

business insurance

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

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Four NYIE syndicates stop writing all business

NEW YORK—Four New York Insurance Exchange syndicates managed by Pruco Managers Inc. have stopped writing new and renewal reinsurance and direct insurance business.

The four syndicates, which ceased underwriting late last month, are Pruco Syndicate Inc., the seventh-largest on the exchange last year in terms of gross premium volume.

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Regulator challenging group coverage program

By JERRY GEISEL

TOPEKA, Kan.—The Kansas Insurance Department is challenging the ability of a group of insurance buyers to tap a federal law that allows them to buy product liability insurance free from state regulation.

In a suit filed in U.S. District Court in Topeka, Insurance Commissioner Fletcher Bell questions whether organizations that do not manufacture or sell products can take advantage of a provision in the federal Risk Retention Act that pre-empts state restrictions on the group purchase of product liability insurance.

The suit says Congress passed the Risk Retention Act to give new risk-financing techniques only to product sellers—manufacturers, wholesalers, distributors or retailers—and not to product consumers.

The controversy centers on a "purchasing group" organized by Doug Ruedlinger Inc., a Topeka insurance

agency, through which national and state high school athletic associations and 70% of the nation's high schools buy coverage underwritten by Insurance Co. of North America. The program provides up to \$5 million of liability coverage for sports injury claims.

"We feel there is no product liability insurance here. The purchasing group concept was not intended to cover this kind of program," said Ted Fay Jr., an attorney with the Kansas Insurance Department. This program is "stretching the law past the snapping point," he adds.

However, a brief filed on behalf of Ruedlinger and INA, a unit of CIGNA Corp., says the coverage provided through the program covers product liability exposures created by the schools' participation in the design, testing and distribution of sports equipment.

The outcome of the Insurance Department's suit, which seeks a ruling that the Ruedlinger program is not a bona fide purchasing group, could have ramifications beyond high school athletic insurance.

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'There is no product liability insurance here. The purchasing group concept was not intended for this kind of program,' says Mr. Fay.

N.J. cancellation rules challenged by insurers

By MEG FLETCHER

TRENTON, N.J.—Insurers are asking the New Jersey Superior Court to throw out the state Insurance Department's emergency rules that restrict insurers' rights to cancel or not renew most property/casualty insurance policies.

The American Insurance Assn., the National Assn. of Independent Insurers and the Alliance of American Insurers—all insurer trade associations—filed a joint challenge Oct. 25 in the appellate division of the state Superior Court.

They charge that the rules, which apply to both admitted and surplus lines insurers and affect both commercial and personal lines coverage, are unconstitutional, arbitrary and unreasonable and violate the department's statutory limits of authority.

They say they threaten the solvency of insurers writing business in New Jersey and severely restrict capacity for new risks.

The rules went into effect Sept. 17 and are in force until Nov. 16, when Insurance Commissioner Hazel Frank Gluck can either cancel them or reinstate them.

Ms. Gluck refused to comment on her plans, but the insurers say in their court papers that she has proposed to make the emergency rules permanent.

Allstate Insurance Co. of Northbrook, Ill., has also filed a separate appeal in Superior Court, seeking to exempt its personal lines coverages from the emergency rules.

Both the trade associations and Allstate have requested that the state Insurance Department be prohibited

from implementing the emergency rules during the appeal process. A hearing on that request was to be held last Friday.

In recent months as the commercial insurance market has tightened drastically, many states have issued orders to control the availability of insurance coverage for public entities and corporations. However, the New Jersey order is much more restrictive than regulations in other states.

"The New Jersey regulation is the most outlandish of all the regulations that have come down," said Patrick O'Brien, senior counsel for the American Insurance Assn.

Specifically, the New Jersey order:

- Prohibits midterm premium increases and/or any reduction in the amount of coverage provided under a policy.

- Prohibits insurers from canceling blocks of policies and from not renewing entire lines of insurance, unless Ms. Gluck approves a plan for such actions that minimizes marketplace disruption and provides for alternative coverage at comparable rates and terms.

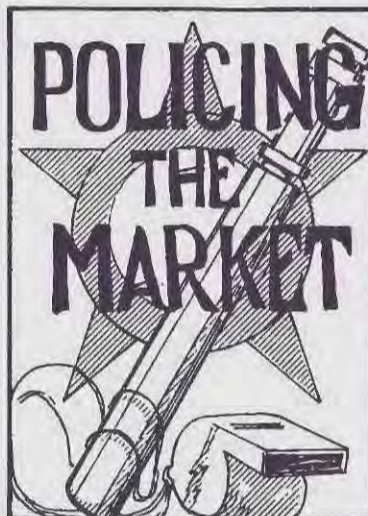
- Prohibits issuance of notices of non-renewal or cancellation by an insurer unless the insurer seeks Insurance Department approval 90 days in advance of the action.

The department then has 30 days to respond after the insurer files all documentation.

This rule does not apply to a cancellation due to non-payment of premium or if the buyer in any other way fails to act in good faith.

Several insurers point out that they did not find out about the new rule until after it was in effect. There

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Next move on claims-made up to regulators

By CAROL CAIN and LORRIE GIBSON

The claims-made controversy is back in state regulators' court.

As it promised in early October, the Insurance Services Office last week filed with all 50 states significant revisions to its proposed commercial general liability claims-made form.

The revisions establish a five-year, automatic extended claims reporting period for known occurrences; change the trigger of coverage to include claims made verbally to the policyholder or insurer rather than only claims made in writing; limit when an insurer can advance the retroactive date of a policy; provide for the reinstatement of the aggregate limits of the policy for tail coverage; and withdraw endorsements that limited the availability of unlimited tail coverage.

These changes—made only after much pressure from buyers, agents/brokers and regulators—will be the last before the Jan. 1 target date for use of the new form, ISO has stressed.

"We have filed a contract that we believe provides the features and safeguards needed by both insurers and policy holders," said Fred R. Marcon, senior executive vp and chief operating officer of ISO.

"No ISO product is cast in concrete," he continued. "But the time for dialogue for the CGL policy is over. Now is the time for action."

"The policy must be in place Jan. 1 so that those insurers who are ready to use it—especially those who need the claims-made form

to renegotiate expiring reinsurance contracts—have it available and fully supported.

"I'm sure that both ISO and regulators will be studying the impact of the policy after it is subjected to its ultimate test—the marketplace."

However, the revisions filed last week do not answer all buyers' and producers' concerns about the new form and, more significantly, do not address specific concessions state regulators cited last month as prerequisites for approval of the new claims-made form (BI, Oct. 28).

Nonetheless, ISO is moving ahead, confident its most recent revisions will satisfy regulators' concerns.

"I am confident that you will be reassured that the claims-made program, with the changes we have introduced, can be marketed to a broad spectrum of the insurance-buying public, satisfying both insurers' objec-

tives and the reasonable coverage expectations of policyholders," said Mr. Marcon in a cover letter attached to the revised filings.

The cover letter, which normally would originate from the ISO field staff rather than Mr. Marcon, explains ISO's perspective on the revisions and why it wants a claims-made form in place for Jan. 1.

"These changes materially reinforce, through additional contractual guarantees and manual rules, the economic and competitive safeguards that already exist. In effect, they put in place the promises and representations about the intended application of the program that have already been publicly made by ISO and our affiliated insurers," Mr. Marcon's letter says.

"We believe you share our view that insurers and reinsurers cannot be expected to commit scarce capital to ill-defined, erratic

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update

4 NYIE syndicates stop writing

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ume; Essex Syndicate Inc.; John Street Syndicate Inc.; and Republic Western Syndicate Inc.

A Pruco spokesman confirmed the syndicates have stopped underwriting but said they have taken no action yet to formally withdraw from the exchange. The spokesman would not say whether the underwriting suspension was temporary. He said, "At this time, we feel our resources can be used more profitably elsewhere."

Pruco Managers had planned earlier this year to merge the operations of the Pruco, Essex and John Street syndicates, but that merger never became effective, the spokesman said.

Pruco Syndicate last year wrote gross premiums of \$13.2 million; Essex wrote \$6.5 million; John Street wrote \$6.6 million; and Republic Western, formed in May 1984, wrote \$196,000.

The four syndicates offered a combined per-risk capacity of \$750,000 on both property and casualty business.

Steel maker to terminate plans

WASHINGTON—The head of the Pension Benefit Guaranty Corp. says the proposed termination of four massively underfunded Wheeling-Pittsburgh Steel Corp. pension plans is an abuse of the PBGC insurance program, and the agency is exploring ways to protect it from picking up all the liabilities.

As expected, Wheeling-Pittsburgh last week told the PBGC it intends to terminate its plans as part of a new labor agreement with the United Steelworkers union. Those plans have \$475 million in unfunded liabilities.

The termination of the plans is the biggest loss in the PBGC's 11-year history and boosts the agency's deficit past \$1 billion, up from \$462 million a year ago.

"The Wheeling-Pittsburgh case clearly demonstrates the need for reforms," says PBGC Executive Director Kathleen Utgoff.

In addition, PBGC officials want the effective date of legislation passed by the House that makes it more difficult for companies to dump their pension liabilities onto the PBGC can be made retroactive so the agency wouldn't have to absorb all of Wheeling-Pittsburgh's pension liabilities (BI, Oct. 14).

Currently, the pending legislation does not include a retroactive date.

Bermuda court to rule on Mentor

HAMILTON, Bermuda—Bermuda's Supreme Court will hold a private hearing Nov. 14 to review the nominations for a committee of inspection to oversee the liquidation of Mentor Insurance Ltd.

About 200 creditors failed to agree on the composition of the committee at their first meeting Sept. 20, but voted on nominations.

The ballot produced a majority vote in favor of a committee of 10 creditors. These are: Rotterdamse Assurantiemas, The Hartford Insurance Group, Continental Insurance Group, American Centennial Insurance Co., Ennia Reinsurance, Manufacturers Hannover Trust, Morgan Guaranty, Bank of America, First City National Bank of Houston and the London law firm of Neville Russell, which represents the interests of Lloyd's of London syndicate 317.

Irving Trust, which is believed to be claiming about \$60 million from the failed insurer, was the only one of five major U.S. banks that was not nominated to the committee.

The 10 nominated creditors are among hundreds of creditors owed an estimated \$178.5 million by Mentor, a subsidiary of New Orleans-based Ocean Drilling & Exploration Co. Mentor was forced into liquidation in June by the Bermuda government after the company failed to meet statutory solvency requirements.

Mentor liquidator Charles Kempe, who predicts the liquidation will take years to complete, said the delay in forming the committee has not held up liquidation work. Bermuda's Companies Act gives the island's official receiver, Verbena Daniels, the same powers as a committee of inspection, he noted.

An interim report prepared in June by the liquidators estimated a \$30.5 million shortfall in Mentor's ability to meet demands from creditors.

Monsanto shareholder files suit

CHICAGO—A Monsanto Co. shareholder is suing Monsanto and G.D. Searle & Co., claiming they wrongfully failed to inform shareholders about hundreds of liability lawsuits pending against Searle when it was acquired by Monsanto last summer.

The suit, which alleges violations of federal securities laws, says the companies should have informed shareholders of the lawsuits and potential liability stemming from the Skokie, Ill.-based Searle's

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Hurricane Juan causes big losses for oil drillers

By STEVE TARAVELLA

NEW ORLEANS—Oil drillers in the Gulf of Mexico say they were caught off guard by the force of Hurricane Juan, which caused extensive damage and several deaths.

"As far as the oil industry is concerned, this was much more devastating than any storm we've seen in the Gulf of Mexico in at least three years and probably since Allen" in 1980, observes Greg Gant, vp at Matthews-Daniel Co., a Houston-based marine surveying and adjusting firm.

Jean Cochran, manager of energy claims for wholesale broker J.H. Blades & Co. Inc. in Houston, estimates Hurricane Juan will be more costly to the insurance industry than Hurricane Elena, primarily because of the loss of human life.

Hurricane Elena caused an estimated \$543.3 million in insured damage when it slammed into the Gulf Coast in September (BI, Sept. 16).

Estimates of total damage from Hurricane Juan last week ranged as high as \$1 billion, including flood damage to some 50,000 homes.

And, that cost could rise higher. Late last week, the storm returned to sea and threatened to strike

the coasts of Alabama and Florida.

Among the commercial property suffering the most extensive damage were two jack-up oil drilling rigs and one oil and gas production platform.

Drillers say they were surprised by Hurricane Juan, which struck swiftly. At the end of the workday on Friday, Oct. 25, the storm was considered only a tropical depression. The next day, Juan was packing winds up to 50 mph and on Oct. 27 its winds reached full hurricane strength of 75 mph, according to the National Hurricane Center.

By the time most drillers realized the danger, the weather was too rough to risk evacuation by either

boat or helicopter, they say.

Juan struck drilling operations on the southwest Louisiana shore for about 48 hours, packing waves as high as 30 feet and winds of up to 85 mph.

Four people are known dead in oil-drilling related accidents, and six more were missing late last week.

The Coast Guard reported losses to five oil-related vessels. And the Coast Guard said it rescued a total of 163 people in the hurricane, which it said is far more than usual.

Penrod Drilling Co. in Dallas is believed to have

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'As far as the oil industry is concerned, this was much more devastating than any storm in the Gulf in at least three years,' says Mr. Gant.

Congressional feud stalls Superfund bill

By ROBERT A. FINLAYSON

WASHINGTON—Wrangling among members of two House committees over key pollution liability and cleanup issues is holding up full House action on legislation to reauthorize the federal Superfund Act.

The taxing authority that finances the hazardous waste cleanup program expired Sept. 30 because Congress failed to reauthorize the cleanup law before that date.

While the Senate has approved a reauthorization measure, House action has been held up because five separate House committees sought and received authority from the House leadership to examine and amend the Superfund legislation.

Although the House Energy and Commerce Committee's bill, H.R. 2817, was used as the primary legislative vehicle by three of the four other House committees examining the reauthorization, the Public Works and Transportation Committee chose to write its own bill.

Members of the Energy and Commerce Committee and the Public Works and Transportation panel are now trying to reconcile differences between the two measures so they can present one bill to the House Rules Committee, the last stop a bill must make on its way to the House floor.

If they fail to reach a compromise, a lengthy debate

on the House floor will likely result, possibly killing any hope that a Superfund reauthorization will be enacted this year, observers say.

One of the sticking points in discussions between committee members is language that would establish a so-called citizen suit provision in the Superfund law.

Such a provision, contained in both bills, would allow citizens to sue companies to compel them to comply with federal environmental regulations. Currently, only the federal government has this right.

The two committees are arguing over whether the law should allow any citizen to bring a suit to force a company to comply with environmental rules or whether only citizens actually injured by an alleged non-compliance could bring suit.

Also under discussion is whether citizen suits could be brought to force a company to clean up a dump site or potential hazard even if the company complied with government regulations.

The provision would also allow citizens to ask federal courts to force the Environmental Protection Agency to take actions specified under the cleanup law, like promulgating regulations and performing studies.

Generally, the Energy and Commerce Committee's bill takes a more restrictive position against consumer suits, while the Public Works Committee's bill grants

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Insurer set to write coverage for asbestos removal firms

HARTFORD, Conn.—A new insurance company specializing in coverage for asbestos removal contractors is expected to write its first policy later this month.

The new insurer, United Coastal Insurance Co., is a subsidiary of United Coasts Corp., which is partially owned by Acmat Corp., one of the nation's largest asbestos removal contractors (BI, June 3).

United Coastal, which is licensed in Arizona, has been capitalized at \$10 million and will write liability, disability and automobile coverages.

Acmat, based in East Hartford, Conn., helped form the company after its property/casualty insurance program was canceled by CIGNA Corp. earlier this year. It has since sued CIGNA and three subsidiaries in a Connecticut state court over the cancellation.

Acmat President Henry W. Nozko, Sr., said United Coastal expects to do business as a non-admitted insurer in about 35 states. The company is forecasting a premium volume of about \$35 million in its first year.

Although the company initially will focus on writing coverage for asbestos removal contractors, it also plans to insure other types of businesses, Mr. Nozko said.

The company expects a maximum capacity of \$1 million for liability coverage for asbestos removal contractors, he said. Liability coverage will be on a claims-made basis and a \$2,500 deductible is expected.

Besides Acmat, other investors are Acceleration Corp., a Dublin, Ohio-based insurance holding company, and Chase Enterprises, a business interest of Hartford developer David T. Chase and his family.

Chase Enterprises will provide United Coastal with management services, while Acceleration Corp. will provide accounting and financial services.

Benefit forms due

The annual directory of employee benefit consultants will be published in the Dec. 23 issue of *Business Insurance*, which will contain a spotlight report on employee benefit issues.

There is no charge to be listed in the directory. However, those employee benefit consultants who wish to be included must complete and return a questionnaire supplied by *Business Insurance*.

If you have not yet received a questionnaire, you may request one by writing: Directory Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611; or by calling 312-649-5279.

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EPA won't delay coverage rules for waste sites

By ROBERT A. FINLAYSON

WASHINGTON—More than 100 businesses that operate or manage hazardous waste disposal facilities may be forced to close these sites Nov. 8 because they cannot obtain environmental impairment liability insurance.

Environmental Protection Agency Administrator Lee M. Thomas told Congress in an Oct. 18 letter the EPA will "fully implement" a November 1984 amendment to the Resource Conservation and Recovery Act, which required businesses to meet federal financial responsibility requirements by Nov. 8 or close their facilities.

Most of the businesses affected by the deadline are small to mid-sized manufacturing firms, including small chemical companies, wood-treating firms, metal finishers, small petroleum refiners and other manufacturers.

Most of the larger companies that operate waste disposal facilities are able to meet the federal financial responsibility requirements by self-insuring their EIL exposures.

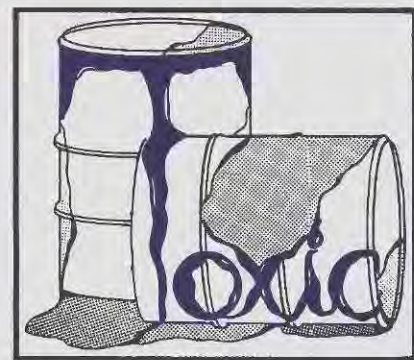
The EPA letter ended months of speculation over whether the agency would grant some relief to businesses affected by the congressional deadline.

However, Congress could still grant that relief.

Although the letter does not specifically ask for Congress to change the Nov. 8 deadline, EPA officials say privately that it gives Congress a chance to evaluate the impact of the deadline.

"The letter says: 'This is what's happening,' and sort of asks the question: 'Is that what you want?'" an EPA official explained.

EPA officials are concerned that the congressional deadline could drive legitimate hazardous waste disposal firms out of business while forcing waste generators to close their own disposal facilities. The result could be a shortage of waste disposal capacity.



Congressional staffers say members are "monitoring the situation closely." Staffers report that several plans to alter the deadline are under consideration by members of the House and Senate committees responsible for environmental laws. But, no decision has been made to move the deadline back, the staffers say.

A staffer with the Senate Environment and Public Works Committee said one option under consideration is to extend the deadline for specific classes of facilities.

For example, the deadline could be extended for facilities run by smaller firms that are in compliance with all other EPA regulations, the staffer said.

But House and Senate staffers say some sort of a deadline will be maintained.

In fact, they point out, Congress originally imposed the deadline out of a concern that the EPA would not use the financial responsibility requirements to close unsafe hazardous waste disposal facilities.

Under the federal financial responsibility rules, companies must either pass a stringent test to demonstrate they have the financial strength to self-insure their EIL exposures or purchase EIL insurance with limits of \$3 million per occurrence and a \$6 million annual aggregate.

But businesses affected by the deadline claim that although they are in compliance with all other EPA regulations, they still cannot purchase EIL insurance because the market for such coverage is practically non-existent.

While House members are somewhat less sympathetic than their counterparts in the Senate, members generally realize the current property/casualty insurance market is making it difficult for even the best-run hazardous waste facilities to obtain EIL coverage, congressional staffers explain.

In the past 18 months, the EIL insurance market has dwindled to just a

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Quake losses

Lack of coverage keeps total lower than feared

MEXICO CITY—U.S. and foreign insurers and reinsurers say their losses from the recent Mexico City earthquakes—although sizable—will not be not as great as they had thought because many buildings damaged or destroyed were not insured.

A United Nations report estimates total losses throughout Mexico from the two September quakes at \$4 billion, including economic losses such as the loss of tourism.

The U.N. report also says 6,000 people are known dead, and 2,000 are missing and presumed dead.

However, Mexico's 44 insurers so far have reported 5,000 claims worth only about \$400 million. And although the insurers say that total could rise, they say most of the claims already have been filed.

The difference between the total losses and the amount of claims received by insurers stems from the lack of coverage on many Mexican property risks.

"The water and drainage networks certainly were not" covered, says Benjamin de la Cueva, director of the Mexican Assn. of Insurance Institutions.

And, it is unclear whether government buildings that collapsed in the initial quake on Sept. 19 were covered, he says.

"Insurance density is not as high in Mexico as it is in the U.S., Britain or Germany," says a spokesman for Munich Reinsurance Co. in Munich. The company says it cannot yet estimate its share of the Mexican quake losses.

The Munich Re spokesman explains: "In 1984, the biggest loss ever to hit Germany was the hailstorms. It cost the economy 3 billion deutschmarks (\$1.1 billion), and of that, 1.5 billion deutschmarks was

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Photo: AP/Wide World

Passers-by inspect the Hotel Regis in Mexico City, damaged severely in the recent quakes.

Florida law calls for certification of health care risk managers

By DONNA DiBLASE

TALLAHASSEE, Fla.—An advisory committee that includes two risk managers will meet this week with state Insurance Department officials to discuss the criteria the state will use to certify risk managers at health care facilities.

Under a law passed earlier this year by the state Legislature, Florida will certify and regulate risk managers at health care facilities in the state beginning June 1, 1986.

Florida is the only state that requires the certification of any type of risk manager.

In addition, the law requires medical facilities like hospitals and health maintenance organizations to develop comprehensive risk management programs by June 1.

While the 90-page law contains a wealth of provisions to reduce medical malpractice litigation and awards, "risk management is the buzzword" of the law, says Roberta Carroll, director of risk management at Mount Sinai Medical Center in Miami Beach and a member of the the advisory committee.

"The law is intended to help to decrease any patient injuries by negligence and to decrease the amount of claims. We're trying to make internal risk managers a

qualified breed of people who know what they're doing," Ms. Carroll explains.

However, other health care risk managers disagree with the regulation of risk managers.

State certification of health care risk managers is "an interesting idea, but I don't think it's going to work," says William Ryan, risk manager at the University of Michigan in Ann Arbor which operates a hospital.

In legislators' effort to lower malpractice insurance costs and claims, "Are they really interested in risk management—a financial function—or quality assurance—a clinical function?" he asks.

Ms. Carroll says the Florida risk manager certification program probably will require risk managers to attend courses in hospital risk management.

Risk managers probably will have to continue taking courses in order to renew their certification, she says, which probably will be required every two years.

Besides Ms. Carroll, other members of the advisory council include Robert Mitchell Sr., risk manager at Holmes Medical Center in Melbourne; Dr. Duane Zimmerman, assistant director of the Orlando Regional Medical Center in Orlando; Patrice Tavernier, a risk management consultant for St. Paul Fire & Marine Insurance Co. in Maitland; and Rosemary Jenkins, presi-

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Insurers want controls on transplant costs

By DIANE LYNN KASTIEL

WASHINGTON—Employers and health insurers need "cost relief" from the debilitating expenses of organ transplants, says one health care lobbyist.

And, this relief will be provided only through some type of governmental regulation, according to Geza Kadar Jr., an attorney and lobbyist for the Health Insurance Assn. of America in Washington.

"Another medical specialty breakthrough may be the payer's bankruptcy," Mr. Kadar told benefit experts at the 39th annual Council on Employee Benefits conference last month in Washington.

"By seeking a more cost-conscious technology assessment and coverage process, we hope to be able to manage our way through this challenge. And . . . to do this effectively and in a manner that is fair to all our citizens, we have to have positive leadership from the federal government."

'By seeking a more cost-conscious technology assessment and coverage process, we hope to be able to manage our way through this challenge. And . . . to do this effectively and in a manner that is fair to all our citizens, we have to have positive leadership from the federal government,' Mr. Kadar said.

The HIAA, a trade association and lobbying group sponsored by health insurers, has set a goal of obtaining a "new and more active government role defined in federal law," Mr. Kadar said.

"Specifically, we're trying to get cost concerns built into technological assessment and Medicare coverage policy," he said.

The insurance industry has changed its position in recent years from not covering organ transplants because they were considered "experimental" to providing coverage,

Mr. Kadar said.

According to an HIAA survey, 97% of health insurers are routinely covering kidney transplants and skin transplants, 85% cover heart transplants, 80% cover liver transplants and 69% cover heart/lung transplants, Mr. Kadar said.

"I wish I could report that this remarkable turnabout in industrywide practice was the result of a well-reasoned policy review process which carefully balanced individual needs with the public good," Mr. Kadar said.

However, the insurance industry instead is responding to the flames of public pressure, fanned by an overzealous media that turn organ transplants into national events, he explained.

He cited the case of Jamie Fisk, the young girl who needed a liver transplant to save her life. Her father's emotional appeal to Congress to help him find a donor was broadcast nationally.

"We weren't well-prepared to deal with the emotionally charged media pressure put on our coverage determination process as it pertains to transplantation," Mr. Kadar said.

"For those of us trying to build a political consensus for a rational, national approach to managing this major technological breakthrough, this development is scary."

In response, the HIAA's board of directors voted to support a limit on the number of health care facilities that can perform transplant operations.

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Hurricane losses

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suffered the largest property losses.

A Penrod jack-up, a drilling rig that is anchored to the ocean floor, broke loose and sank during the storm after damaging a second jack-up rig.

Each rig has an insured value of \$36 million, sources say.

The sunken rig, Penrod #61, had not been declared a total loss late last week, according to a spokesman for the drilling contractor. He could not estimate the amount of damage to the other rig, Penrod #60.

Both rigs are insured in the London market, with a Lloyd's of London syndicate managed by R.M. Pateman Underwriting Agencies Ltd. serving as the lead underwriter, sources say. The coverage was placed through Lloyd's broker Sedgwick Group P.L.C.

All 39 men aboard Penrod #60 were rescued, but a 27-year Penrod

veteran aboard the sunken rig was killed, says the spokesman.

Penrod's liability coverage, which will cover the death claim, is also led by the Pateman syndicate, sources say. Details about the coverage were not available, but Lloyd's sources said no liability reserve has been established.

The company's coverage is believed to have been renewed only three weeks ago, sources say.

Penrod was operating the rigs for Chevron USA Inc. of San Francisco when the hurricane struck.

Both rigs were constructed by Marathon LeTourneau Co. in Vicksburg, Miss., and were designed to operate in up to 300 feet of water, reports the Penrod spokesman. The rigs, two of 129 Penrod rigs operating worldwide, were in about 200 feet of water before the storm.

ODECO Oil & Gas Co., a subsidiary of New Orleans-based Ocean Drilling & Exploration Co., also lost a production platform when winds

ripped it from its ocean-floor anchor. All five crewmen aboard were rescued.

The platform, which is used to process oil and gas, is valued at about \$10 million, sources say. An ODECO spokesman said last week the company had no details on the loss.

ODECO Risk Manager Richard W. Bryan says the company is "well-insured" for the loss.

Mr. Bryan said ODECO's primary coverage for the platform was placed in the U.S. and London markets by broker Marsh & McLennan Inc. in New Orleans.

He also said excess coverage was underwritten by Oil Insurance Ltd. in Bermuda, a captive owned by about 30 oil companies.

He declined to comment further on the coverages.

ODECO evacuated about 10 of its 23 rigs in the Gulf on Oct. 28, the ODECO spokesman says.

Other drilling and shipping businesses also suffered losses.

'There are a large number of shipyards preparing claims as we speak,' says Mr. Sherar.

"There are a large number of shipyards preparing claims as we speak," William G. Sherar Jr., account executive for broker Sherar, Cook & Gardner of Metairie, La., said last week.

"My guess is the overall damage will run into the millions," he said.

There may be some dispute about whether flood insurance or marine hull coverage will apply to vessels damaged by floodwaters while docked in shipyards, he said.

Mr. Sherar added that most of his clients' marine hull coverage is placed with Lloyd's of London underwriters.

Among the ships lost during the storm was a 52-foot oil barge valued at \$300,000 that capsized and sank, killing three crew members trapped in the galley.

The barge, the A.M. Howard, was owned and operated by Cardinal Wireline Specialists of Belle Chase, La. The ship was three miles from port when it sank.

The company has primary liability coverage with limits of \$500,000 underwritten by Trinity Associates of Miami, according to the company's broker, Jerry Cofer, assistant vp-claims of Corroon & Black Corp. in New Orleans. Trinity Associates is a managing general agent for Angelina Casualty Co. of Wilmington, Del.

An undetermined amount of excess liability coverage was written by North American Underwriters in Lafayette, La.

George Roach, part owner and chief executive officer of Cardinal, said that although the A.M. Howard was worth about \$300,000, the hull was insured for only \$225,000. That policy also was written by Trinity Associates.

In addition, the 425-foot freighter Sybil I was aground and taking on water late last week at the mouth of the Mississippi River about 15 miles south of Pilottown, La. One crew member is believed dead.

The salvage agent assigned to the ship by the Coast Guard, Jay Swenson of Smith & Johnson Co. in New Orleans, said the freighter was sailing under a Cypriot flag and was carrying no cargo. Neither the Coast Guard nor Mr. Swenson knew last week who owned the ship.

Exxon Corp. in Houston reported it suffered only minor property damage and no injuries, even though it was able to evacuate only 94 of approximately 1,000 employees working on the company's 108 platforms and mobile rigs in the Gulf of Mexico, according to a company spokesman.

"Sea and weather made it more of a threat to rescue those people than to let them ride it out," the spokesman explained. "The hurricane took us completely by surprise."

In addition, the spokesman said, Exxon experienced a 50% drop in production during the two days of the storm.

The spokesman would not estimate property damage or business interruption losses, but he said Exxon is self-insured for these risks.

Hurricane Juan caused numerous minor losses for companies in the oil and marine industries. Antennae on rigs and platforms were destroyed, navigational lights were broken and boat bumpers were blown adrift.

But despite the suddenness with which Hurricane Juan struck, drillers were able to take some precautions.

The Western Co. of North America was able to evacuate many employees by Oct. 27, leaving only a skeleton crew on two drilling rigs, one a semi-submersible floating rig and the other a jack-up.

Western sustained no property damage, reports Richard H. Moscicki, director of risk management for the drilling operator based in Fort Worth, Texas.

Ron Baron, risk manager of Global Marine Drilling in Houston, said the company suffered no significant losses.

"Any time you have a blow like this you lose an antenna," he said, "Anything less than \$25,000 in a storm like this we don't consider significant."

Mr. Baron said several Global rigs were in the path of the storm. "Our people did not evacuate," he said.

Information for this story was contributed by London Editor Stacy Shapiro and free-lance writer William Booth in Austin, Texas.

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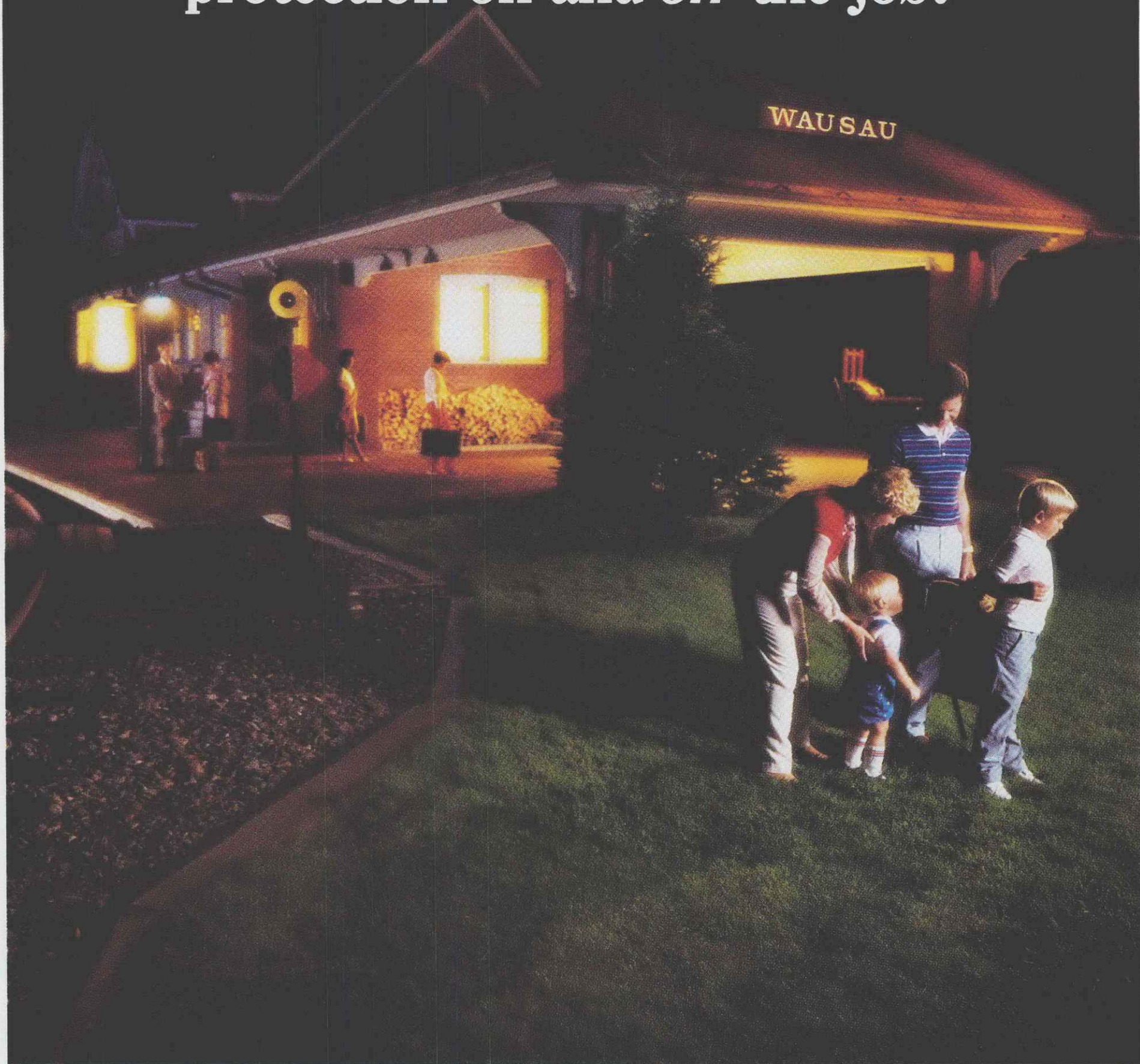
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Florida certification

Continued from page 3

dent of Centurion Development Inc. and Centurion Interiors in Panama City, who represents Florida consumers.

