exposure to asbestos.

In the background document that OSHA submitted to

support its Emergency Temporary Standard for asbestos, OSHA estimated a total of 15 cancer deaths—including deaths from lung cancer, mesothelioma and gastrointestinal cancer—per 100,000 workers exposed to an average concentration of 0.1 fibers/cubic centimeter for one year.

There is clear evidence that the exposure risk to asbestos can be minimized or eliminated by adopting state-of-the-art technologies and work practices. This can, however, be accomplished only if a contractor is knowledgeable and actually follows the control procedures as intended.

This admittedly is not an easy task but, nevertheless, can be implemented. To accomplish this, we recommend the following:

- A contractor licensing/certification program should be developed. This can be instituted through governmental agencies or professional and trade associations.
- Only contractors that meet a certain experience and competence level should be accepted for asbestos removal work.
- Rigid work protocol, including but not limited to, the items mentioned above should be required.
- To ensure that the protocol is strictly followed, an industrial hygienist/environmental professional should be present on-site during the entire project. This person would be engaged by the building owner or insurance company and not by the contractor performing the asbestos removal work.

The industrial hygienist should perform daily monitoring, analyzing the samples on-site by phase-contrast microscopy. Backup analysis by electron microscopy may be necessary but will be performed off-site by shipping the samples to a qualified laboratory.

In addition to monitoring for asbestos exposures, the on-site industrial hygienist will act as an inspector to monitor the work practices and adherence to specified control procedures. The "inspector" will sign off a checklist at the end of each day "certifying" that control procedures were applied as intended.

The field inspector also will verify that the proper protective equipment, such as the specified respirators, were used.

Adopting these strict measures could increase significantly the cost of asbestos removal.

But adherence to an approved protocol would minimize exposure risks to a point that insurers might find acceptable.

The asbestos issue is truly a national crisis, and any measures that would ensure that asbestos is eliminated from schools and other buildings where it may pose a continued risk to occupants is a program that deserves commitment of resources from all concerned.

Coverage decisions have pros, cons

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked, and possible answers to, the three examinations for the A.R.M. designation.

This month's question and answer illustrate that any choices a firm makes about placing its insurance coverages have both advantages and disadvantages, depending on the particular circumstances.

Q: Describe at least two significant advantages and two significant disadvantages to each of the following decisions that an organization may make.

- An organization decides to use just one broker, rather than several, to purchase insurance.
- An organization decides to obtain as much of its property/liability insurance as possible through manuscript policies rather than standard policies.
- An organization decides to obtain as much of its property/liability insurance as possible from admitted rather than non-admitted insurers.

A: Relying upon only one broker can have a variety of potential advantages, such as:

- Greater bargaining leverage with that broker and its insurers in securing more favorable policy provisions and/or settlements of specific claims.
- Greater broker familiarity with, and commitment to fulfilling, the insured's coverage and risk management needs.
- More direct, less repetitious communication and other administrative activities.

A.R.M. exercises

• Greater opportunity to discover and/or avoid gaps and overlaps within the entire insurance program.

But, it also can have disadvantages, such as:

- Reduced access to the greater variety of insurers, coverages and insurance-related products and services that a greater number of brokers could provide.
- A greater tendency of the broker to take the insured's business for granted because it faces no ongoing competition.
- Less cost-effective coverage if the broker does not have access to the "best" insurer for every need.
- More limited examination of all risk management alternatives.

Using manuscript coverages rather than standard policies may have such potential advantages as:

- Broader coverages, including more kinds of property, liability, net income and life/health coverages against a broader range of perils.
- Greater ability to tailor coverages more closely to the insured's particular needs.
- Simpler administration of the insurance program because of fewer separate policy documents required.
- Enhanced ability to modify standard policy conditions and other provisions to clarify or extend coverage.

Potential disadvantages include:

- Increased likelihood of errors or oversights in drafting.
- More limited access to insurers, because relatively few of them are willing to consider manuscript coverages, especially against certain exposures.
- Reduced ability to rely on past judicial decisions interpreting standardized insurance contracts.

• Higher premium costs because of underwriters' caution in setting rates for potentially unanticipated exposures covered by manuscript policies.

Seeking to use only admitted insurers rather than non-admitted insurers may have potential advantages, including:

- Greater ease of collecting claims because the insurer and the insured are more likely to be in the same legal jurisdiction and the insurer is more likely to be regulated effectively.
 - Enhanced ability to determine the insurer's soundness, again because of better regulation.
 - Greater likelihood that the coverage available from an admitted insurer will meet statutory standards for coverages demanded by the law of the insured's state.
 - Greater assurance of the insurer's financial stability through a state guarantee fund, which also would be called upon to meet insureds' policy claims against bankrupt admitted insurers.
- The potential disadvantages include:
- Increased cost of coverage, because non-admitted insurers often offer lower-cost coverage.
 - Inability to purchase types of coverages available only from non-admitted insurers.
 - Greater difficulty in obtaining adequate limits of primary and excess insurance, especially for some liability coverages, because the insured cannot directly tap the underwriting capacity of non-admitted insurers.

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

Book a valuable map to 'Pathways to RMIS'

"Pathways to RMIS: Guidelines for Acquiring, Managing and Using Risk Management Information Systems."

Edited by James D. Blinn and Mitchell J. Cole

Published by Risk Management Society Publishing Inc., 205 E. 42nd St., New York, N.Y. 10017

\$24.95 for RIMS members; \$29.95 for non-members
Softcover, 164 pages

By Kenneth J. Kortz

THE RISK MANAGEMENT Society Publishing Co.'s new book, "Pathways to RMIS", is a useful aid for risk managers interested in finding and using risk management information systems.

The book is edited by James Blinn and Mitchell J. Cole, and it is comprised of articles by several RMIS specialists.

The guide breaks down its subject matter into three areas: defining risk management needs, managerial control of RMIS development and acquisition and applications of an RMIS.

The first section provides a broad overview for the risk manager trying to define his or her system needs. It emphasizes the wide range of uses of a

books & ideas

risk management information system and stresses that a well-designed and well-implemented program can be useful to the entire line of management.

The first chapter is written by Mr. Cole, who is a vp and principal of Tillinghast, Nelson & Warren Inc. Mr. Cole makes several predictions regarding the future information systems.

Specifically, he feels that in the near future:

- All risk managers will have a personal computer on their desks.
- All RMIS users will be able to communicate through personal computers.

• An RMIS should be considered a decision-support system, and future RMIS data will have to be more risk-management than claims oriented.

Mr. Cole says that proper use of an RMIS will hasten the blending of pure and speculative risk management.

In another article, G. Theodore Nygree provides the risk manager with a way to analyze his or her needs in an information system.

This chapter is particularly helpful, outlining seven specific and detailed steps to be made assessing individual needs in an RMIS. It makes suggestions about departments and corporate officials that should be involved in the decision and warns against some common pitfalls.

The author cautions that even if there is proper initial assessment, a continuing analysis of needs and available system options must be done to assure that the RMIS meets a company's changing needs. But, this chapter should get the risk

manager on the right track.

The third chapter explains how to interview both external people, like system vendors, and internal corporate officials about the RMIS. It includes a detailed outline to be used for preparing the interviews and a sample letter that can elicit maximum participation from all corporate departments.

Chapter four seeks to identify the data flow and the phases of the data processing program.

The types of data to be considered in establishing the program are outlined and examined closely. And, the chapter includes helpful exhibits and diagrams of information flows.

An article by author James Blinn examines the question of whether it is best to devise a system internally or to purchase one from an outside vendor. It covers all aspects of such a decision, including in-house software development, the options of software purchase and lease or rental of systems. And, it also analyzes the problems and advantages of using internal and outside help to develop the system.

The second section of the book involves managerial control of the system and its development and acquisition. A chapter written by Ronald Grimm of Xerox Corp. provides an outline that can be used to review a risk manager's specific requirements.

The 4½-page outline provides key questions about about user's specifications, but perhaps even more importantly, it gives warnings about problems to avoid.

The author also says that from six

months to two years should be allowed for implementation of an RMIS.

Another chapter provides a cost-benefit analysis of an RMIS. It explores basic costs of implementing a system and compares the costs of micro-computers and large computers. It also reviews the personnel costs involved.

This chapter also cautions that the main benefit of an RMIS is not a decrease in staffing but an increase in quantity and quality of information and a more professional risk management staff.

Finally, the book points out that installing an RMIS is only part of the task: The greater task is using its capabilities. And, using the system for such functions as budgeting, setting objectives of the departments and preparing an annual report further enhances its value.

The six chapters of the final section cover six case studies of actual uses of an RMIS. Although not every risk manager would find each of these uses applicable to his or her situation, these case studies provide an in-depth look at the kinds of uses that can be found for an RMIS.

I strongly recommend this manual to any risk manager involved in or wishing to become involved in an RMIS.

Like all general guides, the book probably provides more information than an individual risk manager needs. However, all risk managers can find help in the book for solving their particular problems with information systems.

This book is a detailed guide to an expensive and time-consuming operation, and the risk manager who uses it will have an easier time and more successful results in entering the age of the RMIS.



Kenneth J. Kortz, A.R.M., is risk manager for Holiday Warehouse in Minneapolis.

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North Miami expects PPO to cut city's health costs

The city of North Miami, Fla., expects to save at least \$45,000 in medical insurance premiums by replacing its traditional fee-for-service health care plan with a preferred provider organization.

On Aug. 1, the city's traditional plan, underwritten by Blue Cross & Blue Shield of Florida, was replaced with "AMICARE," a PPO network sponsored by American Medical International Inc., a Beverly Hills, Calif.-based hospital and health care services company. The PPO includes nine area hospitals and 500 doctors.

Besides the first-year premium savings of \$400 per covered employee, AMI has guaranteed the city's premiums will not rise more than 5% during the second year, provided 75% of the total claims are paid to participating providers, says Adele Hartstein, personnel specialist for the city. Even if this requirement isn't met, AMI has guaranteed the health care premium won't increase more than 10% in the second contract year, she said.

Previously, employees had a choice between a traditional comprehensive medical plan, underwritten by Blue Cross & Blue Shield of Florida, and two health maintenance organizations.

Under the comprehensive medical plan, employees had been required to pay a \$300 deductible for individual coverage or \$600 deductible for family coverage. They also

benefit beat

paid 20% of expenses exceeding the deductible, up to an out-of-pocket limit of \$1,000 for individual coverage, and \$3,000 for family coverage, Ms. Hartstein said.

Under the AMICARE PPO, employees must pay a deductible of \$100 for individual coverage and \$300 for family coverage for care from a preferred provider. In addition, they pay 10% of hospital expenses and outpatient surgical expenses exceeding the deductible, and 20% of other outpatient services, like office visits, that exceed the deductible.

Out-of-pocket expenses are capped at \$1,000 for individual coverage, \$2,000 for an employee and one dependent and \$3,000 for an employee and more than one dependent.

Employees enrolled in the PPO also pay 10% of the cost of prescription drugs after meeting their deductible, as long as they use a pharmacy that participates in the PPO network. If not, they pay 20% of the cost, Ms. Hartstein said.

If employees receive services from a health care provider that does not belong to the network, he or she must meet a \$200 deductible for individual coverage or a \$600 deductible for family coverage, Ms. Hartstein said.

The employee must also pay 30% of all expenses exceeding the deductible, up to a maximum out-of-pocket limit of \$2,000 for individual coverage, \$4,000 for coverage for an employee and one dependent and \$6,000 for coverage for an employee and more than one dependent, Ms. Hartstein said. In addition, if an employee enrolled in the PPO goes to a non-network hospital, he or she must pay a \$500 "admission charge" in addition to the deductible, which cannot be applied toward the out-of-pocket maximum limit, Ms. Hartstein said.

As another cost-containment measure, employees who receive pre-certification of any service, including office visits, receive an additional 10% reimbursement for expenses that exceed the deductible, Ms. Hartstein said.

Employees still have the HMO option available to them, Ms. Hartstein said. The city makes the same premium contribution to both the HMO and PPO plans.

Under the PPO plan, employees pay nothing for individual coverage, while the city contributes \$96.40 a month. Employees pay \$82.56 a month for coverage for themselves and one dependent, while the city contributes \$130.57. For coverage for an employee and more than one dependent, employees pay \$119.06 a month, while the city contributes \$130.57.

Employees who enroll in an HMO must pay the difference between the cost of the HMO and the city's premium contribution, Ms. Hartstein said.

About 275 of the city's employees currently are enrolled in HMOs; about 132 use AMICARE, Ms. Hartstein said.

comings & goings: buyers

Constance Clayton named Philadelphia risk manager

Constance A. Clayton has been named risk manager for the city of Philadelphia. In this newly created position, Ms. Clayton will be responsible for the city's property/casualty insurance and employee benefits programs, as well as for administering the city's self-insured and loss-prevention programs. She will report to Angela Dowd-Burton, deputy director of finance. Ms. Clayton previously was corporate risk manager for Keystone Foods Corp. in Bryn Mawr, Pa. She has a bachelor of science degree in business administration from St. Joseph's University in Philadelphia. In addition, she currently is working toward the Chartered Property Casualty Underwriter and the Associate in Risk Management designations. Ms. Clayton is past president of the Delaware Chapter of the Risk & Insurance Management Society and will serve on RIMS' board of directors for the 1986-88 term.

Insurance Management Society.

Juanita M. Marshall, 49, has been named risk management coordinator at GenCorp in Akron, Ohio. In this newly created position, she is responsible for coordinating department functions with special emphasis on project progress, report filings and review of leases and contracts for unacceptable risks. She reports to Denis Julien, manager of corporate insurance. Ms. Marshall, who joined GenCorp 31 years ago, had been secretary to the treasurer and has worked in the treasurer's office for more than 20 years.



Ms. Marshall

John J. Frawley Jr., 34, has been named vp and director of risk management and insurance at Thomson McKinnon Securities Inc. in New York. In this newly created position, Mr. Frawley will be responsible for administering the company's risk management and property/casualty insurance programs. He reports to Michael S. Shapiro, executive vp-financial division. Mr. Frawley formerly was risk manager at Paine Webber Inc. in New York. He has a bachelor of science degree in business administration from St. Frances College in Brooklyn, N.Y.

We'd like to report on staff changes in your company's risk management, safety or employee benefits department. Just drop a note to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5282.



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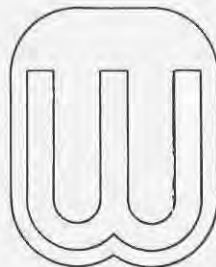
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California issues rules for banks

SACRAMENTO, Calif.—California Insurance Commissioner Bruce Bunner has issued a special bulletin on regulations regarding insurance activities by banks and other financial institutions.

The six-page publication, Bulletin 85-13, spells out guidelines for the marketing of insurance by California banks and other financial institutions.

The bulletin outlines 10 principles to be applied "to any unlicensed financial institutions or unlicensed entity or person which announces the availability of or recommends an insurance policy or program, insurer or insurance producer, or that which proposes to be advertised as being associated in some way with an insurance solicitation."

Bulletin 85-13 also cites the specific sections of the state insurance code that apply to each principle.

The principles outlined are designed to clarify and expand on existing California regulations concerning such activities as:

- Insurance solicitation, announcements or recommendations by an unlicensed entity.
- Misrepresentations by producers.
- Unlawful rebates.
- The sharing of personnel between a financial institution and agency.
- The leasing of space on the premises of a financial institution.

Also covered are regulations on the sale of financial institutions' customer lists; consumer tie-in sales; and the application of state laws to federally chartered banks.

CIGNA expands HMO unit in Northeast

CIGNA Healthplan Inc., a CIGNA Corp. unit that operates health maintenance organizations, is expanding into Connecticut and Massachusetts.

CIGNA Healthplan of Connecticut Inc. and CIGNA Healthplan of Massachusetts Inc. expect to begin providing HMO coverage for employees in Hartford, Conn., and Springfield, Mass., by Jan. 1 and plan to expand throughout those states later in the year.

Leonard A. Colavita, president of CIGNA Healthplan's Northeast Division, said, "CIGNA Healthplan's HMOs are rapidly approaching 1 million members and the New England market is a vital part of our expansion plans."

