

business insurance

New work comp rating plan to be considered in Oregon

SALEM, Ore.—A new workers compensation rating system based on loss experience is expected to be presented this week to a governor's task force in Oregon.

If the task force and Insurance Commissioner Josephine M. Driscoll approve the program, which applies only to construction classifications, it could go into effect in Oregon as early as January and would become a

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

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Results look better, but insurers not cheered

By JUDY GREENWALD

Although the major property/casualty insurers' losses leveled off in the third quarter, observers say the insurers' results are not going to improve very quickly.

The aftertax operating income of the 25 major insurers surveyed by *Business Insurance* declined 51.8% in the first nine months of 1984; however, that's better than the 60.1% decline reported by the insurers in the first half of the year.

But, these results are not cheering the insurers, who point to their overinflated combined ratios and sagging operating profits (see chart).

In addition, observers warn that operating results will not improve in the fourth quarter, when insurers traditionally boost their reserves.

"We believe the fourth-quarter results will probably be as bad as the third-quarter results and possibly worse," says David Anthony, an analyst at New York-based Smith Barney Harris Upham & Co. Inc.

"It looks like the fourth quarter is also going to be pretty bad and may be accentuated by reserving," says Frederick V. Hill, a principal at New York-based Derby Securities, who adds, however, "Certainly, it appears the bottom of the (underwriting) cycle has been reached."

Most analysts and insurers agree that the seeds of recovery, in the form of higher rates, have already been planted, though they are not expected to sprout in earnest until at least the second half of 1985 and won't really blossom into substantial gains before 1986.

The vital key to a long-term improvement in operating results is the continuation of price increases, say observers.

"It's just tough sledding till rates come up," says Michael A. Lewis, a

vp and financial stock analyst at New York-based E.F. Hutton.

Price increases are the "order of the day," says Charles T. Bell, director of investor relations for Aetna Life & Casualty Co.

"The industry needs several cycles of upward movement right now," points out Caleb Fowler, senior vp and chief financial officer for CIGNA Corp.'s property/casualty group. "Looking at the pricing activity many companies have experienced recently, CIGNA particularly, causes us to be more optimistic, less pessimistic, than before."

For now, however, "We're kind of living with last year's mistakes," says Sean Mooney, an economist at the Insurance Information Institute.

Those "mistakes" manifested themselves in the insurers' aggregate nine-month results. According to the *Business Insurance* survey:

- Underwriting losses grew by 71.9% during the first three quarters to \$7.1 billion. However, this compares with a 114.8% rise in underwriting losses during the first half of 1984, indicating that the effect of early price increases may be starting to be felt. Also helping the nine-month comparison was the lack of any major catastrophes this year vs. the effect of Hurricane Alicia in last year's third quarter.

- The insurers' aggregate combined ratio remained rock steady at 120.4%, the same mark reported during the first half. This aggregate reflects a range of 106.1% for American International Group Inc. to 146.3% for Mission Insurance Group Inc.

- Investment income grew by 7.1%, again the same increase that

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ticker

Worst combined ratios

Mission Insurance Group	146.3%
The Home Group Inc.	130.0%
CIGNA Corp.	129.8%
Fremont General Corp.	129.2%
The St. Paul Cos. Inc.	128.9%

Best combined ratios

American International Group	106.1%
SAFECO Corp.	109.3%
Ohio Casualty Co.	113.5%
Reliance Insurance Co.	113.9%
Continental Corp.	114.3%

Gulf's Bermuda captive halts all underwriting

By DOUGLAS McLEOD

PITTSBURGH—The pioneer among Bermuda-based captive insurers writing commercial insurance, Gulf Corp.'s Inco Ltd., is no longer writing any new or renewal business.

The captive's oil company parent announced last week that Inco has stopped writing both non-related and Gulf-related risks effective Nov. 16.

Non-related risks produced 62%, or \$46.5 million, of Inco's 1983 net premiums of \$75.5 million and Gulf-related risks produced 38%, or \$29 million.

With policyholder surplus of \$94.8 million at year-end 1983, Inco was the fourth-largest captive in Bermuda writing unrelated-risk business and was one of the leaders. Over the past eight years, Inco wrote a total of \$254.7 million in net premiums on unrelated business, including property, casualty, marine and aviation risks.

Gulf also is shutting down the underwriting operations of Transinsco Inc., a Stamford, Conn.-based subsidiary formed in 1982 to produce non-related U.S. business for Inco and Hartford Insurance Group.

Business produced by Transinsco accounted for about half of the Bermuda captive's non-related book in 1984, according to Noel Turner, Inco's president.

Inco's offices in Bermuda and its staff of 48 will be maintained to run off the captive's book, Mr. Turner said. The portion of the runoff requiring staff to handle the paper flow will last from three to five years, he added.

Transinsco, with offices in Stamford and Los Angeles, is expected to let go most of its staff of 30 over the

next few months.

The acquisition of Gulf earlier this year by Standard Oil Co. of California is cited as the main reason for Inco's demise.

Gulf "liked the insurance business" and had taken its first steps toward expanding into the U.S. marketplace with the formation of Transinsco in 1982, but "Chevron did not like that strategic plan," according to William Clark, president of Transinsco.

"Chevron felt, 'Holy Moses, we have so much on our plate already (with the merger),' that they didn't want to expand operations that were not a part of their home territory," Mr. Clark said.

Gulf executives said that Inco's 1983 net operating loss of \$16.2 million, its first ever, was not a factor in the decision to close the insurer.

San Francisco-based Chevron has its own Bermuda captive subsidiary, Bermaco, which writes almost exclusively parent-related business.

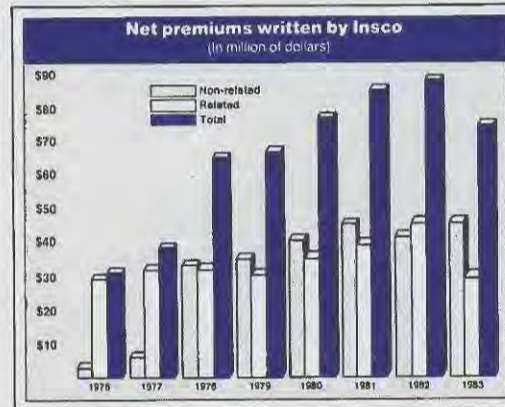
Chevron hasn't yet decided whether the Gulf liability risks written by Inco will be picked up by Bermaco or whether they will be placed on the open market or self-insured, sources say.

Bermuda brokers, while expressing disappointment over Inco's withdrawal, say that it won't have a significant impact on overall market capacity.

Some questioned Chevron's decision to close the operation now, when rates in many property/casualty lines are beginning to rise.

"Because rates and conditions are hardening, it surprises us that any company would withdraw from the market now," said Roy Bray, vp and director of Amberco Brokers Ltd.

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Aetna's defense costs capped under Dalkon Shield agreement

By STEPHEN TARNOFF

RICHMOND, Va.—A.H. Robins Co.'s recent settlement of insurance litigation with Aetna Casualty & Surety Co. gives Robins a potential \$70 million in additional coverage for Dalkon Shield injury claims but caps the insurer's liability for defense costs.

Under the Oct. 31 agreement, Aetna will increase by a total of \$23.8 million the limits of six comprehensive general liability policies Robins purchased from Aetna during the period from March 1, 1971, through the end of February 1977. Aetna was Robins' primary and excess insurer from March 1968 through Feb. 28, 1978.

In addition, Aetna also will provide \$46.2 million that Robins will use to pay claims for injuries caused by the intrauterine device for which it has no insurance.

In return, the agreement stipulates that all defense costs in the litigation will be paid from within the limits of Robins' insurance coverage, including the additional coverage provided under the agreement, and Dalkon Shield claims will be paid based on when the injuries became manifest rather than when the victims first began using the Dalkon Shield.

Thus, Robins receives more coverage than Aetna has wanted to provide, but Aetna does not have an unlim-

ited duty to defend Robins.

With the settlement—which ends five years of litigation between Robins and Aetna over Dalkon Shield defense and indemnification costs—Robins has \$153 million remaining in insurance coverage to pay Dalkon Shield claims, according to its third-quarter 10Q statement filed today with the Securities and Exchange Commission.

But Robins says this will not be enough insurance to cover all the Dalkon Shield claims it faces (see story, page 28).

Already in the first nine months of this year, Robins has incurred \$67 million in uninsured Dalkon Shield claims and expenses—a 390% increase over the first nine months of 1983—and is studying the feasibility of establishing a "substantial" reserve for pending and future uninsured claims.

Robins, which currently faces more than 3,600 Dalkon Shield claims, is being hit with an average of 30 new lawsuits a week. And, it expects that the pace of new suits will increase following a recent advertising campaign encouraging women who are still using the Dalkon Shield to have it removed.

So far, Robins and Aetna have disposed of more than

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Property/casualty insurers' nine-month results detailed
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update

Oregon comp rating change

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model for other states.

The new system proposes using a credit or debit factor based on an employer's loss ratio in figuring workers comp premiums, said Michael Camilleri, assistant vp and director of national affairs for the National Council on Compensation Insurance. The New York-based ratemaking and research group designed the system after surveying Oregon's construction employers earlier this year (BI, Sept. 24).

Oregon, like 48 other states, uses a rating system that multiplies a job classification rate times \$100 of payroll to determine the work comp premium. The NCCI's survey supported allegations by construction industry employers that rates were inequitable for employers, usually union shops, whose workers were at the high end of pay scales. These employers said they had better-than-average loss ratios, yet were paying higher rates. The new system would factor in a credit for employers with a better-than-average loss experience and a debit for employers with a worse-than-average loss ratio.

The new system could be used throughout the country and, if the data warrants, it can be used in other classifications, he said. It already is being discussed in other states and by other industries, including ironworkers, he added.

Chicago teachers set to strike

CHICAGO—Chicago public school teachers are planning to strike Dec. 3 to protest the Chicago Board of Education's decision to deduct from teachers' paychecks a portion of health insurance premium costs.

The first payroll deductions affected teachers' Nov. 16 paychecks. The average Chicago teacher, who earns between \$22,501 and \$27,500 annually, saw monthly deductions of \$21.24 for individual coverage or \$25.50 for family coverage, a Chicago Teachers Union spokeswoman said.

The school board says it intends to withdraw these amounts from teachers' paychecks once a month to cover 25% of the cost of medical insurance premiums.

The teachers union gave strike notice Nov. 19 and simultaneously filed an unfair labor practice charge with the Illinois Educational Labor Relations Board. The teachers decided to wait until Dec. 3 to strike so that they can walk off the job with members of other unions, who expect to see similar deductions in their Nov. 30 paychecks.

Manville petition not dismissed

NEW YORK—The 2nd U.S. Court of Appeals refused to dismiss Manville Corp.'s petition for reorganization last week when it rejected an attempt by a committee representing asbestos litigants to obtain immediate review of whether the company's petition was filed in good faith.

"The legitimacy of Manville's intentions will be reflected, to some extent at least, in the plan of reorganization it submits to the bankruptcy court. Before any such plan is confirmed, it must satisfy the requirement that it was proposed in good faith," the appeals court said, indicating the issue should be dealt with once the reorganization plan is complete.

The appeal by the asbestos litigants stemmed from a refusal earlier this year by U.S. Bankruptcy Court Judge Burton R. Lifland and U.S. District Judge Constance Baker Motley to dismiss the Manville reorganization petition.

Indiana Blues face antitrust suit

INDIANAPOLIS—Lawyers for Blue Cross & Blue Shield of Indiana are reviewing an antitrust suit filed by 61 Indiana hospitals seeking an injunction against the formation of a preferred provider organization by the Blues.

BC/BS announced in August its plans to form the PPO early next year, shortly after the state's new PPO law takes effect Dec. 31. The day before the lawsuit was filed in U.S. District Court in Indianapolis, BC/BS had secured signed agreement proposals from 74 of 115 hospitals in the state that were invited to participate in the PPO, a spokesman for BC/BS said.

The lawsuit claims that BC/BS's share of the health insurance market and its method of attempting to enroll hospitals as preferred providers violate federal antitrust laws and four state statutes, including the Indiana Antimonopoly Act and the Indiana PPO Act, said Kenneth G. Stella, president of the Indiana Hospital Assn.

"The plaintiff hospitals believe that the proposed Blue Cross contract is not designed to control hospital costs but is an attempt by the insurer to use its monopolistic power in the insurance business to force a discount which will only benefit itself and will result in higher costs for other consumers," Mr. Stella said.

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Order may ban rate deviation by Texas Lloyd's companies

By CAROL CAIN

AUSTIN, Texas—Rates for just about all lines of insurance in the competitive Texas market may finally plateau or even increase as a result of an order being drafted by Texas Insurance Board Chairman Lyndon Olson Jr.

The target of the order is the Texas Lloyd's companies, which, according to Mr. Olson, have skewed the state's rate regulatory mechanism by excessive downward deviation from approved rates.

The Texas Lloyd's companies, which have existed since the early 1920s, are patterned after Lloyd's of London, but are not affiliated with it, said Evelyn Ireland, director of research and information services for the Texas Insurance Board.

The Texas Lloyd's companies are unincorporated associations of individual underwriters who are individually and jointly liable for the risks they underwrite, Mr. Olson said.

In August of this year, there were 78 Texas Lloyd's companies, compared with 68 a year earlier and only 34 in 1980 (BI, Oct. 13, 1980).

Unlike Texas stock and mutual insurers, Texas Lloyd's companies are exempted from rate restrictions under a 1921 provision in the Texas insurance code that

allowed for the establishment of such associations.

A Texas Lloyd's company can write any kind of coverage except life insurance, Mr. Olson said. He estimates that about 50% of the commercial property insurance in Texas is written by Texas Lloyd's companies. Some of the companies also write liability, workers compensation and health insurance, but the state has no statistics on what coverages these companies actually write.

During the past several years, Texas Lloyd's companies have charged 50% to 60% less than the manual rates approved by the Insurance Department, Mr. Olson said.

Many of the Lloyd's companies, especially those formed in the early 1970s during a competitive cycle, are affiliated with insurers, he said.

To reduce—or raise—their rates by more than the deviations allowed by the department, these insurers will place their business in their own Texas Lloyd's company at as much as 50% off the manual rate, he said. And the deviation does not have to be approved by the Insurance Board, he added.

"A number of very bright people... have found a way to do what we didn't want them to do," Mr. Olson said.

The board order that Mr. Olson is proposing will attempt to prohibit insurers from putting business in Texas Lloyd's companies at rates lower or greater than the deviations the Insurance Department approves for the parent insurer.

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Tanker owner adds to cover after accident

By STEVE TARAVELLA

SAN FRANCISCO—Keystone Shipping Co.'s damaged petrochemical tanker, the Puerto Rican, is now docked at a San Francisco Bay shipyard after the company purchased an additional \$100 million in pollution liability coverage to satisfy authorities.

The insurance was placed Nov. 16 by Lloyd's of London broker Thomas R. Miller & Son (Insurance) Ltd., reports Charles Achuff, partner with Keystone's principal retail broker, H.C. Knight & Co. in Philadelphia. Lloyd's underwriters wrote the insurance.

The coverage was arranged at the request of the U.S. Coast Guard and the state attorney general's office, which acted on behalf of the California Regional Water Quality Control Board, a state agency.

Before it would admit the tanker to port, the state required the Philadelphia-based shipping company to obtain an additional \$100 million in pollution liability insurance to guarantee accessible cleanup funds if a cargo spill occurred during the tow-in, explains a Keystone spokesman. The coverage remains in effect until the cargo is completely removed.

Two explosions occurred Oct. 31 on the 630-foot Puerto Rican, killing one man and injuring nine others. The stern sank three days later, spilling about 1 million gal-

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N.J. surplus guaranty fund is constitutional, judge says

By MEG FLETCHER

NEWARK, N.J.—New Jersey's controversial guaranty fund for surplus lines insurers is constitutional, a U.S. District Court judge says.

In addition, the state Legislature last week approved amendments to the law that established the guaranty fund. The amendments are awaiting Gov. Thomas Kean's signature.

"The Surplus Lines Insurance Guaranty Fund Act is an important piece of remedial legislation designed to meet the crisis facing the state as a result of the Ambassador (Insurance Co.) insolvency," Judge H. Lee Sarokin said in a 53-page opinion issued Nov. 19. "The court finds no constitutional infirmity in the act..."

The class-action lawsuit challenging the law's constitutionality was filed by four plaintiffs: Evanston Insurance Co. of Evanston, Ill.; Appalachian Insurance Co. of Johnston, R.I.; the New York-based Risk & Insurance Management Society; and Donald A. Brody of Springfield, N.J., a policyholder of an admitted insurer (BI, Sept. 24).

The plaintiffs had alleged that the state had overreached its authority when it enacted the law, that the law permitted an unconstitutional taking of property and that it violated the requirements of due process.

In rejecting their arguments, Judge Sarokin said: "The state has a substantial interest in protecting its citizens who have obtained insurance on risks within its borders from defaults by insurers outside of its borders. A common fund is an accepted and established means of affording such protections."

The lawsuit was filed by attorney William Holzapfel of the Cranford, N.J., firm of Holzapfel, Perkins & Kelly, a New Jersey partner of LeBoeuf, Lamb, Leiby & MacRae in New York, U.S. general counsel to Lloyd's of London.

Attorneys for the plaintiffs are reviewing the decision and must discuss it with clients before deciding whether to appeal, said Donald Greene, a partner with LeBoeuf, Lamb.

New Jersey Insurance Commissioner Kenneth D. Merin said that Judge Sarokin's ruling was a vindication of his belief that the law, as originally enacted, was legally sufficient to accomplish its purpose of protecting New Jersey residents.

The fund was specifically designed to generate at least \$12 million to pay outstanding claims of New Jersey policyholders of Ambassa-

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N.J. doctors face charge for fund debt

By JULIE TRUCK

TRENTON, N.J.—Health care practitioners in New Jersey may face an assessment to pay off a \$42 million deficit in the state malpractice reinsurance fund.

The amount of the assessment and who will have to pay it hinge on the recommendations of a recently appointed state panel that will explore ways to erase the deficit in New Jersey's deactivated Medical Malpractice Reinsurance Assn.

State Insurance Commissioner Kenneth D. Merin said an assessment is necessary to bail out the fund.

The panel will consider how to structure the assessment for state health care practitioners, he said, though Mr. Merin will have the final say on the structure of the assessment and on whether all physicians and podiatrists, regardless of whether they were covered

under the fund, will be assessed.

The panel's recommendations on the assessment are due by mid-December.

The explosion in medical malpractice suits and awards in the 1970s and early 1980s created the projected \$42.1 million deficit in the fund's reserves, according to a spokesperson for the Insurance Department.

The fund's deficit was reported earlier this year by the actuarial firm of Tillinghast, Nelson & Warren Inc., which was retained by the association to audit its funds.

The malpractice reinsurance association was created by a 1976 state statute at a time when most insurers refused to write medical malpractice insurance, Mr. Merin said (BI, Sept. 26, 1983).

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Construction firm looks beyond price. Wausau Insurance figures in their planning.



Vappi & Company is a prominent general contractor in New England.

"It's not our style to shop solely for price," says Mr. James Flynn, Counsel and Risk Manager. "I looked at *all* the insuring candidates and then picked Wausau for *service*."

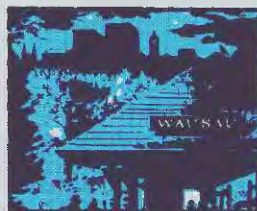
"We started doing business with Wausau in 1982 after 30 years with another insurer. We're a very stable organization and don't like short-term relationships."



"I've come to know Wausau, and their claims handling has been excellent. Wausau is *responsive*. They have knowledgeable people assigned to us — plus a cooperative back-up staff."

"Wausau's loss-control specialists and ours work well together. We've learned a lot from Wausau. That's why they now serve us with four lines of business insurance. I anticipate a successful, lasting partnership."

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Insert photo: Chemical Engineering Building, Massachusetts Institute of Technology, completed by Vappi & Company in 1976.

opinions

The cost of cost containment

IF YOUR MANAGEMENT were to ask you tomorrow, could you detail how much that new second surgical opinion program is saving in health care claims vs. the cost of implementing it? Or, how much was saved when you contracted with a service firm to audit health care claims last year vs. the bill you paid for the auditing service?

If not, you have not been doing your homework as benefit manager and may be wasting precious dollars. As a recent survey by Towers, Perrin, Forster & Crosby shows, not all cost-containment measures necessarily save more than they cost (*BI*, Nov. 19).

For example, did you implement that voluntary second surgical opinion program thinking it would be as effective as a mandatory program while less likely to alienate employees?

The respondents to the TPF&C survey found that voluntary programs produced very little savings over the cost of implementing the plan. In contrast, savings were evident with a mandatory second surgical program. Do you know how your voluntary program stacks up against the cost of running it?

Similarly, over the last year or so there has been

much publicity over the need to audit hospital bills. The companies that sell their services to employers to conduct these audits report they find an error in nine out of 10 hospital bills, and several employers have started programs to reward their employees if they find errors in their hospital bills.