State Insurance Commissioner Bill Gunter, who appointed the council, says it "will guide our department by telling us what qualifications are essential for risk managers who attempt to prevent medical malpractice.

"With government and health care individuals working together, we should be able to come up with the best system for certifying and licensing health care risk managers," he says.

State Rep. Art Simon, D-Kendall, chairman of the House Subcommittee on Medical Malpractice, says beefed-up qualifications for health care risk managers are needed in Florida. "Requirements in terms of qualifications are somewhat of a joke," he remarks.

Mr. Simon said that when he questioned authorities about requirements for health care risk managers, he was told, "If they've got a pulse, they qualify."

A 1975 Florida law requires hospitals to designate a risk manager for the purpose of maintaining records and reports.

In addition, Mr. Simon says the Florida Department of Health and Rehabilitative Services requires health care risk managers to have a degree in business administration and a minimum of one year of practical experience; or two years of experience without a degree; or "any other qualification deemed acceptable by the governing board."

"We found that these statutory requirements weren't enough," says Fred Hawks, staff attorney for the House Healthcare and Insurance Committee, who wrote much of the law.

According to Mr. Hawks, many hospitals appoint a person who isn't really qualified for the risk management post.

Besides calling for risk manager certification, the law also says health care facilities must establish "an internal risk management program which shall include the following components":

- The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients.

- The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, "including at least annual risk management and risk prevention education and training programs."

- The analysis of "patient grievances which relate to patient care and the quality of medical services."

- The development and implementation of an "incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the health care facility to report injuries and adverse incidents to the hospital risk manager."

The state Department of Health and Rehabilitative Services, along with the Insurance Department, will establish rules under which these programs must be operated, the law says.

The law also states that each facility must submit to the Insurance Department an annual report summarizing incidents of injuries occurring at the facility. The report will include:

- The total number of incidents.
- A categorical list of operations and diagnostic and treatment procedures causing injuries.
- The names of individuals directly responsible for causing the injuries.

- The number of incidents with which they were involved and their relationships to the facility.

- A description of all malpractice claims filed against the facility, both pending and closed.

- A report of disciplinary actions taken against medical personnel as a result of injuries to patients.

The report also must name the risk manager of the facility and the procedures employed by the risk manager to reduce patient injuries.

The law will not greatly affect some hospitals, members of the advisory council point out.

For example, Ms. Carroll says Mount Sinai has had a risk management program, including regular incident reporting as a means of identifying risks and preventing losses, in place since 1976.

If hospitals do not comply with the new law, they can be assessed unspecified fines and face suspension or revocation of their licenses, Mr. Hawks said.

He added that hospitals have the responsibility to make sure medical personnel comply with the reporting standards of the law. Hospitals may curtail or strip a doctor's medical privileges in the facility if he or she refuses to submit incident reports when necessary. Repeated infractions may even be grounds for dismissal, he said.

"If the doctor doesn't comply, the hospital will be penalized. . . It's up to the hospital to see that it gets done," he says.

Some health care risk managers

agree that the new Florida law is a positive step, though some say they don't believe the risk management requirements will have an effect on the number of medical malpractice suits filed.

"Somebody has to take the initiative to develop quality assurance programs for hospitals; they ought to have some minimum qualifications," says Gene Marsh, president of California Hospital Assn. Insurance Services Inc. in Sacramento.

"A difficulty is that if it's a requirement applicable to all hospitals, the economies can be a real burden for smaller rural hospitals," he says.

And, he adds, certifying risk managers "isn't really addressing

the cause" of the medical malpractice problem.

Nonetheless, "the problem is big enough that it needs to be attacked from every angle," Mr. Marsh adds. "So, it's not really going to hurt. I don't like to see anything mandated, but the problem is big enough that it needs to be done."

John O'Connell, risk manager at Holy Cross Shared Services in Notre Dame, Ind., says he is concerned about what kind of criteria will be used for certification.

"The responsibilities placed on the risk manager, even with certification, are outside of his realm. A risk manager cannot control the medical and legal communities," he says.

Continued on next page



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Continued from previous page

"I really don't believe that that's the answer to the malpractice problem in Florida. That won't necessarily accomplish what they want—that is reduction of claims and suits filed."

David Meyers, director of the American Society for Hospital Risk Management in Chicago, an organization affiliated with the American Hospital Assn., says the effectiveness of the legislation remains to be seen. "It's not particularly good or bad; it reflects hope to try to improve the situation," he says.

"The implementation of the legislation will make it or break it," he says.

Jon Harkavy, director of govern-

mental affairs for the Risk & Insurance Management Society in New York, says medical malpractice reform should concentrate on changing the tort system, not regulating risk management.

"While we welcome the recognition of risk management, I fail to see what they're trying to accomplish. I don't see how certifying risk managers will lower malpractice claims.

"I feel a lot more comfortable setting standards for malpractice prevention or injury than I do with certifying risk managers.

"Risk management is a group effort by nature," Mr. Harkavy added. "Unless the standards set are adopted by medical personnel,"

implementation of a program may be difficult, he said.

Besides calling for the certification of health care risk managers and mandatory risk management programs, the law also:

- Requires that plaintiffs give defendants 90 days' notice before they file a medical malpractice suit.

During this 90-day period, a self-insurer or the defendant's insurer will conduct a review "to determine the liability of the defendant." At the end of the period, the insurer or self-insurer can reject the claim; make a settlement offer; or admit liability and call for arbitration to decide the amount of damages.

If the defendant admits liability,

the plaintiff has 20 days to accept arbitration or reject it and file suit. Acceptance of the arbitration offer waives the plaintiff's right to sue.

- Allows courts to require that a medical claim be submitted to non-binding arbitration if either party so requests in cases in which negligence is alleged.

- Allows courts to review attorneys' fees in medical malpractice cases to determine whether the fee is excessive.

- Requires medical malpractice insurers to give the policyholder 60 days' notice before a policy is canceled or not renewed. If cancellation or non-renewal is due to non-payment of premium or loss of license, 10 days' notice is required. ■

comings & goings: buyers

Hindman fills new position at retailer

Randall Hindman, 33, has been named risk management administrator at Service Merchandise Co. Inc. in Nashville, Tenn. In this newly created position, Mr. Hindman will supervise workers compensation claims, other claims administration and any litigation. He will report to Thomas R. Ainsworth, director of risk management. Mr. Hindman was previously owner of the Corinthian Insurance Agency in Nashville. Mr. Hindman received a bachelor of arts degree in sociology and business from Franklin College of Indiana in Franklin, Ind., and completed coursework for a master of arts degree in communications from Florida Technological University in Orlando. In addition, Mr. Hindman holds the designation of Certified Insurance Counselor.

Thomas Cipollone, 31, has been named risk management administrator at Gencorp Inc. in Akron, Ohio. In his new position, Mr. Cipollone will be responsible for administration of the corporation's property and casualty insurance programs. He reports to Risk Manager Denis Julien, and replaces **Wilmer Hough**, who is now corporate risk manager for Mack Trucks Inc. in Allentown, Pa. Mr. Cipollone formerly was office manager of the Toledo, Ohio, engineering office of Cleveland-based Davy Inc. Before transferring to the Toledo office, he had worked in the Cleveland office in the company's insurance department. Mr. Cipollone received a bachelor's degree in business administration from the University of Cincinnati. Mr. Cipollone also has a juris doctor degree from Cleveland State University.

Business Insurance would like to report on staff changes in your company's risk management, safety or employee benefits department. Just drop a note to Marla Antelis, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5282. Photographs to be included with the column also would be appreciated.

ASSE presents awards to officers

NEW ORLEANS—Thomas J. Reilly, immediate past president of the American Society of Safety Engineers, and Harry Partlow, 1983-84 president of ASSE, were awarded the American Academy of Safety Education Award of Merit at the National Safety Congress and Exhibition in New Orleans last month.

The awards, presented for outstanding contributions to the field of safety, were given to Mr. Reilly and Mr. Partlow for their continuing efforts to establish safety engineering accreditation programs for universities and for work in forming ASSE student chapters to increase the effectiveness of safety engineering graduates.

They are among the first non-educators to receive the awards. Mr. Reilly is the director of safety and health for Schirmer Engineering Corp. in Deerfield, Ill. Mr. Partlow is manager of industrial hygiene, safety and compliance for Amoco Corp. in Chicago.

Both also are certified safety professionals and licensed professional engineers. ■



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opinions

No certified solution

LET'S BE REALISTIC.

Florida's law mandating minimum standards for risk management programs in health care institutions and state certification of risk managers is not the solution to the medical malpractice problem in Florida or anywhere else.

Obviously, every health care facility needs a comprehensive risk management program and, obviously, a qualified person should be responsible for the implementation of the risk management program. A comprehensive risk management program under the direction of a qualified manager will reduce the number of accidents in health care facilities.

But, we don't think that mandating risk management programs for health care facilities and certifying health care risk managers will necessarily create effective risk management programs and successful risk managers.

The best risk manager with the best risk management program can't make a dent in any organization's accidents without the support of management and the cooperation of those in the trenches. Successful risk managers always credit management support and cooperation from others for their accomplishments.

Sure, Florida health care risk managers could read the law, chapter and verse, in an effort to win support and cooperation. And, they could point to their certificates as proof of their ability—and perhaps even a hint of authority.

But, we think that effective risk managers don't use intimidation to sell themselves or their programs. Instead, effective risk managers are those who can convince management and those in the organization that identifying risks and preventing and controlling the possible losses are in everyone's best interest.

Certifying risk managers also is unlikely to be worth the time and effort involved, no matter how carefully the certification standards are drawn.

It's possible that some health care facilities in Florida will be forced to assign a more qualified person to the risk manager's role as defined in the law than they have in the past. But, those institutions that cared so little about risk management in the past to assign unqualified people to the responsibility are not likely to

suddenly heed the advice of a risk manager just because he or she has been certified by the state.

Mandating health care risk management programs and certifying health care risk managers also could backfire on the legislators who are trying to improve the quality of risk management in Florida's health care facilities. When health care facilities are handed minimum standards for a risk management program and risk manager, the minimum standards could well become the highest standards some managements strive to achieve.

Finally, even if each health care institution in Florida were suddenly to embrace risk management with full commitment, risk managers cannot work miracles. As important as we view risk management, we don't think that risk management can solve the medical malpractice problem.

The most effective risk manager with the best program cannot prevent all accidents from happening. And, once an accident has occurred, the civil justice system determines whether the victim should recover damages and how much in damages.

A risk manager is no match for an aggressive plaintiff's attorney wielding liberal laws before a sympathetic judge or jury bent upon handing a huge award to a plaintiff perceived to be in need.

The Florida lawmakers are to be applauded for including in the Comprehensive Medical Malpractice Reform Act of 1985 significant reforms designed to attack the real causes of numerous and costly malpractice awards. The legislation, for example, caps contingent fees, provides for periodic payments of malpractice awards and encourages the use of arbitration. However, the legislation falls short of comprehensive reform because it does not cap awards for pain and suffering or punitive damages.

On balance, the legislation is an admirable effort to control medical malpractice legislation.

So why criticize provisions in the law that mandate risk management programs and certify risk managers?

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letters

Earthquake cover mandate sets dangerous precedent

To the editor: Steve Taravella's article, "A Shaky Situation" (BI, Oct. 7), illustrates California property owners' frustration and desperation in finding earthquake insurance at reasonable prices and deductibles.

Recently passed legislation mandating that all California personal lines insurers offer earthquake coverages to their property clients has only served to aggravate the problem. Curiously, this legislation was passed, ostensibly, to improve the situation by increasing availability and capacity. It did neither.

The catastrophic nature of earthquakes and adverse selection will always make this peril expensive to insure. The "stop-loss" reinsurance deal being promoted by State Farm Insurance Cos. and the Reinsurance Assn. of America seems to be a step in the right direction, but I suspect that it could take several lifetimes to complete, assuming that it ever is.

A better approach would be to offer

earthquake coverage nationwide, as a normal coverage item. We could charge different rates for different parts of the country. True, this would in effect be a subsidy of California's exposure. But the precedent exists for this to work: wind-storm insurance is now a normal coverage item, even though most of the country faces minimal exposure.

Therefore, isn't this also a form of subsidization? If we didn't subsidize the exposure to wind, capacity wouldn't exist for insureds in the hurricane and tornado belts. Besides, didn't New York just experience an earthquake?

If every property owner contributed to

the earthquake peril, then I feel that capacity would increase dramatically and rates might even be reduced, or at the least, stabilized.

What is needed is relief from inadequate capacity and excessively high rates. If we allow the U.S. Congress to legislate this relief, we might be setting an even more dangerous precedent: direct government involvement in insurance. What would become of McCarron/Ferguson then?

Rick Curtis

President

Curtis Insurance Agency Inc.
Northridge, Calif.

NAIB clarifies position on ISO form

To the editor: Your article on "Regulators scrutinizing claims-made revisions" (BI, Oct. 21) states that the National Assn. of Insurance Brokers has "given the (CGL) form their 'qualified' support, pending release of the final language."

This is not the case. We "expressed qualified support" for the Insurance Services Office's "modifications to its proposed claims-made form." The distinction between qualified support for the "modifications," as opposed to the form, is an important one.

Although the changes outlined by ISO appear to make sense, the complex interaction of various policy provisions has always given us cause for concern. ISO's ac-

tions on the modifications are helpful, but we still have other reservations about ISO's proposed forms.

The NAIB will study the modifications, particularly as they relate to other policy provisions, to determine whether they appear to provide appropriate financial protection for our clients.

Until the NAIB receives details of the modifications and has the opportunity to conduct an in-depth study, we can only give the modifications our qualified support.

Robert H. Moore

President

NAIB

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benefit beat

Tennessee passing savings from PPO option to workers

All Tennessee state workers are paying less for health care coverage because the introduction of a preferred provider organization option in their health care plan is expected to save the state \$30 million over 15 months.

The entire savings realized because of use of the PPO will be passed on to employees, said David Manning, executive assistant to the state treasurer.

The state had offered its 55,000 employees a choice between traditional fee-for-service medical coverage and a health maintenance organization.

The new PPO will operate as a part of the traditional, self-insured plan, Mr. Manning explained. It will be a "swing PPO," meaning that workers covered under the traditional plan will be able to choose between preferred providers and non-preferred providers, he explained.

However, when workers go to the preferred providers, they will be reimbursed for 90% of their expenses exceeding the deductible, rather than the usual 80%, Mr. Manning said.

Previously, employees paid 30% of the premium, or \$20.07 for individual coverage and \$50.09 for family coverage under the traditional plan.

The state paid the remaining 70% of the premium, or \$46.83 for individual coverage and \$116.88 for family coverage.

The state also paid \$46.83 for individual coverage and \$116.88 for family coverage for employees who joined an HMO. The employees paid the difference.

Under the new arrangement, effective Oct. 1, employees pay 20% of the premium for traditional coverage, or \$11.77 for individual coverage and \$29.17 for family coverage. The state will pay 80% of the premium, which will keep the state's contribution at \$46.83 for individual coverage and \$116.88 for family coverage.

The state will make the same contribution for employees who choose HMO coverage.

The total savings to the self-insured health care plan is expected to be about \$2 million a month for the 15 months of the contract with Blue Cross & Blue Shield of Tennessee, which administers the plan, Mr. Manning said.

This estimate is based on a projection by consultants at William M. Mercer-Meidinger Inc. of Nashville that the state's health care bill would total almost \$100 million between Oct. 1, 1985 and Jan. 1, 1987, if the plan were unchanged.

Blue Cross/Blue Shield estimated that, with the addition of a PPO option, the bill will not exceed \$71 million.

If the state's health care costs exceed that level, Blue Cross/Blue Shield will contribute to any health care costs over \$71 million, Mr. Manning said.

The Blues will pay 100% of the first 2% in health care expenses exceeding \$71 million and 90% of the next 2.25%. This sharing will continue in diminishing percentages until Blue Cross is paying 50% of the extra expenses, Mr. Manning said.

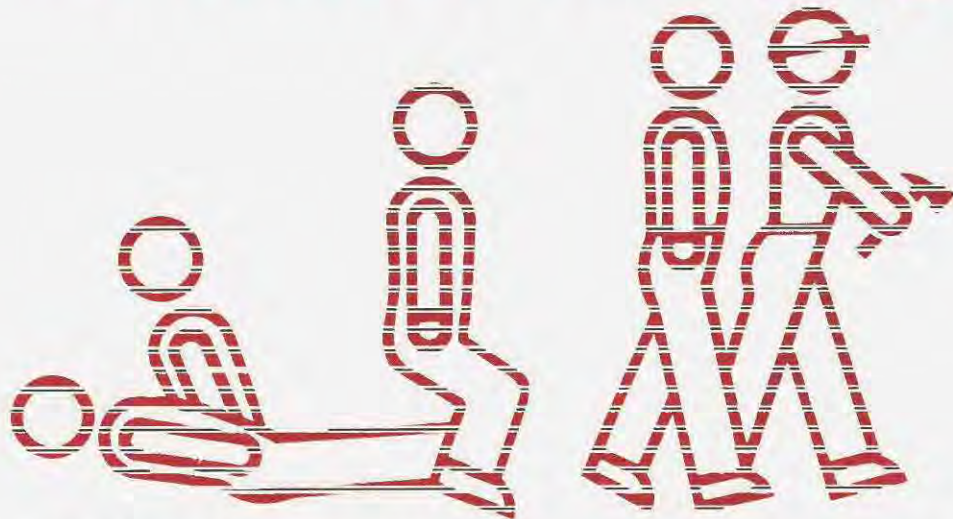
Under the state's traditional plan, workers pay deductibles of \$150 per individual or \$450 per family and 20% of expenses exceeding the deductible, up to an out-of-pocket limit of \$1,000 for individual coverage and \$2,000 for family coverage.

The deductibles and out-of-pocket limits will remain the same with the introduction of the PPO option.

Workers who pick the HMO option basically receive first-dollar coverage, Mr. Manning said.

Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Diane Kastiel, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5393.

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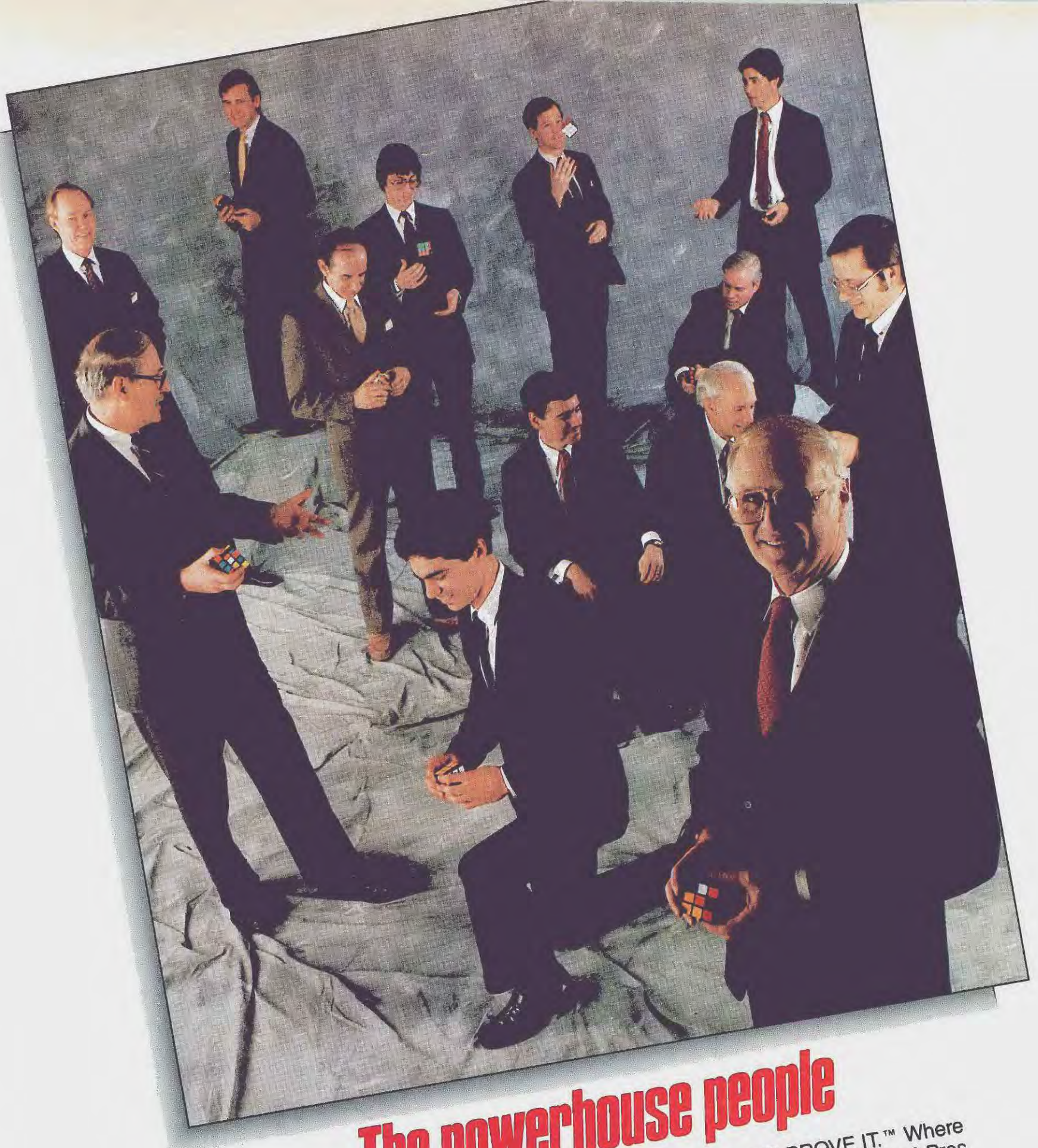
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Social Security taxes to increase in 1986

By JERRY GEISEL

washington

WASHINGTON—Employers and employees will be hit with higher Social Security taxes next year, the Social Security Administration says.

On Jan. 3, both the FICA tax rate and the taxable wage base will increase.

The tax rate for both employers and employees will rise to 7.15% from 7.05%. And, the first \$42,000 of an employee's salary will be subject to the FICA tax, up from \$39,600.

The increase in the tax rate and the taxable wage base will raise the maximum tax paid by employers to \$3,003 per worker from \$2,791.

Other Social Security changes that will take place on Jan. 3 include:

- A rise in the tax rate for the self-employed to 12.3% from 11.8%. With the increase in the taxable wage base, the maximum tax for the self-employed will rise to \$5,166, up from \$4,672.80.

- An increase to \$5,760 from \$5,400 in the maximum salary a beneficiary under 65 can earn without losing benefits.

- An increase to \$7,800 from \$7,320 in the maximum salary beneficiaries between ages 65 and 69 can earn without having benefits reduced.

For beneficiaries age 70 and over, there is no limit on earnings.

In addition, beneficiaries will receive Social Security benefit hikes

of 3.1% on Jan. 3. That will increase the average monthly benefit paid to a retired individual to \$478 from \$464.

Currently, about 37 million people receive Social Security retirement benefits.

New 401(k) proposal

Another option to limit the attractiveness of 401(k) salary reduction plans may be in the offing.

Rep. Beryl Anthony, D-Ark., may propose an amendment to the tax reform package now being hammered out by the House Ways and Means Committee that would save 401(k) plans from elimination,

as proposed earlier this year by the Reagan administration.

However, the proposal would impose new restrictions on the popular plans.

Under a draft version of the Anthony proposal that is being circulated by the Assn. of Private Pension & Welfare Plans, the maximum annual individual salary deferral to a 401(k) plan would be set at \$12,000.

In addition, employee contributions to an Individual Retirement Account would be offset dollar for dollar by 401(k) deferrals that exceed \$10,000.

This proposal would be more favorable to employers and employees than a House Ways and Means Committee staff option that would slash the maximum 401(k) salary deferral to \$5,000 and offset dollar

for dollar employee contributions to IRAs by their 401(k) plan deferrals.

Under current law, the maximum annual salary deferral to a 401(k) plan is \$30,000.

The Anthony proposal would retain two non-discrimination tests advanced by the Reagan administration in May.

Under the Anthony proposal, the average deferral percentage (ADP) by a company's highest-paid employees could not exceed the greater of:

- 125% of the ADP of the lower-paid workers.

- 200% of the average deferral of the lower-paid workers, as long as the difference between the average deferrals of the two groups does not exceed 2%.

In addition, withdrawal of funds from 401(k) plans before retirement would be permitted under the Anthony proposal if the employee could prove the money was needed because of hardship, such as to pay uninsured medical expenses, for the first purchase of a primary residence or to pay a child's educational expenses.

Meanwhile, before taking a one-week break from drafting a tax reform package, the Ways and Means Committee agreed to eliminate a tax incentive for employers that invest in payroll-based Employee Stock Ownership Plans.

The committee would eliminate—by the end of 1985—a provision in current law that allows employers to take a tax credit equal to 0.5% of employee compensation. That ESOP tax credit provision is now set to expire at the end of 1987.

In addition, the committee would eliminate a provision in the Deficit Reduction Act of 1984 that allows employers to take tax deductions for dividends paid on stock held by an ESOP if the dividends are passed through to employees as taxable income.

The panel also recommended wiping out a DEFRA provision that allows banks, insurers or other lending institutions to exclude 50% of the interest they receive in connection with loans made to an ESOP to acquire employer stock.

In another matter, the House Rules Committee last week allowed a Ways and Means Committee-passed bill, H.R. 3128, that among other things boosts pension insurance premiums, to proceed to the House floor.

That action raises the possibility that the House will pass two bills that set different premium levels to be charged by the Pension Benefit Guaranty Corp. The House already has approved a budget bill, H.R. 3500, that raises the PBGC annual premium to \$8.50 per plan participant, while H.R. 3128 calls for raising the premium to \$8 for the next three years and then rolling back the premium to \$2.60 by 1989. A budget bill, S. 1730, now on the Senate floor, calls for an \$8.10 per participant premium.

Presumably, a House-Senate conference committee will iron out these conflicting provisions.

IRS gives LTV waiver

The Internal Revenue Service will allow Dallas-based LTV Corp. to defer about \$175 million in payments to three pension plans covering its subsidiary LTV Steel Co. in Cleveland.

The funding waiver allows LTV to spread out the payments over a 15-year period.

As part of the waiver agreement, LTV also pledged assets of its aerospace unit as collateral in case it can't make pension contributions.

LTV sought a funding waiver to conserve corporate cash because of losses at LTV Steel. ■

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Cargo rates cut in three Persian Gulf areas

By STACY SHAPIRO

LONDON—In a departure from recent actions, London cargo war risk underwriters are lowering rates for cargo shipped to and from three areas near Kuwait in the Persian Gulf.

The London War Risks Rating Committee has set the minimum rates for covering cargo against war, strikes, riots and civil commotion to:

- 0.125% of the insured value, down from 0.25% of the insured value, for cargo to and from Sirri Island.

- 0.1% of the insured value, down from 0.2%, for cargo to and from the ports of Rastinura and Dubai in Kuwait.

But, other minimum rates for cargo in the Persian Gulf remain

london line

unchanged, according to the committee.

Underwriters still can charge whatever they want for shipments to and from Iraq, Iran and Iran's major oil terminal, Kharg Island, where much of the fighting between Iran and Iraq has taken place.

Minimum rates also are as low as 0.05% of the insured value for shipments to areas in the southern part of the Persian Gulf.

Willis Faber sale

Lloyd's of London broker Willis Faber P.L.C. is selling most of its managing underwriting agency

business to the existing underwriters and management of the agency, Willis Faber & Dumas (Agencies) Ltd.

All the syndicates managed by Willis Faber except one—non-marine syndicate 570—are being sold for 7 million pounds (\$9.9 million) to Wellington Underwriting Agencies Ltd., a new company formed by the underwriters and management of Willis Faber & Dumas, Willis Faber announced.

Syndicate 570, underwritten by Michael Cockell, is being transferred to Mr. Cockell's underwriting agency, M.H. Cockell & Co. Ltd., for an undisclosed sum.

John Prentice, current chairman

of Willis Faber & Dumas (Agencies) Ltd., is leaving the board of Willis Faber to become chairman of Wellington.

Willis Faber & Dumas (Agencies) will continue to be a members' agency, says Willis Faber. Roger Elliott, deputy chairman of the agency, will become chairman.

Lloyd's Council vote

Lloyd's of London Chairman Peter Miller is seeking re-election to his seat on the 28-person Council of Lloyd's.

Four vacant seats among the 16 held by Lloyd's working members will be filled in today's election. There are three vacancies among the eight seats held by external members. The remaining three seats are filled by non-Lloyd's

members.

There are six candidates for the four working-member seats. In addition to Mr. Miller, the candidates are Viscount Chelmsford, director of broker Willis Faber P.L.C.; Michael Wade, director of broker Holman Wade Ltd.; Sir Francis Dashwood, chairman of Dashwood Outhwaite Underwriting Agencies Ltd.; John Greig, chairman of broker Greig Fester Group Ltd.; and Gordon Hutton, chairman of G.W. Hutton & Co. (Underwriting) Agencies Ltd.

Besides Mr. Miller's seat, the other vacancies are created by the retirement from the council of Frank Barber, David Barham and Terence Higgins.

Eight candidates are seeking three external council seats, including Phil C. Gallagher, the only American seeking a seat. Mr. Gallagher, who is a principal with the Miami retail insurance agency Gallagher-Cole-Boon Associates, says this is his third attempt to be the first American to sit on the council.

Phil Gallagher is not related to the Gallaghers of Arthur J. Gallagher & Co. in Rolling Meadows, Ill., the 10th largest U.S. broker.

Other members from outside Britain who are seeking seats are John Van der Hagen of the Netherlands, and Derek C. Hannaford of Canada.

Incumbent external members seeking re-election are Eddie Kulukundis and John Marks.

Sir Kenneth Berrill is stepping down as an external member.

Tax agreement

The 42.5 million-pound (\$60.8 million) settlement made recently by Lloyd's of London with Inland Revenue will not end all the tax problems of Lloyd's members (BI, Oct. 28).

The agreement settled Inland Revenue's questions about some types of reinsurance, especially "rollover" policies, in which reinsurance premiums were paid to offshore companies for catastrophe coverage. Inland Revenue had claimed the policies were not legitimate reinsurance.

Although the agreement announced last month settled the tax issue on such policies with all but about 25 Lloyd's members, Inland Revenue still is investigating other reinsurance arrangements of Lloyd's members.

Lloyd's members were told by Lloyd's Chairman Peter Miller at an agencies' meeting that an investigation is continuing.

The news about the ongoing investigation was released when Additional Underwriting Agencies (No. 3) Ltd. sent a letter informing members of the former PCW Underwriting Agencies Ltd. that Inland Revenue is still checking PCW accounts.

AUA3, which manages accounts for PCW and its successor agency, Richard Beckett Underwriting Agencies Ltd., said in the letter that "names who underwrote with syndicates formerly managed by PCW/Richard Beckett Underwriting Agencies Ltd. appreciate that, even if they are not one of the 25 excluded names, their tax affairs are not resolved."

AUA3 said it received a letter from Inland Revenue saying that "there are other points at issue between us which need to be resolved before the names' tax affairs can be settled finally for past years. . . . If these matters cannot be settled quickly, there could be a block against a name claiming full repayment of tax until agreement has been reached."

A spokesman for Lloyd's says other agencies' accounts also may be under investigation by Inland Revenue.

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BI 11/85

Setting up group captive is no easy task

By MEG FLETCHER

NORTHBROOK, Ill.—Risk managers may have to consider group-owned captive insurance companies to create adequate insurance capacity, but it's not easy to do, a consultant warns.

The process of establishing a captive is a complex, time-consuming endeavor and requires a committed effort, advises R. David Turner, president of Rollins Burdick Hunter Management Inc., in Chicago, the consulting arm of broker Rollins Burdick Hunter Inc.

And, the risk manager of a cooperative that has formed a captive insurance company agreed with Mr. Turner's assessment.

Mr. Turner outlined key considerations in forming group-owned captives at the Midwest Regional

Workshop sponsored last month by the Chicago, Northeastern Illinois and Wisconsin chapters of the Risk & Insurance Management Society.

Group-owned captives are risk-financing alternatives to commercial insurance that allow companies to contribute capital to form an insurance company. The insurance company then underwrites insurance for its owners and buys needed reinsurance or excess insurance for its owners.

Mr. Turner did not address the formation of single-parent insurance companies. These captive insurers do not offer their owners the tax advantage of deductions for premiums paid, according to numerous court rulings.

Mr. Turner said creating a successful captive requires:

The emphasis at RIMS' Midwest Regional Workshop was on techniques to survive the tight insurance market. Coverage continues on Pages 18 and 20.