He said expansion in the Northeast is "motivated by our desire to complement CIGNA's existing indemnity insurance business by providing a full range of health benefit options to our customers in this New England market."

CIGNA Healthplan of Connecticut will be established in cooperation with the Hartford County Medical Assn. and will operate as an individual practice association. Subscribers will select a primary care physician and will receive health care services at the physician's office. Physicians may refer members to specialists and hospitals associated with the plan.

CIGNA Healthplan of Massachusetts, also an IPA, is being established in cooperation with the Sisters of Providence Health and Human Systems Inc. of Springfield.

For information, contact Martha Payne, CIGNA Corp., Hartford, Conn. 06152; 203-726-4450.

Execs to buy firm

The senior executives of CMA Consulting Group in Morristown, N.J., have announced they will purchase the company from Thomas C. Schleifer.

The sale will be effective Jan. 15. At that time, Roy Adams Jr., currently the company's southeast regional vp and one of the purchasers, will become CMA's president and chief executive officer.

Mr. Adams declined to disclose the purchase price for the firm, which provides consulting services for financial institutions, insurers and law firms. Its services include calculating and documenting losses, claims settlement and determining proper insurance coverages.

The firm is being bought by Mr. Adams and a group of five others who will form an executive committee to direct business strategy.

Mr. Schleifer, who founded CMA in 1976, will continue to hold a position on the company's board of directors.

New PPOs in Illinois

A new preferred provider organization available in two Illinois counties offers workers an option to receive health care services from more than 120 physicians.

PPO-Joliet is a joint venture of Joliet physicians and Silver Cross Hospital. The PPO is available to workers in Will County and parts of Cook County.

Health care services are available from the participating physicians, Silver Cross and its satellite facilities in Wilmington and Homer Township.

Under PPO-Joliet, physicians and Silver Cross have agreed to a predetermined reimbursement formula in return for the anticipated increase of new patients.

Dr. Barry Ladd, president of the new PPO, said, "While HMOs offer similar services, a major complaint has been that the doctor-patient relationship is often disrupted because the HMO plan offers a few

markets

locations and a limited number of physicians. PPO-Joliet offers area residents a choice of more than 120 physicians."

Charles Hedke, executive director of PPO-Joliet, said, "Employers who self-insure their benefits or whose premiums are based on their own claims experience will find that PPO-Joliet can have a significant impact on their health care costs."

"Savings through PPO-Joliet will allow employers to waive or reduce employee deductibles and coinsurance, providing a financial incentive for employees to utilize our physicians and facilities," Mr. Hedke added.

The PPO also will provide utilization reviews, claims management, benefits package design and claims analysis services.

Initially, PPO-Joliet will be offered to larger companies, according to Mr. Hedke.

For more information, contact PPO-Joliet at 2450 Glenwood Ave., Joliet, Ill. 60435; 815-725-8896.

Home pension unit

Home Life Insurance Co. in New York has formed a new sales organization to market group pension products.

Regional offices of the new unit have opened in Atlanta, Chicago and Los Angeles. Other offices are planned for northern New Jersey, Texas, New York and San Francisco by the end of next year.

Ted Ludlam, senior vp of Home Life, said the group pension products are aimed at employers with 100 to 1,500 lives.

According to Mr. Ludlam, the new sales force would market guaranteed investment contracts as well as a variety of funding vehicles for plan sponsors and individual participants.

In addition, the new sales force offers "terminal funding," which allows employers to buy annuities for retirees or for plans that are terminating.

"We believe we can become more competitive with a dedicated

sales force focused on this market and working closely with our customers," Mr. Ludlam said.

Brokerage expands

The brokerage services of Hobbs Brook Agency Inc., a unit of Waltham, Mass.-based Arkwright-Boston Insurance, have been expanded to include commercial property/casualty insurance.

Hobbs Brook, whose services formerly were offered only to Arkwright-Boston customers and prospects, will operate as a separate entity and seek non-Arkwright-Boston clients. Sales activities previously handled by Arkwright-Boston's sales force will be augmented by a Hobbs Brook staff.

Hobbs Brook will operate regional offices in seven major U.S. insurance centers. The Great Lakes area, headquartered in Schaumburg, Ill., will be headed by Kenneth R. Mikula, vp and area manager. A manager for the East Coast area, based in Greenwich, Conn., will be named at a later time.

The Southern region, based in Atlanta, will be headed by James H. Costner, vp and regional manager. And, Earl G. Kehl, vp and regional manager, will direct the Western region, based in San Mateo, Calif.

Hobbs Brook also will continue operating out of the Waltham headquarters.

Outpatient centers

The New Medico Head Injury System has opened its first outpatient treatment programs in Chicago and Jacksonville, Fla.

The centers, known as Rehabilitation Services centers, are part of New Medico's nationwide network of head injury treatment facilities. The facilities provide specialized care for head injury victims.

The Chicago and Jacksonville centers are staffed by speech and language pathologists, vocational specialists, physical and occupational therapists, educational specialists and behavioral analysts.

New Medico says the staff at its Rehabilitation Services centers will "assist neurologically impaired individuals with community reintegration."

Frank Woodrich, program director of the Jacksonville office, said: "From an intensive, five-day-a-week program to a less frequent concentrated program in one therapy area, we'll provide tailored, individualized plans."

Janet Walton is program director of the Chicago office.

More information about the New Medico system is available by calling 800-343-1238.

New offices

Bledsoe & Drennan Insurance Agency Inc. has changed its name to **Drennan & Wuensch Associates** and is now located at 11104 W. Airport, No. 155, Stafford, Texas 77477; 713-568-0568.

Huggins Financial Services Inc. has relocated its Chicago area office to Suite 3820, 200 W. Madison St., Chicago, Ill. 60606; 312-236-0080.

RLI Insurance Co., based in Peoria, Ill., has opened an office at 101 E. Fifth St., Suite 1802, St. Paul, Minn. 55101; 612-227-6097.

Premier Brokerage Corp. is moving to 33 Walt Whitman Road, Huntington Station, N.Y. 11746; 516-423-0300.

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Underwriting basics

Continued from previous page

to do a lot of cash-flow underwriting are now trying to get combined ratios below 100%."

Nationwide Insurance Group's commercial insurance operations are aiming for a combined ratio of 107% this year, which would be a decline from 118% the year before, says James C. Morrow, Nationwide's vp of commercial insurance in Columbus, Ohio.

"So far, we're satisfied with what has happened," Mr. Morrow says.

At St. Paul, underwriters are "told to write business that will produce a good return considering the exposure. We will write willingly and freely those coverages where we can target a combined ratio of under 100%," says Mr. Bachman.

St. Paul was one of the first companies in 1984 "to receive notoriety for what we were doing with prices," Mr. Bachman contends.

"We were the hard guys on the block. We priced aggressively in 1984 and 1985," he explains.

As a result, St. Paul's combined ratio for the first six months of this year was 121.2%, compared with 127.2% in the first half of 1984.

At Houston General, underwriters are now told profit is the main objective through a program called "Operation Black Ink," explains Mr. Gostkowski.

"Investment income is not an underwriter's concern," he said. "Their concern is to write at a profit."

To make an underwriting profit, underwriters are demanding more information, involving more people in their decisions, adhering to minimum rates and even sharing their talents with one another.

All that translates not only into real underwriting, but also working longer hours, executives point out.

Insurance agents and brokers attest to insurers' new commitment to underwriting profits, but they also complain they often aren't getting the reception or service they would like (see story, page 24C).

To make an underwriting profit, "You've got to do things like make sure your information requirements are up to your standards. You've got to clearly get back to the fundamentals of account reviews," stresses Chubb's Mr. Dunlop.

Fred Marziano, executive vp in charge of commercial insurance at Fireman's Fund Insurance Cos. in Novato, Calif., says underwriters aren't demanding any more information from agents or policyholders than it did two years ago, but now the insurer is not letting anyone cut corners. Two years ago "all the requirements were not always met," Mr. Marziano admits.

Commercial underwriters are now demanding that motor vehicle reports be submitted with commercial automobile risks, that loss-control surveys be included with manufacturing or contracting submissions and enough claims history be submitted to give the underwriter an idea of the account's loss trends.

"We need three years of claims history to use as a base," Mr. Marziano said.

"It's not always possible, but we ask the producer to provide it if he can get it," he says.

Mr. Nothem says that Travelers is also ask-



ing a lot more questions about individual risks.

He pointed out that underwriters during the soft market were not as concerned about obtaining information like claims history, loss experience and loss-control and engineering reports.

"We're asking a lot more questions now, and there is a lot more engineering involvement than in the soft market," Mr. Nothem said.

"We're back in the business of underwriting again rather than hanging onto business with a competitive price. We're analyzing more, studying losses for patterns," USF&G's Mr. Maxwell says.

At St. Paul, there is "a much heavier emphasis on individual risk underwriting," Mr. Bachman says.

Underwriters are paying much more attention to "the details of an account. They completely understand the exposure, and there is more of a willingness to say no if a price is inadequate," Mr. Bachman says.

"If we don't have the information, we decline the business," declares John Wagner, vp of underwriting at Argonaut Insurance Co. in Menlo Park, Calif.

"In part, we were writing without adequate information," Mr. Wagner admits.

"Then, we were much more willing to gamble. We would close our eyes and cross our fingers," he says. "Now we want to have all the information we need to meet our profit objectives."

In addition to improving underwriting results, another reason for demanding more information about an account is "our reinsurers are asking for a lot more these days," Mr. Wagner notes.

More people also are likely to review a submission to an underwriter today.

At Travelers, for example, Mr. Nothem

said underwriting is "a collaborative approach."

"It involves more actuaries, engineers and management on each risk," he said. "Even senior managers are getting into the trenches."

At Houston General, any dividend plans for workers compensation policyholders must be approved by the insurer's management, notes Mr. Gostkowski.

Underwriters today also are not granted as much flexibility on pricing as they were in the competitive market.

USF&G lowered rates to stay competitive during the soft market, straying well below the company's traditional rating benchmarks: Insurance Services Office advisory rates.

"We filed our own rates based on our own data" during the competitive cycle, said Mr. Maxwell.

"One essential change that we have made is an attempt to restructure our rate level so that it is much more in synch with ISO rates" (see story, page 24E).

At Houston General, target prices are set for property business and underwriters are "not to go below it," points out Mr. Gostkowski, explaining that rates for most of the insurer's casualty business are set by state regulators.

Training also is more important.

USF&G has also reorganized its separate property and casualty departments into one unified commercial lines department, Mr. Maxwell points out.

There is now a lot of "cross-training," he explained, with underwriters experienced in casualty lines receiving property training and vice versa.

All this additional work and training translate into longer hours for many underwriters.

"We have a lot of people working 60 and 80 hours a week. We've got guys walking around here like zombies," says Travelers' Mr. Nothem. "We rely on the seasoned, sage counsel of those that have been around for a while. Some of them have been asked to do double duty."

Fireman's Fund underwriters are also working longer hours, and Mr. Marziano says "there are three reasons for that."

"One, Fireman's Fund has no capacity shortfall for the business we want to write. Two, underwriters are undergoing training for the new ISO policies. That is taking extra time. And, three, we have asked each branch to be an independent profit center and to be accountable for its results. That requires more knowledge of the marketplace... that is taking more time."

While working hard at underwriting again, the results won't be immediate, most underwriting executives concede.

Houston General might not meet its goal of underwriting profitability in 1985, Mr. Gostkowski notes.

And, while the insurer's Operation Black Ink plan for 1986 is still being developed, he says it's doubtful that the goal will be reached next year, either.

"But we hope to be in the position to make a profit by 1987," he added.

Travelers' Mr. Nothem takes even a longer, but also optimistic, view: "We'll know in 1995 if the decisions of 1985 were profitable. We believe they will be." ■

Fireman's Fund changed its ways two years ago

Many commercial insurers swept up in the competition for accounts did not overhaul their underwriting strategy until late last year. Others pushed their luck until this year.

But at Fireman's Fund Insurance Cos. in Novato, Calif., deteriorating underwriting results prompted a change in underwriting strategy in 1983, said Fred Marziano, executive vp in charge of commercial insurance.

"Two years ago this month, we introduced an approach to reverse our underwriting program and regain control of our business," Mr. Marziano said.

The insurer's widening underwriting losses demanded the insurer abandon a strategy that favored increased market share over prudent underwriting, he said.

In 1982, Fireman's Fund's \$117 million pretax underwriting loss was more than offset by pretax investment income of \$327.4 million.

However a 27.1% increase in investment income in 1983 to \$415.3 million did not come close to matching the insurer's underwriting loss, which soared 500.8% to \$703.8 million.

During the first months of the underwriting reorganization, "We didn't make much headway," Mr. Marziano conceded. But, by October 1984, Fireman's Fund's profit objectives were firmly in hand, he said.

One of the insurer's first actions was to stop writing certain classes of business that didn't offer a reasonable chance of making a profit: long-haul trucking, municipal liability and liability coverage for day-care centers, said Mr. Marziano.

Fireman's Fund also set up certain criteria aimed at better controlling underwriting results at its branch offices.

Each office's personnel were judged according to their expertise in underwriting, loss control and claims handling. If they didn't meet the mark, "We modified the authority that the branch could have in certain classes of business," explained Mr. Marziano.

In addition, "We have re-emphasized a return to the underwriting standards we have always had," like obtaining detailed information and thoroughly analyzing the characteristics of each risk, Mr. Marziano remarked. "They haven't really changed, but we have re-emphasized the need to follow those standards. We did avoid some of those standards during our quest for market share."

"We just said, 'Hey, let's go back to basics and do what we do best.' It seems to have worked."

In 1984, Fireman's Fund reported an underwriting loss of \$598.1 million, a 15% improvement over 1983. Although investment income amounted to \$403.7 million in 1984, 2.8% less than the previous year, operating income rose 42.2% to \$42.8 million.

So far in 1985, Fireman's Fund underwriters are hitting the pricing targets set for each class of business written in the insurer's 50 branches, Mr. Marziano says. ■

Welcome to *Insurer Topics*' premier issue

Welcome to the first edition of *Insurer Topics*, a new editorial section of *Business Insurance* devoted exclusively to the concerns of insurance and reinsurance company executives.

This special section is sent to you as an additional editorial product. It is mailed only to the 6,500 insurance and reinsurance company subscribers among the nearly 46,000 subscribers to *Business Insurance*.

We've long valued the dedicated readers among our insurance and reinsurance company subscribers. Now, we've created *Insurer Topics* for you after a survey of insurance and reinsurance company subscribers by the *BI* research department earlier this year found that while you value and use the information presented in our weekly issue, you also want a special editorial section geared specifically to your interests as executives and employees of insurance and reinsurance companies. Ninety-six percent of the 448 respondents said so.

There will be no dearth of subjects to cover in the new section. Our survey found that our insurance and reinsurance company readers have a wide variety of responsibilities and interests.

Underwriting, administration, broker/agent liaison, marketing/advertising and office management are the most common responsibilities of our insurance and reinsurance company readers, who are about equally divided between the corporate home offices and field offices of insurance and reinsurance companies.

The respondents to the survey cited underwriting most often as a topic they wanted to read about in the special section. New technology in office systems, telecommunications and automation also interested the respondents, as did loss prevention services and sales training.

These topics and more will be covered in upcoming editions of *Insurer Topics*.

The creation of *Insurer Topics* will not change the weekly content of *Business Insurance*, which is written and edited specifically to answer the needs and concerns of corporate and institutional executives responsible for risk management and employee benefit management. Instead, this new section is designed to provide you with more information specific to your interests and to help you in your work.

You also can trust that *Insurer Topics* will uphold the editorial standards of *Business Insurance*. Our reporters and editors will report fully and fairly on developments in your field, bringing you the comments not only of your colleagues but also those who observe your activities.

For example, for our premier report on insurers' renewed emphasis on underwriting rather than investment income, we interviewed brokers for their opinions on today's underwriting techniques and service (see story on facing page).

Four editions of *Insurer Topics* are scheduled for publication in 1986 as special supplements to the regular weekly issue of *Business Insurance*. The 1986 publishing dates for *Insurer Topics* are: March 10, June 16, Sept. 8 and Dec. 8.

