NOVEMBER 7, 1988

# Business Insurance®

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**Update**

## Texas commissioner steps down pending investigation of agency

AUSTIN, Texas—Insurance Commissioner Doyce Lee is stepping down until an investigation into the Texas State Board of Insurance is completed.

Some Texas legislators have called for Mr. Lee's resignation because of the board's handling of the insolvency of Dallas-based National County Mutual Fire Insurance Co.

The agency late last month found that the insurer was insolvent by about $54 million, making it the largest failure of a

*Continued on next page*

**Nine-month 1988 broker results**
**(In thousands of dollars)**

| Broker | Gross revenues | % change | Net income | % change |
|---|---|---|---|---|
| Marsh & McLennan | $1,728,000 | 5.8% | $245,700 | -1.5% |
| Alexander & Alexander | 857,300 | 2.4 | 53,100 | -8.0 |
| Corroon & Black | 318,265 | 5.6 | 107,900[1] | 182.9 |
| Arthur J. Gallagher | 117,870 | 8.8 | 13,636 | -1.1 |
| Hilb, Rogal & Hamilton | 32,147 | 17.6 | 3,500 | 35.8 |
| Poe & Associates | 27,193 | 13.0 | 3,725 | 95.7 |

[1] Includes non-recurring gain from sale of investment in Minet Holdings P.L.C.

# Insurer competition stunts broker growth in third quarter

By LINDA J. COLLINS

Competition among property/casualty insurers continued to siphon growth from the publicly held insurance brokers in the third quarter.

And, brokers and securities analysts are not optimistic that any stabilization in rates will occur within the next few months.

"We're not seeing any change with respect to rates. It's more of the same in terms of rate decreases," said Frank R. Wieczynski, corporate secretary for Alexander & Alexander Services Inc. in Baltimore.

"We have been in a very competitive rating environment this year —probably about 12% to 15% (rate reductions) on a year-to-year basis—and we don't see any abatement in that," agreed J. Michael Bischoff, vp-corporate development group for Marsh & McLennan Cos. Inc. in New York.

*Continued on page 56*

# Texas antitrust lawsuit poses unique concerns

By MICHAEL BRADFORD

AUSTIN, Texas—The antitrust suit filed against property/casualty insurance industry defendants in a Texas state court may pose a tougher challenge to the industry than the consolidated antitrust suits pending in federal court, legal observers say.

It is more likely, for example, that a Texas jury will harbor disdain for companies based in the northern states, observers suggest.

In addition, although the litigation in U.S. District Court in San Francisco and the suit in the Travis County District Court in Austin are similar, the Texas complaint contains broader allegations of wrongdoing, legal observers point out.

**'The Texas case might provide more problems and difficulties than the federal case,' says Eugene Pavalon, immediate past president of ATLA.**

The Texas case also charges that the defendants violated state antitrust law, from which insurers do not enjoy the same limited immunity as from federal antitrust statutes under the McCarran-Ferguson Act.

And, while the monetary penalties sought in both the federal and the Texas litigation are comparable, the Texas suit additionally seeks to prevent the Insurance Services Office Inc. from operating in the state, which insurers contend would harm consumers as well as the industry.

Many observers also predict that neither court will influence each other's decision.

But, the defendants in the Texas litigation see a glimmer of hope in their continuing efforts to have the case removed from the jurisdiction of the state court: The presiding judge says he will hear arguments by defendants on granting the Texas State Board of Insurance primary jurisdiction in determining whether the defendants violated state insurance regulations.

The Texas suit was filed by Texas Attorney General Jim Mattox in March, at the same time the first wave of federal litigation was filed (*BI*, March 28).

In the federal litigation, suits filed by 18 state attorneys general in late August were consolidated with at least 20 nearly identical suits originally filed on behalf of private entities in federal courts across the country.

California Assistant Attorney General Jesse Markham said that any future federal suits filed against the insurance industry defendants also would be consolidated into the existing litigation.

Defendants named in both the Texas and the federal litigation include: ISO; Aetna Casualty & Surety Co.; CIGNA Corp.; Hartford Fire Insurance Co.; the Reinsurance Assn. of America; and Lloyd's of London underwriter Robin A.G. Jackson.

The Texas suit also names Lloyd's non-marine syndicate 799, managed by Merrett Underwriting Agencies Management Ltd. and underwritten by Mr. Jackson. The federal suit names the Merrett agency but not the syndicate.

Also named in the Texas suit but not in the federal court suit are Liberty Mutual Insurance Co., The Travelers Insurance Co., USF&G Corp., Fireman's Fund Insurance Cos. and St. Paul Fire & Marine Insurance Co.

Defendants named in both the Texas and California litigation are not saying publicly whether one case or forum concerns them more than the other. But legal observers point out several differences between the

*Continued on page 58*

# 49% of uninsured Americans are employed

By DAVE LENCKUS and LAURA MALT

Workers and their dependents largely account for the growing number of Americans without health insurance, despite economic growth over the past several years, according to the Employee Benefit Research Institute.

The growth of the retail trade and the personal service industries—which traditionally offer fewer health benefits than other industries—mainly has fueled the increase in the number of uninsured Americans during the economic expansion that began in 1983, according to EBRI, a Washington-based employee benefits think tank.

At the other end of the spectrum, nearly all employees in the public sector and the finance, insurance and real estate industry have employer-provided health insurance, according to a just-released EBRI study.

In addition, few workers in the manufacturing and mining industries are without health insurance, the study shows.

However, nearly 88%, or 32.7 million, of the 37 million Americans without health insurance are employed or are dependents of workers, according to the study.

The number of workers without health insurance increased 24.8% to 18.1 million, or 48.8% of the uninsured population, in 1986, compared with 14.5 million, or 44% of the uninsured, at year-end 1982, according to EBRI.

In addition, another 8.2 million, or 22% of the uninsured, lived in families of workers who were unemployed for one or more weeks, while 6.5 million, or about 18%, of the uninsured lived in families in which the family head was either a seasonal or part-time worker.

Only 4.4 million uninsured Americans, or 12% of the uninsured, lived in families in which no member worked, according to the study.

"This should be saying to employers that the uninsured population rests squarely in their court," said Deborah Chollet, a senior research associate for EBRI and the author of the study, "Uninsured in the United States: The Non-elderly Population without Health Insurance, 1986."

According to EBRI figures, the number of uninsured Americans at year-end 1986 reached 37 million, a 12.1% increase from 33 million uninsured Americans in 1982, before the latest economic recovery began.

The percentage of Americans without health benefits increased to 17.8% of the 208 million non-elderly Americans in 1986, up from 15.6% of the non-elderly population in 1982, according to EBRI.

*Continued on page 63*




**Congressional actions may aid Bermuda captives**
**Page 2**

**Risk management congress explores leisure-time risks**
**Page 3**

**Chubb, farmers' attorneys seek drought cover settlement**
**Page 3**

## Update

### Texas regulator steps down

*Continued from previous page*

Texas property/casualty insurance company. The insurer wrote about $100 million in premiums in 1987, mostly personal automobile coverages.

Critics charge that Mr. Lee and the board did not act soon enough to place National County Mutual Fire into receivership.

Mr. Lee and the three-member board "mutually agreed" that Mr. Lee would temporarily step down while an investigation into the board's operations is conducted, a board spokesman said. It has not been determined who will conduct the investigation, he said.

The spokesman said the investigation will center on:

- Whether there was a breakdown in regulatory oversight of National County Mutual.
- Questions raised by legislators about the overall effectiveness of the state's regulation of insurers and whether proper steps are taken when a company is known to be in financial trouble.
- Whether Mr. Lee has properly managed the agency.

"Assuming nothing is found to merit his resignation or dismissal, (Mr. Lee) apparently will come back," the spokesman said.

### Miles to appeal AIDS award

ATLANTA—Miles Laboratories Inc. says it will appeal a $1.6 million U.S. District Court jury award to a hemophiliac who contracted acquired immune deficiency syndrome from a blood product the pharmaceutical company manufactured.

Randy J. Jones of Douglasville, Ga., contended he contracted AIDS after using Koate, a blood-based clotting product manufactured by Elkhart, Ind.-based Miles Laboratories.

The company received the plasma used in the Koate product from a Texas blood bank that allowed an AIDS-contaminated man to donate blood, according to Mr. Jones.

A Miles Laboratories spokesman would not comment on whether the award is insured.

Blood banks did not begin testing their products for AIDS contamination until 1985. Because of the delay between the time when the AIDS virus first became evident in 1978 and the time that testing began in 1985, it is estimated that there are 1,000 people, like Mr. Jones, who received transfusions during this period and have since developed AIDS (*BI*, Jan. 25).

### Missouri health pools favored

JEFFERSON CITY, Mo.—Missouri voters favor a ballot proposition that calls for establishing three health care pools funded in part by taxes on employers that offer minimal health care plans, several polls indicate.

Constitutional Amendment 8, the Missouri Health Care Trust Fund, or MedAssist, would establish three health care pools:

- A plan for low-income residents, whose premium payments would be subsidized.
- A pool offering partial payment for catastrophic illness costs incurred by insured and uninsured state residents.
- A high-risk pool for residents who cannot find health care coverage.

MedAssist also would extend Medicaid coverage to certain individuals who currently are ineligible for the coverage.

The pools would be funded through: a 0.6% tax on the net income of Missouri-based for-profit businesses; a 0.6% tax on workers' gross earnings; premiums, copayments and/or deductibles assumed by participants; and federal government funding.

The plan is expected to generate about $511 million of funding annually: more than $286 million from taxes; $60 million-$65 million from premiums; and about $160 million in federal Medicaid matching funds.

However, since employers would be able to offset most or all of their new tax liability by offering comprehensive health care plans to employees, the proposition likely would cost Missouri employers only about $20 million annually, said a spokeswoman for the Missouri Hospital Assn. in Jefferson City.

The association estimates that the plan would provide health insurance to more than 440,000 uninsured state residents.

### Eagle-Picher boosts reserves

CINCINNATI—Eagle-Picher Industries Inc. has increased by $554 million its reserves for asbestos claims. The move reduced shareholder equity by $499 million, effectively wiping out the net worth of the company on its balance sheet.

However, Eagle-Picher says the company remains solvent.

Eagle-Picher now has a total of $613 million, including available insurance, to pay an ever-increasing number of asbestos bodily injury claims. In 1987 alone, some 20,800 asbestos claims were filed against Eagle-Picher, which is a former member of the now-defunct Asbestos Claims Facility. The company predicts that by year-end, total expenses since 1985 due to asbestos litigation will exceed $280 million.

### PRMC seeks court confirmation

LOS ANGELES—Attorneys for Pacific Reinsurance Management Corp.—the defunct reinsurance pooling subsidiary of Los Angeles-based Mission Insurance Group—are seeking court confirmation of an arbitration panel's decision that six reinsurers must pay Mission almost $94 million, including interest.

The U.S. District Court for the Central District of California is scheduled to review the panel's award on Nov. 21.

Arbitrator William J. Gilmartin Jr. and umpire William C. McIlwain Jr. on Oct. 19 and Oct. 25, respectively, signed the final award ordering the reinsurers to pay an estimated $12 million immediately and post the remainder in letters of credit or other securities (*BI*, Oct. 17).

*Continued on page 61*

# Insurers cite new state law to deny cleanup coverage

**By STACY ADLER**

SAN BRUNO, Calif.—Insurers writing liability insurance for California policyholders maintain that they do not have to cover the cost of government-mandated hazardous waste site cleanups under a new state statute.

However, the California attorney general's office, which supported the new statute, says insurers are misinterpreting the law.

The new law, part of the California Insurance Code, says: "No policy of insurance shall provide, or be construed to provide, any coverage or indemnity for the payment of any fine, penalty or restitution in any civil or criminal action or proceeding. . . ."

A group of London insurers is now arguing before the California Court of Appeals that government-mandated cleanups of hazardous waste sites are a form of restitution and therefore are not insurable under this statute.

The insurers presented this argument in the latest round of litigation between La Jolla, Calif.-based Aerojet-General Corp. and 55 of its general liability insurers from 1956 to 1934.

The appellate court decision will be the first California appeals court ruling on whether government-mandated hazardous waste cleanups are insurable.

And, that decision could influence the massive Shell Oil Co. litigation and other hazardous-waste coverage disputes nationwide.

Shell is suing more than 260 of its comprehensive general liability insurers for the costs of cleaning up two hazardous waste sites—one in California and the other in Colorado. The estimated cost of cleaning up the sites is $2 billion (*BI*, Aug. 1; May 30; May 2).

San Mateo County Superior Court Judge John J. Bible ruled May 25 that the costs incurred by Aerojet in complying with government orders to purify the groundwater beneath its Sacramento, Calif., plant are equitable or restitutionary in nature and therefore are not covered by CGL policies (*BI*, June 13).

Aerojet subsequently appealed the ruling to the California appellate court.

At the heart of the insurers' argument is that government orders to clean up a polluted site are a form a restitution, because the polluter is being forced to restore the land to its original condition. Insurers maintain that costs that are restitutionary or equitable in nature are not insurable under CGL policies. They maintain that only damages awarded by a court are covered under the CGL policies.

However, policyholders maintain that the distinction insurers are trying to make between policyholders' costs under a government order to clean up a hazardous waste site and damages awarded by a court is creative lawyering. Policyholders contend that costs incurred under the Comprehensive Environmental Response, Compensation & Liability Act—better known as the Superfund Act—are insurable.

To date, a majority of the courts nationwide that have heard the issue have sided with policyholders and found that government-mandated cleanup costs are

*Continued on page 10*

## *BI* unveils new forum for opinions

A new feature appearing in this week's edition of *Business Insurance* gives risk managers and employee benefit managers a chance to share their personal opinions on controversial risk and benefit management topics with their peers.

At Issue, which is compiled by Editorial Assistant Christine Woolsey, will contact risk managers and benefit managers around the country for their thoughts on questions ranging from legislative issues to the shape of the insurance market.

The premiere At Issue column, which appears on page 10, asks a group of benefit managers whether employees should be taxed on employer-provided health care benefits.

# Tax laws may help Bermuda captives

**By DOUGLAS McLEOD**

WASHINGTON—Some offshore captive insurers could receive significant tax benefits under provisions of the technical corrections act approved by Congress and the Bermuda tax treaty ratified by the Senate.

One section of the technical corrections act will allow controlled foreign corporations in the insurance business to choose to be treated as U.S. corporations for tax purposes.

The provision effectively will lift the threat of triple taxation from certain offshore insurers.

While the Tax Reform Act of 1986 could have imposed three separate taxes on captive income in some cases, the technical corrections act would allow the captives to pay only U.S. income tax while allowing U.S. owners a deduction previously unavailable under tax reform.

However, captive and tax experts are uncertain about how many captives will avail themselves of this "domestication election," with some experts predicting relatively few captives will choose to be taxed as U.S. companies.

Meanwhile, the Bermuda tax treaty eliminates federal excise taxes on premiums paid to Bermuda insurers and reinsurers, including captives, putting the domicile on an equal footing with Barbados, which has enjoyed the same exemption since 1986 (*BI*, Oct. 17).

However, the technical corrections bill will end the excise tax exemptions for both Bermuda and Barbados as of Dec. 31, 1989.

In addition, the excise tax exemption for Bermuda insurers applies only to controlled foreign corporations and is retroactive to either Jan. 1, 1986, or the date on which the Bermuda insurer first was deemed a controlled

*Continued on page 61*

## Inside


- Chubb Corp. is offering to settle a class-action suit on behalf of farmers in 10 states stemming from the insurer's drought coverage, a plaintiffs' attorney says. **PAGE 4**
- Employers and benefit lobbyists must share some of the blame for the onerous Section 89 regulations, says this week's editorial. **PAGE 8**
- A proposed settlement between the Federal Deposit Insurance Corp. and insurers of Continental Illinois Corp. would allow the FDIC to recover about $60 million from Continental's D&O insurers. **PAGE 11**
- The world of employee benefits will change radically in the next two decades, benefit experts say at the Seventh Annual Employee Benefits Symposium sponsored by the International Society of Certified Employee Benefit Specialists. **PAGE 14**
- Any method of reserve analysis is only as good as the underlying assumptions on which it is based, says Richard E. Sherman of Coopers & Lybrand in Ask a Casualty Actuary. **PAGE 35**
- Despite recent changes in Italy's social security scheme, most Italians are waiting for a much-promised overhaul of their country's social security program, says Jerome Karter of Johnson & Higgins in International Issues. **PAGE 36**
- Globalization and specialization will be among the keys to success for large insurance brokers in the 1990s, a brokerage executive says. **PAGE 54**
- Balboa Insurance Co. plans to fight an attempt by Massachusetts to fine the insurer $1 million and bar it from doing business in the state for five years. **PAGE 55**


### Departments


Ask a casualty actuary ..... 35
At issue ..... 10
Benefit beat ..... 6
Bermuda ..... 12
Classifieds ..... 58
Insurance services guide ..... 62
International issues ..... 36
Letters ..... 8
Opinions ..... 8
Perspectives ..... 35
Ticker ..... 63


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# The risks of recreation

## Safety sleuths document risks in theme parks

**By STACY SHAPIRO**

BRISBANE, Australia—Managing amusement park risks is serious business, a group of risk managers learned after posing as safety inspectors for a day at Australia's two biggest theme parks.

The daylong "field trip" to Sea World and Dreamworld helped illustrate the theme of the First World Congress on Risk & Insurance Management, "Leisure in the Age of Technology," while also giving risk managers an opportunity to exercise their skills.

Hopping on various amusement park rides to test their safety and roaming the parks to check faulty footpaths were just two of the many "onerous" tasks assigned to the risk managers who participated in the park inspections.

Afterward, the risk managers were invited to pass their reports onto the management of the two parks.

Among the risks uncovered by the safety sleuths:

- Seemingly harmless bumper cars can cause whiplash.
- Pregnant women can become ill if they ride the roller coasters that whiz passengers around 360-degree loops.

*Continued on page 22*




Photo: Kathryn J. McIntyre

***Risk takers***

**Participants at the First World Congress on Risk & Insurance Management studied leisure-time risks from all angles, including upside-down aboard the Corkscrew roller coaster at Australia's Sea World. The congress, sponsored by the International Federation of Risk & Insurance Management Assns., also examined many other risk management matters. See stories beginning on page 27.**

## Leisure industry poses own kind of business risks

**By KATHRYN J. McINTYRE**

BRISBANE, Australia—Risk management challenges for the leisure industry are similar to those in other commercial pursuits but do hold their own characteristics, according to a broker and an underwriter.

"The leisure industry is intertwined with exposures to the same risks of loss as any other," said William Wilson, chairman, president and chief executive officer of Alexander & Alexander International Inc. and executive vp of its parent company, Alexander & Alexander Services Inc. of New York.

IFRIMA Brisbane

The leisure industry "encompasses services such as travel and entertainment agencies and tour operators. It includes activities that involve massive investment in physical plant and equipment but where no durable, tangible goods are manufaetured," he explained.

"It also includes classic manufacturing operations, such as the production of skateboards, all-terrain motorcycles, yachts,

*Continued on page 19*

## Air crash victims' survivors not paid full loss: Study

**By ALISON KITTRELL**

The survivors of people killed in airline disasters receive compensation equal to less than half of their actual economic losses, according to the results of a 3½-year study recently released by The Rand Corp.'s Institute for Civil Justice.

Airlines and other defendants—or their insurers—paid the survivors of airline crash victims only an average of $363,680 per death, or 48.6% of actual economic losses of $748,777 per death, concludes the five-volume study by the Santa Monica, Calif.-based Rand.

About one-third of the $363,680 paid to survivors represented awards for pain and suffering and other non-economic damages. "As a result," Rand says, "average compensation for economic loss alone was approximately 31 cents on the dollar."

This means that the current system of compensating victims of airline disasters does not meet the two major objectives of the U.S. tort system: To deter harmful behavior and to ensure that injured parties are compensated adequately and fairly for their losses, the study authors say.

However, the Washington-based American Torn Reform Assn. disputes the results of the study, which examined 2,198 fatalities involving airline passengers and people on the ground in 25 major

*Continued on page 61*

## Insurers must base rates on costs, ISO chief says

**By MEG FLETCHER**

CHICAGO—Property/casualty insurers should stress cost-based pricing rather than cash-flow underwriting, especially now that insurers' recovery is waning, says the president of the Insurance Services Office Inc.

"Experience has shown us—sadly—that company reliance on investment success is not a 'Yellow Brick Road' to the land of healthy insurer financial operations," ISO President Fred R. Marcon told the Chicago Union League Club's Insurance Group at an Oct. 27 luncheon meeting.

"Over the long haul, it's underwriting results, not investment results, that determine whether companies have operating income or operating losses," Mr. Marcon said.

As the commercial property/casualty insurance market softens and insurers are tempted to depart from cost-based pricing, executives should keep in mind their own admonitions that they would not allow "short-sighted pricing strategies to undermine market stability," he said.

Property/casualty insurers paid "a very high price" for the rapid, wrenching hard market of the mid-1980s, including diminished goodwill from the public at large, enactment of "onerous" data-reporting laws in 27 states and pressure to remove insurers' limited exemption from antitrust laws.

Another binge of cash-flow underwriting could bring on a huge crackdown on the industry, a transfer of significant business from the private sector and substantial controls on remaining business, he said, echoing comments that Edward J. Noha, chairman, president and chief executive officer of CNA Financial Corp., made to the Arizona Independent Insurance Agents of America in September.



Mr. Marcon

"This underwriting cycle clearly has not lasted as long as other recent recoveries," Mr. Marcon said.

"The old rule of thumb was that the industry would have three years of improving combined ratios followed by three years of deteriorating combined ratios. But in the most recent down cycle, the combined ratio got steadily worse for seven straight years," he said.

"And, now, instead of the extended recovery we

*Continued on page 53*

# Most HMO enrollees satisfied: Survey

**By DONNA DiBLASE**

WASHINGTON—Most employees enrolled in health maintenance organizations are very satisfied with the cost and quality of the services delivered, a new survey shows.

Most of the Washington, D.C.-area employees surveyed said they planned to re-enroll in their present HMOs, according to the National Capital Area Health Care Coalition 1988 HMO Survey, conducted over the summer by The Wyatt Co.

And, more than a quarter said they have had no problems with their HMOs.

However, most of the people who do withdraw from an HMO do so because they are not satisfied with the quality of care, the survey also shows.

"Employees seem to have bought into the concept" of HMOs and managed care, summed up Dindy Weinstein, executive director of the coalition.

"I think there are two particularly impressive findings in this survey. One is that people are joining HMOs for reasons of cost and the comprehensive scope of benefits covered. But, the reason people disenrolled (from HMOs) was because of a negative perception of the quality of care" delivered by the HMO, observed Gino A. Nalli, a consultant in the Washington office of The Wyatt Co.

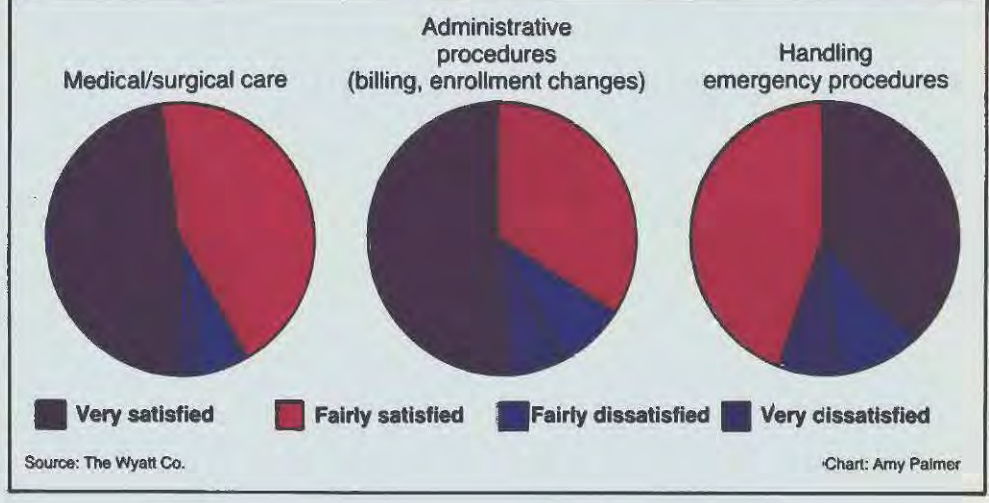
The National Capital Area Health Care Coalition comprises 25 major employers in the Washington, D.C., area, including large banking organizations like First American Bankshares Inc., utilities like Potomac Electric Power Co. and publishing firms like The Washington Post Co.

Nineteen of the coalition's members surveyed a total of 12,000 of their employees enrolled in HMOs; 6,000 responses were received. However, the survey did not include employees who had been enrolled in HMOs but then switched back to their employer's indemnity plan.

Along with finding out how employees feel

*Continued on page 57*

**Employees' satisfaction with HMO services**




Source: The Wyatt Co.

Chart: Amy Palmer

# Chubb, farmers' attorneys seek settlement

By LAURA MAZZUCA

CINCINNATI—Chubb Corp. is offering to pay $43.5 million to settle a class-action suit on behalf of farmers in 10 Midwestern states stemming from the insurer's failure to bind some $400 million in drought coverage sold by its agents, a plaintiffs' attorney says.

Under the terms of the offer, made late Thursday in U.S. District Court in Cincinnati, Chubb would make payments to farmers who applied for—but did not receive—the coverage whose drought-related losses exceeded the premium and an earlier goodwill payment made to farmers by Chubb, said Michael J. Freed, an attorney with Much, Shelist, Freed, Deneberg, Ament & Elger P.C. in Chicago.

Mr. Freed serves on the plaintiffs' lead counsel committee in the class action.

Any goodwill payments received by the farmers would be deducted from any individual reimbursement, he added.

A Chubb spokeswoman Friday would only say that Chubb indicated its "willingness to reach a settlement." She would not confirm how much Chubb is willing to pay to settle the litigation.

At the Thursday hearing, U.S District Judge Carl B. Rubin, who is presiding over the class action informally instructed the parties to expedite negotiations, Mr. Freed said.

"Ideally, it would be a Christmas present," Mr. Freed added.

The drought insurance controversy arose in July, when Chubb—which marketed the drought insurance last spring through underwriting manager Good Weather International Corp. of Jericho, N.Y.—announced it could not meet the overwhelming demand for the coverage. Chubb contends it authorized Good Weather to only bind applications for coverage totaling $30 million in premium volume (*BI*, July 18).

Chubb later spent $11 million on "goodwill" payments to farmers who applied before the deadline for applications but were denied coverage. Chubb took a $20 million charge in the second quarter and a $6.6 million charge in the third quarter because of the drought insurance policies.

The offer to settle the federal court litigation was described by several observers as an extension of an earlier settlement Chubb negotiated in Minnesota to include farmers in all 10 states.

However, a settlement in the federal court class action would negate the $5.2 million settlement negotiated by Chubb and the Minnesota Department of Commerce to settle a class-action lawsuit filed in a Minnesota state court by Minnesota farmers.

Judge Rubin instructed Chubb to delay finalization of the Minnesota settlement, pending negotiations in the federal litigation, according to Mr. Freed.

As a result, Minnesota Commerce Commissioner Michael A. Hatch has stated that the Minnesota attorney general's office is investigating filing suit against plaintiffs' attorneys for the federal class for interfering in the state class action settlement.

The Chubb offer in the federal litigation also places in limbo an offer it made in Indiana to reimburse all Indiana farmers who applied for the drought coverage as if the coverage were bound. The Indiana offer must be approved by Judge Rubin, explained Leonard P. Weinstein, deputy commissioner for the Company Services Division of the Indiana Insurance Department in Indianapolis.

Mr. Weinstein added that regulatory charges are still pending against Chubb in the state, with hearings scheduled for Dec. 13-15.

At least three other states—Illinois, Iowa and Ohio—plan to proceed with regulatory hearings concerning the marketing of the drought insurance next month. Penalties sought against Chubb could include revocation of its licenses.

"There are regulatory issues that aren't issues" in the class-action litigation, said Richard W. Carlson, assistant director of the Illinois Department of Insurance.

But Chubb and plaintiffs' attorneys "recognize that they need to get the regulators involved in the settlement as well," he said, adding that Illinois Insurance Director John Washburn is hoping to meet today with representatives from Chubb, plaintiffs' attorneys and regulators from other states to discuss the negotiations.

Under the settlement approved late last month in Minnesota, more than 770 Minnesota farmers may be eligible for payments.

In addition, the agreement settles administrative actions by the Minnesota Department of Commerce against Federal Insurance Co., the Chubb unit that wrote the controversial polices.

Chubb had previously announced that it issued 228 policies in Minnesota providing coverage with limits totaling $8.7 million. Incurred losses on these policies amounted to $2.7 million.

In addition, Chubb already made 773 goodwill payments totaling $1.4 million to Minnesota policyholders (*BI*, Aug. 8).

The Minnesota settlement was granted preliminary approval Oct. 28 by Steele County District Judge Frederick Hough.

Settlement negotiations proceeded smoothly in Minnesota, said Alan Gilbert, assistant Minnesota attorney general.

Although the state and Chubb had been in regular contact since the controversy arose, "negotiations got very serious just before" an administrative hearing on the drought insurance controversy set for Oct. 31, said Mr. Gilbert.

Under the settlement, Chubb also agreed to pay a $50,000 civil penalty, plus an additional $50,000 to cover expenses incurred by the Minnesota Commerce Department.

Although protection of Chubb's license in Minnesota was "definitely a motivating factor" in the insurer's eagerness to settle, the farmers affected by the lack of coverage seem content with the settlement, said Mr. Gilbert. "Farmers are very happy with the resolution here in Minnesota," he commented.

However, Chubb's "attempted shortcut" through the Minnesota settlement is an example of the insurer protecting itself against regulatory problems rather than concern for consumers, plaintiffs' attorney Stanley M. Chesley said early last week before the offer was made in the federal class action.

Mr. Chesley is an attorney with Waite, Schneider, Bayless & Chesley Co. in Cincinnati, one of the law firms representing members of the national class action. ■


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# A&A implements AIDS awareness policy

By GLENN HUNTLEY

Employees of Alexander & Alexander Services Inc. who refuse to work with AIDS-infected co-workers may be subject to disciplinary action, including termination, under an AIDS policy implemented recently at the insurance brokerage.

The specific rule about cooperation in the workplace is just part of an overall policy intended to foster compassion and support for employees who have acquired immune deficiency syndrome, according to James F. Murphy, managing vp in A&A's Los Angeles office.

The policy, which also calls for providing AIDS information and education, applies to A&A's 8,000 employees throughout the United States, he said.

The document states: "It is the policy of Alexander & Alexander to treat employees with AIDS and AIDS-related diseases the same as those with any other chronic or life-threatening illness."

It also reminds employees that they are not at risk by working with someone who has AIDS.

"This policy was developed in response to overwhelming medical evidence that AIDS is not spread by casual contact and does not represent a threat in the workplace," the document states.

While discipline for those who refuse to work with others infected by the AIDS virus could extend to firing, it's more likely that such employees would be moved or reassigned to other duties, Mr. Murphy pointed out.

A policy specific to AIDS was developed out of concern that ignorance about the disease and prejudice against its victims could interfere with a productive work environment, he said.

One of the administrative guidelines calls for the company to provide information and education about AIDS for employees.

At the company's West Coast offices, the American Red Cross has been invited to provide the AIDS education programs, Mr. Murphy said.

The policy also sets out other administrative guidelines:

- Extending all applicable employee benefits to AIDS victims.
- Avoiding applicant and employee testing for the AIDS virus.
- Refering employees with AIDS and their dependents to available community support resources.
- Maintaining confidentiality for all employees, including those with AIDS.
- Accommodating employees with AIDS in terms of schedules, workloads, etc., where reasonable with the needs of the business unit and consistent with treatment of other employees with special needs.

"I don't think this is anything other than a realistic approach to something that is very real," Mr. Murphy said.

Though conceding he "wouldn't be surprised by negative feedback," Mr. Murphy said he has not heard any complaints about the policy in the first month it has been in effect.

## Benefit beat

### Stock plan

Lifetime Corp., a leading provider of health care personnel, is offering employees an opportunity to purchase company stock at a discount.

The Boston-based company is offering the stock purchase plan to encourage employees to become more involved in the company and to help retain trained personnel, Lifetime officials said.

"We are very enthusiastic about this program. It rewards loyalty and strengthens commitment among our nurses.

"We think it has important social implications as well, given the continuing national nursing shortage," explained Lifetime Chief Executive Officer Anthony Reeves.

The plan is expected to improve the company's recruitment and retention of both temporary and permanent employees.

The company's major operating division, Kimberly Quality Care, operates 336 home health care and institutional staffing offices throughout the United States and Canada.

The plan allows employees to buy stock at 10% below the current price without paying broker fees, Ms. Brown said.

Employees must have worked for Kimberly Quality Care or Meditest, the company's insurance examination unit, for at least 12 weeks and generally work more than 20 hours a week to be eligible to buy the discounted shares.

The employee stock purchases will be available Jan. 1. Employees will pay for the shares through voluntary payroll deductions. They can designate from 1% to 10% of gross pay during any four-week pay period for stock purchases. Because enrollment in the plan began just last week, the company does not know how many employees will participate, Ms. Brown said.

Lifetime stock, which trades on the American Stock Exchange, has been selling for about $4 per share in recent weeks, she said. It closed at $3.50 per share on Oct. 31.

The plan differs from the more common employee stock ownership plan because it is entirely voluntary and employees buy the shares rather than receive them as additional compensation, Ms. Brown said.