- A close partnership among all the parties.

The most critical part of establishing a captive is arranging commitments from fronting and excess carriers, since many insurers have dropped out of the market and the ones that remain are extremely selective, Mr. Turner said.

Fronting insurers, which issue the insurance policies and reinsure risks with the captive, and the excess insurers want conservative un-

derwriting and good claims management.

Those considering the feasibility of establishing a captive insurer should talk with underwriters before collecting all loss and planning information for its captive plan to determine what information fronting insurers and excess insurers want today.

In the competitive insurance market, fronting insurers and excess insurers were willing to consider captive programs as proposed without demanding a lot of additional information.

- A long-term commitment to provide stability.

When participants provide the capital to the captive, it demonstrates their commitment to the program, Mr. Turner noted.

In return, a captive insurance

company can provide stability in soft and hard insurance markets, said Mr. Turner.

- Competent actuarial analysis of previous coverage and policy data, detailed premium and exposure information for at least five years and sophisticated manipulation of loss data to determine insurance rates to be charged.

Mr. Turner urged those companies considering a captive to use a good actuary to ensure the best possible data analysis.

- Using risk management techniques.

Risk management techniques are "a must" with captives, and companies have a vested interest in controlling losses since they are assuming more risk, he said.

The cost of establishing a captive is increasing, Mr. Turner noted. Fronting fees are now about 12% of a captive's gross premium, or about five times greater than during the soft market, he said.

The gross premium for a typical multiemployer workers compensation captive can be broken down as 12% for fronting fees; 15%, administration; 15%, excess insurance; and 58%, losses, according to Mr. Turner.

Once established, a captive requires constant surveillance. Ongoing concerns include keeping rates and funding at appropriate levels, controlling costs and adverse trends and periodically reviewing the data base and report design, Mr. Turner said.

In addition to creating insurance capacity and a more stable market, the advantages of funding risks through a captive insurer include: the opportunity to amass underwriting profits and investment income; development of better accident prevention and loss control programs; more input into the claims-handling process; and building and controlling a data base on the group's experience.

William H. Voss, manager of the insurance department for Cotter & Co., agreed that there are many bases to cover when forming a captive. He organized a Bermuda-based captive in 1981 for Cotter, which is the cooperative for True Value hardware stores.

Cotter planned for two years before establishing the captive.

The captive, which serves several thousand privately owned retail stores nationwide, provides general liability and automobile insurance and some employee benefit products.

The idea of establishing the captive was explored during the soft insurance market because the cooperative wanted to capture investment income on loss reserves and the cooperative's commercial insurer was not willing to cooperate.

In establishing a captive, an unbiased view of its feasibility is essential, Mr. Voss said. The cooperative had contracted for two independent feasibility studies.

Mr. Voss advised that captive owners "take an active role" in selecting the captive's management company, attorney and auditor.

Cotter's approach was to spend 10 days interviewing candidates for those posts in Bermuda. Cooperative officials also directly dealt with reinsurers.

In addition, the cooperative officials took "a very active" role in seeking investment income. The captive's money manager operates under strict guidelines to invest funds conservatively.

The captive is now earning at least an 11.5% tax-free yield on its investments, according to Mr. Voss.

The cooperative chose U.S.-based fronting companies with high visibility to inspire confidence among cooperative members.

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Loss control vital in tight insurance market

By MEG FLETCHER

NORTHBROOK, Ill.—Loss prevention and tight claims control are particularly important risk-control measures in today's constricted insurance market, according to risk managers and insurance company executives.

Loss control is an "attitude" that must have top management's support before it can filter down to operating managers, said Phil Kelling, insurance manager for Cary, Ill.-based Cotter & Co., which operates 14 distribution centers for a co-operative of 7,800 True Value hardware stores nationwide.

Mr. Kelling discussed loss control during a panel discussion at the Oct. 17 Midwest Regional Workshop sponsored by the Chicago, Northeastern Illinois and Wisconsin

chapters of the Risk & Insurance Management Society.

Other panelists included Jack Gardner, a second vp with Travelers Group in Hartford, Conn., and Robert J. Gas, the casualty claims manager for Walgreen Co., the drug store chain based in Deerfield, Ill.

Mr. Kelling outlined several techniques to create a good loss-control program:

- Make cost allocation systems loss-sensitive. This creates an incentive for an operating manager to seek out and use available safety programs and loss-control resources.

- Identify loss-prone operations and personnel and make them accountable.

Mr. Kelling said he motivated the managers of the three Cotter

operations with the worst loss records by ranking operations from best to worst when reporting loss-control data to top managers.

All three managers called him after they were identified at the bottom of the list, he said.

In addition, operating managers with the worst safety records are chosen to serve on the company's national safety committee. Thus far, no manager has had to serve a second term, Mr. Kelling said.

Problem employees at Cotter are identified through an accident repeater list. Once identified, they can receive safety counseling.

- Spread the word about large losses. In the guise of educating everyone, an "embarrassment factor" is created when a large loss is reported to the entire company. This can motivate an operating manager

to prevent future losses, he said.

- Audit and report the use of safety resources and programs so top managers know which operating managers are not using available safety tools.

- Establish realistic training programs and safety guidelines.

- Use a risk management information system to analyze data.

- Inform operating managers of new statutory safety requirements.

- Have written inspection procedures and checklists.

Loss-control engineers are better guided during reviews of operations when the operating manager provides the engineer with specific goals, Mr. Kelling said.

- Reinforce safety goals with awards, plaques and pay.

"Safety bingo," in which a bingo

number is drawn every day there is no time lost because of injury, is Cotter's most successful safety program, Mr. Kelling said. Employees, wishing to increase their chances of winning, tend to be more safety-conscious, he explained.

Not all losses can be prevented, but steps can be taken after an accident occurs to minimize its severity, the panel stressed.

Careful monitoring of claims is an important risk control tool at Walgreen Co.

The Travelers Group provides some claims adjusting services as part of the paid-loss retrospectively rated liability insurance program it underwrites for Walgreen, said Mr. Gas, who previously worked for Travelers.

While Travelers has no authority to independently settle product liability claims against Walgreens for merchandise or pharmaceuticals, it can offer up to \$2,500 without special approval to settle general liability, auto and some workers compensation claims.

This limit recently was reduced from \$7,500 to further increase Walgreen's control over claims, Mr. Gas said.

Annually, Travelers handles about 5,000 claims for Walgreen. Walgreen audits claim settlements by tapping into Travelers' data base through an on-line computer and visiting Travelers' field offices.

Also, Walgreen's staff spot checks loss runs. The company sometimes asks the insurer to assume payment of a claim when its claims handler has violated prescribed settlement limits, Mr. Gas said.

For the two-year period ending October 1985, Mr. Gas estimates the claims-control program saved Walgreen's about \$571,880 in settlement costs. The savings reflects the difference between the settlement suggested by the insurer's claim adjusters and the lesser amount Walgreen authorized.

This figure does not reflect claims that ultimately were settled for amounts higher than Walgreen authorized. At the time of the report, Travelers was authorized to settle non-pharmaceutical and non-product related claims up to \$7,500.

Walgreen's "very aggressive" and "hard-line" claims-handling approach is even tougher in cases involving prescriptions and products, since they are the bulk of its business, according to Mr. Gas. Thus far, the outcome in about a dozen cases have been "very good," he said.

For example, Walgreen paid \$200,000 in a case involving a prescription filled incorrectly for a customer who lost the use of one kidney and whose other kidney was damaged. The amount was about \$35,000 less than originally requested, Mr. Gas said in an interview. The structured settlement involved a low-income woman.

Risk management information systems are an important loss-control tool for Walgreen and other companies, said Travelers' Mr. Gardner.

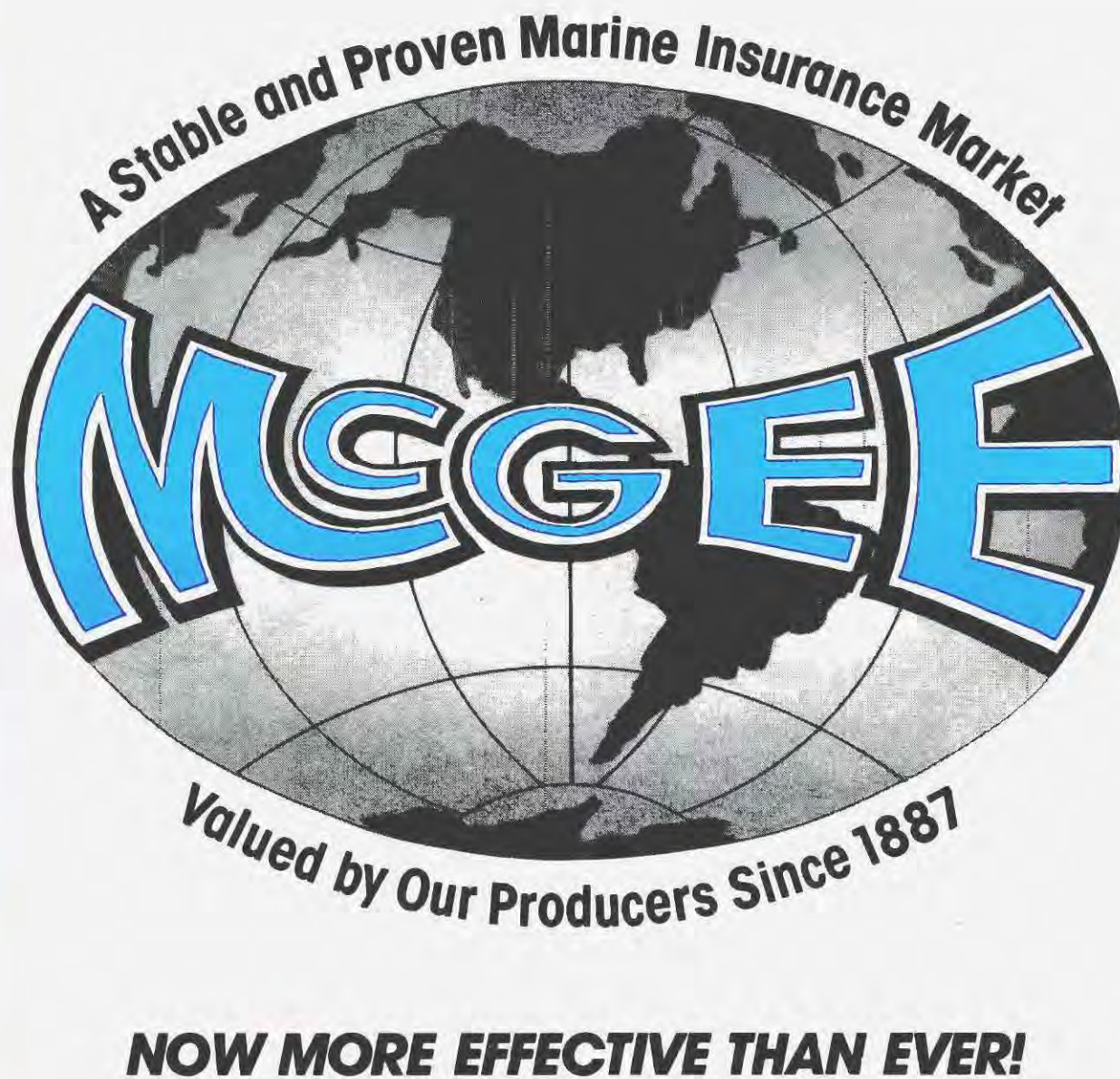
He emphasized that using a single good data base for all aspects of insurance program management gives everyone involved the "same gun and same target."

But not all companies have a good data base.

"The problem I see in loss control today is the unusability of the data," Mr. Gardner said. Data becomes worthless if it is improperly or inconsistently coded.

Risk managers should simplify coding and use approaches that are similar to those of other companies in the same industry, he said. They should also code their own data and review it and update it as needed, Mr. Gas added.

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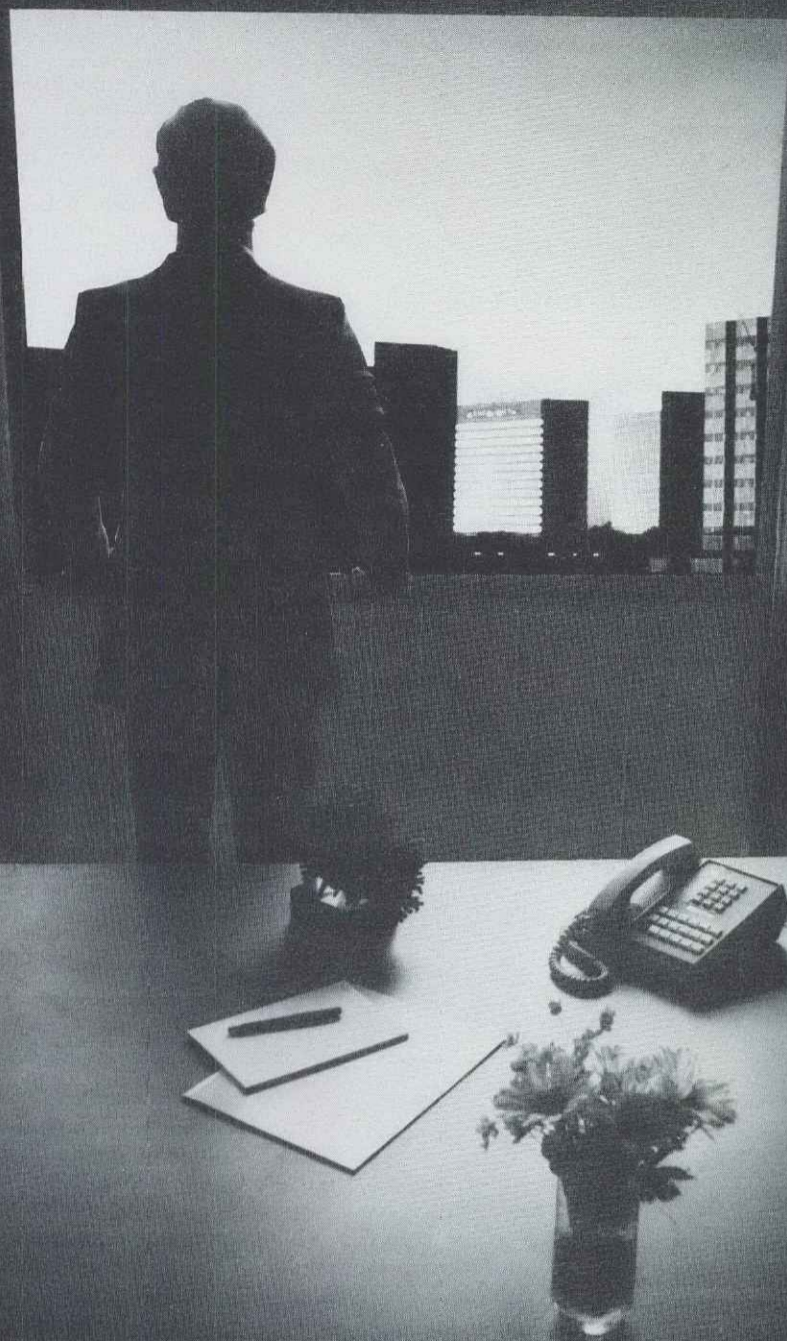
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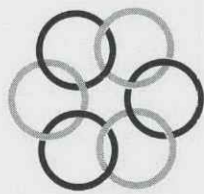
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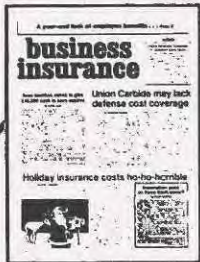
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HAS

Funding alternatives require close look at tax implications

By MEG FLETCHER

NORTHBROOK, Ill.—The only new risk-funding alternatives are variations of established techniques.

And, those must be considered in light of recent changes in tax law.

Those are the perspectives of George M. Betterley, vp and principal in the Boston office of the consulting firm Tillinghast, Nelson & Warren Inc., and Charles J. Auer, a partner in the Chicago office of accounting firm Peat, Marwick, Mitchell & Co.

Both spoke at the Midwest Regional Workshop sponsored last month by the Chicago, Northeastern Illinois and Wisconsin chapters of the Risk & Insurance Manage-

ment Society.

"There has been nothing new in risk financing or funding for the past 40 years," said Mr. Betterley. "The only thing that is new in risk funding is the variation on old themes."

Risks are either shared or retained, according to Mr. Betterley.

Risks are shared traditionally by buying insurance from a commercial insurance company or more recently through participation in group insurance captives. Risks are retained when a corporation pays claims out of cash flow, establishes self-insured reserves or creates a captive insurer.

Risk managers must be aware of the tax implications of self-insuring and captives, said Peat, Marwick's Mr. Auer.

Recent tax legislation, for example, altered the so-called "all-events" test for determining the timing of tax deductions for self-funded losses.

Previously, the all-events test permitted a tax deduction when all events that determined the liability had occurred and when the amount of the liability could be determined with reasonable accuracy.

The all-events test was interpreted by the Ninth Circuit Court of Appeals to permit tax deductions for self-funded reserves to pay uncontested workers compensation claims in the future when the loss was known and the employer could predict the amount of the loss.

But, the Tax Reform and Deficit Reduction Act of 1984, which went into effect July 14, 1984, replaced the all-events test with an "economic performance" test.

Now, self-funded losses are tax deductible only when the loss actually has been paid.

The economic performance test has the effect of forcing employers to use a cash rather than an accrual accounting system for workers compensation and tort liabilities, Mr. Auer said.

The tax legislation, however, did lengthen to 10 years from three years the allowable carryback of net operating losses attributable to "deferred statutory or tort liability losses," Mr. Auer noted.

Now, cash-flow insurance programs sold by insurers as alternatives to self-insurance are being scrutinized by the IRS, Mr. Auer said.

The IRS is developing technical guidelines for reviewing when and if premiums paid for cash-flow plans are tax deductible, Mr. Auer added.

An IRS spokesman said in a follow-up interview that no decision has been reached on the issue.

Already, the IRS has won its battle to deny tax deductions for premiums paid to single-owner captive insurance companies.

The IRS has prevailed in court cases in all but one case with highly unusual circumstances (*BI*, Aug. 26).

"I think wholly-owned captives are losers from a tax perspective," Mr. Auer said.

"The sole source captive is dead," he said.

"A group captive may have some viability, but we don't know what the rules are," he added.

It is uncertain how much ownership diversity and third-party risk a captive needs to insulate itself from IRS challenges over the tax deductibility of premiums, Mr. Auer observed.

The only definitive guide is a 1978 IRS ruling, 78-338. That ruling said that each of 31 unaffiliated oil companies that owned less than 5% of a captive insurance company was permitted a tax deduction for premiums paid the insurer. ■

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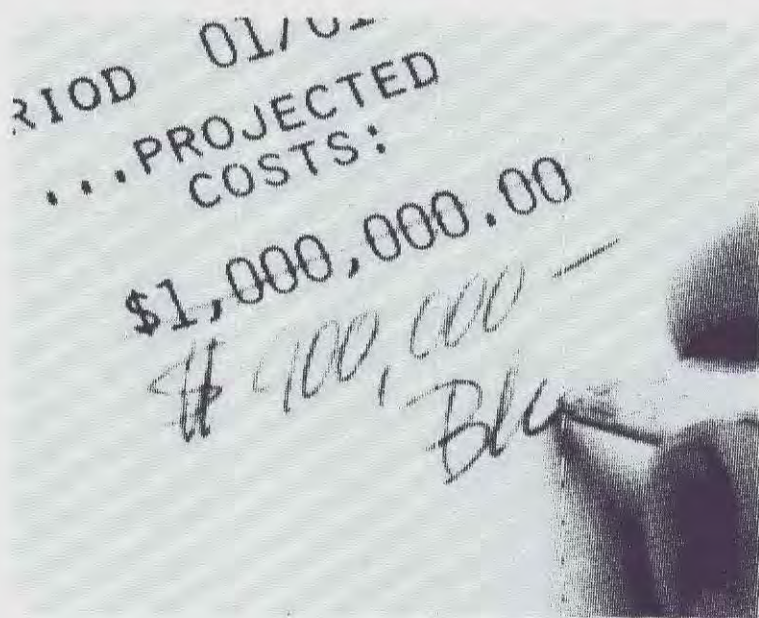
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NOV. 17-20. 31st Annual Educational Conference of the International Foundation of Employee Benefit Plans in Honolulu, sponsored by the IFEPP. For fee information and registration, members should contact the Public Relations Department, IFEPP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

NOV. 17-20. Seminar for Non-Insurance Professionals—Property/Casualty in Princeton, N.J., sponsored by The College of Insurance; \$540 for College sponsors; \$620 for others. Russel Fersheiser, The College of Insurance, One Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

NOV. 17-22. Assets Protection Course I in Los Angeles, sponsored by the American Society for Industrial Security; \$690 for members; \$750 for non-members. ASIS Membership & Meetings Services, 1655 N. Fort Myer Drive, Suite 1200, Arlington, Va. 22209; 703-522-5800.

NOV. 18. CPCU Northern Ohio All-Industry Day—Turning Point or Turmoil: Transition in the Insurance Marketplace in Cleveland; \$25 advance; \$30 at the door; \$250 for reserved table for groups of 10. Robert Hippert, Cleveland Chapter, CPCU, 3934 W. 158th St., Cleveland, Ohio 44111; 216-623-4210.

NOV. 18. "Risk Management of PCBs in Electrical Systems" course in Salt Lake City, sponsored by Electro-Test Inc.; \$95. Also **Nov. 20** in Denver; **Nov. 22** in Albuquerque, N.M.; **Dec. 4** in San Diego; **Dec. 5** in Newport Beach, Calif.; **Dec. 6** in Los Angeles; **Dec. 10** in Phoenix, Ariz. Electro-Test Learning Center, P.O. Box 159, 3470 Fostoria Way, San Ramon, Calif. 94583; 415-866-8566.

NOV. 18-19. Hazardous Waste Litigation Symposium in Garden City, N.Y., sponsored by Hofstra University School of Law and Rivkin, Radler, Dunne & Bayh; \$375; \$350 for two to four registrants from the same organization; \$325 for five or more registrants from the same organization. Michael Dwyer, Hazardous Waste Litigation Symposium, P.O. Box 5009, Garden City, N.Y. 11530; 800-438-8890; 212-544-1245 in New York.

NOV. 19. Introduction to Business Insurance: Law and Litigation satellite program in New York, sponsored by the Practising Law Institute. Broadcast to 36 cities; \$125. For location information and registration, contact the Practising Law Institute, Department 105-DD, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, Ext. 286.

NOV. 19. Utilization/Data Management conference in Chicago, sponsored by the Illinois State Chamber of Commerce; \$90 for members; \$135 for non-members. Registrar, ISCC, Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

NOV. 20-21. Principles of Petroleum Insurance workshop in Fort Worth, Texas, sponsored by the Professional Development Institute and Self-Insurance Resource Inc.; \$450. Jonathan Jeffrey, Professional Development Institute, P.O. Box 13288, NTSU, Denton, Texas 76203-3288; 817-565-2483.

NOV. 21-22. "Tax Planning Under Subpart F" seminar in Chicago, sponsored by The World Trade Institute; \$610; \$575 for each additional registrant from same organization. Make checks payable to The Port Authority of New York and New Jersey. Registrar, The World Trade Institute, One World Trade Center, 55W, New York, N.Y. 10048; 212-466-4044.

NOV. 22. Experience Rating and Open Competition seminar in New York, sponsored by the National Council on Compensation Insurance; \$60 for members; \$85 for non-members. Michelle Lajzer, NCCI Public Affairs Department, One Penn Plaza, New York, N.Y. 10119; 212-560-1026.

DEC. 24. Basic Safety Management seminar in Houston, sponsored by the International Safety Academy; \$445; \$415 for three or more registrants from the same organization. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147, 215-241-5800 in Pennsylvania.

DEC. 24. Loss Control Management course in Atlanta, sponsored by the International Loss Control Institute; \$695. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-554-6001; 404-466-2208 in Georgia.

DEC. 3. AIDS and the Employer seminar in New York, sponsored by The New York Business Group on Health Inc.; \$75 for members; \$125 for non-members. The New York Business Group on Health Inc., 622 Third Ave., 34th Floor, New York, N.Y. 10017; 212-808-0550.

DEC. 3. Tax Effective Total Compensation: Using 401(k) and 125 Plans seminar in New York, sponsored by the Practising Law Institute; \$215. Practising Law Institute, Department 105-CF, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, Ext. 286.

DEC. 4. Health Claims Management System seminar in Indianapolis, sponsored by Resource Information Management Systems Inc.; free. Also **Dec. 5** in Columbia, Md. Ellen Lockwald, Resource Information Management Systems Inc., 2015 Spring Road, Suite 220, Oak Brook, Ill. 60521; 312-789-0230.

DEC. 4-6. Techniques of Risk Management course in New York, sponsored by the Risk & Insurance Management Society Continuing Education Program; \$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. 4-6. Fundamentals of Insurance course in Atlanta, sponsored by the Risk & Insurance Management Society Continuing Education Program;

\$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. 4-6. Health Agenda 1986 conference in Washington, sponsored by the Washington Euisness Group on Health and the National Assn. of Manufacturers; \$400 for members; \$500 for non-members. Washington Business Group on Health, 229½ Pennsylvania Ave. S.E., Washington, D.C. 20003; 202-547-6644.

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

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

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

DEC. 5-6. National Product Safety Symposium in Chicago, sponsored by the National Safety

Council; \$180 for members and U.S. Government employees; \$225 for non-members. Russ Marhefka, National Safety Council, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800.

DEC. 5-6. Audio-Visual Media for Safety & Health: Developing and Producing Inexpensive Programs course in Los Angeles, sponsored by the University of Southern California Institute of Safety and Systems Management; \$400. Registrar, University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089-0021; 213-743-6523; 213-743-6524.

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

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

DEC. 9-10. Banks and Insurance Joint Venture Marketing Strategies conference in West Palm Beach, Fla., sponsored by The Banking Law Institute; \$750; \$650 for each additional registrant from the same organization. Make checks payable to Executive Enterprises Inc., #5CINS22/E5349, 33 W. 60th St., New York, N.Y. 10023-7988; 212-489-2680.

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

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

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

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

DEC. 11-13. Legal Operational Issues in HMOs,

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

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

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

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

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Colavecchio named to head Sayre & Toso

John B. Colavecchio has been promoted to president of Sayre & Toso Inc., Mission Insurance Group's wholesale managing general agency.

Mr. Colavecchio was formerly executive vp. He replaces **W.A. Greenup**, who relinquished his responsibilities as Sayre & Toso president but remains an officer of Mission Insurance Group.

Other suppliers

David H. Gluck named president of Hunter & Associates, a San Diego-based benefit communications and consulting firm that specializes in self-funded health, disability and 401(k) plans.

Al Garcia named vp at Adams & Porter Life Associates Inc. in Houston, the employee benefit and estate planning affiliate of Adams &

comings & goings: industry

Porter Associates Inc. Mr. Garcia previously worked for American General Life Insurance Co.

James E. Carroll joins Claims Management Services, a risk management resource division of Marsh & McLennan Inc., as manager of the New York office. Mr. Carroll previously worked for United States Aviation Underwriters Inc.

Insurers

William R. Strack named president and chief executive officer in the Chicago office of All American Life Insurance Co., a wholly owned subsidiary of New York-based USLIFE Corp. Mr. Strack succeeds

Leonard J. Pelletiere, who has served since August 1983 and is seeking early retirement. Mr. Strack, who joined USLIFE subsidiary The United States Life Insurance Co. in 1982, most recently served at that company as senior vp-field marketing.

Also at All American, **John F. McManus** named to the new position of executive vp and chief operating officer. Mr. McManus previously served as senior vp and chief operating officer.

Edward M. Titus named vp at Reliance United Pacific Surety Managers Inc., which manages the U.S. and Canadian bonding operations for the Reliance Insurance

Cos. Mr. Titus, who joined Reliance in 1978, most recently served as controller.

Oscar Zimmerman named vp-U.S. pension operations at Crown Life Insurance Co. in Toronto. Mr. Zimmerman formerly was vp of actuarial services-U.S. insurance operations.

Mary Brainerd named chief operating officer of HMO Minnesota and vp of St. Paul-based Blue Cross & Blue Shield of Minnesota. Ms. Brainerd, who has been with the two affiliated companies for six years, most recently served as vp-health services.

Bill Gaines named vp-underwriting and actuarial at Cotton States Mutual Insurance Co. in Atlanta. Mr. Gaines, who joined the company in 1959, most recently headed the company's actuarial,

rate/product and personal lines policy service operations.

Klaus Ullman named vp-engineering at Arkwright-Boston Manufacturers Mutual Insurance Co. in Waltham, Mass.

Mr. Ullman, who joined Arkwright-Boston in 1978, most recently served as assistant vp and manager-boiler and machinery engineering.



Mr. Ullman

William W.

Ward appointed

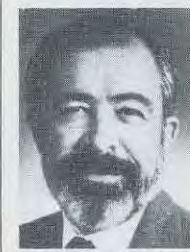
chairman of Phoenix Continental Management Ltd. in Toronto, a property/casualty company jointly owned by Phoenix Assurance P.L.C. and The Continental Corp. He succeeds **Jack B. Murch**, who has retired. Mr. Ward, who joined Continental in 1948, continues as president and chief executive officer of Phoenix Continental Management, as well as vp and manager of Continental's Canadian operations.

Also at Phoenix Continental, **Glen G. Martin** appointed senior vp. Mr. Martin, who joined Continental in 1964, most recently served as vp-administration and planning.

David Bowers, former vp and assistant general counsel for CNA Insurance Cos., named vp, corporate secretary and general counsel at Zurich-American Insurance Co. in Schaumburg, Ill. Also, **Thomas Hite** named vp at Zurich-American.

Russell H. Folk named vp at Prucare of North Texas in Dallas, a health maintenance organization that is a wholly owned subsidiary of The Prudential Insurance Co. of North America. Mr. Folk, who most recently served as director of group insurance marketing, joined Prudential 13 years ago. The HMO is expected to start operating in January, following accreditation by the state of Texas.

Roy H. Kirch III named senior vp of Westchester Fire Insurance Co. in Basking Ridge, N.J., a Crum & Forster organization. Mr. Kirch, previously vp of personnel, joined the organization in 1973.



Mr. Howard

Martin

Howard named vp and regional manager at the Seattle Group Office of Great West Life Assurance Co. Mr. Howard most recently was vp and regional manager.

G. Richer

Budke named vp-claims for Beaver Insurance Co. and vp-California operations for BPC Risk Management Services Inc., both subsidiaries of San Francisco-based Beaver Pacific Corp.

Agents/brokers

Donald J. Kosinski and **James V. Martin** named executive vps of Frank B. Hall & Co. of Ohio Inc. in Cleveland. Mr. Kosinski will continue to be responsible for new commercial insurance account development and servicing of existing accounts. Mr. Martin joined the company in 1981.

Also, **W. Presley Young** named president of the Akron office of Frank B. Hall of Ohio. He had been a senior vp. And, **Gerald P. Jones** named executive vp and chief operating officer of the Akron office. He had been a vp.

At Frank B. Hall & Co. of Missouri, **Sandy A. Steiner** named vp and manager of the St. Louis consulting office.



Detail of The Biglin Brothers Racing, Thomas Eakins; National Gallery of Art, Washington; Gift of Mr. and Mrs. Cornelius Vanderbilt Whitney

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RENEWAL WOES

U.S. losses causing problems with coverage for overseas units

By Jerome Karter

UNTIL RECENTLY, worldwide property and casualty programs have been the most stable element in the insurance portfolios of U.S. multinationals companies.

As long as subsidiary operations didn't involve exports to the United States, overseas programs profited from the good loss experience most insureds were having abroad.

But to the extent that overseas subsidiaries do export to the United States, corporate risk managers should expect to have trouble at January renewal time. They are going to find that the insurance they buy locally overseas is not going to include coverage for U.S. jurisdiction.

Why this sudden change? The answer lies in the increasingly unacceptable underwriting performance of insurers of U.S. casualty risks.

In fact, international reinsurers in today's market easily can be brought to a level of high anxiety by mentioning the subject of U.S. casualty business. Their usual reaction is both immediate and uniform: "An unwritable class of business!" "A judicial system that's out of control!" "Utilization of the commercial insurance industry as a vehicle for implementing social policy!"

As international reinsurers in general are restricting their activities, the exposures they want most desperately to avoid are liabilities emanating from the United States—particularly products and professional liability.

In essence, the non-London foreign reinsurance market has decided to abandon the underwriting of U.S. casualty business, whether on a monoline basis or within a multiline policy.

International reinsurers are wary about U.S. casualty business largely because of the excesses of the U.S. legal system. Contingency fees, the enormity of jury awards, awards for punitive damage, the adoption of a theory of absolute liability and attorney advertising all feed these excesses.

One underwriter recalled the day that he was riding on a New York subway and saw, sandwiched between advertisements for a beauty school and a pesticide for roaches, a law firm advertisement with the eye-catching headline: "Had an Accident? Been Injured on the Job?"