As always, *Business Insurance* is interested in your opinions on our editorial product. If you would like to comment on our premier issue of *Insurer Topics* or offer suggestions for our 1986 editions, please write to Kathryn J. McIntyre, Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611.

Brokers can't get underwriters' attention

By JUDY GREENWALD

NEW YORK—The main problem with commercial lines underwriting today, brokers say, is that too little of it is being done.

"For the most part, we went from a soft market where no underwriting was being done to a hard market where no underwriting is being done," contends Phillip J. Buchanan, president and treasurer of Curtis Day & Co., a San Francisco-based broker.

"There's an effort to look for ways not to write business, not for ways to write business," says Stuart W. Seiler, president of San Francisco-based Richard N. Goldman & Co.

"If an account is marginal, it's a 'no.' If it's excellent, it's a 'maybe.'"

Brokers, who for several years watched insurers slash prices and discard underwriting practices in an effort to write as many accounts as possible, now must deal with fussy underwriters who often reject risks after only a cursory glance.

Brokers, showing their frustration with the hardening market, can cite a litany of complaints against underwriters, including:

- Most underwriters can't handle all the business submitted to them.
- Experienced, qualified underwriters are in short supply.
- Insurers are placing unnecessary constraints on underwriters regarding the amount and classes of business they can write.

Underwriters are demanding information that is not necessarily used in deciding whether to accept or reject the risk.

Some underwriters are just plain arrogant now that they have the upper hand.

There are "too few people, too many risks and just about too many restrictions on everything," sums up Howard Kaye, senior vp of The Kaye Group Inc. in New York.

However, brokers say they do sympathize with the plight of today's underwriters.

"I think overall, today the toughest job in the world is an underwriter's job—besides a broker's job trying to find a market," says Charles L. Ruoff, senior vp of property and casualty for Fred S. James & Co. in New York.

Underwriters are "between a rock and a hard place" in trying to satisfy the demands of both brokers and insurer-managements, adds George Stevoff, president of the Milwaukee-based Laub Group. "I feel for them."

Brokers also note that many underwriters are expected to process more business than they possibly can handle.

"Experienced underwriters are very much in demand these days," observes Ken Pinkston, senior vp at Corroon & Black Corp. in Nashville, Tenn. "They're very hard to get to. They're really overworked."

"A lot of the underwriters are strung out," adds David J. Lane, chairman ISU/Hastings-Tapley Insurance in Cambridge, Mass. "They're overworked because of the changes that are occurring in the business. It makes every renewal a project" for both underwriter and broker.

"They're really inundated," agrees William D. Hall, vp-manager at Calco Insurance Brokers & Agents in San Mateo, Calif.

The crush of business underwriters face often leads to short tempers, Mr. Hall explains.

"We're all pounding on them," he says, adding, "We're pounding in a nice way. We're having to be more persistent in getting our story across."

In some cases, he notes, underwriters say they definitely will write a risk, but will hold off giving the broker a quote. Underwriters will "issue it, but won't take the time to quote it," Mr. Hall says, explaining that he sometimes has to wait until the policy is issued before he learns the rate at which it was written.

Underwriters are so overworked that "in many cases they're declining risks they probably shouldn't decline," says James H. Atkins, chairman and chief executive officer of Atkins Insurance Corp. in Little Rock, Ark.

A broker sometimes must call an underwriter five to 10 times before the broker catches the underwriter at his or her desk or the underwriter returns the call, adds Jim Stone, president of Emmett & Chandler of Illinois in Chicago.

Underwriters at some insurers will only accept calls between 9 a.m. and noon on



Mondays and Fridays, says Mr. Stone. "If you can't talk to the underwriter, it's very difficult to present your case," he observes.

The problem of too much work is compounded by a shortage of qualified underwriters.

Brokers point out that underwriters who entered the field within the past several years are now facing a tightening market for the first time and do not have the experience to deal with it.

The current market requires a return to the "art of underwriting, and many of the underwriters don't have the training or the depth to do that," says Mr. Stone.

"Of course, a lot of underwriters never had a chance to underwrite before," says George G. Phillips, president of Henderson & Phillips in Norfolk, Va.

"They're just lacking the foresight as to what to accept and what to reject," agrees Goldman's Mr. Seiler.

"One of the things the insurance companies need very badly right now are skilled underwriting people," says James' Mr. Ruoff.

"We are dealing with some companies willing to write business, but they don't have the experienced underwriters to write it," says Calco's Mr. Hall.

On the other hand, "The professional and the trained person is the one who's beginning to shine in this market," says Gaston Caperton, president of the McDonough Caperton Group Inc. in Charleston, W.Va.

But, brokers note, there are fewer underwriters with those qualities than there were several years ago.

"There's no question that people who had traditional underwriting style, experience and philosophy were clearly out of fashion the last five years," explains Michael O. Leavitt, president and chief executive officer of Leavitt Group, based in Cedar City, Utah.

"A lot of people who said repeatedly, 'This isn't going to work, this isn't going to work, this isn't going to work' and continually had bells go off, were just pooh-poohed" during the competitive market, Mr. Leavitt explains.

"I think a lot of the old pros became disgusted during this period" and took early retirement, he says.

One result of this shortage of experienced underwriters is that, "with good reason," company headquarters are giving their underwriting personnel little authority to make decisions, Mr. Leavitt says.

Brokers say that insurer managements, in their effort to return to profitability, are keeping a very tight rein on underwriters by establishing rigid guidelines on the classes of business they can underwrite, often at the expense of potentially profitable business.

At the same time, brokers say, current market conditions and the fear of heavy losses have engendered an atmosphere of tension and apprehension among underwriters, making it even more difficult for brokers to place business.

Mr. Ruoff says that guidelines on what classes underwriters should avoid are not

necessarily based on an analysis of the classes but on "feelings and perceptions."

For instance, many companies are turning down day-care center risks simply because others are rejecting them and therefore they feel "there must be something wrong with it," Mr. Ruoff says.

Underwriters are "usually pretty bright and perceptive" and "should be allowed to make judgments on an individual-risk basis," he says.

"How creative can you be when you're not allowed to write anything?" asks William B. Conner, president of Robinson-Conner Inc. in Erie, Pa.

Robinson-Conner is having significant problems placing some business that it has handled for years, Mr. Conner says. When underwriters are asked to consider alternatives they can use to write the business, "basically, the answer has been 'No, don't talk to us about it.'"

"I think the companies have just said, 'Don't write this type of business,'" he says.

Michael Segal, president of Chicago-based Near North Agency, says underwriters' primary concern is their premium-to-surplus ratios and—with those limits in mind—they pick the most loss-free and most profitable types of business to write.

A broker can conduct a six-year study on how his client approaches the issue of loss control, "but the underwriter can say that because of capacity, he is just not interested," Mr. Segal says.

When underwriters do accept a new piece of business, "it's almost as if they do it very resentfully," says one broker.

"I think there is a communications problem between the field offices and the regional and home offices," says Atkins Insurance Agency's Mr. Atkins.

As orders filter down from one office to the next, problems become exaggerated at each level to the point where the impression is: "The home office just doesn't want the business at any price."

"The easiest thing to say is 'no,'" adds Howard Miller, senior vp and director of sales at New York-based B.R.I. Coverage Corp. "I think underwriters today are just frightened to make a mistake. They don't want to be second-guessed by anybody."

Underwriters have come up with more reasons to turn down business "than I could ever have dreamed up in a good day," Mr. Miller says.

Nobody will blame the underwriter if he won't quote a chancy risk, agrees Emmett & Chandler's Mr. Stone. But, if he writes such a risk, "he's now open to criticism."

"I think today there's panic in the average underwriter and, because of that, they're trying to make up for the losses in a very short period of time and it's very difficult to get a handle on how they get out the rating structure," says Robert F. Driver, chairman of Robert F. Driver Co. in San Diego.

"A lot of them are afraid to stick their necks out," agrees Sidney A. Stewart Jr., chairman and chief executive officer of

Memphis, Tenn.-based Crump Cos.

Robert Hilb, president of Hilb, Rogal & Hamilton Co. in Richmond, Va., says that underwriters who are approaching retirement and who—unlike their younger counterparts—know how to underwrite many different types of risks are often afraid to.

"They don't want to rock the boat," Mr. Hilb says. Their attitude is, "I've got three years to retirement and I'm just not going to take any gambles on it."

Most brokers say, however, they do not have any quarrels with underwriters' demands that more information about a risk be submitted.

"The quality of their procedures has improved tremendously," says Near North's Mr. Segal, noting that underwriters are pre-inspecting the business they write "instead of just accepting things on the back of cocktail napkins."

Samuel Alcorn, senior vp-operations for Bayly, Martin & Fay International Inc. in Fort Worth, Texas, says brokers must submit a detailed application and accurate prior loss history "or you don't get looked at at all."

If the broker's file is not up-to-date, "you've got to scramble" because if everything is not in "apple pie order" six weeks in advance, the broker may not get a quote, he says.

Mr. Alcorn adds that it's probably the broker's fault if the information is not on file. "I don't think we can blame anyone in the world for that problem, except ourselves."

But brokers do complain about the time it takes underwriters to assess this information and offer a quote.

Calco's Mr. Hall complains that underwriters ask for detailed information 60 days in advance, but then give a quote a week after the coverage's effective date.

In one case, says Emmett & Chandler's Mr. Stone, information on a simple placement was sent to an underwriter with a request for a quote within 45 days. A week after the requested date, after the broker already had called five or six times, he says he was told, "We're missing this, this and this and we won't quote until we get it."

Brokers also complain some underwriters are making the most of their relatively powerful position in today's market.

While some underwriters are fair-minded, says Fred S. James' Mr. Ruoff, "There are others who have been waiting for this environment for some time" and demand that brokers meet the most difficult terms.

Some underwriters, in fact, are being "very dictatorial," says Mr. Ruoff. "It's their turn at bat. They have the bat and the ball, and we're trying to play by the rules."

While many underwriters want to write business offered by brokers, "there's a whole bunch of others who could care less and don't even want to talk to you," says Curtis Day's Mr. Buchanan.

Because brokers say it is difficult to convince insurer field offices to write business, some say they appeal negative underwriting decisions to company headquarters, although generally this is done with the field office's knowledge.

"The underwriters in the field don't have the same point of view as the home office underwriters," says Corroon & Black's Mr. Pinkston. "More often than not, underwriters in the field tend to be much more protective."

As a result, "brokers are trying to get to the home office a lot more to get things to work. We're having to make too many appeals."

Mr. Pinkston says the chances of successfully appealing a field office decision are "about 50-50."

Atkins Insurance Corp. has been "pretty successful" in asking insurer headquarters to reverse field office decisions because it always has maintained good relationships with both field offices and headquarters, says Mr. Atkins.

However, Mr. Hilb says he is rarely successful when appealing a field office decision.

"All you do is incur the wrath of the local people," he says. "All I do is get my local office into trouble with the local people and the local managers."

"The broker must be very careful in how he approaches it," says BMF's Mr. Alcorn. "When it's done astutely, though, the (field office) underwriter doesn't get his nose out of joint."

New software makes underwriting decisions

By MICHAEL BRADFORD

Although many commercial property/casualty underwriters claim their work is an art form that can never be fully accomplished by a machine, computers are beginning to make some underwriting decisions.

While computerized policy rating systems, claims administration and clerical functions have been available to commercial insurers for several years, some of underwriters' actual thought processes can now be computerized through the advent of artificial intelligence systems.

"There are a lot of commercial rating packages, but not underwriting packages," says Carole Hess of Equifax Insurance Systems

in Atlanta, which has developed software that automatically can accept or reject the risk or refer it to an underwriter for more information.

"It is a tool to gather information or make a decision on a risk," she explained.

The system was developed after a year of research in which Equifax picked the brains of underwriters and insurers throughout the country for their thoughts on what goes into the underwriting decision-making process.

The software, which is designed to run on an IBM microcomputer, can be used for personal or commercial lines risks, says Ms. Hess. "It doesn't care which line of business."

The package's prototype was

completed in June and Members Mutual Insurance Co. in Dallas became the first user, applying the system to personal lines operation.

According to Ms. Hess, the system will:

- Allow an insurer to enter standardized rules for checking the completeness of a policy application. The system then will check an application to make sure the necessary information is available to make an underwriting decision.

- Allow the company to enter its own criteria for making underwriting decisions. Using the criteria, coverage applications automatically are accepted, rejected or referred to an underwriter.

A referral is made if the system questions information on the application or finds it incomplete.

- Decide what level underwriter an application should be referred to if it needs further review.

- Log statistics that monitor the production levels of agents or underwriters.

- Automatically send underwriting data to the company's mainframe computer, which interfaces with other data processing systems that handle accounting and claims administration.

The system is built around criteria established by the insurer that purchases the package, Ms. Hess said. "It is flexible enough that the underwriter can build in the rules" that allow a decision to be made.

While companies like Equifax are marketing underwriting systems to insurers, some companies

are devising their own systems.

For example, Fireman's Fund Insurance Cos. is developing a system that will put the knowledge of its most seasoned underwriter at the fingertips of the newest employee.

"We're working on an artificial intelligence system that allows an inexperienced underwriter to have the underwriting thought process of our most experienced underwriter in each class," explains Fred Marziano, executive vp in charge of commercial insurance.

Mr. Marziano said the system, now being developed jointly by the insurer and Syntelligence, a software company in Sunny Vale, Calif., will allow underwriters to walk through the thought process that determines whether a risk should be written or rejected.

For example, he said, "You can pull up on the screen a command that says, 'These are the common types of exposures to evaluate for this risk.'"

Later in the process, a keystroke will prompt the computer to ask whether certain factors have been considered in the decision-making process. "It brings you through the complete thought process," he said.

To develop the system, Fireman's Fund gathered its most knowledgeable underwriters from around the country, "pumping their brains for the thought processes that go into underwriting," he noted.

The system should be installed in all Fireman's Fund branches in the next 12 to 14 months, he added.

The St. Paul Cos. Inc. also is looking into implementing artificial intelligence systems for underwriting, says James Bachman, senior vp of the commercial insurance division.

Mr. Bachman said St. Paul's current computer system is centered on "clerical or routine function," including rating and policy processing. "Decision-making and risk selection is not automated at all."

But that may change, he adds. "I think we can use machines in the underwriting decision process with the use of artificial intelligence systems. We have made investments in those areas to enhance our underwriting decision-making capabilities," though he adds that implementation of such a system at St. Paul is still several years away.

At Chubb & Son Inc., "We're attempting to get the computers to the point where they will give us the underwriting information we need to make risk decisions," said Senior Vp Edward Dunlop.

Mr. Dunlop points out that much of the actual underwriting process at Chubb is currently computerized. "The decision process is not a computer process at all."

However, he admits "that probably will change," though "not dramatically in the short-term. We're trying to write relatively sophisticated risks and our business tends to require some review."

Chubb is looking for computer programs that will serve as "information support mechanisms," he said. "But we will still rely on one-at-a-time review of our risks."

Although many insurers are interested in using computers as an underwriting tool, some apparently are not interested in reducing the art of underwriting to a mechanical task.

John W. Purkis, a vp at Liberty Mutual Insurance Co. in Boston, said that while the insurer has software programs for rating policies, "None of the underwriting is computerized. That is a decision-making process."