Lifetime will buy the shares at the current price when employees elect to purchase them and then sell them to employees at a 10% discount, she said.

Lifetime has about 25,000 employees, including registered nurses, licensed practical nurses and therapists, who work on a temporary basis at health care facilities and for individuals.

However, over the course of a year the company employs as many as 60,000 people.

The stock program is "unprecedented" because it allows part-time and many temporary employees to participate, said Susie Brown, industrial relations manager.

•

*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 Glenn Huntley, Business Insurance, 6404 Wilshire Blvd., Los Angeles, Calif. 90048, 213-651-3710.*


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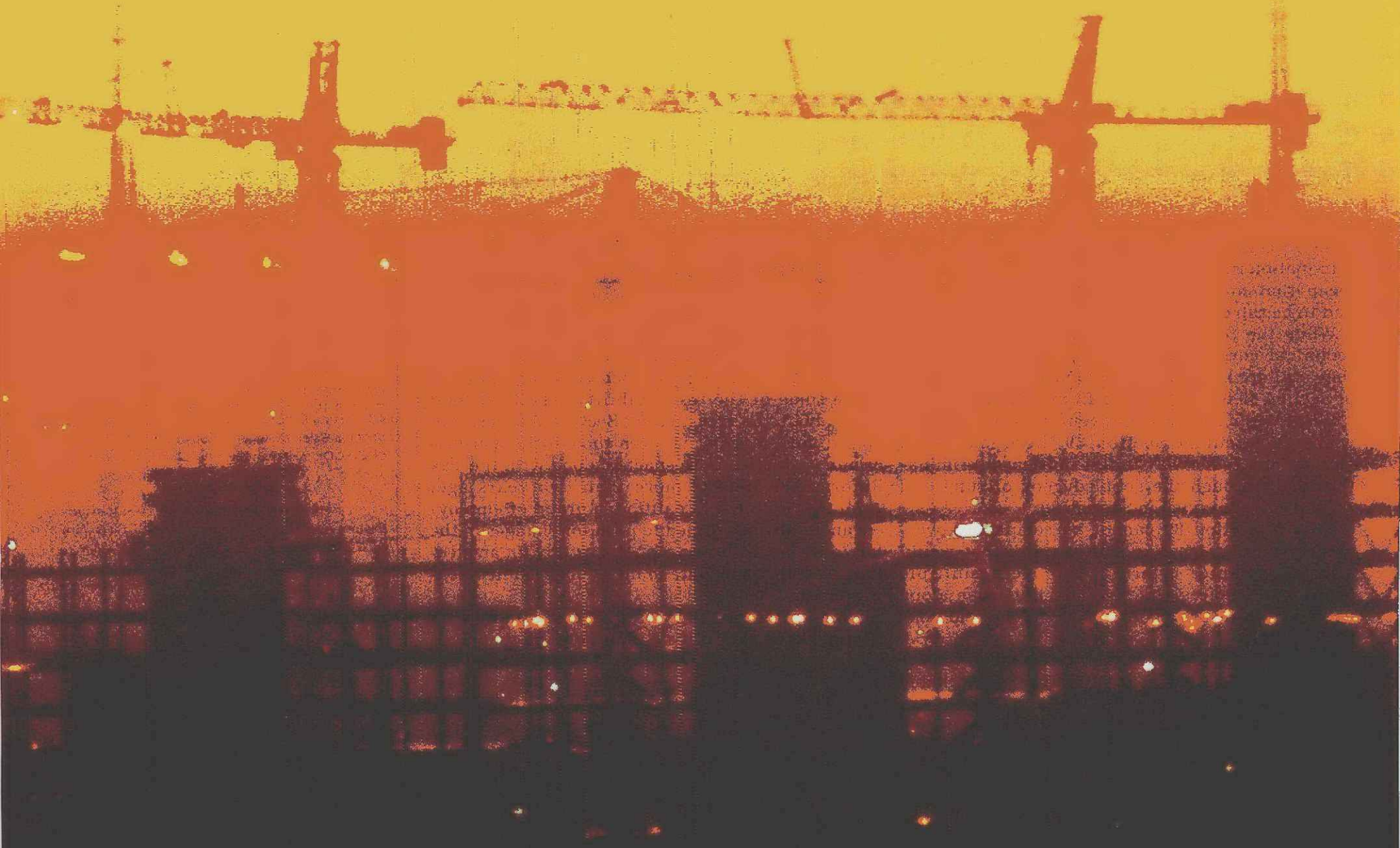
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# Opinions

## Section 89: Who's to blame?

WE WISH EMPLOYERS luck come January, when they must begin Section 89 non-discrimination testing of their welfare benefit plans.

They're going to need it.

Much of the relief from Section 89's horrific provisions that employers had hoped Congress would approve never materialized. In passing a technical corrections bill in the last hours of this year's session, a conference committee—and later the House and Senate—largely approved the Section 89 relief provisions that were contained in a Senate bill (*BI*, Oct. 31).

While the legislation falls way short of what benefit lobbyists and employers wanted, it will ease some of Section 89's administrative burdens. Perhaps most importantly, the legislation allows the non-discrimination tests to be run once a year on the date of the employer's choosing. Under the original wording of Section 89, welfare plans had to be in continuous compliance with the non-discrimination rules, which experts had interpreted to mean that non-discrimination tests would have had to be run daily.

While the Section 89 changes contained in the technical corrections act are, indeed, welcome, they still are not going to eliminate the nightmare of Section 89 testing for benefit managers.

While responsible employers have no quarrel with the intent of Section 89 there must be a quicker and easier way to test for non-discrimination than through the gobbledygook of rules and regulations contained in Section 89.

And, if Section 89 cannot be completely overhauled, then at least a "safe harbor" that would allow companies offering employees multiple health care choices—like an indemnity plan along with several health maintenance organization options—is needed.

But, alas, employers must now be ready on Jan. 1 to meet the amended—but still largely unworkable—Section 89 requirements.

Who's to blame?

Congress can be singled out, not only for not listening to the pleas of employers for more substantial relief, but for passing the Section 89 rules in the first place. These regulations were drafted by congressional committee staffers with little—if any—input from employers and benefit experts.




However, employers and benefit lobbyists must share some of the responsibility. The first loud cries about the injustice of Section 89 were not voiced until last spring, even though the non-discrimination rules were enacted along with the Tax Reform Act of 1986 more than two years ago. And, the Section 89 Coalition, a group of employers and lobbyists formed to push for changes in the law, only unveiled its proposals in July. In an election year, that's too late to introduce technical legislation in Congress.

While employers likely will have to comply with Section 89 on Jan. 1, it's still not too late to amend the non-discrimination rules. A coalition of employers and lobbyists, like the Section 89 Coalition, must find a sponsor to introduce legislation on the first day the new Congress convenes. Then, benefit managers, as well as those on the scene in Washington, must put pressure on legislators so that Section 89 relief becomes reality.

# Letters

## Employer health plans should cover abortions

To the editor: I was surprised and disappointed that you chose to print Joe Theisen's letter, "Abortion 'Benefit' Cause for Concern" (*BI*, Oct. 17).

But since you are apparently willing to consider the debate over abortion rights within the bailiwick of an insurance industry publication, please consider both sides of that debate.

Employers that provide health benefits that include payment for abortion are simply accepting what is the law of the land: An abortion is permitted in the United States if a pregnant woman wishes to have such a procedure performed.

For the employer to be more sensitive to anti-abortionists than to those who support the right of the mother to choose would be ridiculously unfair to its employees.

The employer need not consider the "morality" of the question of abortion; the person obtaining the abortion does. The employer needs only to recognize that abortion is legally available in the United States and is a medical procedure; it should be included in health benefit plans as much as any other legal medical procedure.

**Randall Cooper**
Philadelphia

## Health care policy requires unanimity

To the editor: Your article on the candidates' differences over health care and benefits policy, "Dukakis, Bush Clash Over Benefits Agendas" (*BI*, Oct. 10), highlighted the altogether expected disagreements between Messrs. Bush and Dukakis on these vital issues.

While it's important for voters to see these differences clearly articulated, another—and far scarier—message was implicit in your account: In the absence of a clear and integrated national policy regarding access to health care, the new administration, Congress and the business community will continue to wage legislative warfare on multiple fronts, wrangling over problems designed to appease—or penalize—specific constituencies instead solving the problem.

The business community, especially the small business community, must necessarily wage defensive warfare in this kind of environment. The multiple mandates that the 100th Congress has attempted to foist upon business—which Gov. Dukakis apparently supports—deserve opposition because they are unworkable, inflationary and horrendously expensive.

But the business community, like the Bush campaign, has not yet been successful in articulating a vision of how better to address the needs of the working uninsured. A key answer lies in a cooperative effort involving business (especially small business), the insurance industry and government to enhance the ability of the private sector to voluntarily address the problem by reducing the market-related and regulatory impediments to obtaining coverage for small employers.

Mandates on employers do not represent a new approach to health policy; they are an acknowledgment of a failure of policy. A far wiser course, before the 100th Congress begins yet another round of attempting to legislate as much as it can on a piecemeal basis, would be to bring the parties together to agree on a sense of where we wish our nation to be headed with respect to health care, then develop a rational, cooperative and workable policy for getting us there. Radical thinking, indeed, in an election year.

**John J. Polk**
Executive Director
Council of Smaller Enterprises
Cleveland

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# Cleanup coverage

*Continued from page 2*
not restitutionary in nature.

However, two U.S. Circuit Courts of Appeal have held that the cost of government-mandated cleanups are not insurable (*BI*, March 7; July 27, 1987).

Insurers now are adding a new spin to their argument by claiming that the California insurance statute, which was signed in August, reinforces their contention that costs incurred by policyholders under Superfund are not insurable.

Richard L. Seabolt, an attorney with Hancock, Rothert & Bunshoft in San Francisco who represents London insurers collectively known as Cheshire & Cos., says the intent of the statute was to prohibit wrongdoers from using insurance to pay any fines, penalties or restitution and to deter policyholders from engaging in activities harmful to the public, such as polluting.

"It is always cheaper to pollute," he said. "If you don't have a deterrent effect you are going to have a massive problem for the next generation."

Furthermore, Mr. Seabolt said: "The legislative history indicates that the attorney general proposed the legislation because of concern that insurance eliminated individual accountability and the deterrent effect of statutory enforcement claims brought by California."

But, California Deputy Attorney General Timothy R. Patterson says the insurance statute was not intended to encompass hazardous waste litigation.

The law was designed to prohibit businesses from using insurance to pay for fines related to unfair business practices and false advertising, he explained.

"The intent of the legislation is to deal with consumer protection statutes," Mr. Patterson said. "It was never discussed nor considered in the Legislature with respect to hazardous wastes or hazardous substances."

Aerojet agrees with Mr. Patterson that the insurers are misinterpreting the new statute.

In its latest brief, Aerojet says: "Section 533.5 (of the California Insurance Code) derives from a bill sought by the attorney general to meet a situation arising under the Unfair Competition Act, which aims at fraudulent and deceptive advertising by which dishonest sellers swindle customers out of money or property.

"The Unfair Competition Act permits the attorney general or district attorney to seek penalties, and, among other relief, to obtain an order compelling the fraudfeasor to return to the defrauded persons what was wrongfully taken from them. The purpose of Section 533.5 was to prevent the fraudfeasor from keeping his/her ill-gotten gains."

However, insurer attorney Mr. Seabolt contends that "the statute is not limited to false advertising and consumer protection actions. It also applies to environmental litigation.

"The public policy expressed in the statute clearly applies to pollution litigation," he said.

Aerojet attorney Moses Lasky of Lasky, Haas, Cohler & Munter in San Francisco also points out that the statute was not signed until Aug. 22 and does not take effect until Jan. 1, long after the trial court issued its ruling in the Aerojet case. The law therefore is not relevant to this appeal, he said.

But Mr. Seabolt said the date of the new statute is irrelevant because the statute merely clarifies existing law.

In fact, the statute provides that it "does not constitute a change in, but is declaratory of, the existing law." ■

# At issue

## Should employees be taxed on employer-paid health insurance premiums?



**Stuart Larimore**
Manager-compensation and benefits planning
**Boise Cascade Corp.**
**Boise, Idaho**

No. You have to promote the tax effectiveness of benefits. It is really a question of public policy; it's a poor way to collect tax revenues.



**Traylor Renfro**
Vp/manager-employee benefits
**First Union Corp.**
**Charlotte, N.C.**

Benefits that are currently available could be taxed, but if compensation is deferred, for example pensions, let's not make the employee pay now. Whether or not we tax or don't tax, health care benefits are here to stay.



**Teri Edman**
Manager-compensation
**Century Cos.**
**Waverly, Iowa**

The tax status of benefits encourages the providing of health care through employment. If employees were taxed that would discourage this. If you tax employees on benefits, it will hurt the lower income employees more.



**Jane G. Roszel**
Manager-employee benefits
**Rich's, Atlanta, Ga.**

From a compensation standpoint it makes sense because benefits are a form of compensation. But from an employee morale standpoint, I'd hate to see it happen.

Compiled by Christine Woolsey




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# Bank's D&O insurers reach tentative pact

**By MARK A. HOFMANN**

CHICAGO—A proposed settlement agreement between the Federal Deposit Insurance Corp. and directors and officers insurers of Continental Illinois Corp. would allow the FDIC to recover about $60 million from Continental's five D&O insurers.

If all of the insurers agree to the plan, the payment would represent the largest D&O insurance settlement ever recovered by the FDIC.

Four insurers—Harbor Insurance Co.; Allstate Insurance Co.; National Union Fire Insurance Co. of Pittsburgh, Pa.; and First State Reinsurers Co. of New England, an affiliate of Hartford Fire Insurance Co.— confirm they have agreed to the settlement.

The fifth insurer, CNA Financial Corp. in Chicago, refused to comment.

The FDIC itself would receive about 77% of the settlement, while Continental Illinois stockholders will receive the remaining 23%, said Barry Rosen, an attorney with the Chicago firm of Sachnoff, Weaver & Rubenstein, which represents the FDIC.

Mr. Rosen, while stressing last week that the agreement was not yet final, said the settlement—if approved—would mark the end of all derivative suits against Continental's D&O insurers.

The settlement stems from the near failure of Continental Illinois and subsidiary Continental Illinois National Bank in 1984 after the bank wrote off about $1 billion in bad loans after the failure of Penn Square Bank of Oklahoma City.

The FDIC bailed out Continental following its near collapse and subsequently took over an existing shareholders' suit against several of the bank's officials.

The stockholders alleged in the suit that Continental Illinois officials had known that one of the bank's vps had accepted payoffs from Penn Square officials in return for loaning money to the Oklahoma bank.

The FDIC in 1984 began attempting to recover some of the costs of the bailout from Continental Illinois' D&O insurers. However, three insurers—Harbor, Allstate and National Union—sued to void the policies in August 1985 (*BI,* Aug. 19, 1985). The insurers held that Continental and its directors and officers had misrepresented the bank's financial condition when they had increased the bank's D&O limits to $100 million from $40 million in 1981.

The proposed settlement would end the insurers' suit as well.

Los Angeles-based Harbor, one of the five insurers that wrote D&O coverage for Continental from August 1981 to August 1984, previously agreed to pay $15 million—the limits of the primary D&O policy it issued Continental's directors and officers—to the FDIC, said a Harbor official.

In addition, a spokeswoman for Northbrook, Ill.-based Allstate confirmed that Allstate had agreed to pay $9.05 million to cover the obligations of its former subsidiary, Northbrook Excess & Surplus Insurance Co., which had written a $10 million layer excess of $15 million (*BI,* Nov. 25, 1985).

A spokeswoman for National Union, a New York-based unit of American International Group Inc., confirmed that National Union would pay about $28 million as its portion of the settlement. National Union had written a $25 million layer excess of $25 million and $15 million share of a $50 million excess layer of $50 million.

A spokesman for Hartford Fire Insurance Co., parent of Boston-based First State Reinsurers Co. of New England that since has been renamed, said the company had agreed to contribute about $2.6 million to the tentative settlement.

The spokesman could not confirm the limits of Continental Illinois' policy.

CNA Financial Corp. refused to comment on whether it had agreed to the settlement and whether it would pay $6.4 million.

James G. Hiering, an attorney with the Chicago law firm of Keck Mahin & Cate that had represented Harbor, National Union and Allstate, declined to comment on the proposed settlement.

Officials of the FDIC declined comment until a settlement is final. Most D&O insurers and attorneys also withheld comment on the case, citing the tentative settlement.

However, observers agreed that the settlement would have little impact on the directors and officers liability insurance market.

"The repercussions have already been handled," said Betsy Headd, vp of New York-based Continental Guaranty & Credit Corp., a unit of Continental Insurance Co. that specializes in writing D&O coverage for small and medium-sized banks.

Ms. Headd noted that the policies had been issued before the hard market of the mid-1980s and were consequently free of many of the exclusions that D&O policies written since 1985 routinely contain. D&O insurers, she said, now use clearer language in their policies than they did in the past to prevent themselves from being exposed to what they consider unjustified claims.

In addition, she said that D&O insurers have attempted to protect themselves by using exclusions that restrict recovery. The so-called regulatory exclusion, which was introduced in the mid-1980s but which some insurers are now willing to relax in some cases, holds that a D&O insurer is not liable for claims against directors and officers brought by the FDIC, the Federal Savings & Loan Insurance Corp. or other regulatory bodies.

This exclusion, as well as the so-called "insured vs. insured" exclusion that excludes an attempt by a company itself to recover losses from its own directors and officers insurer, has been a common addition to policies issued during the second half of the decade.

John W. Morrison, an attorney with Altheimer & Gray in Chicago, agreed that the impact of the Continental settlement on the D&O marketplace and D&O law should be negligible.

"It really doesn't have any impact on D&O law," he said.

Like Ms. Headd, Mr. Morrison said that insurers have already taken significant steps to protect themselves from being liable in similar cases.

He added, however, that U.S. district courts in Iowa and Utah in the past two years have invalidated the regulatory exclusion. And, he predicted there would be more litigation involving the exclusion.

The proposed settlement must be approved by U.S. District Judge John F. Grady, who had presided over the original shareholders' suit. ■



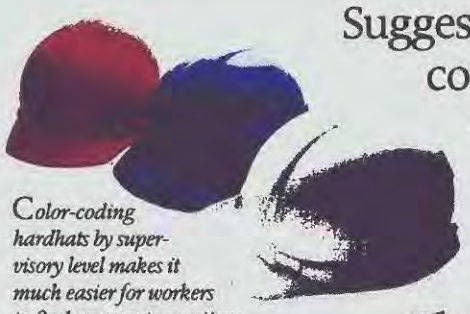
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# Treaty to bolster Bermuda: Tax expert

By ROGER SCOTTON

HAMILTON, Bermuda—The U.S.-Bermuda tax treaty, which was ratified by the U.S. Senate late last month, will put Bermuda on virtually equal footing with Vermont as a captive insurance company domicile, a tax specialist says.

The treaty is bound to help make Bermuda a "considerably more attractive captive location," said Walter Duer, a Houston-based partner with Peat Marwick Main & Co., at a tax seminar late last month attended by local captive managers.

In addition, he noted that the technical corrections act passed by Congress in the closing hours of its session will aid Bermuda because a section of it allows U.S.-controlled foreign corporations in Bermuda to elect to be treated as domestic U.S. corporations for tax purposes, avoiding liability for special excise taxes.

"The treaty and the flexibility now allowed under the (technical) corrections act mean that Bermuda has moved toward establishing a more level playing field after being hit with the branch profits tax under the Tax Reform Act of 1986," he said.

"There are still some situations that favor an onshore location, but these are now fewer than before and the onshore/offshore argument is more neutral now," he said.

The tax treaty will exempt from U.S. federal excise taxes on premiums paid to both insurers and reinsurers. The government generally imposes a 4% tax on direct insurance premiums paid to foreign underwriters, while it imposes a 1% tax on premiums to foreign reinsurers.

The exemption in the Bermuda treaty, which is retroactive to Jan. 1, 1986, is due to expire on Dec. 31, 1989, the same date that an excise tax provision in a treaty between the United States and Barbados is due to expire, explained Bob Steinhoff, a Peat Marwick partner in Bermuda.

"The last person in the United States to have handled the premium would have been the one to pay the (federal excise tax) and will be the one who should apply for a refund," pointed out Albert D'Ambrosio, Peat Marwick's Bermuda-based tax manager. "Documentation is going to be required by the Internal Revenue Service to substantiate the premiums and excise taxes that have been paid, but we don't yet know exactly what information the IRS will be requiring. I think the IRS will be coming out with a package of documentation for the refund procedure."

One of the most important parts of the treaty effectively clarifies what activity will constitute a "permanent establishment engaged in trade of business in the United States," said Joe Jordan, a tax partner with Peat Marwick in New York.

This is important because it will give Bermuda-based companies guidance on how much business can be conducted onshore, he said.

## Bermuda briefs

### Forum reorganization

Forum Re Group (Bermuda) Ltd. and related Forum Group companies intend to modify their corporate structure to achieve "an overall simplification and reorganization of the ownership of the group and relationships among the Forum Re group of affiliated companies."

As part of the restructuring, the capital of Aneco Reinsurance Underwriting Ltd., a wholly owned unit of Forum Re Group (Bermuda), will be boosted and the group will sever its direct common shareholding links with Panama-based Magnolia Trading S.A., a company 100% owned by Forum Chairman Mark Hardy.

The reorganization, which will be submitted to shareholders for approval at a special meeting early next year, includes the sale of Forum Reinsurance Co. Ltd.'s entire 72% stake in Forum Re Group (Bermuda), which was formerly Aneco Reinsurance Ltd. Forum acquired a controlling stake in Aneco Reinsurance Ltd. in April through a tender offer valued at about $6.3 million.

If the restructuring is approved by shareholders, Forum Re Group (Bermuda) Ltd., eventually will emerge as the organization's company listed on the NASDAQ system.

The transactions that comprise the restructuring include:

- A loanstock conversion that will give Forum Re Group (Bermuda) the right to acquire on July 31, 1989, a 49.9% interest in the common shares of Forum Reinsurance Co. Ltd. of Bermuda, which specializes in writing financial reinsurance products.
- Forum Re Group (Bermuda) will acquire 28% of Forum Re Group Inc., the Concord, Mass.-based affiliate that owns Oil & Gas Insurance Co. and Petrosurance Casualty, both based in Columbus, Ohio, and Millers National Insurance Co. and The Illinois Insurance Co., both in Chicago.
- Loanstock conversion that will grant Forum Re Group Inc. the right on July 31 to acquire a 25.05% interest in the common stock of Forum Reinsurance Co. Ltd.
- Creation of a leveraged employee stock ownership program for the Forum Group's 130 employees—both in Bermuda and the United States. The ESOP will acquire for $5 million some 1.8 million newly issued Forum Re Group (Bermuda) shares, representing about 33% of the company.
- An offer to sell Forum Reinsurance Co.'s and subsidiary Forum Investment Ltd.'s 72% interest in Forum Re Group (Bermuda) at a price that will allow the companies to recoup their investment.
- Issuance to Magnolia Trading of 16.6 million preferred shares in Forum Re Group (Bermuda) in exchange for $16.6 million of convertible loan stock in Forum Reinsurance Co.
- The acquisition by Forum Re Group Inc. of $8.3 million of Forum Reinsurance loanstock held by Magnolia trading in exchange for the issuance of 83,500 preferred shares in Forum Re Group Inc. at $100 each.
- Granting to Mr. Hardy a warrant to acquire, at any time, 2 million common shares of Forum Re Group (Bermuda) at $2.75 a share. These shares represent about 25% of the company.
- Issuance to Forum Reinsurance Co. of $10 million of new preferred shares in Aneco Reinsurance Underwriting Ltd. to bring Aneco's capital and surplus to almost $22 million. At the conclusion of the reorganization, Forum Reinsurance Co.—which currently is owned by Magnolia Trading and former Forum President Peter Wilson—will be about 49.9% owned by Forum Re Group (Bermuda); 21.2% owned by Mr. Hardy; 25% owned by Forum Re Group Inc.; and 3.7% owned by Mr. Wilson.

As a result of the proposed reorganization, the directors of Forum Re Group (Bermuda) are recommending that its name be changed to Forum Re Group Ltd. ■


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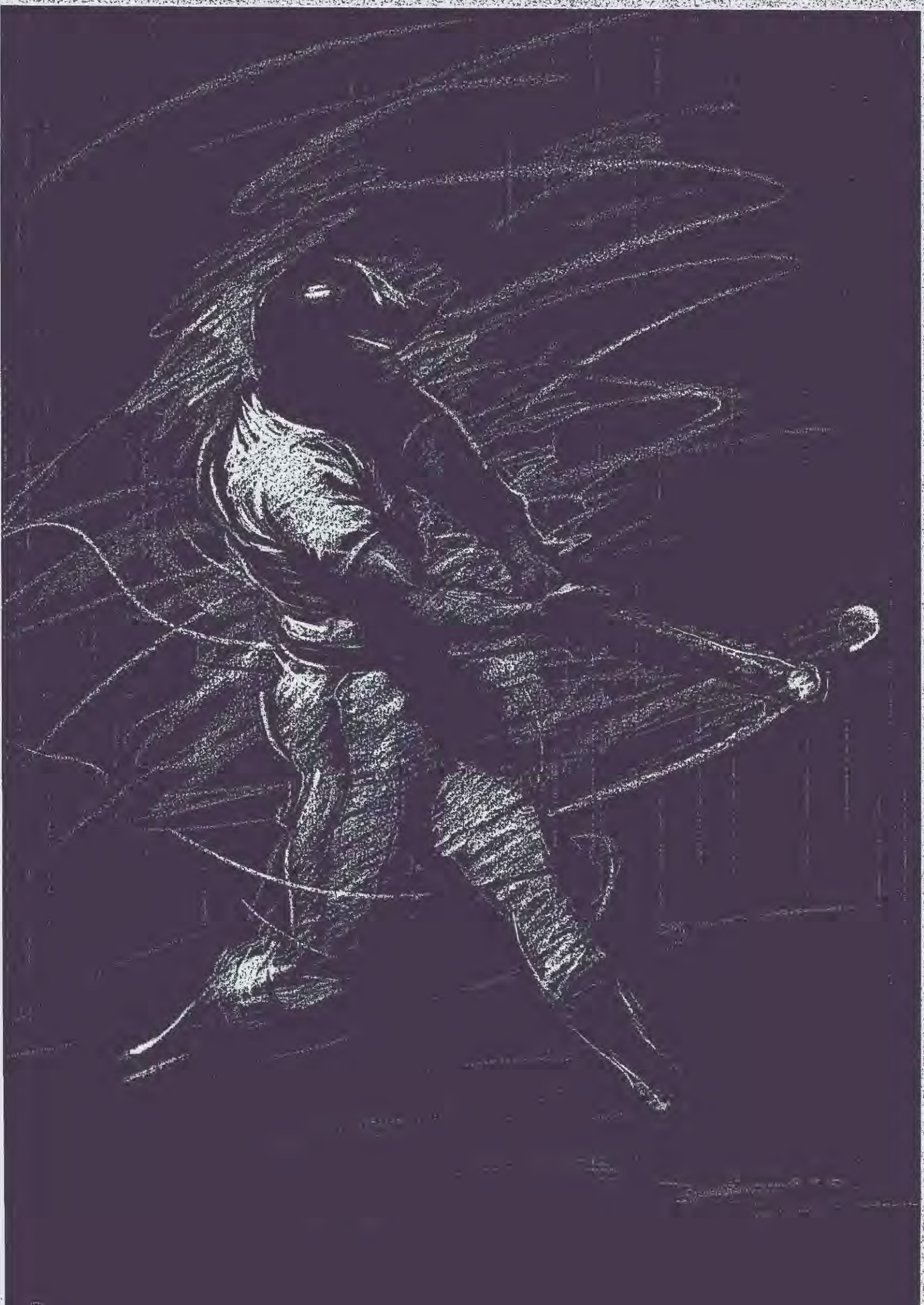
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## CEBS symposium

# Radical changes in benefits loom

By STACY ADLER

CHICAGO—The world of employee benefits will change radically in the next two decades, benefit experts say.

And, employee benefit managers should take a leadership role in this benefits evolution, experts add.

"To survive in the 1990s, benefits people are going to have to be able to pull a rabbit out of their hat now and then," pointed out David E. Scherb, director of employee benefits at PepsiCo Inc. of Purchase, N.Y.

'By taking a leadership role, benefits managers will be shaping the future of employee benefits," Mr. Scherb said.

"Our task in the next decade is not only to be innovative, but to guide and influence our legislators," added Robert A. Bildersee, an attorney with Morgan, Lewis & Bockius of Philadelphia.

Mr. Scherb and Mr. Bildersee spoke at the Seventh Annual Employee Benefits Symposium sponsored by the International Society of Certified Employee Benefit Specialists held in Chicago in October.

Among the changes that employee benefits managers must be prepared to deal with in the next two decades are escalating health care costs, which will force employers to take more aggressive cost containment measures.

In addition, employers will have to tailor their benefits programs to a workforce consisting of more women with children and more older workers.

Health care costs will continue to soar in the next decade partly because of costly advances in medical technology that enable people to live longer, Mr. Scherb said.

**'To survive in the 1990s, benefits people are going to have to be able to pull a rabbit out of their hat now and then,' according to David E. Scherb, director of employee benefits at PepsiCo Inc. of Purchase, N.Y.**

In addition, he noted there are no solutions for ongoing costly health care problems such as substance abuse and acquired immune deficiency syndrome.

And as health care costs continue to climb, employers will be forced to shift more of these costs onto employees, Mr. Scherb said.

Employers will have to consider more seriously implementing managed care programs to hold down costs, he added.

For example, employers can realize substantial savings by implementing case management programs for employees with severe illnesses, he said.

"In the 1990s more and more of the (health care) costs will come from fewer claims," he said.

Similarly, 'preventive care will be a trend in the 1990s," he predicted. "Very few companies are covering preventive care, but more and more companies will be stepping up these plans."

Mr. Bildersee said health care costs for the elderly also will be a major concern of benefit managers in the future.

In 1980 health care for retirees and other elderly persons cost $50 billion annually nationwide, but by the year 2000 these costs will quadruple to $200 billion, he said.

In addition, by the year 2000, the number of physician visits will have increased 80% nationally from 1980 levels, he said.

And, by the year 2040, there will be a 240% growth in the number of nursing home residents in the United States from 1980 levels, Mr. Bildersee said.

"Unless the present pension and health care financing systems are changed, health care for the elderly could consume 60% of the federal budget by 2040," he said.

*Continued on next page*

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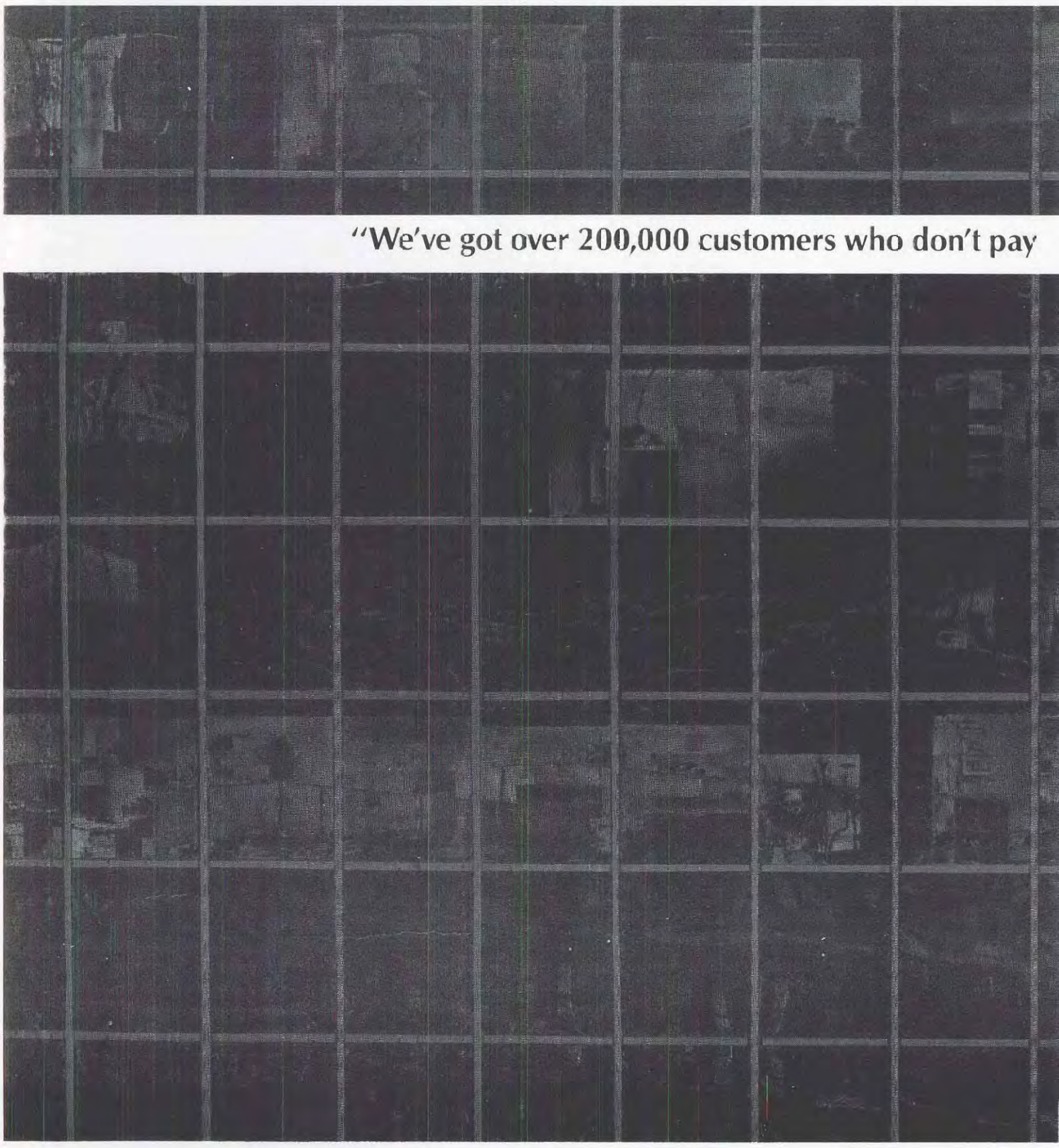
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*Continued from previous page*

The composition of the typical workforce also will change dramatically in the next two decades, according to the speakers. There will be more working mothers and more elderly workers, they said.