But, when the companies surveyed by TPF&C looked at the cost of conducting the audits compared with the amount saved, they concluded that at best only a slight savings in health care costs is achieved.

How much has the auditing of hospital bills really saved your company?

The survey also found that employers are seeing very little savings from their participation in employer health care coalitions. This may be because many of the coalitions are very new, but if you consistently come to the conclusion that your coalition is not accomplishing much, it's time to suggest how the group can be more effective or to look for a new coalition.

It's great to list all those cost-containment measures you've implemented over the years, but if you can't quantify the saving they have brought, you're only fooling yourself.

Don't pass up chance to be heard

THE INSURANCE INDUSTRY is passing up a valuable opportunity to limit the expansion of tort liability in this country, a defense attorney specializing in appellate work warns.

When an important liability issue is before the California Supreme Court, it's difficult to line up amicus curiae briefs from members of the insurance industry, says Ellis J. Horvitz.

In contrast, the plaintiffs' bar is "brilliantly organized. They are in with amicus briefing in every major case. They do a splendid job," Mr. Horvitz said recently in address to insurers attending the annual meeting of the National Assn. of Independent Insurers.

All insurers should take this criticism to heart and change their ways.

We can understand that insurers may not be eager to pay their attorneys to write amicus curiae briefs in

cases in which they are not a party. Insurers' legal bills are staggering already.

But, Mr. Horvitz contends that courts' inclination to ever expand tort liability can be stemmed if they are convinced that the ultimate adverse social consequences of expanded liability outweigh the benefit of compensating an injured claimant. To sway the judges, the insurance industry will have to be more persuasive than the organized plaintiffs' bar.

If insurers can successfully fight cases that would expand tort liability, they will avoid future defense and claim costs associated with defending claims under a new cause of action.

Next time insurers are called upon to supply amicus curiae briefs, we hope they respond enthusiastically, promptly and professionally, to give the court all the information it needs in its deliberations.

letters

New CGL policy opens door to myriad of problems

To the editor: There are two additional questions that have to be addressed regarding the new general liability policy proposed by the Insurance Services Office (*BI*, Oct. 29). They are:

- Why are the companies going to offer both the standard occurrence and the new claims-made form on an optional basis.

- With regard to the claims-made form, why are they going to use this approach to all types of liability coverage rather than to just product liability coverages?

There is no question that the claims-made form could be tremendously valuable in curbing the problems brought about by product liability claims filed 20 and 30 years after the occurrence took place. This claims-made form certainly should help insurers underwrite exposures like product liability better than the occurrence form has.

The reason for the importance of the claims-made form to product liability insurance is that, for all intents and purposes, there is no effective statute of limitations in any state. But, because there are definite statutes of limitation with respect to automobile and other kinds of general liability claims, I can see no reason why the coverages applicable to those sections of the policy are to be changed to the claims-made form.

In addition, it is my understanding that the companies are going to allow the use

of occurrence and/or claims-made forms on an optional basis. Does this mean that one company could be issuing either form of coverage? If so, will each policy consistently be either claims-made or occurrence, or will it be a combination of the two in any one policy?

A potentially very serious problem can be created by a named insured being provided coverage one year on a claims-made form and another on an occurrence form. Imagine an account that has a claims-made form in 1985 and renews under an occurrence form in 1986. Suppose that the insured sustained an occurrence in 1985 that did not lead to a claim until 1986. Because the occurrence took place the year before, and not in the term of the occurrence form, the company would deny coverage.

Up until the recent form, no reference had been made to the utilization of a retroactive cutoff clause in the claims-made form. It appears that the retroactive endorsement will go back no further than the effective date of the claims-made form. But, suppose a firm obtains a claims-made form for 1985, and in 1986 that firm renews with an occurrence form and then in 1987 the firm renews with a claims-made form with a retroactive cutoff date of the effective date of the 1987 claims-made policy. If an occurrence took place in 1985 during the term of the first claims-made form but was not reported or a claim was not filed until 1987, unless the

named insured purchased a "tail" policy covering a term of more than one year, the client would have no coverage whatsoever for this claim.

These ambiguities are going to put a tremendous burden on brokers and agents and could result in an untold number of errors and omissions claims against producers. The agent and broker, always on the first line of defense, would be the obvious victims of this medley of inconsistencies and ambiguities.

There should be a more complete hearing on this CGL form before it is an accomplished fact. There are many important questions that have yet to be answered.

The new CGL form is one of the most difficult to comprehend of any that I have ever read. I defy anyone to clearly explain every clause of that particular policy. As a result, it may end up being one of the most difficult contracts ever to successfully defend in a court of law.

Lawrence F. Smith
Colonial Insurance Agency Inc.
Stamford, Conn.

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ADVERTISING: New York: 212-210-0133
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Treasury official says benefit changes are part of tax package

By JERRY GEISEL

WASHINGTON—The Treasury Department's tax simplification proposal, which will be sent to the White House next month, includes employee benefit provisions, says the Treasury's top benefit spokesman.

Benefit tax changes "are in the tax package," said Harry Conaway, attorney/adviser in the Treasury Department's tax legislative counsel section.

Mr. Conaway, speaking last week before the Washington Employee Benefits Forum, declined to specify the benefit changes the administration will propose as part of its long-awaited overall tax reform program. But Mr. Conaway, who has played the lead role at the Treasury Department in developing rules on flexible benefit plans and 401(k) savings plans, said benefits have been part of every recent major tax package and "they will be linked" to the next tax package.

Mr. Conaway also confirmed that:

- Final Treasury Department regulations on 401(k) savings plans could be indefinitely delayed if Congress decides to consider its own rules. Even if Congress decides not to act on 401(k) plans, the government's final 401(k) rules will not be published before the first half of 1985.

- The Treasury Department is considering new hardship rules that would make it more difficult for employees to withdraw funds from 401(k) plans to pay for a child's college education or to buy a house. "Hardship is an open issue," he said.

- Final rules are expected by the end of the year that will implement provisions in tax laws that affect small, so-called "top-heavy" pension plans.

- Treasury Department rules on benefit provisions in the Deficit Reduction Act of 1984 and the Retirement Equity Act, which gives women a better chance to earn a pension, will be published in the form of questions and answers. A similar format was used when the government published proposed rules on flexible benefit plans earlier this year (BI, May 7; May 14).

Mr. Conaway didn't specify when these rules will be published, though he hopes it would be no later than sometime next year.

Mr. Conaway is the first administration official to confirm that the administration's tax simplification or reform package will contain employee benefit provisions.

That package, which the Treasury Department is supposed to send to President Reagan next month, is expected to simplify the tax code by applying flat tax rates. Under such a flat tax system, many people would be taxed at lower rates.

But to achieve a broader tax base, which would be needed to make up for the revenue lost by lowering tax rates, many current tax deductions and exclusions would be eliminated.

Many experts expect that the tax simplification proposal will include a provision to tax group health insurance benefits (BI, Nov. 12). Those predictions are based on the fact that a huge amount of revenue could be gained—which would be needed if basic tax rates were cut—if employer health care contributions became taxable income to employees.

For example, the congressional Joint Committee on Taxation estimates the federal government would gain more than \$20 billion in revenues if employers' paid health insurance contributions were included as taxable income to employees.

Continued on page 11

At issue at NAI

Experts differ on problems of civil justice system

By KATHRYN J. McINTYRE

SAN FRANCISCO—Who's to blame for increases in the number of lawsuits filed, the cost of litigation and the number and cost of liability awards?

The current civil justice system is a product of a trend that began 70 years ago to compensate victims of loss regardless of fault. The insurance industry has encouraged it by successfully bearing the cost, says an appellate attorney who represents the insurance industry.

Problems in the current civil justice system stem from one root problem, contends a journalist who specializes in legal issues: There are too many lawyers.

Appellate attorney Ellis J. Horvitz and CBS News law correspondent Fred Graham discussed the civil justice system as part of a panel on "Our Courts and Their Economic Impact: What Price Justice?" during the 39th annual meeting of the National Assn. of Independent Insurers, held Nov. 11-15.

The panel, moderated by Donald E. Schaffer, senior vp and general counsel at Allstate Insurance Cos., also included Deputy U.S. Attorney General Carol E. Dinkins, who concentrated her remarks on the cost of crime.

Mr. Horvitz and Mr. Graham not only see the current problems in the civil justice system from different perspectives but also forecast different futures.

Mr. Horvitz, who specializes in handling appeals, believes "the pendulum has swung as far as it will swing." He predicts that judges will stop expanding the scope of tort liability when they are convinced that the adverse social consequences of their rulings outweigh the benefit of compensating the injured claimant.

Mr. Graham contends that law-

yers and judges who control the civil justice system will not contain the growth or the costs of the system. More economic and more efficient methods of settling disputes will have to be developed and used by private enterprise, Mr. Graham suggested.

Mr. Horvitz, a partner in the Encino, Calif., law firm of Horvitz & Levy and a frequent advocate for the insurance industry, explained the courts are increasingly less interested in fault and more interested in status, meaning which party can better bear the loss and which party can better distribute the loss.

He traced the courts' tendency to expand the scope of liability for injuries to 70 years ago and to a trend that until recently was paralleled in the political and legislative fields. The trend has been, he said, "to spread the risk of injury and loss away from those who are the victims to the community at large."

In the litigation system, risk spreading is done through the instrument of insurance, Mr. Horvitz said.

"I would suggest the insurance industry is in large measure the victim of its own success," he said. "The court looks around for risk spreading; it looks to the insurance industry because, for whatever warts and faults the insurance industry may have, it is the most sensitive and effective method of risk spreading that has ever been devised."

"There is an implicit flattery" here, he suggested, since judges "feel that however heavy a load they put on the insurance industry, the insurance industry will be equal to the task. The courts are well aware that the insurance industry is the banker of the tort system. If

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The Golden Gate Bridge in San Francisco was among the attractions that awaited the insurers attending the NAI conference.

Tight reinsurance market casts pall on conference

By KATHRYN J. McINTYRE

SAN FRANCISCO—In mood, sight and sound, the annual meeting of the National Assn. of Independent Insurers earlier this month reflected the tightening conditions in the reinsurance marketplace.

While the typical group of a few hundred registrants attended the formal program presentations in the Fairmont Hotel, outside the meeting room, in the hotel lobby where most registrants traditionally gather to make reinsurance contacts, faces were more somber and the crowd was sparser and quieter than in recent years when the reinsurance market was competitive.

Although 1,650 people were registered for the conference this year—up 150 from last year—the attendance seemed smaller because more registrants were cloistered in hotel rooms negotiating upcoming reinsurance renewals than were back-slapping and greeting old friends in public lounges.

When small talk was exchanged, it generally opened with the question: "Are your treaties completed?" rather than the traditional opening line: "How's the year been?"

In early November, few treaties were finalized and com-

mitments were being sought.

Richard Foss, president of National Underwriting Agency Inc. in Chicago, for example, is still seeking commitments to complete the last 25% of the reinsurance treaties for 1985 to allow his company to provide \$10 million of liability insurance capacity, down from \$15 million this year, as well as \$7 million of property insurance.

Last year at this time, Mr. Foss had secured all the commitments to renew the reinsurance behind NUA's 1984 underwriting.

"The last 25% will be like pulling teeth," Mr. Foss says. Some London reinsurers are having problems with their retrocessions, Mr. Foss said. "Everybody is having the same trouble. They can't get an answer."

Only one reinsurer on the NUA account has outright refused to renew and that's because a new underwriter is making the decision this year, Mr. Foss said.

But, some reinsurers on the NUA account have left the market, among them British National Insurance Co. and Exxon's captive insurers.

"One major reinsurer increased its line," Mr. Foss reported, Continued on page 27

Two new computer bulletin boards set up

By ROBERT A. FINLAYSON

ATLANTA—You have an idea (or a question) relating to a tricky risk management problem. But, how do you reach your professional peers to discuss it?

You could spend several days telephoning friends in the business, send out a dozen letters to colleagues, or wait for the next risk management meeting or seminar. Or, you could put today's technology to work and use a computer-facilitated information exchange.

In January, risk managers got their first chance to communicate via a computer bulletin board designed specifically for them through the Golden Gate Chapter of the Risk & Insurance Management Society (BI, Jan. 16). And, now another bulletin board program is up and running with a third one the way.

The Atlanta Chapter of RIMS recently set up the nation's second computer bulletin board for risk managers, and the Public Risk and Insurance Management Assn. is getting set to launch an electronic mail network for its members.

Those involved in the RIMS and PRIMA

efforts see continued growth both in information transfer systems and in the use of microcomputers by risk managers, the tool that makes such systems possible.

Calling the computer bulletin board "the wave of the future," Dennis F. McGovern, risk manager for Gold & Kist, an agricultural concern based in Atlanta, says he can see a day when every RIMS chapter will have its own computer bulletin board.

Because computer bulletin boards use commercial telephone lines, having one in the user's local dialing area can save the cost of long distance telephone calls, he points out.

Mr. McGovern, who is president of the Atlanta RIMS chapter, explains that Gold & Kist is set to purchase a microcomputer, which will give him access to the bulletin board. In general, he plans to use the com-

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puter to help him solve risk management problems, develop management reports and improve his filing system.

While the approaches taken by the RIMS chapters for the computer bulletin boards and PRIMA for the electronic mail system differ in application, the concept is the same: to allow

rapid information transfer among risk managers.

The computer bulletin board is open to anyone with access to a microcomputer and a modem, a device that permits computers to communicate via telephone lines. An electronic mail network, however, can only be accessed by those with the system password, and the information is transmitted over privately leased lines, rather than public telephone lines.

The Atlanta RIMS Chapter's bulletin board

is the brainchild of Weymouth D. Walker, a vp with Anistics Inc., a subsidiary of Alexander & Alexander Inc., based in Atlanta.

Mr. Walker says he decided in March that he could "get some exposure" for Anistics and help the local RIMS chapter by setting up the bulletin board. So he offered to have Anistics buy the necessary computer equipment and operate the system if the Atlanta RIMS Chapter would agree to sponsor the project. The chapter agreed, and after several months of planning and the purchase of \$6,000 in equipment, the bulletin board became operational in August.

Mr. Walker is not bashful about explaining Anistics' motive for providing the equipment and operating the system. He sees the bulletin board as a means of helping risk managers get comfortable with using a microcomputer "in a non-threatening way."

As more and more risk managers begin using microcomputers, he explains, there will likely be a growing demand for risk management software and related services that vendors such as Anistics can supply.

PRIMA has a different reason for setting

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Gulf captive stops writing all business

Continued from page 1

Mr. Clark conceded that this may not be the best time to pull out of the market.

"It's disappointing, obviously, because of the timing," he said. "It's taken so long to get the marketplace back to where it's exciting for a lot of people in it."

Some brokers in Bermuda say that Insko's withdrawal—following Exxon Corp.'s decision to stop writing third-party risks in its insurance units, including Bermuda-based Ancon Insurance Co. S.A.—may further tarnish the image of Bermuda captives as professional reinsurers (*BI*, Oct. 8).

However, Insko executives and other Bermuda sources maintain that Gulf's decision doesn't reflect on the viability of offshore captives as commercial insurers and rein-

surers and that the Insko withdrawal represents nothing more than a business decision by Chevron.

Insko, formed in 1971, was one of the first Bermuda-based captive insurers to plunge into commercial insurance underwriting and created a splash in the worldwide market in 1977 when it appointed Leslie Dew, a former deputy chairman of Lloyd's of London, president. Mr. Dew is credited with attracting the first substantial commercial insurance business to the developing offshore insurance market in Bermuda.

Mr. Dew, who retired from Insko last April at age 69, could not be reached for comment.

Net premiums from non-related business first outpaced Gulf-related premiums in 1978, when they ac-

counted for a little more than half of the Insko's total net volume of \$66.5 million (see chart, page 1).

Total net volume increased steadily each year until 1983 when it dropped to \$75.5 million from \$88.9 million in 1982.

The main reason for the decline was Gulf's decision in 1983 to stop reinsuring the first \$25 million layer of its own marine and property risks in Insko, opting to assume these risks as a self-insured retention instead (*BI*, June 6, 1983).

Insko's net premiums from writing Gulf-related risks dropped to \$29 million last year from \$46.5 million in 1982.

Insko also stopped writing non-related aviation business in March 1983 and non-related marine risks in May 1983.

Gross premiums fell last year to

\$114 million from \$140 million in 1982, and Insko reported a net operating loss of \$16.2 million—its first ever—compared with an operating profit of \$13.5 million in 1982.

Mr. Turner would not comment on premium volume or underwriting results for the first nine months of 1984.

Mr. Dew, in Insko's 1983 annual report, blamed the 1983 net loss on reduced premium volume; rising losses, including three shock losses on Gulf-related business that cost Insko \$10 million; and increased loss reserves for non-related business (*BI*, April 2).

On the advice of its accounting firm, Coopers & Lybrand, Insko added \$25 million to its loss reserves for non-related business in 1983, including \$7 million for incurred-but-not-reported losses. Re-

serves for third-party business at the end of 1983 stood at \$114 million including IBNR reserves of \$44 million, compared with 1982 reserves of \$89 million including \$37 million for IBNR losses.

Insko's underwriting loss widened to \$54.6 million last year from \$9.6 million in 1982.

Transinsco, a joint venture between Gulf and Hartford that was wholly owned by Gulf, organized its underwriting staff in 1983, according to Mr. Turner.

Insko reinsured 50% of the first \$500,000 of risks assumed by Hartford Insurance Cos. through Transinsco. In addition, Transinsco produced business for other U.S. insurance companies, which then reinsured portions of the risks with Insko, according to Mr. Clark.

Transinsco's overall business consisted mainly of first-dollar primary casualty risks, with very little property business, Mr. Clark said.

Hartford's share of gross premiums produced by Transinsco amounted to only about \$2 million and came mainly from excess and umbrella business, according to John Tickner, senior vp with Hartford Specialty.

"It was a very small facility, deliberately so because of the soft market," he explained.

Bermuda brokers weren't happy about the news of Insko's withdrawal, but most were expecting it.

Although some worry about its effect on capacity for international risks, others say the impact on capacity for these risks and for the reinsurance of Bermuda captives themselves will not be severe.

"I hope it's not going to have an adverse effect on the market. It's obviously going to have a shrinking effect on market capacity," said Mr. Bray of Amberco.

"It's disappointing, but it's not a disaster," said Robert J. Hedges, vp of Intere (Bermuda) Ltd., a branch of New York-based Intere Intermediaries Inc. "Each decision such as theirs does not help."

"It's a pity that Bermuda loses another piece of capacity, if you look at what Insko was doing a couple of years ago," said A.W. Hunt, vp of Pearson Webb Springbett (Bermuda) Ltd.

But Mr. Hunt and others point out that Insko's role as a commercial insurer has been shrinking steadily since the announcement of the Chevron-Gulf merger and even before then.

"There's been a cloud hanging over Insko. Their announcement simply gives us a decision on what's been expected for some time," Mr. Hunt said.

Chevron's use of its own captive, Bermaco, suggested its views on the assumption of unrelated business and, thus, on its plans for Insko, Mr. Hunt said.

"Chevron's got a captive here that does not write any outside business, so you know what Chevron's attitude is," he observed.

Although Insko was a significant market for PWS at one time, it has not been a major market lately for international risks placed in Bermuda, he added. Most of the business brokered by PWS in Bermuda comes from PWS in London, and about half of it is related to U.S. risks.

"Of course it affects the image of Bermuda, but as far as J&H Ltd. is concerned, it will not affect our ability to make placements," said Roger Gillett, vp and managing director of Johnson & Higgins' Bermuda-based reinsurance intermediary.

Insko had once been a big market for J&H Ltd. for captive reinsurance, but had become less willing to compete with U.S. markets in the last couple of years, Mr. Gillett

Continued on page 8



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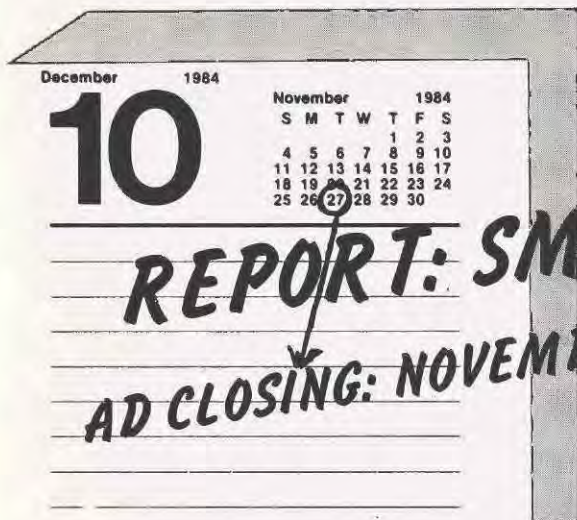


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Insco halts underwriting

Continued from page 4
said.

"I don't think it's going to have a big impact on local brokers," said a Bermuda reinsurance executive who asked not to be named. He pointed out that after Mr. Dew's retirement, Transinsco started producing a larger part of Insco's business.