"Underwriting will never be computerized," says Mr. Purkis. "You'll still be looking at the facts and making decisions." ■

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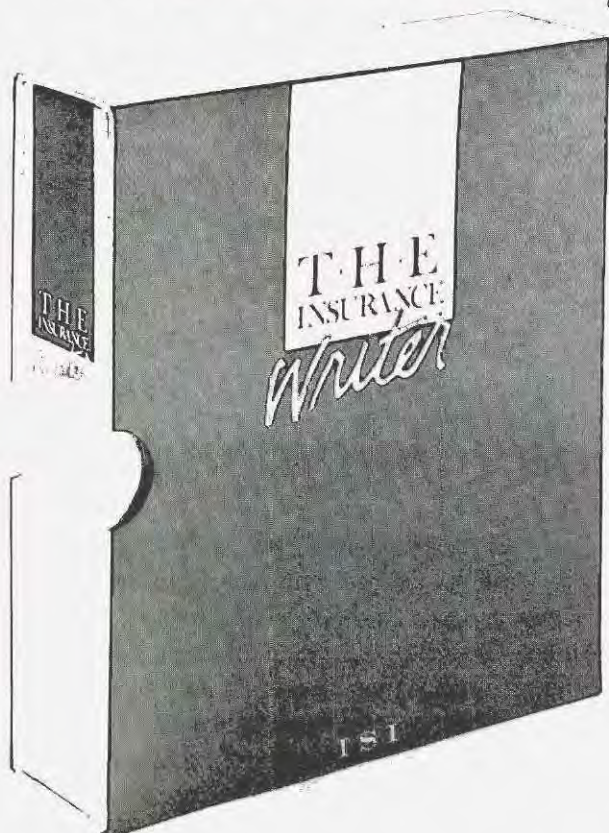
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Insurers once again following ISO, NCCI advisory rates

By MICHAEL BRADFORD

Insurers are turning back to the prices established by rating bureaus.

Rates offered by the Insurance Services Office and the National Council on Compensation Insurance are now the benchmark for pricing products.

Many insurers concede they deviated widely from rates set by the ratemaking and advisory services organization during the competitive market.

"In general, the trend has been to return more closely to the ISO rate levels," says Donald C. Maxwell, assistant vp of underwriting in the commercial lines division of United States Fidelity & Guaranty Co.

He pointed out that 18 months ago, USF&G strayed well below the rating guidelines set by ISO. But in 1985, USF&G restructured its rating to reflect more closely the advisory service's benchmarks, he said.

"We've been committed to that policy and will continue to be so," he added.

James Bachman, senior vp of St. Paul Cos. Inc.'s commercial insurance division, said: "We are much closer to ISO rates now. That is part and parcel of our price strengthening. We have reduced a significant amount of the deviation from those rates."

Don D. Hutson, president and chief executive officer of Maryland Casualty Co., said: "As a policy, we adopt every rate ISO has filed and approved. We haven't deviated as far as the market in general."

Mr. Hutson said commercial auto rates were among the "most prostituted" during the soft market.

"We made up our mind in 1983 that if we had to give up market share to get the price up, we would do it," he said.

He added, "Things are getting back more to normal. We've mandated changes in our pricing strategy limiting how far we can deviate from ISO rates."

Fred S. Mina, senior underwriting officer at The Home Insurance Co., said, "We feel ISO continues to be a fairly good barometer by which we can gauge our rates for standard types of business."

"When we determine their rates are adequate, we use them. Whenever these are not, we'll find out to what degree they're lacking and modify them."

Eighteen months ago, Argonaut Insurance Co. in Menlo Park, Calif., was pricing its property/casualty coverages "far below" ISO's recommended levels, according to John Wagner, vp of underwriting.

"We have raised prices dramatically," he said. "We use ISO as a guideline and give the proper price for an account. Sometimes it is above the ISO rate, sometimes it is below."

Eighty percent of Argonaut's business is workers compensation, Mr. Wagner pointed out, noting his company is now more closely following work comp rates established by the National Council of Compensation Insurance and other ratemaking groups.

In states where NCCI establishes rates, companies typically filed for 20% discounts two to three years ago, Mr. Wagner said.

Also, in states that permitted scheduled rating, insurers commonly tagged accounts with credits or debits—bonus points or demerits—that could move a policyholder's premium up or down by 25%, he noted. The credit and debit system takes into account characteristics of a policyholder's operation that potentially could either further minimize its risks or add to its exposure.

"That has changed dramatically at Argonaut," Mr. Wagner said. "We are no longer deviating, and the use of scheduled credits and debits is down. I think that is true with most companies."

While most insurers say they now calculate their rates based on ISO's advised rates, factoring in variables particular to each individual risk, an exception is large accounts. Insurers often base those rates on the policyholder's experience rather than on ISO advisory rates.

Mr. Mina at The Home points out that for large accounts "we consider such additional aspects as loss-development factors, inflation and growth factors, social and legal issues," he said.

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Insurers emphasize underwriting training

By MICHAEL BRADFORD

A commercial insurance underwriter needs more than a college degree.

Most commercial insurers conduct classes for new recruits and ongoing training programs to keep underwriters' skills as sharp as their pencils.

Even if recruits have experience with another insurer, chances are they will undergo some retraining at a new company. And, some of that training may occur in a classroom.

Commercial insurers have become aware of how important well-trained underwriters are in the current hardening marketplace, and many are re-emphasizing classroom and on-the-job training to produce

personnel who can help attain company profit objectives.

"Companies are putting a lot more emphasis on training programs," says Donald E. Jeffers, chairman of Jeffers & Associates Inc., an insurance personnel recruiting and consulting firm in Chicago. "And undoubtedly there needs to be more emphasis on training."

"We're strengthening substantially the training for our existing underwriters," says James Bachman, senior vp of the commercial insurance division of The St. Paul Cos. Inc.

"We have more comprehensive training programs that we are requiring participation in," Mr. Bachman says. Underwriters at St. Paul also are requested to attend addi-

tional seminars focusing on the particular exposures they write.

Recruits at St. Paul must take part in on-the-job and classroom training over a two-year period, Mr. Bachman explained.

And, St. Paul's commercial underwriters also participate in educational programs focusing on the proposed comprehensive general liability policy forms developed by the Insurance Services Office.

Mr. Bachman says St. Paul is a "strong supporter" of the CGL revisions and plans to implement them next year.

St. Paul's commitment to thorough training for existing underwriters and newly hired personnel is typical of the way most commercial insurers are reacting to the current market.

The tightening marketplace, in which insurers are paying more attention to the risk characteristics of a piece of business rather than how much investment income its premium would generate, has created an awareness of the need for skilled underwriters (see story, page 24G).

Fireman's Fund Insurance Co., like St. Paul, is aware of the need for well-trained underwriters.

"For a number of years, we've had a series of training programs for all our professional people," said Fred Marziano, executive vp in charge of commercial insurance.

"It's a combination of formalized classroom and on-the-job training." A commercial underwriter hired by Fireman's Fund will first serve in a branch office for an orienta-

tion period.

The new underwriter attends four weeks of "intensive" classroom instruction sometime during his or her first six months of employment, explained Mr. Marziano. The eight- to nine-hour daily classroom sessions cover "all aspects of all lines of business they are hired to underwrite," he said.

The underwriter then returns to the branch office for on-the-job training. Usually, a new underwriter becomes responsible for a portion of the branch's business after a year, Mr. Marziano said.

There is a two-week refresher course after two years of employment. The course updates underwriters on changes in the marketplace, legislation and other factors that could affect the way they underwrite, Mr. Marziano noted.

Fireman's Fund also is preparing its underwriters for the switch to the new ISO forms next year. "We bring in underwriters from all over the country to be trained," Mr. Marziano said. "They in turn go back and train the rest of the people and our agents."

At United States Fidelity & Guaranty Co., commercial underwriters are periodically required to attend either a weeklong seminar at the insurer's Baltimore headquarters or a regional meeting near their offices.

Donald C. Maxwell, assistant vp of underwriting for USF&G's commercial lines operations, said the insurer holds one or two seminars annually to hone the skills of its some 600 commercial underwriters in its home office and 57 branches.

In addition, the insurer has "rejuvenated" its underwriting trainee program, Mr. Maxwell said. He noted that the insurer has hired 20 to 24 trainees this year, with plans to add the same number in 1986.

"It's the lifeblood of our system," he said of the trainee program.

New commercial lines recruits go through an 18-month training program while working in branch offices that use printed educational materials developed in part by USF&G, Mr. Maxwell explained.

The program is designed to educate the trainee while enabling him to work in the underwriting environment, he said. "As time wears on, he begins to function on a routine level. He begins to work with other underwriters."

An aspiring commercial underwriter at Chubb & Son Inc. can expect to start in one of 46 branch offices for a month or two of training, followed by a stint in the home office.

Edward Dunlop, senior vp with Chubb & Son, said the training at the home office in Warren, N.J., could last from three to 16 weeks, depending on the job involved.

When the home office training is completed, the trainee returns to the branch for nine months. "Then they take an authorized job in that branch or another," he notes.

Chubb's commercial underwriters also undergo ongoing training at each branch, he explained.

The insurer trains around 200 new commercial and personal lines underwriters each year, Mr. Dunlop said. An additional 50 experienced underwriters are hired annually, he added.

As is the case at most other companies, experienced underwriters that come to Chubb don't undergo the same training as new recruits. "They get a history of the company and learn the style of how we conduct business," Mr. Dunlop said.

Training programs for experienced people are not formal, he said. "They attend periodic meetings with people on their same level."

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Insurance companies search for experienced underwriters

By MICHAEL BRADFORD

Now that commercial property/casualty insurers say they want underwriting profits, many complain they can't find underwriters who know their jobs.

"Probably 75% of the underwriters today haven't been through a full cycle," says John Bowdish, commercial lines underwriting officer for Kemper Group in Long Grove, Ill.

He noted that "1974-75 was the last time it was tough. And that was so long ago, even many of the ones that were around then think the way you underwrite is, 'If you can price it and write it, it must be a good piece of business.' There's a heck of a lot more to underwriting than that."

Don D. Hutson, president and chief executive officer of Maryland Casualty Co. in Baltimore, adds: "A person that entered the market in 1980 is now learning something about underwriting. A person with five years' or less experience has never underwritten before. Now they are."

At Travelers Insurance Co. in Hartford, Conn., the national accounts department is "more experience-conscious today," says Vp James M. Nothem.

Insurers may find experienced underwriters in short supply because of the salaries they pay compared with other service industries.

While most insurers contend that they pay competitively with other insurers, at least one professional recruiter who has also been an insurance company president says insurers should improve their pay scales.

"The insurance industry has notoriously underpaid its people," says Donald E. Jeffers, chairman of Jeffers & Associates Inc. in Chicago and former president of Interstate Insurance Group in Chicago.

"Only a very few people at the very top receive six-figure salaries," he says. "And it's not at all uncommon for underwriters—who commit their companies where exposures run into the millions of dollars—to be paid \$20,000 to \$30,000."

"It's amazing we've attracted as many intelligent people as we have," he observes.

Insurers are paying entry-level commercial underwriters \$15,000 to \$18,000 per year. Salaries for more experienced personnel fluctuate according to the size and type of insurer and where it is located.

Frank W. Majewski, president of Phillips, Majewski & Associates Inc. in Union, N.J., says "a commercial property underwriter may make \$21,000 with one company and \$26,000 doing the same thing with another."

And, two vps of underwriting for insurers of vastly different size might make the same salary—up to \$70,000—if the smaller insurer with \$30 million in premium volume is located in New York and the larger insurer with \$200 million in volume is located in the South.

Reinsurers and managing general agents, however, often pay their underwriters more.

Insurers looking for underwriting talent not only use executive recruiters but also advertise, accept walk-in applications and recruit at colleges.

Applicants ranging from underwriters to CEOs are among the walk-ins at Kemper, Mr. Bowdish notes. "They have just as good a chance as anybody—and in some cases maybe better. We get more enthused about someone who picks out our company as one they want to work for."

Chubb & Son Inc. uses its "best

people to recruit at colleges where they were recruited," notes Senior Vp Edward Dunlop.

But, he complains there is "too much turnover in the current crop of college graduates. They seem to want to try four or five different things by the time they're 30, then decide what they want to do for the rest of their lives."

In contrast, Boston-based Liberty Mutual Insurance Co., which only hires entry-level commercial underwriters to train itself, finds more commitment from college graduates, says Vp John W. Purkis.

"The kids we're hiring are very much interested in getting ahead; they're willing to work at it. Seven or eight years ago, they seemed to want to be a manager faster." ■

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Cash-flow underwriting going, but not yet gone, experts agree

By MICHAEL BRADFORD

Cash-flow underwriting is down, but not necessarily out.

Enthusiasm for slashing prices just to generate premiums that can be invested at high yields is no longer rampant, according to insurance industry executives and observers.

"In fact, most companies which used this approach are still digging out from the problems it caused them," observes Fred Mina, senior underwriting officer at The Home Insurance Co. in New York.

But, most insurers also admit that to some extent they continue to consider investment income when pricing insurance.

"Many state regulatory bodies

ask that investment income be figured into the pricing of products," explains Richard DeChene, vp in charge of commercial lines at Continental Casualty Co. in Chicago, a unit of CNA Financial Corp.

"It is a regulatory requirement in some cases," he adds.

A 1984 resolution of the National Assn. of Insurance Commissioners advocates total-return ratemaking methodologies—those that recognize underwriting income and investment income—be used if states use regulation, and not market competition, to set rates.

"From an underwriting point of view, investment income is one of the things you have to look at when pricing," says John W. Purkis, a vp at Liberty Mutual Insurance Co. in Boston.

"Commercial pricing still contemplates investment income, but not on a risk-by-risk basis," says James C. Morrow, vp of commercial insurance at Nationwide Insurance Group in Columbus, Ohio.

However, insurers also point out that large accounts—generally those with annual premiums of more than \$10 million—often are priced with investment income in mind. These policyholders often are given some type of discount based on the investment income the insurer expects to earn on loss reserves.

The insurance industry also could return en masse to cash-flow underwriting, many agree, especially if interest rates again soar to high double digits.

Mr. Morrow of Nationwide says he doubts that those companies that wrote for cash flow during the competitive market have learned a lesson from the problems that resulted.

"It very definitely could happen again," he says. "I doubt we can make the statement, 'We've learned our lesson.'"

Edward Dunlop, senior vp at Chubb & Son Inc. in Warren, N.J., says he also would like to think the industry has learned its lesson. However, he adds, "I wouldn't want to bet a whole bunch of money on it."

Some observers suggest a new foray into cash-flow underwriting could be precipitated by insurers that decide to undercut rates in some classes of business that have seen astronomical price hikes.

"That would get the ball rolling," says Robert A. Brian, a general partner with industry analyst Conning & Co. in Hartford, Conn.

Within a year or two, Mr. Brian expects some competition among insurers for business that is considered "a good risk" and currently is priced at a high rate.

"The good risks aren't going to take these huge rate increases lying down," he says. "And insurers will have to respond to these good risks or the companies will have to use other means of insuring themselves."

"This is why we see so much captive insurance company activity; it's good risks looking for less expensive ways of funding their losses."

If cash-flow underwriting does come back into vogue, its backlash could be severe for some companies, Mr. Brian warns.

"Many companies just barely survived this cycle and I don't believe some of them could make it through another one," he says.

"I think reserves for many companies are very weak and they might spend a few years strengthening them. They may not be strong enough two or three years from now to withstand another period of cash-flow underwriting," he advises.

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Continental suits

Continued from page 3
ance Co., an affiliate of Continental Corp., an insurance holding company not related to Continental Illinois; Allstate Insurance Co., whose participation in the coverage was written by Northbrook Excess & Surplus Insurance Co.; and National Union Fire Insurance Co. of Pittsburgh, Pa., an American International Group Inc. unit.

Harbor wrote a \$15 million primary layer; Allstate wrote a \$10 million layer excess of \$15 million; and National Union wrote a \$25 million layer excess of \$25 million. National Union also wrote a \$15 million share of the \$50 million layer excess of \$50 million.

The other insurers on Continental Illinois' D&O risk are not part of the litigation.

Harbor, Allstate and National Union alleged in their suits against Continental Illinois that the bank holding company deliberately misrepresented its financial condition when the corporation's D&O coverage was increased in 1981 to \$100 million from \$40 million.

They also seek a declaratory judgment rescinding policies in 1981 and 1982 and declarations that underlying claims against Continental Illinois are excluded from coverage or that the insurers are not liable under the policies.

In its counterclaims filed earlier this month, Continental Illinois contends the three insurers have breached their duty of good faith and fair dealing. The company also charges the insurers failed to act in the best interests of its insureds and to deal fairly with claims and prospective claims under the policy.

"Counterdefendants have ignored these duties and instead have pursued a course of action designed solely to postpone the need to make payments under the policies," the counterclaim says.