Employers will have to be prepared to offer employees monetary assistance with child care and elder care, Mr. Scherb said.

He also predicted more employers will begin offering workers flex-time schedules and sabbaticals without pay while maintaining their benefits.

And, as America's workforce begins to age, more employers will design their employee benefit plans to encourage older employees to remain on the job longer before retiring, Mr. Bildersee predicted.

"There is an emerging national retirement policy" whereby employers are discouraging retirement at the normal retirement age age, Mr. Bildersee said.

For example, the Age Discrimination in Employment Act precludes retirement mandated by age—except for certain highly paid executives, he noted.

And, the Social Security retirement age has been raised for those born after 1938, resulting in a reduction in benefits for those who wish to retire at age 65 beginning in the year 2000, he said (*BI*, April 4, 1983).

Messrs. Scherb and Bildersee also warned benefits managers that the federal government will continue to encroach in the employee benefits arena during the next two decades.

**'There is an emerging national retirement policy' whereby employers are discouraging retirement at the normal retirement age, says Mr. Bildersee.**

Congress will continue to push for mandated benefits, Mr. Scherb predicted.

"Do you want Congress to be your personnel manager?" he asked. "If the answer is 'No,' try grassroots employer campaigns," he suggested.

"When it comes to legislation, your job in the next decade will be to get involved," Mr. Scherb said.

Mr. Bildersee agreed. "Employers should not look to Washington for help with their benefit plans."

He also advised benefit managers to design their benefit plans defensively and to assess the true value of "tax carrots" such as 401(k) salary reduction plans.

The session was moderated by Alan P. Cleveland, an attorney with Sheehan, Phinney, Bass & Green of Manchester, N.H. ■

# Benefit materials can curb litigation

**By STACY ADLER**

CHICAGO—Employers must make certain that all employees receive accurate information about benefit plans to avoid benefit-related litigation, according to an attorney.

Employee benefit materials must be written accurately and in way that can be understood by the average employee, said Katherine A. Hesse, an attorney with Murphy, Hesse, Toomey & Lehane of Braintree, Mass.

The most critical employee benefit communication is the summary plan description, which details the benefit plan for employees, Ms. Hesse told attendees at the Seventh Annual Employee Benefits Symposium sponsored by the International Society of Certified Employee Benefit Specialists held in Chicago last month.

The summary plan description must apprise employees of their rights and obligations under the benefit plan, she said.

"This is the area where we will see the most litigation," Ms. Hesse said.

Among the things that employers must include in their summary plan descriptions is a detailed explanation of all of the circumstances under which an employee may be disqualified from the plan, she said.

Ms. Hesse suggested that employers print all such exceptions in boldface or highlights.

The summary plan description also must be written so that it is easily understood by the average employee, she said.

Ms. Hesse suggested that employers pay some employees to read a draft of the summary plan description and comment on areas they found confusing.

**The most critical benefit material is the summary plan description, says Ms. Hesse.**

Ms. Hesse also noted that employers may want to consider printing the summary plan description in foreign languages if English is not the native tongue of many of their employees.

The summary plan description also must be accurate and updated within 120 days of any plan changes, according to Ms. Hesse. Employers must be careful to keep employees abreast of all changes to their benefit plan to avoid litigation, she cautioned.

"In the last two months courts have held that when there are discrepancies between the summary plan description and the plan, the summary plan description is controlling," Ms. Hesse pointed out.

"Review your summary plan description very carefully," she continued.

Employers also must be careful that they deliver the summary plan description to all employees.

"Often employees in litigation claim they never received a summary of the plan," Ms. Hesse noted.

"The best method for delivering a summary plan description is by handing it to the employee at work," she said.

Some employers also make employees sign a form acknowledging that they have received the summary plan description, Ms. Hesse noted.

Ms. Hesse also recommended mailing the summary plan description to employees' homes. "Simply leaving the information at the employees' worksite is not enough," she stressed.

Ms. Hesse also noted that an employee benefit consultant who helps an employer write the summary plan description also can be held liable for any errors.

However, both consultants and employers will not be held responsible for errors when they can show due care was taken to avoid mistakes, she said.

The session was moderated by Charles L. Miller, assistant vp of Provident Capital Management Corp. in Philadelphia. ■

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# Robinson named president of NWNL Re

**Angus Robinson** has been named president and chief executive officer of NWNL Reinsurance Co. in Minneapolis, a subsidiary of Northwestern National Life Insurance Co.

Prior to joining NWNL Re, Mr. Robinson was president and chief operating officer of Trenwick Group Inc. in Stamford, Conn. Mr. Robinson joined Trenwick in 1978 as senior vp and director and was named president in 1984.

Mr. Robinson succeeds Leonard J. Meredith Jr., who resigned.

**In other reinsurer changes:**

**Gerald S. King** promoted to president of Facultative Managers Corp. in Norwalk, Conn.

**Richard L. Weiler** joined Scor Reinsurance Co. in New York as vp. Most recently, Mr. Weiler was president of N.R.G. America Syndicate Inc. in New York.

**David K. Bradford** named vp at Reliance Reinsurance Management Inc. in Philadelphia.

**Robert F. Kennedy** joined Thomas A. Greene & Co. Inc. in San Francisco as vp and treaty broker. Most recently, Mr. Kennedy was treaty underwriting vp with American Re-Insurance Co. in New York.

**John H. Slattery** named president of MultiPlus Insurance Co. in White Plains, N.Y., a subsidiary of Pan Atlantic Re Inc.

## Comings & goings: industry

## Insurers

**Kenneth H. Pinkston** promoted to executive vp of Corroon & Black Corp.'s Benefits & Specialty Sales Group in New York.

**James P. Chick Jr.** named president of Selective Insurance Co. of the Southeast and Selective Insurance Co. of South Carolina, two Charlotte, N.C.-based subsidiaries of Selective Insurance Group Inc.

**George E. Hillier** named president and **Thomas J. Coyle** named vp and underwriting manager of Environmental Protection Insurance Co.—Risk Retention Group in Chicago.

**Fred J. Fietkiewicz** appointed vp and chief operating officer of New York operations for Nationwide Insurance Co. of Columbus, Ohio, effective Jan. 1.

**Harold F. Hirt** appointed executive vp of Associated Aviation Underwriters of Short Hills, N.J.

**Thomas E. Schadler** named vp-actuary, a newly created position, at The Shelby Insurance Co. in Shelby, Ohio.

**Leslie C. Boughner** appointed vp and regional manager at Arkwright Mutual Insurance Co. in Waltham, Mass. Mr. Boughner is based in the San Mateo, Calif., office.

**Bernal T. Chomeau**, chairman of The Reliable Life Insurance Co. of St. Louis, was named to the additional post of chief executive officer. Mr. Chomeau replaces David D. Chomeau, who continues as vice chairman.

**Gary J. Gruber** named vp and controller of Great American Insurance Cos. in Cincinnati.

**David G. Hansen** appointed resident vp of Beaver Insurance Co. in San Francisco.

Continental Insurance Agency Group in New York announced the following appointments to senior vp and zone manager: **Joe Roth**, Eastern zone; **Alan Dekker**, Central zone; and **Carl Castoldi**, Western zone. Also, named to vp and manager were: **William Bender**, New York region; **Sal Ricciardone**, Livingston, N.Y., region; **George Gress**, Glens Falls, N.Y., region; **Dick Erickson**, New England region; **John Conn**, Kentucky region; **Robert Leonard**, Columbus, Ohio, region; **Anthony Warren**, Chicago region; **Jim Parkinson**, Denver region; **Glenn Watkins**, Kansas City, Mo., region; **Brad Williams**, Dallas region; and **Ron Waisner**, Sacramento, Calif., region.

## Agents/brokers

**William J. Prenger** appointed senior vp of Johnson & Higgins of Hawaii in Honolulu. Also, **Jack D. Tribble** named senior vp of J&H of Alabama in Birmingham and **Harold J. Pratt** named senior vp of J&H of Georgia in Atlanta.

In its overseas operations, J&H announced the following appointments: **Wayne Harvey** to manager of the Rio de Janeiro, Brazil, office; **Roy Hubber** to office manager of the Djakarta, Indonesia, office; **Rod Fajardo** to country manager of the Bogota, Colombia, office; **David Frediani** to country manager in the Kuala Lumpur, Malaysia, office; and **Terry Gilbert**, effective in November, to manager of the Lima, Peru, office. Also, **Steven Workman** named manager of the international department in the San Francisco office of J&H.

**Clark Payan** joined Payan-Stitt Corp. in Palos Heights, Ill., as vp. Previously, Mr. Payan was director-agency services with the Independent Insurance & Brokers Assn. of California.

**Sandra K. Carr** named vp of Kelter-Thorner Inc. of Michigan in Southfield, Mich.

**Thomas J. Penney** joined Frank B. Hall & Co. of California/San Diego Division as chairman and chief executive officer. Previously, Mr. Penney was president and profit center manager of Fred S. James & Co.'s Omaha, Neb., office.

**Robert A. Hutchins** joined Frank B. Hall & Co. of Louisiana Inc. in New Orleans as vp. Previously, Mr. Hutchins was a principal at Stalter, Wise & Michel Inc., a property/casualty insurance agency in New Orleans.

Also, **Leo G. Walter III** named vp of Frank B. Hall & Co. of Ohio Inc. in Akron.

**William J. Colgan** joined Frank B. Hall & Co. of Michigan as vp-aviation. Previously, Mr. Colgan was branch manager for Associated Aviation Underwriters of Short Hills, N.J.

**Robert A. Ahern** joined BRI Coverage Corp. in New York as a senior vp.

**Steven I. Pincus** named vp of the New York office of Chicago-based Near North Insurance Agency.

**John C. Harper Jr.** appointed vp and chief operating officer of Robson, Cavignac & Associates in San Diego.

**A. Hunter Long** joined Rollins Burdick Hunter Co. in Chicago as vp and special projects coordinator for the Major Account Support Team. Previously, Mr. Long was president of American International Financial & Risk Services Inc.

**Ray Sommers** named executive vp of Affiliated Insurance Consul-

*Continued on next page*


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The complexity of AIDS typifies the challenges in medical case management today. And there is no organization better equipped to handle those challenges than Intracorp.

For more information on how Intracorp Medical Case Management can provide high quality, cost-effective care for your employees and dependents stricken with AIDS, call 1-800-345-1075 (in AK, HI and PA call collect at 1-215-687-9450).

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# Allstate to abandon some national accounts

Sears, Roebuck & Co. last week announced that its Allstate Insurance Group subsidiary will phase out the underwriting of primary property/casualty insurance for national accounts as part of a major restructuring plan aimed at improving the financial performance of Sears.

The announcement came on the heels of Allstate's previous announcement that it is selling the bulk of its group life and health insurance business (*BI*, June 20).

Northbrook, Ill.-based Allstate now intends to direct its efforts toward the sale of individual life insurance and investment products as well as group life/health policies sold by Allstate Insurance agents. It will market property/casualty products to individuals and small and medium-sized employers with up to 250 employees.

The change in marketing strategy affects Allstate's national accounts operation, which was directed at employers with more than 250 full-time employees and more than $750,000 in annual premium, according to an Allstate spokesman. Although Allstate intends to write no new national accounts business, it will renew coverage for some clients including Sears itself, he said.

**Markets**

Northbrook Property & Casualty Insurance Co. and Allstate Insurance Co. primarily wrote the national accounts business. Allstate's national accounts operation generated about $234 million of Allstate Insurance Group's $15.6 billion 1987 revenues.

Put on the block were Allstate's corporate accounts unit—which sells group life, health, dental and long-term disability coverages for Sears employees—and the group brokerage operation—which sells and services life and health coverages to employers with between 50 and 2,000 employees.

The two divisions accounted for 65% of Allstate's group life and health business and generated revenues of $923 million in 1987. It also generated a pretax loss of $20 million.

Unaffected were marketing units that sell pensions to groups of fewer than 50 and group life/health business marketed through Allstate agents.

## New consultant

A new human resources risk management services company has been formed to provide consulting services to employers that have 20 to 2,500 employees.

Leavitt, Dennington & Weitzel Inc. helps employers reduce risks associated with litigation stemming from wrongful termination, COBRA compliance, the Employee Retirement Income Security Act, the Equal Opportunity in Employment Act and employee rights.

Among the services offered by the company are policies manuals, employee handbooks, supervisor training in human resource management, labor relations services and compensation studies.

The company shows managers the proper methods for hiring, managing, compensating and terminating employees with reduced risk, said Chairman and Chief Executive Officer John W. Kabaker.

"Never before have these services been offered through one firm on an integrated basis," said Mr. Kabaker, "In the past, most employers had to engage the services of personnel consultants, labor law firms, employee benefits consultants and compensation specialists to amass the information needed to properly manage employees."

Leavitt, Dennington & Weitzel Inc. is located at 1701 Novato Blvd., Suite 209, Novato, Calif. 94947; 415-892-4484. ■

## Comings & goings: industry

*Continued from page 16*

tants Inc. in Western Springs, Ill.

**Lawrence J. Babbitt** appointed managing vp for the Tampa office of Alexander & Alexander Inc. in Florida.

### Excess/surplus

**Phil Mazur** promoted to vp at Sherwood Insurance Services in San Francisco.

**James D. Jewell** joined Crump E&S of Dallas Inc. in Dallas as vp and underwriting manager. In his most recent position, Mr. Jewell was an insurance broker with Acton Inc. in Oklahoma City.

### HMOs/PPOs

**Teresa Scott-Carano** named director of claims at United Health Plan Inc., a Columbus, Ohio-based health maintenance organization.

### Other suppliers

**Lynn A. Gaughan** named staff consultant and assistant to principal consultants at J.H. Albert International Insurance Advisors Inc. of Needham, Mass.

**Frank Lozano** appointed vp of Specialty Claims Adjusters, a Miami-based automobile claims adjusting company.

Buck Consultants Inc. of New York announced the following promotions to benefit consultant: **Cathleen M. Canavan** in the Boston office; **Daniel H. Carlson** in the Chicago office; **Deborah Schmieder** in the New York office; and **Paul C. Schoenfelder** in the Secaucus, N.J., office. Also, **Marsha Venturi** promoted to consulting actuary in the Secaucus office.

**Paul R. Daoust** named vp and manager of The Wyatt Co.'s Boston office.

**William McQuaid** named Southwest division vp of Republic-RSB Cos. Inc. in Naperville, Ill. Also at RSB Cos., **James Doody** promoted to vp-North Central division.

**Dr. Thomas R. Mayer** joined William M. Mercer-Meidinger-Hansen Inc. in Los Angeles as a consultant in the company's managed health care practice. In his most recent position, Dr. Mayer was vp at Pacific Mutual Life Insurance Co.

**Kenneth J. Diamond** joined Health Risk Management Inc. in Minneapolis as vp of HRM CarePASS, a managed health care/purchasing system. Previously, Mr. Diamond was vp-business development of Health One Corp. in Minneapolis. ■





**Visitors to Dreamworld in Coomera, Queensland, are allowed to pet the kangaroos at the theme park's Koala Country.**
Photo: Kathryn J. McIntyre

# Leisure risks

*Continued from page 3*

sporting rifles and handguns," Mr. Wilson said.

From the point of view of the underwriter, the growth of leisure industries means that the balance of exposure between property and liability "is probably weighted towards liability to a greater extent than the commercial/industrial average," according to Barry West, head of general insurance for Commercial Union Assurance Co. P.L.C. in London.

"There is an exposure to substantial bodily injury claims," he said.

Mr. Wilson and Mr. West discussed "The Challenge and Threats of Leisure in the Age of Technology" from the point of view of a broker and an underwriter, respectively, during the First World Congress on Risk & Insurance Management held in Brisbane last month.

Their topic was the theme of the congress and also was addressed by risk managers (see story, page 20).

Mr. Wilson cited Walt Disney Co. in Burbank, Calif., to illustrate risk management in the leisure industry.

"Risk management at Disney concentrates on three basic issues: the security of the shareholders' assets and the earnings that can be reasonably derived from those assets; the safety and comfort of the public; and the welfare of the staff," Mr. Wilson reported.

The strategy is obviously successful, since there have been minimal property or liability losses suffered at Disney's theme parks in California, Florida and Japan, he said.

Now, Disney is building a theme park in Paris, and A&A is the broker and provider of risk management services, along with its French partner, Societe Generale De Courtage D'Assurances S.A.

SGCA acts as the "eyes and ears" of Disney's risk manager and carries out his instructions, Mr. Wilson said.

Union des Assurances de Paris is the insurer for the Disney park in Paris, to be called EuroDisney.

Mr. West of Commercial Union noted that the leisure industry generally is well-regarded by insurers as a growth industry, except perhaps in the United States, where foreign insurers have concerns about U.S. liability exposures.

To insure the leisure industry, underwriters need detailed underwriting information, Mr. West said.

For example, when writing property insurance for a hotel, it is important to the underwriter whether the hotel is a "modern city center hotel built to high standards and subject to knowledgeable local authority inspection, compared with a complex of lightly constructed chalets in a developing area with limited inspection, no professional firefighters, a shortage of water and perhaps exposure to severe elemental perils."

And, when writing liability insurance for a leisure concern, "sites vary enormously in the risks presented," Mr. West said, citing the liability exposure from especially crowd accumulation. "Surveys are essential and should not be limited to the physical inspection of, for example, stands in a stadium, but also should include the system of crowd control," he said.

Mr. West also stressed what he called an "obvious point" that has been overlooked by some risk managers: "There is not much point in surveying when the site is silent. You should go when it is attended."

Even then, the problems are not always obvious, he said. As an example, Mr. West noted that Commercial Union insures the Wimbledon tennis complex in the United Kingdom. "We had to persuade the organizers to reconsider their policy of allowing the star players to appear on outside courts. The risk of a stampede by over enthusiastic fans in the congested alleyways between these courts is only too real."

Underwriters of a leisure industry concern also want to investigate contractual liability, since the leisure industry sells many services that are provided by others, Mr. West said.

"The philosophy or practice of accepting liability by contract and the need to be sure that liability passed by contract is backed by adequate security of insurance is particularly pertinent," he explained.

Underwriters of the leisure industry also are particularly concerned about the quality of management of the concern. The system for handling complaints and potential insurance claims must be "quick and clear," he said.

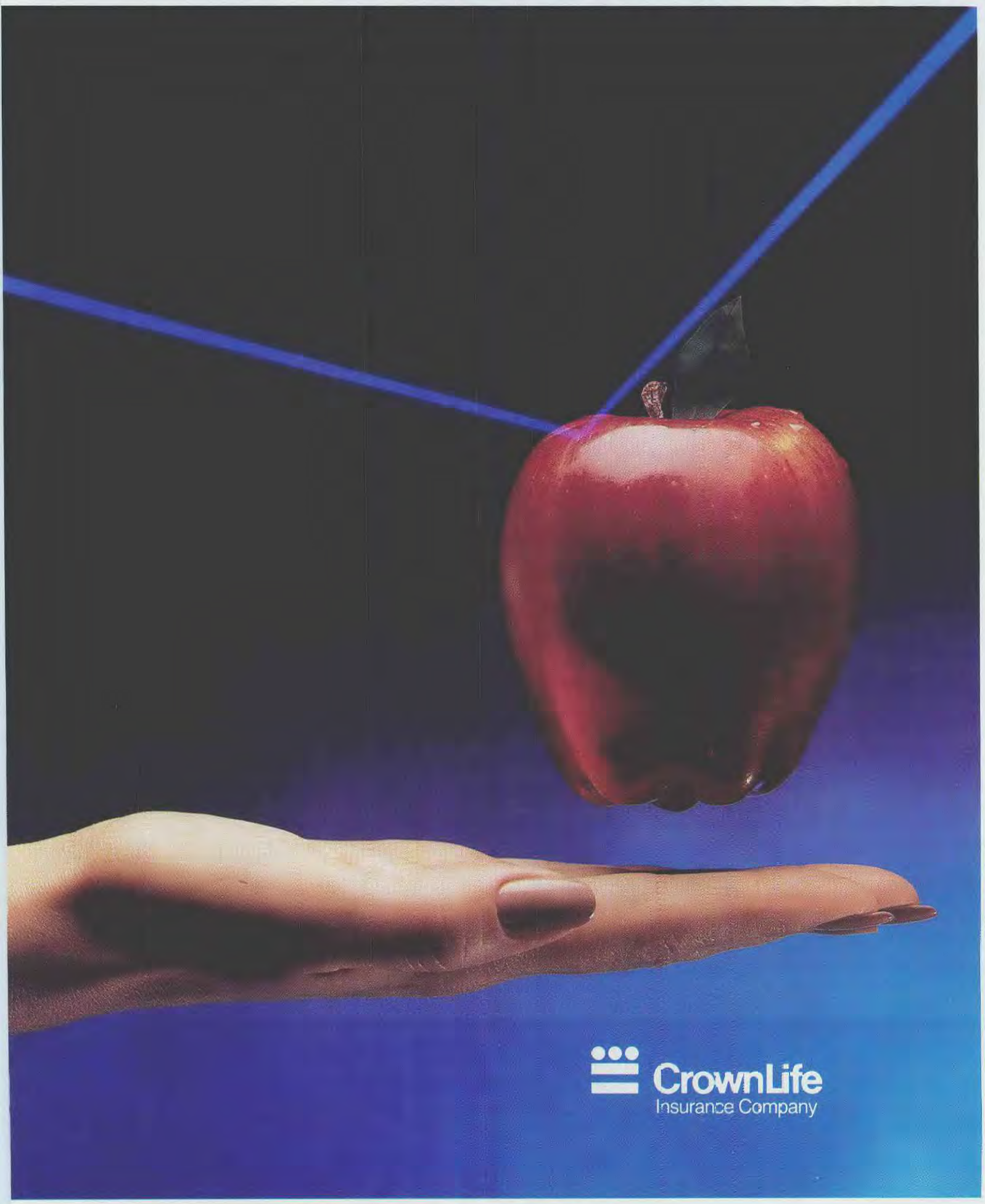
Claims handling is a sensitive subject in the leisure industry, Mr. West pointed out. "The industry is concerned with providing enjoyment to a large number of people. If something goes wrong, customers will complain strongly. There is a need to respond quickly. Claims can involve loss or liability that may or may not be the subject of insurance. It is not always clear initially which is which," he said.

Therefore, a "clear claims policy needs to be in place and followed," with claims involving serious loss identified and referred to the insurer, Mr. West advised.

"Case underwriting must predominate" in insuring the leisure industry, with underwriters applying debits and credits to the rate depending upon their assessment of the risk presented by each concern, Mr. West pointed out.

"The leisure industry is an industry where risk management and

*Continued on next page*



## Leisure risks

*Continued from previous page*

control strategy and practice is a critical factor in determining the quality of risk," Mr. West said.

"First-class systems for monitoring and controlling risk, checking contractual liability and dealing with complaints and claims will give a high probability that the risk is above average and should reflect directly in premium rates and terms," he said. However, "risk managers do not do themselves justice" when their risks are submitted to underwriters, Mr. West said.

"It is still unusual to see a presentation to underwriters with detailed information giving risk control philosophy and systems. What usually comes in is a paragraph from the broker's word processor which pays lip service to the aspect of risk management. Rare indeed is it to have it supported by a document emanating from the risk manager setting out in detail what they actually do. If I see one, I'm impressed. I don't see them very often."



Mr. West



Mr. Wilson

Mr. Wilson of A&A offered six remedies for problems created by leisure industries and new technologies:

● Businesses should reaffirm a commitment to ethical equilibrium, such as Disney has done.

"The corporation that uses technology irresponsibly is committing economic suicide in today's world. The irresponsible corporation may well need risk management and insurance, but it merits neither," he said.

● Businesses that use technology "must remind the societies in which they live that there is a price to be paid for technological progress."

For example, the low incidence of complications caused by vaccines should be no reason to force the vaccines off the market and threaten entire public health programs, he said.

● Taxation should be changed to enable businesses to set aside the funds needed to pay huge claims from pretax earnings.

● Regulation should be streamlined to attract more capacity to the insurance business.

● Conventional insurers should encourage the development of alternative risk financing mechanisms by participating in them.

● Businesses should afford risk managers the level of recognition "that fully reflects his or her important responsibilities. ■

## Job affords little leisure: Heydinger

**By STACY SHAPIRO and KATHRYN J. McINTYRE**

BRISBANE, Australia—Faced with a growing list of market, legal and business concerns, risk managers worldwide find it increasingly difficult to carve out some leisure time for themselves, say two risk managers.

Few risk managers have time to enjoy leisure, asserted Richard Heydinger, president of the Risk & Insurance Management Society Inc. of New York, during the First World Congress on Risk & Insurance Management in Brisbane.

At a session titled "The Challenge and Threats of Leisure in the Age of Technology," Mr. Heydinger, observed: "To be honest, I really struggled with the session title and the theme, particularly the aspect of leisure, because I personally have experienced and observed among my peers a declining role for leisure in present-day American business life."

Mr. Heydinger, who is director of risk management for Hallmark Cards Inc. in Kansas City, Mo., listed five major issues he has encountered in the last six months as RIMS president that he described as "pressing" for risk managers:

IFRIMA Brisbane

● The state of the insurance market. "The trade press and the brokers would have us believe that we are right back in the early 1980 era—when anything goes. But I have not experienced that personally, nor do I find any risk managers expressing the same thought. I think it is true that rates are down but by percentages in the range of 10% to 20%, not massive price slashing or all-out rate wars."



Mr. Heydinger

● The massive antitrust litigation filed by state attorneys general against the property/casualty insurance industry. "It is very serious activity not to be ignored," Mr. Heydinger said.

RIMS intends "to make certain that related and important public policy issues—like tort reform and insurance regulation—do not get damaged in the process."

● The state of the U.S. civil justice system. "I am sure you have all heard the horror stories about how the U.S. system is neither civil nor just," he said. While RIMS has been active in trying to find legislative solutions to the problem, "it is not a very encouraging picture."

● Whether alternative risk financing mechanisms that developed during the mid-1980s are temporary or permanent. "I personally believe most of them are here to stay," he said.

● The cost of employee benefits. The medical care component of the Consumer Price Index rose 7.3% in the first eight months of 1988, according to the U.S. Bureau of Labor Statistics. By contrast, the general inflation rate was 4.6% during the first eight months of 1988 (*BI*, Sept. 26).

And, lying ahead for risk managers who handle employee benefits are some important issues "like nationalizing our health delivery system; how to provide and pay for medical care of our rapidly aging population; employer responsibili-

*Continued on page 22*


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# Leisure time

*Continued from page 20*

ties for providing day-care centers; paternal/family leave practices; and wellness programs."

Another key issue for risk managers is the increase in mergers and acquisitions, which reduces the number of risk management jobs and cuts risk managers' staffs and budgets, Mr. Heydinger said.

"Today I know very few U.S. risk managers struggling with how to spend their leisure time," he said. "I do find many struggling with how to create more leisure time. Many of them are turning to technological advances in communications, record-keeping and loss control as a possible answer for dealing with the expanding workload and complexity of their new tasks."



Mr. Bassett

Risk managers of multinational conglomerates face even more problems, noted Stuart Bassett, international risk manager for Mayne Nickless Ltd. of Melbourne, Australia. Mayne Nickless, which employs approximately 32,000 people at more than 800 locations throughout the world, is "the largest armored car group in the world," and it provides complete guard and patrol services for Australia's Adelaide Grand Prix, Mr. Bassett said.

For example, risk managers of multinational conglomerates have to overcome the language barrier between nations, as well as the domestic jargon used across borders of countries that share a language.

International risk mangers also must understand the legislative process in various jurisdictions, not only between countries but also among states, such as in Australia and the United States.

And, risk managers for multinational companies have to overcome the lack of international insurance services, Mr. Bassett said.

"When one tries to put together a global catastrophe program, this can become a real problem," he said.

Because of the numerous exposures multinational companies face, risk managers "can't ever relax in the area of loss control," Mr. Heydinger said. "There is no end to the exposures of modern business and society. The risks are too great. The job is never done. Unfortunately, we are reminded of that too often.

"As risk manager, we are quick to focus on loss prevention for property exposures but not as quick on liability exposures beyond the slip-and-fall and OL&T exposure," he said, referring to owners, landlords and tenants liability insurance.

Risk managers also "can't spend enough money on the educational process," he said. "If you spend $1 on insurance, in 12 months that is fully depreciated. If you spend $1 on the education of employees, that has a life span a lot longer than the $1 spent on insurance. Proper manuals, proper systems, are the way to go."

Responding to a question from a member of the audience who asked what a risk manager should do if he realizes that his company is making a product that will cause substantial liability problems in 15 to 20 years, Mr. Bassett answered: "I'd make sure that management was well aware of the consequences and if management refused to budge, I'd step away."

Mr. Heydinger agreed, adding: "I would shout good and loud and make sure they hear you. I can't believe that in the States that a firm would continue too long to operate in that environment."

But, Mr. Heydinger said, if the company did not heed his advice, he too would leave the company. "We all work too hard for our firms to operate one that we are not proud of," he said.

T. Ramanan, a member of the audience and speaking as the president of the India Institute of Insurance & Risk Management in Bombay, called on multinational corporations to act after a loss "in a more human manner."



Mr. Ramanan

He commented that Union Carbide Corp. offered $6,000 in compensation for each person who died because of the 1985 poison gas leak in Bhopal, India, while the minimum compensation for loss of life in Australia is $98,000 Australian ($80,650).

In an interview, Mr. Ramanan noted that the Indian government asked for $11,000 for each person who died. "The people who died were not very rich, but many were young who could have been good breadwinners for many years," he said. ■

# Amusement park risks

*Continued from page 3*

• Park patrons can suffer from heat stroke if there is not enough shade, or they can suffer injuries by tripping on potholed pavement.

The risk managers also noticed that, for the most part, the amusement park managers are aware of the dangers inherent in their rides and take precautions to prevent or mitigate accidents.

For example, bright red-lettered warning signs are posted at each ride for park patrons to read while waiting in line.

And, when an accident does occur, strict procedures are followed by park personnel.

In addition, the parks also purchase as much as $100 million Australian ($82.3 million) in liability insurance limits.

Despite their open invitation, "the parks are nervous about having all of you insurance-types out there," Johnson K. Lee, vp-loss control at Alexander & Alexander of California Inc., told the estimated 180 risk managers during a briefing just prior to the Sea World and Dreamworld inspections.

But, Mr. Lee said he was "delighted" that the First World Congress attendees would have a "hands-on experience" in surveying risks.

"Inspecting a plant is the most important thing you can do" as a risk manager, Mr. Lee said.

Although risk managers often receive outside reports about the condition of their company's assets, "you need to go out there and find out for yourself" if a site is safe, he said.

"Inspections should reveal increased risk of loss, which could lead to increased (insurance) premiums," Mr. Lee said.

When inspecting any site, risk managers should check for faulty wiring, blocked off exit doors, open sprinkler valves, poor housekeeping, broken glass, cracks and planking with large gaps, Mr. Lee said.

At the parks, Mr. Lee instructed the risk managers to look for properly marked exits, inspect the condition of first-aid equipment and fire extinguishers, and scrutinize the general appearance of the parks and the condition of their walkways.

Mr. Lee also distributed fire, safety and property inspection forms and facility survey reports used by Knott's Berry Farm in Buena Park, Calif., the third-largest U.S. theme park after Disneyland and Disneyworld (see story, page 26).

The risk managers were asked to keep these forms in mind when touring the two Australian parks. Among other things, the reports ask:

• Are receptacles provided for separate waste materials, and are they emptied regularly?

*Continued on next page*

NO CANNED ANSWERS

*Continued from previous page*

- Are "no smoking" signs posted in areas that contain combustibles and flammables?
- Are warning signs conspicuously located at all electric motor-driven machines that start automatically?
- Are directional signs posted in areas of limited access to the general public?

The risk managers also were invited to use a Knott's Berry Farm notepad, which contained the park's motto—"Safety is Everyone's Job"—at the top of each page.

The first stop on the inspection tour was Sea World, about a one-hour drive south of Brisbane on what the Australians call the "Gold Coast" to just north of the city of Surfer's Paradise.

The park—similar to Sea World in San Diego, Calif., with dolphins and killer whales among its main attractions—has been openat its current location since October 1971 and is continually expanding.

**'The management of risks and public safety has been integrated into all activities at the park, or—at the risk of being frivolous—we have a risk management team of 350 members (Sea World's employees),' Mr. Searson says.**

One of the first risks noticed was the lack of shade for park patrons lining up to get into the World of Sea Theater, where the risk managers waited for Peter C. Searson, executive assistant to the chairman of Sea World Properties Ltd. in Brisbane, a subsidiary of Pivot Group Ltd.