Gulf insurance executives themselves say that Insco's withdrawal should have no impact and concede that Insco has been less of a factor in Bermuda for some time.

"I don't think it should affect capacity seriously. We pulled out of marine and aviation a couple of years ago," noted William D. McGuinness, Gulf's assistant treasurer, adding that Insco has been "more or less restricting our underwriting" since the announcement of the Chevron-Gulf merger.

"Since our new owner had so

many things to do with the acquisition and merger, it seemed to be the prudent thing to wait to see how (Chevron) wanted to proceed," Mr. McGuinness said.

Some Bermuda insurance executives say the Chevron decision will further damage the reputation of the island's captive markets.

"Every closing of a captive doing non-related business obviously impinges on the credibility of captive companies as professional reinsurers," said the reinsurance executive who asked not to be named.

Others, however, say that such fears are unjustified.

"Whether I think it is justified or not, I think Bermuda has this high profile in the insurance industry in terms of publicity of negative events," said Mr. Gillett of J&H Ltd. "It happens in other areas as well, but they just seem to get more attention in Bermuda.

"I think this decision was brought about by a change in corporate ownership," he added. "It really isn't a change of mind on the part of Gulf."

"This is the same sort of decision that's been made by other companies in the U.S., Britain and all over the world," observed Intere's Mr. Hedges.

For their part, Gulf executives also insist that Insco's demise was simply a business decision by Chevron and doesn't reflect on the viability of the captive concept or the advantages or disadvantages of Bermuda as a domicile.

"It's a decision that grew out of the oil business in San Francisco, not out of the insurance business in Bermuda," said Transinsco's Mr. Clark.

"I do not see this as trend-setting," added Mr. McGuinness.

Although Insco becomes the third oil company captive in Bermuda to stop underwriting commercial insurance and reinsurance, following Phillips Petroleum Co.'s Walton Insurance Co. and Exxon's Ancon, several U.S. oil industry captives continue to operate in Bermuda and underwrite unrelated risks. Among the most active are Texaco Inc.'s Heddington Insurance Ltd. and Ocean Drilling & Exploration Co.'s Mentor Ltd. ■

Mexican insurer to cover explosion

MEXICO CITY—Aseguradora Mexicana, a government-owned insurer, will pay for property damages resulting from the explosions that leveled a liquefied-gas storage facility located in San Juan Ixhuatepec, just north of Mexico City.

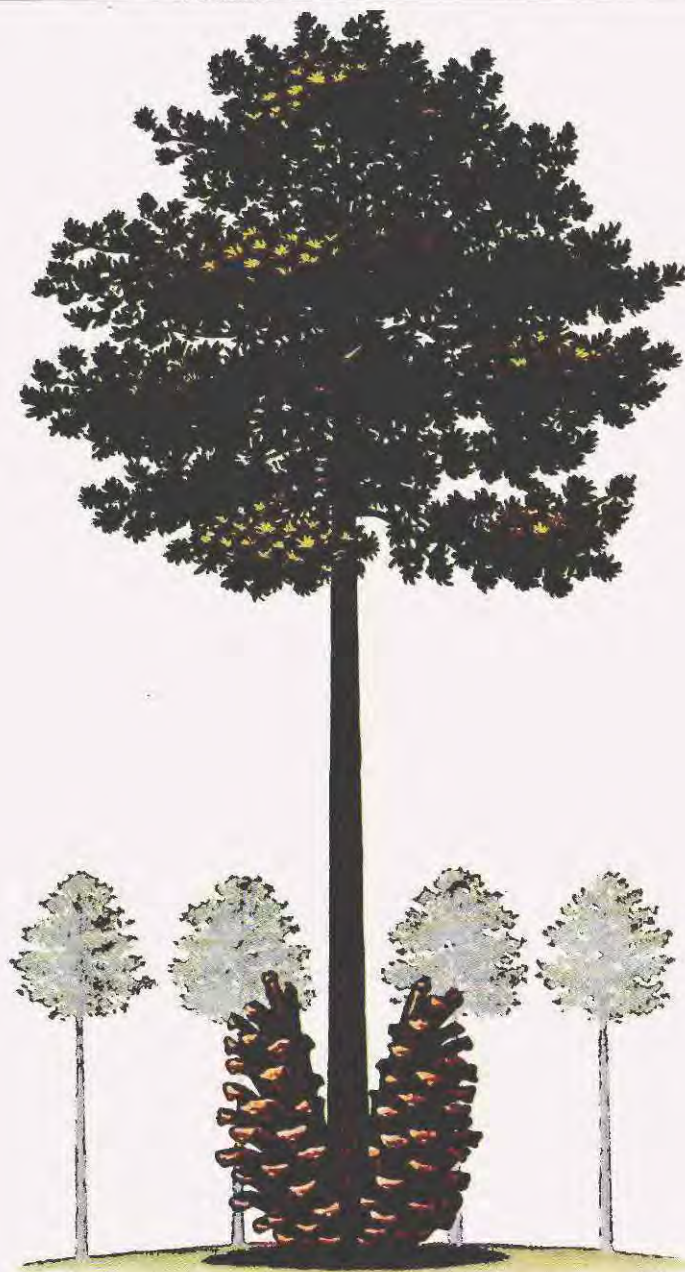
Unofficial estimates put the cost of the damage to the Pemex facility and surrounding residential area at \$100 million.

As of Wednesday, the death toll from the blast was 315, and government officials expect it to increase. However, experts familiar with the Mexican legal system said they do not expect large third-party liability losses since third-party liability lawsuits are uncommon in Mexico. Such claims are settled by a judge based on the minimum wage for the area where the plaintiff resides.

The conclusions of an investigation into the cause of the explosions were expected to be released late last week, sources said. Facilities operated by a liquefied-gas distribution company called Unigas are believed to have been the site of the original explosion.

Details of the coverage carried by Pemex, the state-owned oil monopoly, have not been released by the Mexican government.

Reinsurance for Pemex was brokered by Marsh & McLennan Inc. of New York to the London market, sources said. M&M could not be reached for comment. ■



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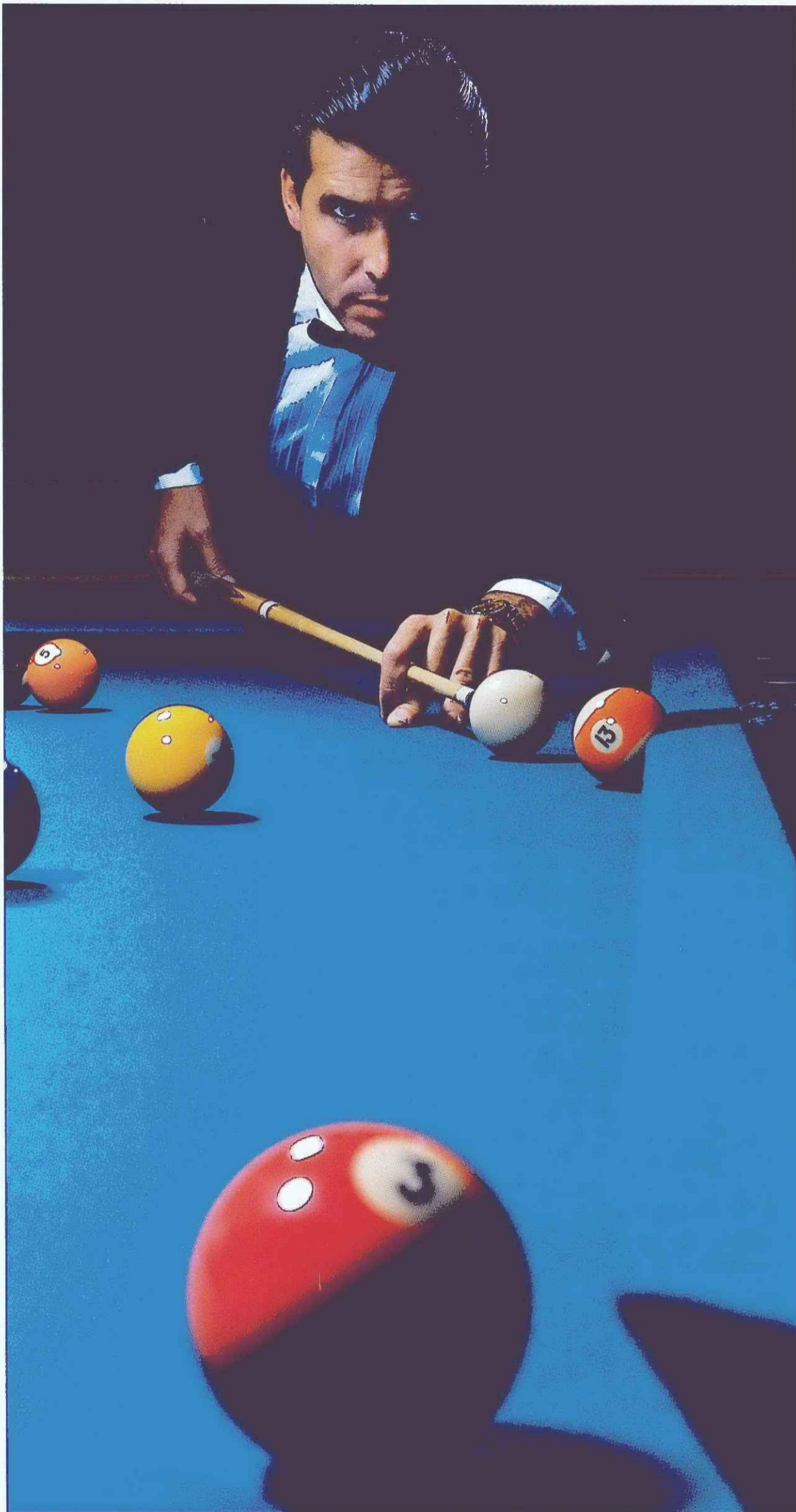
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DEC. 11. Effective Safety Committees seminar in Los Angeles, sponsored by the International Safety Academy; \$175; group discounts available. Registrar, ISA, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147.

DEC. 11. Data Workshop & National Statistical Data Base Briefings workshop in Chicago, sponsored by the Health Research Institute; free. Also Jan. 22 in Miami, Feb. 12 in Los Angeles. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-876-2320.

DEC. 12. Health Improvement/Prevention workshop in Chicago, sponsored by the Health Research Institute; \$195. Also Jan. 23 in Miami, Feb. 13 in Los Angeles. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-876-2320.

DEC. 12. Third-Party Administrator workshop in Chicago, sponsored by the Health Research Institute; \$395; \$195 for subsequent registrants from same company. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-876-2320.

DEC. 13-14. Fundamentals of Insurance course in Atlanta, sponsored by the Risk & Insurance Management Society Inc.; \$445 for members; \$545

for non-members. Fran Jordan, Administrator-Continuing Education Program, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

DEC. 13. Cost Containment and Health Claims Management System seminar in Atlanta, sponsored by Resource Information Management Systems Inc.; free. Ellen Lockwood, 2015 Spring Road, Suite 220, Oak Brook, Ill. 60521; 312-789-0230.

DEC. 13. Builders Risk & Wrap-Up Liability Insurance luncheon meeting in Montreal, sponsored by Quebec Risk & Insurance Management Assn.; \$18 for members and non-members. Suzan Ness, Chairman, Dominion Textile Inc., 1950 Sherbrooke St. West, Montreal, Quebec H3H 1E7; 514-989-8297.

DEC. 13. Risk Management and the Financial Executive seminar in Atlanta, sponsored by Tillinghast, Nelson & Warren; \$600; \$500 for subsequent registrants from the same company. Pat Kelley, Tillinghast, Nelson & Warren, 3340 Peachtree Road, Atlanta, Ga. 30026; 404-261-5420.

DEC. 13-14. How to Audit and Check Insurance Policy Costs and Coverages conference in Washington, sponsored by the American Management Assn.; \$620 for members; \$715 for non-members. Also Dec. 17-18 in San Francisco. Registrar, AMA, 135 W. 50th St., New York, N.Y. 10020; 212-903-8177.

DEC. 13-14. Security in the Electronic Office: Micros, Word Processors, and Work Stations conference in Toronto, sponsored by the Computer Security Institute; \$545 for members, \$575 for non-members. Registrar, Computer Security Institute Educational Resource Center, Department ERC, 43 Boston Post Road, Northborough, Mass. 01532; 617-845-5050.

DEC. 14. Health Care Cost Containment conference in Chicago, sponsored by the Illinois State Chamber of Commerce; \$80 for members; \$120 for non-members. Carol Jensen, Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

DEC. 17-19. Behavior Science: A New Approach to Accident Prevention course in Los Angeles, offered by the University of Southern California; \$400 tuition. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089-0021; 213-743-6523/6524.

JAN. 10. Products Liability Insurance luncheon seminar in Montreal, sponsored by the Quebec Risk & Insurance Management Assn.; \$18. Suzan Ness, Chairman, Dominion Textile Inc., 1950 Sherbrooke St. West, Montreal, Quebec H3H 1E7; 514-989-8297.

JAN. 11-12. Preparation and Trial of a Complex Toxic Chemical or Hazardous Waste Case seminar in New York, sponsored by the Practising Law Institute; \$350. Registrar, PLI, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

JAN. 11-13. End Crisis Management seminar in Atlanta, sponsored by Retirement Advisors Inc.; \$425; \$375 for registration three weeks in advance. Retirement Advisors Inc., 919 Third Ave., New York, N.Y. 10022; 212-421-2400.

JAN. 15-16. Application of Microcomputers to Occupational Health and Safety course in San Diego, offered by the University of Southern California; \$375. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089-0021; 213-743-6523/6524.

JAN. 17. Pre-Admission Certification seminar in New York, sponsored by the Task Force on Utilization Review; free for members; \$25 for non-members. The New York Business Group on Health, Inc., 1633 Broadway, 46th Floor, New York, N.Y.

JAN. 21-25. Industrial Ventilation Fundamentals course in San Diego, sponsored by the University of Southern California; \$650. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089-0021; 213-743-6523/6524.

JAN. 23-25. 10th Annual Enrolled Actuaries meeting in Washington, sponsored by the American Academy of Actuaries and the Conference of Actuaries in Public Practice; \$275. Sue Hendrickson, AAA, 1835 K St. N.W., Washington, D.C., 20006.

JAN. 29-30. Annual Flexible Compensation conference in Washington, sponsored by Charles D. Spencer & Associates Inc.; \$400. Registrar, Charles D. Spencer & Associates Inc., 222 W. Adams St., Chicago, Ill. 60606; 312-236-2615.

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Treasury official says tax plan will affect employee benefits

Continued from page 3

Mr. Conaway noted in his remarks that every major tax bill passed by Congress in the past several years has included employee benefit provisions.

For example, the Economic Recovery Tax Act of 1981 expanded Individual Retirement Accounts so that employees who were enrolled in corporate pension plans could set up IRAs.

The next major tax bill—the Tax Equity and Fiscal Responsibility Act of 1982—rolled back and then froze the maximum benefits paid under a defined benefit pension plan and the contributions that employers can make to defined contribution plans.

DEFRA, the most recent tax law, extended the freeze on maximum pension benefits and contributions until 1988. It also placed limits on tax deductions employers can take for reserves held by tax-exempt Voluntary Employee Beneficiary Assns., also known as 501(c)(9) trusts.

Mr. Conaway also told his audience he hopes final regulations governing 401(k) plans can be published by the end of the first half of 1985. But that timetable could be indefinitely delayed if 401(k) provisions are included in major tax bills, he said.

Mr. Conaway noted that Treasury and IRS officials are divided over the so-called hardship conditions under which employees would be able to withdraw funds from 401(k) plans before retirement (BI, Nov. 5).

Harry Conaway, attorney/adviser in the Treasury Department's tax legislative counsel section, says that employee benefits have been a part of every recent major tax package, and he says "they will be linked" to the next tax package as well.

Some government officials believe that 401(k) plans, which are retirement savings vehicles, should not be tapped to finance a new home or a child's college tuition before an employee retires, Mr. Conaway said. Some, though, favor withdrawals for such purposes.

While 401(k) rules are up in the air, Mr. Conaway said the government does expect to publish rules by the end of the year to implement provisions in the 1982 and 1984 tax laws that affect top-heavy pension plans. A top-heavy plan is one in which 60% of benefits go to key employees.

Further down the road are government rules to help employers comply with DEFRA as well as the Retirement Equity Act, the law Congress enacted this summer to give female employees a better chance to earn pension service credits and collect benefits.

Mr. Conaway said increased legislative activity—which ties up regulators' time—is one reason why it takes the Treasury Department so long to develop rules after Congress passes legislation with benefit provisions. When regulators are so frequently called to Capitol Hill to testify on bills or provide technical advice, there is less and less time to write rules on previous bills enacted.

"Seventy-five percent of my

time goes to legislative issues," Mr. Conaway said, adding that "I suppose I am something of a bottleneck."

Mr. Conaway also noted that as many as 20 Treasury Department officials may become involved in drafting a rule affecting benefits and other issues, and it takes time to educate new regulators who are not familiar with an issue.

And, Mr. Conaway noted candidly that benefit rule-making does not always have the same priority as other tax issues.

For example, while 401(k) rules are important for the employee benefits community, there are many other, more serious tax issues to which regulators must first devote their time, he said.

Giles named risk manager at Inspiration Resources

Stephen R. Giles, 36, is manager of risk and insurance at Inspiration Resources Corp., a New York-based mining firm. He is responsible for risk management and insurance for the firm and its subsidiaries. He reports to John Melville, corporate director. Mr. Giles replaces Claude Bernier, now risk and insurance manager at Kidd Creek Mines Ltd. in Toronto. Mr. Giles had been manager of risk management at Schering-Plough Corp. in Madison, N.J. He received a bachelor of business administration from Fairleigh Dickinson University in Madison, N.J., in 1969 and is an Associate in Risk Management.

Stephen W. Roberts, 35, has been promoted to assistant treasurer of risk management and credit at Welch Foods Inc. in Westfield, N.Y. In this newly created position, he is responsible for risk management and insurance, portfolio management and credit operations. He will retain his responsibilities as manager of risk and insurance. He reports to Donald E. Riederer, treasurer. Mr. Roberts earned a bachelor of arts in international affairs from Lafayette College in Easton, Pa., in 1971 and is studying for a masters in business administration at St. Bonaventure University in Olean, N.Y. He is a Chartered Property & Casualty Underwriter and an Associate in Risk Management.

Byron B. Holman, 51, has

coming & goings: buyers

joined G.D. van Wagenen Co. in Minneapolis as director of risk management services. In this newly created position, he is responsible for developing insurance and related programs for the managing general agent's clients. He reports to Kent Daley, president. Mr. Holman had been vice president and corporate risk manager at First Bank System Inc. He earned a bachelor's in business administration from the University of North Dakota in 1959.

Karen M. Doolittle, 40, has joined the First Bank System Inc. in Minneapolis as vp and corporate risk manager. She is responsible for the risk management programs of more than 90 banks and reports to Albin Dubiac, vp and treasurer. Previously, Ms. Doolittle was director of risk management for Super Valu Stores Inc. in Minneapolis. She replaces Byron B. Holman, now director of risk management services at G.D. van Wagenen Co.. She earned a bachelor of business administration in 1966 and a masters of business administration in 1971.

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N.J. doctors face assessment to pay malpractice fund's debt

Continued from page 2

About 280 New Jersey insurers, licensed to write property damage and liability insurance, were mandated to participate in the association, said Hugh P. Francis, general counsel of the association.

The association, governed by a 12-member board, wrote primary insurance and reinsurance for some 3,300 physicians, 450 podiatrists and 60 hospitals, according to Laura Sanders, director of consumer affairs for the New Jersey Insurance Department.

The reinsurance association was disbanded last year when its board of advisers decided that the medical malpractice insurance market had reopened in the state, Mr. Francis said. The reinsurance association is no longer issuing new pol-

icies, but it is still paying old claims.

In the past 15 years, about 40 states have passed enabling legislation to permit the formation of such associations as a safeguard in case the voluntary market stopped writing medical malpractice coverage, Mr. Francis said.

Of those 40 states, 17 actually established associations, but five of those associations, including New Jersey's, have been deactivated.

When the New Jersey association broke up in 1983, it was left with the \$42.1 million deficit—\$34.9 million from physician-related claims and \$7.2 million from podiatrist-related claims, Ms. Sanders said.

The panel created by the insurance commissioner will recommend ways to spread an assessment to pay off this deficit and measures to reduce the frequency and cost of medical malpractice claims, she said.

For instance, the panel could recommend that all New Jersey physicians and podiatrists be assessed the same flat fee spread over several years. Or, it could suggest that those physicians whose specialties have a higher risk factor, like neurosurgeons and obstetricians, pay a higher assessment.

The panel also could recommend separating the two groups, so that physicians would be assessed to cover their \$34.9 million portion of the deficit, while the state's 519 podiatrists would pay a separate assessment to cover their \$7.2 million portion of the deficit.

If the two groups are separated, the podiatrists would end up paying a higher per-person assessment, Ms. Sanders said. This is because \$7.2 million would be paid by only 519 podiatrists, while \$39.9 million would be paid by the state's approximately 13,000 physicians.