Continental Illinois also claims that the insurers have refused to make any offer to settle the claims by its shareholders against the directors and officers and have said on numerous occasions that the defendants should litigate the shareholder claims because there is no evidence of liability.

"If counterdefendants believed at that time what they have now alleged—that Continental's officers and directors were guilty of gross misconduct and misrepresentations even before the events complained of in the consolidated action—their course of action was a deliberate fraud on the insureds," the counterclaim adds.

In its counterclaim against National Union, Continental also alleges that the insurer "has over the last few years engaged in a pattern and practice of filing recision actions, without regard to the merits of the actions, whenever it is faced with the possibility of a significant claim on a directors and officers liability policy."

In addition to unspecified compensatory and punitive damages, Continental seeks from Harbor and Allstate reimbursement of about \$3 million in attorneys' fees and expenses Continental has advanced on behalf of its officers and directors and a declaratory judgment that the insurers be required to continue to pay these costs.

James G. Hiering, an attorney with the Chicago firm of Keck, Mahin & Cate who represents the three insurers, called the counterclaims "totally without merit" but declined further comment.

The outcome of the coverage litigation will play a key role in the proposed settlement of the shareholder litigation pending against Continental Illinois, attorneys for the shareholders say.

Under the terms of the proposed settlement, Continental Illinois would pay shareholders \$25 million in cash, according to the attorneys. In addition, Continental Illinois

directors and officers named as defendants would assign to the shareholders and the Federal Deposit Insurance Corp. the right to Continental's disputed D&O coverage.

The shareholders and the FDIC would then attempt to recover \$85 million under the policies, with shareholders seeking \$20 million from the insurers and the FDIC seeking \$65 million, explained plaintiffs' attorney Mr. Eiger.

However, recovering under the disputed coverage is a major obstacle blocking a final settlement, shareholders' attorneys say.

Another potential obstacle is the FDIC, which may not be willing to go along with the settlement proposal, possibly because it may think it can recover more from the insurers on its own, the attorneys say.

The FDIC is involved in the negotiations because it assumed responsibility for a derivative shareholders' suit as part of the agency's \$4.5 billion bailout of Continental Illinois last year.

In a derivative action, shareholders, acting on behalf of a corporation, sue directors and officers, contending they failed to act in a prudent manner to the detriment of the corporation.

Other shareholder class-action suits against Continental Illinois have been consolidated. Among the allegations in these suits is that Continental Illinois and its subsidiary, Continental Illinois National Bank & Trust Co., fraudulently misled stockholders and did not adequately disclose the extent of its problem loans involving Penn Square Bank of Oklahoma City, which failed in 1982 (*BI*, July 16, 1984).

A trial in the case is scheduled to begin next February in U.S. District Court in Chicago.

Mr. Eiger said several steps must take place before a settlement is concluded, including obtaining approval from the U.S. District Court, Continental's board, the individual defendants and the FDIC.

However, Mr. Eiger said Continental's attorneys have agreed to recommend the settlement to its board of directors and that attorneys for the officers and directors will recommend it to their clients.

Lawrence Walner, another shareholder attorney, said that the amount that will ultimately be recovered from the D&O insurance is what is at issue in the settlement negotiations.

One possibility is for the insurers to participate in a settlement with shareholders, the FDIC, Continental Illinois and its directors and officers, said Mr. Walner of Lawrence Walner & Associates in Chicago.

However, another option would be for the shareholders to settle only with Continental Illinois, its directors and officers and the FDIC. The shareholder would subsequently sue the D&O insurers for the insurance proceeds, he said.

"But even that course has not been agreed upon," Mr. Walner

said, adding that there is no settlement but that "very fragile negotiations" are continuing.

He said no serious negotiations between insurers and attorneys for shareholders have been held although there have been some talks between the FDIC and the insurers.

Attorneys for the FDIC and Continental Illinois declined to comment last week.

A spokesman for the FDIC denied that a settlement had been reached, though he acknowledged that discussions are continuing.

A Continental spokesman also denied a settlement had been reached.

Mr. Hiering, the attorney for the insurers, said he could not comment on the settlement negotiations in the shareholder litigation.

Officials at Harbor and National Union would not comment on the settlement negotiations. Officials at Allstate could not be reached for comment. ■

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The Creative Link Between Insurers and Brokers

State action

Continued from page 3

Mr. Gunter says he is seeking authority to stabilize rates so that buyers are not hit with huge, unanticipated rate increases.

"I've been around the state talking to all kinds of Floridians, and I'm convinced this crisis is shutting down business," he said.

"I've seen truckers who can't get on the road because they can't afford the insurance. I've seen day-care center owners who are required by law to carry insurance and can't get it."

Mr. Gunter compared the roller-coaster rates in the unregulated commercial insurance market to the relatively stable rates charged for automobile and workers compensation insurance, which are regulated.

Specifically, the legislation would:

- Give the Insurance Department authority to disapprove commercial insurance rates that are not justified by an insurer's loss experience and to disallow the inappropriate use of surcharges and credits, which insurers use to raise and lower premiums regardless of filed rates.

- Require insurers to give commercial policyholders a minimum of 60 days' notice before increasing rates, canceling or refusing to renew a policy.

- Create a commercial joint underwriting pool, which would provide property and liability insurance to businesses and professionals who are required to have coverage but are unable to obtain it. All property/casualty insurers doing business in Florida would participate in the pool.

- Allow professional associations and groups of small businesses to self-insure liability risks. Currently, employers may self-insure these risks only on an individual basis, making this option impractical for small- and medium-sized businesses.

- Allow financial institutions like banks to own or control reinsurance companies in hopes of attracting new reinsurance capital.

- Establish an excess profits regulation for property/casualty rates, similar to a law governing workers compensation rates, in which insurer underwriting profits greater than a 5% margin would be placed in a fund to reward businesses that

adopt good risk management practices and cut their losses.

- Allow businesses to purchase commercial property/casualty insurance on a group basis to allow policyholders to increase their buying clout.

The department's legislative package was prepared following hearings held by the department in September throughout the state (BI, Sept. 16).

While the bill has broad support—six senators and nine representatives are sponsoring the legislation—Mr. Gunter acknowledged it will meet some stiff opposition.

"We've already heard rumblings from the insurance industry that they will work hard to defeat this bill, which is the one chance Florida business people have for relief," Mr. Gunter said.

Similar legislation failed to pass when proposed by the department in 1982, Mr. Gunter said.

The Insurance Department also is working with insurers to develop a market assistance plan, which is expected to be available by year-end.

In a market assistance program, insurers join together to help provide types of coverage that are unavailable in the marketplace or cannot be obtained at reasonable rates.

Insurers in Florida have been requested to submit to the department by Dec. 2 a list of risks they would cover under the MAP.

Meanwhile, the Ohio Insurance Department made its MAP available to buyers earlier this month. The Ohio MAP is designed to assist any type of business in the state obtain primary and excess property/casualty coverage.

All 650 property/casualty insurers licensed in the state are eligible to participate in the voluntary program, according to a department spokesman.

A business in Ohio must meet several criteria before it can buy coverage from the MAP:

- The business must have been denied coverage by at least three insurers, including one surplus lines insurer. If the business has received a quote for the coverage, it is ineligible for the program.

- Risks cannot be eligible for the Ohio Automobile Insurance Plan or the Ohio Fair Plan, an assigned risk pool for property risks.

- Risks must be submitted to the MAP by a licensed Ohio insurance

'I'm convinced this crisis is shutting down business. I've seen truckers who can't get on the road because they can't afford the insurance. I've seen day-care center owners who are required to carry insurance and can't get it,' Mr. Gunter says.

agent or broker.

Meanwhile, the Pennsylvania Insurance Department still is fine-tuning its MAP, which will provide liability coverage to municipalities, day-care facilities and establishments that serve alcoholic beverages (BI, Nov. 11).

In Wisconsin, a new state law is intended to provide relief for businesses and municipalities that have seen liquor liability insurance costs soar and coverage availability constrict.

The 1985 Wisconsin Act 47 grants limited immunity from civil liability to taverns, restaurants and liquor stores that sell or serve alcoholic beverages to a person who later injures another person.

The law also grants immunity to municipalities that issue liquor licenses or allow organizations to sell alcoholic beverages on municipal property.

However, immunity is not granted to those who serve a minor who subsequently injures another person if the provider "knew or should have known" the individual was underage.

However, a provider can claim as an absolute defense that the minor verbally indicated he or she was of age, presented false identification to that effect and appeared to be of age.

Immunity is also not granted to those that force alcohol upon an individual or that misrepresent an alcoholic beverage as being non-alcoholic.

The Legislature approved the law on Oct. 31 in a special session called by Gov. Earl, who signed the measure the next day.

The new law essentially reinstates Wisconsin common law that was reversed by the state Supreme Court in two cases handed down since June 1984, explained Juan Colas, Gov. Earl's legal counsel.

The court ruled in June 1984 in *Sorensen vs. Jarris* that commercial establishments can be held liable for damages caused by patrons to whom alcohol was served. The court extended that liability to non-commercial servers and social hosts in an April 1985 opinion.

Since those rulings, businesses that sell alcohol have seen their insurance costs rise.

Gil Meisgeier, president of the Tavern League of Wisconsin, explains that tavern owners generally did not purchase liquor liability coverage before the *Sorensen* ruling because they generally were not liable for their customers' actions.

However, since the ruling, tavern owners have bought the coverage, which costs an average of \$800 to \$900 a year, he said.

Organizations that served alcohol at events conducted on municipal property also have run into coverage problems since the rulings.

For example, the Madison Muskies, the Class A farm club of the Oakland Athletics baseball team, did not serve alcoholic beverages at its first four home games at Madison's municipal ballpark this season because it could not find liquor liability coverage. And, when it did finally purchase coverage, its cost increased to more than \$5,000 from \$281 in 1984.

"Nobody at that time was willing to write" liquor liability coverage, said Guy Johnson, a producer at Fish & Schulkamp, the Muskies' Madison-based agency.

Mr. Johnson said the team contacted 40 different markets.

"Some were willing to write restaurants and taverns, which have a

little more controlled environment for serving minors," he explained.

The team formerly bought \$1 million in liquor liability coverage to satisfy a municipal requirement from Great Southwest Fire Insurance Co. of Scottsdale, Ariz., a Sentry Insurance Group affiliate. The premium for the 1984 season was \$281, says Mr. Johnson.

However, Great Southwest did not renew the coverage for the 1985 season, forcing the team to abandon beer sales for the first four games.

Finally, in May, the Muskies secured \$100,000 in liquor liability coverage for a \$2,500 premium from Western World Insurance Co. Inc. of Keene, N.H. Great Southwest then wrote a 30-day, \$400,000 policy for a \$213 premium and St. Paul Fire & Marine Insurance Co., the team's umbrella liability insurer, agreed to drop its attachment point to \$500,000, according to Mr. Johnson.

When the temporary \$400,000 layer expired, the team secured \$400,000 in coverage from a syndicate on the Illinois Insurance Exchange for a premium of \$2,575, he said.

In Maine, a nine-point medical malpractice reform bill is intended to reduce physicians' exposure to malpractice claims and cut their insurance costs.

The legislation was drafted over the past year by a dozen professional groups, including those representing physicians, attorneys, hospital officials and insurers, says Frank Stred, executive director of the Maine Medical Assn.

Specifically, the legislation would:

- Reduce the statute of limitations under which minors can file medical malpractice claims to six years from the current 20 years. However, the statute of limitations for non-minors would be expanded to three years from the current two years.

- Specify that the statute of limitations generally begins when an alleged malpractice occurs, not at the time at which it is discovered. This provision applies not only to medical practitioners, but also to other professionals like lawyers and architects.

- Prohibit claims in cases when sterilization failure results in the birth of a healthy child.

- Authorize defendants to use structured settlements to pay medical malpractice damages in excess of \$250,000.

- Require the testimony of expert witnesses to be given within 90 days after a claim is filed.

- Allow the findings of a mandatory physicians' screening panel to be introduced as evidence in any medical malpractice trial.

- Require hospitals to report when a physician's privileges have been limited or revoked. The legislation also would require the state Board of Registration in Medicine to review the record of physicians who have been involved with three paid claims over a 10-year period.

In an effort to prevent consideration of conflicting legislation, the groups that drafted the proposal have "agreed not to support additional legislation on tort reform," Mr. Stred noted.

He expects the Maine Legislature to consider the bill in late January or early February.

Meanwhile, the California Chamber of Commerce is attempting to collect enough signatures to put a "deep-pocket" reform initiative on the June 15 ballot.

California liability law currently

holds that any single defendant in a civil liability case can be required to pay all of the damages to an injured party if the other defendants are unable to pay or are not adequately insured.

The initiative—the Fair Responsibility Act of 1986—would limit a defendant's liability for an accident victim's non-economic damages, like emotional suffering, to the defendant's share of responsibility for the accident.

However, under the initiative, all defendants would continue to be jointly and severally liable for economic damages.

The Chamber expects to collect by January 200,000 more signatures than the nearly 400,000 required to place the initiative on the June 15 ballot, said Roberta Cook, employee benefits counsel for the Chamber. "We're right on schedule. We anticipate making the goal."

Response to a survey of the Chamber's 5,000 members prompted the organization to draft the initiative. Twelve percent of the respondents said they no longer had liability insurance, either because the coverage for their risks was no longer available or they could not afford to purchase coverage.

But, apparently, the affordability and availability of property/casualty coverages is no more of a problem in Alaska than in other states, a special fact-finding task force appointed in September by Gov. Sheffield has concluded.

The group's report will be used as the basis for legislation by the governor and the Legislature when it reconvenes in January, said Loren Lounsbury, commissioner of the Department of Commerce and Economic Development in Juneau.

Mr. Lounsbury chaired the task force, which was composed of the state attorney general, several other Cabinet members, a former state Supreme Court justice, a retired insurance broker and Arizona Insurance Director S. David Childers.

Because the group was assigned strictly to gather information, it made no recommendations, Mr. Lounsbury explained.

"There were no surprises. . . The major thing that comes out is that we in Alaska are not being singled out in affordability and availability," he said.

The report is based on a public hearing held throughout the state via a teleconference, reports from other states and "reams of information," Mr. Lounsbury said.

Alaska Insurance Director John George, who assisted the panel, currently is writing its report, which is expected to be given to the governor by Dec. 10.

"We found that in most cases, insurance is available, but the price is the problem. So now the job is to determine if the price is excessive," Mr. George said. "We're finding that rates are not unreasonable. . . just in comparison to last year, they're high."

The Alaska Insurance Division is also working with day-care center operators and insurers to provide day-care liability coverage, Mr. George said.

"We found an underwriter that would consider the good day-care risks, if those good risks could be determined," Mr. George said, noting the underwriter asked for public anonymity.

Mr. George noted that "good" day-care risks have been identified through reports by a state inspection department that assesses the centers.

The Insurance Division also is working with day-care operators to help them identify their risks in a favorable light when negotiating coverage.

Because of this effort, some day-care centers that would have been denied coverage now have insurance, Mr. George said. ■



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Guaranty funds

Continued from page 1

by the amendments is uncertain. However, a BI search of a computerized data bank of 10,000 publicly held companies showed that 6,200 exceeded a net worth of \$10 million. About 300 foreign companies are included in the data bank and could not be excluded.

"The average consumer ought not to be bailing out large corporations that, for whatever reason, choose insurers that aren't capitalized at what they should be," says Kenneth W. Smith, deputy director of the Illinois Insurance Department's property/casualty division in Springfield.

Illinois regulators chair the NAIC's subcommittee task force on guaranty funds. Other states on the task force include New York, California, Florida and Texas.

State guaranty funds currently impose caps on the amount that can be recovered per claim. These caps vary from a low of \$50,000 in Missouri to a high of \$1 million with only one state—Maryland—imposing no cap. The funds also exclude coverage for claims filed under certain policies, including reinsurance.

But, the funds do not exclude protection for certain policyholders.

"It does seem unusual at times that we'd pay claims to companies that have more assets than many of the local insurance companies," observes John Gates, executive director of the California Insurance Guarantee Assn. in Los Angeles.