Because no one at the park is specifically responsible for insurance and risk management, Mr. Searson was flown in by helicopter that morning to discuss the park's safety programs.

The risk managers also noticed an open construction site surrounding the park's monorail station, which was being expanded, creating the possibility that park patrons could wander in and hurt themselves. One risk manager wondered out loud whether a bodily injury loss would be the responsibility of the park or the construction firm.

Conference members eventually were invited to escape the sun and view the aquarium located inside a building next to the theater. Inside, they found a clearly posted "no smoking" sign accompanied by a picture of a fish smoking a cigarette inside a red circle with a line through it.

There also was a "smokers bin," or barrel ash tray, into which visitors could deposit their cigarette butts.

After Mr. Searson arrived, the risk managers were escorted into the World of Sea Theater, where they were greeted with a giant tank of shark, manta rays and other large fish indigenous to the Great Barrier Reef.

A curtain fell over the viewing screen of the tank, and Mr. Searson began his short talk on how Sea World manages risks.

"The world of insurance is an ever-changing environment, especially when we consider the way modern technology enables us to come up with more and more 'thrill-seeker rides' and the way in which we see multimillion-dollar claims being sought for damages in the United States," he said.

"These things all add up to the risk takers wanting more money for premiums and in some cases forcing the business houses of the world to carry their own risks."

"We in Australia are caught up in this as we go to the world markets to obtain better buying prices for our insurance, and obviously Australian insurers are aware of these world events," Mr. Searson said.

Sea World opened in 1958 at another location with water ski exhibitions in the Nerang River, a show that is still a part of the park's features. Sea World moved to its current site in 1971 and has developed the site extensively, according to Mr. Searson.

"This land was originally all mangrove swamp and sand dunes and, as you will agree, is now considerably improved," he said.

Sea World has no risk manager per se or risk management manual, Mr. Searson admitted. "Instead, the management of risks and public safety has been integrated into all activities at the park, or—at the risk of being frivolous—we have a risk management team of 350 members (Sea World's employees), each one of them a specialist in his own area."

For example, Sea World employs 12 people to keep the park clean. In addition to following a daily cleaning schedule, the workers hose down all footpaths each night so that they will be dry by morning, he said.

The park's rides also comply with federal and state legislation and codes of practice, which also require the park to train operators, maintain records of their training, inspect machinery and investigate accidents.

None of the rides, however, were designed to comply with Australian Standard 353, the "Amusement Rides and Devices" code, because the code was adopted by the government only in early October, Mr. Searson explained.

But, the park's reputation is dependent on the safety of its rides, Mr. Searson stressed.

"So how did we design so many things that have proved to be safe for our patrons?" he asked. The park used designs proven to be safe in other parks worldwide, he said.

Sea World rides include:

- The Corkscrew roller coaster that carries 28 people at speeds of up to 100 kilometers per hour, or 62 mph, upside down.

Riders must be at least 4 feet tall, and operators use two measuring gauges to check height. Once seated, riders are held safely in place by padded securing hoops that are locked into position by the ride operator.

Among the other safety measures on the ride, a daily maintenance check is carried out and logged for reference, and maintenance tests are compared year by year.

- Lassiter's Lost Mine, an indoor ride that carries 14 riders on an eight-minute boat trip. The ride's special effects include the murky waters of an underground mine and simulated mining scenes, including explosions.

The building for Lassiter's Lost Mine is entirely non-combustible. In addition, there is a stand-by generator to ensure full ventilation and emergency exit lighting. The entire mine is floodlit with infrared lighting that is invisible to the naked eye but which allows infrared cameras to monitor the ride in 12 locations. The monitors are viewed in a control room. "And you'd be surprised what people get up to on a slow day," quipped Mr. Searson.

On inspection, the risk managers noticed the infrared cameras as well as the ratchets installed at elevated sections of the channel ramps to ensure that the boats do not fall backward or back up against other boats.

- Nine individual water slides, all made of fiberglass and pumped

*Continued on next page*


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## Amusement parks

*Continued from previous page*
with chlorinated water.

Trained lifeguards are stationed at both the top and bottom of the slides. Each morning, attendants walk the length of all of the slides, except for hard-to-reach sections of the two steep freefall slides, to check for damage or possible sharp edges. Only one patron is permitted on the slide at a time, which is monitored either visually or with time checks, and water quality is tested regularly.

Sea World also owns Australia's first monorail, which initially posed an insurance problem for the park, according to Mr. Searson. Because the park's insurer had never seen a monorail before, it wanted to hike its liability insurance premium by 50%, he noted.

But after Sea World flew in an underwriter from Melbourne to see the site and "satisfy him that the risk factor was low," the insurer offered only a minor loading for the liability coverage, Mr. Searson said.

Sea World now carries $50 million ($41.2 million) in liability insurance placed by Jardine Australia Insurance Brokers. The coverage is written in three layers, led by the Government Insurance Office, a state-owned insurer, according to Mr. Searson. The three layers are $10 million Australian ($8.2 million). $20 million Australian ($16.5 million) excess of $10 million Australian and $20 million Australian excess of $30 million Australian, he said.

Sea World's main attractions—its dolphins and killer whales that perform throughout the day—also posed an unusual risk, according to Mr. Searson. At first, the park's mortgage holder wanted the park to insure the dolphins against unusual risks, such as wind and fire damage, Mr. Searson recalled. However, the park's broker convinced the mortgage holder that such coverage was unnecessary.

**Dreamworld is considering posting warning signs about the possible dangers of petting kangaroos.**

And, now that that the mortgage is paid up, those kinds of "hurdles" have been overcome, he said.

About 647,000 people visit Australia s Sea World annually, and the park logged nearly 6 million guests from Jan. 1, 1979, to Dec. 31, 1987, Mr. Searson said.

"In the same period, we have had fewer than 30 claims, and we believe this is exemplary for a theme park with a turnover of nearly 6 million people," he said. The 30 claims totaled no more than $100,000 Australian ($82,300) in losses, according to Mr. Searson.

After Mr. Searson's speech, the risk managers began their three-hour safety inspection of the park.

While most agreed that the park was clean, safe and enjoyable, the risk managers also noticed some risks of which they felt Sea World should be aware:

- Shade was not available for lunch or at the the whale show, which is the main water attraction. Since the temperature often reaches a searing 90 degrees in the spring, patrons could suffer heat stroke, they said.
- Gas barrels were stored below the monorail.
- Safety nets to stop children from falling into the seal pool were not used.
- Three whale trainers had suffered broken eardrums while performing an act in which the whale holds onto the trainer's feet, dives with the trainer and then lifts him out of the water. Trainers' ears are now tested to make sure they can handle the rapid pressure change.
- Protrusions and some uneven spots make the foot paths unsafe.
- Parts of the Corkscrew roller coaster are close enough to the ground to endanger pedestrians underneath the structure.

After the Sea World inspection, the risk managers were transported by bus to Dreamworld at Coomera, Queensland.

The contrast to Sea World was immediately obvious when guests were greeted with cool drinks and asked to sit under the shade of the Music Bowl. Shade was available throughout the privately owned, tree-filled family entertainment park, an Australian version of Disneyland, with different areas devoted to various themes.

Dreamworld also employs its own risk manager: Garth Bell, general manager of operations.

The risk managers listened to Mr. Bell's brief speech about the layout of the park before taking a one-hour inspection tour.

Afterward, they met at the IMAX theater, where Mr. Bell described the park's safety and risk prevention programs.

During their tour, many risk managers visited the park's "Koala Country" to have their pictures taken with a koala, while others were drenched on the Thunder River Rapid Ride, where rafts shoot through water slides. Still others rode the park's train or walked around the Blue Lagoon water slides, where grown-ups as well as children played.

Among the risks noticed during this frolic:

- "No Diving" signs posted at the lagoon had fallen down.
- Walkways were very uneven throughout the park.
- There were no railway gates at points where the train crossed a pedestrian path.
- Children were allowed in open cars on the train.

The park, which opened on Dec. 15, 1981, is located on a 200-acre site of which only 56 acres has been developed. There are 600 employees on the payroll in the off-season and 1,000 employees during the holidays. The park is open from 10 a.m. to 5 p.m. daily year-round, except for Christmas, which leaves no time to shut down the park and do a complete maintenance inspection, Mr. Bell said.

So far, the park has had nearly 1 million visitors, but Mr. Bell would not say how many injuries or claims there have been.

Dreamworld follows many of the same safety requirements for its rides as Sea World does. For example, the rides are inspected daily, and an attendant at the top of the Blue Lagoon water slides makes sure riders are seated feet-first, not head-first.

Dreamworld management is considering posting warning signs about the possible dangers of petting the kangaroos at Koala Country after an incident in another Australian amusement park in early October in which a visitor was attacked by a kangaroo and required 30 stitches.

"But we have to depend a lot on the common sense of the guests," Mr. Bell said.

In addition, seatbelts have been installed in the bumper cars at the Country Fair area, where many of the park's rides are located.

"We have had tremendous benefit from that alone," Mr. Bell said.

Seatbelts also are used in the six-man Thunder River Rapid Ride.

In addition, harnesses keep riders of the Thunderbolt, the world's longest double-looped roller coaster, firmly in place. Before each ride, Thunderbolt attendants check every passenger's safety harness to be sure it is locked. The restraints cannot be lifted without first pushing away the lap bar, which would be difficult to do accidentally.

*Continued on page 26*


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## Amusement park risks

*Continued from page 24*

Seeing the world upside down from the top of the loop is the same sensation as doing cartwheels, only as a passenger in a roller coaster there is no sensation of control that a gymnast has. But before a passenger can decide whether this is fun, the second loop has been completed and the rest of the ride feels the same as any roller coaster—jerk to the right or left on bends and a quick drop on the last descent that leaves your stomach behind.

Like Sea World, Dreamworld also trains its ride operators. And, Dreamworld staff members are trained to attend to park patrons' injuries.

The park has two on-site first-aid stations staffed by nurses. In addition, 41 Dreamworld employees already have paramedic training, while 41 others are currently being trained. Hospitals and doctors can are on call 24 hours a day, and emergency cases can be flown from the park to hospitals.

In the event of an injury on a ride, the operator, equipped with a first-aid kit and a radio, would contact one of the park's two nurses. The patron is allowed to sit on the ride until the nurse comes and then is taken away to the first-aid station for treatment.

The nurse and the ride operator and other witnesses would then give as precise a description as possible of the incident to a park supervisors for the park's records, Mr. Bell said. Independent witnesses also would be sought, and treatment details and photographs would be logged.

Documentation is absolutely vital and should be as complete as possible in case a bodily injury suit is subsequently filed Mr. Bell said.

"We then notify our insurance broker as soon as possible," he said. Sedgwick Ltd. in Brisbane places between $50 million Australian ($41.2 million) and $100 million Australian ($82.3 million) in liability coverage for Dreamworld.

"We take risk management very seriously," Mr. Bell said.

# Knott's stresses park safety

**By STACY SHAPIRO**

BRISBANE, Australia—Every employee, manager and supervisor at Knott's Berry Farm in Buena Park, Calif., is accountable for safety.

In fact, the park motto—safety is everyone's job—"is a written policy signed by the president of the company," said Donald Troudy, director of occupational health, safety and emergency services for Knott's Berry Farm.

This emphasis on safety has kept accidents to a minimum at the United States' third-largest theme park, said Mr. Troudy. Despite its more than 3.6 million theme park guests and 5 million shoppers annually, the park has never had a ride-related death or serious injury, he said.

In fact, Knott's Berry Farm averages just 1 5 first-aid incidents for every 100,000 rides, a decline from 3.5 to 3.6 incidents per 100,000 rides three years ago, Mr. Troudy said.

The visitors "are all there to have a good time," he told risk managers attending the First World Congress on Risk & Insurance Management held last month in Brisbane, Australia. "But occasionally things do go wrong."

The origin of Knott's Berry Farm goes back to the Great Depression, when farmer Walter Cordelia Knott and his wife decided to stop growing boysenberries and start selling chicken dinners. Realizing that his customers might get bored waiting for their chicken dinners, Mr. Knott bought the buildings of an old ghost town and started his theme park, which now ranks third in size behind Disneyland and Disneyworld.

In addition to emphasizing visitor safety, the management of Knott's Berry Farm communicates the importance of employee safety with a carnival game.

"We play Bingo every day," Mr. Troudy said. Each department head receives two bingo "squares" per day if his department had no injuries to report. If there is an injury, that department's bingo card is ripped up and started again. Each winner receives a $5 gift certificate.

"We have given out $40,000 in the last two years in bingo prizes, which is the cost of one back injury," he said.

So far, 12 employees have been injured this year compared with 28 employees injured in 1985, said Mr. Troudy. "We are proud of this track record."

As part of the park's safety program, all personnel who are trained to operate the rides are given three separate orientation sessions and a minimum of 16 hours of on-the-job training.

In addition, the park has "an outstanding maintenance program" to prevent equipment malfunctions that lead to accidents, he said. Inspections of all rides are conducted daily, written reports from which are collected from safety people assigned to each ride. Each week, the entire facility is inspected.

When an accident does occur, detailed records are kept. All park visitors who are injured must complete and sign "incident reports" when they reach the farm's first-aid center.

Although only about 5% of the accident reports end up being sent to insurers to settle claims, "we keep these files for years," Mr. Troudy said. Photos also are kept in the files.

In addition to these safety features, Knott's Berry Farm:

- Will soon implement drills for emergencies such as tornadoes, power failures, fires and earthquakes.
- Has an all-volunteer fire department on site, which is registered as a fire department in the state of California and can be called for an off-site fire in the area.
- Carries out an audit safety survey form, which is filled in by management every four months.
- Employs 100 interpreters who can speak 37 languages to help overseas visitors interpret the various English warning signs posted throughout the park.

In addition, "we are looking at going to picture-grams (for warnings), according to Mr. Troudy.

- Trains its employees on handling heat stroke victims. "We deal with heat stroke as an emergency, but we have had only one serious heat stroke case in the last four years," he said.

Mr. Troudy could not provide details on Knott's Berry Farm's property/casualty insurance program, which is brokered by Alexander & Alexander of California Inc. ■

Protection . . .

# Computer crime grows as a risk to businesses

BRISBANE, Australia—Computer crime is a growing risk for businesses, a consultant warns.

"Most businesses are computerized to some extent," says John Hawkins, an information technology consultant in the Brisbane office of Peat Marwick Hungerfolds.

And, while today many people have a broad knowledge of computers, those in middle and upper management who are responsible for protecting computers are not generally knowledgeable about computers, he points out.

As a result, "the computer illiterate are responsible for controlling the computer literate," Mr. Hawkins said.

Mr. Hawkins discussed the growing risks of computer crime during a seminar at the First World Congress on Risk & Insurance Management last month in Brisbane.

Computer crimes include pilfering computer equipment, stealing confidential information in a computer system, committing fraud using the computer system, unauthorized use of a computer and sabotaging a computer system, according to Mr. Hawkins.

Based on limited statistics gathered in Australia, the culprits are computer programers, computer operators, thieves, hackers and managers, Mr. Hawkins said.

Exactly who is committing computer crimes, however, is unknown because there is inadequate reporting of computer crimes, Mr. Hawkins acknowledged.

And, this is a major problem, according to Mr. Hawkins.

The numerous scenarios that are involved in computer crime include changing a program to redirect funds or hide actions, changing a master file to increase a credit limit or reduce a liability, falsifying data, stealing information, introducing virus codes to destroy data and misappropriation of funds by electronic fund transfer, Mr. Hawkins explained.

Businesses can protect themselves against computer crime, Mr. Hawkins said, by:

- Engaging external auditors to review operations.
- Controlling access to computers, both physical access and programming, or limiting access through use of passwords.
- Carefully controlling the outside technicians who work on the computers.
- Monitoring and regulating all changes to the computer system.
- Implementing strong administrative controls over staffing of computer operations.

IFRIMA Brisbane

Mr. Hawkins also suggested that businesses should better explain to the public that the cost of computer crime is passed onto society in the higher price of goods and services and counteract the prevailing attitude that computer crime is a victimless crime.

He also suggested that laws need to be reviewed and updated to deal appropriately with computer crime.

*—By Kathryn J. McIntyre*


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# Fault, event 'trees' help analyze risks

By KATHRYN J. McINTYRE

**Fault-tree analysis is 'top down' analysis in which possible hazardous events are identified and the various factors that can lead to them are analyzed, while event-tree analysis is 'bottom up' analysis in which possible outcomes of an event are identified.**

BRISBANE, Australia—Risk managers can formalize the risk assessment process by using two techniques, a consultant advises.

The techniques—which are particularly useful in helping risk managers assess the risk of losses that are less likely to occur but would be very severe if they did—are fault-tree analysis and event-tree analysis, explained Raghu Raman, managing consultant with Industrial Risk Management in St. Leonards, New South Wales, during a seminar at the First World Congress on Risk & Insurance Management in Brisbane.

Fault-tree analysis is "top down" analysis in which possible hazardous events are identified and the various factors that can lead to them are analyzed.

Event-tree analysis is "bottom up" analysis in which the possible outcomes of various incidents are identified.

"We often spend our dollars on perceived risks instead of real risks," Mr. Raman said. These methods help risk managers decide how to most effectively develop loss prevention budgets.

To construct a fault-tree analysis, the risk manager first has to identify the potential hazardous event and then what protection systems would have to fail for the hazardous event to occur.

To illustrate fault-tree analysis, Mr. Raman identified a fire in a printing plant as the hazardous event. He then identified the factors that could lead to this: the use of low flash point solvents and inadequate cleaning schedules that allow ink to build up on press components, which was estimated to happen 30 times a year; a solvent spill and inadequate ventilation due to an inoperative fan or a blocked duct, which was estimated to happen 0.22 times per year. These frequencies are added together to determine that a flammable atmosphere can be expected 30.22 times a year.

Furthermore, sources of ignition were identified, such as uncontrolled smoking, and the probability of such ignition was pegged at 0.07. The frequency of 30.22 is then multiplied by the probability of 0.07 to determine that a fire in the press is probable 2.1 times a year.

The advantages of fault-tree analysis are that: It can handle analysis of major outcomes from several small events; the principal contributors to a particular outcome can be detected; and the analysis can deal with a variety of system structures such as parallel, redundant or alternative fault paths, Mr. Raman said.

Fault trees can be so complex that computer analysis may be required, Mr. Raman noted.

While a fault tree starts from a particular event and works from the top down, an event tree begins with a particular initial event and works from the bottom up, Mr. Raman said.

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An event tree is constructed by defining a primary event and then defining the possible consequences.

To construct an event tree, the risk manager must define an initial event of interest and then define the relevant secondary events, such as failures in systems or components required to operate following the occurrence of the initial event. The failure paths then are traced until the system works or fails.

To illustrate an event tree, Mr. Raman cited a fuel pipe failure. The first question is, "What is the probability that fuel will leak?" There is a 0.05 probability that fuel will not leak—meaning there is a 0.05 probability there will be no hazard—and a 0.95 probability that fuel will leak.

The next question is, "What is the probability of ignition?" Given a 0.5 probability of ignition—and, therefore, also of no ignition—there is a 0.475 probability of pollution from a leak with no ignition source (0.95 multiplied by 0.5).

Following the path of a fuel leak and a source of ignition, the next question is, "Are there adequate fire prevention measures?" Assigning 0.8 to the probability of adequate fire prevention measures, the probability of limited damage from a fire caused by a fuel pipe failure if there is adequate fire prevention becomes 0.38 (0.95 times 0.5 times 0.8). However, assuming the 0.2 probability there are inadequate fire prevention measures, the probability of major damage from the fuel pipe failure is 0.095 (0.95 times 0.5 times 0.2).

The main advantage of an event tree analysis is its simplicity in identifying which fault sequences are significant and that might require a fault tree analysis, Mr. Raman explained. ■

## Risk manager offers creed for his peers

BRISBANE, Australia—Hugh Loader, group insurance manager of Tetra Pak P.L.C. in the United Kingdom, offers the following as a possible creed for risk managers:

"A fundamental set of beliefs in the power to take charge, the courage to go your own way, the resolution to pursue what you want, the intuition to demand quality, the sophistication to express a dynamic image in a dignified manner, the willingness to take risk in the quest for excellence, the reluctance to compromise, the wisdom to insist upon safety, the determination to be a step ahead and the faith to know that you can have it all."

Mr. Loader moderated sessions at the First World Congress on Risk & Insurance Management in Brisbane.





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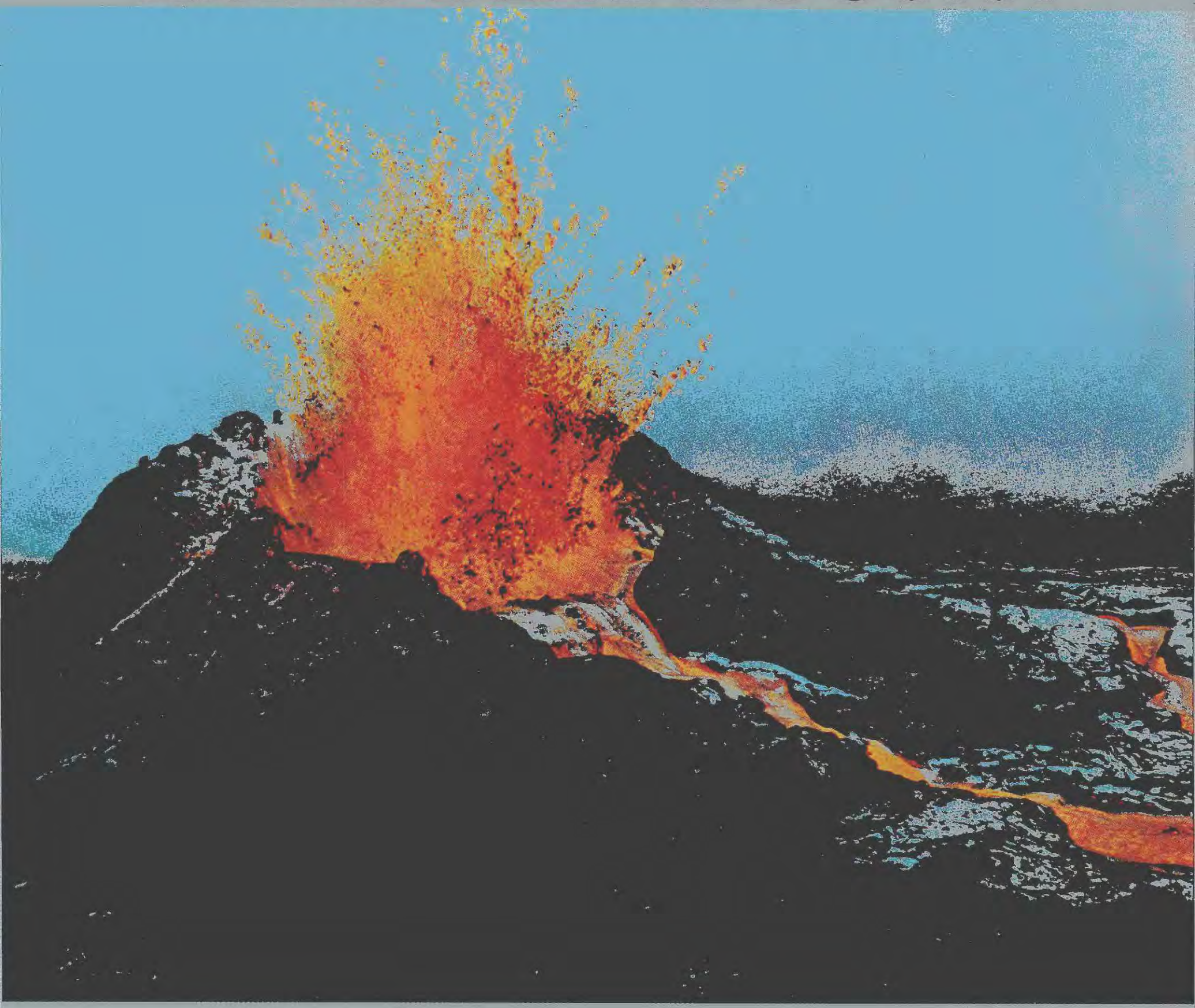
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# Australian state reviews comp system

**By STACY SHAPIRO**

BRISBANE, Australia—A government-appointed committee is examining the workers compensation law in the Australian state of New South Wales to determine its impact on both employees and employers.

After a state election earlier this year, which returned the more conservative Liberal Party to power, the government appointed a review board consisting of six people representing insurance, legal, corporate and consumer interests to decide if the workers compensation law is adequate, said Graham E. Butchard, a New South Wales workers compensation commissioner.

In particular, the review board will determine whether employees should be allowed to sue their employers for workplace accidents, a "common law" right that was taken away from employees in the state's Workers Compensation Act of 1987, he said (*BI,* Sept. 7, 1987; July 7, 1986).

"My own opinion (is that)...common law will come back into the law but with limits," said Mr. Butchard. For example, it may be that employees are only allowed to sue employers for pain and suffering cases rather than for compensatory damages for an injury, he said.

New South Wales workers compensation law historically started in 1926 when the first workers compensation act in the state was passed. The act allowed for licensed insurers to write workers comp coverage and allowed employers to self-insure the risk, Mr. Butchard said at the First World Congress on Risk & Insurance Management last month in Brisbane.

Then, in 1984 and 1985 several changes took place. Several amendments were passed to the 1926 act establishing a State Compensation Board, composed of a chairman, two members representing the concerns of the employers and one members who is a trade union representative, he said.

The board was responsible for research, collection of statistics, the monitoring of the operations of statutory workers compensation programs, such as programs for the coal industry and railroads.

The board also was responsible for the rehabilitation of employees. While that responsibility was later transferred to the Department of Industrial Relations & Employment, Mr. Butchard believes it soon will be transferred back to the State Compensation Board.

Other amendments in 1985 established:

- The appointment of commissioners to exercise certain powers of the Compensation Court of New South Wales. There currently are 11 commissioners, including Mr. Butchard.
- A formula-related premium tariff structure that allowed for surcharges and/or rebates in light of employers' safety records. Employers have the right to appeal the premium charged.
- The extension of the power of the Compensation Board to review, revoke and/or renew the licenses of existing licensed insurers or to license other insurers in accordance with new criteria.

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The changes were necessary because "the (workers compensation) premium costs in New South Wales in recent years had been increasing exponentially," said Mr. Butchard.

The cost of the system rose to $1 billion Australian ($825 million at year-end 1984 exchange rates), up from $412 million Australian ($486 million at applicable exchange rates) in 1980 and $295 million ($368.8 million at applicable exchange rates) in 1975, according to statistics from the former Workers Compensation Commission's annual report in 1984.

Then, in May 1987, legislation was introduced to the state in the form of the Workers Compensation Act of 1987.

Under this law, workers compensation risks are now insured by a state-controlled workers compensation fund called Workcover, though private insurers can be licensed to help administer the program, said Mr. Butchard.

The 1987 law also:

- Abolished common law rights of workers to sue employers for worker-related injuries.
- Increased weekly benefits for incapacitated workers with dependents.
- Limited some workers compensation awards to partially incapacitated workers. These workers must undergo rehabilitation training and seek employment or prove that suitable employment is not available.
- Mandated that employers with more than 20 workers must implement a rehabilitation program by January 1989 and employers with fewer employees by July 1989.

"Rehabilitation is one which has now taken on a new dimension, a far greater responsibility by the employer to provide suitable and more rapid programs which would benefit the employee," said Mr. Butchard.

"Much can be said about workers compensation from the applicant and respondent's viewpoint, but I consider vast improvements have taken place in New South Wales and no doubt this present government will continue to refine and administer a system which will be beneficial to the injured worker and be an efficient system to the employer," he said. ■


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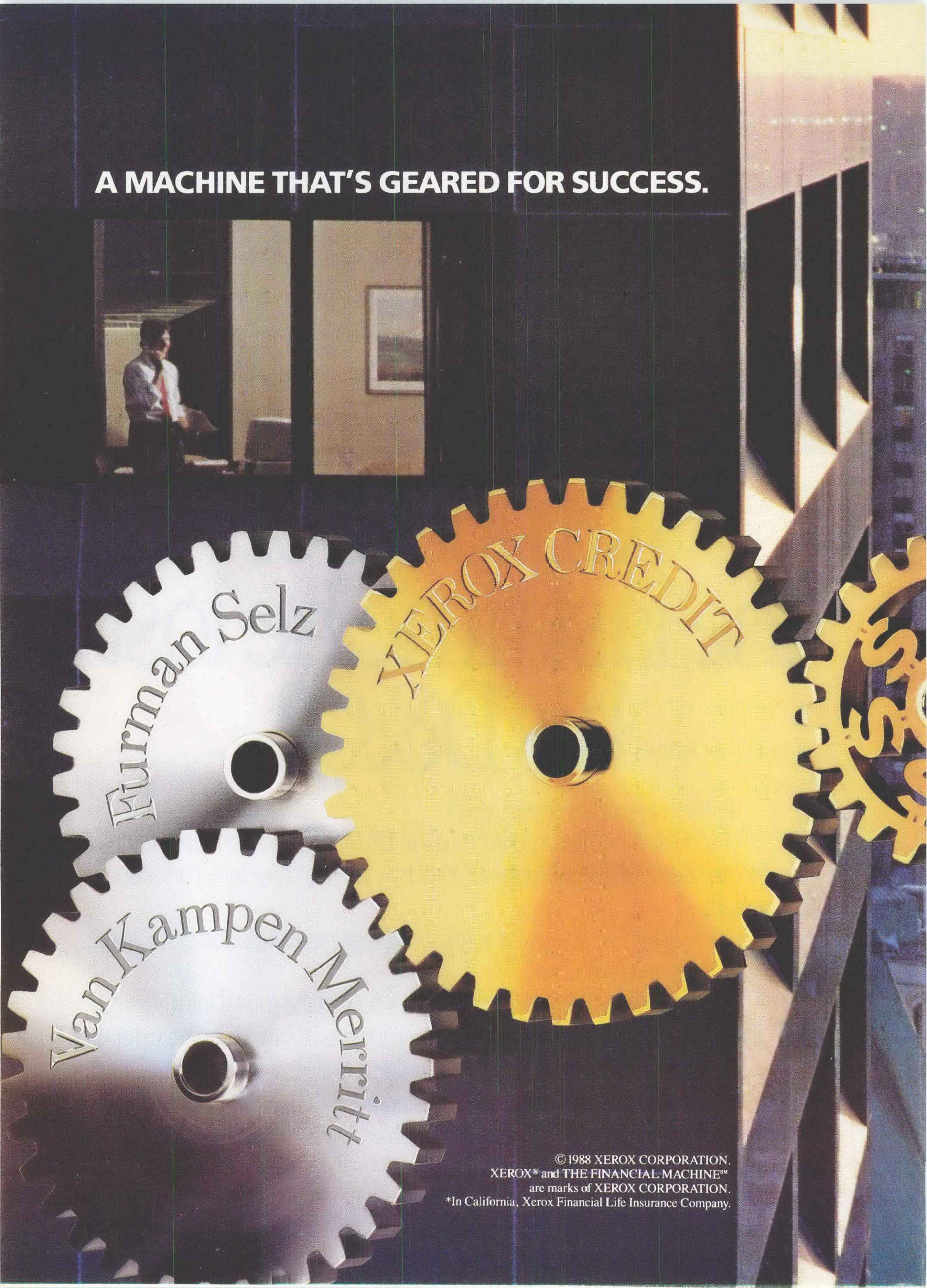
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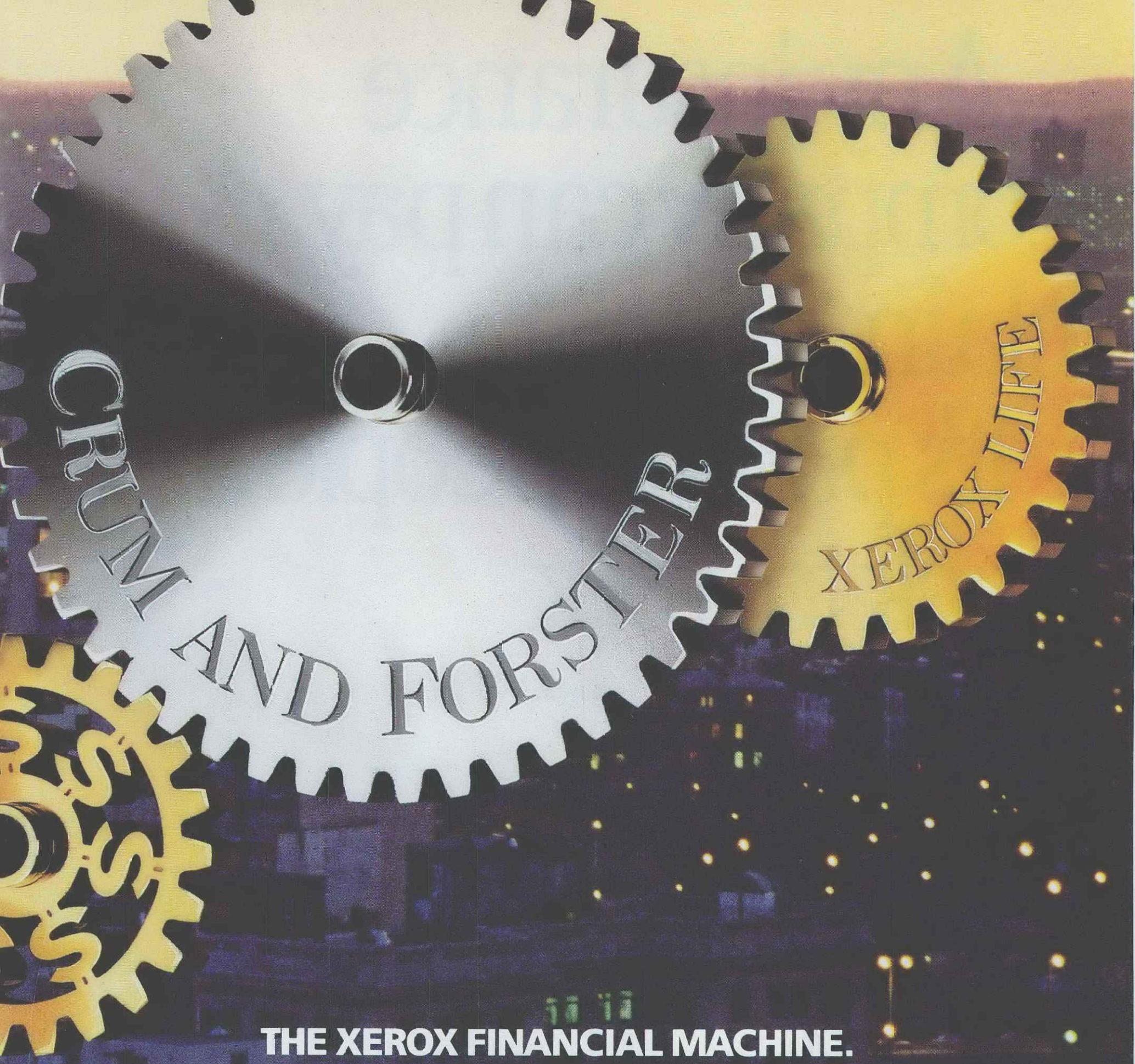
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# ASK A CASUALTY ACTUARY

## Several methods used for accurate estimate of loss reserve picture

**Q** **If you had to pick only one method for estimating loss reserves, to the exclusion of all others, which one would you select and why?**

**A** Before answering your question, let me first say that I would never recommend the use of only one method in estimating loss reserves, no matter how good the method was.