Health care practitioners are questioning the fairness of assessing all providers in the state.

There is "great opposition" to assessing physicians who were never covered through the reinsurance association, said Peter Sweetland, president of the Medical Inter-Insurance Exchange, a physician-formed insurance company in Trenton.

"We think a surcharge (assessment) is warranted. . . . Who gets the surcharge remains under discussion," he said.

The legality of assessing all practitioners also is a factor to consider, said the reinsurance association's Mr. Francis.

"I think it's going to get more complicated. . . . I wouldn't be surprised if there will be litigation," he said.

"The situation (facing medical malpractice reinsurance associations) generally speaking is not good," said Peter Bies, president of the Medical Malpractice Insurance Assn., a physician and hospital insurer in New York.

For example, the Medical Malpractice Insurance Assn., New York's counterpart to New Jersey's deactivated reinsurance fund, has assets of \$250 million and liabilities of \$500 million, he said. ■

Poultry processor joins TRY program

WASHINGTON—The Occupational Safety and Health Administration has approved the Horace W. Longacre poultry processor in Franconia, Pa., for the TRY program. This is the first poultry processor to be approved for a voluntary protection program.

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Fireman's Fund relocates financial group

Fireman's Fund Insurance Cos. is relocating its financial insurance operation from Novato, Calif., to New York in a move it believes will generate additional business for the unit.

Lewis L. Glucksman will become executive vice president of the financial insurance group, which provides municipal bond insurance, note and lease coverages and municipal bond guarantees.

The move will give the group better access to the financial community and opportunities through another American Express Co. unit, Shearson Lehman/American Express, said William M. McCor-

markets

mick, Fireman's Fund chairman and chief executive officer.

"Financial insurance is a relatively new, but fast-growing and profitable business," he said. "Lew Glucksman's investment banking experience, combined with our existing insurance expertise, give us an important edge."

Transamerica

Transamerica Insurance Co. is restructuring its U.S. agency opera-

tions in an effort to work more closely with clients.

The company, the major property/casualty insurance subsidiary of Los Angeles-based Transamerica Corp., will replace its present branch structure with a network of 15 regional offices.

"With this change, authority, responsibility and accountability are clearly delineated," explained Gerald A. Isom, president of the company.

"That will mean the best management and most efficient operation possible at the level closest to our agents and customers."

The regional offices will be re-

sponsible for branch offices and other field facilities in their areas.

Charter affiliates

Metropolitan Life Insurance Co. in New York has agreed to pay Charter Co. \$52 million in cash for three of its life insurance subsidiaries at the time of the sale and \$32 million in five years.

The company said the group of banks that holds a security interest in the Charter units has agreed to the sale. Final approval has to come from state insurance departments and the judge overseeing Jacksonville, Fla.-based Charter's reorganization under Chapter 11 of the Federal Bankruptcy Code.

The three Charter Security Life Insurance Cos., which weren't part of the bankruptcy, are in New Jersey, New York and Louisiana.

New salvage firm

A new company, Michael A. Mentuck & Associates Inc. in Salem, Mass., offers salvage and appraisal services.

Michael A. Mentuck, owner of the firm, said his company offers assistance in reconditioning and disposition of damaged property. The firm will also provide loss-control consultant services.

The firm is located at 240 Canal St., Salem, Mass. 01970; 617-744-7813.

New ISU member

I. Berman Co. Inc. of Montgomery, Ala., has joined ISU/Insurers-Group, a franchise network of independent agents and brokers.

Mergers/acquisitions

The Roy L. Geesey Agency and the Arthur J. Glatfelter Agency, both of York County, Pa., have merged to form the Geesey, Glatfelter & Zarfoss Agency Inc. The new agency becomes part of the Glatfelter Insurance Group and will operate from its headquarters at 183 Leader Heights Road, York, Pa. 17402; 717-741-3868.

James & Co. Inc., an insurance agency, has merged with INA/National Insurance Associates and will operate from the INA/National office at 66 Route 17, Paramus, N.J. 07652; 201-845-6600.

New offices

National Risk Management Inc. has moved its office to 2682 Bishop Dr., Suite 116, San Ramon, Calif. 94583; 415-833-2530 (administration), 415-833-2533 (legal).

Hospital Insurance Services Inc., which underwrites hospital medical malpractice and general liability on behalf of Fremont Indemnity Co., has moved to 1709 W. 8th St., Los Angeles, Calif. 90017; 213-484-4676.

Fleming & Associates, a claims administration firm in La Canada, Calif., has opened a new office at 150 Cayuga St., Suite 15; Salinas, Calif. 93902; 408-424-0410.

Bierly & Associates, a claims administrator in South Pasadena, Calif., has opened a new office at 720 Olive Way, Seattle, Wash. 98101; 206-223-1240.

Applied Risk Funding Services is located at 25201 Paseo de Alicia, Suite 104, Laguna Hills, Calif. 92653; 714-770-9722.

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PBGC considers earlier premium payment

By JERRY GEISEL

WASHINGTON—The Pension Benefit Guaranty Corp. is considering a plan to make large employers pay termination insurance premiums earlier in the year.

The PBGC said last month it may propose that premiums for employers with 500 or more participants in their pension plans be due no later than 60 days after the close of the plan year. Now, premiums are due no later than seven months after the end of the plan year.

"This amendment is needed to bring the PBGC practice in line with the collection practices of other governmental programs and typical insurance industry practice," the PBGC said.

Establishing new deadlines would mean millions of dollars in additional income for the PBGC, since the agency would have more time to invest the money.

Currently, the PBGC charges employers with defined benefit pension plans an annual premium of \$2.60 per plan participant. The money is used to pay guaranteed benefits to participants when plans are terminated without enough assets to pay promised benefits.

Employers who want more information about the proposed change in the premium due date may contact Renae Hubbard, Special Counsel, PBGC, Corporate Policy and Regulations Department (611), 2020 K St. N.W., Washington, D.C. 20006; 202-254-6476.

Safer workplaces

Workplaces are becoming safer, according to federal statistics.

The number of work-related deaths declined last year to 3,100, down from 4,090 in 1982, says a Bureau of Labor Statistics survey.

The annual survey, which covers employers with more than 10 employees, also found that the number of workplace injuries dropped to 4.74 million last year, down from 4.75 million in 1982.

Other key findings include:

- Some 36.37 million lost workdays resulted from work-related injuries, up slightly from 36.11 million in 1982.

- The number of injuries involving lost workdays declined to 2.140 million from 2.141 million in 1982.

- Insurance, finance and real estate had the lowest occupational and illness rate: two per 100 workers, unchanged from 1982.

- The construction industry had the highest injury and illness in 1983: 14.8 per 100 workers, compared with 14.6 in 1982.

- About 30% of the 3,100 job-related fatalities last year resulted from car and truck accidents.

New pension agency

The Labor Department's Office of Pension and Welfare Benefit Programs has completed an 11-month reorganization.

The OPWBP, which had been part of the department's Labor-Management Services Administration, now is a separate office reporting to the Secretary of Labor.

As part of the reorganization, Alan Lebowitz, former assistant administrator of the Office of Fiduciary Standards, has been promoted to deputy administrator of the OPWBP. He and Morton Klevan, the other deputy administrator, report to Robert Monks, the administrator of the OPWBP.

Branches of the OPWBP and their top officials include: Office of Enforcement, Charles Lerner; Office of Regulations and Interpretations, Elliott Daniel; Office of Policy and Research, Richard Ippolito; Office of Information Management,

washington

Mervyn Schwedt; Office of Program Services, June Patron; Division of Fiduciary Interpretations, Ivan Strasfeld; Division of Reporting and Disclosure, Howard Hensley; Division of Exemptions, Peter Straub; and Division of Research, Walter Kolodrubetz.

Military benefits board

President Reagan has appointed A. Haeworth Robertson, a managing director in the Washington office of benefit consultant William M. Mercer-Meidinger Inc., to chair a newly created board of actuaries that will oversee financing policies of the military retirement system.

Mr. Robertson, 54, who was chief actuary of the Social Security Administration between 1975 and 1978, will serve a 10-year term on the three-member board.

Other board members are John H. Grady, a partner in the actuarial, benefits and compensation division of Coopers & Lybrand in New York, and Thomas P. Bowles Jr., 68, a principal and advisory director of Tillinghast, Nelson & Warren, an Atlanta-based employee benefit consulting and actuarial firm. Mr. Gray has a 15-year term, and Mr. Bowles has a five-year term.

The military retirement system covers 3 million people on active or reserve duty and pays monthly retirement or survivors' benefits to 1.4 million people.

The system's unfunded liability

has been estimated at up to \$600 billion, Mercer-Meidinger said.

Tax status of benefits

Will Congress next year revise the current tax-favored status of employee benefits?

Recent statements made by some key legislators suggest that employee benefits could be in for a rough time next year.

Those suggesting tax changes and their comments include:

- Rep. J.J. Pickle, D-Texas, chairman of the House Ways and Means Social Security subcommittee: "While a great deal of good comes from these (employee) benefits, it must be recognized they also cause a significant erosion of the tax base. We cannot let business and employees continue to have it

both ways—without Uncle Sam being the loser."

- Sen. Robert Dole, R-Kan., chairman of the Senate Finance Committee: "To the extent narrowing the tax base causes pressure to increase marginal tax rates, these tax-free benefits will appear to be free, because ultimately every taxpayer will have to pay for them in the form of higher taxes on the portion of his compensation that is subject to taxes."

- Rep. Daniel Rostenkowski, D-Ill., chairman of the House Ways and Means Committee: The continued tax-free status of educational assistance and group legal benefits "should be considered... in the context of a comprehensive examination next year of the exclusion of statutory fringe benefits from the income, wage and benefit bases." ■

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Tax probe of Lloyd's syndicates continues

By STACY SHAPIRO

LONDON—The Inland Revenue, Britain's equivalent of the Internal Revenue Service, is continuing its probe of Lloyd's of London syndicates, Lloyd's Chairman Peter Miller told members at Lloyd's annual general meeting Nov. 7.

In April, the tax agency launched an investigation of nearly 200 Lloyd's underwriting agencies to see if back taxes may be owed by members (*BI*, April 30).

Mr. Miller said that the Inland Revenue has:

- Challenged some underwriting agents' 1981 accounts, which just closed under Lloyd's three-year accounting system. The names on the affected syndicates have been given estimated tax assessments for this year by the In-

london line

land Revenue and could be liable for additional taxes.

- Turned down Lloyd's suggestion to bargain a general agreement on back taxes affecting all syndicates, though Mr. Miller did not explain the contents of the agreement. The Inland Revenue will examine each syndicate separately.

- Decided to review the tax implications of various reinsurance arrangements of the syndicates.

- Decided to review the tax implications of syndicates' reinsurance to close arrangements.

Under Lloyd's three-year accounting system, reinsurance to close lets syndicates carry outstanding losses to future years.

"The Revenue has a right and a duty to satisfy itself as to the validity of the sums of money involved," Mr. Miller said. "The problem of adequate reserves for past liabilities is critical for the whole insurance industry."

Besides explaining the tax issue to members, Mr. Miller also told them that the Council of Lloyd's will change its focus next year.

In 1985, the Council will focus less on new regulations and more on improving management of underwriting agencies and the market services Lloyd's requires.

Next July, Lloyd's will re-register all underwriting agencies to "ensure that within the agencies, a satisfactory standard of management" exists, Mr. Miller said.

Through re-registration, the Council can make sure that all the

underwriting agencies meet the requirements of the bylaw on underwriting agencies passed in October.

Mr. Miller also said the Council wants to improve Lloyd's claims and policy handling in 1985, as the market plans to move to an electronic computer system proposed for the new Lloyd's building.

Lloyd's broker closes

A small Lloyd's of London broker that produced most of its business from the United States is no longer trading, after failing to meet Lloyd's financial requirements.

Greenway Insurance Brokers Ltd. voluntarily suspended itself from trading Nov. 14, after it failed to meet Lloyd's requirements regarding the solvency of brokers.

Lloyd's issued a statement that

Greenway executives indicated certain irregularities "may have arisen concerning the company's account for periods prior to the acquisition of the business in 1982."

A Lloyd's spokesman said that before 1982 Greenway was owned by Padway Holdings Ltd.

The spokesman said that Greenway now is owned by its directors, including R.A.H. Greenway.

A spokesman for Mr. Greenway referred inquiries to Lloyd's.

Greenway has instructed accountants Coopers & Lybrand to investigate the company's accounts, according to the Lloyd's statement.

Greenway's annual revenues are about 200,000 pounds (\$250,000), the statement said. About 60% of its business comes from the United States, a Lloyd's spokesman said.

The Council of Lloyd's has assumed authority for Greenway's U.S. dollar accounts. Lloyd's is also guaranteeing that any valid claims under Lloyd's policies placed through Greenway will be paid.

Members' bylaw

Lloyd's of London members' resignations can only be effective at the end of an underwriting year, according to a new bylaw passed by the Council of Lloyd's.

The move follows Lloyd's High Court victory in a case involving two former directors of Alexander Howden Group P.L.C., Alan Page and Jack Carpenter. The men, who face disciplinary proceedings at Lloyd's, had tried to resign their membership, but Lloyd's said—and the court agreed—that they could only resign at the end of the year.

Lloyd's Council

Seven spots on the Council of Lloyd's were filled during a recent election.

The four new working members of the Lloyd's Council are:

- Henry Roy Dobinson, director of Robert Bradford (Underwriting) Ltd.

- Richard Ballantyme, underwriter for syndicates managed by Sedgwick Forbes (Lloyd's Underwriting Agents) Ltd.

- Peter Thomas Daniels, underwriter for syndicates managed by Lamber Brothers (Underwriting Agencies) Ltd.

- Alan Parry, chairman of Carter Brito e Cunha Ltd.

Three of the external members on the current council were re-elected. They are:

- Christopher Davidge, a landowner and director of several companies, including Concrete Holding P.L.C.

- Colin Baillieu, a business consultant.

- Robert Elborne, consultant for lawyers Elborne Mitchell & Co.

The new external member is John Andrews, a retired banker.

No SEC for Britain

A Securities and Exchange Commission for Britain's financial industry is not being considered by the British government even though the government is tightening its regulation of industry, a Cabinet minister says.

"With all due respect to the lawyers amongst us, we do not want to impose a commission with a detailed set of statutes and regulations which would require you to have a legal eagle at your elbow every time you do business with each other," said Alex Fletcher, minister with responsibility for corporate and consumer affairs for the Department of Trade and Industry.

Instead, Mr. Fletcher feels the government prefers to set up self-regulatory bodies within the financial service industry. ■



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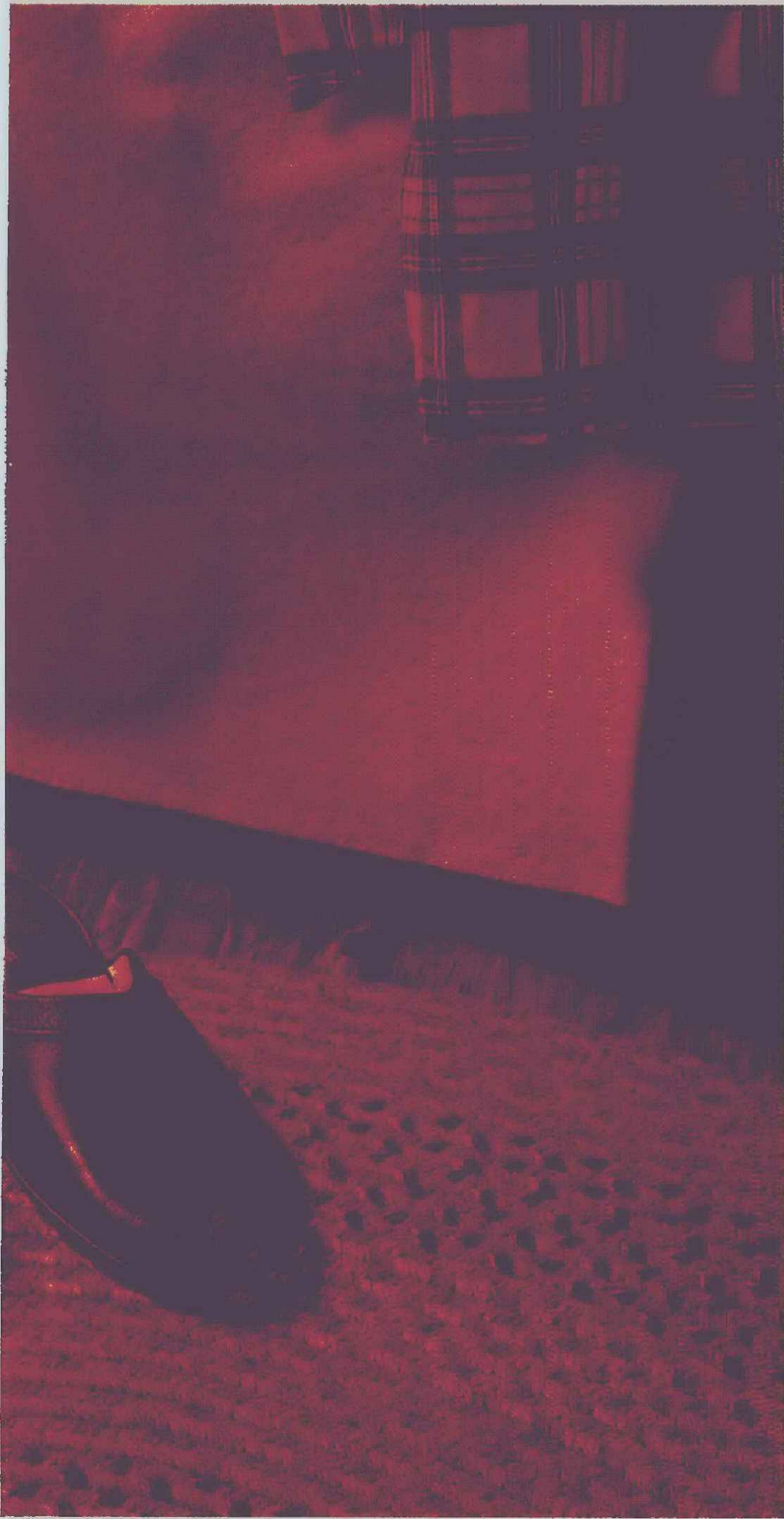
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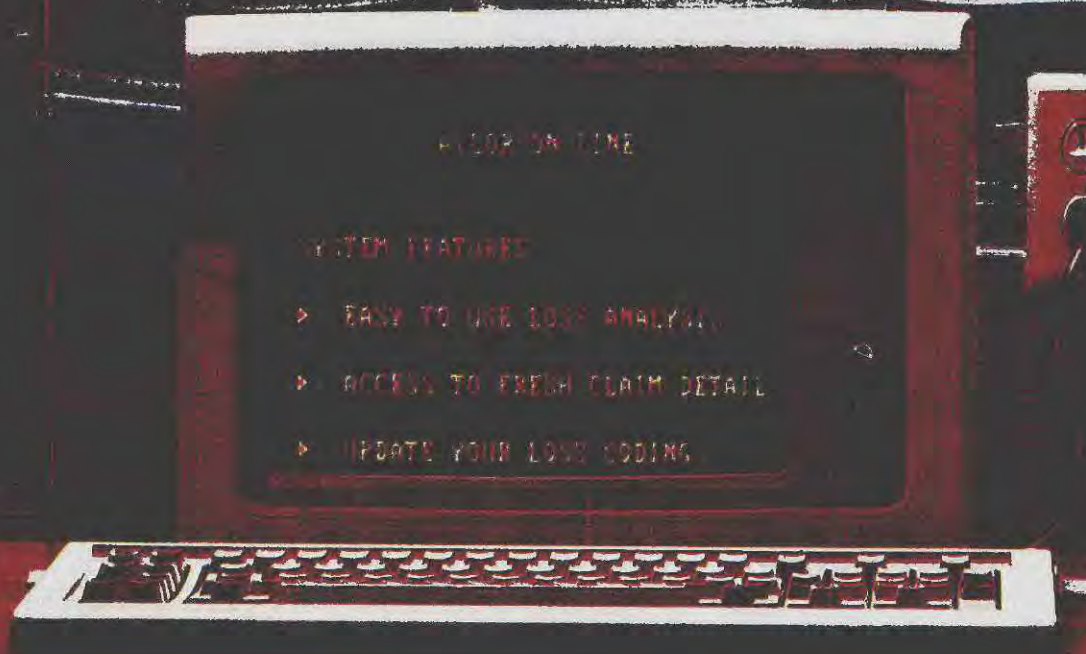
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TREATING MEDICARE'S ILLS

Employers must make views heard as Congress weighs options

By William J. Arnone

WHILE CONGRESS has just tinkered with a small part of Medicare's problems in the Deficit Reduction Act of 1984, there are strong indications that interest and attention in the political arenas are rising to a level that matches the seriousness of the program's ills and the need for a comprehensive, long-term cure.