In 1984, insurers in all states except New York were assessed \$74.1 million by guaranty funds, according to the National Committee on Insurance Guaranty Funds in Schaumburg, Ill. The assessment in 1983 was about \$48.9 million.

New York's preassessment guaranty fund paid out \$21.5 million for the year ending March 1, 1985, but has not assessed insurers in about six years because it has not fallen below its minimum level.

"A lot of money is being assessed, and it doesn't appear it'll let up in the near future," observed Richard J. Marcus, executive secretary of the guaranty fund association.

Indeed, Mr. Marcus predicts that this year's assessments will be larger than last year's.

Most recently, insurers in several states were assessed to pay claims filed against Iowa National Mutual Insurance Co. in Cedar Rapids, placed into liquidation Oct. 10 by the Iowa Insurance Department. Its insolvency is estimated at \$40 million to \$60 million.

"The guaranty fund's intent is to protect the unsophisticated buyer, the individual or small business, not the larger corporations that employ risk managers," says James W. Schacht, chief deputy director of the Illinois department in Springfield.

Mr. Schacht observes a "unanimity among the task force members" on eliminating guaranty fund coverage for certain sized businesses and wealthy individuals.

He says when the NAIC's guaranty fund model law was adopted in 1971, its intent was to protect the small, unsavvy buyer who might be devastated by insurer insolvency.

It was responding to insolvencies of small, substandard auto insurers. The intent was not to address insolvencies of major markets like Mission Insurance Co. and Ideal Mutual Insurance Co., whose policyholders include prominent U.S. corporations.

At the NAIC meeting, regulators and insurer representatives will attempt to fine-tune the proposed amendments, including consideration of the \$10 million net worth limit for coverage.

The task force has considered using policyholder assets or sales to determine if guaranty fund coverage should apply, but Mr. Schacht says the cutoff point that has the most support is a net worth of \$10 million. He declined to predict the law's chance of being adopted by the NAIC in Reno.

"It certainly will be considered," he says. "But whether or not it will be adopted is another question."

Most risk managers appear largely unaware of the proposal, perhaps because today's tight market has forced them to focus on securing insurance.

As Jon Harkavy, director of governmental affairs for the Risk & Insurance Management Society, puts it: "The commercial insureds have other things to be concerned about now in this hard market."

But others point out that ever if risk managers were aware of the proposal, it may not concern many of them. The per-claim payout limit imposed by most guaranty funds often renders recoveries for larger businesses to an almost insignificant amount.

For example, Missouri's fund will only pay \$50,000 per claim, Arizona and Wyoming each pay only \$100,000 and California pays only \$500,000.

In a paper that RIMS' Mr. Harkavy presented at a recent NAIC meeting in Syracuse and will resubmit in Reno, he says RIMS has "strong concerns" about the proposals: "It is, after all, the large commercial insurance

buyer who indirectly, through premium volume, contributes to these guaranty funds."

But, RIMS would not be entirely opposed to a reduction in guaranty fund coverage if another change to state law also were made: repealing existing regulations that restrict access to the surplus lines market.

Most states prohibit buyers from using a surplus lines insurer unless the coverage cannot be purchased from admitted insurers, who are assessed by guaranty funds.

"The rationale behind restricting large commercial insureds' access to unlicensed insurers is at best weak. However, when you drop large commercial insureds from guaranty fund coverage the rationale behind these restrictions becomes non-existent," he said.

If the NAIC took guaranty fund protection away from large buyers but did not remove existing market barriers, it would place "an illegitimate regulatory advantage on licensed carriers," foster "interstate protectionism" and open the regulations to constitutional attack, Mr. Harkavy said.

In addition to errors and omissions and directors and officers insurance and financial guarantee products, the amendments would exclude guaranty fund coverage for warranties and insurance service contracts. Already, most guaranty funds exclude protection for reinsurance policies and surety, ocean marine and mortgage guarantee claims.

With input from an industry advisory committee chaired by Michael Duncan, assistant general counsel of Allstate Insurance Co. in Northbrook, Ill., the task force has addressed a variety of revisions in the guaranty fund law for more than a year.

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Sub-total... 22,087
Associations...804
Government, unions and educational systems...1,030

Commercial Consumers

Sub-total... 23,921
Insurance agents and brokers 9,548
Insurance companies...6,089
Financial institutions...536
Actuaries, attorneys, adjusters, appraisers and consultants...3,464
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TOTAL... 44,878

* Source: Business/Occupational breakdown of qualified circulation, May 6, 1985 issue, as submitted to BPA for June 1985. BPA Publisher's Statement.

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Lloyd's policy

Continued from page 1

Basically, the new Lloyd's claims-made form establishes two definitions for the term "accident" to separate long-latent injury claims that are not tied to an event or catastrophe that occurs at a specific time from claims stemming from events or catastrophes that can be tied to a specific time.

How an accident is defined under the policy is critical because the policy makes the policyholder responsible for a retention for each accident.

The first definition of accident, according to the policy, is an event which commences at a specific time and for which the underwriter receives notification within 15 days of the specific time.

The definition says all injuries stemming from this event will be treated as resulting from one accident.

Therefore, under the terms of the policy, the policyholder will be responsible for only one retention, despite the number of claims, and insurance coverage below the Lloyd's excess coverage will respond only once before the Lloyd's coverage kicks in.

All claims, however, are subject to the aggregate limits of the policy and the policy specifies they must be filed within five years of the time the insurer was notified of the accident.

In contrast, the second definition of accident is "any other event" that results in injury.

Although the policy does not elaborate on what types of events would fall under this category, the difference is that the event that triggers coverage under this definition of accident does not occur "at a specific time."

Lloyd's sources say this second definition refers to long-latent injuries for which it is impossible to cite specifically when the injury occurred.

For example, did asbestos-related injuries occur when the injured party was exposed to the asbestos or when the asbestos disease manifested itself 20 years later?

The second definition then adds that injuries suffered by each individual person or each individual entity in this second type of accident "shall be treated as resulting from a separate accident."

So, under the terms of the policy requiring a separate retention for each accident, the policyholder will be responsible for a retention for each long-latent claim and insurers below the Lloyd's excess coverage will have to respond to each claim before the Lloyd's coverage is triggered.

There is no aggregate limit on the amount of policyholder retention.

Therefore, a policyholder who has assumed a \$500,000 retention under its general liability policy and is hit with 1,000 long-latent claims stemming from a particular product would pay up to that \$500,000 retention 1,000 times to trigger its excess coverage, assuming the aggregate limits of the excess policy are not exhausted be-

The new Lloyd's policy states that coverage will be excluded for 'fines, penalties, punitive damages, exemplary damages, treble damages, or any other damages resulting from the multiplication of compensatory damages.'

fore the 1,000 claims are paid. In addition, the policyholder also pays related defense costs until the \$500,000 retention is depleted by indemnity payments.

The size of the retention—which can be insured—and the limits of the underlying insurance must be specified in the coverage proposal submitted by the policyholder to the Lloyd's underwriters, and cannot be changed by the policyholder or underlying insurers once the policy is signed.

For the first time, the underwriting proposal, which also includes details on the policyholder's loss experience and other underwriting information, must be included as part of the policy and must be signed by an officer of the company purchasing the insurance.

Besides requiring the policyholder and underlying insurers to cover their share of each long-latent claim, all claims stemming from one event must be filed within five years of the date the first such claim was filed.

And, the policy further specifies that coverage will be granted only for claims in which an injured party or entity is identified by name.

The policyholder's retention for either type of accident must reflect indemnity payments only and not any defense costs incurred by the policyholders.

These defense costs would be paid by the policyholder.

However, the Lloyd's form does recognize defense payments made by underlying insurers as satisfying their limits of coverage. And, while Lloyd's includes defense costs within policy limits, the policy adds that Lloyd's has no duty to defend the policyholder and will not pay any defense expenses until the claim is resolved.

In contrast, the Weavers form does not recognize defense costs in either the retention required of policyholders or the underlying coverage—unless it is written on Weavers form.

In this respect, the Lloyd's policy meshes better with the ISO primary coverage form, which effective July 1, 1986, is expected to include defense costs within policy limits.

In addition to being unique in its definitions of "accident," the Lloyd's policy specifically excludes coverage for punitive damages, an exclusion not contained in the Weavers or ISO forms.

The Lloyd's policy states that coverage will be excluded for "fines, penalties, punitive damages, exemplary damages, treble damages, or any other damages resulting from the multiplication of compensatory damages."

Since courts often award punitive damages today and since the

size of the punitive damages can easily exceed compensatory damages awarded, Lloyd's exclusion of indemnification for punitive damages creates a significant reduction in coverage available under the new Lloyd's form.

Although Lloyd's states that coverage for risks excluded under the new form could be bought back for additional premium, Lloyd's sources say underwriters are not likely to agree to sell back coverage for punitive damages.

The Lloyd's form also specifically excludes coverage for injuries stemming from pollution, which is similar to the ISO form. Lloyd's form does allow pollution coverage to be bought back, but on a named perils basis only, Lloyd's sources say.

And, the Lloyd's form specifically states it will not pay for the cost of evaluating, monitoring, controlling, removing, nullifying and/or cleaning up seeping, polluting and/or contaminating substances.

The Weavers form, however, does not specifically exclude pollution coverage although Weavers plans to exclude this exclusion in endorsements to its policies, except for pollution stemming from named perils.

In addition, for the first time, the Lloyd's excess form specifically excludes coverage for:

- Employers liability as respects occupational disease or any workers compensation, unemployment compensation or disability benefits law or statutes.
- Any liability arising out of any partnership or joint venture of which the policyholder is a partner or member.
- Payment of any personal injury claims for discrimination or humiliation.
- Any liability arising out of watercraft, aircraft and aviation products.

Policyholders, however, can negotiate to buy back coverage for these exclusions.

Like Weavers and ISO, the Lloyd's policy does contain a retroactive date; any claims stemming from events that occur before the retroactive date are not covered by the Lloyd's policy, even if claims are first filed during the Lloyd's policy period.

The retroactive date will be the inception date of the first Lloyd's claims-made policy.

The presence of a retroactive date presents a problem for policyholders that are canceled by insurers or switch insurers because the next insurer may move the retroactive date ahead to the inception date of his policy. This can create a gap in coverage.

To counteract this, Lloyd's—like ISO and Weavers—offers policy

Jackson defends new policy

Robin A.G. Jackson, one of the four Lloyd's of London underwriters who drafted the new claims-made excess liability insurance form, says the new form is the only alternative—short of no coverage at all.

Speaking at a luncheon meeting of the The Assn. of Lloyd's Brokers and Lloyd's Surplus Lines Assn. of Illinois earlier this month, Mr. Jackson declared, "If you continue to write general liability on an occurrence form, we will be unable to insure or reinsure you," he said.

Lloyd's names are telling their syndicates that they don't want to continue to support general liability insurance written on an occurrence basis, Mr. Jackson of Merrett Syndicates Ltd. said.

"I have committed to my names that I will write no new individual risk business that is not claims-made," Mr. Jackson said. Individual risk business includes both direct policies and facultative reinsurance.

Mr. Jackson also said later that he would try to "work treaties of a claims-made basis" if the ceding company continues to write occurrence form policies.

Mr. Jackson defended the switch to claims-made, citing past losses and Lloyd's names' reluctance to continue to write occurrence liability forms.

"A very large share of the ultimate asbestos bill is being paid by Lloyd's," Mr. Jackson said, refusing to say just how much. "Asbestos can't be dismissed, on what it has done to London and to Lloyd's," he said.

Acknowledging the widespread criticism of the claims-made form, Mr. Jackson said he hoped that the new Lloyd's claims-made form "will be seen as a sincere effort to come up with a risk transfer product."



Mr. Jackson

holders the option of purchasing extended reporting or tail coverage if the underwriter cancels coverage or refuses to renew a policy.

If a policy is canceled, the coverage will be extended for 12 months.

This is more restrictive than the tail coverage offered under either the ISO or Weavers claims-made forms.

ISO offers tail coverage for an unlimited period of time and Weavers offers a 36-month tail. Insurers using the ISO form can charge up to 200% of the original premium for the tail coverage while Weavers offers it for no additional cost.

Lloyd's and Weavers only offer the tail coverage if the insurer cancels the policy or does not renew, while the ISO form offers the coverage if either the insurer or policyholder decides to cancel or not renew coverage.

Besides offering tail coverage if an entire policy is canceled or not renewed, the new Lloyd's claims-made form also offers the buyer tail coverage if a particular risk is excluded upon renewal of the Lloyd's policy.

Under such circumstances, the policyholder will have the option of purchasing tail coverage for five years for the risk excluded but only if the policyholder ceases to "manufacture, sell, handle and/or distribute" the excluded product or ceases the excluded activity.

Some fear the differences between the Lloyd's and Weavers claims-made forms will create gaps in coverage for policyholders that look to the London market for excess coverage.

Weavers generally leads the first \$5 million layer and then follows Lloyd's on higher layers.

However, sources in London believe that Weavers may move to-

ward the Lloyd's form because there is such a marked difference between the two claims-made policies.

Now, both Weavers and Lloyd's say their policies stand alone and are not subject to the terms of any other policy. Besides the differences cited above, the Weavers form also does not define "accident" in the same terms as the Lloyd's form and, consequently, does not specify that every long-latent claim will be subject to the policyholder retention.

Despite the possible confusion in the market, both the Lloyd's and Weavers forms are being circulated. Weavers already has given about a dozen quotes under this form.

Lloyd's new form was issued to about 50 Lloyd's brokers on Nov. 15, sources say.

The policy is still in draft form, but is expected to be filed with Lloyd's Non-Marine Underwriters' Assn. for an official Lloyd's number in the near future.

Lloyd's brokers already are working to file orders on the new Lloyd's form, *Business Insurance* learned.

The new policy was written by four leading Lloyd's U.S. casualty underwriters and their technicians. The underwriters are Robin Jackson and John Fenn of Merrett Syndicates Ltd., Gale Coles of Janson Green Ltd. and Richard Hazell of F.R. White syndicates.

Last week, Lloyd's underwriters also met with non-Lloyd's underwriters in the London market to discuss the new claims-made form, London sources say. The new Lloyd's form is available to any London insurance company underwriters that wish to use it and to underwriters on other Lloyd's syndicates. ■

Engineers found negligent

Continued from page 2

a proper review been performed, the complaint charged.

Mr. Duncan was in charge of structural engineering work on the skywalks, while Mr. Gillum was responsible for overall engineering and design of the structural aspects of the hotel project, the complaint said.

Judge Deutsch concluded that Mr. Duncan was grossly negligent for failing to adequately prepare or supervise the preparation of design drawings for elements of the skywalks' support system, and for failing to properly review the completed drawings. Mr. Duncan also failed to review shop drawings of the connectors used in the hotel's skywalks for conformity with the design concept, an omission that "precluded any possibility of detecting the presence of an undesigned and grossly inadequate set of connections in the Hyatt skywalks," Judge Deutsch wrote.

Judge Deutsch also concluded that Mr. Duncan was guilty of misconduct for assuring Hyatt architects of the adequacy of

the connector elements, though he had done no engineering calculations to support that assurance. "Respondent Duncan knew of the architects' reliance upon him in his professional capacity for his definitive determination in this regard, knew of his responsibility for making such a determination pursuant to request, and materially misrepresented to the architects that the double hanger rod box beam connection was structurally safe and sound," Judge Deutsch wrote.

Mr. Gillum was also found "vicariously liable" for Mr. Duncan's omissions and was found grossly negligent himself for failing to review the structural drawings of skywalk support elements. "Had respondent Gillum made inquiries of respondent Duncan or caused the Hyatt project file to be checked against the drawings, he would have discovered that no design work had been done for the box beam hanger rod connections," the judge concluded. Mr. Gillum was also found guilty of unprofessional conduct for refusing to take responsibility—imposed under a Missouri state statute—for the entire

engineering project.

In addition, Judge Deutsch found Mr. Gillum guilty of misconduct for failing to comply with a request from architects of the Hyatt hotel to check the entire design of the hotel atrium after the atrium roof collapsed while under construction. Mr. Gillum only checked the design of the roof, though he represented to the architects that a complete design review of the atrium was also being carried out, the judge concluded.