There are several reasons for this, which can be illustrated by the following story:

Eversure Corp. hired a consultant named M. Penn Dingdoom to evaluate the adequacy of the loss reserves of its captive, The Insurmountable. Using the commonly accepted method of incurred loss development to test the reserves, Mr. Dingdoom concluded that the carried reserves of $100 million were short by about $45 million and presented his findings in a well-documented report to Eversure's chief financial officer.

The CFO was so concerned about the findings that he sought a second opinion, and brought in a second consultant, Mr. Moore Caw Shush. Mr. Shush, who conducted his study by applying only the paid loss development method, indicated that the carried reserves were redundant by more than $35 million, and he, too, presented a well-documented analysis based on this widely accepted method.

**Having two methods that produce nearly the same result is no substitute for having a thorough understanding of recent trends and events that could distort your reserve indications.**

The bewildered CFO instructed his staff to carefully verify the accuracy of the data and the application of both of the methods employed by Messrs. Dingdoom and Shush, and this review corroborated the correctness of each study.

What went wrong? How could two different analysts arrive at such completely different conclusions?

What needs to be understood is that all methods of reserve analysis are highly sensitive to the effects of changes in the captive's claims operations and the operating environment.

It is not possible to say beforehand that one method is inherently better than another, because the appropriateness of a given method is highly dependent on the particular circumstances of each situation.

Any method is only as good as the underlying assumptions on which it is based. For example, the incurred loss development method assumes that those who have been setting case reserves have been following consistent practices over the historical period that was reviewed.

If there have been significant changes in those practices, this method can produce very distorted indications.

In the example above, about two years ago the claims administrators for the captive made major changes in their procedures and philosophy in setting case reserves. This caused the claims administrator to set up more adequate individual claims reserves at a much earlier stage for most claims than previously used.

By applying the incurred method without understanding this, Mr. Dingdoom was developing projections that greatly exceeded the real need.

At the same time, Mr. Shush completed his analysis without being aware that during the past three years the claims administrator had become much less adequately staffed. This change resulted in claims being settled and paid much more slowly than before. This slowdown caused the paid loss development method to substantially understate the real reserve need.

What can be easily seen from the above example is that the use of more than one method can force you to try to explain any major differences between the reserve indications.

**It is not possible to say beforehand that one method is inherently better than another, because the appropriateness of a given method is highly dependent on the circumstances of each situation.**

To the extent that this causes you to better understand the claims operation and whatever changes are taking place in terms of the nature of the insured risks, this process can be very valuable, if not indispensable.

The major danger here, however, is that both methods could have been equally wrong, and thus have produced the same, or nearly the same, incorrect indications.

Having two methods that produce nearly the same result is no substitute for making sure that you have a fairly thorough understanding of recent trends and events that could distort your reserve indications.

Another widely used reserve estimation technique is the Bornheutter-Ferguson method.

This method estimates the amount of losses yet to be incurred (or paid) based on a predetermined loss ratio (or pure premium) for the most recent accident periods.

This predetermined loss ratio is modified, however, to the extent that incurred (or paid) losses to date differ from what would have been expected to this point in time (based on history).

One advantage of the Bornheutter-Ferguson method is that the indications developed by it aren't based on applying a large factor to the relatively small base of what has been reported (or paid) to date.

The weakness of this method, however, lies in its dependency on a predetermined loss ratio—which may or may not be accurate or relevant.

This can be particularly true when there have been major changes in rate levels, retentions or deductibles, the forms and conditions of reinsurance coverage, the types of risks covered or a variety of other changes.

Yet another common reserve method is based on separate projections of the ultimate number of claims and of ultimate losses per claim.

Obviously, this type of method is quite sensitive to changes in how claims are counted (e.g., one claim per coverage or per claimant or per all claimants), as well as to changes in the retentions or deductibles, the forms and conditions of reinsurance coverage, the mix of risks covered, and so forth.

There are, of course, still other changes that could cause a reserving method to be inaccurate. Not uncommonly, with a change of claims administrator, there is little or no assurance of any real level of continuity in how claims are reserved or negotiated or even recorded.

Significant changes in the legal environment also can cause past claims settlement patterns to no longer be relevant. Shifts in attitudes as to whether to defend or settle can also make a big difference.

When it comes to reserving loss adjustment expenses, it is also important to find out if there have been any changes in billing practices by law firms (e.g., at settlement vs. interim).

After having considered most of the things that could cause a particular method to produce distorted indications, it is usually possible to come up with a reasonable assessment of how accurate the method should be in these particular circumstances. And, it also should be possible to roughly estimate the direction and extent of the distortion likely. If several methods are applied, and evaluated as noted above, it should be possible to avoid the risk of substantially misstating the reserve indication.

Once a set of reserve predictions (e.g., by accident year) have been initially selected, they should be translated into ultimate loss projections (paid plus reserve projection).

These ultimate loss projections should then be reviewed for reasonableness in terms of ultimate losses per exposure unit (or per claim or relative to premiums at present rates) over successive accident periods.

Such a reasonableness test may suggest that the initial set of projections may not make as much sense as they should for the most recent accident years.

In closing, I should try to answer your question in the event that there are not any of the above types of concerns about any of the methods. In that case, which method would I favor?

My answer would vary according to which accident years were being considered. For the oldest (and most mature) accident years, I would tend to favor the incurred loss development method. For the intermediate accident years, I would tend to favor the average of the incurred and the paid loss development methods. And, for the most recent accident years, I would tend to favor the Bornheutter-Ferguson method, where the loss ratios (or claim severities or pure premiums) were selected after a careful review of the indications from the intermediate accident years.

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*Would you like advice from an experienced colleague on a risk management, benefit management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.*

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



Mr. Sherman

*This month's column on actuarial issues in the casualty field is written by Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions in the benefits field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. And, Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions.*

*Mr. Sherman's and Mr. Miner's columns appear alternately on the first Monday of each month. Ms. Werner's and Mr. Duva's columns appear alternately on the second Monday of each month. Mr. Sherman's next column will appear in January.*

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

# Italian pensions

## Changes increase scrutiny of nation's social security system

**By Jerome Karter**

IN ITALY, recent legislative measures have given the boot to former salary ceilings in the state social security pension schemes. The changes, which fly in the face of Italy's mounting budget deficit, have rekindled the smoldering argument over whether to completely overhaul the Italian social security system.

The need for change is rooted in Italy's strong socioeconomic traditions, which include a generous public health scheme and a widespread state pension system. Historically, conventional company-sponsored employee benefit plans have not existed in Italy, nor has the jurisprudence necessary to propose their introduction. Instead, the Italian repartition system was broadened in 1969 to give pension rights to all citizens, even those who had not contributed to the scheme.

Through the mid-1970s, social pension benefits met the needs of most retirees because average salaries tended to be well below the pensionable salary ceilings set by the government. At retirement, a full-career employee could expect to receive a pension benefit equal to 80% of his or her final average salary—not exceeding the pensionable salary ceiling—as well as a lump-sum severance payment that was calculated on the basis of the employee's salary level at termination.

Unfortunately, a downturn in the economy, spurred by the oil crisis, saw unemployment grow and population decrease in the late 1970s. The resulting double-digit inflation rate, as well as a changing populace, have put a strain on the state social security scheme.

**International issues**

During Italy's economic crisis, direct salary increases were the exclusive employee incentive. But, Italy's expansive high-inflationary period caused a critical gap between quickly escalating salary levels and lagging social pension ceiling adjustments.

The problem was compounded when compulsory termination payments were modified by Law No. 297 of May 1982. In effect, the lump-sum severance benefit that traditionally supplemented an employee's old age retirement pension was changed to a deferred monthly salary that is further reduced by taxation. Also, the law stipulated that severance benefits were to be calculated on the basis of an employee's career average salary instead of on his or her salary level at retirement.

At the same time, Italy's demographics were helping to fuel its mounting public debt as the workforce shrank and retirees swelled the ranks of pensioners. By the year 2010, there will be only one contributing worker for every pensioned retiree in Italy and the deficit of the state pension plan—the INPS—will exceed 3% of Italy's gross national product.

These recent government statistics pose the question: Will INPS be financially sound and capable of meeting its future obligations?

The answer is not so simple. To be sure, Italy's first tier of benefits—that is, its state health and pension system—is in need of long-awaited reform.

The general social security scheme currently encompasses the following national health system benefits that are payable to all workers:

- General practitioner care.
- Specialist care.
- Prescription drug reimbursement.
- Inpatient and outpatient treatment.
- Maternity care.

Basic old age retirement, disability and survivors pensions as well as unemployment benefits for most workers and for *dirigente*—or executives—in the commercial sector are provided by the INPS. A second contributory plan, called the Mario Negri Fund, supplements basic pension benefits for commercial *dirigente*.

All INPS pensions paid after Jan. 1, 1988, are calculated on the basis of an employee's total earnings rather than on the former basis of 80% of final average salary, subject to a ceiling.

In addition, the previous basic and supplemental pension provisions for a commercial *dirigente* have been consolidated into a single benefit formula.

About 100,000 *dirigente* in the industrial sector rely on the INPDAI plan for basic old age retirement, disability and survivors pensions.

A second contributory plan, called FIPDAI, supplements basic pension benefits.

The maximum INPDAI pension payable to a *dirigente* with a full 30-year contribution period is 87.9 million lira ($66,804). This represents an income replacement ratio of 56.7% for a *dirigente* with a maximum pensionable salary of 155.2 million lira ($117,952).

Supplemental pension packages for *dirigente* grew out of a need to motivate and maintain qualified personnel through indirect remuneration.

As a result, national collective labor contracts for all *dirigente* have been negotiated to include a second tier of benefits—namely, supplementary health and pension benefits that are either employer-funded or jointly paid by both parties.

Today, supplemental medical benefits for *dirigente* are provided through special autonomous funds or stipulated medical insurance policies. Other supplementary benefits for executives include: obligatory lump-sum accident insurance for death and/or disability, permanent




sickness-related disability coverage, life insurance in decreasing amounts up to age 65 and a supplementary pension that is payable in the form of an annuity or lump sum.

Not surprisingly, insurance companies in Italy are riding the wave of new compensation strategies.

In fact, the companies that underwrite employee benefit products are showing a notable increase in spending for mass marketing.

As a result, market demand for direct written individual life insurance policies has increased by 35% to 40% recently, while indirect demand has grown through national collective labor contracts and internal company agreements.

Another key area of activity is private pension plans. Many large corporations, as well as some banks and insurance companies, have introduced private company-sponsored pension plans for their *dirigente*.

Many believe that this trend should be broadened to include all workers, not just executives and middle-management personnel.

In a related move, newly revised tariff rates have been proposed for employee benefit products. In addition, insurers have introduced a funding vehicle for sharing return on investment—up to 4%-5% in real terms—with large employee benefit clients.

Despite the increasing demand for supplemental benefit schemes and private pension plans, innovative products are not available yet in the Italian market.

Currently, the group deferred annuity is the only technical instrument used to fund a pension plan in Italy.

Unallocated funding vehicles, including "deposit administration" contracts, are not allowed and immediate annuities have not yet gained popularity.

A concept that is becoming popular, however, is a third tier of benefits: contributory plans. Both second-tier and third-tier plans have been aided by the general fiscal law that was enacted in Italy last Jan. 1.

More specifically, the tax advantages offered by the new law have created interest among both employers and employees for matching defined contribution or savings plans.

Under the new law, an employee's taxable income excludes any retirement or welfare contributions paid by the employer and the employee to an autonomous body or a "cassa" (third-party trust) in accordance with a legal obligation, national labor agreement or internal company agreement or regulation.

Other exemptions to taxable income include:

- Employer-paid premiums for life and/or accident insurance up to a limit of 2.5 million lira ($1,900). If such insurance is stipulated on a personal basis, the employee may deduct the same level of premium from his/her individual tax return.

This tax break is analogous to the Individual Retirement Account in the United States, except that the monies must be directed to an insurance contract.

- Employer-paid premiums for tax-deductible employee medical expenses such as surgical procedures, outpatient treatment and dental care. Otherwise, employer-paid premiums are considered taxable income to an employee but reimbursed claims can qualify for partial tax deductions.

As matching-type defined contribution and savings plans grow in number, employers in Italy will have to concentrate on effectively communicating the total cost involved in funding employee benefits. These costs include salary, contributions to the social security scheme and any private benefits.

In summary, recent legislative changes in Italy's social security scheme are viewed as a "mini reform" only. In fact, most Italians are watching and waiting for the much-promised overhaul of their country's social security program.

In the meantime, U.S. risk and/or benefit managers should re-examine their benefit formulas in Italy in light of the recent legislative changes. This review is especially important if your subsidiary has a defined benefit pension plan that is integrated with an INPS or INPDAI social security pension.

Nothing is simple. But, if special attention is paid to program design, second- and third-tier plans may suit your corporation's needs in Italy.

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*Jerome Karter is senior vp and manager of the New York International Department of Johnson & Higgins. His column appears the first Monday of every month.*



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# Broker outlines 4 C's of risk management

By KATHRYN J. McINTYRE

BRISBANE, Australia—The risk management discipline should embrace four basic principles: cause, change, chance and commitment to quality and safety, a broker suggests.

"Let me call this the theory of the four C's," said Marnix Guillaume, president of Corroon & Black International in New York, a unit of Corroon & Black Corp.

Mr. Guillaume presented his theory in remarks on "Risk Management into the 21st Century," during the First World Congress on Risk & Insurance Management last month in Brisbane.

Cause is an important principal because "without exploring the 'why,' we cannot fully understand and treat all the potential effects of an action," he said.

"What a feat it would have been if we had known, prior to the development of asbestos, what the downside risks were compared with its beneficial uses," he pointed out.

Now, risk managers have access to increasing sophistication in global communications and diagnostic software in the scientific, medical, industrial and meteorological areas. These advances must be made available to developing countries, too, Mr. Guillaume said.

"Through their global network and associate relationships throughout the globe, brokers and insurers must transfer this risk management technology," he said.

Studying the methodology of change, Mr. Guillaume said, involves determining whether change has taken place in quantity, quality or if nothing remains of the original quality.

This "develops a risk management appreciation to add to cause. We will then be much closer to an understanding of the positive and negative risk probabilities and also to opportunities to reduce the chance of loss," he said.

Chance, the third "C" in Mr. Guillaume's theory, involves the chance event, which Mr. Guillaume contends "is only less predictable in occurrence because we are ignorant of its causes, not because of any endemic condition within the natural order."

"With greater knowledge of causation, random chances will become more predictable and so more avoidable," he maintained.

However, the fourth "C," commitment to quality and safety, permits the control or elimination of the fortuitous, according to Mr. Guillaume.

Quality control and safety programs require the joint cooperation among production, research and development, sales and risk management, he said. And, the program should be audited by outside qualified specialists because "no one, single internal auditing entity will want to point the finger at its own errors or misdeeds," he said.

The program must involve reward to motivate people to make a willing and enthusiastic commitment to quality and safety, he added.

However, Mr. Guillaume said, "There is evidence that worker safety may be taking a back seat to the emphasis on product quality" in the highly competitive world market.

The subject of safety needs proper emphasis and association with quality of product or service for several reasons, Mr. Guillaume said:

- The consumer is demanding safe products.
- Unions are emphasizing worker safety and health more than ever before.
- Court awards to injured parties are growing larger.
- Technology has created a need for more extensive and dynamic safety programs and people feel that things can and should be safe.
- Legislative bodies are imposing safety requirements.
- The workforce has changed with requirements for equal opportunity in hiring and with workers' general desire for more out of their jobs than just a livelihood.
- Costs are controlled more effectively if machinery is made to last longer, and fires and other property damage are prevented.
- New research is identifying hazardous substances and products, creating new liabilities for businesses.

**'Without exploring the "why," we cannot fully understand and treat all the potential effects of an action,' Mr. Guillaume says. 'What a feat it would have been if we had known, before the development of asbestos, what the downside risks were.'**

"If safety is rightly regarded as critical to people and product quality, then it is evident that these two have a lot in common," Mr. Guillaume said.

A commitment to safety and product quality both "seek to maximize the positive outlook that leads to job pride that produces quality products, safely and on time," he said.

"Both seek to provide adequate training and retraining as needed for critical tasks where past training has been inadequate or nonexistent. The right way to do the job must include the safe way as well as the way that conforms to accepted quality requirement," he said.

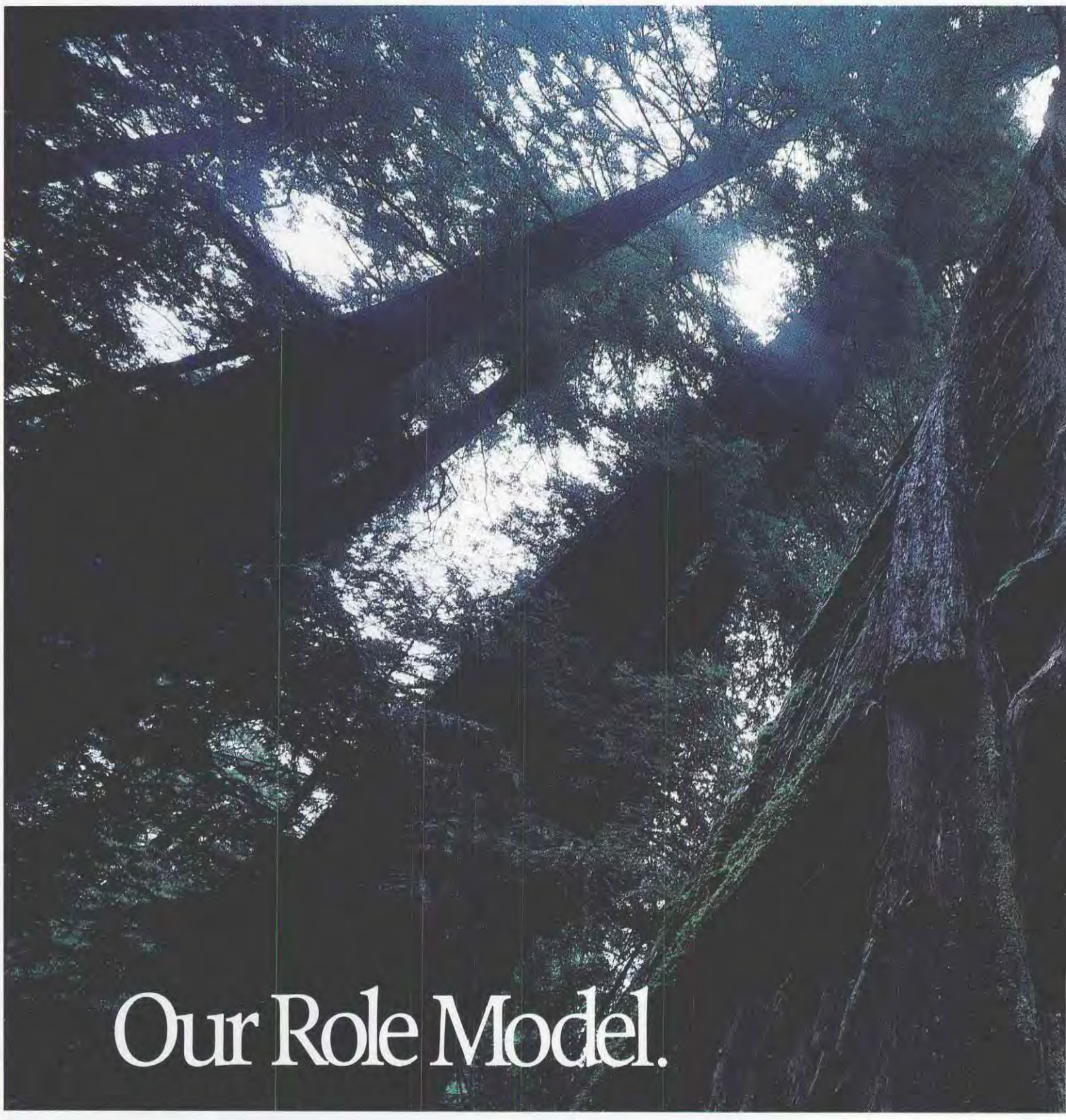
A worker's mental and physical fitness also is important to both preventing accidents and producing quality products, Mr. Guillaume continued, as are adequate machinery and properly maintained equipment and safe structures.

"Safety as a major part of people quality and product quality as a part of total quality go hand-in-hand," Mr. Guillaume said. "One without the other could eventually jeopardize the entire objective of overall quality."

Product and people quality "form an active part of risk management," he said.

"However, they will not work in an environment that does not motivate every single employee, from the CEO down to the janitor," he advised.

"This motivation can only be stimulated by reward, whether it is a promotion, financial reward or the proverbial pat on the back." ■




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# Australian still looking for true 'risk manager'

By STACY SHAPIRO

BRISBANE, Australia—There is no such thing as a risk manager, claims Australia's Risk Manager of the Year.

Companies employ people who call themselves risk managers but who really are risk coordinators, according to Paul Viciulis, safety controller for Grace Bros. Pty. Ltd.

And, more than one manager often controls one or more of the functions that contribute to the overall risk management process, pointed out Mr. Viciulis, who was named Australia's Risk Manager of the Year by the Assn. of Risk & Insurance Management of Australia during the First World Congress on Risk & Insurance Management in Brisbane last month.

"Risk management is not a profession and, indeed, when one meets executives from various organizations with the title of risk manager, the question begs: 'Have I finally met a real risk manager?' "



Mr. Viciulis

Mr. Viciulis said during a session titled "Risk Management as a Discipline."

"Alas, the answer must be in the negative," he said.

"There is no such creature as a risk manager, for not one person on this planet possesses all the necessary skill and technical attributes to be able to fully implement, organize and control an all-encompassing risk management role," he said.

**'There is no such creature as a risk manager,' says Australia's Risk Manager of the Year.**

"To create such an animal would entail tertiary education spanning the full gamut of engineering, accounting, economics, health, the law, insurance, underwriting, brokering and so on, ad infinitum."

Mr. Viciulis also contends that risk management is not a profession, because it lacks two basic criteria to qualify as a profession: advanced education and an "avowal of belief by other professionals that risk management is pertinent, scientific and of high standing in the business community."

But Mr. Viciulis said he believes that risk management can have the status of a profession if the people who call themselves "risk managers" show the desire and conviction to achieve that status.

"We need to be committed to the goals (of risk management) rather than talk about them as we have done so eloquently in the past," Mr. Viciulis said. "Risk management should be a profession. It deserves the status, and its contribution to profits and continued success of the public and private corporate sectors has in the past been greatly underrated."

To achieve this end, all risk management associations around the world, particularly those belonging to the International Federation of Risk & Insurance Management Assns., should make a "concerted and combined effort to spread the gospel and alert the business community to what the real risk management process is all about and the specific benefits that can be realized by implementing good risk management techniques," Mr. Viciulis said.

He called on risk managers in Australia in particular to pool their talents and resources to become a united group spearheading risk management to "professional heights."

However, T. Ramanan, insurance manager of Hindustan Lever Ltd. in India, believes that risk management "is the oldest profession in the world."

Humans have been managing risks for years by, for example, trying to prevent wars and minimize the effects of flood, earthquake and other acts of God "where there is no solution," Mr. Ramanan said.

"Risk management starts with a sense of great devoted sacrifice of time and energy," he said.

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Risk management is "the daughter of insurance. Insurance and risk management are intricately intertwined," he said.

However, Mr. Ramanan would like to see more risk management education on an international level and suggested that IFRIMA set up a committee to develop a course of study outlining a common approach to risk management.

There also should be a uniform definition of risk management, according to Mr. Viciulis.

Felix Kloman, a principal and vp of Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc. in Stamford, Conn., agreed.

Mr. Kloman, a consultant who has been preaching the risk management gospel for many years, believes that risk managers "are still evolving."

"What is risk management? How do you define this discipline with which we are involved? There are of course numerous definitions of risk itself," Mr. Kloman said.



Mr. Kloman

But, "there is as yet no commonly accepted definition" of risk management, he observed.

"I suggest that the old definitions, the definitions that we used in the past, are indeed outmoded. The response then, for you as risk managers, is to develop a new definition, a re-definition, that will enable the discipline to move ahead as it must."

Mr. Kloman suggested that the definition of risk management should be: "a decision-making process for living with the potential realization of unwanted consequences from impending events."

He explained that the definition should include the words "decision-making process" because risk management is a part of management, and the words "living with" because risk managers "must live with risk all the time."

Risk managers also should abandon the theory that risks can be transferred by a risk-financing technique like insurance.

"Risk cannot be transferred to anybody else," he asserted. "It is always our responsibility," Mr. Klo-



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# Singapore welcomes influx of new captives

By STACY SHAPIRO

BRISBANE, Australia—Singapore increasingly is recognized as an attractive domicile for captive insurers, says the insurance commissioner of the city-state.

Singapore, which attracted its first captive in 1983, now boasts 30 captives. Captive premium volume has increased to more than $100 million Singapore ($50 million) from $8.4 million Singapore ($4.2 million) in 1984.

The city-state also has 12 captive managers, the largest of which is Sedgwick Management Services Pte. Ltd., which manages 16 captives.

**Although 28 of the 30 captive insurers in Singapore are Australian-owned, Singapore officials hope that parent companies in other Asian/Pacific countries, particularly Japan, will consider forming captives in Singapore.**

Although 28 of the 30 captives in Singapore are Australian-owned, Singapore officials hope that parent companies in other Asian/Pacific countries, particularly Japan, will consider forming captives in Singapore.

Singapore is an island nation in Southeast Asia, situated at the southern tip of the Malaysian peninsula, explained Law Song Keng, Singapore's insurance commissioner, at the First World Congress on Risk & Insurance Management last month.

The country was a British colony until it became part of independent Malaysia in 1963. Two years later, Singapore became an independent country.

Singapore achieved rapid economic growth in the 1970s and early 1980s and "today has a standard of living in Asia second only to Japan," Mr. Law said.

The small island of 620 square kilometers has a population of 2.6 million people, Mr. Law said.

It is on the crossroads of the world's major sea and air routes linking the East with the West, with 700 shipping lines passing 30,000 ships annually through Singapore ports.

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It also is becoming a major convention center, as several of the First World Congress members who attended the Risk & Insurance Management Assn. of Singapore conference last week at the new Pan Pacific Hotel know.

And, Singapore boasts of being one of the key offshore financial centers in the Asia-Pacific region. "We have 133 commercial banks, 62 merchant (investment) banks, 31 finance companies, 101 insurance companies and 47 representative offices of financial institutions from all corners of the world," Mr. Law said.

Today, Singapore's financial sector contributes 14.6% of the total gross national product of the country, up from 4.5% in 1968, according to Mr. Law.

Singapore now wants to develop into an "important insurance center with the capacity to write business in the region as well as internationally," he said.

As a result, the government has targeted offshore reinsurance business and captive insurance as the most important areas for growth.

Since licensing its first reinsurer in 1973, Singapore today has 18 professional reinsurers, "many of whom are using Singapore as a regional base for their Far East operations," Mr. Law noted.

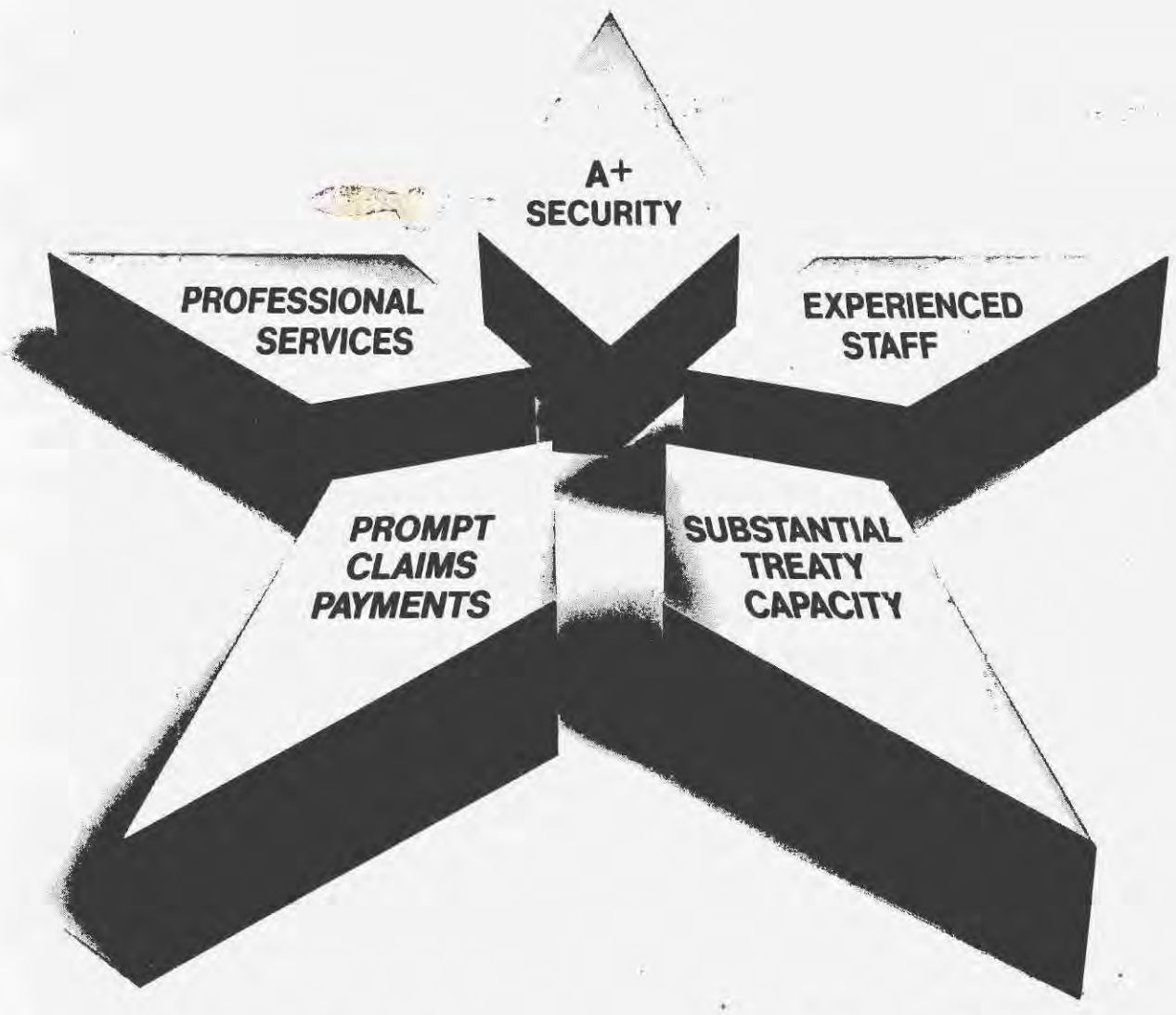
"We are keen to attract financially sound and reputable companies and multinationals with good track records to use Singapore as a domicile for their insurance captives," he said.

The government will consider rent-a-captives and mutual captives as well as single-parent captives. However, captive insurers are not allowed to write third-party business and "operate as a commercial insurer," Mr. Law pointed out.

Companies should conduct a feasibility study to decide whether a captive is commercially viable, Mr. Law said.

*Continued on next page*

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*Continued from previous page*

And a captive based in Singapore should be of "meaningful size," with more than $1 million Singapore ($500,900) in premium volume, he advised.

All captives are required to be licensed in Singapore and must have a minimum paid-up capital requirement of $1 million Singapore. Captives also need to maintain a surplus of $1 million Singapore.