The 1985 legislative agenda most likely will find Medicare near the top. Congress may remain content, however, with more piecemeal efforts and wait until the latter part of the decade to come up with a comprehensive remedy, perhaps under emergency conditions.

Employers as well as current employees and retirees have a large stake in the effort to keep the Medicare program solvent. Solutions no doubt will reflect the apparent success of the 1983 Social Security Amendments formula—something to offend almost everyone. Indeed, some members of Congress are suggesting the convening of another bipartisan commission to reform Medicare, modeled after the National Commission on Social Security Reform.

This balancing act could tilt the wrong way if employers do not examine carefully and articulate clearly to Congress the possible ramifications of proposed changes in areas that might not be immediately obvious.

The 1984 annual report of Medicare's trustees indicates that under intermediate assumptions, the Medicare Part A (hospital insurance) trust fund will run out of money in 1991 if no action is taken. By 1995, the fund will have a deficit of more than \$200 billion. According to the Medicare trustees, either the fund's outlays must be cut by 32% or revenues must be increased by 48% to restore the Part A trust fund to a sound fiscal footing over the next 25 years.

The Medicare Part A trust fund, which is financed by Social Security payroll taxes, has in the past maintained a significant surplus. However, in recent years the Part A fund has come under great pressure, because of seven factors:

- Unprecedented escalation in health care costs.
- Expensive health care technology.
- Increased numbers of Medicare enrollees.
- Increased longevity of older individuals.
- A growing volume of covered services.
- Substantial loans to the Social Security Old Age and Survivors Insurance trust funds.
- A reduction of the payroll tax rate allocated to Medicare between 1974 and 1978.

Expenditures under Medicare Part B (medical insurance) also are escalating rapidly.

It was originally the intention that the premiums from voluntarily enrolled eligible individuals would finance approximately one-half of Part B costs. However, inflation, political pressure and legislative changes have resulted in nearly 75% of the cost of Part B being provided through general revenues from the U.S. Treasury.

The wide variety of solutions that have been proposed can be grouped into eight categories. These categories are interrelated and overlap. Yet, each category of solutions has potential problems for employers and their benefit plans.

Cost controls on providers

This solution seeks to curtail the growth of outlays by limiting the amounts that Medicare reimburses providers of health services. A major step in this direction has already been taken with the establishment of a prospective payment system for hospitals based on set reimbursement schedules for diagnostic-related groups of services, or DRGs.

The most significant current example of this type of solution is legislation that was introduced by Sen. Edward Kennedy, D-Mass., and Rep. Richard Gephardt, D-Mo. Called the Medical Solvency and Health Care Financing Reform Act of 1984, the bill would address Medicare's problems through a two-phase comprehensive cost-containment system that would neither increase payroll taxes nor raise out-of-pocket expenses for beneficiaries. Instead, this bill would build upon the DRG

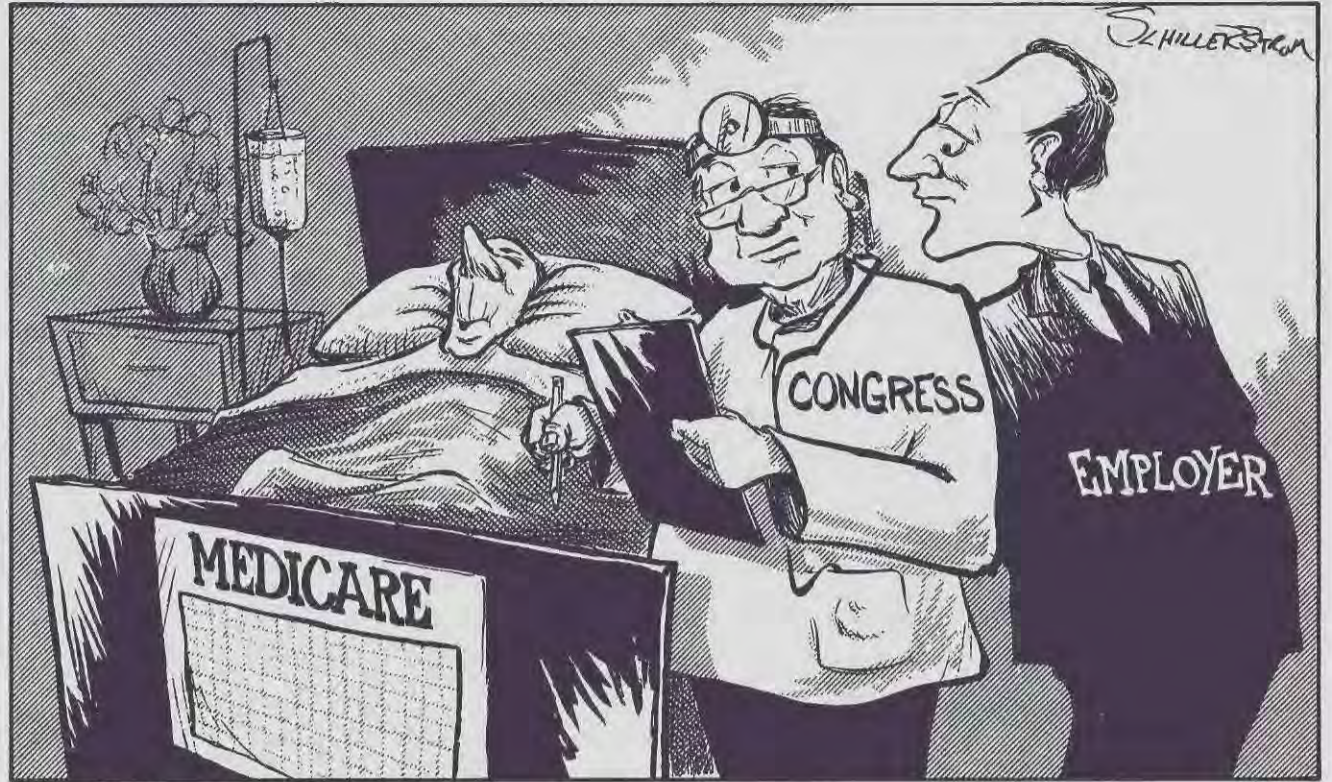


Illustration: Roger Schillerstrom

system for hospitals and gradually extend it to all providers of health services.

The bill's sponsors estimate that the measure would save Medicare about \$1 trillion through 2005. The sponsors plan to reintroduce the measure in the next session of Congress.

A more limited cost-control approach is one of the recommendations of the 1982 Advisory Council on Social Security. The council recommended that the secretary of health and human services further limit any annual boost in DRG rates by eliminating an extra increase for technological advances. From 1988 through 1995, according to the council, this proposal would save the Part A trust fund nearly \$35 billion.

In DEFRA, Congress has taken further steps in the direction of controlling costs. These steps include limiting (somewhat) future increases in DRG rates; freezing the level of payments to physicians under Part B's "reasonable charge" system until Sept. 30, 1985; instituting an elaborate system of price monitoring and sanctions to prevent physicians from increasing their charges to Medicare patients; and establishing incentives to encourage doctors to accept assignment, under which they agree to bill patients no more than the difference between Medicare's benefit payment and its approved charge for all Medicare services.

A major problem with this type of remedy, however, is that it runs the risk of shifting the costs of health care from Medicare to individuals and private payers, like employer health care programs. DEFRA's price controls already have been criticized as unworkable and possibly counterproductive if they result in lower rates of physician participation in Medicare.

The Kennedy-Gephardt bill, or similar measures, would attempt to control costs in both the public and the private sectors. Whether it actually would curtail cost-shifting is questionable.

Cost sharing by beneficiaries

This solution seeks to increase the share of costs paid by Medicare beneficiaries through higher deductibles, coinsurance and premiums. These changes would result in considerable Medicare savings, but would also increase, perhaps substantially, out-of-pocket costs for beneficiaries. To the extent that employer-provided health care plans for retirees are integrated with Medicare, this solution would increase expenses for employers.

Greater cost-sharing can take different forms, including:

- Higher deductibles and coinsurance payments under Part A.

- Introducing a premium under Part A.
- Higher deductibles and coinsurance payments under Part B.

Higher premiums under Part B. Greater cost-sharing in the form of increased deductibles and coinsurance payments by beneficiaries under Part A would directly affect only the approximately one out of four Medicare beneficiaries who is hospitalized during a year; most of these are over age 75.

On the other hand, greater cost-sharing in the form of higher premiums or deductibles for Part B coverage or, as some have suggested, the introduction of premium to help finance Part A, would spread cost-sharing more widely.

Increasing premiums would affect all Medicare enrollees, since they would have to pay these premiums, whether or not they receive Medicare-covered services. Virtually all Medicare enrollees also would have to pay a higher annual Part B deductible, since nearly all have covered medical expenses each year.

Similarly, raising beneficiary coinsurance payments under Part B, which are currently 20% of Medicare's approved charges, would affect the great majority of Medicare enrollees.

In DEFRA, Congress has changed the formula for determining Part B premium increases with the likely result that future premiums will be higher for enrollees. It is estimated that Part B monthly premiums will be \$19.10 in 1986, or 8% higher than under the previous formula, and \$21.30 in 1987, or 14.5% higher.

The Reagan administration appears to favor this type of solution to Medicare's crisis. The administration has proposed coinsurance payments of \$28.50 per day for the second through the 15th day of hospitalization in a Medicare benefit period and \$17.80 per day for the 16th through 60th day, but no coinsurance thereafter.

Under current law, after a deductible of \$356 for the first day of hospitalization, a Medicare beneficiary pays no coinsurance charges for the second through 60th day. From the 61st through the 90th day, Medicare patients pay \$89 per day. For a single lifetime extension of benefits, from the 91st through the 150th day, they pay \$178 per

Continued on next page



William J. Arnone is a benefits consultant with Buck Consultants Inc. in New York.

Employers should make views on Medicare heard

Continued from preceding page day. These coinsurance amounts increase automatically each year.

The Reagan administration's Medicare proposal would affect employer group health plans that coordinate with Medicare on one of three bases:

- Coordination of benefits basis. The employer plan pays the lesser of normal plan benefits or the amount necessary to pay 100% of expenses.
- Equivalency basis. The employer plan pays whatever amount is necessary to provide the Medicare-eligible individual with the same total benefit as an employee who is not eligible for Medicare.
- Carve-out basis. The employer plan deducts Medicare benefits from the total covered charges and then applies normal plan benefits to the balance.

In this example, the employer health plan has a \$100 deductible, then pays 80% of the first \$10,000 and 100% over that amount. The individual is hospitalized for 10 days at \$185 per day for room charges, plus \$1,500 in extra hospital expenses. The surgeon's fee is \$1,000 and is considered reasonable and customary by the employer plan, but Medicare Part B recognizes only \$600 as an approved charge. In this example, the annual Part B deductible of \$75 had been spent.

The employer plan benefits would be \$3,400 for an active employee.

Under current law, Medicare would pay \$3,474 out of the total bill of \$4,350. Under the administration proposal, Medicare would pay only \$3,217.50, or \$256.50 less.

Under coordination of benefits, this leads to a direct increase of \$256.50 to the employer's plan. Lesser increases would result in other approaches.

The impact of this proposal on the three types of employer plans is:

- A COB plan would pay \$876 in benefits under the current law and \$1,132.50 under the Reagan proposal.
- Equivalency would pay nothing under the current law and \$182.50 under the Reagan proposal.
- A carve-out plan would pay \$620.80 under the current law and \$826 under the Reagan proposal.

Solutions that would increase beneficiary cost-sharing could have significant implications for employers.

Many employers could find themselves faced with either freezing their pickup of Medicare deductibles and coinsurance payments, therefore risking retiree dissatisfaction over higher out-of-pocket costs, or shouldering more of the financial burden. Attempts to strike a balance will involve health plan redesign and more administrative complications.

Enhancing competition

This solution attempts to rely more on free-market mechanisms to reduce Medicare outlays. Proponents would build incentives into Medicare for beneficiaries to either reduce unnecessary use of health services or shop around for lower-priced care. Ideally, this would introduce more competition among hospitals and doctors to provide services more economically in

order to attract Medicare consumers.

While variations of this solution often require exposing beneficiaries to increased costs, its fundamental element usually is the introduction of a voucher system for the elderly and disabled. The 1982 Advisory Council, for example, recommended the introduction of a voluntary voucher system modeled after the current Federal Employees Health Benefits system. A voucher system would reward Medicare enrollees with lower out-of-pocket costs if they were able to obtain lower-priced care or private insurance in the health market.

The Advisory Council also favored taxing employees for employer contributions to health care plans above a certain level. In theory, this could encourage employees to "shop around" for lower-cost care and thus help control the increase in health care costs in the private sector and, by extension, for Medicare.

There is currently little support among employers or employees for taxing any portion of employer contributions to health care plans, which is another option that Congress may consider. Furthermore, it is far from clear that this approach will actually control Medicare costs.

Tax increases

This solution would raise taxes in order to generate additional revenues for Medicare. It would result in taxpayers paying more in order to finance health costs for Medicare beneficiaries. Proponents would typically increase the

FICA payroll tax rate paid by employees and employers to finance Part A.

A variation on this theme is offered by those who would maintain the payroll tax rate as currently scheduled, but either reallocate more of it toward the Part A trust fund or widen the definition of wages subject to payroll taxes.

Other tax sources also are often pointed to, such as more general revenue appropriations, a surcharge on personal income tax to be diverted to Medicare or increased excise taxes with proceeds earmarked for Medicare.

In light of the planned increase in the Social Security payroll tax rate as well as past increases, there probably will be much resistance to increased payroll taxes to help resolve the Medicare crisis. Employers may have to guard against attempts to raise the employer payroll tax rate but not the employee rate. Increases in general revenue appropriations would accentuate an already unprecedented federal deficit, unless offset by reductions in other federal expenditures.

Eligibility delays

This solution would delay the age of eligibility for Medicare, thus shortening the period of Medicare coverage. The Advisory Council favored this approach. It recommended that, on a phased basis, the age of eligibility for Medicare be raised to 67 from 65. It urged a much faster timetable than the gradual increase in the age of eligibility for unreduced Social Security retirement benefits enacted into law by the 1983 Social Security Amendments. The council added that the eligibility should be further increased after 1990, according to future increases in life expectancy.

This approach deals head-on with one aspect of the demographic cause of Medicare's condition by reducing in the future the number of years of coverage for eligible individuals. Of all the council's recommendations, this is the big-ticket item. If implemented exactly as suggested, the council estimated it would save the Part A trust fund almost \$75 billion through 1995. The Part B trust fund would also reap nearly \$5 billion in savings.

Suggestions to delay eligibility are controversial. Many interest groups are certain to object to raising the age at all. Others, who might accept the argument that average life expectancy since Medicare's inception in 1966 has increased enough to justify a higher eligibility age, will strongly oppose placing Medicare eligibility out of line with Social Security's normal retirement age.

Indeed the council's basis for decoupling the age of eligibility for Medicare from that for Social Security is shaky. It pointed to the growing number of people receiving Social Security benefits between ages 62 and 65, despite having to wait until 65 to receive Medicare's protection.

The council overlooked the role of employer-provided health insurance coverage for retirees to fill the gap in health care protection until Medicare coverage begins. It did not consider what proportion of people who apply for Social Security retirement benefits before age 65 do so without the protection of employer-based health insurance. Furthermore, those who do not apply for Social Security until age 65 might include many who could least afford additional delays in Medicare eligibility.

Continued on page 24

Punitive award not due in coverage dispute

The purpose of awarding damages for breach of contract is compensatory, not punishment, and only in cases involving a particularly aggravated, willful breach will punitive damages be awarded, a federal appellate court ruled.

On March 25, 1980, Aetna Casualty & Surety Co. issued an insurance policy to Norman's Heritage Real Estate Co. providing coverage of \$9,000 for damages or loss to equipment and furnishings from fire as well as loss of business earnings resulting from business interruption. On Aug. 4, 1980, a fire in an adjacent building spread to Heritage's property, causing a near-total loss. There was no dispute over the evaluation of the property loss, as the actual loss exceeded the coverage. But, the parties disputed the loss of earnings. Heritage sought \$51,160 for interruption of business and \$100,000 in punitive damages for Aetna's willful and intentional failure to pay a valid claim. The trial court allowed recovery of \$22,500 for business interruption but denied a jury award of \$10,000 for punitive damages.

The appellate court said punitive damages are not compensatory but to punish a party whose action is malicious, reprehensible and intentional. "The principal purpose of the award of punitive damages," the court said, "is to punish the

legal briefs

wrongdoer and to deter others from acting in the same way as the wrongdoer." The court said an insurer is liable in tort for a willful, malicious, bad-faith refusal to pay only a valid claim. Since there was a valid, legitimate dispute over coverage, resort to a judicial forum to settle the dispute did not constitute per se bad faith or unfair dealing on Aetna's part, the court said. *Norman's Heritage Real Estate Co. vs. Aetna Casualty & Surety Co.*, U.S. Court of Appeals for the 10th Circuit, Jan. 27, 1984 (BI/01/D.-\$5).

Unexplained fall compensable

An unexplained fall on an employer's premises during working hours while an employee was performing required duties was compensable if the employee showed it was not caused by idiopathic factors, the Supreme Court of Oregon ruled.

Peter Russ had finished a full eight-hour shift sorting onions on a production line for his employer, Phil A. Livesley & Co. He was walking down a crowded aisle to a time clock to punch out when he unaccountably fell and broke his right hip. While crowded, the area was free from any substance that would account for a fall. Also, Mr. Russ denied getting dizzy or losing consciousness. He filed for benefits. The employer and insurer denied liability. However, the Workmen's Compensation Board allowed benefits.

On appeal, the employer said that an unexplained fall was non-compensable. The court said Mr. Russ' accident occurred during the course of his employment, as he was required to walk to the clock to punch out. The court also was satisfied that no

idiopathic factor caused the fall. Hence, the court said the fall was compensable. *Phil A. Livesley vs. Russ*, Supreme Court of Oregon, Nov. 15, 1983 (BI/02/D.-\$5).

Bad advice is not advertising

Allegedly bad advice given by a bank to a customer about a proposed business transaction was not covered by an insurance policy for "advertising injury," the Supreme Court of New Hampshire ruled.

The First Bank & Trust Co. was insured by New Hampshire Insurance Group under a policy that included coverage against "personal injury or advertising injury... arising out of the conduct of the named insured's business." Subsequently, the Gardners sued First, claiming a breach of contract for failing to give proper advice regarding their purchase of a business. They also claimed the bank had acted negligently in the giving of the advice and assistance.

First submitted the claim to the insurer, which denied coverage. First then brought suit to determine if the Gardners' claim was covered under the policy. The trial court ruled in favor of the insurer.

The appellate court agreed that the insurer was not required to cover the claim, saying the mere explanation of bank services to the Gardners in a private office could not be considered "advertising," and that an alleged failure on the part of the bank to provide an advertised service did not result in an "advertising injury" under the insurance policy. *First Bank & Trust Co. vs. New Hampshire Insurance Group*, Supreme Court of New Hampshire, Dec. 30, 1983 (BI/03/D.-\$5).

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

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Construction creates special loss exposures

By the Insurance Institute of America

The following question and answer is drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the types of questions asked, and possible answers to, the three examinations for the Associate in Risk Management designation.

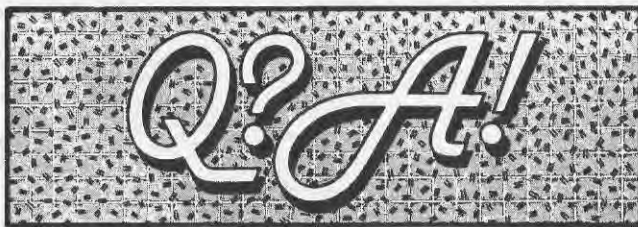
Construction projects involve special loss exposures, not only for the building owner, but also for the contractor. This week's question focuses on some options beyond insurance through which the contractor can deal with some of these exposures.

Q: Constructing a building exposes a building contractor to property and liability loss exposures while the building is under construction and to additional liability loss exposures after the building has been completed. Insurance is not generally available to cover adequately all these property and liability loss exposures facing a contractor. This unavailability of insurance protection increases the importance of effective risk control measures for a building contractor.

• Briefly describe three property or liability loss exposures arising out of the construction of a building for which a building contractor generally cannot purchase insurance.

• Describe in detail how three property or liability loss exposures that a building contractor faces in connection

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.



A.R.M. exercises

with the construction of a particular building can be minimized through:

1. Proper operating procedures and quality controls.
2. Provisions of the construction contract between the contractor and the entity for which the building is being constructed.

A: • Three property or liability exposures for which the contractor generally could not purchase insurance are liability for breach of implied warranties of workmanship or materials, a loss exposure that may require the contractor to rebuild, at its own expense, portions of the structure that do not comply with these warranties; liabilities or fines or penalties imposed under local, state or federal safety statutes; and liabilities for environmental pollution, which may give rise to both civil suits and criminal penalties for violations of statutes or regulations designed to protect the environment. (Note: While these three exposures focus on liability rather than property losses, an appropriate answer could be confined only to property loss exposures or could mix both property and liability loss exposures.)