G.C.E. also was found liable for Mr. Duncan's and Mr. Gillum's acts and also was guilty of gross negligence, misconduct and unprofessional conduct, Judge Deutsch ruled.

Mr. Grebel added the outstanding Hyatt injury cases do not name G.C.E., Mr. Duncan or Mr. Gillum as defendants.

About \$90 million in judgments and settlements have been paid by insurers for Hyatt, the operator of the hotel, and Hallmark Cards Inc., whose Crown Center Redevelopment Corp. owned the hotel. The insurers are now appealing an order apportioning coverage between the two lines of insurance. ■

update

Mentor committee to meet

Continued from page 2

preme Court, a nine-person committee of inspection to oversee the liquidation of Mentor Insurance Ltd. will hold its first meeting next month, says joint liquidator Charles Kempe.

The nine, who are among hundreds of creditors owed an estimated \$178.5 million by Mentor, were selected by the court from 16 corporations nominated for places on the committee at the first meeting of Mentor creditors on Sept. 20. The creditors were unable to agree on the composition of the committee.

The newly appointed committee includes four American banks, four insurance companies and one London accounting firm acting on behalf of Lloyd's of London syndicates. They are: Manufacturers Hanover Trust, Morgan Guaranty, Bank of America, First City National Bank of Houston, Ennia, Hartford Group, Continental Insurance, American Centennial and Nevill Russell.

Glacier General in liquidation

HELENA, Mont.—A state District Court judge ruled Nov. 12 that Glacier General Assurance Co. of Missoula, Mont., is insolvent and placed it into liquidation. Montana Insurance Commissioner Andrea Bennett, who was appointed liquidator, said Glacier General was insolvent by at least \$131 million.

Glacier General, which had been in rehabilitation since March 12, had written medical and legal malpractice and commercial automobile coverages and financial guarantee bonds nationwide. It had also written workers compensation and fire policies in Montana, according to the state Insurance Department.

Glacier General wrote coverage on insufficiently collateralized loans that caused Bank of America to take a \$95 million charge against its 1984 earnings. That loss is now the subject of several lawsuits (*BI*, Nov. 11; March 11).

In addition, Ms. Bennett brought suit June 11 against shareholders and directors of Glacier General seeking to recover more than \$5 million in dividends. Glacier General paid those dividends from 1982 through 1985, while the company was insolvent by millions of dollars, according to the department's preliminary review.

Chase Manhattan settles suits

NEW YORK—Chase Manhattan Corp. says in a report to shareholders it has reached a \$32.5 million proposed settlement of several lawsuits connected with the 1982 collapse of Drysdale Government Securities Inc. and Penn Square Bank.

The settlement is expected to be paid by several of Chase's insurers. A spokesman for Chase did not name any of the insurers involved in the settlement, saying only that there were several.

The action would settle a derivative lawsuit that consolidates the claims in several similar suits brought earlier by Chase stockholders that charge officers of Chase and Chase Manhattan Bank N.A. were negligent and wasted corporate assets in handling energy loans to Penn Square Bank.

Chase lost \$200 million when the Oklahoma City bank collapsed (*BI*, Oct. 22, 1984).

The suit charges also that the officers were negligent in dealings with Drysdale Government Securities. Chase acted as an intermediary between Drysdale and firms that lent Drysdale securities; when Drysdale failed, Chase suffered a \$285 million pretax loss.

The proposed agreement also would settle a suit filed by Chase against several of its senior officers.

The plaintiffs originally sought more than \$315 million in various suits against the defendants. The settlement includes plaintiffs' attorney fees of about \$5.7 million.

The settlement could be approved at a Dec. 2 hearing at the Court of Chancery in Wilmington, Del., the spokesman said.

Tax proposal

Continued from page 1

required to reduce its loss reserve deductions by 15% of its tax-exempt income from investments acquired on or after Nov. 15, 1985.

- Insurers would be taxed on a portion of their unearned premium income over the next five years. Premium income currently is not taxed until it is earned.

This tax would be 4% during the 1986 tax year, and increase four percentage points each year until the tax reaches 20% in 1991.

Also, the Ways and Means Committee accepted a staff recommendation to increase to 4% from 1% the federal excise tax on casualty reinsurance premiums paid to foreign insurers. The excise tax would take effect in January.

The committee, though, rejected far-reaching proposals recommended by its staff in September. The most severe of these recommendations would have barred insurers from taking immediate tax deductions for loss reserves established to cover claims to be paid in the future.

Under the staff proposal, a deduction could be taken only at the time a claim is actually paid.

Insurers, who doubted that the Ways and Means Committee would adopt this proposal, which would force companies to adopt the cash method of accounting, had warned that the proposal alone could have increased rates by 15% to 30%.

"The committee realized that the cash-method accounting proposal was ridiculous," said the Alliance's Mr. Broadie.

But the committee left open the possibility that it may reconsider the issue. It ordered the Treasury Department and the Joint Committee on Taxation to study the current tax treatment of property/casualty companies' loss reserves and to make recommendations for changes by Jan. 1, 1987.

Two other staff proposals rejected by the committee include:

- Barring companies filing consolidated tax returns from totally offsetting corporate profits with losses incurred by their property/casualty units.

Under that proposal, only 35% of a property/casualty insurer's losses could have been deducted from a parent company's consolidated taxable income, even if the insurer reported a net gain on Line 18(b) of the annual statement. The proposal adopted by the committee only affects the relatively few insurers that report a net loss on Line 18(b).

Insurers had warned that companies that file consolidated tax returns would have been reluctant to invest in and purchase property/casualty insurers if they were unable to offset property/casualty losses against profits earned by other corporate units.

- Limiting the amount of net operating losses that property/cas-

'Our attitude is that the proposals are not as bad as they could have been,' says Mr. Broadie.

ualty insurers could carry forward from a past tax year and apply against current income. The carry-forward would have been limited to the lesser of 35% of previous net operating losses or 35% of a company's current taxable income.

The committee backed off from adopting the more comprehensive proposals advanced by its staff after objections by Rep. Fortney (Pete) Stark, D-Calif., who said more time was needed to study the issues, said Walter Vinyard Jr., a partner with Zuckert, Scoutt, Rassenberger & Johnson in Washington.

"Stark said you need more time to write an equitable bill for the property/casualty industry," he said, noting it took Congress more than a year to draft and agree on the new tax rules affecting life insurers contained in the Deficit Reduction Act of 1984.

Essentially, Mr. Vinyard observed, the committee left most of the property/casualty taxation issues on the table for another two years.

"The committee got so much input from different groups that they abandoned the idea of writing a comprehensive tax proposal (for the property/casualty industry) in the remaining few weeks," Mr. Vinyard said.

While the net changes of the stop-gap proposals will not be as great as some feared, the property/casualty industry does live under the threat that tax rules could be re-examined within several years, he said.

"The bullet might strike in two years," Mr. Vinyard said.

Indeed, there are questions on whether the alternative tax proposal, scheduled to go into effect in 1988, ever will occur.

The alternative tax proposal may be a device to force the property/casualty industry to come up with its own recommendations for tax changes, lobbyists said last week. They added they needed more details about the alternative tax proposal before they could judge its impact.

Besides revising property/casualty tax rules, the Ways and Means Committee also proposed eliminating BC/BS plans' tax status effective Jan. 1.

The Joint Committee on Taxation estimates that making the Blues taxable entities would raise \$1.7 billion over the next five years; however, the Blues put the five-year revenue estimate at \$240 million.

If Congress enacts this proposal, BC/BS officials say their plans will have to tighten underwriting standards, a change they say will have its greatest impact on the small-employer market now dominated by the Blues.

Because of their tax-exempt status, many BC/BS plans use more liberal criteria when underwriting small-employer accounts than commercial insurers.

"Blue Cross/Blue Shield plans do market small-group business on a different basis than other insurers. They do make it easier for small groups," said Peter Hutchings, a partner at benefit consultant Kwasha Lipton in Fort Lee, N.J.

For example, many BC/BS plans covering small employers will cover pre-existing conditions. "Most of our plans do not ask medical history questions of small groups. A filling station can get coverage with no questions asked. That is something they do to justify their tax-exempt status," said Ms. Lenhard, the BC/BS vp in Washington.

In addition, many of BC/BS plans use community rating for small employers, in which companies of a certain size, often those with fewer than 50 employees or lives, will pay the same rate. Community rating means a small company with adverse risk experience will not be hit with a huge rate increase or lose its coverage because of an extraordinary claim, said John Thompson, president of Blue Shield of Massachusetts in Boston.

However, some BC/BS plans lose money on small-employer business because of these liberal underwriting standards. For example, last year the Massachusetts Blues lost \$7.63 million on groups with fewer than five lives, Mr. Thompson said.

If BC/BS plans are taxed, "Our sense is that we will have to get as tough as everyone else. There will be a new cost to cover," said Ms. Lenhard.

She noted that the Ways and Means Committee proposal only applies to the Blues and not to other tax-exempt health care providers, like some health maintenance organizations and Voluntary Employee Beneficiary Assns., also known as 501(c)(9) trusts.

"We can't figure out why we were singled out," she said.

But other observers say that because the Blues will lose some of their competitive advantages compared with taxable insurers, they will have to become more efficient, such as in claims delivery service and other areas.

The Blues have been slower to move in these areas and will have to become more competitive if they have the same tax status as other health insurers, said Larry Lenahan, a benefit consultant with Buck Consultants Inc. in New York.

"That could be a plus for buyers," Mr. Lenahan said.

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Java Sea settlement

Continued from page 3

30 days, Mr. Keaty says.

Individual awards range from about \$300,000 to \$5.5 million, according to Herbert Resner, an attorney with Melvin M. Belli's law offices in San Francisco who represents families of four of the accident victims.

The size of the awards is being determined by economic loss and by family considerations. The largest award, for example, is being given to a 25-year-old Denver woman with two children whose husband was an ARCO supervisor earning \$100,000 annually.

The \$51.2 million reflects the amount of cash Global, ARCO and their insurers have agreed to pay out, but the claimants actually may receive more if structured settlements are arranged.

If a plaintiff chooses a long-term settlement instead of a lump-sum payment, the interest earned on the original sum would increase the total amount of money the plaintiff would eventually receive.

The settlement was reached Nov. 11, the day before a trial in the case was scheduled in U.S. District Court in Houston. That trial would have considered Global Marine's contention that if it were judged liable for the workers' deaths, its liability should be limited to only \$4.3 million under the Federal Limitation of Liability

Act of 1851 (*BI*, Jan. 30, 1984).

Global Marine had "no real hope" of succeeding with this position, Mr. Hagans says.

"The biggest complaint the families had was that ARCO and Global didn't put the safety of the men above their desire to drill, drill, drill," Mr. Keaty says.

Last week's agreement settles all liability claims against Global Marine and most against ARCO: Fourteen of the plaintiffs settling with Global Marine would not settle last week with ARCO.

These families maintain that "ARCO is at least as responsible as Global Marine and should pay at least as much if not more," explains Mr. Hagans.

He expects these claims to be heard in Harris County Civil District Court in Houston early next year.

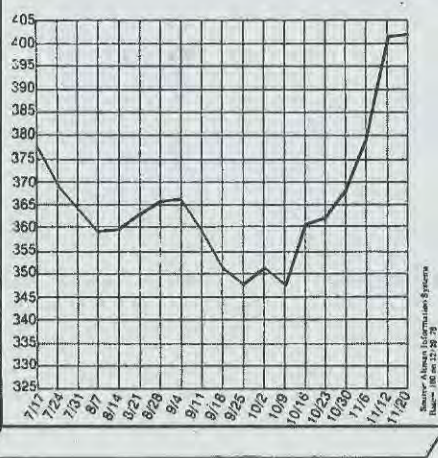
That trial will also address a dispute between ARCO and Global Marine over whether ARCO employees aboard the Java Sea were covered under Global Marine's liability policy.

ARCO says Global Marine agreed to indemnify it under the drilling contract, but Global Marine disagrees, Mr. Hagans says.

The issue has become "a big bone of contention" between ARCO and Global Marine, according to Mr. Keaty.

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BI Insurance Index



Insurers' quarterly earnings outperform most estimates

By **MYRON M. PICOULT**
Special to Business Insurance

WITH THE APPROACH of Thanksgiving, our initial thought was to talk about the turkeys in the insurance business. However, we remember the industry's annual pilgrimage to "reserve land" and feel that there will be sufficient opportunities to provide commentary on remaining problems.

Third-quarter earnings and operating results for all of the major property/casualty and multiline insurers now have been reported. With the exception of The St. Paul Cos., earnings were basically better than expected.

In addition, underwriting experience was not as severely impacted by Hurricanes Elena and Gloria and by the Mexican earthquake as originally feared.

In fact, analysts should have left their original third-quarter earnings projections intact. On the operating side of the equation, volume gains and underwriting experience were as good as or better than projections.

Investors should note that the industry, as expected, is becoming more leveraged. Furthermore, we are beginning to see some property/casualty companies, albeit reluctantly, address the prospect of non-recoverability of reinsurance. Could additional "refinements" to realistic asset evaluation also be in the wings?

Also costing underwriters money are assessments being made by the "Fair Plans" and state guaranty funds. Through the first nine months of 1985, many primary companies have incurred several millions of dollars of assessments, compared with virtually nothing last year.

Third-quarter results seem to underscore the old maxim that in the downside of the underwriting cycle, analysts' estimates are too high, and in the upside they are always too low. We continue to believe that not all

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Mr. Picoult

companies will participate equally in the coming recovery.

Our survey, which now accounts for about half of the stock industry's annual premium volume, showed the following for the three months ended Sept. 30:

- Net premiums written soared an average of 37.6%. Excluding Kemper Group because of last year's pooling change, the average gain was still a robust 25.7%. Four underwriters were above the average and 16 were below. Only Fireman's Fund Insurance Cos. recorded a decline in volume for the period. Excluding Kemper, the sharpest gain was registered by American International Group Inc. with a 98.8% gain. The only company reporting a single-digit increase was The Home Insurance Group.

- Pretax net investment income increased 8.9%. Twelve companies were above the average and eight were below. Three companies posted lower profits.

The overall gain appears paltry relative to the volume gains being recorded. Although cash flow from operations is clearly improving, the reported investment income figure is laboring from earlier cash-flow shortfalls and a lower yield curve.

- The combined ratio, after policyholder dividends, equaled 117.7%, compared with 120.4% in the third quarter of last year. All of the improvement was centered in the expense ratio as the loss ratio held steady at 88.7%.

Thirteen companies were below the 117.7% mark and seven were above. Five underwriters still showed some deterioration in their ratio. And, no company reported a combined ratio of less than 100%.

As a sign of the times, the following companies produced ratios below 110%: American International Group Inc., GEICO Corp., Ohio Casualty Group and SAFECO Insurance Co. of America.

- As expected, the premium-to-surplus and the reserve-to-surplus ratios deteriorated. For the companies on which we have data, the written-to-surplus ratio crept up to 2.6-to-1 while the reserve ratio stood at 3.1-to-1.

- Loss reserve growth is improving as many more underwriters are beginning to view current reserving practices more realistically. However, much work remains on prior writings.

Total loss reserves increased an average of 13.6% during the quarter. Only Kemper

showed a lower figure. Paid losses for the quarter rose 6.1%.

- Finally, property/casualty earnings rose an average of 23.9%. However, as has been the case with the first and second quarters, averages are misleading as many underwriters have gone from red ink to black ink or pink ink. In a few instances the ink even went to a darker shade of red.

Overall, consolidated earnings were up some 31.0% with non-casualty earnings providing the spread.

We sense that some of the areas, like the group health area, will soon have its own property/casualty cycle too. It would be too much to expect managements to pull all the strings in the same direction.

Hartford

Hartford Fire Insurance Co., the principal member of Hartford Insurance Group, has announced a public offering of 2.5 million shares of Class A Preferred Stock, 8.95% Series 3, at \$50 per share.

The shares are redeemable at the option of the company at \$54.48 per share if redeemed before Jan. 15, 1987, declining annually to \$50 per share if redeemed on or after Jan. 15, 1994, provided that no redemption may be made prior to Jan. 15, 1991, through certain refunding operations if the interest or dividend rate on the refunding operation is less than the dividend rate of the preferred stock.