Singapore captives are required to submit annual audited balance sheets and accounts of their insurance operations, as well as quarterly returns detailing premiums and claims.

The majority of the captives in Singapore are Australian, "not only because (Singapore) satisfies all of the important basic requirements, but also because (Australian companies) feel comfortable with Singapore as a legitimate center of trade and finance in this region," said Ross Bovill, chief executive of Sedgwick Management in Singapore.

Sedgwick carries out 25 feasibility studies annually for Australian and New Zealand corporations. Those that should have a captive, "almost without exception, have decided, rightly or wrongly, that their captive should be domiciled in Singapore," said Mr. Bovill.

For corporations located in Australia, New Zealand and the Asian/

**Singapore has 12 captive managers, the largest of which which manages 16 captive insurers.**

Pacific region, Singapore has an ideal time zone and location, he said. Singapore is at most three hours behind the majority of Australian cities, compared with Bermuda, which is as much as 14 hours behind Australian time. Flights from Australia to Singapore are also no more than nine hours, while the journey to Bermuda can take more than a day.

Australian companies also benefit from Singapore's tax system, which imposes only a 10% tax on profits derived from offshore business. Singapore does tax captives' profits, though, so it is not considered a "tax haven."

However, "the two most significant changes affecting the operation of captives owned in this region are the recent changes and proposed changes to the way in which foreign sourced income is taxed in New Zealand and Australia," Mr. Bovill said.

In May, the treasurer of the Australian government released a consultative document on the nation's tax code, including a section on the tax treatment of controlled foreign corporations.

Under the proposal, the profits of a controlled foreign corporation —in which the Australian parent owns more than 10% directly or indirectly—could be taxed by the Australian government at the Australian corporate tax rate of more than 40% if the CFC is based in a tax haven.

So far, Singapore is not considered a tax haven, though the Channel Islands and Bermuda are, Mr. Bovill noted.

"Whether this remains the position is still completely open as the document was only a consultative one and is subject to change," he said.

Mr. Bovill suggests that before Australia decides whether Singapore is a tax haven, the Australian government should remember that:

- Very little revenues will be gained by taxing controlled foreign corporations domiciled in Singapore.
- The offshore captive already pays income tax on every dollar of premium paid by the parent company.
- Singapore is very serious about developing its economy, and "such a move by the Australian government will be seen as a direct attack on one of the few options Singapore has—its financial services industry," according to Mr. Bovill.

In addition, New Zealand recently announced that foreign source income to a New Zealand parent company will be taxed at a 33% rate on an accrual basis unless the income is derived from the United Kingdom, Australia or the United States, Mr. Bovill said. However, a credit will be allowed for taxes paid to a foreign nation.

"This means that both captive formation logic and strategy must be very sound to justify offshore captives owned by New Zealand parents—circumstances which should of course exist in any event," Mr. Bovill said. ■


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# Brisbane seeking its first risk manager

By KATHRYN J. McINTYRE

BRISBANE, Australia—This city of Brisbane, host to the 1988 World Expo and the largest Australian municipal government in area, population and budget, is looking for its first risk manager.

The Brisbane City Council adopted its first official risk management policy on Sept. 19 and is now advertising for a risk manager and two loss control engineers, its Lord Mayor told a gathering of risk managers here late last month.

"These appointments will further strengthen and enhance our risk management activities," said Lord Mayor Sallyanne Atkinson in a keynote address to the First World Congress on Risk & Insurance Management in Brisbane last month sponsored by the International Federation of Risk & Insurance Management Assns.

The Brisbane risk manager's position is advertised to pay a salary of $38,000 Australian to $42,000 Australian ($31,274 to $34,566).

Brisbane covers an area of 488 square miles, has a population of almost 750,000 and operates with an annual budget of $621 million Australian ($511.1 million).

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Brisbane also hosted Expo '88, which attracted about 18 million visitors during its 26-week run that ended Oct. 30. Attendance at Expo exceeded Australia's population of about 16 million.

One in four Australians attended the world exhibition; the others were from overseas (see story, page 44).

The Brisbane municipal government is a hybrid between the U.S. and British municipal systems and is second only to Los Angeles "in what we do," in providing municipal services, said Lord Mayor Atkinson.

Brisbane employs 7,500 people to carry out its responsibilities for public transportation, water, sewage, roads, libraries, parks, land use and traffic control.

"Brisbane's identified risks are much the same as any other city in the country, but the most significant difference is they are on a much larger scale," Lord Mayor Atkinson said. She noted that Brisbane is second only to the state government in Queensland in terms of litigation activity and maintains 14 solicitors along with support staff to handle legal matters.

The risk management policy adopted by the city council in September states, in part, that the council considers "risk management an essential function," which is the "responsibility of each manager and every employee to support.

"Risks should be foreseen and reasonable protections taken," the statement continues, adding that the prime objective is to avoid injury to people.

The policy statement also sets the goal of a "better-structured insurance program."

Lord Mayor Atkinson commented: "I believe that this document in itself will make very clear statements on (the) council's attitudes to the general risk management issue."

While the council only recently adopted a risk management policy statement, it has been practicing risk management.

Beginning in 1987, Brisbane launched a risk management education program for employees with lectures by the city solicitor, a risk management consultant and the city's insurance broker.

The lectures were given to senior engineers and supervisors to "increase awareness of legal liabilities and the strategies of prevention," according to Lord Mayor Atkinson.

"In 1988, the whole risk management and insurance area of the council was restructured," Lord Mayor Atkinson continued.

"The information on 50,000 claims over many years forms the data base for the new computerized claims processing system which provides a consistent, centralized claims management system," she added.

**The risk management policy statement also sets the goal of a 'better-structured insurance program.'**

Last year, consultant Harry Whiteside of Sydney, Australia, a recognized expert in municipal risk management in Australia, spent seven months in Brisbane identifying risks.

Brisbane now employs six people in its insurance section, and two employees of its broker, Jardine Australian Insurance Brokers Pty. Ltd., are assigned full-time to the council on its premises.

Brisbane is spending $4.3 million Australian ($3.5 million) on insurance this year, including $2.2 million Australian ($1.8 million) for workers compensation insurance under the Queensland monopolistic system.

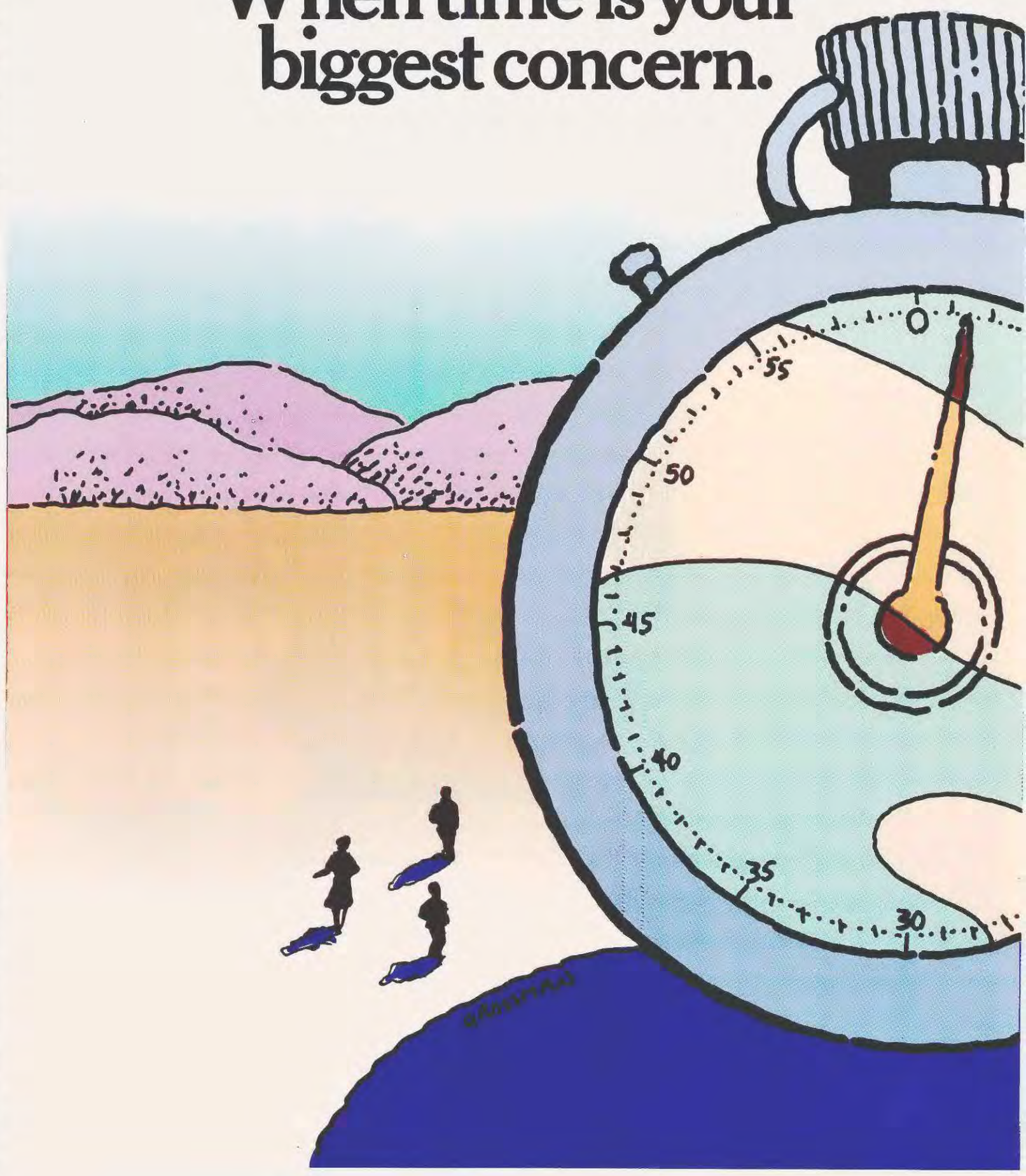
The city insures its motor vehicle liability exposure, property risks, marine liability risks and public liability risks.

The city is expanding its self-insurance program, Lord Mayor Atkinson noted.

"One of the major aims of our strategies is to seek to reduce unnecessary dollar-swapping with underwriters," Lord Mayor Atkinson explained.

*Continued on next page*


When time is your biggest concern.



*Continued from previous page*

As a result, the city recently began self-funding its marine hull exposure, saving a $30,000 Australian ($24,690) annual premium. The value of the council's 11 ferries is about $3.5 million Australian ($2.9 million).

"As the Brisbane City Council has an historically low incidence of claims with the ferry fleet, it was clearly indicated that (the) council could further expand self-insurance in this area," Lord Mayor Atkinson said.

The city also self-insures physical damage losses to 3,000 motor vehicles.

While taking risk management steps to prevent injury to people, when injuries do occur, the city will treat people "fairly and properly," Lord Mayor Atkinson emphasized.

In delivering the keynote address, Lord Mayor Atkinson took the opportunity to seek some risk management advice.

Recently, she recalled, the city's parks department sought permission to study Brisbane's playground equipment and surfaces for their safety. She was ready to authorize the study when a council lawyer questioned whether such a study would expose the city to liability claims for injuries at its playgrounds.

As a result, the city solicitor is now studying the issue.

"It seems very difficult," she said, "when what we want to do is a very responsible study to discover whether council playground equipment is safe and what is best,' yet the study may lead to more liability for the city.

One conference participant who spoke with Lord Mayor Atkinson after her remarks suggested that the city council more likely would be liable for claims stemming from injuries at its playgrounds if it did not conduct such a safety study rather than if it did conduct the study and made any needed safety improvements. ■



Photo: Stacy Shapiro

**The city of Brisbane, Queensland's capital, counts public transit, libraries and parks among its risk management responsibilities.**

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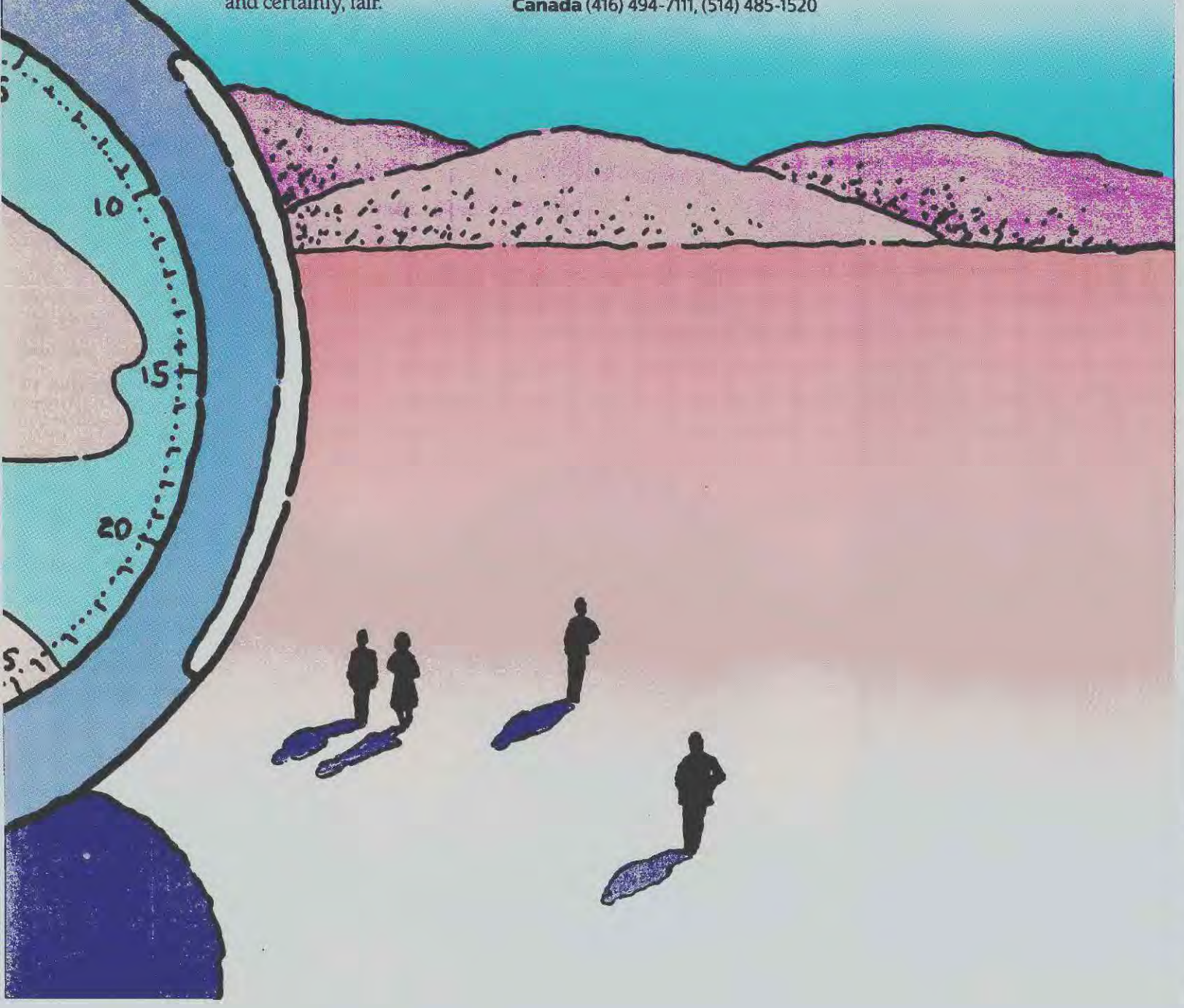
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# Congress unites 350 professionals

BRISBANE, Australia—The First World Congress on Risk & Insurance Management in Brisbane attracted 350 registrants and guests from 16 countries.

The congress was sponsored by the International Federation of Risk & Insurance Management Assns., which was founded in 1984 and now has more than 20 association members, including the Risk & Insurance Management Society Inc. in the United States and Canada, the Assn. of Risk & Insurance Managers of Australia, the Assn. of Insurance & Risk Managers in Industry & Commerce in the United Kingdom and the Assn. Europeenne des Assures de l'Industrie of Europe.

The newest IFRIMA member was admitted during the congress: the Public Risk Management Assn. of Washington, D.C. PRIMA is the first organization composed exclusively of public entities to join IFRIMA.

Kevin Knight, Queensland security manager for Australia Post, is the president of IFRIMA and chaired the First World Congress.

The congress took its theme, "Leisure in the Age of Technology," from World Expo '88, the world's fair in Brisbane that was entering its last week during the First World Congress.

The largest delegation to the congress was from the host country of Australia; ARIMA skipped its annual congress and supported instead the First World Congress.

Other countries represented at the meeting included: Belgium, Bermuda, Canada, Finland, France, Hong Kong, India, Italy, Japan, New Zealand, the Philippines, Papua New Guinea, Singapore, the United Kingdom, the United States and West Germany.

The congress received financial assistance from: Australian Airlines, Alexander Stenhouse Ltd., Anistics Pty. Ltd., Commonwealth Bank of Australia, Rushton Group, Frank B. Hall & Co. Australia Pty. Ltd., Marsh & McLennan Pty. Ltd., proRM Pty. Ltd., Qantas, Royal Insurance Australia Ltd., Sedgwick Ltd., Sun Alliance Australia Ltd., The Hartford Steam Boiler Inspection & Insurance Co. and Willis Faber Johnson & Higgins Ltd.

During the Congress, Paul Viciulis was named the ARIMA Risk Manager of the Year. The award is sponsored by risk management information system providers proRM Pty. Ltd. of Australia, which presents the winner with a plaque and a risk management information system software program (see story, page 39).

Executives of ARIMA judge nominations for the award. The judges use criteria established for the *Business Insurance* Risk Manager of the Year award.

This was the second year that ARIMA has presented the risk management award. ■

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# Few losses make Expo '88 risk management triumph

By KATHRYN J. McINTYRE

BRISBANE, Australia—World Expo '88 in Brisbane will go down in history as a financial and risk management success.

The number of participating countries, the attendance and the anticipated budget surplus were more than expected, and the number of incidents of loss was small, according to Sir Llew Edwards, chairman of the Expo '88 Authority.

Sir Llew addressed the First World Congress on Risk & Insurance Management in Brisbane last month, the theme of which was borrowed from the 1988 world's fair: 'Leisure in the Age of Technology." After his remarks, delegates had the opportunity to visit Expo '88, which was a short train ride from the congress hotel.

The idea to host Expo '88 in Brisbane was conceived 10 years ago. It was to be the first international exposition held in the Southern Hemisphere in this century and would coincide with Australia's bicentennial celebrations.

In 1983, when Brisbane offered to host Expo '88, it expected 30 nations and 10 corporations to participate with exhibits, 7.8 million visitors and a budget of $250 million Australian ($205.8 million) with no government funding.

But, when Expo '88 opened on April 30, 52 governments and 20 corporations were hosting exhibits. And, when it closed Oct. 30, attendance had exceeded 18 million, according to press reports. In addition, its operating budget was $625 million Australian ($514.4 million).

When dismantled materials are sold, Expo '88 expects to report a surplus, which will make Expo '88 the first such fair held without government subsidies and the first to end with a surplus, Sir Llew said.

About 5,800 people were employed at Expo '88, cleaning, tending the gates and providing security at the nearly 100-acre site on the south bank of the Brisbane River.

The 1,000 security personnel were assisted by 200 police officers. None carried firearms, though the Expo authority occasionally permitted special security forces to carry firearms to protect particular dignitaries visiting Expo.

About 4,500 volunteers also were involved in staging Expo, each giving eight hours a week to Expo, including helping to staff exhibits of countries whose budgets left them shorthanded.

IFRIMA Brisbane

Only 625 people were employed in the head office, Sir Llew noted.

Although Expo was designed to accommodate up to 160,000 people a day, even 90,000 visitors crowded the site, making walking slow and in some cases creating more than one-hour waits for exhibits.

Nonetheless, the crowds were orderly, politely lining up in designated waiting areas to enter pavilions that revealed the diversity of cultures from around the world.

Outside many of the pavilions, entertainers from the countries hosting exhibits helped pass the time. The popular New Zealand pavilion, for example, staged Maori singing and dancing.

Throughout the Expo site, entertainers walked on stilts and performed magic acts. Parades marched. A water skiing show complete with dare-devil acts was staged on the Brisbane River. Musical groups performed. And, food for all tastes was served.

Expo closed every night at 10 p.m. with a fireworks display, enjoyed not only by Expo visitors but also by the crowds that lined up on the bridge over the river for a free view.

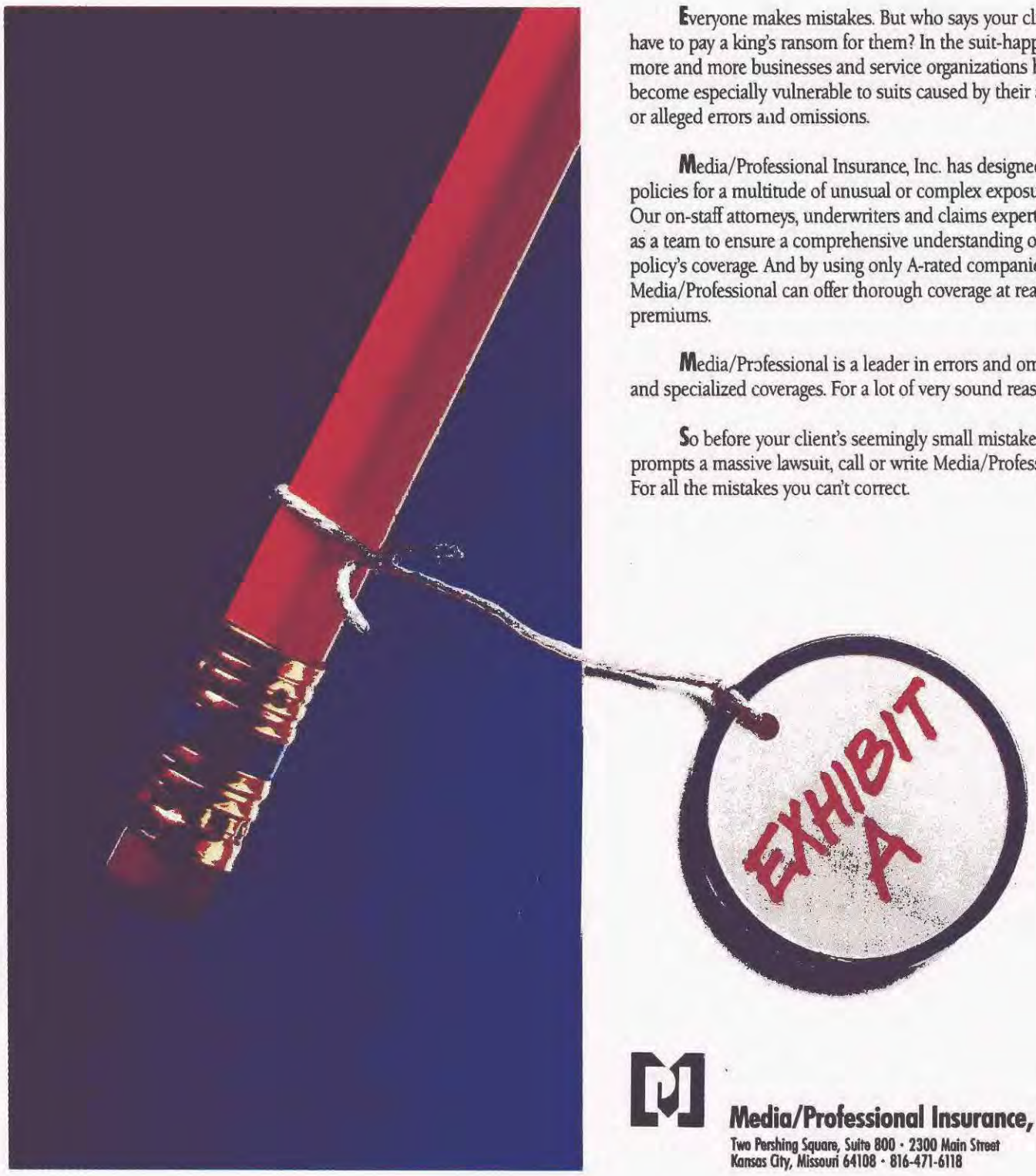
Crowd control, a major concern to underwriters of leisure businesses, was carefully planned at Expo. For example, every evening Expo hosted a "Light Fantastic Parade," which wended its way through the park. In preparation for the parade of brightly lit floats and performers decked out in lit costumes, a truck carrying stanchions and rope drove along the parade route, politely parting the crowd. Expo employees then roped off the route.

As soon as the parade passed, the ropes and stanchions were picked up again, preventing anyone from tripping over them.

Slip-and-fall accidents also were controlled by painting edges of steps a bright yellow and by keeping the site very clean. Sir Llew said the goal was to sweep up litter within two minutes, but that goal was clearly obstructed by the large number of people who made it difficult for cleaning crews to see the ground, let alone get through the crowds quickly. But every night,

*Continued on next page*

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Photo: Kathryn J. McIntyre

**Visitors waiting to enter the New Zealand pavilion at Expo '88 in Brisbane are entertained by Maori singing and dancing.**

*Continued from previous page*

the paved areas were scrubbed and an estimated 50 tons of garbage removed from the site.

Despite these precautions, "a number" of liability claims were filed against Expo, according to its liability insurer, Zurich Australian Insurance Ltd. But none of the claims at this time appear serious. The claims include allegations by people that they fell on the site.

Only two arrests had been made in 25 weeks, Sir Llew said six days before Expo was closing, and those involved intoxication. Expo visitors were discouraged from over indulging in alcohol by restrictions on consumption, such as requiring food purchases with beer at several food sites and prohibiting visitors from leaving designated eating and drinking sites with beer.

Among the property damage incurred at Expo were two losses resulting from storms: a fire in the 20-story sky needle sculpture built at a cost of $1.5 million Australian ($1.2 million) and tears in one of the giant sails that formed tents.

In addition, a large sculpture was destroyed when it was hit by a truck.

Total property losses were about $1 million Australian ($823,000).

Zurich Australian Insurance Ltd., a unit of Zurich Insurance Co. of Switzerland, wrote coverage for Expo in three stages: during its establishment, during its operation and now during the dismantling, said John Peters, property underwriter in Sydney, Australia.

A construction policy provided $20 million Australian ($16.5 million) of coverage during the establishment of Expo, and it was complemented by what is known in Australia as an industrial special risks policy, or ISR, that covered the completed projects once they were turned over to Expo. Separate coverage also was written for the monorail at Expo.

During the operation of Expo, the ISR policy was written to a $70 million Australian ($57.6 million) limit.

Zurich Australian also issued the primary public liability insurance policy, with a $20 million Australian ($16.5 million) limit, which runs through the dismantling of Expo.

Expo also purchased excess liability insurance to a limit of about $100 million Australian ($82.3 million), according to Sir Llew.

A new ISR policy with a limit of $25 million Australian ($20.6 million) attached on Oct. 31 to cover the property during dismantling.

The broker for Expo's coverage was Cliff Rivers & Associates of Australia, which won the account by competitive bid. Expo's insurance budget is estimated to exceed $1 million Australian ($823,000).

The pavilions were insured separately by their host countries.

The Expo site will be cleared by the end of the year, and it is hoped a landmark parcel of open entertainment space will remain for citizen use, Sir Llew said. ■


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# Filipino firm faces terrorism risk

By STACY SHAPIRO

BRISBANE, Australia—Extortion, kidnapping and assassination are very real threats for the San Miguel Corp. in the Philippines.

The largest company in the Pacific nation receives extortion demands about once a week, said Col. Filemon A. Elefante, San Miguel's assistant vp and corporate security director.

And in the last two years, one San Miguel executive has been killed and another kidnapped because the company refused to meet such demands.

The brewery and food products manufacturer also has been faced with product extortion threats and holdups, all of which have cost about 3 million pesos ($144,000) in losses since January, Col. Elefante said.

"This (3 million peso) figure does not only pertain to the money taken from salesmen but also includes losses suffered as a result of the burning of company trucks and the loss of goods taken by the perpetrators," he said.

Manila-based San Miguel is seeking to minimize terrorist losses by following guidelines it established that emphasize that the company will not give in to extortion and that the lives of all employees are "paramount over that of the security of its business assets," said Col. Elefante.

During a workshop at the First World Congress on Risk & Insurance Management last month, Col. Elefante offered his first-hand experiences with terrorists to risk managers.

Terrorism "quite simply is a tactic or means to achieve an end," he said. "As distinguished from mere vandalism and non-political crimes, terrorism means motivated violence for political ends. Terrorism presents a clear danger to international business."

Terrorism in the Philippines is carried out by three major factions of insurgents who oppose the government of President Corazon Aquino, Col. Elefante noted.

Of the three factions in the country, the Communist Party "poses the most serious threat through the three most powerful arms of their revolution: the party itself, the New People's Army and the National Democratic Front," he said.

The Communist Party "has a dedicated and determined leadership, a dynamic organization and resources to wage a sustained campaign day by day," said Col. Elefante. Its ranks have grown from 155 members in 1969 to 25,800 as of June 30 this year, he said.

The New People's Army is the most visible among the three arms of the party, he noted. The New People's Army has raided military detachments and police stations; ambushed military convoys and foot patrols; and assassinated military personnel and police, he noted.

But in what appears to be a shift in strategy, the NPA is now increasing its raids on businesses, said Col. Elefante. This includes hijacking delivery trucks, destroying productive equipment and disrupting production activities.

Most of the NPA terrorist attacks on businesses are attempts to extort "progressive taxation." These demands for money are directed at large agro-industrial firms, commercial establishments, wealthy individuals and sometimes ordinary citizens, he said.

**'As distinguished from mere vandalism and non-political crimes, terrorism means motivated violence for political ends, says Col. Filemon A. Elefante. 'Terrorism presents a clear danger to international business.'**

"Coercion for resistance in the payment of progressive taxes range from partial paralyzation of business operations to complete closure through raids, sabotage, destruction of equipment, kidnap for ransom and even assassination," he said.

The other two insurgent organizations in the Philippines are:

- The Moro National Liberation Front, which is composed of disgruntled Muslims in the southern Philippines who want to establish a separate country. The MNLF currently is consolidating and strengthening its forces through recruitment to sabotage the government, assassinate officials, attack military units and take over major ports to isolate the region it wants to declare as an independent state.

"The MNLF will continue to threaten to resume armed hostilities and conduct agitation propaganda activities to destabilize the situation in the south," said Col. Elefante.

- The Ultra-Rightist group, composed of loyalists to former President Ferdinand Marcos, which has little popular support and faces leadership problems. However, it is still continuing armed activities and attacks on government installations.

San Miguel, which has grown sevenfold in the last decade with current assets exceeding 15 billion pesos ($720 million), has had specific threats from several of these factions, Col. Elefante told conference members.

For example, the corporation receives taxation demands and other threats at least once a week at one of its installations, he said.

Specifically, on June 24, San Miguel received a letter from Salvador Guerroro of the New People's Army demanding 5 million pesos ($240,000) a year in progressive taxes. In July, the corporation also received a letter demanding 4 million pesos ($192,000) in progressive taxes. "Threat letters from the NPA are either in English or the local dialect," said Col. Elefante.

Also on June 30, 1987, the NPA assassinated one of San Miguel's supervisors by shooting him in front of the farm gate at the Cabuyao Magnolia Poultry farm, which is owned by San Miguel.

*Continued on next page*

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*Continued from previous page*

The MNLF also staged a kidnapping of a resident manager and a male nurse at the company's Tagbita Mines for refusal by the company to pay 75,000 pesos ($3,600) in taxes to the MNLF. San Miguel negotiated with the MNLF for three months before the employees were released unharmed.

The NPA on June 1 also raided one of the company's chicken farms, took one hostage, carted away office equipment, firearms and live chickens and eggs before four of 18 bundles of dynamite planted in the breeding house exploded.

The loss was estimated at an additional 500,000 pesos ($24,000) and was spurred by the company's refusal to pay revolutionary taxes.

To counteract these threats, San Miguel has set up a strong corporate security system, said Col. Elefante, who is in charge of plans for the entire company.

Line managers also are responsible for their own divisions' security. As part of the security measures, San Miguel asks customers to pay in checks rather than cash, employs ex-marines as security guards and has salesmen use "bait money" to prevent kidnappers from harming them, said Col. Elefante.

The company set up a crisis management team after the kidnapping at its mine. The team is divided into the long-term decision-making authority at the head office; the management policy committee, which bears the authority to make all decisions during a crisis; and the incident management team, which is responsible for carrying out the decisions.

**'Extortion or kidnapping incidents may range from those lasting a matter of days to months or perhaps several years,' says Col. Filemon A. Elefante of the San Miguel Corp. 'Deputies or alternates should be clearly identified to prepare for such a protracted incident.'**

The kidnapping made the company realize that the management policy committee and the incident management teams should be separate, said Col. Elefante. The separation "is to protect the policymakers from the effects of the immediate emotional pressure experienced by the negotiating team, resulting from their direct contact with the kidnappers."

The crisis management team should be small and include employees who are not essential to the daily operations of the company. "Extortion or kidnapping incidents may range from those lasting a matter of days to months or perhaps several years," he said. "Deputies or alternates should be clearly identified to prepare for such a protracted incident."

In addition to the team, San Miguel has a control center manned 24 hours a day that links the corporate head office with its line operations. This ensures that no matter where a threat is received or an incident occurs, "the details are passed as quickly and securely as possible to all concerned," said Col. Elefante.