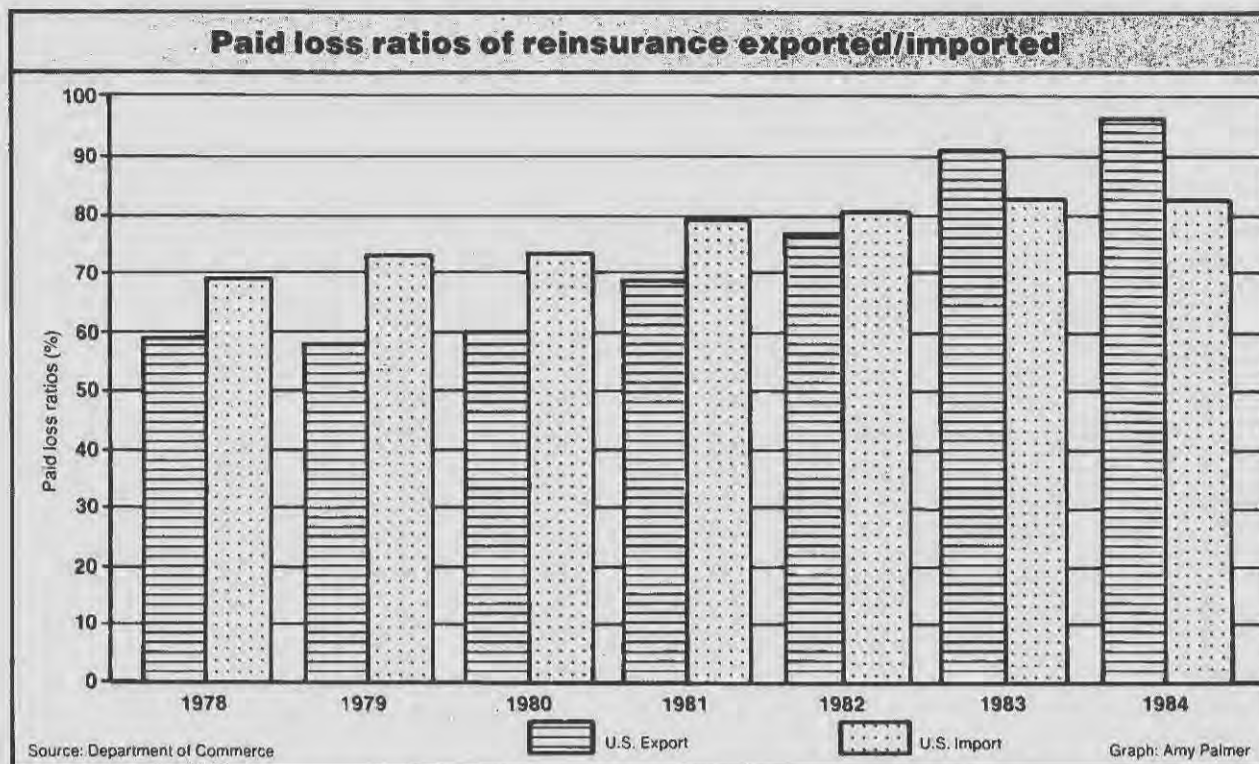
This vision crystalized his attitude toward the problems inherent in writing U.S. casualty business today.

While U.S. property/casualty underwriting results have been at an all-time low, overseas insurers have not fared so badly. It is an acknowledged fact that U.S. underwriters of imported reinsurance have fared much better than both the international and domestic reinsurers of U.S. business.

In fact, those companies that have been reasonably prudent in their underwriting—and have avoided picking up U.S. exposures through the back door—consistently have had combined ratios in the high 90s and low 100s on business actually underwritten in their U.S. offices.

Data from the Department of Commerce (see chart) shows the contrast between paid loss ratios (that is, the ratio of paid losses to net premium) on reinsurance ceded or exported from overseas.

(Premium and loss transactions between the United States and Bermuda have been deleted from this data, on the assumption that such transactions involved



international issues

essentially domestic business.)

As indicated in the chart, ceded results appear to be superior to assumed results during the late '70s and early '80s, but beginning in 1981, they show a marked deterioration.

The magnitude and speed of this deterioration may indicate that the seemingly superior results of earlier years were merely an illusion arising out of a general pattern of underreserving in long-tail classes of business.

Without a major restructuring of the mechanism for handling third-party liability claims, the European and Japanese markets will be closed to this class of business for an indefinite period.

And, even with such a change, it may be a generation or so before underwriters venture into this field again.

While foreign reinsurers have the option of simply withdrawing from the U.S. casualty market, they face a somewhat more complex problem in their home or regional markets.

Indigenous exporters of goods to the United States need product liability insurance with U.S. jurisdiction coverage, even if their exposure is only incidental. The definition of "incidental" varies from one reinsurer to another, but it generally can be described as an operation that generates U.S. sales volume while having no actual manufacturing, distribution or servicing operations in the United States. Further, an incidental U.S. exposure should generate less than \$10 million or 10% of total sales annually.

For truly incidental exposures, an indigenous exporter probably will be able to secure product liability coverage from his or her local insurer for claims occurring in the United States, whether through an endorsement to the local liability policy or through a separate contract.

Either way, coverage undoubtedly will either be highly restricted, entailing a claims-made form with defense costs included as part of the indemnity, and with full exclusions for pollution and for punitive damages.

Indigenous foreign exporters with greater than incidental U.S. exposures will have trouble securing product liability coverage for claims occurring in the United States because their local insurer probably will lack adequate reinsurance capacity for policies covering that broadened territory exposure.

These exporters will have to secure product liability coverage directly in the United States for claims

occurring in that market, or through their vendor/distributors, who may possibly be able to add exporters as an additional insured under their liability contracts.

Again, coverage probably will be provided only on a highly restricted basis.

As part of centralized risk management programs, foreign subsidiaries often maintain local liability policies—either through controlled master programs or individual programs—that defend product liability claims brought anywhere in the world for occurrences that take place outside the United States.

These foreign subsidiaries then rely on the parent corporation's domestic product liability coverage to respond to suits brought in the United States for occurrences that take place in the United States, regardless of whether the product involved was manufactured in the United States or abroad.

While the current contraction in reinsurance capacity may force the U.S. parent to maintain greatly reduced liability limits, this method of insuring product liability exposures is expected to continue in the near future, as U.S. insurers decide whether foreign excess/difference-in-conditions coverage should remain on an occurrence basis or be switched to a claims-made form.

But as capacity shrinks and U.S. policy forms restrict recovery for exposures such as environmental pollution, local foreign markets may offer broader coverage for risks within their own marketplace.

For example, both the financial guarantee cover provided by endorsement to the U.K. liability contract and the water pollution coverage provided by German liability underwriters are exposures that U.S. underwriters are becoming reluctant to reinsure within controlled master programs.

Perhaps the one positive development for insureds that require U.S. casualty coverage is that the situation may ease for international reinsurers of U.S. business because of the initial strengthening of foreign currencies against the U.S. dollar.

Reinsurers that wrote a portfolio of U.S. business in the late '70s and early '80s and then watched the tail of that business push combined ratios into the 120s, 130s and higher will now be paying their losses in cheaper dollars than a year ago.

To the extent that they can anticipate further relief in this area if the "soft landing" of the U.S. dollar is accomplished, they may be more willing to take on reinsurance of U.S. risks in the future.

Although the international reinsurance community
Continued on next page



Jerome Karter is vp and manager of the New York International Department of Johnson & Higgins. Mr. Karter takes over the International Issues column this month from S. Robert Beane, who was promoted to senior vp. Mr. Karter's column on international issues appears the first Monday of every month.

Book a valuable shopper's guide for PPOs

"The New Healthcare Market: A Guide to PPOs for Purchasers, Payors and Providers"

Edited by Peter Boland

Published by Dow Jones-Irwin, 1818 Ridge Road, Homewood, Ill. 60430

\$65 hardcover; 1,117 pages

By Linda A. Manuel

THE NEW HEALTHCARE Market: A Guide to PPOs for Purchasers, Payors and Providers," reads like a guide to a shopper's paradise, offering an individual a chance to sample all the benefits to be gained by purchasers, payors and providers looking for a bargain: the preferred provider organization.

The book, edited by Peter Boland, offers an anthology of articles by a variety of experts about PPOs. And, it is extremely timely because the PPO concept has hit America like a new item at the grocery store that is being examined by every employer and benefits expert and at the same time attracting a great deal of interest and attention.

Preferred provider organizations serve as another alternative in the health care industry that gives purchasers choices in the type of comprehensive health care programs we offer. And the economic impact health care has had on the budget of companies has made it necessary to seek these services on a supply and demand basis.

The public and private sectors are seeking a particular type of health care and banding together to contract for this care through brokers and/or hospitals,

books & ideas

clinics and physicians directly. The concept is very attractive today, since hospital beds are empty, after-hour clinics are popping up conveniently in neighborhoods and such alternative care options are becoming the preferred options.

Flexibility, convenience and cost control through utilization controls and discounted rates are characteristics being sought in the marketplace. PPOs are being looked upon as powerful new medical care programs that can bypass the family doctor and local hospital and yet appear attractive and competitive.

Physicians and hospitals are realizing the need to market themselves because they no longer can compete as they had been. And, "The New Healthcare Market" gives the purchaser of health care services and insurance a shopping guide to help find the best deal that money can buy, in terms of both price and quality of service.

The "shopping guide" examines the whole spectrum of things to consider when setting up a PPO. It covers benefits coverage, quality assurance, choice of providers, service area, organizational structure, provider membership criteria, sponsorship, methods of payment for physicians and hospitals, risk-sharing, financial incentives and disincentives, utilization review, administrative services, and information management through purchaser and provider reports.

Finding the right combination of these ingredients is a must in order to set up an effective PPO relationship.

The design of a benefit plan should be tailored to the needs of the individual groups seeking care through this type of network, and the book helps those in charge of tailoring the program find the right combination of ingredients.

America's willingness to change from the traditional set-up for providing and paying for health care is a sign that we are questioning spiraling costs and trying to do something about the means of obtaining health care. And, that attempt is long overdue.

The decision to elect a program such as a PPO must be an educated, well-thought-out one. And benefit managers, hospitals, physicians, employers and other interested parties will get that education by reading "The New Healthcare Market."

A lot of questions are being raised concerning the who, what, when where and how of starting or joining a preferred provider organization. And those answers can be found in this interesting reference guide edited by Peter Boland.

Everything you need and want to know about PPOs is in this book. . .so read it!

Linda A. Manuel is corporate employee benefits director of Kurz-Kasch Inc. in Dayton, Ohio. She coordinates insurance and employee benefits for more than 350 employees in Dayton, Wilmington and Newcomerstown, Ohio, and Erie, Pa.



Insurance certificate is not start of coverage

The issuance of a certificate of insurance under a group policy to an individual had no effect on the commencement of coverage where the master policy provided that coverage would be effective on the first day of the month after receipt of the application, a Tennessee appellate court ruled.

Mattie Mae Paul, an employee of the Durango Boot Co., applied for family coverage under a group accident policy issued by the Insurance Co. of North America on June 4, 1982. Her husband was killed in an accident on June 8, 1982.

When Ms. Paul signed the enrollment form on June 4, her employer gave her a booklet explaining the policy and coverage and containing a Certificate of

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.

legal briefs

Insurance. The certificate did not specify when coverage was effective; however, it said the insurance was subject to the terms and conditions of the policy.

The booklet also stated that insurance would take effect on the first day of the month after receipt of applications. Ms. Paul filed a claim for benefits. The employer denied her claim. She sued but lost in the trial court.

On appeal, Ms. Paul argued that because she was issued a Certificate of Insurance she was covered under the policy, since the policy language did not authorize issuance of a certificate to one who was not insured.

But, the court said that the language Ms. Paul relied on was not concerned with the effective date of the policy but rather with the allocation of responsibilities of the contracting parties.

Further, the court said the policy clearly set the effective date as the first

day of the next month following receipt of the application. *Paul v. Insurance Co. of North America*, Court of Appeals of Tennessee, May 22, 1984, *Application for Permission to Appeal Denied by Supreme Court* Aug. 27, 1984 (BI/02/Au.-\$5).

Alaska comp law overturned

The Supreme Court of Alaska has ruled unconstitutional a state law reducing the amount of workers compensation benefits for recipients who later move out of the state.

This case involved the constitutionality of a former provision of the Alaska code that adjusted benefits of work comp recipients who moved from Alaska after being awarded the compensation.

In this case, Robert Brown was injured on the job in Alaska in January 1977 and was awarded benefits. He later returned to his home state of California and his

benefits were adjusted under the Alaska law, reducing them by about \$340 a week.

He filed a class-action lawsuit against his employer's insurer, alleging the law violated his constitutional guarantees of equal protection and due process. The trial court found it unconstitutional on equal protection grounds.

On appeal, Mr. Brown asserted that the Alaska law imposed a direct penalty on those workers compensation recipients who chose to leave Alaska, and that law therefore burdened their right to travel.

The court concluded that the risk of severe benefit reduction based upon variations in economic conditions that do not reflect the purchase power of benefit dollars was a significant penalty and did constitute a violation of Mr. Brown's equal protection guarantee, rendering the state law invalid. *Alaska Pacific Assurance Co. v. Brown*, Supreme Court of Alaska, Feb. 17, 1984, *rehearing granted in part and denied in part*, July 20, 1984, *as modified* July 20, 1984 (BI/01/Jy.-\$5).

U.S. losses cause problems with coverage for overseas units

Continued from previous page

has focused a great deal of attention over the past year on the U.S. casualty market, reinsurers also have been seriously affected by developments in other classes of business, both inside and outside of the United States.

Surprisingly, recent natural disasters have not been as devastating to property insurers and reinsurers as might be anticipated. For instance, while Hurricanes Elena and Gloria caused widespread damage, the storms fortunately did not seem to reach the critical mass that would have started a chain reaction of claims in the reinsurance and retrocession markets.

And although it will take some time to assess the full impact of the Mexican earthquake, the reinsurance community feels that losses, while significant, may not be as severe as first feared.

This good news is offset by events in other areas,

however.

The fact that natural catastrophes were less devastating than they might have been to international reinsurers is of little consolation to companies that need aviation and satellite insurance. Staggering losses in these categories are now causing severe constriction in capacity.

If it can be said that an inordinate number of insurers relied on reinsurance during the past decade for operating capacity, then it is even more true to say that a greater degree of reinsurance capacity relied upon the retrocession market. The international market has suffered its greatest contraction in this area, and reinsurers who depended on the retrocession market rather than their own financial strength are, for all practical purposes, out of business.

Nowhere is this fact more clearly evident than in the

property and casualty facultative markets, which have been decimated over the past year. Reinsurers that have remained in the facultative market now look on capacity as a commodity. There is very limited supply and it goes to the highest bidder.

Unfortunately, the price for exposure is no more rational at today's cost per million than it was at yesterday's, but the higher cost for reinsurance will be passed along to the insurance buyer when coverage is available.

Thus, the tight property-casualty market cannot be expected to ease in the near future. Indeed, it may worsen considerably for overseas exposures.

This means that informed risk managers should be bracing themselves for Jan. 1 renewals so that they are prepared to deal with problems worldwide that until recently were limited to their U.S. programs.

info

● The Fisher Associates offers a **training manual on the new claims-made commercial general liability form**. The manual—designed for use by risk managers, insurers and agents and brokers—analyzes the new form, raises questions about problems in implementing the form and poses solutions to those problems. Including defense costs within policy limits also is discussed. The manual costs \$20 and is available from Fisher Associates, 3465 Torrance Blvd., Suite N, Torrance, Calif. 90503; 213-540-8803.

● The "1985-86 Property/Casualty Insurance Fact Book" contains **information on property/casualty insurance topics** from auto insurance to workers compensation. The yearbook, offered by the Insurance Information Institute, includes a section on the civil justice crisis and tort reform provisions and a detailed look at actions taken by states to curb drunken driving. The cost for single issues is \$4.50 for Institute members and \$9 for non-members. The cost for orders of three or more is \$4.50 a copy for members and non-members. Copies can be obtained by writing to the Insurance Information Institute, Publications Service Center, 110 William St., New York, N.Y. 10038; 212-669-9200.

● A free brochure from Alexander & Alexander Inc. explains how self-insured employers can purchase **coverage for major organ transplants** through a fully insured supplemental policy. Write to Peter Kautz, Alexander & Alexander, Three Embarcadero Center, San Francisco, Calif. 94111; 415-434-1500.

● Custom-tailored **plan documents and summary plan descriptions for self-funded health care plans** are offered by Hunter & Associates, a consulting firm. Samples of the plan documents and summary plan descriptions are available for \$4.75. To order, write to Susan L. Waybourn, Vp-marketing, Hunter & Associates, 8595 Aquarius Drive, San Diego, Calif. 92126; 619-578-7461.

● "How to Prepare for an Earthquake/A Guide for Businesses," a book now available from the Insurance Information Institute, outlines **steps a company can take before an earthquake strikes**. The book includes sections on protecting employees at home and at the office, protecting office and computer facilities, operations and company assets. The cost is \$20, but discounts are available for orders of multiple copies. To order, write to the Insurance Information Institute, 110 William St., New York, N.Y. 10038; 212-669-9200.

● Peat, Marwick, Mitchell & Co. has prepared a booklet providing an overview of **insurance in the Bahamas**. The booklet, "Insurance in the Bahamas" includes a review of recent legislation regarding captives, along with sections on establishing insurance operations in the Bahamas and taxation considerations. Free copies are available from any Peat, Marwick, Mitchell & Co. office.

● The importance of accurate **record keeping in the administration of defined contribution plans** is the subject of a brochure prepared by Coopers & Lybrand. The brochure is intended to help companies understand what to expect from a record keeper and what a recordkeeper needs to operate efficiently. Free copies are available from Coopers & Lybrand, Arlene Nowak, 400 Renaissance Center, Detroit, Mich. 48243; 313-

446-7346.

● Educating employees about **alcohol use and its effects on health** is the point of a new booklet from Fax Communications Inc. The 16-page booklet, "Thinking About Drinking: Your Guide to Developing Healthy Attitudes About Alcohol," includes sections on types of drinkers, sensible drinking tips, blood alcohol levels and warning signs of problem drinking. The cost ranges from 79 cents each for 50 to 99 copies to 39 cents each for 25,000 or more

copies. Contact Fax Communications Inc., Department BI, 3279 20th St., San Francisco, Calif. 94110; 415-641-7422.

● The Reinsurance Assn. of America is offering the 1985 edition of its biennial "Loss Development Study." The edition contains raw **loss development data** of 23 companies and tables for casualty excess reinsurance for automobile liability, general liability and workers compensation. Copies are \$15 each from the Reinsurance Assn. of America, 1025 Connecticut Ave. N.W., Suite 512, Washington, D.C. 20036.

● Planning, marketing, imple-

menting and evaluating **employee wellness programs** are discussed in several packages of material available from Corporate Health Designs in Seattle. A free brochure describing different packages available to employers can be obtained by writing to Larry Chapman, President, Corporate Health Designs, P.O. Box 55056, Seattle, Wash. 98155; 206-364-3448.

● A brochure listing the **average physician charges in Florida** for 23 common medical procedures is available from the Florida Hospital Cost Containment Board. The brochure lists charges by county. It also includes seven questions health care consumers should ask

their doctors. Copies are free and can be ordered from the Hospital Cost Containment Board, Public Information Office, Woodcrest Office Park, Suite 101L, 325 John Knox Road, Tallahassee, Fla. 32303; 800-342-0828.

● *Have a new report, booklet or promotional brochure you'd like to send to buyers of insurance? Business Insurance will describe material costing less than \$25 as an editorial service in the weekly Info for Buyers column. Simply send us a short description of the material to be offered, along with the cost and a mailing address. Address all contributions to Info for Buyers, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.*

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Insurers sought for new financial guarantee bond

By MICHAEL BRADFORD

NEW YORK—Its developers claim a new financial guarantee bond could generate about \$30 million a year in premiums for underwriters while modernizing an outdated technology.

However, the new product is having trouble getting off the ground.

The bond is called Signasure, and it is a new technology called "medallion guaranty" being developed by a group of financial and securities industry representatives as a way to change the method of guaranteeing signatures in securities transfers.

Currently, when stock certificates or certain registered securities documents change ownership, a guarantor must verify that the signer of the document has the authority to transfer ownership of the document.

A guarantor generally does this by rubber-stamping a validation on the back of the document, signing it and sending it to the issuing company's transfer agent.

Transfer agents serve as a record-keepers for the issuing companies.

Most transfer agents are large commercial banks, although some big corporations may do their own transfer work.

Part of the transfer agent's responsibility is to accept or reject the guarantee, based in part on an assessment of the guarantor's financial stability.

Currently, guarantors are usually large commercial banks or trust companies, or they can be members of an established stock exchange.

If a loss does occur for the issuing company because a guaranteed signature was invalid, a guarantor's blanket bond coverage usually will cover the loss.

However, if a loss occurs and the guarantor cannot for some reason fulfill its financial commitment, the transfer agent becomes responsible for the loss.

As a result, transfer agents historically have accepted guarantees only from large financial institutions, because of the perceived financial stability of those companies.

Even though there are no laws that restrict smaller institutions from offering the services, transfer agents still are reluctant to accept their guarantees, claiming they are not prepared to make a proper evaluation of the financial stability of all potential guarantors.

The aim of Signasure is to make transfer agents less reluctant by allowing the guarantor to purchase coverage that in effect would back up its guarantee.

Guarantors would use a desk-top machine that would imprint a medallion on the back of the document, verifying the authority of the document's signer.

The imprint would tell the transfer agent that not only has the guarantor verified the signature, but that the guarantee is backed by Signasure.

Robert F. McKeon, executive vp of financial services at Fred S. James in New York, was asked by the Stock Transfer Assn. to work as a consultant in the development of Signasure.

The project was begun two years ago in response to a suggestion from the Securities and Exchange Commission.

A board made up of members of the STA, the United States League of Savings Institutions and other associations and stock exchanges was formed to develop the new product.

Developing the product was the easy part, Mr. McKeon says; getting

products & services

insurers to underwrite it is not so simple.

"The entire industry is supporting it," he remarked, pointing out that the SEC, the STA, major stock exchanges, the American Bankers Assn., insurance agents, brokers and various other financial industry groups support Signasure.

But, Mr. McKeon laments, "We can't get the interest of the insurance companies."

Bringing a new product into a marketplace in which underwriters are restricting their writings "is a horror show," he says.

The only positive response from an insurer thus far has been a

verbal agreement by the Credit Union Mutual Insurance Co. in Madison, Wis., according to Mr. McKeon.

The reaction from insurers is especially frustrating, according to Mr. McKeon, because he says the product would produce an acceptable loss experience and could generate as much as \$30 million annually in premiums for underwriters.

He said a recent survey of seven major transfer agents with more than 100 years of combined experience revealed only a few cases that involved "a loss where an agent was stuck with a claim."

In an informational "white

paper" that describes the proposed Signasure program, several insurers are identified as ones the bond's developers feel are qualified to underwrite the product.

The insurers include Aetna Casualty & Surety Co., American International Group, CIGNA Corp., Continental Casualty Insurance Co., Chubb & Son Inc., Seaboard Surety Co. and Transamerica Insurance Co.

The bond would be sold through insurance agencies and brokerages, Mr. McKeon said.

Mr. McKeon explained that a company called Signasure Service Co. in New York would administer the program on behalf of insurers that underwrite the bonds. The service company's duties would include:

- Pre-qualifying all guarantor

applicants.

- Issuing policies and preparing premium invoices.

- Ordering and maintaining records on the Signasure machines.

- Collecting premiums from insurance agents and brokers and remitting the premiums to the insurer.

- Preparing annual accounting services.

Proposed limits for coverage under the bond would depend on the number of annual transactions performed by the guarantor.

Even though its developers have not yet found an insurer to underwrite Signasure, Mr. McKeon says he expects the program to be in place by the end of the year.

He is continuing to meet with insurers, explaining the merits of the Signasure program. ■

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Transplant cover

Continued from page 3

"The board felt that if payers responded to the growing public pressure by reimbursing for transplants wherever performed, we may lose forever the opportunity to manage the national investment of health care resources in this area," Mr. Kadar said.

"Our failure to act now, it felt, could cost us dearly in the years to come."

The HIAA advocates limiting transplants to specific "qualified medical centers" for two reasons, he explained.

First, limiting the number of centers that can perform organ transplants will increase the quality of those operations, he said.

Secondly, such limitations would reduce the proliferation of transplant facilities at hospitals, which can contribute to the escalation of health care costs, he said.

An unsuccessful attempt was

'If Medicare set this important precedent, we felt we in the private sector would stand a fighting chance to limit our own payments to such centers and better manage our own financial security,' Mr. Kadar said.

made to place certain limitations on organ transplants as part of the National Organ Transplant Act, which Mr. Kadar said aims to coordinate organ acquisition and supply to facilitate the linking of donors with receivers.

Originally, it had been proposed that, under the act, the Department of Health and Human Services be granted authority to limit Medicare payments for transplants to a designated medical center; to approve Medicare payments on a conditional basis; and establish patient selection criteria.

Although the HIAA endorsed

this proposal, it ultimately was rejected, Mr. Kadar said.

"If Medicare set this important precedent, we felt we in the private sector would stand a fighting chance to limit our own payments to such centers and better manage our own financial security," Mr. Kadar said.

Although the proposal to limit diffusion of organ transplants was rejected, states like Ohio, California, Massachusetts and Connecticut have passed legislation that restricts reimbursement to "qualified centers" or requires a hospital to meet certain requirements for ap-

proval before they can establish transplant facilities.

"States which have done nothing to control transplant diffusion, like Pennsylvania, are reportedly seeing remarkable competition among hospitals to get their program started before the ones across town do," Mr. Kadar said.

"The issue is not necessarily dead, and we will solicit your support whenever another legislative opportunity presents itself," he said.

However, the HIAA still fears that, without a national policy limiting transplant diffusion, insurers may lose authority to limit private reimbursement on that basis, Mr. Kadar said.

Antitrust also has become an HIAA concern, he said.

"Some providers and physicians have already put us on notice as an industry that they will regard the private designation of centers of excellence as unfair restraint of trade," Mr. Kadar said.

And, without a federal policy, the insurance industry may be a fair target for antitrust suits, Mr. Kadar said.

"If Medicare and Medicaid say yes (to paying for organ transplants performed at any facility), how long can the private payers say no?" he asked.

Mr. Kadar also argued with the assertion that the astronomical expense of organ transplants is offset by their relative infrequency due to lack of donors.

"Indeed, the present low-frequency caseload does not appear financially unmanageable," he said. "However, clouds on the horizon are dark. There are numerous activities presently underway that have the potential for greatly expanding the donor pools—in months, not years."

Mr. Kadar also cited laws that have been passed in some states, like New York and Oregon, that require hospitals to solicit an organ donation from the family of a patient who dies.

Such laws will greatly increase the number of organs available, thus increasing the number of organ transplants actually performed, Mr. Kadar said.

Other developments—such as states changing the legal definition of death to total cessation of brain activity, rather than cessation of bodily functions—will make organ retrievals more timely. This again will increase the number of usable organs available for transplants, Mr. Kadar said.

"So, if we believe those who argue that natural limits on the availability of organs will keep today's costs manageable, and that therefore employers and insurers should not rush to seek a rational national policy in this area, we may delude ourselves into a false sense of security," Mr. Kadar said.

Another development that is a "great source of concern" to the HIAA is the artificial heart, which he said has the potential to increase the number of transplants performed.

"If we even get to the stage where we can ignore the concern for the supply of natural organs, then we have truly entered the mega-bucks arena," Mr. Kadar said, referring to artificial heart operations.

And, the government probably won't be in the position to pay for many of the growing number of organ transplants, Mr. Kadar said.

"At this moment, House and Senate conferees are ironing out details of a plan to eliminate the federal debt in the next six years by cutting \$36 billion from that debt each year," Mr. Kadar said. "Federal health programs are sure to see their share of cuts."



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CEB conference attracts 275

About 275 employee benefits specialists gathered in Washington Oct. 17 and 18 for the 39th annual Council on Employee Benefits conference.

The conference, held in the Washington Hilton Hotel, featured discussions on a variety of employee benefit topics, including post-employment benefits liability, high-tech health care and the federal government's proposals to tax employee benefits.

Speakers from a variety of disciplines, including life insurance experts, employee benefits consultants, lobbyists and congressmen, gave conference attendees 1½ days' worth of information, ideas, warnings and perspectives on the issues confronting employee benefits specialists.

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Is high-tech treatment worth the cost?

By DIANE LYNN KASTIEL

WASHINGTON—The federal government should form a national health care policy to guide employers and health insurers in determining whether high-tech medical advancements are worth the cost, one health insurer says.

And, it is up to insurers to ask the federal government to play a more significant role in developing this policy, says Arthur Lifson, vp with the Equitable Life Assurance Society of the United States in New York.

Mr. Lifson spoke on the high cost of advanced medical procedures at the 39th annual conference of the Council on Employee Benefits last month in Washington.

Rather than limiting their concerns to health care premiums and

'A major reason, we believe, that the decisions associated with high tech are tough is we are not convinced that we will wind up with a reasonable outcome when all the anguish is over and all the money has been spent,' Mr. Lifson said.

expenses, insurers also should initiate "open, public discussions" of the moral and ethical issues surrounding high-tech medical care, Mr. Lifson said.

"There are a whole host of 'experimental' high-tech—both high-cost and not so high-cost—procedures currently in the pipeline," Mr. Lifson said.

"No one wants to be run over as we all were by the proliferation of

bypass surgery. However, we still lack a national policy to conduct formal technology assessment studies and engage in basic studies of efficacy for new procedures or any process for implementing their findings.

"Individually and collectively, we are incapable of saying 'no' to the individual," Mr. Lifson explained.

"No one wants to look anyone in

the eye and say, 'It's too expensive, the odds are too long. I'm sorry, but you or your loved one will not get this costly medical cure.'

"Yet, without restrictions as to either availability or eligibility, that is exactly what will confront those employers who wish to control their exposure."

Therefore, it is imperative that the government, insurers and employers together decide how advanced medical technology should be used, he said.

One of the most important things to be determined in formulating this policy is whether a particular technology is really a medical cure, he explained.

"Realistically, we come to this discussion knowing that care which is costly and 'high tech' may not be a cure," Mr. Lifson said. "A major

reason, we believe, that the decisions associated with high tech are tough is we are not convinced that we will wind up with a reasonable outcome when all the anguish is over and all the money has been spent."

Some purported "cures" are really technologies to prolong life, Mr. Lifson said.

For example, he noted that the iron lung kept polio victims alive but was not a cure. Polio vaccine, which prevented contraction of the disease, was the real cure for polio, he pointed out.

"Many of the costly medical 'cures' which currently are causing all of us great concern are intuitively perceived as more analogous to the iron lung than the polio vaccine," Mr. Lifson said.

"If these new technologies were cheaper and 'caused no harm,' we would gladly pay the price. The perception, whether accurate or not, is that the technologies are astronomically expensive, they are successful about 50% of the time and incur very high ongoing expenses."

The coupling of the prohibitive expense of "high-tech" medicine and the uncertainty of its effectiveness makes many insurers wary and eager to put controls on its use, Mr. Lifson said.

"We are currently faced with having to confront the limits of our resources in ways which have the potential for causing great discomfort to all the parties at interest," Mr. Lifson said.

"Frankly, we don't like putting a price on lives. That's what's perceived as the ultimate outcome of making tough decisions," Mr. Lifson added.

In making these decisions, however, insurers are taking certain facts into account that may not be well-known by the general public, including the unnecessary nature of many surgeries, Mr. Lifson explained.

For example, "There is growing evidence that a high proportion of some 200,000 (artery) bypass procedures performed a year, at a cost of some \$4 billion, might not be necessary," he said.

"It now appears that equally effective lower-cost, less-radical procedures might produce the same or similar results."

But, because there is no formal process for evaluating and comparing surgical procedures, health care providers have increasingly performed such high-cost procedures, and patients readily followed "doctor's orders," Mr. Lifson said.

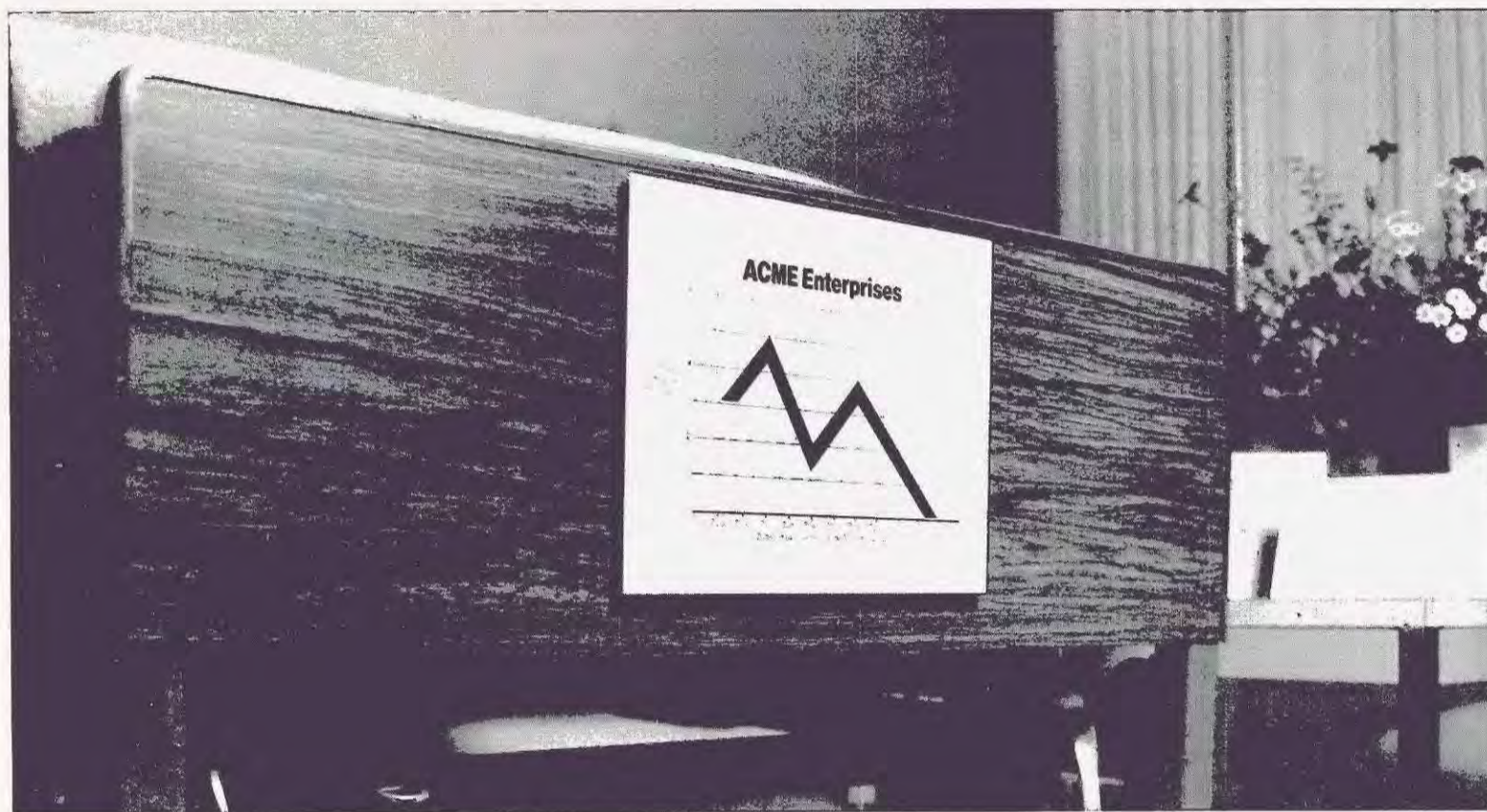
"This lack of control produced market demand, which swamped any attempt by insurers or employers to limit their availability," he said. "Only after (bypass surgery's) widespread acceptance were efficacy and cost-benefit studies attempted."