The stock also will be subject to an annual mandatory redemption beginning on Jan. 15, 1992, sufficient to retire the shares on Jan. 15, 1996.

The First Boston Corp. is the manager of the underwriting syndicate.

Hartford intends to add the net proceeds from the offering to its general corporate funds to enhance its surplus position and add capacity.

American Bankers

American Bankers Insurance Group Inc. has filed a registration statement with the Securities and Exchange Commission relating to 1.5 million shares of common stock.

Kidder, Peabody & Co. Inc. and The First Boston Corp. will be co-managers of the offering. The underwriters also have been granted an over-allotment option of 225,000 shares.

Miami-based American Bankers will use the proceeds of the offering to increase consolidated investment income and to increase the capital and surplus of its property/casualty subsidiary.

Warwick

Warwick Insurance Managers Inc. has filed a registration statement with the Securities and Exchange Commission relating to a public offering of 850,000 shares of common stock. The company will be offering 800,000 newly issued shares and selling shareholders will offer 50,000 shares.

The offering will be managed by Furman, Selz, Mager, Dietz & Bierney Inc.

Warwick Insurance Managers, based in Morristown, N.J., is the parent of Warwick Insurance Co., which primarily writes commercial multiperil and workers compensation coverages in New Jersey.

Guaranty National

Guaranty National Corp., based in Englewood, Colo., reported earned revenues of \$65.3 million for the first nine months of 1985, compared with \$55.4 million for the same period in 1984.

Guaranty National reported net income of \$1.7 million for the nine-month period in 1985, compared with a loss of \$3.7 million for the same period in 1984.

In the third quarter of 1985, the company reported earned revenues of \$20.4 million, compared with \$17.2 million in the same period a year earlier.

The company reported net income of \$801,000 for the third quarter of 1985, compared with a loss of \$2 million in the third quarter a year earlier.

British Issues

19 Nov Companies	Price	P/E	Div. pence	Yield %	1 Week High—Low
Comm Union	240	N/M	16.9	7.0	253-246
Genl Accident	748	37.4	31.4	4.2	748-720
Gdn Royal Exch	760	66.1	38.6	5.1	760-741
Royal	773	48.3	35.0	4.5	783-730
Sun Alliance	563	N/M	23.6	4.2	571-555

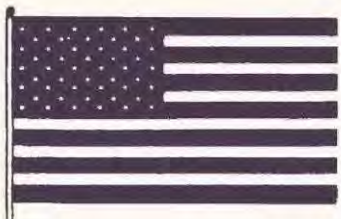
Brokers	Price	P/E	Div. pence	Yield %	1 Week High—Low
CE Heath	683	8.9	37.5	5.5	723-693
Hogg Robinson	280	11.7	14.3	5.1	299-290
JH Minst	225	10.2	11.4	5.1	228-223
Sedg Grp	375	15.0	17.8	4.8	383-368
Stew Wrightson	740	14.2	32.8	4.4	753-740
Willis Faber	792	20.3	23.6	3.0	800-792

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

BI Industry Stock Report

November 20, 1985 11/14/85 thru 11/20/85

Brokers	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol.(000)	
Alexander & Alexander Svcs	NYSE	31.63	-0.8	0.0	1.00	31.88	30.88	438.2	
Baldwin & Lyons Inc	OTC	61.00	-6.2	13.5	0.80	66.50	61.00	6.2	
Corroon & Black Corp	NYSE	57.50	2.4	77.7	1.00	58.25*	57.25	74.2	
Crump E H Cos Inc	OTC	19.13	3.4	20.6	0.25	13.25*	19.00	86.3	
Eaett & Chandler Cos Inc	OTC	15.50	1.6	26.7	0.00	15.50	14.75	255.6	
Gallagher Arthur J & Co	OTC	47.00	-4.1	23.0	0.28	48.75	47.00	51.6	
Hall Frank B & Co Inc	NYSE	28.00	-5.9	0.0	0.00	29.88	28.00	301.7	
Marsh & McLennan Cos Inc	NYSE	79.50	0.6	19.0	2.68	80.00*	78.50	161.8	
Poe & Assoc Inc	OTC	14.00	19.1	0.0	0.80	5.7	14.00*	12.00	8.7
AGENTS/BROKERS	AVERAGE			143.6				1.9	
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	48.00	0.3	15.4	1.36	48.38	47.88	5,179.2	
Anderson Clayton(Ranger/PanAm)	NYSE	48.00	3.8	33.3	1.32	48.00*	47.13	50.6	
Ameco Inc	NYSE	8.88	0.0	0.0	0.00	8.88	8.25	455.7	
Berkley W R Corp	OTC	26.50	3.4	82.8	0.32	26.50	26.00	282.1	
CIGNA Corp	NYSE	61.00	-1.0	29.6	2.60	61.88	60.75	824.5	
CNA Financial Corp (CNA)	NYSE	62.00	1.3	19.4	0.00	63.13*	61.75	134.3	
Genl Re Corp	NYSE	99.13	3.3	107.7	1.56	99.63*	96.13	484.0	
ITT (Hartford Group)	NYSE	33.25	-1.3	10.4	1.00	34.00	33.25	2,290.3	
Sears Roebuck & Co. (Allstate)	NYSE	37.13	3.1	10.4	1.76	37.38	36.13	3,983.2	
Tedley Inc (Argonaut)	NYSE	279.50	2.1	6.1	0.00	280.63*	274.00	198.2	
Transamerica Corp	NYSE	33.50	0.8	16.2	1.68	33.63*	33.50	521.0	
CONGLOMERATES/HOLDING COS.	AVERAGE			11.4				1.6	
Insurers									
Aetna Life & Cas Co	NYSE	51.63	-1.0	19.4	2.64	53.00*	50.38	2,005.2	
American General Corp	NYSE	32.50	-2.3	9.9	1.00	32.88	32.50	1,577.1	
Amern Heritage Life Invst Co	NYSE	36.25	7.0	10.4	1.20	36.50*	35.13	6.2	
American Intl Fint Corp	OTC	17.75	-1.4	0.0	1.12	18.38	17.75	8.4	
American Intl Group Inc	NYSE	98.38	1.5	24.5	0.44	98.38	97.25	880.9	
Aneco Reins Ltd	OTC	0.94	7.2	0.0	0.00	0.94	1.88	31.5	
Avenco Corp	NYSE	36.38	2.1	14.4	0.60	36.75*	35.25	16.7	
Business Mens Assurn Co Amer	OTC	29.25	0.9	8.2	1.04	29.25	28.50	47.6	
Chubb Corp	NYSE	52.50	-0.7	19.0	1.56	53.63	52.38	250.2	
Combined Intl Corp	NYSE	50.13	3.1	9.1	2.16	4.3	50.25*	49.75	206.5
Continental Corp	NYSE	46.50	-1.1	23.0	2.60	46.88	46.38	531.4	
Crown Life Ins Co	OTC	235.00	2.2	14.2	0.00	0.0	235.00	220.00	0.2
Durham Corp	OTC	40.50	0.0	7.5	1.28	3.2	41.00	40.50	11.9
Farmers Group Inc	OTC	68.88	0.9	11.6	1.76	2.6	68.88	68.50	306.6
Fireman Fd Corp	NYSE	30.50	-2.8	0.0	0.30	1.0	31.00	30.25	724.7
Fremont Gen Corp	OTC	24.63	-4.8	2.4	0.48	1.9	26.00	24.63	286.5
Great West Life Assurn Co	OTC	431.00	0.0	11.1	1.60	0.4	431.00	431.00	0.0
Home Group Inc	AMEX	24.00	2.1	0.0	0.00	0.0	24.00	23.50	1,199.3
Hanger Ins Co	OTC	50.75	0.5	52.9	0.56	1.1	51.00*	50.50	16.4
Hartford Steam Boiler Inspntn	OTC	57.75	-2.9	13.6	2.00	3.5	59.00	57.00	35.0
Kans City Life Ins	OTC	27.50	2.8	10.8	0.87	3.2	27.50	26.75	21.0
Keeper Corp	OTC	63.88	1.8	18.4	1.80	2.8	63.88*	63.38	154.3
Liberty Corp S C	NYSE	32.38	-1.1	14.0	0.72	2.2	32.75	32.38	17.9
Lincoln Natl Corp Ind	NYSE	50.38	-0.2	11.9	2.00	4.0	52.38	50.38	188.9
Mission Ins Group Inc	NYSE	2.88	4.5	0.0	0.00	0.0	2.88	2.13	285.0
Monumental Corp	OTC	37.25	2.8	12.6	1.40	3.8	37.25*	35.88	51.6
Nobel Ins Ltd	OTC	11.00	-4.3	14.5	0.25	2.3	11.50	10.75	26.3
Northwestern Natl Life Ins	OTC	25.63	4.1	6.7	0.50	3.1	25.88	25.00	415.7
Ohio Gas Corp	OTC	69.13	-3.7	23.3	2.80	4.1	72.00	69.13	126.9
Old Rep Intl Corp	OTC	32.75	-3.0	8.9	0.74	2.3	33.00	32.63	142.7
Orion Cap Corp	NYSE	29.75	-1.7	0.0	0.76	2.6	30.75	29.38	105.6
Protective Corp	OTC	21.50	0.0	8.0	0.66	3.1	22.00	21.50	129.8
Provident Life & Acc Ins Co	OTC	25.75	-4.2	6.9	0.76	3.0	26.75	25.63	209.4
St Paul Cos Inc	OTC	77.38	-3.7	0.0	3.00	3.9	80.13	77.38	304.1
SAFECO Corp	OTC	44.50	-1.4	15.8	1.60	3.6	45.50	44.50	218.1
Sri Corp	OTC	19.13	-0.6	637.5	0.80	4.2	19.38	19.00	63.7
Seibels Bruce Group Inc	OTC	22.50	0.0	4.6	0.80	3.2	22.75	22.50	56.5
Statesman Group Inc	OTC	4.13	-5.7	0.0	0.05	1.2	4.25	4.13	79.8
Tokio Marine & Fire Ins Co	OTC	22.50	-4.3	41.7	1.05	0.5	22.50	22.50	3.7
Torchmark Corp	NYSE	25.50	4.6	10.0	0.60	2.4	26.25*	24.88	744.4
Travelers Corp	NYSE	46.63	1.4	11.3	2.04	4.4	47.00	45.63	796.9
United Fire & Cas Co	OTC	25.00	0.0	11.9	1.20	4.7	25.50	25.50	8.3
United States Fid & Gty to	NYSE	37.63	-1.3	0.0	2.20	5.8	39.13	37.63	781.3
UsLife Corp	NYSE	38.25	-3.5	8.6	1.12	2.9	39.75	38.25	268.8
Washington Natl Corp	NYSE	26.13	4.0	9.0	1.08	4.1	26.63	26.13	164.5
Zenith Natl Ins Corp	OTC	23.25	-3.1	0.0	0.68	2.9	23.25	22.75	137.2
INSURANCE COMPANIES	AVERAGE							2.1	



RIMSTM AUTOMATES ALTERNATIVE HEALTHCARE DELIVERY SYSTEMS

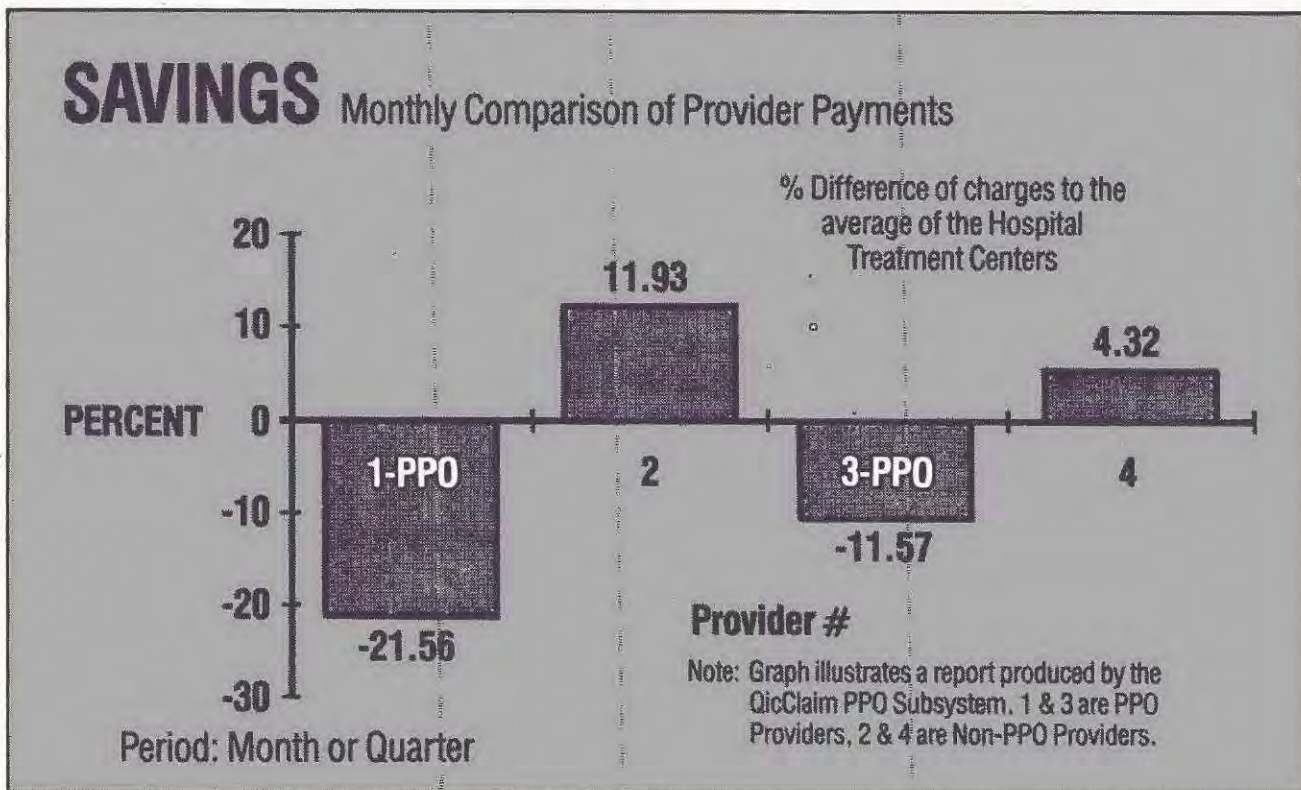
With enrollment in Health Maintenance Organizations and Preferred Provider Organizations growing dramatically throughout the past year, the need for automated claim calculations, management and provider reporting is crucial. Consistent with their commitment to provide superior technology and support for the broad range of health services administration functions, Resource Information Management Systems, Inc. has released software packages for alternative healthcare delivery systems.

Increased Productivity for Preferred Provider Organizations

To accommodate the unique administrative and reporting needs associated with PPO management, the QicClaim PPO subsystem addresses the vital areas of claims payment, provider panel profile reporting, savings reporting and fee schedule management.

A new variable in plan/claimant processing—claim calculations additionally driven by the provider of service—results in a non-increase or reduction in program management overhead and expense. Provider tracking assigns preferred provider benefits and schedule limits automatically where applicable...no longer forcing the claims processor to juggle confusing rate and fee-for-service schedules.

To be effective, PPO's must accurately track provider performance and utilization and the QicClaim PPO subsystem from RIMS provides this plus totally automated claims processing and in-depth reporting.



Total Automation for Health Maintenance Organizations

QicClaim HMO automates group, staff, IPA or network model Health Maintenance Organizations and provides:

- fee-for-service and capitation payments
- claim calculations driven by provider service type
- provider contract date tracking
- HMO management and medical case management reporting
- fee and utilization profile reporting

Surpassing Federal Office and Health Maintenance Organization requirements, QicClaim HMO offers profile and provider comparative reports by: diagnosis, procedure, member and type

of service, inpatient vs. outpatient, average length of stay and lowest charging non-capitated physicians—a complete reporting schedule for detailed performance analysis.

Profitable Health Maintenance Organizations need comprehensive, cost effective administration and QicClaim HMO delivers.

RIMSTM

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