- 1. One set of proper operating procedures and quality controls that could help minimize these three generally uninsurable liability exposures would involve careful

inspection of materials and detailed monitoring of the construction process, using both blueprints and building codes as guidelines, to assure that no implied warranties of workmanship or materials would be breached.

Second, proper operating procedures should include diligent adherence to both Occupational Health and Safety Administration standards and local and state statutes regarding work safety in order to minimize the exposure to fines, penalties or injunctions that might stem from violation of these federal, state or local statutes.

Third, the personnel in charge of construction should be aware of potential sources of environmental pollution arising from the project and should regularly monitor the construction activity to make sure that all applicable regulations are followed.

All three of these generally uninsurable liability loss exposures could be controlled by following some generally sound operating procedures. These procedures include carefully selecting employees and subcontractors; hiring a safety director to issue guidelines for, and to constantly monitor, the construction process; and using a critical path method to schedule construction work to assure its timely completion in conformity with the construction contract.

2. In the contract with the landowner, the building contractor could reduce its exposures by, first, transferring, in as clear a wording as possible, responsibility for these loss exposures to the landowner; second, including in the contract the *force majeure* clause, which would excuse the contractor from completing the construction project if a significant change in conditions of applicable laws made the performance of the contract impossible; and, third, barring landowner from bringing suits against the subcontractors (and, therefore, indirectly against the primary contractor) for any losses for which the landowner has agreed to relieve the primary contractor.

Employers should make views on Medicare heard

Continued from page 22

Faced with delays in Medicare eligibility, employers may respond by continuing coverage to retirees for the period of the delay, thereby bearing the full brunt of cost-shifting from Medicare. Or, they may maintain current coverage only up to age 65, leaving older retirees on their own to obtain health insurance until they are eligible for Medicare. A third option could be to continue coverage for retirees, but require them to pay more of the costs.

Catastrophic coverage

This solution would alter the thrust of Medicare's benefit package by increasing its protection against long-term illnesses that can wipe out a lifetime of savings, in return for decreasing Medicare's role in short-term hospital stays.

It would therefore shift Medicare's responsibilities under Part A away from full coverage for hospitalization for the great majority of beneficiaries toward total coverage for catastrophic care on behalf of the relatively small percentage of beneficiaries needing such care. This solution also could increase costs for most beneficiaries and for private health plans that are integrated with Medicare.

One catastrophic care model has been put forward by Peter Drucker of the Claremont Graduate School in Claremont, Calif. His plan would require every Medicare beneficiary to pay in full for health care expenses up to a certain percentage of pretax income. Health care expenses above this figure would be paid in full by Medicare.

"Catastrophic illness Medicare," according to Mr. Drucker, would provide virtually full reimbursement of health

costs for low-income elderly. For all other beneficiaries, Medicare would provide full protection against catastrophes like chronic or terminal illness, long-term nursing home care or high-technology treatment, most of which have higher occurrence probabilities with advancing age and can ruin a patient financially.

While these approaches would target Medicare dollars more toward long-term care at the expense of Medicare's current concentration on acute episodes of illness, others would expand Medicare coverage in a different direction, namely preventive and diagnostic services. They argue that Medicare's lack of coverage for these types of services may discourage preventive care and early treatment, thereby leading to greater costs of care in the long run.

A catastrophic approach may make sense, but it may well result in shifting much of the cost of non-catastrophic illness to employers.

Direct cost-shifting

Under the Tax Equity and Fiscal Responsibility Act of 1982, employers must offer their employees aged 65 through 69 the option of selecting the employer's group plan as their primary health insurance. If employees choose, Medicare becomes the secondary payer. Employers may not supplement Medicare, so most eligible employees choose to make the employer plan primary.

The change, effective since Jan. 1, 1983, can result in major cost increases to employers with a substantial number of active employees over age 65. It represents another type of solution for Medicare's financial crunch—directly shifting costs from Medicare to employer health plans. Under DEFRA, employers will also

have to give employees under age 65 the option to make the employer group health plan, rather than Medicare, the primary coverage for their spouses age 65 through 69.

The Advisory Council recommended an extensive study of the coordination of Medicare with employer-sponsored group health insurance with respect to spouses of Medicare-entitled employees.

Direct cost-shifting clearly increases employer costs. Employers must be particularly on guard against attempts to make the employer plan primary for retiree health coverage. Both TEFRA and DEFRA may have opened the door to this in the near future.

Means test approaches

This solution seeks to apply conditions—eligibility, cost-sharing or levels of Medicare coverage—upon some test of a beneficiary's ability to pay for health care.

For example, replacing Part B premiums with a new health insurance tax has been urged by Karen Davis and Diane Rowland of Johns Hopkins University. Under their plan, while eligibility for Medicare would continue to be based on age, beneficiaries with higher annual incomes would have to pay more for Part B coverage. This new tax would be levied on a sliding scale according to income. Low-income beneficiaries might pay less than they currently pay in Part B premiums.

Others have suggested that Part A coinsurance amounts be higher for Medicare beneficiaries with higher incomes. Either solution could result in higher costs for employer plans that pick up Part A co-payments for retirees and/or

reimburse employees for Part B premiums.

Another version of this solution would accompany the catastrophic insurance approach as offered by Mr. Drucker. Each Medicare beneficiary's cap on total out-of-pocket health expenses would be related to income level. In his proposal, for example, annual health care expenses above a fixed 15% of pretax income would be paid in full by Medicare.

Any type of means test solution to Medicare is likely to generate intense opposition. In this case, employers are likely to have to pick up health care expenses for retirees who qualify for lower benefits under a means test.

The 1982 Advisory Council, for example, flatly ruled out any consideration of financial criteria as a measure of Medicare eligibility. Apart from philosophical objections to the introduction of a means test in a "social insurance" program like Medicare, arguments against this solution also rest on practical grounds.

For example, many would question whether a previous year's income, either gross or aftertax, is an appropriate indicator of ability to pay for a current year's health costs. Other assets or financial resources may be more valid measures of means, but evaluating and monitoring these could be an administrative nightmare.

The Perspective section, which is a forum for readers' opinions, is compiled and edited by Copy Editor Alison Kittrell. She can be reached at 312-649-5262.

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Experts cite causes, solutions for problems in court system

Continued from page 3
there is no coverage, there is no recovery."

With this in mind, Mr. Horvitz said, "One of the messages I have tried to convey to the California Supreme Court over the past several years is that the insurance industry is a conduit and not a cornucopia. The burden placed on the insurance industry is paid by the insuring public. You increase liability, you increase premiums and in some cases you get consequences sufficiently adverse that the court will stop, will pause and will say that 'we are not going to take this additional step further.'"



Mr. Horvitz cited the California Supreme Court's decision several years ago not to create a new cause of action for loss of consortium between parents and children, a decision not based on the law but on "hard economics."

The court was convinced that it created this new cause of action, "it would flood the courts beyond

the point the courts could manage and would so enhance the administrative costs of disposing of small claims that there was no offsetting compensating benefit that would outweigh that burden," he said.

In two cases attacking as unconstitutional aspects of the 1975 California medical malpractice law, the law was upheld, "again, because the economic impact of increasing liability was actually dislocating the delivery of health care services in the state," Mr. Horvitz said.

Judges are generalists, Mr. Horvitz stressed. "The court lacks the collective background to deal with insurance law and the economics of insurance. Frequently when they decide cases, they don't know what the impact of that decision is going to be when it gets out on the streets."

"Our job—my job—is to educate the courts to the practical implications of what their decisions will be. I have found that if you go to the courts with a simple, clear and direct explanation, they will listen."

"In all these cases, I find that arguing case law or arguing the logical implications of the prior decision are really not right. At the Supreme Court level, policy considerations, hard pragmatic considerations, are much more persuasive," he said.

The insurance industry, however, is not as organized in presenting its views as the plaintiffs' bar, Mr. Horvitz said.

"Frequently when we go out for amicus curiae support, it is tough finding it. The plaintiff's bar in California is brilliantly organized. They are in with amicus briefing in every major case. They do a splendid job. The defense side is a lagard in that regard."

Mr. Graham, a lawyer who reports on legal issues, was more pessimistic in his assessment of the future of the civil justice system than Mr. Horvitz.

The legal system is bringing within its decision-making process ever larger and wider areas of American life but, at the same time, it is failing to provide a decision-making process that is effective, expeditious and cheap, he said.

There are two main problems, according to Mr. Graham: "There are too many lawyers, and those closest to the legal system like it as it is."

Lawyers like the system the way it is because it increases their fees, and judges like the system the way it is because it preserves their independence, power and prestige, Mr. Graham said.

In 1960, there was one lawyer for every 630 Americans; now there is one lawyer for every 390 Americans, Mr. Graham pointed out. While no one can prove that the increasing number of lawyers adds to

litigiousness, a growing number of people are convinced that it does, Mr. Graham said.

Supporting this conclusion, he noted the number of lawsuits has increased with the number of lawyers. The number of civil cases filed between 1978 and 1983 increased 20%, or an average of 4% per year, while the population grew at a rate slightly slower than 2%, Mr. Graham said.



Mr. Graham

"The problem with the problem of too many lawyers is that no one is in charge," Mr. Graham continued. "And I am not optimistic about any change in the trend in that area any time soon."

The legal profession does not control the number of lawyers, nor does it control the number of law schools, he said.

Slight decreases in the number of law school applicants in the last two years is not yet a significant trend, either, he said. The number of law school applicants is far larger than the number of available spots, so there would have to be a far greater decrease in applicants than seen so far for it to result in fewer than 35,000 new lawyers entering the marketplace each year, Mr. Graham said.

"I fear that the increased scramble for the client dollar, which is inevitable, is going to make the legal profession less willing to take steps for reform of the system in ways that appear to threaten their fees and their livelihood in the short term," Mr. Graham said.

A letter from the New York State Trial Lawyers Assn. soliciting new members proves his point, he said. In the letter, the association warns that bills in the state Legislature dealing with such issues as no-fault, a limitation in malpractice suits, contingent fees and product liability "chip away at the rights of New York state citizens and your practice."

"I'm not optimistic about massive, effective reform," Mr. Graham said, "because all up and down the line the lawyers and judges control the process even to the extent that many state legislatures are dominated by the judicial committee or dominated by lawyers."

"The best hopes are in private efforts," Mr. Graham suggested. "It may be—in order to get more expeditious, less cumbersome, less expensive resolution of disputes—people will simply have to go into private enterprise and set up systems and use those systems."

The asbestos claims facility, a proposal under which asbestos producers and their insurers would offer settlements to asbestos claimants, is one such effort, Mr. Graham said.

"It will be interesting to see if

Continued on facing page



Mr. Horvitz

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Pact caps Aetna's defense costs

Continued from page 1

7,700 claims brought by women alleging the Dalkon Shield caused uterine inflammations, pelvic inflammatory disease, sterility and other injuries.

Robins and Aetna have paid about \$259 million in claims and expenses to dispose of those 7,700 claims as well as about \$70 million in defense costs for pending claims.

Under the agreement with Aetna, \$23.8 million of the \$70 million will be used to increase the limits for policy years 1971-72, 1972-73, 1973-74, 1974-75, 1975-76 and 1976-77.

For example, \$6 million in coverage has been added to the 1971-72 policy, \$2.4 million to the 1972-73 policy and \$6.25 million to the 1976-77 policy, said William R. Cogar, an attorney for Robins with Mays, Valentine, Davenport & Moore in Richmond, Va.

The additional limits were allocated based on what percent of each year's policy limits would be expended on defense costs, said John F. Shea Jr., Aetna vp and claim counsel.

Robins had a total of \$335 million in primary and excess liability coverage under Aetna policies in effect from March 1, 1970, through March 1, 1978.

Robins also has an additional \$35 million in coverage for 1968 through 1970. However, very few Dalkon Shield claims have been filed under those policy years because the intrauterine device was not widely marketed until the 1970s, said Mr. Cogar.

During the 1970s, Robins' primary CGL policies generally had \$5 million limits and excess coverage with Aetna ranges from \$30 million in the early 1970s to \$50 million later in the decade, he said.

However, Robins was only able to secure \$10 million in liability insurance in 1977-1978 with a \$5 million deductible. This policy year with Aetna is not part of the Aetna agreement.

After March 1978, Robins had no coverage for Dalkon Shield claims.

Despite the infusion of additional coverage for 1971 through 1977, Robins already has exhausted the limits of three of these policy years, according to the 10-Q report. Aetna had been paying claims during the coverage dispute that under the agreed manifestation theory more than exhausted original available limits.

Robins, however, declined to say which policy years were exhausted.

Robins also has burned through the primary layers of all its coverage with the exception of the 1970-1971 policy against which less than \$1 million in claims have been filed, said Jack D. Kull, Robins' manager of risk management. This policy has limits of \$35 million.

Approximately 1,400 additional claims have been assigned by Aetna to the three policy periods for which all coverage has been exhausted. Another 1,400 claims have also been assigned to the post-1977 period when Robins had virtually no insurance coverage for Dalkon Shield claims.

While Robins can tap the remaining \$46.2 million of the Aetna settlement to pay claims assigned to these policies, the \$46.2 million will not cover all the uninsured claims.

The \$46.2 million will be paid to Robins in three \$15.4 million payments over calendar years 1984, 1985 and 1986. If in any one year Robins does not use all the \$15.4 million, the excess can be rolled over to the next year to pay claims, Mr. Cogar explained.

Robins requested the settlement in a combination of the three-year payments and in the form of additional coverage to avoid being taxed on the settlement.

Robins' losses will exceed insurance

Although A.H. Robins Co. could exhaust a total of \$405 million in insurance coverage to pay Dalkon Shield claims, it will not be enough to cover all the company's losses.

Already, Robins has paid millions of dollars in claims and expenses out of its own pocket—and expects to pay much more.

In the third-quarter 10-Q it filed today with the Securities & Exchange Commission, Robins reports that it has incurred \$67.1 million in losses during the first nine months of 1984 due to Dalkon Shield litigation. This is a 390% increase over the \$13.7 million in incurred losses related to the Dalkon Shield in the first nine months of 1983.

Almost \$25 million in incurred Dalkon Shield losses were reported in the third quarter of 1984 compared with only \$4.7 million in the third quarter of 1983, a difference of 428%.

Net earnings fell 99% for the third quarter and 58% for the first nine months of 1984 compared with 1983, "due primarily to the increase in expenses related to the Dalkon Shield litigation," according to the 10-Q. Higher Dalkon Shield expenses reduced earnings per share for the third quarter by 52 cents and for the first nine months by \$1.39, the report shows.

And, the 10-Q clearly indicates that Robins expects substantial Dalkon Shield losses in the future, too.

"With the conclusion of the Aetna suit, the Company continues to study the feasibility of establishing a reserve for pending and future Dalkon Shield claims.

"The establishment of such a reserve is dependent upon a reasonable resolution of several uncertainties including those inherent in attempting to project future claims and the timing of the disposition of pending claims, their outcome and the amounts involved in their disposition," Robins says in its 10-Q.

"It can be anticipated, however, that the amount

of such a reserve would be quite substantial and would be charged against income for the period in which the reserve is established.

"In the meantime, it is recognized that liabilities attendant to the Dalkon Shield will have a material adverse effect on the company's results of operations in 1984 and may well have such an effect on its consolidated financial condition and results of operations after 1984."

Of the 3,600 Dalkon Shield claims still pending, 2,800 have been assigned to years in which Robins has either exhausted all liability coverage or never had coverage. Robins can use \$46.2 million of the Aetna settlement to pay these claims, but it expects that losses from these and future claims will exceed \$46 million.

"It's clear a number of those (Dalkon Shield) claims will have to be absorbed by the company," said Robins Vp and General Counsel W.A. Forrest Jr.

An additional 30 Dalkon Shields claims are being filed against Robins each week, and it expects that a recent ad campaign to encourage women still using the Dalkon Shield to have the intrauterine device removed will spur more claims.

In addition, Robins' insurance covers only compensatory damages against the pharmaceutical firm, not punitive damages. This adds another element of uncertainty to Robins' final liability.

Punitive damages of \$17.2 million have been assessed against Robins in eight cases so far. Six of these awards, totaling \$8.8 million, already have been paid and the other two are the subject of post-trial motions or appeals.

"While the company does not believe it should be liable for punitive damages, it cannot predict with certainty the outcome of other pending cases seeking such damages," the 10-Q says. "Punitive awards are not covered by insurance and will be payable by the company."

Overall, with the Aetna settlement, Robins has about \$153 million in remaining insurance coverage to pay Dalkon Shield claims, but all of the available coverage may not be tapped. Because claims will be paid only under the manifestation theory, it is possible that the claims filed against the coverage in one given year will not exhaust the limits while the claims assigned to another given year will far exceed the available limits.

"The availability of all of that amount (the \$153 million) will ultimately depend on the timing of injuries allegedly associated with the use of the device," explains Robins' third-quarter 10-Q.

In the insurance litigation, Aetna contended it should not have to defend or indemnify Robins for cases in which a claimant's injuries were medically diagnosed or discovered after the last day of the policy period.

Robins sought a much broader interpretation, contending that any loss should be prorated over policies in place from the time of the insertion of the Dalkon Shield until the time of removal, said Mr. Cogar.

However, by the time of the settlement—which came just a week before the coverage trial was to begin—the main dispute was over payment of defense costs, Mr. Cogar said.

As the years of litigation contin-

ued, Robins' aggregate losses in the Dalkon Shield litigation became so significant that the question of whether claims should be paid during exposure or manifestation became moot.

"It became apparent that all coverage was going to be exhausted," he added. Thus, the parties were primarily looking to settle the defense cost issue.

While it is possible that Aetna's liability in one or more policy years will be limited by the adoption of the manifestation theory, Aetna contends it wanted the agreement to specify that claims would be based on a manifestation theory because that position would be consistent with its position in other coverage cases, not because it would be more advantageous to Aetna to pay claims in this manner, said Mr. Shea.

On the defense cost issue, Robins had argued that the limits of the policies were to be expended only for indemnification and that the cost of defense was excess of the limits. Aetna had contended that both defense and indemnity should be charged to the limits of the policies.

By agreeing that defense costs will be included in policy limits, Aetna has the advantage of knowing exactly what its ultimate costs will be, Mr. Cogar said.

Mr. Shea said that Aetna's liability for the Dalkon Shield claims is

heavily reinsured and that the settlement with Robins has the overwhelming backing of its reinsurers.

Aetna did, however, have to add \$20 million to its loss reserves because of the Robins' settlement, which was reflected in the company's third-quarter operating results.

As part of the agreement, it was specified that Aetna Technical Services Inc. will continue to administer Dalkon Shield claims.

Mr. Kull said it was very important to Robins that Aetna continue to administer claims in light of the steady stream of Dalkon Shield cases still being filed and the difficult medical questions involved.

Aetna's claims personnel in the field have handled these claims, know the issues involved and what to look for, he said.

"That expertise and knowledge would be difficult to replace over the short term," he said.

Aetna will pay the cost of claims administration for those cases for which it is still liable and Robins will reimburse Aetna for the administration of claims not covered by insurance.

Robins purchased the rights to the Dalkon Shield in 1970, began marketing it nationally in 1971 and stopped marketing it in 1974. Approximately 2.2 million Dalkon Shields were used by women in the United States. ■

Programs offered to reduce worker injuries

The National Safety Program and the International Safety Academy each offer a program designed to reduce employee injuries.

The National Safety Council's program, "Lock It Out," shows employees the procedures required to isolate the energy source of equipment being serviced and prevent injuries from unplanned startings.

The program teaches how to safely lock out electrical, steam, compressed air and hydraulic equipment. The slide show includes 65 color slides, cassette narration and a script. The price is \$150 for mem-

bers and \$190 for non-members.

Illustrated "Lock It Out" booklets are available at 35 cents each for 10 or more for members and 44 cents each for non-members. Quantity discounts are available for the slide show and booklets.

Contact the Order Department, National Safety Council, 444 North Michigan Ave., Chicago, Ill. 60611; 312-527-4800.

The International Safety Academy program is on manual materials handling and safe lifting. It includes 78 slides, cassette narration, a leader's guide and a participant's

workbook with tests to be taken before and after the program.

The program, which incorporates guidelines by the National Institute for Occupational Safety and Health Work Practices, is designed to train workers in ways to protect their backs, basic safe lifting techniques and the right approach to manual materials handling.

The program has a \$245 introductory price, plus a \$4 charge for shipping and handling. Contact the Academy at P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147. ■

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Jan 7	Dec 19
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Continued from facing page
vate enterprise can succeed where the system so far appears to be seriously flawed."

Another effort at a private system of settling disputes is hiring retired judges to hear cases between consenting parties.

"The results appear to be promising," Mr. Graham said, because this alternative is cheaper and faster than the civil justice system. "But, of course, both sides have to agree," he noted.

While concentrating on problems created by crime, the Justice Department's Ms. Dinkins also addressed civil justice trends. She suggested that "courts are too liberal in hearing cases not proper for resolution in court."