Mr. Lifson encouraged employers and insurers to work together and take an assertive role in formulating a policy on costly, high-tech medical procedures.

According to Mr. Lifson, Equitable is practicing what it preaches by sponsoring a series of one-hour television programs entitled "Managing Our Medical Miracles," which will look at these moral and ethical issues, Mr. Lifson said.

"Employers and other payers must recognize that their financial concerns are but one among many legitimate factors which will shape whatever consensus might ultimately emerge," he said.

"None of us... can solve the dilemma of costly medical cures alone, nor can we unilaterally make the tough decision. Working together, we stand a chance of producing a result in all of our interest."



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Changing management style

Keeping employees happy, productive is vital in tight market

By LINDA J. COLLINS

The vital need to retain qualified agency personnel in today's tight insurance market is forcing agencies to change their management style, agents and consultants agree.

Agencies are abandoning unresponsive, dictatorial agency management and adopting open management that stresses communication between agency principals and their in-house employees, and principals' commitment to help employees grow professionally, the experts say.

"We try to create an environment in which all employees are allowed to develop to the greatest extent they are capable of growing," says Stanley Butwin, president of Nathan Butwin Co. Inc., a brokerage in Great Neck, N.Y. "If they have special needs, we try to respond to them."

"Communication is the key," says Jess Chappell, owner of FirstInsurance, an agency in Alexandria City, Ala. "If you don't do anything else, you have to communicate with employees. . . . Never underestimate the insecurity that they gather" if you do not tell them what you are thinking and what is happening in the agency, he said.

Much of the change in management style is driven by the recognition that agencies must retain qualified personnel and stimulate productivity among in-house employees to survive today.

In the current chaotic insurance marketplace, in which agents are scrambling to find adequate markets for their clients' business, it is vital to maintain a finely tuned agency operation.

Time spent searching for, interviewing, hiring and training new employees decreases agency productivity and steals time needed to compete in the marketplace. And, that drain

could kill an agency fighting the competition for markets.

In addition, the in-house staff plays a vital role in the agency's day-to-day dealings with current and prospective clients, the experts say.

Although an agency's in-house staff is not out in the field making sales calls, those employees are still in daily contact with clients. They talk to them on the telephone, write them letters and service walk-in customers. They represent the agency to prospects and clients, experts agree.

"You have to have an inside staff that is equal to or stronger than your outside staff, with knowledge of the industry, a good attitude and competency in their positions," says Willis Hargrave Jr., president of Harco Insurance Services, an agency in Houston.

"We want our employees to be excited about what they do," he adds. "The only way to accomplish that is to allow them to grow within their jobs."

To encourage productivity and to keep employees happy—and on the job—many agencies and consultants are stressing a spirit of teamwork (see story, page 30B).

Agency principals should give their employees input into decisions made in the agency, especially decisions about "anything that directly affects their job or their workload," says Carol Hammes, president of The Middleton Group, an agency consulting firm in Naperville, Ill.

"I suggest that agencies have a biweekly or monthly staff meeting to give the concept of teamwork more than lip service," says Peter Zappa, agency systems and automation consultant for The Market Planning Group in Boston.

"Throwing money at an employee is not useful anymore," stresses Marty S. Shuherk, vp of Your Employment Service, an agency recruiting service in Columbus, Ohio.

"Employees like management to talk to them, to listen to their problems. Employers have to have more willingness to talk," he explains.

Consultants and agents also advocate that agencies support the educational endeavors of their employees. The support helps employees grow professionally and enhances the agency's overall professionalism (see story, page 30H).

By encouraging education, such as attaining professional designations or attending seminars or workshops, an agency gives employees "the opportunity for advancement and more knowledge of the insurance industry," points out Gary M. Gregory, president of Lon Worth Crow Insurance Agency in Coral Gables, Fla.

Incentive programs also can boost an agency's productivity (see story, page 30F). But agencies should "do something different each year" if they want an incentive program to succeed, says Mr. Hargrave of Harco Insurance Services.

If an agency keeps the same incentive plan year after year, the plan begins to lose its effectiveness, he explains.

A variety of other factors also contribute to employee satisfaction and productivity, the experts agree. Among these are a pleasant office environment, a spirit of cooperation among staff members, proper distribution of work, adequate pay and benefits, recognition of accomplishments, and the potential for advancement within the agency.

"Get the message across that your employees are important and very valuable to you and that you are concerned for their welfare," advises James Econn, chairman and chief executive officer of James Econn & Co., an agency in Los Angeles.

"You have to promote team spirit and a charging-together feeling to accomplish things," he said.

Communication is key to agency teamwork

By LINDA J. COLLINS

In the current marketplace, teamwork among employees is essential to the survival of an insurance agency, industry sources agree.

Office employees must work with agency principals and producers if the agency is to weather the storm of capacity shortages, fierce competition and other problems for markets, they say.

And, they add, communication is the key to achieving that teamwork.

"In agencies that have done their homework and have worked to improve their internal climate, employees are better psychologically prepared to deal with the (complexities) of the market... and those

agencies do not experience as many difficulties as do other agencies," says A. Russell Chaney, a consulting principal in the Walnut Creek, Calif., office of Business Management Group, which is based in Hartford, Conn.

First of all, the experts say, principals must keep employees informed about the myriad changes in the marketplace.

"Principals should communicate with their staffs about the state of the insurance industry and what their agency is doing" to deal with

market conditions, Mr. Chaney adds.

But, the experts stress, employee communications should not be limited to a discussion of current market conditions and how they affect the agency.

Principals also must communicate one-on-one with employees, so that employees will remain satisfied and productive members of the agency team, the experts say.

"Management should use an open, constructive communicative style with employees. If employees do not get solid feedback—positive or negative—they will simply drift along," says Mary Beth Wise-Bolen, a consultant and vp in the Flint, Mich., office of Sitkins Group Inc., which is based in Fort Myers, Fla.

"Such communications should be

ongoing, and not just done when problems occur," she adds.

Experts say successful employee motivation and cooperation depend on management's ability to:

- Hire the right person for the right job and compensate that person adequately.

- Make sure employees understand the agency's philosophy, objectives and plan for achieving those objectives, and how each employee contributes toward the attainment of those goals.

- Involve the staff in decisions that affect them directly and the agency's ability to meet its goals.

- Stimulate staff enthusiasm through a pleasant working environment, personal attention, a potential for upward mobility, educational support and incentive pro-

grams (see stories, pages 30F and 30H).

Agency management first must

hire the right people and train and manage them properly, says Don Eve, industry consultant and president of Eve Insurance Agency Inc. in Flint, Mich.

"If an agency is having problems with its staff, one of these responsibilities is not being met," Mr. Eve stresses.

Agents should look for new employees who are comfortable in an office environment and who have a sense of mission, he says.

J. Knox Hillman Jr., president of Shuford Insurance Agency Inc. in Concord, N.C., says he looks for new employees who have "good character" and who exhibit intelligence, a good personality and an ability to grasp technical skills.

He also tries to find people who are willing to cooperate with other staff members and can "pitch in and help" when the need arises.

But, he says, once they are hired, "it is vital to make employees feel that they are important to the office and that everyone is working together toward a common goal.

"If an employee feels that he or she is important, that person is going to do important work," Mr. Hillman stresses.

Willis Hargrave Jr., owner of the Harco Insurance Services agency in Houston, says the two personal characteristics he finds "absolutely essential" when hiring an employee are a positive and cooperative attitude and good work habits.

"If people have those two qualities, we can teach them anything else they need to know," he says. "Attitude is a very important ingredient—their interest in educational achievement and their ability to cooperate with others."

But, consultants and agents stress, finding good employees is only part of the battle. The real challenge often is keeping them.

Although the promise of a substantial wage might attract a new employee to a job, the pay alone will not keep that employee, Mr. Eve says.

"Money is a source of dissatisfaction" if an employee's salary is unreasonably low, he said. But if a salary is fair, money alone "is never a source of satisfaction."

"Satisfaction comes from other areas," such as a sense of achievement or personal growth, he says.

Lou VonVille, president of The Confidential Registry, an agency research and consulting firm in Columbus, Ohio, says there is a "changing relationship between employers and employees today."

He explains that most employees in the workforce today are from the "baby boom" generation. Unlike preceding generations, which were motivated mainly by salary and job security, the baby boomers are seeking personal fulfillment in their work, he says.

Because of this change, baby boomers "will change jobs for less money and more job satisfaction," Mr. VonVille says.

However, other consultants stress that for employees in lower-level support positions, who often make only a survival wage, their paycheck indeed may be the primary motivating factor.

"We really still see the actual paycheck as the main incentive for these types of agency employees," says Carla G. Addicks, vp of Russell Miller Inc., an agency consult-

Continued on next page



Mr. Chaney



Mr. Eve

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Continued from previous page
ing firm in San Francisco.

But, the consultants agree, even for support-level employees to remain satisfied, they must feel like a part of the organization. Employees need to know what is expected of them, what the agency's goals are, and how they fit into the overall scheme of things.

One way to get this message to employees is to provide them with a written job description and an employee manual. But, agents and consultants warn, these must be updated regularly.

"We have job descriptions for each job. I'd hate to operate without them. But we can still be flexible because we update them frequently. In this market you have to change," says Robert Nein, president of Scott Insurance, an agency in Lynchburg, Va.

Jon H. Pease, vp of Holmes, Murphy & Associates Inc., an agency in Des Moines, Iowa, agrees that job descriptions and employee manuals must be updated frequently. He says his agency's office manual is in a looseleaf notebook, so pages can be changed frequently.

"Our office manual includes the philosophy of the agency, our focus on customer service and all agency procedures," he says.

Norman F. Tyler, president of Homestate Insurance Brokers of Alaska Inc. in Anchorage says that to make sure his agency's personnel manual is always up to date, the agency is putting the manual on its computer.

The personnel manual spells out such things as employee benefits and eligibility requirements, and travel and entertainment reimbursement procedures, Mr. Tyler says. "We inform our employees and it protects the agency," since all of these things are spelled out in the manual.

Scott F. Welch, president of Bowers, Schumann & Welch, an agency in Washington, N.J., says his office manual includes job descriptions and benefit and procedural information. The manual is in looseleaf form, and the agency requires employees to sign the manual after they read it.

As pages are updated, the agency requires that each employee initial every page to indicate that he or she has read and understands procedural changes, he says.

And the agency also must be careful that the job description describes, rather than limits, an employee's performance, the experts advise.

Mr. Tyler warns that if an agency furnishes employees with a written job description, it should make sure that employees understand that the duties listed are only their minimum responsibilities—not their only responsibilities.

Consultant Ms. Wise-Bolen agrees. "The job description should outline the basic functions of the job. If the descriptions are very specific and the agency does not update them on an ongoing basis, employees can get into a 'not-my-job' syndrome."

All consultants and agents contacted feel staff meetings are important for keeping lines of communications open between staff and management, although they recommend different frequencies for the meetings.

Such meetings are useful, Ms.

Wise-Bolen explains, because "participatory management gives employees a better sense of responsibility for their work and reduces the feeling that they are simply holding down a 9-to-5 job."

Mr. Chaney of Business Management Group recommends staff meetings be held at least once a month. He says staff meetings are useful for soliciting input into decisions that will affect the entire agency.

If the decision would affect only one employee or one department, however, Mr. Chaney suggests management simply turn the matter over to the employee or department to seek a suitable solution.

"I like to see various employees take charge of meetings," says Marty S. Shuherk, vp of Your Employment Service, an agency recruiting firm in Columbus.

"Tell management to turn office meetings over to employees to con-

Continued on next page



Mr. Nein



Mr. Welch

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Job satisfaction

Continued from previous page duct," Mr. VonVille agrees. "Management should let employees express themselves. Managers will be better off making decisions after they hear input from everyone in the agency."

The suggestions made during staff meetings should be published and updated as they are adopted, so employees can "recognize that the suggestions they make have some effect" on the agency's operations, says Carol Hammes, president of The Middleton Group consulting firm in Naperville, Ill.

Mr. Tyler says his agency holds three separate meetings a week: for its personal and commercial lines departments and for customer service representatives.

Then the entire office staff "has meetings at least once a month—or as often as necessary, and employees are encouraged to make sugges-

tions," he adds.

Mr. Hargrave's agency also schedules department meetings each week—one for the personal lines and one for the commercial lines staff.

Also, the entire agency staff gets together once a month to discuss the agency's financial position and how it stands in terms of production, Mr. Hargrave says.

"We hold this meeting outside the office—usually at a restaurant," he adds.

Mr. Chappell says he even shares "balance sheet and profit and loss information" with his employees during their monthly meetings.

"I believe that the strength of any agency is the people who make it up," he says. He believes it is necessary to involve employees in all agency decisions.

Gary M. Gregory, president of Lon Worth Crow Insurance Agency in Coral Gables, Fla., says he also shares agency information,

including financial information, with his employees.

And, he says he illustrates the agency's profit or loss picture through graphs and slides.

"The sharing of this information is important," Mr. Gregory explains. "I would recommend it to agencies of all sizes."

And, staff meetings can be festive as well as informative, the agents and consultants say.

Mr. Welch says his quarterly staff meetings frequently have a theme—such as Christmas or Halloween—and breakfast is usually furnished.

The meetings, which are held in the agency's large classroom, are designed to discuss the agency's goals and provide a progress report. But they are also a time for fun, he stresses. Staff members sometimes dress in costumes that conform with the theme.

For its annual staff meetings, Mr. Nein takes his entire staff to a

nearby resort for two days. The staff uses this time to plan for the following year and to discuss the status of plans made previously.

In addition to the annual planning meeting, Mr. Nein's service personnel meet monthly to discuss internal problems and procedures.

The experts say that in addition to making employees feel a part of the agency, another major motivator for employees is the potential for advancement within the agency.

And most of the agents say they do attempt to promote staff members when possible.

"If we possibly can, we promote from within," Mr. Hillman says. He looks for factors such as length of service, ability to get along with others, leadership qualities, good attendance record and response to available educational opportunities to determine likely candidates for advancement.

James Econn, chairman and

chief executive officer of James Econn & Co., an agency in Los Angeles, says he "constantly promotes from within," unless he cannot find

or train a suitable employee.

Mr. Butwin points out that it can be difficult to find positions to which employees can be promoted. "So we try to upgrade jobs when needed" to keep employees moti-



Mr. Econn

vated, he said.

For example, he says, the agency added word processing responsibilities to its typist's job to add additional skills and responsibilities for those employees.

Mr. Tyler says his agency's turnover is so low that there "aren't a lot of upward opportunities." So, like Mr. Econn and Mr. Butwin, the agency tries to give its employees income opportunities and additional job responsibilities to keep them satisfied, he says.

"Most of our promotions are from inside," Mr. Pease says. "We encourage our people to apply for new positions, and we post all job openings."

If employees ask for a new position, that "is one symbol of their ability to perform and their aggressiveness," Mr. Pease explains.

Mr. Welch says his agency usually depends upon individual employees to express interest in advancement.

"I'd rather deal with someone who's pushing me for opportunity," Mr. Welch says. He adds that the agency tries to create an atmosphere that encourages employees to build their own opportunities.

The ability of an agency to motivate its employees through its management philosophy and through opportunities for advancement will pay off in the long run, agents stress.

Agency employees are no longer the unseen force behind an agency, according to Mr. Eve.

"In the independent agency system, the agent used to be the sole contact with a client. Today, the vast majority of all personal lines business and small commercial lines business is handled by staff people," Mr. Eve says.

"It's terribly important for an agent to recognize that his staff is the backbone of the entire organization," he adds.

Mr. Welch agrees. "I always hear about the agency's bottom line," he says. "What's above the bottom line is the employees. I'm building the people, and that takes care of the bottom line."

And, an enthusiastic staff is self-perpetuating, Mr. Pease says.

"One thing we've learned over the years is that employees want to be surrounded by others who are energetic, loyal and motivated," Mr. Pease says.

"If they are, new employees will grow in the same way. The best management tool an agency has is its employees."

Mr. Gregory says he leaves most "decisions and the responsibility for those decisions" up to the employees.

"And I try to keep our relationship as personal as possible. The door is always open to my office," he adds.

"One of the most important things I do every day is to practice management by walking around," Mr. Econn says.

"I say hello to everybody, and I single out one person each day to chat with. I ask them if anything is bothering them or if they see any areas that need improvement.

"We cannot see every consequence to an action we take, but they do. These things come out in those conversations," Mr. Econn says.



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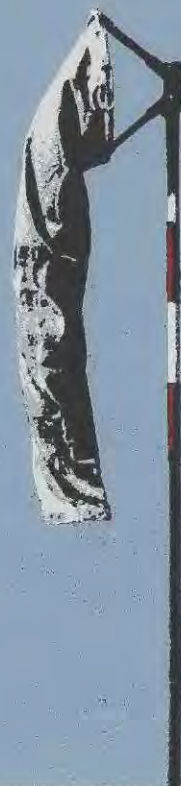
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Incentive plans motivate in-house staffers

By LINDA J. COLLINS

Incentive programs, bonuses and other perks long have been used by insurance agencies to motivate their sales forces.

But, agencies are finding that bonuses and other long- and short-term incentives also can motivate in-house employees, agents and consultants agree.

"I believe incentives are as necessary for the support staff as they are to producers, and it's good to have a mix of cash and non-cash incentives," says A. Russell Chaney, a consulting principal in the Walnut Creek, Calif., office of Business Management Group, a Hartford, Conn.-based agency consulting firm.

But, some consultants say the types of incentives that motivate employees have changed somewhat over the years.

"Long-term incentives, such as pensions, are no longer that effective" to employees, said Lou VonVille, president of The Confidential Registry, an agency consulting and research company in Columbus, Ohio.

He explains that today's employees, most of whom were born during the so-called baby boom, are more likely to change jobs in search of job satisfaction and upward mobility than were employees of earlier generations.

"When baby-boomers go into a job, they know they'll have other jobs. With the stress and constant change today, few people will be satisfied with a career from, say, age 24 through the rest of their working life," Mr. VonVille suggests.

Therefore, pensions are not as significant to these employees, he explains, because they do not expect to work at one job long enough to amass a significant benefit and because they focus on immediate gains.

Younger employees like to see "immediate benefits or incentives...such as flexible hours and

half-days on Friday," agreed Marty S. Shuherk, vp of Your Employment Service, an agency recruiting firm in Columbus.

Carol Hammes, president of The Middleton

Group, an agency consulting firm in Naperville, Ill., cautions that although pensions may be less important to younger workers, they remain very important to older employees.

But, she agrees that "the most effective incentives now are the ones that provide either time off or flexible working situations."

And, she also says this change in emphasis is a result of changes in the makeup of the workforce.

"There are many young working mothers in the agency workforce, and there is a trend away from being terribly motivated just by money," she says.

"Most of the time these younger people aren't planning even a year in advance," she adds. "The tangible things are the most motivating to them."

Flex time, which allows employees to choose from among two or more work schedules, has become increasingly popular among working women in recent years, sources agree.

"Flex time is becoming more and more important to today's workers, and agencies I have visited that have implemented flex time are getting great results," said Mary

Beth Wise-Bolen, a vp in Flint, Mich., with Sitkins Group Inc., a consulting firm based in Fort Myers, Fla.



Mr. Butwin

An agent who uses the flexible scheduling agrees.

"Our people work for eight hours a day, but on flex time. If different schedules work better for them, they work those

hours," says Stanley Butwin, president of the Nathan Butwin Co. Inc. agency in Great Neck, N.Y.

"They are basically on their honor. As long as we get a 40-hour week out of them, that's all that

counts" Mr. Butwin says.

Jon H. Pease, vp of Holmes, Murphy & Associates Inc. in Des Moines, Iowa, says although his agency does not have completely flexible work shifts, it does offer employees a limited choice.

One group of employees works from 8 a.m. to 4:30 p.m. and the other from 8:30 a.m. until 5 p.m., he explains. And in the summer employees get out earlier on Fridays, although they have shorter lunch breaks, he says.

But flex time is not always practical for the agency, some agents say.

"We're located in a small town and have a number of clients who come into our office each day," says J. Knox Hillman Jr., president of Shuford Insurance Agency Inc. in

Concord, N.C.

"It would be hard for us to be on flex time," he says.

Another agent operating a small insurance agency agreed.

"I don't think flex time is going to work in our environment," according to Jess Chappell, owner of FirstInsurance, an agency in Alexandria, Ala.

"So many external factors would interfere with flex time, it's not feasible for us. If you allow flex time and then no one is available to customers when they need you,"



Mr. Hillman

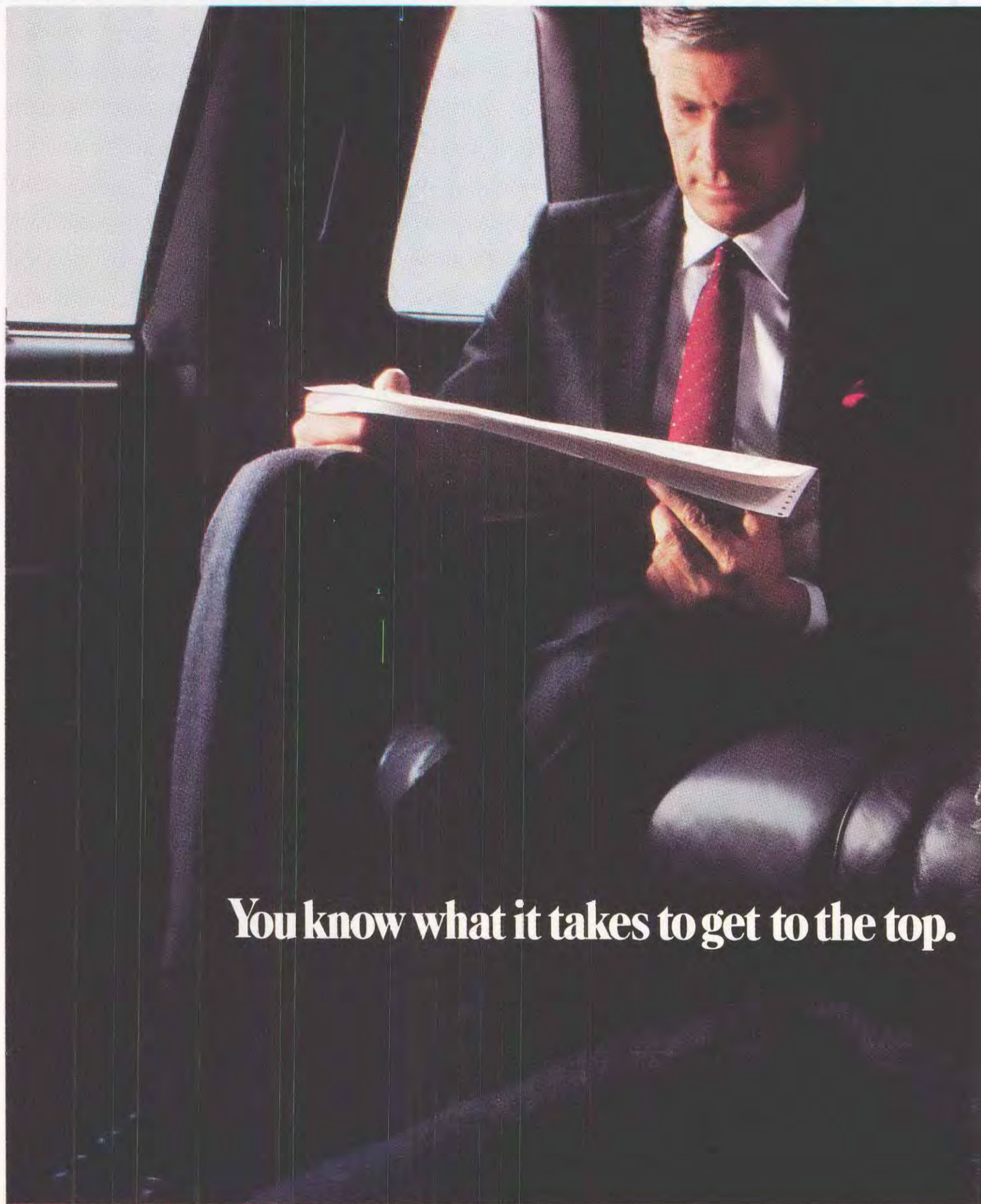
then they will go elsewhere, Mr. Chappell says.

But, he says, whether flex time can work depends on the makeup of the agency's workforce. "If it has a lot of support people who are not on line with customers, then it might work," he says.

Although he cannot use flex time, Mr. Chappell does give employees a half-day off every Wednesday to take care of personal business and appointments that need to be handled during the week.

Norman F. Tyler, president of Homestate Insurance Brokers of Alaska Inc. in Anchorage, provides his employees with a half-day off each month to take care of such personal business.

Continued on next page



You know what it takes to get to the top.

Continued from previous page

Mr. Tyler says he has found that providing this time off actually has reduced the amount of time employees took off otherwise to conduct such business.

"When you give them a half-day off each month, I have found that they take care of these things during that time," Mr. Tyler said.

Mr. Tyler also retains a psychological counseling service for his employees.

The service is free to employees, who set up appointments simply by calling the service.

And, Mr. Tyler says, the service is strictly confidential; the only report he receives from the service is the number of employees who use it each month.

The service is "the most appreciated of any service we provide to our employees," Mr. Tyler says.

And, he adds that the agency benefits as well, because the counseling keeps employees' personal

problems from interfering with their performance on the job.

As a short-term incentive, many agents and consultants feel contests can enhance employee productivity. However, they say contests should be varied and must be promoted on a regular basis to remain effective.

Ms. Wise-Bolen of Sitkins Group warns that if the agency attempts to pit in-house employees against each other in an incentive contest, "They will feel separated and not a part of the group. It defeats the purpose of trying to build teamwork."

"If you split the staff into teams," she added, "it makes it easier."

Homestate Insurance Brokers' Mr. Tyler has offered his agency a travel incentive for the past three years. Under the program, if the office meets an overall premium volume production goal, everyone wins.

Every year, Mr. Tyler sets a goal

for growth in premium volume production for the agency that he believes is attainable. Then, if the goal is met, all employees who have been with the agency for at least a year are rewarded with one week's paid vacation at a resort area.

If the goal is not met, there is no reward.

The first year, Mr. Tyler set the growth goal at 23% and offered employees a trip to Hawaii. He kept the contest on employees' minds throughout the year by such promotional tactics as posters, theme parties, pineapple juice for breakfast, cans of macadamia nuts left on employees' desks and statistics on Hawaii left on computer screens.

"That year we far surpassed our growth goal," Mr. Tyler said.

In the second year, the agency did not meet its goal, he says.

But in this, the third year, the agency already has exceeded the goal. And, this year, the agency's 43 employees again are bound for Ha-

wai.

Willis Hargrave Jr., president of Harco Insurance Services, an agency in Houston, has set up a point system for his employees to help them handle the extra workload caused by the hard insurance market. Points are earned for a variety of accomplishments, including production, attendance and account development.

He then sets up six levels of vacation trips, from an extended weekend in New Orleans all the way to a week in Hawaii. All trips are expense-paid with a cash bonus included.

Based on the amount of points they earn, the employees are rewarded with one of the trips. And, he says, the contest is open to all agency employees.

Mr. Hillman of the Shuford agency said that in 1984 he offered his employees a sales contest. All the staff was broken down into four teams composed of a mix of in-

dividuals from different departments.

"No team could win unless all members had a minimum number of points. Even our claims and accounting people were out asking for business and collecting expiration dates. The reward was a weekend at the beach with their spouse or a companion," Mr. Hillman said.

But cash bonuses "seem to be the most effective" in motivating in-house employees, Ms. Wise-Bolen says.

Carla G. Addicks, vp of Russell Miller Inc., a consulting firm in San



Ms. Addicks

Francisco agreed. And, she says, cash bonuses are most appreciated by employees if they are given at some time other than the end of the year.

"Employees appreciate these bonuses more

because they look at it as a windfall that wasn't in their budget. They also consider it a pat on the back," Ms. Addicks says.

Ms. Addicks adds, "I don't think bonuses should be tied to a percentage of the salary. They should be determined by a gut feeling, as a thank you for specific efforts expended, and not tied to a specific formula."

"We give our employees bonuses at the end of the year based on merit. We also gave a midyear bonus to our staff this year because we were having a good year and we wanted to reward them for their good work," Mr. Butwin says.

Mr. Pease of Holmes, Murphy & Associates says this year he gave all his employees a bonus to reward them for the extra workload they faced as a result of the hardening of the insurance market.

"The bonus was based upon a percent of their three-year average salary with a minimum amount for everyone who had been on staff for at least 30 days," Mr. Pease explains.

Finally, agents report that their employees appreciate more traditional benefits, like pension and profit-sharing plans, as well as incentives like contests and bonuses.

Robert Nein, president of Scott Insurance, an agency in Lynchburg, Va., offers his employees both a pension plan and an employee stock option plan.

His agency contributes an amount equal to as much as 15% of each employee's annual pay each year into the ESOP plan. The trustee invests the money until agency stock becomes available usually realizing an annual return of at least 10% on the investments, Mr. Nein said.

The employees sell their stock back when they retire or leave the agency, which provides them with cash. And, while they are working at the agency, Mr. Nein says, they are motivated by the fact that "they own a portion of the agency with tax-free dollars."

In addition, Mr. Nein's agency puts an amount equal to 10% of each employee's annual salary into a pension plan.

James Econn, chairman and chief executive officer of James Econn & Co., an agency in Los Angeles, said that his agency has had a profit-sharing plan for 17 years. For most of those years the agency's annual contribution to the plan has been a full 15% of each employee's salary.

Employees are fully vested in the plan after six years, he says. And, he says, the plan is especially popular as a retirement savings vehicle for employees.

"I do not want anyone when they retire from this firm to have only a banquet and a gold watch," he said. "I want them to take some money out of here."

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Education benefits employees, agencies

By LINDA J. COLLINS

Providing agency employees with educational opportunities can pay off in many ways, agents and consultants agree.

It gives in-house employees more pride in their work and makes them feel more a part of the agency activities. And, it prepares them for job advancement within the agency.

"If you let employees grow professionally, they will be much happier because they will have a greater feeling of self worth," says Jess Chappell, owner of First Insurance, an agency in Alexandria City, Ala.

Stressing education also benefits the agency, by providing it with better-trained employees that do

their own jobs better and can step in immediately when other jobs become available.

And, clients are impressed and appreciative when an agency's employees are educated and up-to-date, the experts say.

Agents looking for educational opportunities for employees can tap a variety of sources, including:

- Courses sponsored by insurers.
- Trade association schools or seminars.
- Seminars or workshops sponsored by agency consultants.
- Programs sponsored by the insurance industry, which often lead to professional designations.
- Self-study courses available through a variety of sources.

Peter Zappa, systems and auto-

mation consultant for The Market Planning Group in Boston, says a good starting point is to set up an in-house training program.

"Find out what it is that employees need to know to do their jobs better. Then set up internal training programs for one hour a week or so" to provide that training, Mr. Zappa explains.

And, agents who have set up such training programs are pleased with the results.

Don Eve, president of Eve Insurance Agency Inc. in Flint, Mich., says all his employees are involved in continuing education efforts.

"Each employee has one hour of education time per day in which they leave their desks and go to the agency's conference room.

"There they can obtain an insur-

ance technical education from different programs we have designed which utilize self-study tapes, study books and answer books," he says.

The first self-study course, which is required of all new employees, covers personal lines insurance. That course lasts about a year, Mr. Eve says, although employees are not required to complete the course according to any specific timetable.

After they complete the personal lines course, employees take a similar course in commercial lines.

And, after completing that course, employees can select from many different self-study courses Mr. Eve has purchased from insurance companies, trade associations and independent vendors.

Not all these courses relate specifically to insurance, Mr. Eve says,

but all are designed to help employees do their jobs better.

As part of the in-house educational program, Mr. Eve assigns each new employee a "mentor" from the staff to "steer, guide or move the new employee through the business" for his or her first full year with the agency.

"The mentor checks all self-study materials and all work processed by the new employee," Mr. Eve explains.

He adds that all the agency employees take part in this educational program. And, he says, in this way, when a higher-level opening becomes available, someone on staff is always trained and prepared to fill it.

Mr. Eve also pays all expenses for employees when they attend insurance seminars or workshops. Employees attend such seminars in groups of two.