Despite the threats, the company continues to rely on its written policy to minimize losses, said Col. Elefante. The policy statement says:

- The company is a non-political organization and will support government policies involving the national interest.
- The company will "in no way pay a progressive tax to the CPP/NPA and other insurgents, nor will it confer with and enter into any deal with insurgent groups especially if it would compromise the company."
- The lives of company employees are "paramount" over that of the security of its business assets. Every effort should be made to protect the lives of employees and executives.
- When necessary, the company will withdraw its trucks or suspend business operations temporarily in areas controlled by insurgents to minimize or prevent harm to personnel and/or damage to company property. ■

# Video asks tough questions

BRISBANE, Australia—You are the risk manager and ranking financial executive in the home office when you get a call from your chief executive officer saying that he and the chief financial officer have been abducted in France and you must send $5 million in ransom money and tell no one.

What do you do?

This is just one of the five scenarios presented in a video titled "Risk Management Chess" developed by Thomas Hallett, newly promoted executive vp of Frank B. Hall & Co. Inc. in Briarcliff Manor, N.Y.

Mr. Hallett presented the video at the First World Congress on Risk & Insurance Management and asked participants to comment on how they would handle such a situation.

After one person joked that he'd "take the money," some of the serious advice offered included trying to contact the CEO to make sure that the phone call was not a hoax and a general agreement that despite the instructions, the police should be contacted.

Another audience member said that the company should have had a policy on dealing with ransom demands before being confronted with such a problem. Another participant suggested that the risk manager call the company's kidnap and ransom insurer.

Other video scenarios include: discovery that an offshore captive is severely underreserved for the liability insurance it had written for unrelated parties; receiving instructions from the president of the company to file a claim against a policy for coverage that the risk manager knows was never intended but could be argued is available because the policy language is vague; and being offered the choice between reducing the risk management department staff or switching to a new broker who is a friend of a new CEO to save $150,000.

Mr. Hallett, who previously was risk manager for General Motors Corp., will also present the video during a session at the 1989 Risk & Insurance Management Society conference in April in Atlanta.

*—By Kathryn J. McIntyre*

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# Cash-flow analysis aids decision making

By STACY SHAPIRO

**Cash-flow analysis, usually determined with the help of computer software, 'is one that corporations are very comfortable with these days,' said Martin Fry, a partner with Coopers & Lybrand Insurance Services in Sydney, Australia.**

BRISBANE, Australia—Cash-flow analysis can help risk managers make informed decisions about risk financing alternatives, a consultant says.

Cash-flow analysis, usually determined with the help of computer software, "is one that corporations are very comfortable with these days," said Martin Fry, a partner with Coopers & Lybrand Insurance Services in Sydney, Australia. "It is a tool you can use."

In fact, cash-flow analysis "forces you to put numbers to your problems and to think about the reasons for doing something," Mr. Fry said during a workshop on cash-flow analysis at the First World Congress on Risk & Insurance Management last month in Brisbane.

A risk manager undertaking a cash-flow analysis project will go through four main steps before he arrives at figures that he is satisfied will produce the best decision, Mr. Fry said.

These steps are:

- Identify the various elements and financial measures that will impact a decision and identify the risks that are to be analyzed.
- Project those financial measures over a suitable period of time, usually at least 10 years, taking into account changes in interest rates and inflation.
- Analyze the final result of the cash-flow analysis.
- Tinker with the financial measures once again to compare outcomes if other factors are taken into account.

Mr. Fry illustrated the concept by giving some scenarios that risk managers may encounter.

In the first example, a risk manager at a factory is trying to decide whether to pay a $60,000 annual property insurance premium or to upgrade fire protection at the factory at a cost of $80,000, plus $4,000 in maintenance costs per year, which would enable him to increase his retention and reduce his annual property insurance premium to $40,000, Mr. Fry said.

In year one, the risk manager must weigh the $60,000 premium vs. a $120,000 outlay for fire protection and premiums, plus $10,000 in possible claims under the new retention, Mr. Fry said.

If the company's risk management budget for the factory is only $125,000 in this year, then the risk manager would have to buy the insurance and forget about the fire protection, he said.

However, if the risk manager chose to install the equipment, then in the second year the company would pay $40,000 in premiums, $4,000 in maintenance and $10,000 in in possible claims. That would mean that the cost after installing the equipment in the second year would be $54,000, while the cost without such equipment would be $60,000, Mr. Fry said.

After four years, taking into account inflation and increased interest rates, the cost of the alternative would be $326,086, compared with the $281,926 of premiums without the fire equipment installation, he said.

"Our mistake, however, is that we only projected four years," Mr. Fry observed.

If the risk manager projects the cost over 10 years, he will find that the cost of renewal of $707,226 is more than the cost of the alternative with fire installations of $699,406," he said. So the alternative "over a longer period gets cheaper," he said.

As a second example, members of the workshop were divided into groups of five to analyze the problem of a fictitious retail store chain in New South Wales. The managing director of the company has heard about the benefits of self-insuring workers compensation risks and wants the risk manager to prepare an analysis of the situation.

IFRIMA Brisbane

The chain has a 1988 payroll of $40 million. The calculated workers compensation premium rate is 2% of payroll, or $800,000, for the 1988 calendar year. Work comp claims for the past three years totaled $1.87 million.

Mr. Fry asked members to decide what the chain's major considerations should be when conducting a cash-flow analysis of the benefits of self-insuring.

After 15 minutes of discussion within the groups of five, most of those participating in the workshop concluded that there was not enough information provided to make an accurate assessment.

The risk manager would need to know, for example, what the claims experience is of the company over a longer period than three years, the workshop members said.

In addition, they questioned whether the claims during this period were abnormally high or low.

Claims experience "has got to be your building block," Mr. Fry agreed. "Then ask what's the trend for future premiums? Also, you must think of the cost of the claims handling systems, outside consultants' fees, staff costs and reinsurance costs for your self-insurance. Then you will be able to see how (insurance vs. self-insurance) will run in the future."

One group of workshop members concluded that taking into account inflation and the administrative costs of self-insurance, the store chain's risk manager should choose to insure the workers compensation risk rather than self-insure it.

Another group, however, said that the risk manager should examine whether self-insuring would improve the company's risk identification and loss control process, which could make self-insurance a better solution.

Workshop members concluded the state of the insurance market also had to be projected to determine whether insurance premiums would rise in future years. ■


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# Video surveillance spots fraud: Expert

By KATHRYN J. McINTYRE

**The objective of video surveillance is to obtain 'an objective glimpse into the daily life of the claimant so you can weigh his allegations of disability against what he may do on a day-to-day basis,' explains Bill Kizorek, president of InPhoto.**

BRISBANE, Australia—Video surveillance of people claiming disability due to injury can hasten settlement of a valid claim or provide the ammunition to fight a phony claim, says a surveillance expert.

The objective of video surveillance is to obtain "an objective glimpse into the daily life of the claimant so you can weigh his allegations of disability against what he may do on a day-to-day basis," explained Bill Kizorek, president of InPhoto, a Naperville, Ill.-based video surveillance firm, during a seminar at the First World Congress on Risk & Insurance Management held last month in Brisbane.

Video surveillance has become more popular in the last couple of years because equipment needed had been improved, Mr. Kizorek said. Before advances in video technology, investigators had to get so close to claimants they were often detected and they often ran out of film at a critical moment. Also, the finished product looked choppy, as though it had been edited, reducing its value.

State-of-the-art video equipment allows investigators to film claimants from two city street blocks away, provides enough tape to obtain the desired shots and produces a high-quality picture.

Mr. Kizorek played videotapes that InPhoto had produced for clients showing claimants who had claimed total disability trimming trees, lifting heavy objects, pounding with huge mallets and playing baseball.

In one case, Commonwealth Edison Co. in Chicago had reserved $290,000 to settle a claim by an injured worker claiming total disability.

The worker's doctor was convinced that he was totally disabled and the utility hired InPhoto to confirm the disability so that the case could be settled quickly.

But InPhoto videotaped the man walking around a shopping mall without the cane he had used leaving his doctor's office and walking as though he suffered no disability. As a result, the case was settled for $27,000.

Video surveillance is not an invasion of privacy when conducted properly, Mr. Kizorek said. "It is a very admissible investigative technique, but the courts have defined the parameters," he said.

"You don't let an investigator run wild and do whatever he wants, such as cut down hedges or break a milk bottle to flatten tires," Mr. Kizorek said. "These (investigators) run the risk of not only having evidence not admitted but also of alienating the judge."

In addition, due to laws against eavesdropping in the United States, sound cannot be used when videotaping claimants, Mr. Kizorek noted.

While improved equipment permits investigators to film claimants at a greater distance than they could in the past, investigators are on occasion spotted by the claimant. In one such case, a claimant who had been followed and observed acting healthy later noticed the investigator and after parking his car at home, fell out of the car and crawled to his house, Mr. Kizorek reported.

Video surveillance is expensive, Mr. Kizorek said. Generally, a claimant should be under surveillance for two days to build a credible report, he said. The total cost for a typical two-day surveillance would be $1,800 to $2,000, he said.

If investigators offer to film claimants for a lower charge, "the less likely they are using new technology," Mr. Kizorek said. "Look at a sample of their work" before engaging the lower-priced investigators, he suggested.

InPhoto generally is hired by a self-insured company or an insurer to investigate large claims to help determine if the loss reserve should be increased or decreased and whether or not to settle the claim, Mr. Kizorek said.

Most often InPhoto is hired because the claim appears suspicious, Mr. Kizorek said, such as a claimant who claims total disability but no one is ever home to answer the telephone or a claimant who says he is receiving rehabilitation treatment but is sun-tanned and has calloused hands.

If a claimant appears injured, InPhoto will tape him in a variety of activities to give an accurate picture of his abilities, Mr. Kizorek stressed. "We are objective and ethical."

Insurers also must be careful when investigating apparently fraudulent claims, stressed Ray Kent, chief manager of insurance for Suncorp Insurance & Finance in Brisbane, who also participated in the seminar.

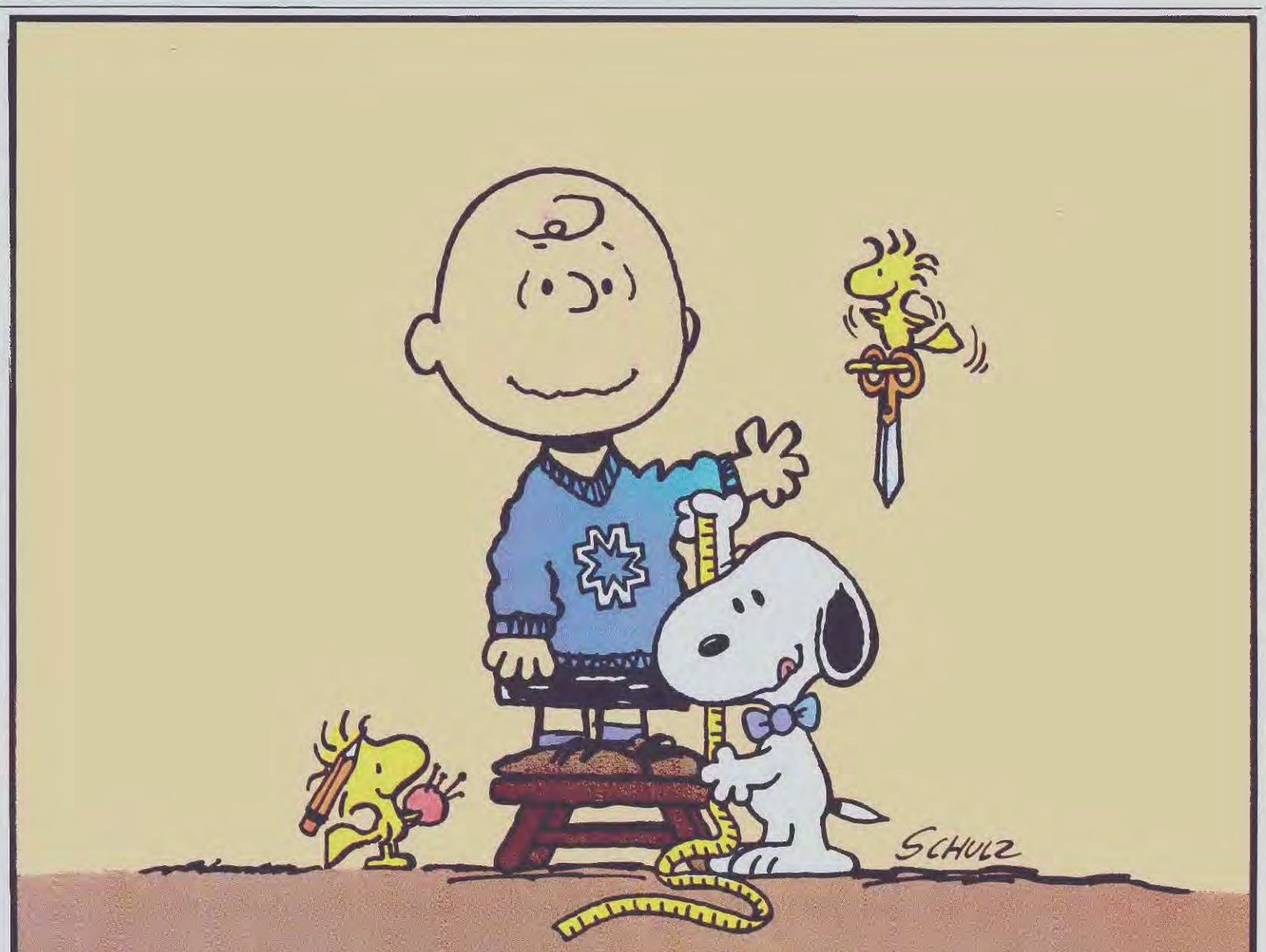
About 98% of people who buy insurance are doing it in all honesty, while 2% have dishonest intentions, he said. However, about 10% of all claims involve an element of fraud, from understating the age of a stolen or destroyed item to much greater deceit, he said.

Mr. Kent noted that there are advantages to having investigators on staff compared with hiring outside investigators. Staff investigators cost less, their priorities are set by their employer and "you have peace of mind as to who the people are investigating your claims," he said.

However, the demand for investigations is uneven, making it impossible to staff for peak times. The cost of equipment also is extremely expensive, he said.

"The answer is to have a bit of each," he said of staff and outside investigators.

Mr. Kent noted that the amount of fraud perpetrated on insurers and by third-party claimants depends on the economy in general and the financial status of the individual claimant. The more difficult the economy, the more people look for ways to find money, he said. And, the weaker the financial status of the individual policyholder or claimant, the more likely there will be fraud involved in a claim, he said. ■


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# Exhibitors promote tools of the trade

**By KATHRYN J. McINTYRE and STACY SHAPIRO**

BRISBANE, Australia—Exhibitors at the First World Congress on Risk & Insurance Management promoted risk management information systems, insurance programs, loss control services, appraisals, claims adjusting services, claims investigation services, risk management consulting and brokerage services.

Innes-Owens Group of Sydney, Australia, demonstrated its workers compensation claims management system, which incorporates artificial intelligence technology into the computer program to determine the recommended claims reserve based on the medical and legal information reported on the claim.

The system records the first claim reserve as indicated by the artificial intelligence system, the current indicated claims reserve based on new information analyzed by the system and the claims reserve established by the insurer, if there is one, explained Gai Innes, who is responsible for administration and claims.

The system produces seven types of reports, including a claims index, action reports, individual claim reports, management reports, insurance reports, ad hoc reports and graphic reports.

Innes-Owens Group, which recently licensed a workers compensation insurer in New South Wales, Innes-Owens Workers Compensation Pty. Ltd., uses the system to manage its own workers compensation claims and sells the software to businesses that want to manage their own claims. It also uses the system to provide claims management services to clients who prefer not to buy the system.

The company's on-line service, which permits a client to tap into the system, costs $80 Australian ($66) per claim. The bureau service, which provides the client with all management of a claim, costs $120 Australian ($99) per claim.

IFRIMA Brisbane

Innes-Owens also uses the system to audit claims reserves for insured companies to help policyholders check the accuracy of their insurers' claims reserves.

Believing that this kind of expert system is not available in the United States, Innes-Owens plans in the near future to market it to self-insurers of workers compensation in California. The system costs $70,000 to $80,000 Australian ($57,610 to $65,840) for software and the needed minicomputer hardware.

Risk management information system designer proRM Pty. Ltd. demonstrated RIMSNET, the computerized information system offered by the Risk & Insurance Management Society Inc. in New York, as a service to the Assn of Risk & Insurance Managers of Australia, said John Williams, development director.

"We are trying to negotiate with RIMS for a data base to make available in Australia," he said, citing the cost to log on to the RIMSNET data base from Australia.

The company's personal computer-based products include software for maintaining information on assets, workers compensation claims, and safety and health programs. The software prices begin at $1,000 Australian ($823), said Lynda Caporn, marketing director based in Crows Nest, New South Wales. The programs can be modified to meet an individual client's needs.

In addition, proRM will provide bureau service to clients.

Ms. Caporn noted that pro RM's systems were developed in the last three years and so incorporate many new computer capabilities that weren't previously available to developers of systems.

Figtree Systems (Australia) Pty. Ltd. of Surry Hills, New South Wales, demonstrated some of its 14 risk management software packages at the congress.

Among Figtree's products is a workers compensation claims program that can furnish risk managers with illness and injury trends.

For example, the system showed that one company with a primarily female workforce experienced a surge in claims during a particular four-week period, explained Paul Hammerton, Figtree's managing director. Those weeks fell during school vacation periods, he explained.

At another company, the system concluded that 20% of workers comp claims occurred on Mondays, 22% on Tuesdays, with the rest spread evenly over the remainder of the week, he said. However, 28.1% of claims costs occurred on Mondays, while only 8.6% of claims costs occurred on Thursday, which is traditionally payday in Australia, he noted.

Among Figtree's clients are the city of Brisbane, which is using the system to log 50,000 workers compensation claims accumulated over the years; the South Australia state government; the British Broadcasting Co.; and British Telecom.

The software costs $5,000 Australian ($4,115). While Mr. Hammerton believes the software is superior to products available in the United States, Figtree does not plan to market its products there because "the expense is stopping me."

The Government Insurance Office of New South Wales, a state-owned insurer, also demonstrated a workers compensation automation system at its exhibit.

The system links a policyholder directly with the insurer's mainframe computer, giving clients information about claims experience overnight, said Richard Gilley, manager of the GIO's safety division. Access is limited, however, to a policyholder's own information.

The software, which was introduced last month, will cost between $8,000 and $25,000 Australian ($6,584 to $20,575) depending on the client and the level of service it wants.

*Continued on next page*


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*Continued from previous page*

American International Group Inc., which has been underwriting in Australia for 30 years, hosted a booth at the conference with a particular interest in discussing captive insurance companies with registrants, said Colin Bruce, deputy general manager of AIG's American Home Assurance Co. in Melbourne.

"We're already working with captives," he said.

AIG also promoted its specialized lines of insurance, including directors and officers liability insurance, which is its biggest growth line, according to John Clark, manager of American Home for Queensland.

AIG writes about $80 million Australian ($65.8 million) in annual premiums in Australia, primarily for Australian-based businesses but also for subsidiaries of U.S. companies with Australian operations.

Officials at Kemper Insurance Co. Ltd.'s booth rebutted charges by other Australian insurers that Kemper was undercutting competitors rates to write more business while touting its loss control and other services.

Kemper is willing to offer low rates only on specific risks, not across the board, said Jim Bell, a Kemper property underwriter.

"We're willing to target good business, give low rates and make a loss, but then bring the risk up to scratch" through loss control engineering and other services, said Penelope Higgs, manager of Kemper's casualty department.

Kemper's booth fit into the theme of the conference, "Leisure in the Age of Technology," by displaying a large photo of a man sitting in a director's chair with "risk manager" on its back under an umbrella on a beach.

"The risk manager is on the beach to show that he can have time for leisure if he uses Kemper," Mr. Bell said. An umbrella and director's chair like that shown in the photo were displayed in the booth.

Adjusters International Inc., which employs 250 people and is the largest adjuster worldwide representing policyholders, announced its professional affiliation with Peat Marwick Hungerfords Loss Assessing Services in Australia at its booth.

Adjusters International has an international professional association with Peat Marwick, said Ronald Cuccaro, president of Adjusters International in Utica, N.Y.

Currently, Adjusters International has 10 managers in Jamaica helping clients prepare claims stemming from the damage caused by Hurricane Gilbert. The managers have access to Peat Marwick's staff of 150 in Jamaica to aid with claims adjusting.

"We're taking care of the work to hopefully expedite the process of filing the claims so policyholders are free to concentrate on their business," explained Mr. Cuccaro.

The loss adjusting process in Jamaica will take over a year, he said.

Rushton Group of Darling Harbour, New South Wales, illustrated the importance of its valuation expertise by offering to award a set of Wilson golf clubs to the person who came the closest in estimating the correct value of an ice cream churn pictured in its booth.

"Companies tend not to have very detailed asset registers," observed Phillip Holzberger, marketing executive with the firm.

Proper valuations are important to maintaining proper insurance coverage and in filing a claim in the event of a loss.

The Rushton Group provides evaluation services throughout Australia, New Zealand, South Africa and the United Kingdom. "We're by far the largest plant and machinery valuers in the Southern Hemisphere," Mr. Holzberger said.

*Continued on next page*




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## Exhibitors

*Continued from previous page*

Estimates of the value of the ice cream churn ranged from $35,000 to $9 million. Robert Ball, town clerk for the Municipality of Waverly, came closest to estimating its value, which was $255,000.

InPhoto Investigations, a claims investigator specializing in covert video surveillance of claimants, will be "compelled to open an Australian operation in the next couple of months," said President Bill Kizorek. The Naperville, Ill.-based company employs 50 people.

InPhoto's literature points out that based on its video surveillance, "when a claimant appears to be injured, the case is often settled quickly. And, conversely, when the claimant appears not to have been telling the truth, the videotapes are used for negotiation for a trial."

A television monitor at the InPhoto booth played tapes showing allegedly injured people engaged in such activities as trimming trees and lifting heavy objects. Mr. Kizorek also played the tape and explained surveillance of claimants at a seminar during the congress (see story, page 49).

IFRIMA Brisbane

RiskeX Pty. Ltd. discussed its loss control engineering consulting services at its booth. The Sydney-based firm, which became an affiliate of Swiss Re Group in January, also has offices in Europe and Asia, including Switzerland, West Germany, Malaysia, Hong Kong, Taiwan and the Philippines.

RiskeX's 30 employees provide risk control services for protecting property, reducing work accidents, controlling environmental losses and assessing quality assurance, as well as claims adjusting services.

Trowbridge Tillinghast, an Australian unit of Towers, Perrin, Forster & Crosby Inc., distributed information about the company's 15 publications.

"Tillinghast is a new name to Australia as it's just a year old here," said Bruce Bow, a Trowbridge Tillinghast consultant in Sydney. "So, we are just showing them we are here."

Australia's two largest brokers—Sedgwick Ltd. and Alexander Stenhouse Ltd.—sponsored unique activities to capture attention.

Stenhouse, a unit of Alexander & Alexander Services Inc., transformed a portion of the area outside the conference center into an open-air cafe that served free coffee, tea and pastries. Conference registrants could sit at patio tables with blue-and-white Stenhouse umbrellas and chat. They could also visit a nearby booth to pick up information about the company.

Stenhouse also spent $10,000 Australian ($8,230) to sponsor a formal dinner for all congress participants. It also hosted breakfasts during the conference.

Stenhouse made the effort because members of the Assn. of Risk & Insurance Managers in Australia, the company's main clients, accounted for the majority of the registrants.

"This is our biggest market," said a spokesman for the brokerage.

At the Sedgwick booth, congress attendees could have their caricature drawn by Brisbane cartoonist Noel Hill, who drew 21 sketches by 3:30 p.m. the first day of the meeting. The caricatures were used to decorate the walls of the booth.

Others attending the conference promoted their services without maintaining a booth.

Coopers & Lybrand, for example, promoted its risk management consulting services through a brochure in the registrants' package and by providing Alvin Dyson, director of risk management for Coopers & Lybrand Insurance Services in Melbourne, as a leader of a workshop that examined alternative risk management techniques (see story, page 52).

A.C.E. Insurance Co. Ltd. of Bermuda also included a brochure about its excess liability insurance capacity in every registrant's package of material and A.C.E. Executive Vp William J. Loschert attended the congress and met with interested registrants.

A.C.E. already has two Australian policyholders, whom Mr. Loschert visited after the congress, and expects to pick up three or four more Australian clients in the next year, he said.

As Australian companies expand their investments in the United States, they will buy more liability insurance, Mr. Loschert predicted.

A.C.E. offers excess liability insurance limits of $150 million excess of $100 million in $10 million increments and $50 million in directors and officers liability insurance limits excess of $25 million. The D&O coverage is available in $5 million increments.

U.S. risk managers will not find A.C.E. marketing itself at U.S. gatherings of risk managers because the company does not want to expose itself to the jurisdiction of U.S. courts. The A.C.E. policy calls for mandatory arbitration in London of any policy disputes.

At June 30, 1988, A.C.E. had assets of $1.2 billion and only $310,696 in liabilities.

X.L. Insurance Co. Ltd. of Barbados, which offers excess liability limits of $75 million excess of $25 million, also was represented at the conference. X.L. has one Australian policyholder and potentially could pick up more Australian policyholders than A.C.E. because it attaches at a lower limit of liability.

Australian brokers, however, point out that the rates charged by A.C.E. and X.L. are much higher than the rates charged in the competitive Australian insurance market (*BI*, Oct. 17).

Mr. Loschert's response is that A.C.E.'s rates will remain consistent in hard and soft markets and so over time will be more economical than buying cheap excess insurance in soft markets and paying huge premiums in tight markets.

Also attending the conference to make a marketing statement were representatives of the Bank of Bermuda Ltd. in Hamilton.

"We want to be known as the niche banker for captive insurers," said John D. Swain, manager of corporate banking, noting the increased interest in captives by Australian companies.

The Bank of Bermuda maintains subsidiaries in Hong Kong, Luxembourg, Guernsey, Isle of Man, London, Cayman Islands and New York, he noted. ■

## Consider options: Consultant

BRISBANE, Australia—Risk managers in Australia tend to consider only insurance rather than other risk management techniques "because it's easiest," says a risk management consultant.

"I don't think many have looked at the alternatives and how important they can be," said Alvin Dyson, director of risk management in the Coopers & Lybrand Insurance Services practice in Melbourne, Australia, during a seminar on "Examining Alternative Risk Management Techniques" at the First World Congress of Risk & Insurance Management in Brisbane.

Noting that risk treatment can be divided into two main areas, risk control and risk finance, Mr. Dyson suggested that risk managers have two choices: "finance it or fix it."

With so much concentration on financing risk, particularly through insurance, Mr. Dyson emphasized the risk control options a risk manager has: avoidance, loss prevention, loss reduction, contractual transfer and diffusion.

Avoidance, he explained, involves acting so as not to create a particular exposure or taking action to completely eliminate an exposure.

Loss prevention is any measure that reduces the probability or frequency of loss while loss reduction measures reduce the severity of losses that do occur.

Through a contract, liability for loss can be transferred to another entity.

And diffusion includes separation, or segregating an asset or operation into two or more separate units, and duplication, or reproducing an asset or operating unit.

"We should concentrate more on risk control," Mr. Dyson said.

But risk managers need confidence to explore how they can use these options, he advised. For too long risk managers have been "sheltered by insurance," he said.

"We have to consider more alternatives than insurance if we are going to grow as professionals," Mr. Dyson said.

*—By Kathryn J. McIntyre*


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# Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers




# Agents seek to corral banks

By LAURA MAZZUCA

Even though hopes for passage of banking legislation setting new limits on banks' authority to sell insurance died with the adjournment of the 100th Congress last month, agent associations are confident that its reintroduction in January will be good for the industry.

In fact, the pause in the discussion will give the insurance industry a chance to press for the fine-tuning that supporters say the bill needs.

"It's been a frustrating year for us," said Joel Wood, a lobbyist for the National Assn. of Professional Insurance Agents, based in Alexandria, Va. "There's been a wide sense that there needed to be a clarification of language, and some golden opportunities to do so were missed."

The bill's author, Rep. Fernand J. St Germain D-R.I., is expected to reintroduce the bill when the new Congress convenes, and agents vow they will continue to seek changes in state laws to prohibit further encroachment by banks within their own states, said Mr. Wood.

While some of the language of the new bill may change, it essentially will reflect the philosophy of the St Germain bill, he added.

In the most recent version, the bill would:

- Prevent most bank holding companies from selling insurance outside the state in which they're based.
- Limit insurance sales to banks located in towns with a population of 5,000 or less, with sales limited to persons who live or work in town or businesses with permanent offices there.
- Limit the ability of bank holding companies to transfer grandfathered rights, as in mergers and acquisitions, to only those banks that have assets of $50 million or less.

In the meantime, the Federal Reserve Board was put on notice by Rep. St Germain and House Speaker Jim Wright, D-Texas, to refrain from expanding banking powers through regulation while Congress is not in session. The legislators have said the power to regulate the industries rests with Congress.

"While we're disappointed that Congress didn't enact legislation this year, it's clear that encroachment will not be allowed by (the Fed) usurping congressional powers," said Paul Equale, vp-government affairs for the Independent Insurance Agents of America Inc. in New York. The IIAA has long opposed

*Continued on next page*

## Banks do not worry some agents

By LAURA MAZZUCA

Even though agency trade associations have warned for years that bank entry into the insurance business could threaten agents' and brokers' existence, some observers—including some agents—believe that agents and banks can work together and prosper.

"The presence of financial institutions marketing insurance is an inevitable fact. It's already happening with thousands of banks and thrifts with consumer insurance marketing programs," said Ken Williams, president of Banclines Programs Inc., a consulting firm based in in Birmingham, Ala.

"Instead of agents fighting banks, they should recognize that they are a resource that banks need and there's a profit opportunity for them if they fill that need," he added.

"There exists a complementary relationship between banks and insurance that makes cooperative ventures a good fit," said a spokesman from the American Bankers Assn. in

*Continued on next page*

# Legislation

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bank's activity in insurance sales.

The failure to adopt the legislation safeguards the Glass-Steagall Act of 1933, which precludes commercial banks from engaging in securities underwriting.

The Senate passed a bill last spring similarly limiting state-chartered bank subsidiaries of national bank holding companies from selling insurance if their parent companies are not headquartered in the same state (*BI,* April 4). But that bill, introduced by Sen. William Proxmire, D-Wis., was stalled in House committees when Congress adjourned.

The House bill, H.R. 5094, was introduced in July by Rep. St Germain and sought to further tighten restrictions on financial institutions entering the insurance field.

The Senate and House bills are "almost identical, down to the periods," said Ken Crerar, chairman of the Alliance for Separation of Banking and Insurance, a Washington-based lobbying group.

But, agents' associations were wary of some of the wording in the House Banking Committee's version of the bill. For example, the bill did not specifically prohibit bank holding companies from buying state-chartered banks already allowed to sell insurance and then marketing such products nationwide. That was an oversight and not the intent of the bill, Mr. Crerar said.

But clarifications contained in the Energy & Commerce Committee's version of the bill restrict state chartered banks to selling insurance only in their base state. The committee's version was helpful to the insurance industry because it addressed the issue through semantics, specifically the definition of "bank holding companies," said Mr. Wood.

Also, the Energy Committee's amendments to the banking bill "more accurately represent the compromises made in the committees in legislative language," said Mr. Crerar.

In the Energy & Commerce Committee's version of the bill, bank holding companies could sell insurance through state-chartered subsidiaries, with some restrictions. However, under the same version, a state-chartered bank in Indiana, which traditionally has been allowed to sell insurance, could be bought by an out-of-state bank that would then be able to sell insurance nationwide.

Lobbyists for insurance agents are asking legislators to change the wording to specify that bank holding companies be allowed to sell insurance only within a state, only if the bank is headquartered in that state and only if the state's legislature allows such sales.

In addition, agents are seeking a clearer definition of the term "insurance" to lessen the probability of misinterpretation, while agents are introducing safeguards against banks coercing customers to purchase insurance through such methods as credit tie-ins, such as prohibiting banks from selling insurance to their customers.

Although insurance industry lobbyists were disappointed that final action was not taken on the bill, they cite an increasing sensitivity to the industry's viewpoint on Capitol Hill as a good indication the bill will succeed next year, according to Mr. Crerar.

Members of the Alliance are: the IIAA, the National Assn. of Casualty & Surety Agents, the National Assn. of Life Underwriters, the PIA and the National Assn. of Surety Bond Producers.