Ms. Dinkins, too, suggested that businesses reduce the burden on the courts by resolving their disputes outside the civil justice system.

"Litigation in publicly funded courts is only one alternative," she

said. Parties can negotiate and arbitrate their differences and bear the cost themselves, she suggested, and they will find that arbitration is less costly than turning to the civil courts.

The federal government, which is the most frequent party to civil litigation, is trying to reduce the burden of litigation on the courts, she said. For the 12-month period ended in March, the federal government was a party in 110,000

civil cases, half of them as a defendant.

On the plaintiff side, the Justice Department is trying to reduce the amount of litigation it brings, including antitrust and civil rights cases.

Members of the audience were



Ms. Dinkins

encouraged when Ms. Dinkins noted that the Reagan administration will appoint 100 federal judges in the next few months alone. The insurance company executives reason that these judges will be more conservative in their opinions than those appointed by Democrats.

Panel moderator Mr. Schaffer in his opening remarks introduced some of the panelists' themes.

The sympathetic response of the courts to pleas for reimbursement has encouraged the American appetite for litigation, which in turn has encouraged the supply of lawyers to increase beyond the level of need, Mr. Schaffer said.

"And the expansion of lawyers has created a need for litigation to support them in a style to which they would like to become accustomed," he added.

"Liability insurance is the stream which furnishes the flood of money to quench the thirst of our civil justice system," Mr. Schaffer said. Insurance is involved in 65% to 70% of

all civil cases, he said.

And, the courts are more interested in compensating victims than in determining who was at fault for an injury, Mr. Shaffer added.

But, more than any of the panelists, Mr. Shaffer criticized "judicial activism," or the tendency of the courts to make laws.

"Reasonable stability and predictability of the law are essential for accurate prospective pricing of liability insurance. Until the last few decades, most changes in tort liability law arose from statutory enactments by state legislatures," Mr. Shaffer said.

Although legislatures were increasingly passing laws that changed tort liability, "at least they were prospective in nature, providing insurers with adequate lead time to price policies properly," he said.

But, in the last few decades, the thrust of liability law has swung from the legislative to the judiciary

branch of government, he said.

In some cases the courts decided issues in manners that had been considered and rejected by state legislatures, he noted.

And in many cases, "these court decisions have been deemed retroactive to outstanding or even previously closed claims under existing policies," Mr. Shaffer said.

In these cases, the courts provided compensation for a liability for which no premium had been charged or for which there may have been a policy exclusion, he said.

"The economic impact on the policyholders in a state may be enormous, but that factor usually is not even relevant for consideration as it would be in a legislative determination," Mr. Shaffer suggested.

"Making tort law in the courts rather than the legislature is destabilizing, expensive and unpredictable for insurance companies and their policyholders," Mr. Shaffer said.

Conferees scramble for reinsurance

Continued from page 3

adding that "I'm confident people will back us."

But, if he can't complete the \$5 million excess of \$5 million treaty, the underwriting manager's liability insurance capacity will be down to \$5 million, Mr. Foss says. Property insurance capacity will be \$4 million to \$7 million, also depending on reinsurance treaties.

Even with only \$5 million in liability insurance capacity, NUA could write \$40 million in liability premiums next year, Mr. Foss says, down only about 10% in premiums from what \$10 million in capacity would generate.

NUA specializes in writing the first-, second- or third-layer liability insurance policy for Fortune 1,000 companies.

Rate increases alone on this business will boost NUA's volume. Now that high-layer excess insurers are demanding \$1,000 per \$1 million of coverage, the insurers on the lower layers, like NUA, will charge around \$5,000 per \$1 million.

(In addition to seeking more reinsurance, NUA also is seeking another issuing company for liability insurance in addition to Transit Casualty Insurance Co., for which NUA now underwrites.

Transit is reducing the amount of business it writes on a gross line basis and increasing the amount of business it retains.

As a result, Transit is no longer a fronting company for captive insurance company business placed through another underwriting manager, Donald F. Muldoon & Co. in New York. Muldoon, which had underwritten about \$100 million in premiums on fronting business for Transit, continues as an agent for Transit, but is writing only business for which Transit keeps a meaningful participation.

The class of business Mr. Foss underwrites, however, dictates that it be heavily reinsured, Mr. Foss noted.

For his part, Mr. Foss wants an additional issuing company because uncertainty in the marketplace about the future ownership of

Director appointed for Testing Institute

COVINA, Calif.—Kenneth M. Lane is the new project director of the Insurance Testing Institute, the license qualification division of the Insurance Institute of America.

Mr. Lane developed the basic concepts and negotiated the agreements with the parties involved in the Testing Institute, which is a new, automated program for delivering state insurance licensing examinations. His office is located in Covina.

Transit Casualty has cost NUA some business. The insurer is for sale as a result of the liquidation of Beneficial Standard Corp. If the company is not sold by May 21, its stock will be distributed to Beneficial Standard shareholders to avoid adverse tax consequences.

And, despite the company's response to questions, Transit Casualty is the continuing subject of industry rumors, Mr. Foss says. Its policyholder surplus has declined and its Best's rating was dropped this year to a B-plus from an A.

"Transit is financially viable and has answered the questions, but some people haven't accepted that," Mr. Foss says.)

Others agree that reinsurers are slow to commit themselves this year to new or renewal business because they are having their own difficulty in placing their reinsurance protection.

Ben Ibesen, director of broker Andrew Weir London Ltd. in London, which specializes in placing retrocessional business or reinsurance for reinsurers, said, "Pro rata retrocessions are about dead now. This is making it very difficult for the professional reinsurers. They need capacity."

Under a pro rata reinsurance contract, the assuming insurer accepts a portion of the original premium and a portion of the loss exposure.

While reinsurers can purchase excess-of-loss reinsurance, which will protect them against losses exceeding an agreed limit, the coverage is more expensive.

In the face of the current market conditions, Mr. Ibesen proposes that ceding companies approach their reinsurers with a proposal to write their protection on an adjustable basis with provisions for both pro rata and excess-of-loss cover-

age. The coverage—and premium—would be adjusted based on loss experience.

It could be agreed from the beginning, he says, that if the loss experience is very good, the excess-of-loss contract would be dispensed with and only the pro rata contract would be recognized. But, if the loss experience under the pro rata contract is very bad, the reinsurance could be written 100% on an excess-of-loss basis—or a combination of both.

Mr. Ibesen credits Columbia, S.C.-based reinsurance broker Seibels Bruce & Co. with developing this idea in the 1950s and 1960s.

"This is not for all companies," Mr. Ibesen noted. "It's not for the large companies that might be able to afford excess-of-loss," he added.

Mr. Ibesen also suggests that reinsurance contracts written on a claims-made basis could answer the concerns ceding companies have about whether their reinsurers will be in business 10 years from now to pay late-developing liability losses.

If the reinsurance is written on a claims-made basis to pay claims made in the current year, the ceding company doesn't have to worry about the financial security of its reinsurer 10 years hence.

However, ceding companies whose reinsurance is written on a claims-made basis do have to worry if their reinsurers will renew, Mr. Ibesen admits.

Most registrants interviewed at the 1984 NAII meeting agreed that the tables had turned and suddenly reinsurers' capacity has become precious instead of plentiful.

"Look at the ceding companies chasing after the reinsurers," remarked one registrant. "Last year, the reinsurers were chasing the ceding companies," he said.

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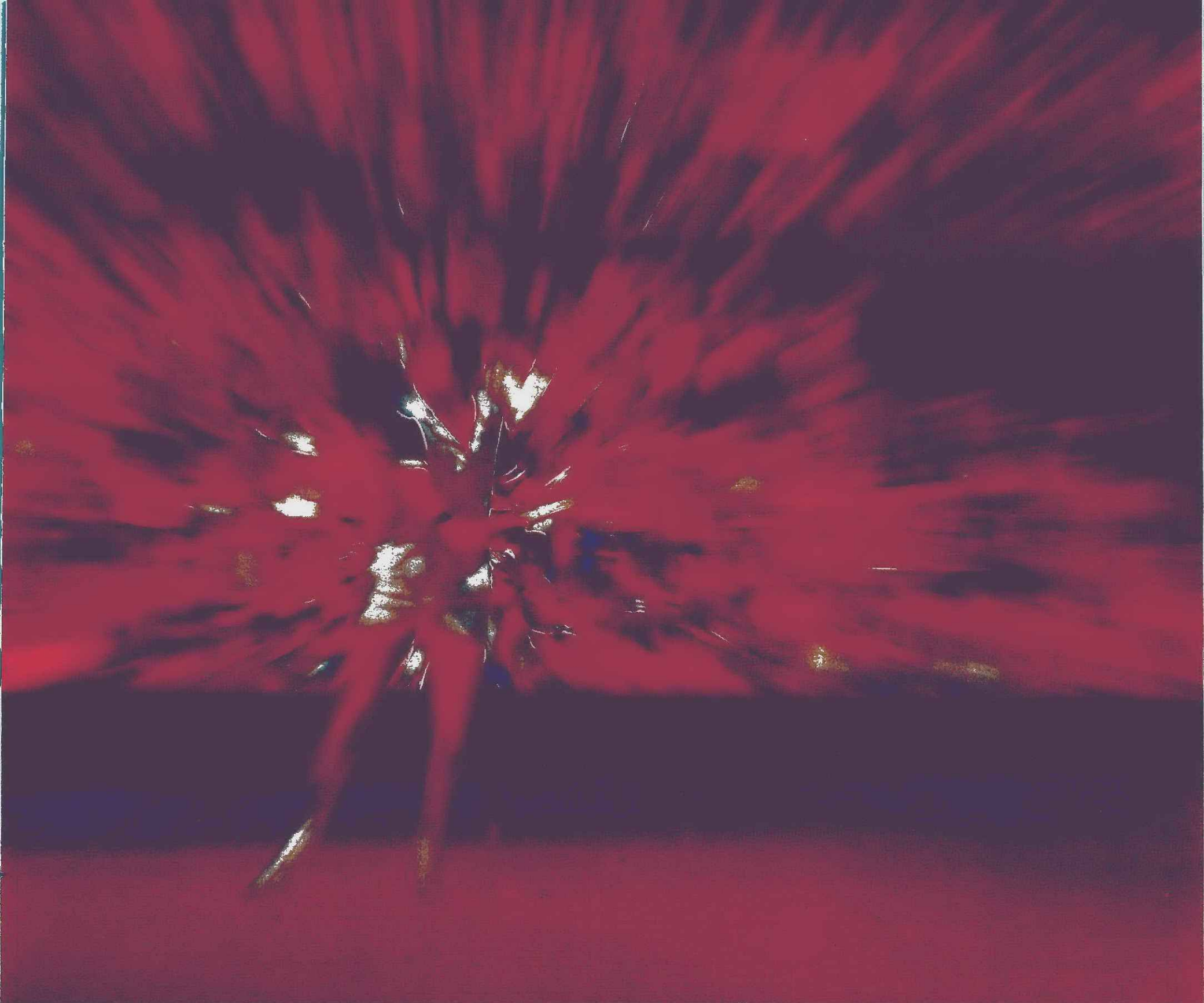


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The game plan that works.

Order may target Texas Lloyd's companies

Continued from page 2

The order is expected to be discussed by the three-person Insurance Board within the next few weeks, Mr. Olson said.

Mr. Olson is fervently moving ahead with the board order to restore "sanity" to the Texas marketplace and to preserve the credibility of the rating data, he said.

Such a move is expected to result in higher rates.

"But that's what we get paid to do... to make those kind of judgments... to keep intact the integrity of the rate regulatory scheme," Mr. Olson said.

"If the state Legislature decides it wants to go to open rating, then it can decide that," he added.

But erosion of the data base is not the only concern Mr. Olson has about the effect of the Texas Lloyd's companies. Since the Texas Lloyd's companies operate without a lot of regulation, there is a concern that property/casualty insur-

ers, through their Texas Lloyd's companies, may be competing themselves into insolvency, Mr. Olson said.

Several of the Texas Lloyd's companies surveyed by *Business Insurance* don't believe the new order will cause them any problems. In fact the independent Texas Lloyd's companies, those not affiliated with a parent insurer, welcome the new order. However, since the details of the regulation are still being drafted, many of the Texas Lloyd's companies are unsure of the ramifications.

Glenn Morris, chairman and president of Houston General Lloyd's in Fort Worth, doesn't agree with the pending board order. "A Texas Lloyd's is permitted flexibility in deviation. If an insurer files a deviation, it has to write all the risks at that deviation... that takes away the flexibility," Mr. Morris said.

The attorney-in-fact for Houston General Lloyd's is Houston General Insurance Co. in Fort Worth.

However, an independent Texas Lloyd's company believes the action by the Insurance Board is long overdue.

"(It's) 10 years too late. For the last 10 years the regular insurers have created Lloyd's companies as a subterfuge to get around rate regulation," said Avrohm Wisenberg, chairman of the board at Delta Lloyd's Insurance Co. of Houston,

which was formed in 1971.

He believes that even if there is a new board order, it will be too late to have an effect on the market, though "as an independent Lloyd's with no parent, we applaud the board's move."

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PRIMA, Atlanta RIMS chapter set up computer bulletin boards

Continued from page 3

up its electronic mail network. Allen Hyman, risk manager for Corpus Christi, Texas, and president of PRIMA, says that public risk managers spend a lot of time comparing programs. The electronic mail network will let PRIMA members "acquire a significant amount of information (about other members' programs) in a short period of time and at minimal expense."

The PRIMANet, as it will be called, also will help members keep each other up-to-date on state and local legislation that affects public risk managers, he explains.

The association will use the Source Telecomputing Corp., which is a subsidiary of The Reader's Digest Assn. Inc., for its electronic network. The Source will use its computer equipment to establish electronic "mailboxes" for each of the PRIMA members. The passwords for these electronic mailboxes will be provided to all of the association's members so they can send and read messages from one another.

Unlike a computer bulletin board, members will pay the Source an access fee when using the system. That fee is typically about \$20 an hour during business hours and about \$7.50 an hour on weekends, according to Natalie Wasserman, executive director of PRIMA. Ms. Wasserman says the fee schedule for the PRIMANet has not yet been negotiated.

In addition to providing the electronic mail system, the Source also provides other information services, such as airline schedules, Dow Jones listings and news summaries.

Ms. Wasserman explains that PRIMA opted to go with the Source because its 800 members are spread out in state and local governments across the country.

To access a centrally located computer network would mean long distance telephoning for most of its members, thereby substantially increasing the cost of using the system.

This is avoided by using the Source, Ms. Wasserman says, because the Source also provides leased communications lines, which means members do not pay long distance telephone charges to access the system.

Final plans for the system are not complete, explains Ms. Wasserman, who says response has been tremendous to a questionnaire sent out just two weeks ago explaining

The computer bulletin board is "the wave of the future," according to Mr. McGovern.

the PRIMANet.

She says PRIMA received more than 40 responses in one week, with more than half of the respondents reporting that they have a microcomputer and a modem and could connect to the system immediately.

Members will be able to gain access to the PRIMANet by dialing a special telephone number that will connect them to the Source network. Then they simply switch on their microcomputer and key in an identification code. The system is menu driven, so that members need only select the function they want (such as "read your mail"), and is "user friendly," meaning that all necessary instructions appear on the computer screen as needed.

The Atlanta RIMS bulletin board operates almost exactly like the Golden Gate Chapter's system, explains Mr. Walker. He says it has been up and running for about three and a half months, and 100 users have already successfully logged on.

Most of these users, however, are from outside the Atlanta area, with one even from Canada. Mr. Walker says he expects to pick up more local risk managers as word of the system begins to circulate within the city. Mr. Walker says the bulletin board will be demonstrated at a RIMS education conference to be held in January in Atlanta.

A risk manager doesn't have to be a computer programmer in order to use the computer bulletin board. All of the necessary instructions are displayed on the computer screen, along with the menu of functions.

The computer bulletin board allows users to send and receive messages (private messages can be arranged if two or more users agree on a password to access such messages), and it allows users to send or receive computer programs from the bulletin board.

Mr. Walker hopes to build up a collection of computer programs or software that will help risk managers with their work. Already the system has several utility pro-

grams, he explains. Such programs help the computer user manage data, communicate with other computers, and perform a variety of other functions.

Because it has been in operation longer and has more users, the Golden Gate RIMS Chapter's bulletin board has many more programs—including some risk management programs—than its Atlanta counterpart. So Mr. Walker is arranging a software swap with the Golden Gate system's operator, Robert C. Herrick, who is insurance manager at Transamerica Corp. in San Francisco.

The Atlanta system also contains two risk management articles, Mr. Walker says. One of the articles discusses premium allocation; the other discusses professional liability in the health care industry. Mr. Walker says he hopes other authors will contribute risk management articles to the bulletin board.

Getting on the system is not complicated. After dialing the bulletin board telephone number the user hears a high-pitched tone. For systems with a built-in modem, the telephone line plugs directly into the computer, and the user simply waits for the "connect" message; for computers with an external modem, the user must place the telephone handset into the modem, and again wait for the "connect" message.

After the user gets the "connect" message, he slowly presses the "enter" or carriage return key three times. This allows the bulletin board computer to tell at what speed the user's computer is transmitting. Most newer computer modems transmit at 1,200 bits per second or baud, although some less expensive models and older equipment transmit at 300 baud.

The bulletin board will then ask several questions about the capabilities of the user's computer, such as whether it can display lower case characters or graphics. Depending on how the user answers these questions, the bulletin board will send all information in a format to match the computer's capabilities.

If the user is a first-time user, the bulletin board will ask him or her to select a password or log on. The bulletin board is menu-driven, meaning that all the information in the system is accessed by selecting from a menu of choices, such as "entering messages" or "reading messages."

To reach the system, which is operated 24 hours a day, seven days a week, call 404-231-2271.

N.J. fund ruled constitutional

Continued from page 2

dor Insurance Co. Although domiciled in Vermont, Ambassador maintained its administrative office in North Bergen, N.J., and wrote about 25% of its business in the state, as a non-admitted insurer. Among its New Jersey policyholders are about 120 public entities.

Ambassador was declared insolvent by a Superior Court in Vermont on Sept. 4, but the insurer is contesting that decision. It is trying to find a loss-portfolio reinsurer in an effort to reorganize (BI, Nov. 12). An earlier attempt to find a reinsurer failed.

The guaranty fund law was hastily passed this summer and signed into law July 27 so it would be in effect before Ambassador was declared insolvent.

At that time, there were 55 surplus lines insurers eligible to do business in New Jersey. But since the law was enacted, 19 of those insurers have notified the state they no longer plan to write business in New Jersey. In addition, Mutual Fire, Marine & Inland Insurance Co. has notified its producers not to write any business in the state.

The law provides for the payment of up to \$300,000 for approved claims not paid by an insolvent surplus lines insurer.

As originally enacted, the fund would be financed by a \$25,000 assessment against each of the surplus lines insurers doing business in New Jersey and a surcharge of up to 4% on each non-admitted insurer's annual premium volume. In addition, the fund could borrow up to \$10 million from the state guaranty fund covering admitted insurers.

The amendments that sailed through the state Assembly and Senate last week would retain the \$25,000 assessment, but now each policyholder would be liable to pay the surcharge of up to 4% of the premium for a surplus lines policy. The insurer would not have to directly pay the surcharge on new or renewal policies.

Other amendments passed by the Legislature:

- Create a committee made up of representatives of surplus lines insurers and agents to advise the board of the admitted insurers' guaranty fund, which also directs the surplus lines fund.

- Give the surplus lines guaranty fund the authority to borrow money from sources besides the admitted insurers' guaranty fund with the approval of the state insurance commissioner.

- Specify that borrowed money can only be used to pay claims.

The amendments would be retroactive to July 27.

Commissioner Merin signed an order last week extending a ban on claims payments from the fund for 30 days or until the amendments are signed, whichever occurs first.

Still pending is another suit filed in a state court in Trenton that challenges the manner in which the fund would operate.

Tanker owner adds to its coverage

Continued from page 2

lons of chemicals and lubricants into the Pacific Ocean. The Puerto Rican carried almost 92,000 barrels of petroleum products, about \$3.5 million of which is salvageable, according to a Keystone spokesman.

The tanker's bow was towed to San Francisco Bay Nov. 18, and is at Triple-A Shipyard. During its tow-in, a deckhand on a tugboat fell overboard and was killed. No spill occurred during the tow-in.

The shipping company already had \$500 million in pollution liability coverage. The first \$300 million is underwritten by the U.K. Mutual Steam Ship Assn. (Bermuda) Ltd., a protection and indemnity club managed by T.R. Miller, says Richard Hervey, manager of the pollution department at Transport Mutual Services Inc. in New York, the P&I club's U.S. representative. The remaining \$200 million is written by both domestic and London excess insurers.

"In my opinion, (the extra coverage) was totally unnecessary, but the state had a different opinion and we were in a bind," Mr. Hervey says, pointing out that maintaining the tanker's exposed bow while it was in the Pacific cost \$50,000 to \$75,000 per day.