"Their responsibility is to tell the rest of the agency what they have learned by making a presentation to the staff when they return to the office," Mr. Eve says.

And, he says, he also encourages and pays for courses leading to professional insurance designations.

In fact, all the agents contacted pay for their employees to attend insurance-related courses that will benefit them in their jobs or provide them with a chance for advancement within the agency.

However, the agents and consultant suggest different ways of footing the bill.

Carla G. Addicks, vp of Russell Miller Inc., a consulting firm in San Francisco, says it is best to pay the employee upon the successful completion of the course.

"If employees pay the entire fee up front, or 50% of the fee up front, it shows more motivation on their part," Ms. Addicks adds.

But, others pay the fees up front. Scott F. Welch, president of Bowers, Schumann & Welch, an agency in Washington, N.J., says his agency is "very liberal with regard to supporting education. We pay for the courses up front, but if employees don't pass, they are supposed to reimburse us for the fees."

He says the agency will pay for any course that is even "remotely applicable" to the employee's job, including conventions, workshops, seminars, college courses or courses leading to professional designations.

Mr. Welch says the agency also has arranged to have outside courses taught in his agency during the day or in the evening. Employees from other agencies also are allowed to attend these courses to help defray the costs, he says.

Gary M. Gregory, president of Lon Worth Crow Insurance Agency in Coral Gables, Fla., also has courses taught within his agency. The agency sponsored Accredited Adviser in Insurance courses in-house.

The courses, which are offered by the Insurance Institute of America, are taught by agency principals.

Initially the agency intended to educate only its sales staff in-house, Mr. Gregory says, but several support staff members also expressed an interest in attending the courses. And, he says, 90% of the support staff enrolled in the course when he opened it up to all employees.

Willis Hargrave Jr., president of Harco Insurance Services agency in Houston, says that his employees who take advantage of educational opportunities often begin to compare themselves with employees of other agencies that do not emphasize education.

"Often they don't realize what they have until they see what the other guy doesn't have," he says. ■

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Change urged to cope with chaotic market

By DAVE LENCKUS

CHICAGO—Agents and brokers still can find premium-generating opportunities during a turbulent market, according to several brokers and third-party administrators.

According to the experts who participated in the Professional Insurance Mass-Marketing Assn. symposium in Chicago on Sept. 20, steady growth rates can be achieved by developing new products that respond to current needs in the market, and developing new ways to deliver these new products and traditional ones to the consumer.

Experts predict the current hard market will last as long as the soft market that preceded it—four to five years, according to Dean V. Ligman, vp of broker Rollins Burdick Hunter of Illinois.

He says there are various ways to hedge against market problems.

First, diversification is "almost mandatory," he said. "I think it's absolutely the best hedge against hard and soft markets."

And, Mr. Ligman said brokers and TPAs should spend the bulk of their efforts figuring out how to best deliver the products they sell.

Telemarketing, for example, "has undergone tremendous changes in the last couple of years," he said.

"Our successful telemarketing program is done with full-time, rather highly-paid, licensed, experienced insurance solicitors," he said.

"They don't call anyone who hasn't responded to us through another vehicle—that is, direct mail or an ad coupon. They're too valuable to be calling people on a chance. They call direct leads," he said.

The experts agreed that a slowing down in the rate of increase of health care costs has resulted in fewer employers panicking and shopping around for health care coverage on the basis of price alone.

Instead, they said, employers are looking at new health care options, like alternative delivery systems and cost-containment features.

But, developing and selling these new products present a challenge for brokers and TPAs.

For example, cost-containment programs can be difficult to market because they require employers to spend money now in the hope of saving money in the future, said Trevor Smith, vice chairman of Plan Services Inc. in Tampa, Fla.

"It requires some up-front funding with a promise of return on the back side," he said.

"I must add that's a tough sale to a small employer who really doesn't care about the delivery system, has no vested interest in the claims rate. He pays a predictable stated cost, called the premium, and his deal is he'll never get asked for anything more and he'll never get any of it back.

"It compounds the educational problem, but I think it also gives you a great opportunity."

Mr. Smith also advised encouraging employers to continue developing employee benefits like fitness and wellness programs and drug and alcohol counseling programs.

"That's good for us all, too, and we should do what we can to encourage it and recognize that it helps us in the never-ending cycle of changes in cost," he said.

The experts agreed that, in the face of the tightening markets, the

insurers, agents and other industry professionals who survive are going to be those that meet the changing needs of the buyer.

Mr. Smith said products should be designed for buyers rather than being based solely on agents' interests. "We need to spend the bulk of our efforts to figure out how best to deliver whatever products we're selling to the ultimate consumer," he said. "For example, why haven't we done a better job of combining workers comp with group health?" he asked.

Some insurers, "from the Metropolitan/Equitable level to the re-

Continued on page 30L



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THE HEALTH PLAN OF AMERICA

Cooperation needed to break cycle: Stewart

By LINDA J. COLLINS

WHITE SULPHUR SPRINGS, W.Va.—Restoring stability and public confidence in the insurance industry is going to take a cooperative effort by all segments of the industry—clients, agents and insurers—says the top executive of a major insurance brokerage.

Sidney A. Stewart Jr., chairman and chief executive officer of The Crump Cos. Inc. in Memphis, Tenn., and outgoing president of the National Assn. of



Mr. Stewart

Casualty & Surety Agents, delivered this message to top agents, brokers, insurance company executives and other industry leaders attending the joint NACSA and National Assn. of Casualty & Surety Executives conference held at the Greenbrier in White Sulphur Springs, W.Va., last month.

"The capital resources and risk management skills of American insurers and agents provide the safety net which underlies American business," Mr. Stewart said.

"By freeing the entrepreneur from the shadow of catastrophic loss, we encourage development of new businesses, new products and new jobs," he explained.

However, the cyclical nature of the insurance business has confused the insurance-buying public

'We must develop a plan to moderate the market swings and let the client have an opportunity to say whether he is willing to make a long-term commitment to his carrier and his agent for more stability.' Mr. Stewart says.

and even many individuals within the industry ranks, he said.

"We reduce prices to absurd levels. Then, just as we should expect, there are astronomical losses. So, we raise our prices again, to absurd levels," Mr. Stewart commented.

As rates fall in a soft market, insurers' combined ratios reach increasingly higher levels, creating

"mounting financial problems," he said.

As premium rates fall, so do agents' and brokers' incomes. Rates move upward only when results are so bad that "survival is threatened," Mr. Stewart said.

By the time this stage of the cycle has been reached, insurers have depleted their capacity. Many insurers then begin to cancel existing

clients midterm, refuse to renew coverages or renew under revised terms, "possibly with gaps in coverage, and often at astronomical increases in premiums," Mr. Stewart continued.

Agents then are placed in the position of having to ask their clients to pay substantially more money for less coverage.

In some cases they are unable to provide their clients any coverage whatsoever, he said.

Besides making life difficult for agents and brokers, this cycle stirs up public dissatisfaction with the insurance mechanism.

"These cyclical extremes in the hard and soft markets are alienating our customers and causing all of us, companies and agents, to lose credibility," he said.

"To say the insurance-buying public is confused is putting it mildly," Mr. Stewart stressed. "In some cases it's more accurate to say enraged."

The cycle's effect on the industry is "like a time bomb with a very long fuse," Mr. Stewart said.

And even as insurers are applauding a return to adequate premium levels, it should be remembered that "in the not-too-distant future, the downward phase of the cycle will begin again," he added.

Mr. Stewart said he is "not naive enough" to believe that the industry will be able to eliminate cycles totally. "But let's consider how we can work toward minimizing the effect of these cycles," he urged.

At the current point in the industry cycle, the industry has the time to develop a plan for modifying subsequent market swings, Mr. Stewart said.

"Before the downward cycle begins, the industry must work off some serious problems brought on by absurdly low rates—problems of reduced surplus, inadequate reserves, uncollectible reinsurance, potential insolvencies and the tort system as it presently exists," he stressed.

While the soft market is still fresh in the minds of companies, agents and brokers alike, Mr. Stewart suggested that all three develop lists of the types of activities in which they will not engage during the next soft market.

Then, insurers, agents and brokers should develop strategies, using the list as a point of reference, so they will be prepared to act when the market once again begins to turn.

Mr. Stewart said there are many approaches the industry could take to minimize the effects of industry cycles. But, he recommends focusing on the three-way relationship among insurers, agents or brokers, and clients.

This approach involves long-term commitment on the part of the client to his or her agent and to the insurer through which the client's coverage is written, and on the part of the insurer and the agent to the client.

"We talk a great deal... about the need for a spirit of partnership between companies and agents," Mr. Stewart said.

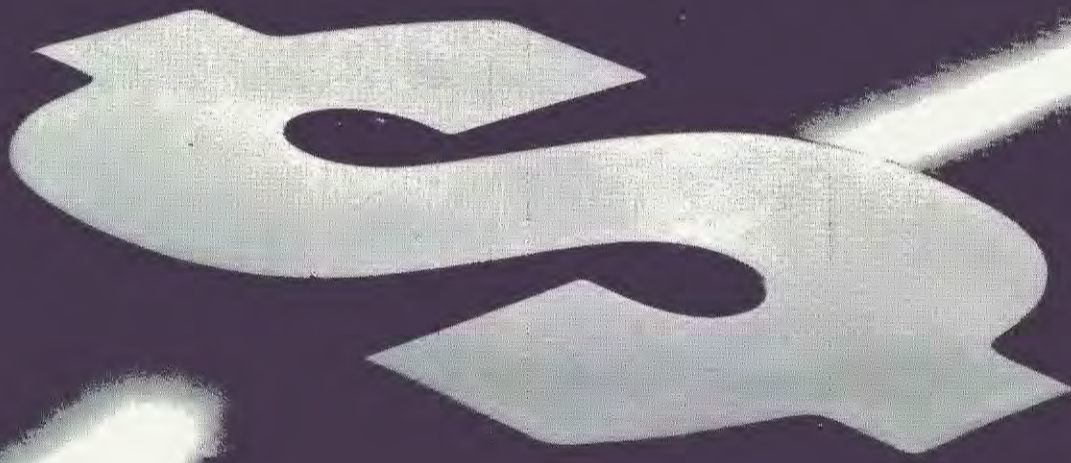
However, this talk does not always include the partnership that should exist between these two and the client, he said.

"As an industry, we must go beyond lip service in establishing a true relationship with our insureds," Mr. Stewart stressed.

The industry must do "something concrete" to show clients the advantage of stable, long-term relationships," he said. "Through our pricing practices of the last half decade, we have convinced clients that insurance is a product whose only significant dimension is this

Continued on next page

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Industry changes a vicious circle: Budd

By LINDA J. COLLINS

WHITE SULPHUR SPRINGS, W. Va.—The property/casualty insurance industry's seesawing market is a vicious circle, an insurance company chief executive officer says.

"We suffer the emotional trauma of either too much competition from too much capacity and too much price-cutting, or too little capacity, too rapid escalation of prices and too little true consideration of our customers," said Edward H. Budd, outgoing president of the National Assn. of Casualty & Surety Executives and chairman, chief executive officer and president of The Travelers Corp.



Mr. Budd

But, the changing market conditions—and the resulting crises in the industry—represent a challenge, Mr. Budd said at the National Assn. of Casualty & Surety Agents/National Assn. of Casualty & Surety Executives' 1985 Conference last month in White Sulphur Springs.

The Chinese symbol for crisis is composed of two symbols, he noted: "One stands for danger and the other stands for opportunity."

And, he said, all three parties should stress attaining long-term, stable relationships.

Clients should avoid the temptation to shop around for the cheapest prices in a soft market, he said. And, insurers should reward those stable clients by ensuring that capacity is available for their risks in a hard market, he said.

Agents should emphasize to their clients "the value of stability and a long-term relationship in a cyclical industry," Mr. Stewart said. Agents should constantly act as their clients' advisers and emphasize professionalism in dealing with their clients' needs.

Above all else, Mr. Stewart stressed, "The agent must be certain that his client understands the market cycles, and the client can then decide if he is willing to make a commitment for more stability."

"The insurance-buying public deserves better than what it has received from our industry," Mr. Stewart said.

"We must develop a plan to moderate the market swings and let the client have an opportunity to say whether he is willing to make a long-term commitment to his carrier and his agent for more stability. And we, in turn, must be willing to respond," he added.

"Let's move, if only by degrees, toward greater cooperation among the providers, their sales forces and the users of our complicated and essential product. In this decision, I believe, lies a hope for smoothing the roller-coaster ride of the insurance cycle," he concluded.

"I wish my actuarial examinations had had that formula in it: Crisis equals danger plus opportunity," he quipped.

Three current crises in the industry present both danger and opportunity: the civil justice system, pending tax changes and the current market environment, Mr. Budd said.

The Insurance Services Office's proposed commercial general liability claims-made form, he said, is a short-term answer to civil justice problems because it "focuses on the issue of coverage definition, which is fundamental to the insurance process."

Mr. Budd admitted that there are difficult transitional problems with the ISO form that must be handled.

But, he said: "We must press on

'We suffer the emotional trauma of either too much competition from too much capacity and too much price-cutting, or too little capacity, too rapid escalation of prices and too little true consideration of our customers,' Mr. Budd says.

with cooperation, because failure to achieve consensus will mean more disintegration of capital" and the threat of government intervention in the insurance industry.

Tax reform proposals not only pose a threat to insurers because of the potential tax burden on an already strained industry, but also show a "lack of understanding in Washington of the role of insur-

ance in absorbing losses, in capital formation and in supporting state and municipal investments," Mr. Budd said.

The insurance industry should educate federal lawmakers about the industry, he advised.

Meanwhile, current marketplace problems are creating "sticker shock and often a shortfall of coverage," he warned.

And, he cautioned that there is danger in a continuation of "auction market" behavior in a business "that depends on a value-added service, on trust, and on a very strong agency/company partnership."

Mr. Budd said that if the industry does not correct itself, it faces the threat that "disenchanted customers facing severe availability problems will stimulate the growing potential for intervention by state and federal government."

While he expects 1986 and 1987 to be much better years for the insurance industry, he said companies and agents cannot become complacent.

The industry must continue to strive to improve its products, services and personal skills, he said. ■

Cooperation urged

Continued from previous page
year's price. All of us share the blame."

And all must share in the remedy, he explained.

A more stable marketplace could be reached through "fair pricing, depending on experience and market conditions," Mr. Stewart said.

He elaborated that fair pricing does not necessarily mean the insurer should provide its client with the lowest price. Instead, it should provide a stable and fair price that still produces a profit for the insurer, he said.

And, he said, all three parties should stress attaining long-term, stable relationships.

Clients should avoid the temptation to shop around for the cheapest prices in a soft market, he said. And, insurers should reward those stable clients by ensuring that capacity is available for their risks in a hard market, he said.

Agents should emphasize to their clients "the value of stability and a long-term relationship in a cyclical industry," Mr. Stewart said. Agents should constantly act as their clients' advisers and emphasize professionalism in dealing with their clients' needs.

Above all else, Mr. Stewart stressed, "The agent must be certain that his client understands the market cycles, and the client can then decide if he is willing to make a commitment for more stability."

"The insurance-buying public deserves better than what it has received from our industry," Mr. Stewart said.

"We must develop a plan to moderate the market swings and let the client have an opportunity to say whether he is willing to make a long-term commitment to his carrier and his agent for more stability. And we, in turn, must be willing to respond," he added.

"Let's move, if only by degrees, toward greater cooperation among the providers, their sales forces and the users of our complicated and essential product. In this decision, I believe, lies a hope for smoothing the roller-coaster ride of the insurance cycle," he concluded. ■



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Market changes

Continued from page 301
gional company," have determined they cannot be all things to all people and instead are carving out market niches, Mr. Smith said.

And insurers often spawn new products to fill these niches, he said.

He cited dental insurance as "an example where carriers are now specializing in dental coverage quite successfully and appropriately."

Some insurers also may decide to target employers of a certain size.

Other insurers, however, may decide to focus on a specific geographical area, Mr. Smith said.

In any case, however, this specialization on the part of insurers also brings challenges for those who sell and service those insurers, and those who are developing products on their own.

Gary F. Thompson, president of Emmett & Chandler Insurance Ser-

'We're in a negative situation, and our job, I guess, is to turn the negative into a positive and stop all the crying and get at it and change things,' says Dean V. Ligman, vp of broker Rollins Burdick Hunter of Illinois.

vices Inc., said the company has developed some new products and delivery systems.

For example, Emmett & Chandler is marketing single premium deferred annuities to clients of a savings and loan that is an Emmett & Chandler client.

Focusing on Individual Retirement Accounts that are rolling over or maturing soon, the program is expected to generate \$40 million of new premium business in its first year, Mr. Thompson said. The average sale price is \$17,000, he said. The media campaign consisted of

heavy print ads and radio spots during key commuting times.

A telemarketing network supported the campaign, and one or two employees in each branch were made responsible for the sale of the product. Also, the branch personnel were offered incentive awards.

Emmett & Chandler also is about to test an automatic teller machine system designed for selling single premium deferred annuities and other insurance products.

Another product Emmett & Chandler Insurance has introduced is a service that lets bank customers get

insurance quotes.

The service, which is a joint venture between Emmett & Chandler Insurance and 47 underwriters that carry Best's ratings of either A or A-plus, allows bank customers to call a toll-free number for a quote on term life insurance.

A computer determines the five cheapest premium quotes from among the 47 insurers. The customer is provided with a printout of that information by the close of business of that day.

"It's a program where people can shop for their low-cost annual renewable term life insurance," Mr. Thompson said.

"And that's a different segment of the marketplace," he said. "Those are people who are just interested in price."

The company also has developed a new delivery system plan for owners of Apple personal computers.

"We manuscript a personal com-

puter insurance policy," Mr. Thompson said.

"The coverage provides for everything from spilling Coke on the keyboard to power failures, brownouts, accidental erasures, etc. We direct-response mailed it to the Apple customers with the endorsement of Apple."

Emmett & Chandler Insurance has netted a 5.2% response—three to four points higher than it had expected, Mr. Thompson said.

Mr. Smith also sees the increasing use of personal computers as a "great opportunity."

For example, he says one of the "new, unique things" is a system that allows agents to call up information about their insurers' policyholders on their personal computers.

The service costs half of what it cost to have an employee track down such information, Mr. Thompson said.

To further encourage the use of personal computers, Plan Services has systems that feed an agent lists of industries in his or her territory, potential clients in those industries, and insurance products that are available to those prospects.

These systems are extremely cost-effective, he said. They are inexpensive to operate. And by helping the agent or insurer target specific companies or groups, they improve the agents' success.

In fact, premium income for firms using them is as much as five times greater, he said.

"Lots of things like that are going to come, and we (insurance brokers and TPAs) are the ones that are going to be the catalyst in getting companies to do that," he said.

The bottom line, the experts agreed, is that the market problems are not going to go away any time soon, so everyone in the industry had better make the best of things.

"We're in a negative situation, and our job, I guess, is to turn the negative into a positive and stop all the crying and get at it and change things," Mr. Ligman said. ■

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Maryland Casualty seeking new agents

BALTIMORE—Maryland Casualty Co. is looking for a few good agents.

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The profile has four categories: agency professionalism, financial responsibility, specific business plan and underwriting/risk selection.

Agency professionalism criteria upon which agents are asked to rate themselves include: cooperative attitude, a solid reputation in the community, a continuing employee education program and a well-managed operation.

In the area of financial responsibility, the agency is asked questions regarding its credit rating.

A documented marketing strategy and growth plan is listed as essential under the specific business plan category.

An agency also is required to show that it actively solicits new accounts, is well-situated geographically and has historically achieved positive growth.

The underwriting/risk selection portion asks agents if they have a viable agency underwriting process and represent other quality insurers. Agents also are asked if they have an acceptable business mix and a stable clientele.

For further information, agents can contact any local Maryland Casualty office. ■

Careful planning needed to handle retirees' benefits

By DIANE LYNN KASTIEL

WASHINGTON—Benefit managers responsible for retiree medical benefit programs are confronted with confusion and uncertainty, says one benefits expert.

However, employers can utilize certain strategies to help them cope with problems surrounding post-retirement benefits, says Anna M. Rappaport, principal with employee benefit consultant William M. Mercer-Meidinger Inc.



Ms. Rappaport

in Chicago. "The facts which form the basis for the management of these programs have been turned upside down since most programs were installed," Ms. Rappaport said at a session on "Managing the Risks in Post-Retirement Medical Benefits" at the annual Council on Employee Benefits conference last month in Washington.

"The legal rules which govern these plans are not clearly defined and are changing almost monthly,"

'The legal rules which govern these plans are not clearly defined,' Ms. Rappaport says.

she said. "And the action which people are taking today will have a significant effect on the bottom line tomorrow."

Ms. Rappaport said benefit managers responsible for post-retirement benefits must confront several problems:

- The cost of retiree medical coverage has grown dramatically since most plans were implemented and will continue to rise. In 1984, employers' per-capita medical care costs for persons older than 65 were estimated at \$4,200, she said.

- Employers cannot discontinue or modify retirees' benefit plans as easily as they previously thought. Employers' options are limited and also poorly defined, she said.

- The plan document is no longer the only binding agreement affecting retiree medical plans; verbal and other written commitments by an employer can create employee rights and employee obligations.

- The portion of older Americans' health care costs paid by Medicare is shrinking.

Complicating these factors is the current legal environment governing retiree medical benefits, Ms. Rappaport said.

"The legal environment is not defined by specific legislation oriented to this benefit," Ms. Rappaport said. "Rather, the legal situation is defined by several court decisions and based on the application of a variety of different laws."

Among the specific questions that remain unanswered, according to Ms. Rappaport, are:

- Can an employer modify or discontinue benefits for current retirees?
- Can an employer modify or discontinue benefits for future retirees?
- Can changes made in the

health plan for active employees be extended to retirees?

- Can retirees' contributions to a plan be increased?

Although no definitive answers to these questions exist, recent court rulings have provided some guidance, Ms. Rappaport said.

She cited the lawsuit filed against Bethlehem Steel Corp. by its retirees after the company tried to modify the retirees' medical plan to match a new comprehensive medical plan introduced for active employees.

Continued on next page



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Retiree benefits

Continued from previous page

In this case, Ms. Rappaport said it has become clear that communications sent by the employer to employees and retirees may create benefit obligations that were not foreseen by the company.

The trial court ruled that Bethlehem Steel could not modify the retirees' benefits since ambiguous plan documents suggested the benefits were promised for life. But, an appellate court overturned that decision.

Ultimately, the opposing parties settled out of court on a medical program that combined features in the old and new plans (BI, March 16; Oct. 22, 1984).

In another case, Ms. Rappaport said, a court ruled that White Farm Equipment Co. had a legal obligation that barred the company from terminating its retirees' medical benefits, although no such obligation is specified by the Employee

Retirement Income Security Act (BI, Oct. 29, 1984).

In a more recent decision involving American General Corp., a judge ruled that retirees have a contractual right to promised post-retirement benefits, and therefore, employers cannot unilaterally cut those benefits (BI, Oct. 28).

Although these decisions are enlightening, they are specific to individual companies and have not been accompanied by legislative changes that can be generally applied to all retiree plans, Ms. Rappaport said.

"This makes plan management difficult for employers, since many are not sure what their situation is and what options are available to them," she said.

Besides reviewing these decisions, employers also must monitor their own actions carefully, she added.

For example, an employer must carefully consider whether the company will continue retiree ben-

fits during union strikes.

"If the company continues retirees' benefits during strikes while active employee benefits are not continued, it can be taken as evidence that these benefits are independent of the current contract."

Another way a company can protect itself when it tries to make changes in a retiree medical plan is to make a practice of always extending changes in the active employees' plan to the retirees' plan.

"Such companies have more options and are less likely to encounter problems if they implement further changes," Ms. Rappaport said. "Companies with track records of changes including retirees should continue to maintain that track record."

Another strategy employers can use is to limit the number of company officials who are allowed to discuss retiree benefits with employees and retirees, Ms. Rappaport said. Employers that wish to enforce this rule should publish a spe-

cific policy statement on this subject, she added.

"Those people who are authorized to discuss these benefits with employees as well as all labor negotiators and individuals involved in acquisitions should be briefed on these issues and their authority (should be) defined," Ms. Rappaport said.

In addition, a management education program should be developed to ensure that managers do not inadvertently make promises the company will have to pay for later, Ms. Rappaport said.

Also, materials that provide employees with information about their retirement benefits should "clearly define the company's rights as well as the benefits provisions," Ms. Rappaport said.

Another tactic is to create a "sunset" provision in a retiree medical plan that provides for automatic termination of the plan at a specified date, Ms. Rappaport said.

In a case where benefits are al-

ready negotiated, a company can try to negotiate a change in retiree benefits by trading for improvements in other areas, Ms. Rappaport suggested.

Or, a company can "buy out" retirees' benefits by offering options like cash or cost-of-living increases in pension benefits in exchange for medical plan changes, she said.

However, changing the design of a medical plan is not the only way to contain retiree health care costs, Ms. Rappaport said.

"The same principles apply in cost containment for retirees as in cost containment for active employees," Ms. Rappaport said. "Strategies can be aimed at reducing the total utilization and cost of medical services, reducing the employer's share of the cost or both."

Utilization controls—such as pre-admission certification, concurrent review and second surgical opinion programs—may be easier to implement than changes in retiree plan design, Ms. Rappaport said.

"Pre-admission certification and concurrent review have a big payoff and are particularly important for retirees because of higher rates of admission for older persons," Ms. Rappaport said. "It may also be possible to introduce these programs in a plan where some other employer action has precluded changing the level and type of benefits paid."

However, Ms. Rappaport cautioned: "These programs, to be effective, need to be mandatory and linked to financial incentives."

However, any action an employer takes to contain medical costs should only be done after careful analysis of the particular situation, Ms. Rappaport said.

"An actuarial valuation and financial forecast is needed to assess the potential costs of the current and alternative programs," she said. "This can then be used to analyze alternative contribution and benefit strategies."

"Creative approaches are possible even in difficult situations," Ms. Rappaport added. "An integrated strategy is needed to address the many issues so the risk of adverse unanticipated costs is reduced." ■

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Funding options ease retiree health costs

By DIANE LYNN KASTIEL

WASHINGTON—Employers can use several funding alternatives to help cope with the rising cost of retiree health care benefits, a consultant suggests.

John C. Hickey, a partner with Kwasha Lipton in Fort Lee, N.J., explained these options to benefits experts at the 39th annual conference of the Council on Employee Benefits, held last month in Washington.

Retiree health plans pose funding problems for benefits managers for several reasons, Mr. Hickey said, including:

- The uncertain nature of retiree health care costs.

"For active employees, all you're trying to do is provide for claims that are going to be incurred in the next year or two," according to Mr. Hickey. "The problem with retiree medical benefits is you have to be concerned with what that plan may cost 10 to 15 years from now," he said.

- The lack of a tax-effective basis for funding retiree medical benefits.

The 1984 tax law repealed tax deductions for contributions to 501(c)(9) trusts used exclusively to prefund post-retirement health care. However, employers can still deduct these contributions if the trust is used to fund benefits for active employees as well.

- Low appreciation by employees of the cost of retirement medical benefits because "it's just too far in the future."

- The fact that medical benefits are not related to years of service. Under most retiree health care plans, an employee must work a certain number of years to be eligible for the benefit, and then he receives the total coverage available under the health plan.

"These benefits are service-related only in the respect that you get no benefit or you get everything once you've reached a certain plateau," Mr. Hickey said.

- Premium contributions to the plan by active employees are not possible. "There's no way in traditional plans to ask people to save their money now to help pay for medical benefits when they get to retirement age," according to Mr. Hickey.

However, benefit managers can set up plans that accumulate funds to pay for retiree medical benefits while the employees to be covered by the plan are still on the job, Mr. Hickey explained.

Under such an arrangement, rather than providing a medical retirement plan, an employer provides employees with cash, which they can use to pay their medical bills in retirement.

Unlike a traditional retiree medical plan, these types of "cash plans" take the administrative burden off the employer and, more importantly, do not tie benefits to the escalating cost of medical care, Mr. Hickey said.

There are several variations on these "cash" arrangements, Mr. Hickey said.

Employers can establish a savings plan "side account" to pay for retiree medical benefits. This plan would be identical to a regular savings plan, except that the funds in the plan can be used only to pay medical benefits.

"This thing would be a medical expense account in name only," Mr. Hickey said.

"In reality, it's just another pot of money. There's all the same tax advantages applied to all savings plans. We'd just make a separate account."

Mr. Hickey recommended that, with this type of arrangement, employers match employee contribu-

tions to the "side account" in the same manner as contributions to regular savings plans are matched.

However, unlike a traditional retirement medical plan where benefits are tax-free to the retiree, the retirees would be taxed when they withdrew the money from this account, even though it would be used to pay medical bills, Mr. Hickey said.

Another disadvantage of the "side account" is that this type of arrangement requires a short-term increase in cash outlay on the part of both the employee and the employer, Mr. Hickey said.

"You'd have to be farsighted enough to make the investment now and realize you'll get the savings down the road," Mr. Hickey said.

Another alternative to the tradi-

tional retiree medical plan is to simply increase employees' pension benefits to help pay for medical expenses following retirement.

The big problem with this arrangement, however, is that there is no way to ensure that retirees will use the extra money to pay for medical costs, Mr. Hickey said. And, again, there is an initial short-term cash outlay increase for the employer.

"The big advantage of this, from the employer's point of view, is that they can use an overfunded pension plan to pay for retiree medical benefits," Mr. Hickey said.

"You can't use that money to pay for retiree medical benefits directly, but you can say, 'I'm increasing your pension, but cutting back on the medical benefits,' with the understanding that the increase

in pension is to make up for the cutback in medical benefits," he said.

A third alternative to a traditional retiree medical plan is the addition of a 401(h) plan in the company's pension plan, Mr. Hickey said.

Section 401(h) of the Internal Revenue Code allows employers to fund retirees' medical benefits with a certain percentage of the money in a defined benefit pension plan that is pre-determined by the employer. However, the amount of money to be used to pay medical benefits cannot exceed 25% of the total assets of the plan.

An employer can use a 401(h) plan in two ways to pay for retirees' medical expenses. Either the employer can pay retirees' medical claims as they are submitted with

money from the fund or the employer can use the money to pay for the premium for retirees' medical insurance or membership in a health maintenance organization.

The advantage of using a 401(h) plan is that not much initial cash outlay is required of the employer since funds are required only when the medical benefit is payable, unlike a savings plan where the employer must contribute money into an employee's account when benefits are promised, according to Mr. Hickey.

In addition, medical benefits paid out would be tax-free, Mr. Hickey said.

The disadvantage of using a 401(h) plan is the limit on the amount of plan assets that can be used to provide medical benefits to retirees, Mr. Hickey said. ■



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Tax reform threatens benefits: Insurer

By DIANE LYNN KASTIEL

WASHINGTON—President Reagan's theory that tax law should not influence social behavior threatens employee benefit plans, an insurer warns.

"I disagree with the theorists who say the tax law should disregard sound social and economic objectives," says Philip Briggs, executive vp at Metropolitan Life Insurance Co. in New York.

Mr. Briggs criticized the Reagan administration's tax reform proposals at the annual meeting of the Council on Employee Benefits last month in Washington.

The Reagan administration's latest tax reform proposals, which were announced in May, would tax a portion of employer-provided health care benefits (BI, June 3). In

addition, the administration later proposed to eliminate 401(k) salary reduction plans (BI, Sept. 9).

"To me, a tax law which encourages a responsible and caring society—a tax law which fosters the economic growth our nation needs to survive—is a better tax law than one that does not," Mr. Briggs said.

"Unfortunately, as a closer look at the proposal reveals, the real price of the promised (tax) rate reduction would be the loss of many basic and well-thought-out rules long relied upon by the broad spectrum of American business and American workers," he said.

"Because of their scope and hence, potential for picking up revenue, employer-provided life, health and retirement programs are heavily targeted in the president's proposal," he said. "The propo-

posal would sweep aside a number of longstanding tax rules which have encouraged these programs."

The administration wants to change these tax rules in an attempt to make up revenue lost by lowering individual and corporate income tax rates, Mr. Briggs said.

"What would we really gain from all this?" he asked. "In my opinion, very little. I am not saying that all 'tax expenditures' under current law are justified. I am saying that if they meet certain standards, our national interest calls for retaining them."

Referring to the work of the late Stanley Surrey, an expert on tax expenditures and a former assistant treasury secretary for tax policy, Mr. Briggs said a three-point test should be applied to determine whether a "tax expenditure"—a

tax deduction, exclusion or credit—is justified:

- The tax expenditure serves a valid public purpose.

- The public benefits generated by the tax expenditure exceed the provision's cost.

- Compared with alternative means of achieving the same public end, the provision is the best choice.

"If a tax expenditure related to employee benefits passes this test, it should be retained in the law, rather than swept aside for the sake of rate reductions," Mr. Briggs said. "In my view, the bulk of employee benefit tax provisions under attack in the president's proposal are sound and desirable and more than meet fair standards for retention."

Various proposals to tax life and

health benefits exemplify the types of proposals that would not survive if the Surrey test were applied to these benefits, Mr. Briggs said. "The target of both the life and health proposals are not a wealthy few but rather the spectrum of American workers."

The current tax law encourages employers to provide health care benefits to employees, taking the burden off the government, he said, adding private industry has provided these benefits more efficiently than the government could.

Similarly, employer-provided life insurance reduces the government's responsibility for caring for survivors, Mr. Briggs said.

"Before the advent of group life insurance, individuals generally put off the purchase of essential insurance protection—often with disastrous results for surviving families and additional strain on social, charitable and governmental services," he said.

The Treasury Department estimates that taxing employees for the full amount of employer-provided health insurance contributions could generate up to \$30 billion annually.