The additional \$100 million policy does not raise Keystone's pollution liability limits to \$600 million, he explains. The extra coverage runs parallel to the first \$100 million portion of the \$500 million in existing coverage.

The coverage was purchased after much negotiation between Keystone and state officials.

It wasn't the amount of coverage that the state quibbled with; it was California's ability to tap it.

Steve Ritchie, senior engineer with the Water Quality Control Board in Oakland, says the state feared Keystone's insurance might be exhausted from a previous spill in the Pacific Ocean or that the shipper might try to limit its liability for a subsequent spill under federal or state laws. That might have

barred claims filed by California for harm to the bay waters, he says.

For example, the federal Limitation of Liability Act permits a vessel owner to limit its liability in an accident to the value of the vessel and its cargo following the accident (BI, Jan. 30).

"The state was concerned if indeed there was a spill, Keystone would raise these defenses and we'd be two to three years litigating them. We wanted some guarantee that the state would be reimbursed," explains Allene Zanger, deputy attorney general in San Francisco.

While California could apply for up to \$35 million in cleanup funds from the federal government if leakage occurred during the towing, that would have generated red tape. And, "The state did not want to have to litigate against the shipowner to pay for any claims that may result from environmental damage," Mr. Hervey says.

So Keystone agreed to waive its right to limit its liability, but for only those oil pollution claims by the state stemming from the towing. The firm then bought the separate \$100 million policy to address those claims, says Mr. Hervey, who says the arrangement is "very unusual and very difficult."

Under the agreement, Keystone retains the right to limit its liability for claims brought by other parties under the previously obtained coverage, Mr. Hervey says.

He declined to reveal the premium Keystone paid for the additional \$100 million layer, but says it is "six figures."

He says chances of California filing a claim for damage related to the towing are now "very remote."

"This is the first (such insurance arrangement) that we've been involved with, but I'm sure you'll hear more about these in the future," Mr. Achuff says, noting that municipalities are increasingly concerned about the environmental damage from oil spills and about shippers' ability to limit liability.

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Insurers' results

Continued from page 1

was registered during the year's first half. Insurers continued to move investment portfolios away from tax-free instruments to higher-yielding taxable investments and began dealing with new types of investments, including put options and sale-leaseback deals.

- Net written premiums grew by 6.8% to just more than \$36 billion, better than the 6.3% growth rate generated during the first half.

- Policyholders surplus for the 21 companies that reported the figure declined by 13.5% to \$15.2 billion.

The deteriorating policyholder surplus, which insurers attribute to underwriting losses, is a cause of concern, observers say.

"No question, that's the fundamental number in a company," says the III's Mr. Mooney. If policyholder surplus is deteriorating,

"that's quite serious."

But, he says deterioration in policyholder surplus could be positive for the overall market because it reinforces a "crisis atmosphere" and forces managements to take a "serious look" at their problems.

"This will probably help to stimulate rate increases," agrees Smith Barney's Mr. Anthony.

"I think they'd better not have any more losses," says David Seifer, an analyst with First Boston Corp. in New York. Insurers must either put additional funds into policyholders surplus, he says, or cut underwriting losses. They are now working to do both, he says.

Although observers are concerned about the insurers' surplus, they agree that the outlook for improved pricing is bright.

"The rates are flying right now," says Norman L. Rosenthal, vp and analyst at New York-based Morgan Stanley & Co., adding that com-

panies must also stiffen underwriting standards.

"We had price increases all during the quarter, and they were accepted much more readily than in prior quarters," says John H. Fitzpatrick, director of financial relations for Kemper Corp.

Bernard C. Hlavac, vp and treasurer of Sentry Insurance Cos., says that in its effort to raise prices, Sentry is relatively less concerned with premium growth. "We're not really stressing growth at all," says Mr. Hlavac, who hopes to slice eight to 10 percentage points off the combined ratio next year.

"We are continuing to push," says Joseph Brown, executive vp and chief financial officer of Fireman's Fund. "We are going to keep pressure on rates until we return to the company's historical level" of underwriting profits.

Noting that Fireman's Fund suffered an 24.9% decline in underwriting income during this year's

third quarter, compared with a 131.9% decline during the first half, he says: "It's a positive indication that things are on their way up."

Maintaining the pace of rate increases is critical, says Mr. Anthony. He notes the increases so far will stop the downward trend of underwriting losses, but are not sufficient to bring insurers to a break-even point. Price hikes will have to continue throughout 1985 to "even approach that."

But, despite industry optimism, looming immediately ahead is the fourth quarter, when insurers are expected to boost their reserves, which will cut into earnings. Analysts, in general, consider the industry to be underreserved, with the Insurance Services Offices' estimate of a 10% reserve deficiency the most-quoted figure.

"It seems prices have turned, and there should be an improvement in results sometime in the not-too-dis-

tant future, but the companies have yet to realize the full extent of weakness in the balance sheet, particularly the under-accrual for loss reserves in the past four years," says James B. Stradtner, a general partner at Baltimore-based Alex. Brown & Sons.

Insurers are expected to boost their reserves during the last quarter with the idea of starting 1985, a year with anticipated higher earnings, with a clean slate.

Chubb has been boosting its reserves throughout the year, and anticipates additional strengthening during the fourth quarter. "We expect things to get better in '85 and better in '86," says a company spokesman, noting Chubb prefers to "make absolutely certain" its reserves are where they should be by year-end, rather than risk hurting future good results.

Some observers say there may be limits on how much insurers will boost their reserves. First Boston's Mr. Seifer says he would welcome a big increase during the fourth quarter, "but I'm not sure the companies have the stomach to do that and admit their reserves of the past few years are inadequate."

Mr. Mooney says that while there is a "lot of evidence" to indicate reserves are now inadequate, "there's limits to what you can do in that whole area." Reserve strengthening, he adds, must be in compliance with regulatory and Internal Revenue Service procedures.

Morgan Stanley's Mr. Rosenthal says one reason for the need for additional reserves is the high number of claims. Medical malpractice, toxic substance liability and "just general liability" claims have risen substantially, he says.

Actuaries, he explains, suspect this growth is related to the strength of the economy, but they cannot explain the connection. "Lots of actuaries are scratching their heads. They certainly have a lot of egg on their face" as they try to explain to their superiors why claim frequency is higher than they originally estimated, he pointed out.

As insurers continue to ring up heavy underwriting losses, they are trying to get the most mileage from investment income by switching from tax-free securities to taxable investments. There is no need for tax-free income because of insurers' underwriting losses, while taxables are higher-yielding, notes Gloria L. Vogel, vp of Legg Mason Wood Walker Inc. in New York.

There have been no "wholesale, large divestitures," however, says Smith Barney's Mr. Anthony. In general, firms have been reinvesting funds in taxable instruments as the funds become available.

Investing in taxables permits insurers to "stretch out the loss of deferred tax credits," says one analyst. Forty-six percent of a property/casualty insurer's underwriting losses are ordinarily tax-deductible if they can be offset against deferred tax liabilities, but these deferred tax credits are being used up by the sheer volume of underwriting losses. Those insurers that have not already run out of these credits are husbanding their remaining credits carefully.

Two other tactics insurers are using to boost investment income are the use of put options and sale-leaseback arrangements.

In a put option transaction, a property/casualty insurer sells municipal bonds to another company for their cost plus a small premium. The buyer is also given a "put," entitling it to sell the bonds back to the insurer after a period of time.

The insurer then takes the proceeds of the sale, invests them in taxable instruments and eventually buys back the municipal bonds.

Continued on facing page

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Summary of major property/casualty insurers' nine-month results

(All amounts in thousands of dollars)
(Ranked by change in aftertax operating income)

Corporate				Property/casualty operations										
Rank 1984	Consolidated revenues 1984	Aftertax operating income 1984	Percent increase (decline) 1983-1984	Combined ¹ ratio 1984	Combined ¹ ratio 1983	Net premiums written 1984	Percent increase (decrease) 1983-1984	Pretax underwriting income (loss) 1984	Percent increase (decline) 1983-1984	Pretax investment income 1984	Percent increase (decrease) 1983-1984	Policyholders surplus 1984	Percent increase (decrease) 1983-1984	
1	Fremont General Corp.	525,652	(2,489)	33.9	129.2	128.9	226,835	33.1	(62,416)	(21.0)	36,962	15.7	N/A	N/A
2	American General Corp.	3,976,000	277,900	29.9	126.8 ³	114.8 ³	772,700	4.8	(196,400)	(112.8)	97,300	3.0	540,800	(10.3)
3	The Continental Corp.	3,450,000	50,000	20.8	114.3	115.1	1,960,000	5.4	(275,100)	2.6	264,200	19.1	N/A	N/A
4	Old Republic Int'l (inc. life) ²	387,915	44,200	13.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	SAFECO Corp.	1,435,796	96,096	1.3	109.3	102.7	729,944	8.4	(64,695)	(267.9)	82,450	7.0	435,934	(12.1)
6	The Travelers Corp. & subs.	10,148,815	225,366	(4.0)	115.5	117.4	2,574,844	12.7	(394,953)	(59.6)	216,406	8.8	937,849	(4.2)
7	American International Group	3,120,000	279,729	(14.5)	106.1	99.5	1,809,367	0.6	(114,057)	(476.1)	243,428	1.8	2,824,021	8.5
8	USF&G Corp.	2,039,900	89,300	(27.8)	123.6 ³	115.2 ³	1,658,300 ³	13.7	(391,600)	(70.2)	323,100	25.5	702,600	(56.3)
9	CNA Financial Corp.	2,734,300	73,900	(32.2)	126.0	119.9	1,404,200 ³	21.2	(389,600) ³	(52.7)	341,300 ³	17.2	1,029,800	1.8
10	General Re Corp.	1,308,373	93,644	(40.1)	119.5 ³	103.2 ³	776,359	16.4	(143,515)	(720.8)	155,969	14.1	641,386	(27.3)
11	Aetna Life & Casualty Co.	11,380,900	149,200	(41.8)	117.6	112.6	2,996,800	7.9	(468,900)	(42.0)	390,800	7.0	1,432,993	(19.5)
12	Chubb Corp.	1,464,200	39,300	(43.8)	114.8 ³	106.4 ³	1,043,600	10.2	(149,700)	(155.9)	113,500	19.5	415,000	(3.1)
13	Hartford Insurance Group	4,245,802	85,518	(51.3)	122.2	112.7	2,373,772	0.7	(500,542)	(70.5)	345,778	2.0	1,274,147	(15.1)
14	Reliance Ins. Co. & subs.	1,063,638	24,008	(54.5)	113.9 ³	108.3 ³	957,227	10.4	(122,753)	(106.9)	127,043	4.9	584,152	—
15	Ohio Casualty Corp.	698,165	20,134	(56.3)	113.5	105.8	684,802	3.6	(87,541)	(131.1)	75,535	12.8	343,999	(26.6)
16	Royal Group (U.S. subs.) ³	N/A	(94,000)	(64.9)	121.5	116.1	954,000	(0.5)	(207,000)	(32.7)	140,000	7.7	N/A	N/A
17	Hartford Steam Boiler	177,286	4,241	(69.3)	115.8	98.0	118,352	(1.8)	(18,567)	(945.1)	15,129	18.8	110,966	(40.8)
18	The Home Group Inc.	1,540,614	17,337	(69.7)	130.0	120.5	1,167,919	(3.5)	(337,182)	(38.3)	240,692	6.3	571,798	(4.1)
19	Fireman's Fund Ins. Cos.	3,023,056	32,553	(81.0)	120.1	111.6	2,133,058	(2.1)	(432,572)	(82.4)	299,638	(5.8)	677,144	(27.6)
20	Kemper Corp.	1,704,142	7,087	(85.1)	122.5	111.6	481,731	(26.4)	(115,594)	(56.1)	58,530	5.9	299,804	(8.0)
21	CIGNA Corp.	10,663,512	2,389	(99.2)	129.8 ³	118.9 ³	3,105,162	14.4	(928,902)	(68.9)	428,331	2.1	1,115,000	(17.2)
22	Crum & Forster Inc.	N/A	(21,283)	(122.5)	121.2	111.5	1,687,453	23.1	(360,700)	(220.6)	246,017	8.7	N/A	N/A
23	Sentry Ins. Cos. ³	354,390	(6,314)	(180.6)	115.7	109.3	641,650	13.1	(108,424)	(77.4)	72,195	7.2	178,266	(21.1)
24	The St. Paul Cos. Inc.	1,731,438	(93,193)	(190.1)	128.9 ³	111.5 ³	1,374,287	8.4	(388,127)	(173.0)	235,407	15.3	568,500	(37.8)
25	Mission Ins. Group Inc.	398,648	(102,010)	(695.3)	146.3	112.0	343,479	13.1	(149,685)	(329.3)	40,894	17.6	142,783	(48.7)
	— Liberty Mutual Ins. Co.	N/A	N/A	N/A	117.9	116.3	2,243,430	3.7	(313,997)	(27.5)	397,681	3.5	N/A	N/A
	— Commercial Union Ins. (U.S.)	N/A	N/A	N/A	122.1 ²	118.5 ²	991,100 ³	(7.2)	(209,000) ³	(4.5)	131,800	(6.7)	380,800	(17.5)
	— Wausau Insurance Cos.	N/A	N/A	N/A	124.7	125.4	847,833	13.0	(208,736)	(65.8)	114,804	(27.8)	N/A	N/A
Cumulative		67,572,542	1,292,633	(51.8)	120.4	113.4	36,038,204	6.8	(7,140,258)	(71.9)	5,234,689	7.1	15,207,742	(13.5)

¹ After dividends.

² Before dividends.

³ Statutory.

N/A—Company did not provide data.

Continued from facing page

USF&G Corp. has invested \$141.3 million in put options, says Paul W. Schlough, USF&G's vp-investor relations. Ohio Casualty put through two put option deals, one for about \$60 million in the third quarter and one for about \$25 million in the fourth quarter, says C. David Mencer, controller.

But some insurers don't engage in put options. For instance, a Chubb spokesman says, "We don't like that kind of an investment."

"They're just going to come back at you at

some point. It's a short fix for what should be a long-term cure," he says. Also, depending on what happens with interest rates, he says companies risk having to buy back the municipal bonds at a loss.

But, Mr. Mencer says, "We don't view it as being a particularly risky transaction for us, the way it's been structured."

The company's tax-exempt bonds, he says, were "not doing us any good because of our underwriting loss." By the time the put comes due in two years, he says, the firm ant-

icipates the cycle will have turned and the firm will need tax-free income again.

In a sale-leaseback arrangement, a company sells a building, usually its headquarters, with the proviso that it can lease it for an agreed period of time. The proceeds of the sale are then invested.

Among companies that have made sale-leaseback deals this year are USF&G, which sold its Baltimore headquarters in July for \$100 million with an estimated capital gain of \$50 million, a spokesman says. Also, CIGNA

sold the Insurance Co. of North America's old headquarters in Philadelphia in a \$135 million transaction, says Mr. Fowler.

Miller Tabak's Mr. Brokaw says companies engaging in sale-leasebacks are doing things that "don't make much economic sense," but CIGNA's Mr. Fowler disagrees.

"It makes economic sense for us to do that," he says. Not only will CIGNA gain an immediate benefit from the sale, he says, but the benefit will accrue over a period of time through investment income.

BI Industry Stock Report

NOV. 20, 1984 11/14/84 THRU 11/20/84

Insurance Cos.	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	34.63	-2.1	17.8	2.64	7.6	35.25	34.63	389.7
American Bankers Ins Group	11.25	0.0	6.9	0.50	4.4	11.38	11.13	100.1
American General Corp	23.75	-5.9	8.8	0.90	3.8	25.00	23.75	572.3
American Indty Finl Corp	17.25	0.0	0.0	1.12	6.5	17.25	17.25	1.7
American Intl Group Inc	64.50	-4.4	12.6	0.44	0.7	67.38	64.50	569.3
American Natl Ins Co	28.00	-3.4	7.7	1.08	3.9	28.88	28.00	52.6
Aneco Reins Ltd	1.38	-8.3	4.0	0.00	0.0	1.50	1.38	5.5
Avaco Corp	19.50	-1.9	13.1	0.60	3.1	20.00	19.50	2.2
Banks Iowa Inc	43.50	-2.2	13.7	1.56	3.6	44.00	43.00	6.2
Bitco Corp	6.50	-7.1	0.0	0.40	6.2	7.00	6.50	45.0
Carolina Gas Ins Co	3.25	0.0	0.0	0.00	0.0	3.25	3.25	0.0
Chubb Corp	46.75	-3.1	11.9	2.20	4.7	48.38	46.75	490.0
Continental Corp	34.88	-2.1	8.8	2.08	6.0	35.50	34.88	66.5
Crawford & Co	31.88	-7.3	212.5	2.60	8.2	34.50	31.88	575.6
Crown Life Ins Co	115.50	0.0	7.5	4.00	3.5	115.50	115.50	0.4
Employers Cas Co	36.25	3.6	8.3	1.20	3.3	36.25	35.00	10.1
Equifax Inc	32.00	-0.4	12.9	1.70	5.3	32.63	32.00	50.3
Farmers Group Inc	49.25	-1.3	10.6	1.52	3.1	49.75	49.25	476.9
Foremost Corp Amer	27.50	-0.9	16.1	0.96	3.5	27.75	27.50	63.9
Fremont Gen Corp	14.50	-14.7	20.7	0.48	3.3	16.88	14.50	177.7
Great West Life Assurn Co	310.50	0.0	8.3	12.00	3.9	310.50	310.50	0.0
Hanover Ins Co	28.00	0.0	13.3	0.56	2.0	28.00	27.75	18.7
Hartford Steam Boiler Inspnt	58.00	-0.9	28.3	3.00	5.2	58.50	58.00	2.7
Jefferson Natl Life Ins Co	21.00	-4.0	9.9	0.44	2.1	21.88	21.00	11.9
Kemper Corp	40.38	0.6	41.6	1.80	4.5	41.00	40.38	74.8
Lincoln Natl Corp Ind	37.50	-7.4	8.7	1.84	4.9	40.38	37.50	476.5
Mission Ins Group Inc	7.63	-4.7	0.0	0.50	6.6	7.75	7.50	348.2
Northwestern Natl Life Ins	26.00	-2.8	10.1	0.80	3.1	27.00	26.00	147.2
Ohio Cas Corp	41.13	0.0	15.6	2.68	6.5	41.13	41.00	53.3
Old Rep Intl Corp	32.75	-0.8	6.6	0.88	2.7	33.00	32.75	24.9
Orion Cap Corp	22.25	-4.3	25.9	0.76	3.4	22.75	22.25	45.1
Preferred Risk Life Ins Co	26.00	2.0	10.2	0.74	2.8	26.00	25.75	1.5
Provident Life & Acc Ins Co	80.00	-0.6	7.5	2.88	3.6	80.00	79.50	33.2
St Paul Cos Inc	47.88	-3.3	97.7	3.00	6.3	49.00	47.88	883.5
SAFECO Corp	29.13	-6.8	8.1	1.50	5.2	30.13	29.13	361.2
Sri Corp	16.75	-2.9	13.8	0.68	4.1	17.25	16.75	70.9
Selberts Bruce Group Inc	20.50	3.8	0.0	0.80	3.9	20.50	20.25	35.6
Statesman Group Inc	5.38	7.5	8.0	0.15	2.8	5.38	5.00	78.9
Tokio Marine & Fire Ins Co	136.75	-1.6	27.6	1.05	0.8	138.50	136.75	1.9
Travelers Corp	35.75	-1.4	9.0	1.92	5.4	36.25	35.75	360.0
United Fire & Cas Co	17.00	0.0	0.0	0.80	4.7	17.00	17.00	0.0

NOV. 20, 1984 11/14/84 THRU 11/20/84

Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)	
United States Fid & Gty Co	23.88	-3.5	7.7	2.08	8.7	24.88	23.88	372.8
United Svcs Life Ins Co	28.63	0.0	8.2	1.20	4.2	28.63	28.63	9.9
Uslife Corp	33.88	1.1	9.4	1.04	3.1	34.38	33.50	760.0
Washington Natl Corp	20.88	-4.6	11.5	1.08	5.2	21.75	20.88	54.3
Zenith Natl Ins Corp	11.50	-2.1	9.1	0.68	5.9	11.50	11.50	31.9
INSURANCE COMPANIES								
AVERAGE								
				13.1			3.9	
Agents/Brokers								
Alexander & Alexander Svcs	24.00	0.0	0.0	1.00	4.2	24.25	24.00	119.2
Baldwin & Lyons Inc	42.00	0.0	14.7	0.80	1.9	42.00	42.00	0.5
Corroon & Black Corp	28.00	-0.9	37.3	1.00	3.6	28.25	28.00	76.4
Crump E H Cos Inc	18.00	5.1	16.1	0.44	2.4	18.38	17.63	28.6
Eneet & Chandler Cos Inc	11.00	0.0	0.0	0.00	0.0	11.00	11.00	0.0
Gallagher Arthur J & Co	27.00	0.9						

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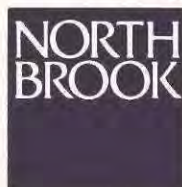
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