But, that's assuming all employees keep their coverage, rather than dropping out of plans to avoid the additional tax, Mr. Briggs said.

Meanwhile, the Joint Committee on Taxation estimates that the government's cost for providing health insurance to American workers would be about \$80 billion, he said.

"Also, (the government's) experience and problems in the administration of Medicare, Medicaid and Social Security indicates that this would not be the best choice and that the present tax rules supporting the private system make much more sense," Mr. Briggs said.

Employers that think workers will become more aware of the value of their benefits if they're taxed are using convoluted logic, he said. "This is a shortsighted view. Once you increase the direct cost to employees through taxes, they will begin to drop out. As they drop out, the cost goes up for the older workers and the less-healthy workers. The whole thing unravels. We call this adverse selection.

"Then, the chickens come home to roost—in higher Medicare costs, welfare costs and hospital bad debts, not to mention the indirect costs in human terms and lost productivity," Mr. Briggs said. "For the most part, these costs would have to be borne by the government and one way or another passed onto business in the form of higher taxes."

Similarly, eliminating or reducing the tax advantages of retirement savings plans like 401(k) salary reduction plans would shift more of the burden of providing retirement income to the government, Mr. Briggs said.

Various proposals to lower the amount employees can contribute to these plans and tighten or eliminate early withdrawal provisions are shortsighted, he said.

"The Treasury's approach to these problems has been entirely too narrow," he said. "The urgencies of coming up with a billion here or a billion there to fulfill predictions of revenue neutrality for the president's tax programs should not prevail over an effort to arrive at sound and coordinated retirement provisions for workers."

Mr. Briggs encouraged benefits professionals to lobby against the various tax proposals he discussed.

"In my judgment, we have built a private system of employee (benefits) of which we can all be proud," he said. "This system has been a product of private enterprise with the cooperation of labor and a reasonable tax law."

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**business
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Quake losses

Continued from page 3 insured. That means Germany's insurance density is 50%. I'm sure Mexico's is less than that."

Some U.S. insurers and reinsurers are reporting losses of only a few million dollars from the Mexican quakes. For instance, The Travelers Insurance Co., American Re-Insurance Co. and American International Group Inc. all expect their losses to be no more than \$3 million each.

Although lingering communications problems between Mexico and the United States have impaired many insurers' ability to ascertain what their exact losses are, most say they feel their estimates are fairly accurate.

The Travelers, based on reinsurance treaties it has with both Mexican insurers and U.S. insurers that write Mexican risks, estimates its total losses to be between \$2.5 million and \$3 million, says a spokesman for the Hartford, Conn.-based company.

"That's what we feel our maximum exposure would be," the spokesman said. "But we have had no claims and have heard nothing through reinsurance."

Similarly, American Re, a subsidiary of Aetna Life & Casualty Co., expects its total losses to be between \$2 million and \$2.5 million, said T. Darrington Semple, resident counsel and secretary of the New York-based reinsurer.

"That's our best estimate," Mr. Semple said. "And, we're being very cautious to not overestimate or underestimate our losses. That's a pretty good figure at the moment."

AIG reports less than \$2 million in claims on direct coverage, according to John Hughes, senior vp with AIG in New York.

CIGNA Corp. expects its losses on direct coverage to be between \$4 million and \$5 million, a spokesman for the Philadelphia-based company said.

"It looks like losses that already have come in are \$4 million," the spokesman said. "And we expect it go up another 20% to 25% from there."

Continental Insurance Co. reports claims up to its \$7 million total retention, said a spokeswoman for the New York-based company. She added that the claims are coming in "very slowly, because of communications problems."

Royal Insurance Co. of America, based in New York, had no losses, according to a company spokesman.

AIG, CIGNA, Continental and Royal, which all wrote direct coverage for U.S. risks in Mexico, said they expected relatively mild losses because property damage to U.S. companies' Mexican subsidiaries was light.

Prudential Reinsurance Co. in Newark, N.J., reported one of the highest loss figures, expecting between \$5 million and \$10 million in actual and projected property claims.

Many European underwriters, including Munich Re, Swiss Reinsurance Co. and underwriters at Lloyd's of London, say they cannot yet estimate what their losses will be. All report they must wait for their ceding companies to determine their losses.

"There are so many wild figures, no one knows at the moment what the real cost is," explains Anthony Howland-Jackson, chief executive of Lloyd's broker Clarkson Puckle Group Ltd.

He added that within the next few weeks, Clarkson Puckle will collect 10 million to 20 million pounds (\$14 million to \$28 million) from London reinsurers to pay Mexican ceding companies for some of the property losses.

But, Mr. Howland-Jackson expects the final loss total will be much greater.

He says the greatest losses will be on facultative reinsurance contracts, and "those losses will be spread around the world reinsurance market."

But, there is one issue that is "desperately worrisome to reinsurers," according to reinsurance consultant Fletcher Phelan, president of Phelan International Consulting in Larkspur, Calif.

That issue is the amount Aseguradora Mexicana, a Mexican government-operated insurer, will eventually pay out to property owners in Tlatelolco, a "grossly underinsured" area of Mexico City.

The Mexican government is reportedly pressuring insurers to pay the claims of certain housing projects at replacement value, not at insured value as the policies usually dictate.

Mexicana insured a housing project of about 25 units that included the Nuevo Leon building,

Continued on next page

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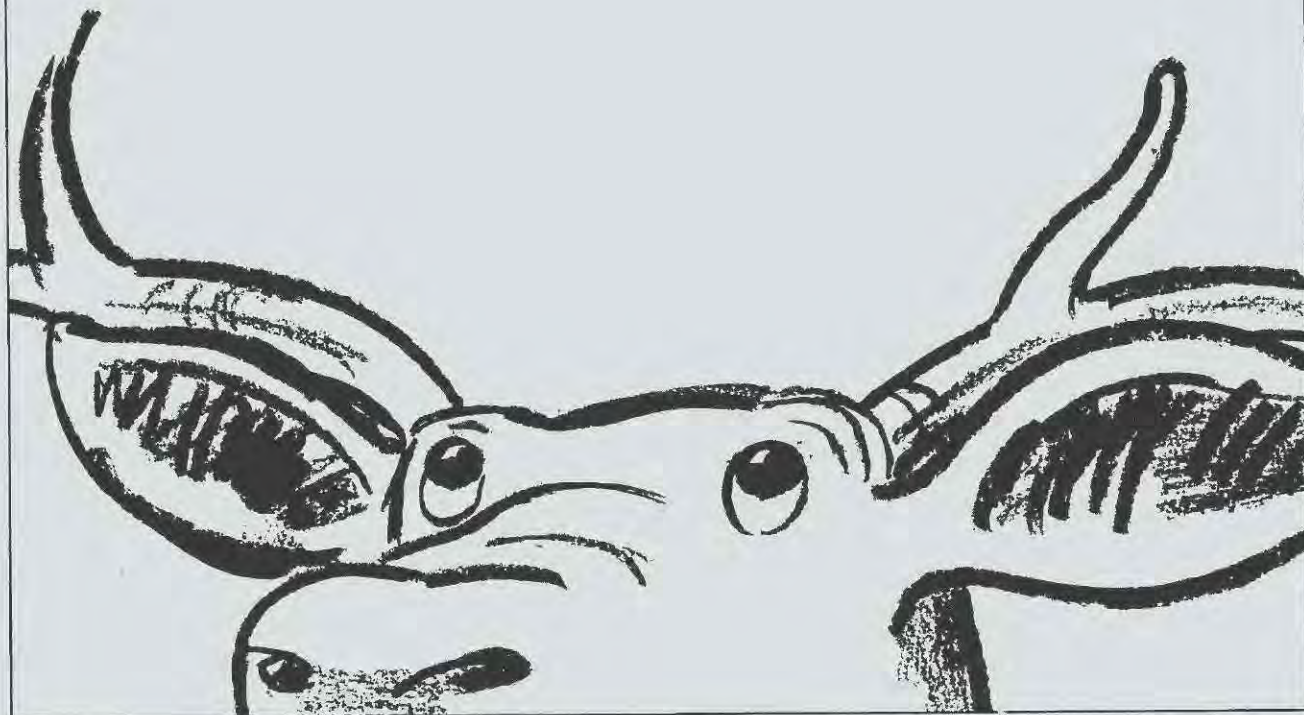
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Quake losses

Continued from previous page which collapsed and killed about 500 people.

The remaining units were condemned by the government, but Mr. Phelan says the condemnation is being appealed by a homeowners association.

If Mexicana pays these homeowners' claims at replacement value, its reinsurers will be expected to pay now out substantially more than they believe is due, Mr. Phelan explains.

The scenario has the potential for becoming "a major brouhaha," he says.

Mr. de la Cueva says Mexico has enough adjusters—some 30 companies—to complete most inspections within two months, though "the more complicated claims could take three or four months.

"Total losses present no problem. A difficulty that could arise in some cases is deciding whether a building can be repaired or not. That is a problem that could take some time to solve," he says.

"As for reinsurance, the scheme is very good. All the risks are well-covered," Mr. de la Cueva says. "Fifty percent of the non-proportional reinsurance is in London and the rest elsewhere."

Mr. Phelan says that reinsurers have given him estimates of the amount some Mexican insurance

'The water and drainage networks certainly were not' covered, says Mr. de la Cueva.

companies will pay—before reinsurance recoveries—for damage in Mexico City alone:

- Seguros La Comercial, 23 billion pesos (\$46 million).
- Aseguradora Mexicana, 17 billion pesos (\$34 million).
- Seguros America, 16 billion pesos (\$32 million).
- Seguros de Mexico, 12 billion pesos (\$24 million).
- Nacional Provincial, 12 billion pesos (\$24 million).
- Seguros Monterrey, 5 billion pesos (\$10 million).

One of the biggest and most complicated claims submitted to insurers is from Telefonos de Mexico, the state telephone company.

Telefonos de Mexico's two most important telephone terminals collapsed during the first quake. The equipment used for the country's national and international long-distance telephone services was also destroyed.

Telecommunications experts said those services may not be restored for six months.

Mr. Phelan says Seguros La Comercial and Mexicana expect to receive a claim of about \$50 million from the loss.

Mr. de la Cueva notes that the insurance association's eight-story building was badly damaged in the first quake.

"A column collapsed, and the building almost fell," he explains. "We are waiting for experts to give us the results of their inspection."

Mr. de la Cueva also points out there so far is no estimate of insurers' losses from life insurance claims.

Only "maybe 30 or 40" of those killed in the quakes—with the exception of civil servants—were covered by life insurance, says Jose Gomez Gordo, director general of Aseguradora Hidalgo.

Aseguradora Hidalgo underwrites life insurance coverage for civil servants, according to Mr. Gomez Gordo. He says only 50 or so claims had been submitted about a month after the quakes.

"But it is a very slow business, and we expect there will be something like 1,600 claims, totaling 2.8 billion pesos (\$5.6 million)," Mr. Gomez Gordo says.

"We have more than enough resources to cover the claims," he says, adding "there is no reinsurance in the case."

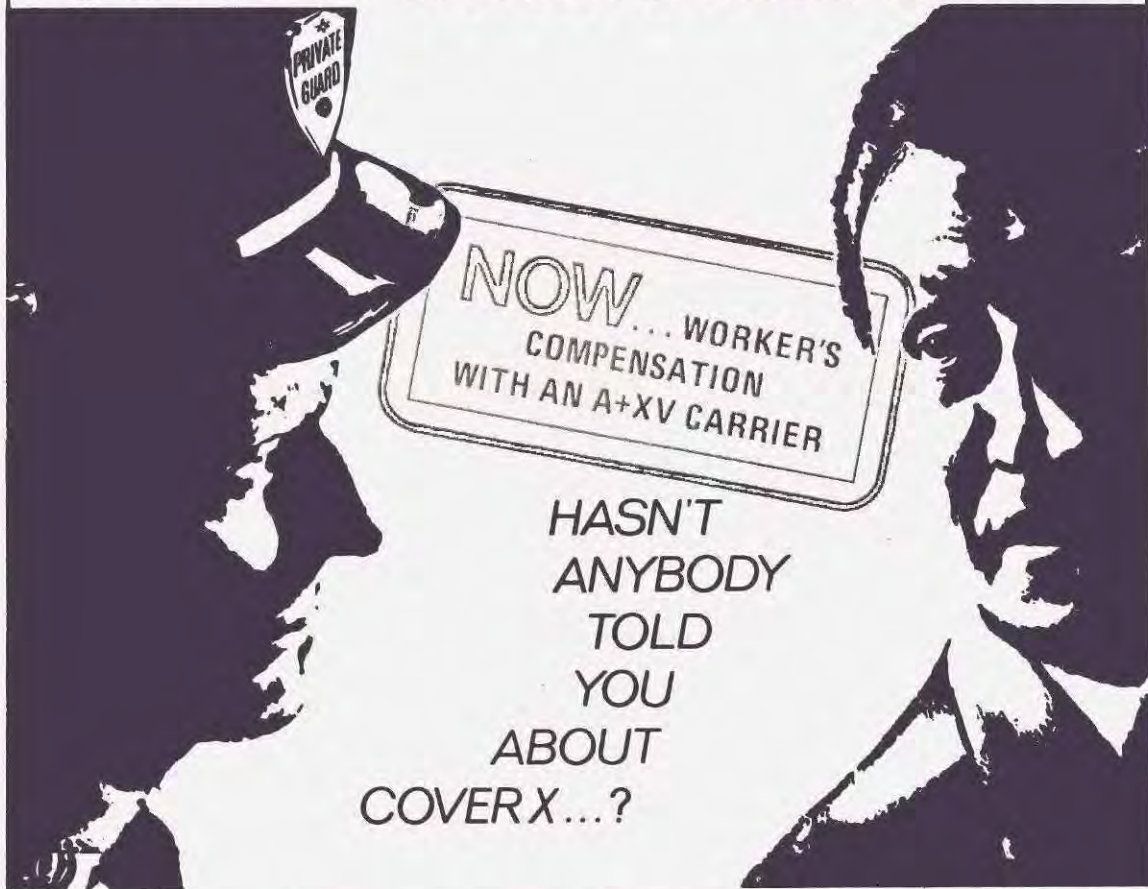
Reinsurers and insurers are considering holding a meeting in Panama later this month to further discuss losses from the quake, according to Mr. Phelan.

Panama was chosen as a convenient site for the meeting because representatives of many companies already plan to be there for the annual meeting of FIDES, the inter-American federation of insurers and reinsurers.

The first quake, which measured 8.1 on the open-ended Richter scale and lasted at least two minutes, was one of the strongest ever to hit Mexico. It was followed 36 hours later by a slightly less-powerful quake.

Information for this report was provided by London Editor Stacy Shapiro, Associate Editor Steve Taravella in Los Angeles, Associate Editor Diane Lynn Kastiel in Chicago, and free-lance writer Stephen Downer in Mexico City.

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Risk Retention Act

Continued from page 1
ance coverage, say attorneys in the case.

"A court will decide what Congress intended to be covered under this act. A lot is hanging on this suit," said Mr. Fay.

"The case is important because it will define the parameters of the authority to utilize the Risk Retention Act," according to Michael Mullen, an attorney with the Washington law firm of Crowell & Moring, which represents Ruedlinger and INA.

The purchasing group provision in the Risk Retention Act allows unrelated companies to collectively purchase product liability insurance on a group basis, pre-empting state laws that prohibit group insurance buying.

Purchasing groups offer individual companies economies of scale and give them buying clout, since the group generates larger premium volumes than individual companies would.

For example, a purchasing group organized through the Washington-based National Assn. of Wholesaler-Distributors has enabled members to obtain broader coverage than the small wholesalers could have obtained individually (BI, Oct. 10, 1983).

Like the wholesalers, the high schools say the purchasing group is essential for them to obtain coverage from athletic injury suits.

"Schools could not buy this program individually," said Brice Durbin, executive director of the National Federation of State High School Assns. in Kansas City, Mo. "The purchasing group concept is a godsend."

The Ruedlinger insurance program has two components. The first component provides up to \$5 million of insurance, underwritten by INA, to cover liability suits filed by students injured during interscholastic athletic programs.

In addition, the program will cover medical and rehabilitation expenses incurred by injured students who agree to give up their right to sue. This settlement option feature was developed by Jeffrey O'Connell, a professor at the University of Virginia Law School in Charlottesville, Va., and an outspoken advocate of no-fault insurance programs.

The program costs \$1.40 per student participating in an interscholastic athletic program.

The year-old program covers the National Federation of State High School Assns., state associations and school districts that are members of the state associations.

While the Kansas Insurance Department says it does not oppose the type of coverage offered under the program, it argues that the schools are not product manufacturers or sellers and, thus, are not purchasing product liability insurance.

"Local school districts are the consumers of athletic equipment, not the manufacturers or vendors of such equipment," the department's memorandum says.

"If the local school district is negligent in providing improper equipment to high school athletes or failing to supervise athletes who are wearing equipment, liability for negligence may indeed be found. But if the school is not a 'manufacturer, wholesaler or retailer' and if 'no sale' has been made by the school district to the athlete, the negligence is not properly characterized as products liability," it says.

The department says when Congress created the purchasing group concept in the Risk Retention Act, legislators limited its use to product sellers: manufacturers, wholesalers, distributors or retailers.

The law did not define product sellers to include "entities who receive no financial remuneration for

selecting safe equipment for the use of the ultimate user. Certainly, the act does not include state high school associations and high school districts as 'product sellers' when the high schools seek to protect their students and purchase safe equipment for use in athletic events," the department said.

But the brief filed on behalf of Ruedlinger and INA argues that the legal authority to establish a purchasing group is not restricted to manufacturers, wholesalers or retailers.

Quoting from the law, the brief says a purchasing group can be formed by "any group of persons" that has "as one of its purposes" the purchase of product liability insurance.

The brief also notes that product liability law is not limited to manufacturers, wholesalers and retailers, but also extends to anyone who participates in the design, labeling, certification and distribution of products.

The Ruedlinger-INA brief says school districts' product liability exposure arises from their participation in the design, testing, certification and distribution of sports equipment as well as affixing warning labels on the equipment.

According to the brief, the National Federation of State High School Assns., along with other sporting groups, help develop athletic equipment standards in its role as a member of the National Operating Committee on Standards for Athletic Equipment.

The national federation publishes lists of certified sports equipment that meet NOCSAE standards. State associations then require school districts to use athletic equipment that is certified in accordance with these standards. School districts also are supposed to affix warning labelings that have been approved by the national and state associations.

The brief notes that the Risk Retention Act defines product liability

as liability arising out of the manufacture, design and distribution of a product.

Since the national federation, member state associations and school districts are involved in the design, testing, certification and distribution of products and warning labels, they face product liability exposures as defined in the law, the brief says.

The Kansas department's lawsuit is the second major legal challenge to the Risk Retention Act.

The first challenge involved another section of the act, which generally bars states from interfering with employers that set up captives, also known as risk retention groups, to self-insure product liability exposures.

That section says that risk retention groups that meet the insurance capitalization requirements of at least one state can operate nationwide with minimal interference from state regulators.

However, David Elliott, then

Delaware Insurance commissioner, refused in 1982 to recognize a risk retention group set up in the state by the Washington-based Home Owners Warranty Corp., a national homebuilders association.

Mr. Elliott said the HOW program covered warranty exposures—as defined under Delaware law—and not product liability exposures, which are the only risks a risk retention group can cover (BI, June 28, 1982).

HOW argued that its program covered product liability risks as defined in the Risk Retention Act and that the federal definition prevails if there is a difference between it and the state definition.

HOW's position was upheld in 1983 by U.S. District Court Judge Walter Stapleton, who struck down Mr. Elliott's position as "untenable" (BI, Oct. 17, 1983).

The Delaware Insurance Department did not appeal Judge Stapleton's ruling and HOW continues to operate a risk retention group. ■

WAREHOUSE FIRES

Several Major Fire Losses of the Last Decade have involved warehouses, which were fully sprinklered and yet completely destroyed. In some cases, the sprinkler system was designed to minimum specifications. In others, the occupancy was changed to a more hazardous storage than originally anticipated. And in still others, temporary storage clogged aisles. A few of these conditions existed in two of the world's largest losses, which are reviewed here:

Automotive Supplies. Fire started in the temporary storage of plastic parts and spread to nearby cans of motor oil in cartons, which were palletized and stored in the aisles. Two employees attempted unsuccessfully to put out the fire with a hose stream from a nearby hose station within the building. A few minutes later, the plant fire brigade arrived and tried to fight the fire but was hampered by storage piled in the aisles. Although sprinklers were operating, the available water densities could not penetrate the intense fire plume generated by the burning plastics and oil. A total of 250 firemen fought the blaze, which continued to rage, overwhelming the sprinkler system and destroying about 18 acres of building. Estimated loss: \$145 million.

Retail Products. A carton of aerosol cans, containing carburetor and choke cleaner, was dislodged from its storage rack, fell to the floor, and split open. One or more cans discharged their contents which became ignited by a nearby electrically powered lift truck. Fire spread quickly over the 15-foot high palletized storage of aerosols, overpowering the existing sprinkler protection. Flaming, rocketing aerosol cans started fires in adjacent storage that included foamed plastic plates, plastic toys, additional aerosols and motor oil.

Within six minutes, the fire alarm had sounded, four sprinkler risers were flowing, the electric fire pump had started, and the fire department was on its way. In the meantime, the warehouse fire brigade entered the building but in less than two minutes was forced out by thick, black smoke. Within 20 minutes, flames broke through the roof and aerosol cans could be seen rocketing through the air. Some 300 firefighters got the blaze under control nine hours later. Estimated loss: \$125 million.

IRI Recently Concluded a Review of Its Major Warehouse Exposures, evaluating the adequacy of existing protection, specifying additional protection as necessary, and isolating exposures that are ticking "time bombs." Here are some of the "time bombs" most commonly encountered:

1. **Aerosol storage** is mixed with otherwise ordinary hazard storage.
2. **Hazard levels** have increased as the result of a change in commodities and their packaging.
3. **Storage height** is greater than planned by protection designers.

Specific suggestions for isolating aerosol storage are available from Mrs. P.A. Sasso, IRI, 85 Woodland Street, Hartford, Connecticut 06102 or telephone (203) 525-2601. Ask for a complimentary copy of **The Sentinel**, 2nd Quarter 1985, which features "The Hazards of Aerosols".

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Hazardous waste

Continued from page 3

handful of companies, and only one insurer, American International Group Inc., is routinely providing EIL coverage for hazardous waste disposal facilities—considered one of the highest-risk categories of environmental exposures.

The EPA says that of the estimated 1,132 companies that must meet the financial responsibility requirements, about 983 will be able to use the self-insurance test to meet its financial responsibility requirements.

Mr. Thomas told Congress that of the 270 companies that probably cannot pass the self-insurance test, 113 do not now have EIL coverage.

The EPA also found that 37 of these companies had purchased EIL coverage, but the coverage was canceled within the last year. The remaining 76 companies never had the coverage, the EPA says.

A separate survey of 40 commercial waste management facilities—companies whose principal business is managing hazardous wastes for other firms—found that nine had EIL policies canceled and have not been able to obtain replacement coverage, the EPA said in its Oct. 18 letter.

An EPA enforcement staffer who worked on the survey said that most of the nation's commercial waste management facilities apparently cannot pass the self-insurance test and are relying on EIL insurance to meet the financial responsibility requirements.

In August, the EPA published a notice seeking comments on the current insurance situation for hazardous waste disposal facilities,

holding out hope that the agency would take some action to amend the financial responsibility requirements.

But EPA officials decided last month the only way to implement an "administrative fix" would be to rescind the financial responsibility requirements, "and no one wanted that," an EPA staffer said.

In fact, the EPA says most of the comments it received on its August notice specifically endorsed the need for EIL coverage for hazardous waste disposal facilities.

Agency officials also concluded that rescinding the federal financial requirements would be of limited help to hazardous waste disposal facilities. The officials pointed out that most states have been delegated authority to regulate hazardous waste facilities within their borders and would not be obligated to follow the EPA's lead.

However, the EPA does plan to make some changes in its financial responsibility rules as a result of comments it has received. But, no changes will be made before the Nov. 8 deadline, according to Mr. Thomas.

One change under consideration is to allow a corporate guarantee for meeting the self-insurance test. Currently, a subsidiary company cannot count the assets of its parent for purposes of the self-insurance test, even if the parent has the financial wherewithal to meet the test.

A corporate guarantee would allow a parent company to assume the environmental liability stemming from its subsidiary's hazardous waste disposal operation.

The EPA also is considering

other changes, which it has not publicized.

"We believe that these new regulations will provide substantial assistance to the regulated community should the insurance market remain unchanged," Mr. Thomas told Congress.

It is not known whether the EPA will alter the current requirement that EIL insurance purchased to meet the financial responsibility requirements be exclusive of legal defense costs.

And, EIL underwriters fear that pressure from reinsurers may force them to include defense costs within aggregate limits, meaning that the coverage would no longer satisfy EPA requirements.

Several of the 113 companies without EIL coverage contacted by *Business Insurance* say they face severe hardship as a result of the financial responsibility requirements.

The list includes a number of wood-treating companies, most of which are small, family-owned businesses. Many of these companies have been unable to obtain EIL insurance or cannot afford the coverage. And, most do not have

the financial resources to meet EPA's self-insurance test.

"I don't see how EPA can require something that's not available," said a spokesman for one wood-treating firm who did not wish to be identified. "All that's available is a nominal amount of coverage for an astronomical premium," he added.

The firm will shut down its hazardous waste disposal operations Nov. 8 and will truck its wastes to a commercial waste disposal firm—a move that will considerably increase its company's waste disposal costs.

According to the company spokesman, the company is planning to phase in a new waste treatment technology in an effort to stay profitable.

A number of small chemical companies are also faced with similar problems in obtaining EIL coverage to meet the EPA requirements.

"A lot of these companies are in areas of the country where there are no commercial hazardous waste disposal facilities," an EPA staffer explains.

"If they have to close their own

waste disposal operations because they can't get insurance, the cost of transporting the waste off-site may be prohibitive."

Other companies on the EPA list are more fortunate.

Gerald "Buss" Trapnell, property insurance manager for San Antonio Public Service, a gas and electric utility, says his company has not been able to purchase EIL coverage for its PCB exposures. Mr. Trapnell says the utility's excess liability insurers "did not want to include any environmental liability" in the company's excess casualty policies.

However, Mr. Trapnell says the utility will likely meet EPA's self-insurance test.

Great Plains Gasification, a Bismarck, N.D.-based company that generates gas and oil from coal, was recently taken over by the federal Department of Energy, so it probably will not be required to meet the EPA financial responsibility requirements, said Richard J. Jablonski, administrator of the company.

Mr. Jablonski says the company has not been able to obtain EIL coverage. ■

Karl Koch named NAIC executive vp

KANSAS CITY, Mo.—Karl W. Koch will become executive vp of the National Assn. of Insurance Commissioners on Nov. 18.

The position has been vacant since June.

Mr. Koch, 45, had been president and chief executive officer of Golden Eagle Insurance Co. in San Diego since 1983. The insurer specializes in workers compensation and commercial liability coverages in the California market.

Prior to that, Mr. Koch was with the Insurance Co. of the West, also in San Diego. He was promoted to president of that insurer, after serving as senior vp of marketing and underwriting.

Mr. Koch also worked for Insurance Co. of North America in several positions. He started as a management trainee and rose to the position of marketing manager of the San Diego branch.

"We were looking for someone with a strong management background and an in-depth understanding of the business of insurance. Karl meets the description," said Bruce Foudree, president of the NAIC and Iowa's insurance commissioner.

"His demonstrated management ability and valuable experience will assure a productive and responsive NAIC central office," Mr. Foudree said.

Mr. Koch said his new NAIC position is "an outstanding opportunity," given the state of the market and the numerous issues facing insurance regulators.

"The challenge there is to understand the various issues and be able to respond to the commissioners' needs," he said.

Mr. Koch has an undergraduate degree in journalism from the University of Kansas.

Mr. Koch is filling the post that was vacated by E. Benjamin Nelson, who returned to his private law practice in Omaha, Neb., this summer. Mr. Nelson had served three years as NAIC executive vp (BI, March 18).

Mr. Nelson, a former regulator from Nebraska, was brought on staff to reorganize, restaff and relocate the NAIC. He accomplished all those goals before leaving. ■

Superfund delayed in House

Continued from page 2

citizens more latitude to bring suits under Superfund.

Other issues that are being debated by the two committees include devising a schedule for cleaning up the nation's worst hazardous waste dumps, mandatory standards for cleanup operations and provisions for reporting to the public certain emissions from waste facilities.

While members of the two committees argue over these issues, Rep. Barney Frank, D-Mass., has told the business community that he plans to offer an amendment on the House floor that would create a federal cause of action in the Superfund law.

Rep. Frank's amendment is expected to be chock-full of the kind of provisions that risk managers and insurers consistently have opposed.

Such a federal cause of action will allow citizens to sue companies for third-party damages in federal court using the strict, joint and several liability provisions of the Superfund law.

Currently, citizens can use only state tort law in legal action seeking restitution for bodily injury and property damage. Supporters of a federal cause of action say the burden of proof in state tort law is too high, making it difficult for those injured by exposure to toxic substances to recover.

Those who oppose federal cause of action within the Superfund law say multimillion-dollar verdicts awarded by state courts in several toxic chemical cases prove that a federal cause of action is not needed.

Insurance industry lobbyists say Rep. Frank's amendment probably will be defeated because neither the House nor Senate versions of the Superfund reauthorization legislation now contain a federal cause of action. They also point out that the House defeated a similar amendment during last year's debate over a Superfund reauthorization measure.

Meanwhile, the House Ways and Means Committee approved language Oct. 17 that would impose a tax on most large manufacturers to finance the Superfund cleanup program.

Currently, the Superfund program is financed by taxes on specific chemical and petroleum compounds.

Once the House finishes action on its Superfund bill, a conference committee composed of members of the House and Senate will have to iron out differences between the Senate-passed bill and the House version.

That compromise bill will then have to be voted on again by both houses of Congress before it can be sent to the president.

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Survey draws a profile of flexible benefit plans

LINCOLNSHIRE, Ill.—Employers are using various devices to provide and communicate flexible compensation plans to their employees, according to a recent study by Hewitt Associates.

The survey, "Flexible Compensation Programs and Practices," is based on data from 120 employers with flexible compensation plans in effect by July 1985. The survey examines employer practices in four areas: plan design, administration, communication and financial results.

Among the survey's findings:

- **Plan design.** The "typical" program offers both choices in several benefit areas and a flexible spending account.
- Some 74% of the employers offer such a "combination" program. Some 14% offer only a flexible spending account, and the remaining 12% offer only benefit choices.

Among plans with benefit choices, the areas in which choices most often are offered are medical coverage, in 63% of the plans that offer choices; life insurance, in 46% of the plans; cash, in 43%; savings plan, in 41%; and time off, in 28%.

• **Administration.** Some 76% of the companies use internal resources for some or all of the computer work required to administer a flexible program. And, 58% of these use internal resources to handle the change to a flexible account, such as payroll modification and development of software.

Some 62% of the companies said their existing staff was able to administer the flexible program. And, 53% said administration of the program was handled by one person.

• **Communication.** The companies surveyed reported using virtually every kind of media to communicate to their employees information about the program when it was introduced and each year at enrollment time.

The most popular ways to communicate the introduction of the program were employee meetings, reported by 98% of the companies; brochures, reported by 77%; newsletters, reported by 75%; memos, notices and posters, reported by 59%; and audiovisual presentations, reported by 58%.

• **Financial results.** Most of the companies reported their flexible benefit programs had not been in place long enough to determine their financial impact.

But, of the 24 companies that had performed financial analysis, 21 said the programs either reduced benefit costs or limited increases, and two companies reported no change in benefit costs under the program.

Only one company said costs rose more quickly under the flexible program than under the prior program.

Using the data provided by the surveyed companies, Hewitt also determined that flexible plans help hold down the rate of increase of employer's medical care costs.

In the first year of a flexible program, the increase in medical costs for employers with the plans were 0.5% less than the national average increase. And, in the second year, the increase in costs for employers with a flexible plan was 4.5% less than the national average increase.

Copies of the survey are available for \$25 each from Cathy Schmidt, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.

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Circulation Breakdown*

Commercial Consumers

Administrative:
CEO's presidents and owners... 2,531
Vice-presidents, general managers and other administrative personnel2,547

Financial:
Chief financial officers and vice-presidents of finance2,075
Secretaries, treasurers, controllers and other financial personnel6,886

Risk/employee benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations8,048

Sub-total 22,087
Associations 804
Government, unions and educational systems1,030

Commercial Consumers
Sub-total 23,921

Insurance agents and brokers 9,548
Insurance companies6,089
Financial institutions 536
Actuaries, attorneys, adjusters, appraisers and consultants3,464
Others allied to the field1,320

TOTAL 44,878

* Source: Business/Occupational breakdown of qualified circulation, May 6, 1985 issue, as submitted to BPA for June 1985. BPA Publisher's Statement.

New Jersey rules

Continued from page 1

fore, they were bound to continue all their coverages for at least 90 days despite circumstances unfavorable to their financial stability.

- Prohibits changes in policy terms and conditions when policies are renewed, unless mutually agreed upon by policyholder and insurer.

This does not prohibit insurers from raising rates but does prohibit reductions in limits and the addition of any exclusions.

The rules subsequently were clarified in two bulletins issued by the department on Oct. 9 and 17.

The insurers' key concern is that the rules force them to continue to underwrite risks for which they no longer may have reinsurance.

In the last year, many reinsurers have canceled reinsurance contracts to try to stem severe underwriting losses. In particular, European reinsurers are refusing to accept North American casualty risks.

"The most frightening prospect presented by the rules is that of being forced to extend insurance coverage without adequate reinsurance protection," the trade associations' court brief says.

"The obligation of the prudent insurer to its shareholders and policyholders when confronted by a suddenly uninsurable risk is to move immediately to modify the terms of the policy or to terminate it," the papers continue.

"The rules, however, place a 90-day freeze on the cancellation or non-renewal of reinsurable risks.

"After the 90-day period, the rules subject the insurer's decision to terminate an uninsurable risk to an arcane, ill-defined and uncertain administrative process."

"Insurers compelled by the rules to continue coverage when reinsurance is lost or unavailable face the potential of catastrophic claims.

Thus, the rules tempt insolvency," the brief concludes.

Several affidavits attached to the trade associations' brief illustrate specifically how particular insurers that have lost their reinsurance would be affected by the emergency rule (see related story).

The Insurance Department has said that it will consider a lack of reinsurance support as a valid reason for an insurer to change its policy terms.

However, the department sets up an "extremely cumbersome" process for an insurer to document that, says Robert J. Sullivan, vp of government affairs for Crum & Forster Corp. in Morristown, N.J.

Consequently, an insurer must still provide coverage until department approval is obtained and a policyholder is given sufficient notification, insurers say.

"You'll be forcing insurers into insolvency," said James F. Johnson, an attorney for LeBouef, Lamb, Leiby & MacRae, which is U.S. general counsel for Lloyd's of London.

Thus far, only two insurers have received the department's approval to reduce the limits of coverage because of a lack of reinsurance, according to Assistant Commissioner Joseph B. Kenny. He would not identify the insurers.

The insurers' brief also points out that the rules, which Ms. Gluck says are intended to preserve the availability of insurance, will further restrict the market.

For example, the insurers say the rules will "sharply curtail" the ability of insurers to write new business in New Jersey and other states.

"To the extent its (an insurer's) existing surplus is dedicated to insuring existing risks, the insurer cannot issue new policies," the court papers point out.

Some insurers already have stopped writing new business in the state, they say.

They also point out that in some

instances if an insurer were allowed to renegotiate more restrictive coverage terms with the policyholder at renewal, coverage on a corporation that has experienced losses might not necessarily be canceled.

But, as the rules are now, it would be better for the insurer to seek cancellation of a bad risk than to be forced to renew it at existing terms, the court papers point out.

Summarizing the negative effects of the emergency rule, the trade associations' brief says: "Rules which compel insurers to violate statutory limitations on the percentage of net assets exposed to liability for a single risk and, thus, to flirt with insolvency, cannot be deemed reasonable.

"Rules which prohibit cancellation of a policy which cannot be reinsured, and thus put insurers at risk of a catastrophic loss borne only by its own shareholders, policyholders and the guaranty funds of this state, cannot be deemed reasonable.

"Rules which encourage cancellations, rather than renegotiations of coverage, reduce the capital available to write new policies of insurance, and which encourage insurers to flee the state in the midst of a proclaimed 'capacity crunch' are clearly arbitrary, capricious and unreasonable."

Ms. Gluck said she was not surprised by the lawsuits, but called them unfortunate because the insurers and the department had been very close to an agreement over the rules.

The insurers' brief says an agreement could not be reached.

Many industry officials say that definitive action on modifying or replacing the emergency regulations, which were approved by Gov. Thomas Kean, would not take place before the Nov. 5 gubernatorial election in New Jersey because the regulations have been part of his re-election campaign. ■

Monsanto shareholder files suit

Continued from page 2

manufacture of the Copper-7 intrauterine device.

The suit, brought by shareholder Richard Rand in U.S. District Court in Chicago last week, is a class-action filed on behalf of all those who bought Monsanto stock between July 18 and Oct. 4, 1985, said Ira Bornstein, a plaintiff's attorney with the Chicago firm of Harvey J. Barnett & Associates Ltd.

The suit alleges there was an "artificial inflation" of the value of Monsanto's stock, Mr. Bornstein said, adding information on the suits and Searle's potential liability should have been disclosed.

The suits against Searle charge the Copper-7 causes pelvic inflammatory disease potentially leading to sterility and even death.

Spokeswomen for Monsanto and Searle declined to comment on the lawsuit or on the companies' insurance.

Xerox C&F moves yield net loss

STAMFORD, Conn.—Xerox Corp. reported a third-quarter net loss of \$15 million because of two actions it recently took at its Crum & Forster insurance subsidiaries that resulted in a \$164 million charge against earnings.

Xerox took a \$97 million charge for the phasing out of Crum & Forster's Industrial Indemnity Financial Corp. and a \$67 million charge for reserves added to L.W. Biegler Profit Center.

Industrial Indemnity Financial Corp. is a San Francisco-based C&F company that wrote financial guarantee and contract surety business. Biegler is a Chicago-based underwriting manager for International Surplus Lines Insurance Co. and other C&F affiliates.

Xerox announced these two actions last month, but did not disclose the amounts involved (BI, Oct. 7).

Xerox reported net income of \$81 million in third-quarter 1984.

Repaired engine on probe starts

EL SEGUNDO, Calif.—Hughes Aircraft Co. has successfully fired the engines of the Syncom IV-3, and further testing of the satellite will determine whether underwriters ultimately can recoup any of the \$80.7 million that was paid when the orbiter was declared a loss.

Space shuttle astronauts repaired the satellite earlier this summer, and on Oct. 27 the probe's engines were successfully fired in an attempt to place it into its proper orbit. Hughes said the Syncom IV-3 was expected to reach its intended orbit last Friday.

Insurers paid \$80.7 million when Hughes filed a total-loss claim on the satellite earlier this year. The orbiter was insured for \$84.7 million, but Lexington Insurance Co. has refused to pay its \$4.7 million share of the coverage. In response, Hughes has filed a \$29 million lawsuit against Lexington (BI, Sept. 30).

The U.S. Navy has agreed to lease the telecommunications satellite if it is fully operational. Hughes said last week that part of any funds received under the agreement would be shared with underwriters according to a complex formula.

Hall stops dividend payment

BRIARCLIFF MANOR, N.Y.—Frank B. Hall & Co. Inc., the nation's fourth-largest insurance brokerage, has suspended payments of quarterly dividends indefinitely beginning in the fourth quarter of 1985 in an effort to strengthen its capital base. The fourth-quarter dividend would have been paid in February 1986.

Payments will resume "when earnings reach a level that will enable dividends to again be issued," said Senior Vp John Addeo.

Hall also announced a net aftertax loss of \$95 million, or \$6 per share, for third-quarter 1985. The loss was due mainly to costs related to the disposal of Jartran Inc., the truck-leasing unit the brokerage has announced it plans to sell, and to the establishment of additional reserves for Hall's discontinued underwriting operations.

Hall's gross revenues for the third quarter were up 17% to \$105.1 million from \$89.6 million in the third quarter of 1984, and net income from continuing operations increased 49% to more than \$2.5 million from \$1.7 million in 1984.

For the first nine months of 1985, Hall's gross revenues increased 12% to \$311 million from \$278 million in 1984. Net income from continuing operations for the same period increased 38% to \$10.7 million from \$7.8 million in the first nine months of 1984.

A&A strengthens reserves

NEW YORK—Alexander & Alexander Services Inc. says it will strengthen the reserves of its discontinued U.S.-based underwriting operations by an estimated \$15.3 million, charged to its third-quarter earnings. The brokerage cited "adverse claim payment experience."

A&A says its third-quarter results will not be released until mid-November due to the accounting complexities involved in reporting the consolidated results of A&A and Reed Stenhouse Inc., the Canadian-based brokerage acquired by A&A on July 31.

Ruling party wins in Bermuda

HAMILTON, Bermuda—Bermuda's ruling United Bermuda Party won an unprecedented parliamentary majority Oct. 29 in the third general election in five years, returning the government to office until 1990.

UBP candidates, led by 50-year-old Premier John Swan, picked up an additional five seats in the House of Assembly and now control 31 of the 40 elected seats. The margin is the biggest this right-wing party has held since the advent of party politics here in 1968.

The leftist opposition, the Progressive Labor Party, suffered its worst electoral defeat ever, losing seven of its 14 seats. Meanwhile, a fledgling centrist group, the National Liberal Party, won two parliamentary seats in its first showing in a general election.

Lois Browne Evans is expected to resign as head of the PLP.

Rules would inflate insurer retentions

New Jersey's emergency order restricting insurers' right to cancel or not renew insurance policies after Sept. 17 would inflate several insurance companies' net retentions beyond reasonable and legal limits because they have lost reinsurance.

The detrimental effects of the emergency order on several insurers are detailed in affidavits filed with the appellate division of the New Jersey Superior Court:

- New England Insurance Co. in Boston would be subject to an additional net exposure of \$387 million by Dec. 31 if it is forced to continue a directors and officers liability insurance policy and a dentists' program, said Ralph J. Palmieri, executive vp and chief operating officer.

The additional exposure is "almost 11 times New England Insurance Co.'s year-end 1984 surplus of \$35.7 million," he pointed out.

The Hartford Insurance Group unit wrote a three-year D&O policy for a New Jersey company providing limits of \$25 million and reinsured all but \$600,000 of the exposure. The D&O insurance policy is due to expire Jan. 1, 1987, but already New England Insurance has lost \$17 million of the reinsurance and expects to lose another \$3 million.

New England Insurance has not been able to find new reinsurers for the program and does not expect it will be able to do so.

"This directors and officers liability policy is only one of several professional liability policies where reinsurance has been lost. This is one of the largest such policies, but the others constitute a further enormous financial exposure for New England Insurance Co.," Mr. Palmieri's affidavit says.

In addition, New England Insurance has lost reinsurance that would have limited its net exposure to \$40.8 million on a professional and general liability program for 136 New Jersey dentists. The reinsurance treaty covered 90% of each of the \$3 million-limit policies issued. But, the reinsurance was not renewed Dec. 31, 1984, and coverage ceases on the expiration or anniversary dates of the policies.

If New England Insurance is forced to continue these policies, its net exposure will be \$408 million because it has been unable to find new reinsurance, the affidavit says.

- California Union Insurance Co., which writes surplus lines insurance in New Jersey, "does not have the available capital and policyholder surplus to support renewal of its New Jersey policies which expire subsequent to Sept. 17," said Vp Robert S. Cernok.

As of July 1, Cal Union already had written \$9 million more in premium in 1985 than it had during all of 1984 and had exhausted the \$150 million premium allocated to it for the entire year by its parent, CIGNA Corp.

And, Cal Union has not been able to purchase facultative or treaty reinsurance applicable to the policies due to expire in New Jersey.

"If Cal Union is forced to renew all of its New Jersey policies which expire after Sept. 17, 1985, its exposure on each individual risk will increase to \$5 million to \$10 million or more per risk," Mr. Cernok said. Cal Union usually retains no more than \$850,000 on any one risk.

Cal Union reported 35 policies on New Jersey risks that are scheduled to expire in December and January, including fire, all-risk and excess umbrella policies.

- Western Employers Insurance Co., which as of September had approximately 380 New Jersey umbrella policyholders representing about \$3 million in written premium, lost its reinsurance treaty effective July 1 and has not been able to secure new reinsurance, according to Vp James L. Pickering.

Under the canceled reinsurance treaty, WEIC retained only \$50,000 of the first \$1 million of risk and \$40,000 of the next \$4 million and none in excess of \$5 million per occurrence.

WEIC has sent non-renewal notices to its policyholders, but some policies expire after Sept. 17.

In addition, WEIC's assets total about \$50 million but some policy limits exceed \$5 million. New Jersey limits an insurance company exposure on any one risk to no more than 10% of its net assets.

Among the policies at issue is a \$10 million excess policy issued to the New Jersey Highway Authority that expires Jan. 1.

- Pacific Employers Insurance Co. has 26 policies due to expire by Jan. 1 for which PEIC has been unable to secure facultative reinsurance sufficient to limit its exposure to no more than the customary \$150,000 retained, says the affidavit of Vp Nicolas Yuschenkoff.

Its net exposure on one risk could be as high as \$25 million if it is forced to renew all of its New Jersey policies which expire after Sept. 17, 1985.

- St. Paul Fire & Marine Insurance Co. has "several three-year term financial institution bonds which we issued with \$25 million limits, but we currently only have reinsurance for \$15 million limits and will suffer irreparable harm if we are forced to renew them at the \$25 million limits for another three years," according to Executive Vp Richard W. Tongen. ■

CGL revisions

Continued from page 1
and potentially unlimited risks," he continued.

"By making the claims-made form available on Jan. 1, 1986, I believe we will have taken a necessary major step toward addressing the availability and capacity problems that have beset our industry.

"To do otherwise will result in placing the interests of commercial lines policyholders in the hands of the non-admitted and non-regulated markets."

Mr. Marcon's letter ends with a plea for quick consideration of the new policy form from regulators.

"I recognize that a letter of this type is a unique departure from normal ISO filing procedures. However, I'm sure you'll agree that these are not 'normal' times for the property/casualty business generally, and general liability insurance specifically.

"We believe strongly that the ISO CGL program is needed urgently and we respectfully request your priority consideration."

But, late last week, regulators were not guaranteeing quick approval of the revised form.

Illinois Director of Insurance John Washburn, who has spearheaded recent meetings between ISO and some commissioners, said regulators are still talking about how they will respond to the revised form.

They are "serious that there is a problem. We've talked about concepts, now we have to go through the language."

"I don't think anyone will act on the revised forms until such time as we receive responses to the points we raised," added Richard Rogers, deputy director of the Illinois Insurance Department.

Other insurance commissioners said they had not had time to formulate a response to the new form.

A Jan. 1 effective date for ISO's new forms, however, is guaranteed in six states, whose laws neither require insurance department approval for use of this form nor give the department authority to reject the form. Those states are: California, Colorado, Idaho, Minnesota, Vermont and Wyoming.

One key area of disagreement between the regulators and ISO centers on the reinstatement of a

policy's aggregate limits when a policyholder purchases unlimited tail coverage.

Both sides agree the reinstated limits would apply only to claims arising out of occurrences unknown and unreported when the endorsement takes effect. Claims first made or for which notice of occurrence is given within 60 days of the end of the policy period would not be covered by the reinstated limits.

But, the regulators want the reinstatement of policy limits to be guaranteed when the tail is purchased.

However, the policy revisions filed last week make the reinstatement of policy limits for unlimited tail coverage only an optional endorsement that insurers can extend to buyers or choose not to extend.

The policy states, "This endorsement is being filed as advisory, and will not be distributed as part of ISO's standard forms portfolio."

An ISO spokeswoman said ISO does not plan to make the endorsement guaranteed.

"We believe that to guarantee a reinstatement of the aggregate is a form of retroactive insurance. . . This would lead to adverse selection," she said.

ISO also does not intend for insurers to limit the use of the claims-made form to long-tail or latent injury exposures, the spokeswoman said. Regulators last month had demanded an explanation on why the use of the claims-made form could not be limited to specific risks.

Besides offering the buyer an opportunity to purchase unlimited tail coverage, the previously filed claims-made form provided for a free, automatic 60-day mini-tail for claims arising from occurrences within the policy period. In the revised form, ISO adds an additional automatic five-year extended reporting period free of charge for claims arising from occurrences within the policy period that are known before the end of the 60-day tail.

"The automatic extended reporting period applies only to claims as a result of an 'occurrence' of which we are notified after the retroactive date. . . but not later than 60 days after the end of the policy period of this policy," reads the revised form.

And, to avoid stacking of insurance coverage by the buyer, the revised form adds, "These automatic reporting periods apply only if no subsequent insurance you purchase applies to the claim, or would apply but for the exhaustion of its applicable limit of insurance."

Neither the 60-day nor the five-year tail can be canceled, according to the policy form.

Responding to buyers' concerns that insurers would arbitrarily advance each policy's retroactive date, forcing them to buy expensive tail coverage, ISO revised the policy to stipulate that the policy's retroactive date can be moved forward in only four circumstances.

According to the revised policy, these circumstances are:

- If there is a change in insurer.
- If there is a substantial change in the insured's operations that result in an increased exposure to loss.
- If the insured fails to provide the company with information he or she knew or should have known about the nature of the risk insured.
- With the agreement of the insured.

The revised policy stipulates that the retroactive date only "can be advanced with the written consent of the first named insured."

Regulators have stressed they want the policy to mandate that the policyholder acknowledge in writing both acceptance or rejection of a change in the retroactive date from policy to policy.

Insurance commissioners also had requested an explanation from ISO of the meaning of "recorded" in its policy revision that states coverage will be triggered when claims are "received and recorded" by the policyholder or insurer, rather than only when written claims are received by the policyholder.

The revision states: "If a claim is received by an insured you must:

"Immediately record the specifics of the claim and the date received; and

"Notify us as soon as practicable. "You must see to it that we receive written notice of the claim as soon as practicable."

ISO does not explain in the policy what recorded means, but an ISO spokeswoman said it means some sort of notation that the claim has been made. This could be in written notes, on a personal computer or even recorded on a tape recorder, she said.

In both the section of the revised form dealing with recording notices of claims and in another section related to the policyholder's duties in the event of an occurrence, claim or suit, ISO has replaced the mandate that the insurer be notified "promptly" of an occurrence to requiring notification "as soon as practicable."

The previously filed form also said notice of an occurrence should include how, when and where the "occurrence" took place and the names and addresses of any injured persons and witnesses.

The revised form adds that the notice should include "the nature and location of any injury or damage arising out of the 'occurrence.'" The revised form still notes that notice of an occurrence is not notice of a claim.

ISO also amended another section of the form to clarify its right to investigate an occurrence that could give rise to a claim even if no claim has been filed.

The previous form said, "We may investigate and settle any claims or 'suit' at our discretion."

The new form says, "We may, at our discretion, investigate any 'occurrence' or settle any claims or 'suit' that may result."

"We always were able to investigate a case before claims came in, but this makes it clearer," said the ISO spokeswoman.

Claims-made terms

The new Insurance Services Office commercial general liability claims-made policy form differs from the traditional occurrence form principally regarding when coverage is triggered.

Under the claims-made form, coverage is triggered when a claim is first made against the policyholder during the policy period that involves incidents that occur after the form's retroactive date. The policyholder must be notified of the claim either in writing or verbally to trigger coverage.

Under the occurrence form, coverage is triggered by an occurrence and the policy responds regardless of when the claim related to the occurrence is filed.

The new claims-made form and the new occurrence form for commercial general liability coverage both exclude coverage for pollution liability and apply separate aggregate limits to products/completed operations losses and all other coverages combined.

Important terms used in the claims-made form include:

- **Retroactive date:** Claims for bodily injury and property damage that occur before the date entered on the declarations page are excluded from coverage, even if the claim is made during the policy period.

- **Tail coverage:** Provides coverage for claims first made after the policy period for injury or damage that occurred before the end of the policy period but after the retroactive date under an extended reporting period or unlimited tail coverage.

The extended reporting period is an automatic tail period of 60 days and guarantees availability of an endorsement providing unlimited tail coverage. When no other insurance is applicable, the automatic tail is extended to five years for occurrences during the policy period reported before the end of the 60-day tail. Both the 60-day and five-year extended reporting periods apply only when no other insurance is applicable.

Unlimited tail coverage can be purchased by the policyholder at a premium of up to 200% of the original policy premium.

Spelling it out "will encourage" quicker settlement, she said. When an incident occurs that the insurer suspects will result in a claim, "we may go out and investigate right away."

The revised policy form also deletes endorsements that would have precluded the availability of unlimited tail coverage if the policyholder canceled the coverage and made it possible for an insurer to limit to a specific number of years the length of tail coverage purchased by the buyer.

Before Jan. 1, ISO says it also will file with insurance departments a separate submission to introduce

advisory factors for pricing tail coverage. The claims-made form now says only that the cost of the tail coverage cannot exceed 200% of the cost of the original policy.

Buyers and brokers have said the cost of the tail coverage instead should reflect the amount of coverage remaining under the policy's aggregate limits.

In addition, ISO plans to submit to regulators, on an informational basis, advisory language that could be used by insurers to inform their policyholders about the nature of the claims-made policy and to remind them of their option to purchase unlimited tail coverage. ■

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Third-quarter results offer more treats than tricks

By MYRON M. PICOULT
Special to Business Insurance

AS THIRD-QUARTER property/casualty underwriting and earnings reports begin to trickle in, the industry once again is recovering from its annual Halloween bash.

If the initial earnings releases are any criteria, it appears there were more treats than tricks this year. While this would appear to be a pleasant respite from the relatively recent quarterly patterns, it may be more apparent than real, as the quality of earnings continues to be forsaken for the quantity factor.

To begin with, some background on this year's industry Halloween party is in order. It was distinctly different from the gatherings of the past few years, mirroring a more upbeat perspective by industry participants.

Costumes once again were required for all those attending. The coordinators of the party strongly suggested costumes with broad shoulders and puffed-out chests, to provide the subliminal message: "We survived the six-year cycle."

The wearing of masks was not encouraged. It apparently was time for all players to show their real identities, as further evidence of the shift in industry psychology.

Bright colors also were in evidence. Black, a reminder of the not-too-distant past, gave way to lots of oranges and yellows.

This year the party was held indoors in a traditional room rather than outdoors. Apparently, industry leaders felt there were no more skeletons or cobwebs to be found.

Although capacity is tight, the steering committee did not perceive it as a major problem, and companies of all sizes were invited.

Also, all the jack-o-lanterns were smiling rather than frowning this year. And, black cats, witches and the like were ordered not to appear.

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts.



Mr. Picoult

All the traditional Halloween food was served, including pumpkin pie, candy corn and candied apples. Best of all, the food was served with real dishes instead of paper plates and plastic forks, underscoring a return of cash flow.

For entertainment, new games were introduced, including "Pin the Tail on the Commissioner" and "The Capacity Toss," which happened to abut the "Surplus Drain" game.

Another new game was called "Tax Scam," patterned after blackjack. And, the old standby, "Hit the Bell with the Hammer," was brought back to life, as players tested their strength to see who could ring up the "Best" rating.

For some unexplained reason, that old standby, "Bobbing for Earnings," was not played this year.

And, party-goers were treated to a short skit called "The Sting." Could it have been a takeoff on a con game?

After the party was over, though, some problems remained.

It is apparent that over the past year, investors have been entranced by the earnings recovery predicted for property/casualty insurance companies, particularly those with heavy exposure to commercial lines.

This fascination with the quantity of earnings has overshadowed attempts to assess the quality of both the income statement and the balance sheet.

We fervently believe that more attention should be directed toward quality factors, which will become increasingly important investment criteria for the stocks, not to mention rating perspectives for regulators and agents.

When we cite the quality of the income statement, we are referring to items that enhance earnings. Industry earnings are not coming from the underwriting side of the equation, but from investment income, aided by capital appreciation, pension plan recoveries, tax recoveries and the wizardry of some questionable reinsurance contracts. In many instances, the full impact of these factors still is not known.

Company financial statements allege that they portray an accurate picture of an insurer's financial condition. However, the picture seems to be distorted by accounting procedures for loss reserve transfers, bond sales with put options, recognition of true asset values, asset and liability matching, the quality of reinsurance contracts with an eye to-

ward recoverability, the quality of receivables, the recoverability of deferred acquisition expenses, reserve discounting methodologies employed and the accuracy of aggregate loss reserves, including loss adjustment expense reserves (BI, Oct. 7).

It would appear some refinement of existing procedures is long overdue. Earnings and balance sheet leverage are attractive attributes for property/casualty companies, as long as the base from which the prospective calculations are to be made is fairly accurate.

We think it is time for investors, regulatory authorities and rating agencies to "queue up" and recognize the differences between the quantity of earnings figures and the quality of both the income statement and the balance sheets for many of the major public companies.

Investors, agents, regulators and policyholders no longer can afford to permit the property/casualty industry's headless horseman to run amok!

Best's ratings

A.M. Best Co. says it will now review Best's ratings of property/casualty insurers on a quarterly basis.

The company this month published a list of rating changes and a "Ratings Watch" list of companies with significant adverse changes since year-end 1984 based on their June 30 financial statements.

Best says it will publish similar lists based on third-quarter results.

Corroon & Black

New York-based Corroon & Black Corp. has purchased 4 million shares of Lloyd's of London broker Minet Holdings P.L.C. With the purchase, Corroon & Black has increased its interest in Minet to 25.2% of ordinary share capital, up from 20%.

Corroon & Black says the additional shares were bought for investment purposes.

Transamerica Corp.

Transamerica Corp. has filed a shelf registration with the Securities and Exchange Commission for the proposed public offering of up to 750 shares of Dutch Auction Rate Transferrable Preferred Stock at \$100,000 a share. The offering is underwritten by Goldman, Sachs & Co. and Salomon Brothers.

Proceeds of the \$75 million offering will be used for Transamerica's property/casualty operations and to repay short-term debt, the company says.

Swiss Re

Swiss Reinsurance Co. has announced that its 1984 group earnings increased to 120 million Swiss francs (\$56 million), up 14.3% from 105 million francs (\$49 million) in 1983. Gross premium income in 1984 rose to 11.53 billion francs (\$5.38 billion), up 13.6% from 10.15 billion francs (\$4.74 billion) in 1983.

Increased underwriting profits from life insurance business more than offset a sharp increase in underwriting losses from casualty and other non-life business, the company said.

In addition, Swiss Re is proposing an increase in its non-voting shares to raise capital.

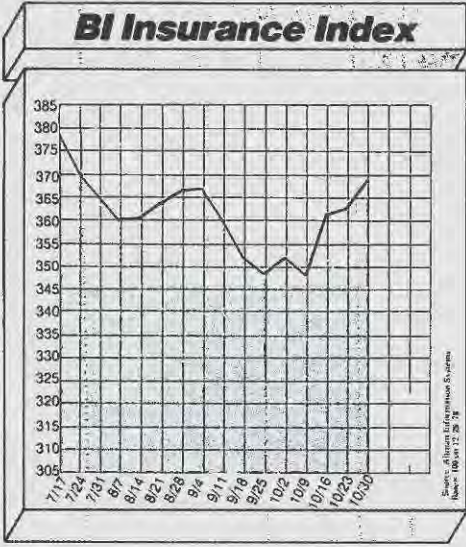
A program to raise its participation certificate (non-voting share) capital will be proposed to the company's annual general meeting on Nov. 22 in Geneva, Switzerland.

Capital will be initially increased by 5 million Swiss francs (\$2.32 million) by the issue of the remaining 100,000 shares approved by shareholders in 1980.

These shares will be offered on international markets. The issue price will be determined according to the market price at the time of issue.

Shareholders will also be asked Nov. 22 to approve the board's proposal to increase certificate capital (voting shares) by the issue of 270,000 shares.

Of these, 266,000 will be offered to existing shareholders. The issue price will be 750 francs (\$348).



The Business Insurance stock index continued its upward climb for the third consecutive week. The Business Insurance index closed at 369.2 points for the trading period ending Oct. 30, an increase of 6.3 points from 362.9 points on Oct. 23. Altogether, a total of 40 stocks posted gains, 13 stocks declined and five stocks were unchanged. The biggest gains for the week were posted by Poe & Associates Inc., up 12.1%; The Home Group Inc., up 11.7%; The Crump Cos. Inc., up 9.2%; Ohio Casualty Corp., up 7.3%; and Fireman's Fund Corp., up 6.8%. The biggest losses during the most recent trading period were posted by Frank B. Hall & Co. Inc., down 7.0%; American Indemnity Financial Corp., down 5.7%; Mission Insurance Group Inc., down 4.5%; SRI Corp., down 3.4%; and Kansas City Life Insurance Co., down 2.1%. The Business Insurance stock index increased 1.7% during the period, while the New York Stock Exchange composite gained 0.5%; the Standard & Poor's 500 index rose 0.5%; and the Dow Jones 30 Industrials index increased 0.6%.

British Issues

30 Oct Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence
Comm Union	249	N/M	16.9	6.8	254—248
Genl Accident	680	28.3	31.4	4.6	685—663
Gdn Royal Exch	705	61.3	38.6	5.5	710—693
Royal	718	89.8	35.0	4.9	723—712
Sun Alliance	500	N/M	23.6	4.7	502—490

Brokers	Price	P/E	Div.	Yield	1 Week High—Low
CE Heath	687	8.9	37.5	5.5	687—665
Hogg Robinson	283	11.8	14.3	5.0	284—280
JH Minet	233	10.6	11.4	4.9	234—230
Sedg Grp	373	14.9	17.8	4.8	375—372
Stew Wrightson	725	13.9	32.3	4.5	728—718
Willie Faber	753	19.3	23.6	3.1	753—740

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

BI Industry Stock Report

October 30, 1985 10/25/85 thru 10/30/85

Brokers	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol.(000)	Business Mens Assurn Co Amer	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	30.50	3.4	0.0	1.00	3.3	30.50	28.88	431.2	Chubb Corp	50.13	4.4	16.9	1.56	3.1	50.13	48.42	195.5
Baldwin & Lyons Inc	65.00	3.2	10.7	0.80	1.2	65.00	63.00	0.4	Combined Intl Corp	44.38	2.9	8.4	2.16	4.9	44.63	43.75	416.4
Corroon & Black Corp	50.00	1.0	0.3	1.00	2.0	50.13*	49.00	123.4	Continental Corp	43.25	1.5	21.2	2.60	6.0	43.25	42.25	475.4
Crump E H Cos Inc	17.75	9.2	19.1	0.25	1.4	18.00*	17.25	99.4	Crown Life Ins Co	215.00	0.0	13.0	0.00	0.0	215.00	215.00	0.0
Eaett & Chandler Cos Inc	14.00	1.8	35.3	0.00	0.0	14.00	13.75	4.1	Durham Corp	37.50	-1.0	6.9	1.28	3.4	38.00	37.50	0.3
Gallagher Arthur J & Co	42.25	-0.6	20.7	0.28	0.7	42.50	41.75	85.0	Farmer's Group Inc	65.00	2.4	10.8	1.76	2.8	65.00	61.75	327.9
Hall Frank B & Co Inc	26.50	-7.0	0.3	1.00	3.8	28.00	26.50	533.9	Fireman Fd Corp	29.63	0.0	0.0	0.30	1.0	29.63	29.25	3,312.9
Mazeh & McLennan Cos Inc	75.25	1.3	18.3	2.68	3.6	75.25*	73.75	171.9	Fresant Gen Corp	23.88	2.7	0.0	0.48	2.0	23.88	23.00	140.8
Poe & Assoc Inc	9.25	12.1	0.3	0.80	8.6	9.25*	8.50	5.6	Great West Life Assurn Co	450.00	0.0	11.6	1.60	0.4	450.00	450.00	0.0
AGENTS/BROKERS	AVERAGE		39.4		2.4				Home Group Inc	27.25	11.7	0.0	0.00	0.0	20.25*	18.63	1,664.7
									Hanover Ins Co	47.00	2.5	64.4	0.56	1.2	47.00	46.00	28.3
									Hartford Steam Boiler Insprtn	56.00	5.7	13.3	2.00	3.6	56.00*	53.00	22.2
									Kens City Life Ins	22.75	-2.2	9.0	0.87	3.8	23.00	22.50*	11.4
									Kemper Corp	56.25	0.4	16.2	1.80	3.2	56.25	55.13	165.2
									Liberty Corp S C	29.75	-0.8	13.1	0.72	2.4	29.88	29.50	35.8
									Lincoln Natl Corp Ind	44.88	1.7	10.8	1.84	4.1	44.88	43.88	74.9
									Mission Ins Group Inc	2.63	-4.3	0.0	0.00	0.0	2.75	2.63*	256.3
									Monumental Corp	32.88	1.9	12.0	1.40	4.3	33.13	32.75	20.0
									Nobel Ins Ltd	10.75	0.0	14.1	0.25	2.3	11.00	10.75	18.6
									Northwestern Natl Life Ins	22.75	2.2	3.9	0.80	3.5	22.88	22.63	415.5
									Ohio Cos Corp	65.88	7.3	22.2	2.80	4.3	65.88	62.75	176.1
									Old Rep Intl Corp	32.13	6.6	8.6	0.74	2.3	32.13	30.63	99.8
									Orion Cap Corp	27.25	5.3	0.0	0.76	2.8	27.25	25.63	66.7
									Practactive Corp	20.00	-0.6	7.4	0.66	3.3	20.00	19.00	85.7
									Provident Life & Acc Ins Co	24.50	1.0	6.6	0.76	3.1	24.50	24.13	57.7
									St Paul Cos Inc	73.38	3.3	0.0	3.00	4.1	73.38	71.00	272.8
									SAFECO Corp	43.63	5.8	15.5	1.60	3.7	43.63	41.25	277.9
									Sri Corp	17.50	-3.4	51.5	0.80	4.6	18.25	17.50	105.2
									Selbels Bruce Group Inc	21.00	3.7	0.0	0.80	3.8	21.00	20.25	222.9
									Statesman Group Inc	4.00	0.0	0.0	0.15	3.8	4.13	4.00	33.7
									Tokio Marine & Fire Ins Co	224.25	2.7	42.2	1.03	0.3	224.25	207.25	17.7
									Torchmark Corp	22.88	1.1	9.0	0.60	2.6	22.88	22.25	538.7
									Travelers Corp	44.75	0.6	10.9	2.04	4.6	44.75	43.75	2,330.3
									United Fire & Cas Co	24.00	2.1	20.9	1.20	5.0	24.00	23.50	1.6
									United States Fld & Cty Co	36.25	-0.3	151.0	2.20	6.1	36.63	36.00	892.8
									UsLife Corp	38.00	1.3	8.5	1.12	2.9	38.00	36.13	395.6
									Washington Natl Corp	24.88	-0.5	7.2	1.08	4.3	24.88	24.63	39.7
									Zenith Natl Ins Corp	21.75	2.4	0.0	0.68	3.1	21.75*	21.25	105.9
									INSURANCE COMPANIES	AVERAGE				18.7			2.2

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