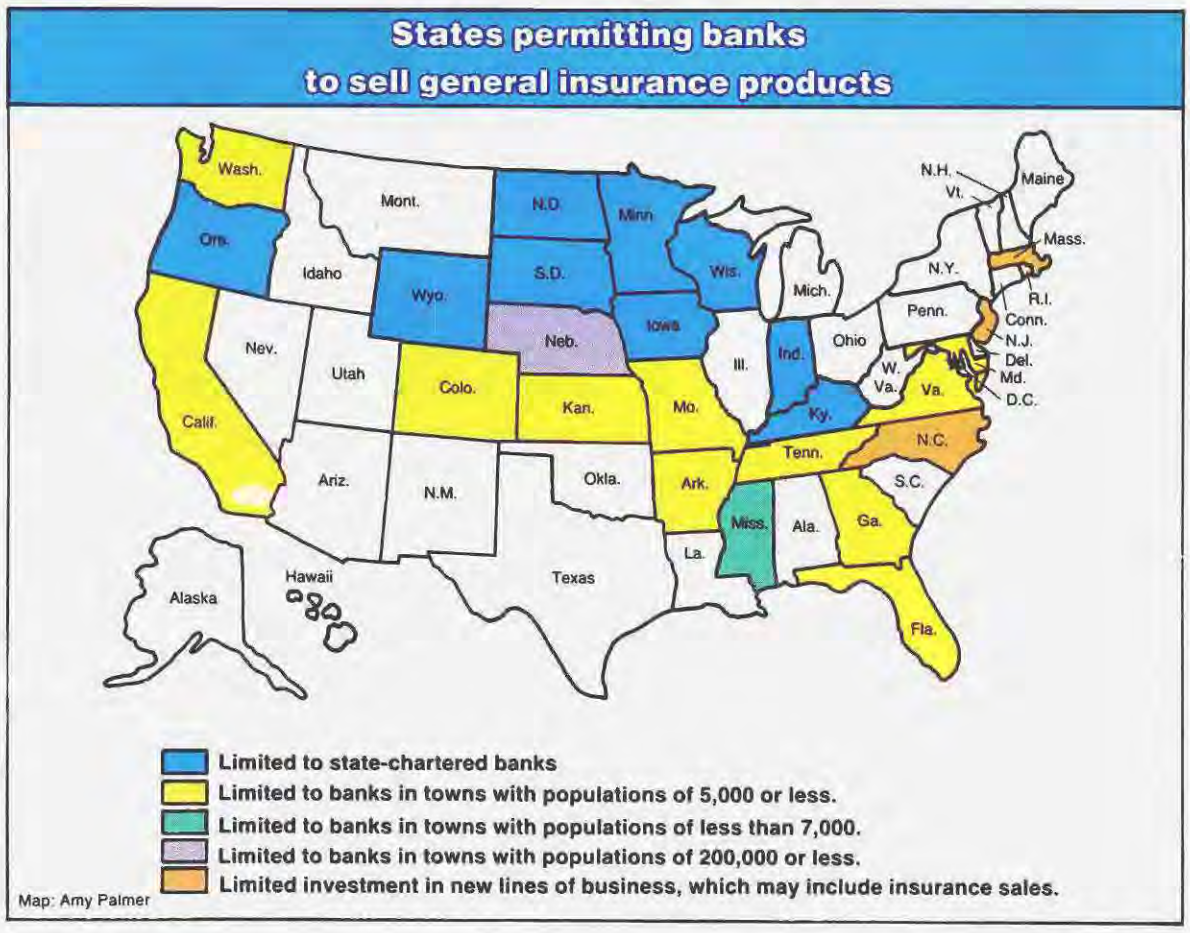
The issue of bank encroachment upon the insurance industry has been simmering for many years. Under the 1956 Bank Holding Company Act, banks are restricted from affiliation with a parent company that engages, directly or indirectly, in commerce. These restrictions were most recently expanded under the Garn-St Germain Depository Institutions Amendments of 1982, which prohibits new insurance activities by major bank holding companies (*BI,* Oct. 11, 1982).

Agents are concerned that banks would pose a threat to fair and open competition, as well as subject consumers to coercion in the course of the sales.

However, the threat to agents is not from the smaller financial institutions with assets of $50 million or less, "it's the Citicorps that give us pause," said Mr. Wood.

"Banking has traditionally been and continues to be a publicly guaranteed industry," said Mr. Crerar. "It is a special federal industry, not a plain, old business like insurance agencies."

And with legislative focus on the perilous state of the Federal Savings & Loan Insurance Corp., which faces a $40 billion to $80 billion bailout for failing savings and loans, the banking bill is sure to garner a lot of attention in the new Congress, he added. ■




# Bank/insurer relationships

*Continued from previous page*
Washington, D.C. "Banks must be able to provide insurance products to fit our clients' needs. Until the laws change in many states, cooperative ventures are the only choice that banks have."

Such arrangements with agencies and banks can take many forms, said Mr. Williams, including the establishment of a separate corporation, or a "paper corporation" owned outright by the bank and managed by the agency. Although Mr. Williams serves as a consultant to both agencies and banks, 80% of his business is from the latter, "because there are so few agents out there who recognize the opportunity."

However, "agents, instead of fighting the concept, should try to develop joint ventures with financial institutions to get their market back from the direct writers," he added.

Banks primarily are involved in selling life insurance and annuity products, using low cost, convenience and an alternative distribution system to appeal to consumers, said Mr. Williams. However, commercial property/casualty insurance —the bread and butter of independent agents—is too technical and specialized of an area for banks to handle, he said.

The mass-marketing techniques that work well for banks in personal lines don't apply to commercial lines, which require more hands-on attention, Mr. Williams explained.

"I don't consider banks any more of a threat to the independent agency system than if a new agent opens up down the street," he said. Because of this, banks hoping to sell any line of insurance must build insurance resources or contract with existing agencies to get into the business. Often, this means entering into a joint venture with an agency, he said.

"The two industries need each other, and by joining together they can have the best of both worlds," he said.

Such an arrangement would be a "growth opportunity for an aggressive agency," he said. Affiliation with a prominent bank also enhances the image of an agency, he added.

"Like it or not, banks and financial institutions have better image credibility with the consumer," he said.

Agents already affiliated with financial institutions agree and suggest that more agents should follow their lead.

"If independent agents really knew the inner workings of banks, they'd have no apprehension" about banks entering the insurance business, said Jess Chappell, president of First Insurance in Alexander City, Ala., a commercial and personal lines agency that operates a branch office in leased space in the lobby of a local bank to sell personal lines insurance.

Banks "are interested in interest rates, and their loan officers are trained to think that way. . .I don't think they have the capability to make the change (to an insurance mindset) so quickly," he said.

Agent associations, which primarily are concerned about both competition from banks and the possibility of customer coercion, are "overly paranoid," suggested Ward J. Merchant, president of Midwest Commerce Insurance, a division of Midwest Commerce Banking Co. in Elkart, Ind., a state in which there is no prohibition against state-chartered banks selling insurance in towns with small populations.

"They're scared of the size of the banks and afraid that some will act illegally, and that will probably be the case," he said. "But I can cite you a number of disreputable independent insurers, too."

Midwest Commerce Insurance has been in the insurance agency business—and owned by Midwest Commerce Banking Co.—since at least 1910, said Mr. Merchant. The agency, which employs 60 people and is housed in a building completely separate from the bank, has an annual premium volume of about $33 million.

Mr. Merchant's agency is very active in the national Independent Insurance Agents of America Inc. and is operated "just like any independent agency," he said. "In fact, we're more independent than the independent agent who is a COMPAR for CIGNA," he said, referring to CIGNA Corp.'s preferred agent program.

Midwest Commerce Insurance does not rely on the bank for financial assistance or client lists for marketing, said Mr. Merchant. Instead, "we furnish money to them as a profit center," he said.

"The only advantage of bank association (for an agency) is the name recognition," Mr. Merchant said. "If your name is the same as theirs, you're going to get a lot of rub-off (business).

"Our conflict, in a nutshell, is that we don't believe that banks in the insurance business are bad per se," Mr. Merchant said. Instances of coercion and/or the use of confidential data to be "rare," he pointed out, adding that these practices already are prohibited by state laws.

"You can run a good or bad agency, whether you're an independent or a bank on the street," he added.

Mr. Merchant also believes banks' threats to the survival of the independent agent are overrated. He feels that small agencies face more of a threat from direct writers and from insurers that demand higher premium volume requirements.

However, Mr. Merchant admits that financial institutions do have "staying power," and "can sustain years of loss," although it is doubtful that any business organization would continue to accept losses in any business segment for long.

If thought out carefully, independent agents can benefit from similar arrangements with banks, especially in the area of perpetuation—agencies and banks entering into buy-sell arrangements to ensure the agency is perpetuated after the death or retirement of a principal, said Mr. Merchant.

"Banks are generally large institutions that don't go away," agreed Mr. Williams. "Agencies are small businesses that are spearheaded by the entrepreneurial spirit of one or two people. Once they run their lifespan, the agency goes away."

However, one drawback to an agency's involvement with a bank is a client's discontent with service received by the bank, said Mr. Merchant. "We've lost some sizeable accounts because of it," he commented.

But Mr. Merchant was emphatic about the good outweighing the bad. He noted that instead of creating a problem, the entry of banks into the insurance business could benefit the consumer by providing more competition, and the presence of banks as potential suitors for agencies would also probably drive up the value of a well-run agency, he added.

"Nobody likes competition," said Mr. Merchant. "But if you go into a state where banks have been for years and the state association has many bank agencies, they get along fine."

In Alabama, Mr. Chappell's agency—First Insurance—is composed of five offices, one of which operates out of leased space in the lobby of the First National Bank in Alexander City. It is strictly a formal lease arrangement, he stressed, with the bank having no interest in the agency's business. Most of First Insurance's sales come from walk-in business and referrals.

Mr. Chappell started the agency from scratch 3½ years ago. "The idea was sound to work with a bank rather than against it," he said. The presence of the bank also is a move to expand the agency's personal lines business and lends an air of credibility to an agency, he added.

Agency growth has been "very good," he added, estimating the agency's premium growth at 25% to 30% annually. The agency now produces $6 million in premium volume.

Like other agency principals affiliated with banks, Mr. Chappell believes that charges by various insurance industry groups that banks that sell can coerce customers to use other bank services have been "overplayed."

He pointed out that even if a bank buys a well-run agency outright, it must have the marketing skills to make it successful, and historically, banks have done poorly in marketing their services.

Traditionally, banks were poor at marketing because when they were heavily regulated, all banks paid the same interest rate, so they didn't have to advertise or market, said Mr. Merchant. "They just had to give away toasters because all the products and rates were the same." But they're "forced to" do a better job of marketing because of deregulation, he added.

"The bigger the bank, the bigger the problem," Mr. Chappell noted.

Since the independent agent's main selling point is his ability to give personal attention to clients, the positive aspects of a big bank's big name are lost when it comes to making sales, he added.

Mr. Williams believes the agents' trade associations' efforts to halt banks from entering the insurance field are "futile," and that the associations could spend their time and money in far more beneficial ways.

"Insurance represents 40% of the financial services market," he said. "It just makes sense that banks should be in insurance." ■

# Stock options present right incentive

By THOMAS K. MacDONALD

Different types of incentives are needed to encourage various types of employees to contribute to an insurance agency's growth and profitability.

In most agencies there are two types of employees: "Value Creators" and "Income Maintainers." (Some agents have observed a third type that falls into the category of "less than fully productive.")

Both Value Creators and Income Maintainers are vital to a growing and profitable agency.

The Value Creators in an agency initiate and accomplish things that add to the market value of the agency. Their efforts add a permanent level of new profits.

In contrast, Income Maintainers efficiently service existing accounts and productively perform their tasks. Their efforts maintain existing levels of productivity and profitability.

Value Creators are building value and should be encouraged to continue contributing their value-adding efforts. It will benefit all parties if those selected key employees are given the opportunity to buy into the future growth of the agency. Incentive stock options do precisely that.

An incentive stock option is a formal option entitling the employee to purchase corporate stock at a future time at a fixed price. The price is fixed when the option is granted.

Here's an example of how a typical stock option works. In 1988 an option is granted to a selected employee. The option entitles the employee to purchase one share of stock at today's fair market value of $100. The purchase right may be exercised anytime in the next 10 years at the frozen price of $100.

By 1998 the stock has appreciated in value to $300. The employee chooses to exercise the option by purchasing the stock for $100. However, even though the corporation has just sold a share of stock to an employee at $200 below market value, the employee does not yet pay income tax on the $200 since the employee has not yet realized a gain on the transaction.

Finally, by 2008 the stock has appreciated to $500. The employee then decides to sell the stock. Only then is tax assessed on what is now a $400 capital gain for the employee.

From the employee's viewpoint, investment stock options deal positively with the issues of fairness, limited current resources and taxes.

Many agency owners have heard the common complaint of good producers: "Why should I work hard to build the agency's book of business? It just increases the price that I will have to pay for the agency in the future."

Incentive stock options are the perfect response. If the producer builds the book of business this year, he will be granted the opportunity to buy shares of stock at a frozen price. He is not penalized for his value-creating efforts. Once the option is granted, the employee benefits from any appreciation in stock value but without making any capital investment and at no risk.

**If the producer builds the book of business, he will be granted the opportunity to buy stock at a frozen price. He is not penalized for his value-creating efforts. Once the option is granted, the employee benefits from any appreciation in stock value.**

If the value of the stock declines during this period, the employee loses nothing since he or she has invested nothing.

Incentive stock options have favorable tax treatments for employees. Options are not taxable at either the time of grant or the time of exercise. If holding period requirements are met, long-term capital is finally recognized when the stock is sold, and that could be decades from now.

To receive the favorable tax treatment, incentive stock options must meet the IRS regulations that were published in 1982. They are quite simple and allow a high degree of freedom in designing a plan to meet the agency's unique needs. A few of the most significant requirements are:

- The term of the stock option cannot exceed 10 years.
- The option price must equal or exceed the fair market value of the stock at the time the option is granted.
- The employee must hold the stock for at least one year after exercising the option and for at least two years after the option was granted.
- The option expires three months after employment ceases.
- Employees owning more than 10% of the company can be issued options with prices equal to or exceeding 110% of fair market value with an exercise period restricted to five years or less.

The rules are not complicated. In addition, investment stock options are not subject to Employee Retirement Income Security Act of 1974 restrictions or Labor Department regulations. Most investment stock option plan documents can be written in two pages and still cover every feature of the plan.

While investment stock options are a very positive benefit to selected value-creating employees, they are not a giveaway program. The employee is not being given stock. He or she is only being granted the opportunity to purchase stock.

*Continued on next page*



Mr. MacDonald

*Thomas K. MacDonald is president of MacDonald & Associates, a San Francisco firm that provides financial advisory services to insurance firms including agency valuation, perpetuation and ESOP feasibility studies, merger and acquisition advisory services, and expiration valuations.*



*Continued from previous page*

If administered wisely, the employee will be offered an amount of stock less than the value that he or she added to the agency. And when the option is exercised, the employee actually pays cash (or equivalent) to the corporation.

Usually, options are being issued to individuals that you expect to be the majority owners of the agency in the future. Stock options help to ensure that these future buyers will still be there.

For those agents concerned about the potential abuses of stock options, it is typical for the plan to have some built-in protective features. There is usually a vesting feature to prevent hit-and-run exercising of options. Also, in the event of voluntary termination, some agents create a holding period on the stock. This prevents a producer from using stock option capital gains as a source of funds to establish a competing agency.

Often, agents ask whether they should install an incentive stock option or an employee stock ownership plan. The answer is that you can use both, but you should probably use them at different times for different objectives.

Incentive stock options are ideally suited to encourage and reward growth. They help to attract, motivate and retain the best Value Creators. Agents implement incentive stock options during the growth years of the agency.

ESOPs are best suited for liquidating value. The many financially attractive features of ESOPs are best employed when it is time for a major owner to cash in his shares.

Incentive stock options and ESOPs are frequently referred to as the one-two punch. Incentive stock options are for creating value. ESOPs are for liquidating value. ■

# PIA opposed to reductions in crop policy commissions

WASHINGTON—The federal government's recent drought-relief measure is supported overall by agents' associations, but some are voicing concern about a provision that could cut commissions paid to insurance agents and brokers selling crop insurance.

"This emergency drought-aid bill is designed to provide financial assistance to farmers and ranchers whose livelihoods are being threatened by this summer's severe weather," said Willis J. Hargrave, president of the National Assn. of Professional Insurance Agents, based in Alexandria, Va., in a letter to Secretary of Agriculture Richard Lyng.

But Mr. Hargrave expressed concern regarding a provision in the law giving the secretary of agriculture the power to cut commissions paid to insurance agents, brokers and companies on crop insurance sold through the Federal Crop Insurance Program. "Any cut in agents' commissions that will apply on a permanent basis is unacceptable to the PIA," he stressed.

Under the program, the government offers the nation's farmers subsidized assistance in the form of insurance, loans and direct payments. In objecting to the proposed reduction of commissions, Mr. Hargrave explained to legislators that one of the reasons for low participation in the program is the lack of incentive for agents in the form of sales commissions.

The PIA is seeking assurances that the proposed changes are "temporary and would not necessarily apply to the rest of the Federal Crop Insurance Program."

## A/BT briefs

### Virginia exams

CHARLESTON, W.Va.—West Virginia has revised its insurance examinations for resident agent and solicitor licenses to reflect changes in the state's laws and regulations.

The new exams, affecting the life, accident and health, and property/casualty categories in the state portion of the exam, will be introduced at the Dec. 3 testing.

Major changes include an additional topic, "Mass Marketed Life & Health Insurance" in the life/health category, and "Malpractice Policies" and "Risk Retention Act of West Virginia" in the property/casualty category.

### Interface planning

A new group of agents and insurer representatives held its first meeting last month to address agency requirements for effective interface within the United States agency system.

The 15-member Interface Systems Requirements Panel's objectives are to "describe, from the agency viewpoint, effective multiple company electronic interface requiring only slight changes to existing agency and company systems," said Arthur Pavelle, senior vp of ACORD, which provides administrative support for the panel. ACORD, or Agency-Company Organization Research & Development, based in White Plains, N.Y., is devoted to computer interface research and development.

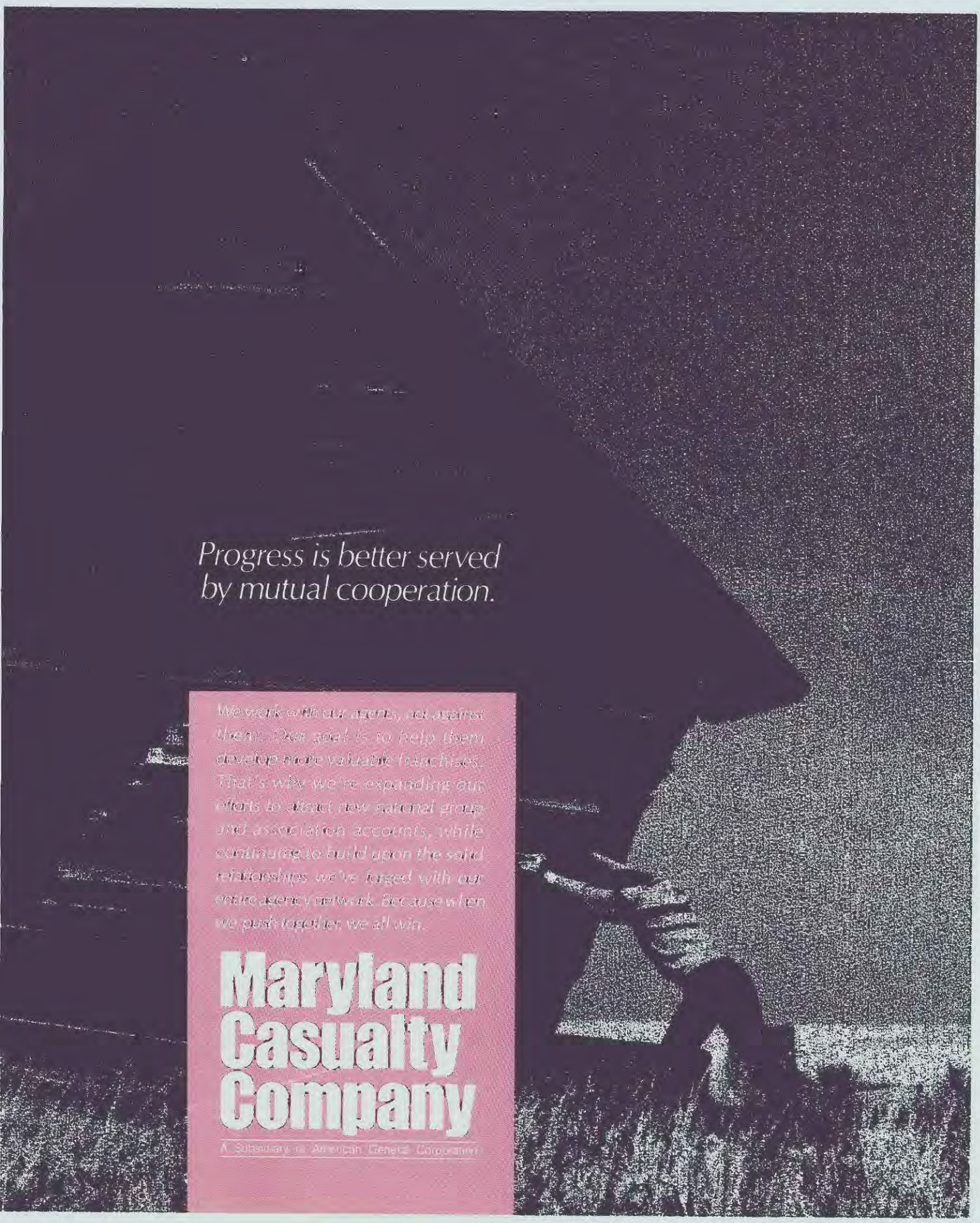
The panel held its initial meeting Oct. 12 in Newark, N.J.

The co-chairmen elected by the panel are William Hartnett of Interstate Insurance in Tiverton, R.I., representing the National Assn. of Professional Insurance Agents; and George A. Porter of El Camino Insurance Agency in Vista, Calif., representing the Independent Insurance Agents of America.

Other panel members are: Joel M. Benisch of Benisch & Co., Orange, N.J.; William Cadenhead of Cadenhead Schreffler Insurance, Bedford, Texas; Greg Deimling of Globe Insurance Agency Inc., Cincinnati; John Hardy of Charles E. Hyde Agency, Port Washington, N.Y.; Vernell Hogan of Brown Arris Langhorne, Virginia Beach, Va.; Nancy Joy of Payson & Noyes, Portland, Maine; Tripp Leach of Red Leach & Sons, Gadsden, Ala; and Peter Wilson of Emmons & Wilson Inc., New Canaan, Conn.

Company members are Wyndham E. Eberle, assistant vp, Chubb & Son Inc., Warren, N.J.; Donald Goldstein, director, Maryland Casualty Co., Baltimore; Jack Stiegler, SAFECO Corp., Seattle; and Donald E. Williams, assistant secretary, Selective Insurance Group Inc., Branchville, N.J.

Association liaisons include Shirley Lukens, director of agency automation, IIAA; and Carol Stacey, director of automation, PIA. ■



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# States streamlining producer licensing

By LAURA MAZZUCA

Buried under paperwork and inundated with license processing requests, insurance regulators are taking steps to streamline producer licensing.

One such measure is single licensing of producers, which requires agents and brokers to procure only one license per state, rather than multiple licenses for each insurer they represent.

Although some states adopted single licensing years ago, the issue gained momentum in 1987, when the National Assn. of Insurance Commissioners developed its Single License Procedure Model Act, which is based on a 1978 model law, said Patricia A. Borowski, vp of government and industry affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va. Ms. Borowski also chairs an advisory committee for the NAIC Task Force on Agent/Broker Licensing.

Under the 1987 model act, agents and brokers no longer would have to secure a separate license for each company and subsidiary they represent, as well as for each line of insurance they write. Instead, a single license would be issued, which would list lines of business the producer is qualified to write. And, at each state's discretion, the license could also list each company the producer represents.

While several states have adopted elements of single licensing into their regulatory system, so far only two—Illinois and Tennessee—have adopted the NAIC model act verbatim, said Commissioner Andrea Bennett of the Montana Insurance Department in Helena.

Ms. Bennett, who serves on the NAIC Agents Licensing Study Task Force and its subgroup on Multistate Licensing Systems, said Montana has not adopted single state licensing, although she expects the state Legislature will adopt the act when its session begins in January.

Tennessee adopted the act in its June 1988 legislative session and Illinois has required agents and brokers to obtain only a single license since 1983.In fact, the 1987 NAIC model act was partially based on the pre-existing Illinois format, added Ms. Bennett.

So far, the number of states interested in adopting the NAIC's model act, or at least elements of it, is on the rise, said Ms. Borowski. In the past three years, this trend has increased from three states revising their procedures to 10 or 12, she said. While many of these states' adaptations are not exactly the same as the model act, "the general thrust of the changes are in sync" with it, with an emphasis on single licensing, she said.

States enacting at least some facet of single licensing include North Carolina, Virginia, Kentucky, Illinois, West Virginia, Tennessee and Missouri, she said.

The 1987 model act does not repeal any provision of its predecessor, the 1978 NAIC Agents and Brokers Licensing Model Bill, which defined terms and presented model language in a first step toward statewide standardization of licensing procedures, said Ms. Borowski.

Therefore, a state that enacts the single license model act needn't replace the 1978 NAIC licensing model or any other licensing law already in effect in that state. Both NAIC models address pre-licensing testing and how the producer should apply for a license.

"The industry in general looks at it as a step in the right direction," said Montana's Ms. Bennett. "At least we have regulators agreeing to some general terms and accepting the idea of actual uniformity."

But, like the as-yet-unrealized standardization of automation interface between independent agencies and insurers, the single licensing system is far from universal.

"Just getting it (the single license act) written and passed was the first step" for most states to consider adding it, said Carol Hartman, supervisor of the licensing section at the Missouri Division of Insurance in Jefferson City. "It would be a big step forward if states could just get to the single licensing concept." Ms. Hartman

*Continued on next page*



**SEVEN OUT OF TEN AGENTS ARE GUILTY OF NOT TAKING THEIR OWN ADVICE.**

How often have you recommended a client go for the policy that offers the best coverage? Cautioned against sacrificing important protection to get the cheapest price? Or stressed the importance of comparing apples to apples when it comes to comparison shopping? Odds are, frequently. Yet all too often, agents are so wrapped up in advising their clients, they fail to apply this same good sense when it comes to purchasing their own errors & omissions coverage.

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serves on the NAIC model legislation and multistate licensing subcommittees.

"It's going to be a long haul, but I think we've turned the corner," said Ms. Borowski, who noted that both the NAIC individual regulators acknowledge the need for such streamlining and networking.

Under the licensing systems now in existence in many states, it can take from 30 days to 60 days for a non-resident agent to become licensed in the state, or for an agent to add an insurer to the companies he represents. In the meantime, the agent can't write business in the state or for the new insurer.

Agents also complain about the burden of paperwork and the time lag as certificates and forms are sent by mail, she said. The insurance department faces the same onerous pile of paper, which raises the cost of administration.

"The timeliness issue is a factor for everybody, not just agents and companies but the insurance departments," said Ms. Borowski. "It's not an adversarial issue; everybody agrees and is trying to get to the same place."

Although the advisory committee has been working on single licensing since 1984, the final act wasn't approved until last December at the NAIC's winter meeting in Phoenix, Ariz., said Ms. Borowski.

In the months since its introduction, the committee has focused on working with state regulators to ensure that records kept on agents and brokers adequately conform with the new licensing model, she added. The group's next meeting, scheduled for December, will further clarify language and specifics of the act.

To simplify state licensing even further, the 1987 act introduces the term "insurance producer," eliminating the distinction between agent and broker for licensing purposes. As a result, only once license is issued rather than two, cutting down on paperwork for the state.

Meanwhile, committee members admit that the model act still needs some modifications and amendments, especially in the area of a streamlined agent appointment process, said Ms. Borowski.

Typically, once an agent agrees to represent a specific insurer, the insurer notifies the state regulator of the appointment. The department then examines the qualifications of the agent before approving the arrangement.

If the department finds the agent is qualified, it sends a notice to both the insurer and agent, stating when the agent can begin to transact business. From the time of signature, this can take from about 30 days to three months if the agent is a resident of another state, she said.

Under the streamlined appointment system proposed by the advisory committee for the NAIC Task Force on Agent/Broker Licensing, an agent can write business for an insurer immediately upon signature of the agreement. The insurer would be responsible for checking out the agent's qualifications and would report to the insurance department on a regular basis—weekly or monthly—to update its list of representatives.

The advisory committee and the NAIC are scheduled to meet this month to introduce this recommendation, which, if approved, may be added to the model act, she said.

The NAIC model act has, though, come under fire from some critics. For example, some feel the generic use of the term "insurance producer" in the act's language blurs the distinction between agents and brokers and the duties each must perform.

"The broker represents the client, and an insurance agent represents the carrier," said Mike Cabot, executive director of the Western Assn. of Insurance Brokers in San Francisco, which is opposed to the semantics used in the model act. "Commercial insurance consumers look to brokers to help them in the risk transfer area, and brokers feel this is their prerogative."

In Montana, some agents and brokers objected to the term because the state's case laws are based on the distinction between the two, Ms. Bennett said.

However, the National Assn. of Insurance Brokers in Washington, D.C., fully supports the NAIC model act and has no problem with the term "producer."

"An agent is a broker up to the point where he decides to place business. Up until then, he's a free agent," said Coletta Kemper, director of public affairs for the NAIB. "The benefits (of the model act) far outweigh the subtle blurring of the distinction."

In addition, since the term "producer" is only used for licensing purposes, it doesn't change the way either agents or brokers operate in a state, since the license itself does not impart any authority, said Ms. Borowski.

Others have expressed concern about the possible reduction of revenues if a state insurance department switches from multiple to single licensing. However, since licensing fees in most states are "woefully small," these fees could simply be increased, as well as levied for each change or correction, said Ms. Borowski.

*Continued on next page*

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# Producer licensing

*Continued from previous page*

Missouri, for example, increased the agent's initial fee to about $50 from about $25 when single licensing was introduced, said Paul Dobinsky, president of Dobinsky Insurance Agency Inc. in St. Louis. Additionally, when notifying the department of new appointees, the insurer must pay a fee and also is charged for changes and corrections, he added.

A similar increase in fees was made in Illinois when the single licensing concept was introduced five years ago, said Sharon K. Heaton, president of Heaton Agency Inc. in Pontiac, Ill. The current annual fee for a producer's license is $50. In the past, the insurer paid a $2 fee for each license obtained, she added.

Since the introduction of the new system, the amount of paperwork in the Insurance Department "has gone down tremendously," said Dick Rogers, deputy director of the Illinois Department of Insurance in Springfield.

Under the old system, the department would process about 300,000 agents' licenses and 40,000 brokers' licenses every two years, said Mr. Rogers. Under the new system, about 70,000 producers licenses are processed annually, with the due dates staggered to prevent a single rush in the department, he said.

Fees have changed too: Under the old system, the department charged $10 per license; the new system fee is $50 per producer license.

Ms. Heaton believes the new system is "much better" than the old one and that other states will follow Illinois' lead in single licensing.

Automation is another important element in both single licensing and multistate licensing, added Ms. Borowski. Since state insurance departments are in various states of development, this is not easy. An NAIC survey released in August indicated that more than 50% of the state insurance departments are automated in their agent licensing and disciplinary processes, and others are working on it now.

Missouri adopted single licensing in 1982 and at the same time converted from a weekly batch system of processing licenses to a computerized format. The licenses are now issued daily rather than weekly, significantly "cutting back on the mounds of paper the department had," she said.

"We had to issue a license to each agent for every company he was with," said Ms. Hartman. The single licensing system, coupled with automation, "is definitely a savings for us in man hours and in getting licenses out," she added.

And, although brokers in the state must still renew their licenses annually, the former due date of July 1 has now been staggered to "cut down on the processing," she added. And, brokers who once were required to file an official copy of their license with the department each time they placed new business now have 10 days to notify the department.

This streamlined process is not only beneficial to the agents and brokers, but also helps the industry in general, since agents now can immediately produce business for their companies rather than wait for the department to issue a license, she said. In fact, she considers this the main benefit of the new system.

Before the single license law went into effect, "there was a false sense of who was out there," since some smaller insurers would drop agents and not inform the department, said Mr. Dobinsky. "This way you're cleaning (the licensing system) out, and you know who is licensed and active."

"It was a very advantageous thing for this state to do," he said. "Hopefully, the next step will be national recognition of licensing." ■

# NAIC looks to multistate licensing

By LAURA MAZZUCA

The next item on the National Assn. of Insurance Commissioners' agent licensing agenda is the development of a model act for multistate licensing, which would allow producers who operate in more than one state to obtain only one license.

This aspect of the agent licensing picture is becoming increasingly important as more producers market their products across state lines, said Patricia A. Borowski, vp of government and industry affairs for the National Assn. of Professional Insurance Agents.

The proposed NAIC multistate program would make licensing easier and less expensive for the producer, as well as make it simpler for commissioners to monitor producers, she added.

"It's better for both agents and regulators to have a single clearinghouse, even if each state acts independently after that," said Dick Rogers, deputy commissioner for the Illinois Department of Insurance in Springfield.

"The downside to not doing it is that agents would have to go through several layers of bureaucracy," said Mr. Rogers, who serves on the NAIC committee for multistate licensing.

"Since more and more states have continuing education laws, and agents by their nature deal in several states, there should be more clarity in the reciprocity between states," said Jeffery M. Yates, executive vp and general counsel for the Independent Insurance Agents of America Inc. in New York.

"Our feeling is that we're hoping the issue will move faster, particularly in the area of continuing education," said Mr. Yates.

He said the IIAA supports the multistate system because it could reduce costs for agents retaining licenses in several states, as well as standardize state-by-state continuing education requirements, which are becoming an "administrative nightmare" for agents operating in more than one state, he added.

The NAIC released a paper in June presenting its idea for multistate licensing to regulators and the industry. While it's "still in the discussion and developmental stages," regulators understand the need for it, said Ms. Borowski.

However, before multistate licensing can become a reality, participating states would have to adopt single licensing procedures, which require just one license for an agent to represent several insurers. Currently, most states require separate licenses for each insurer represented.

The multistate licensing system would tie in with a 1987 NAIC model act for single agent licensing, said Commissioner Andrea Bennett of the Montana Insurance Department.

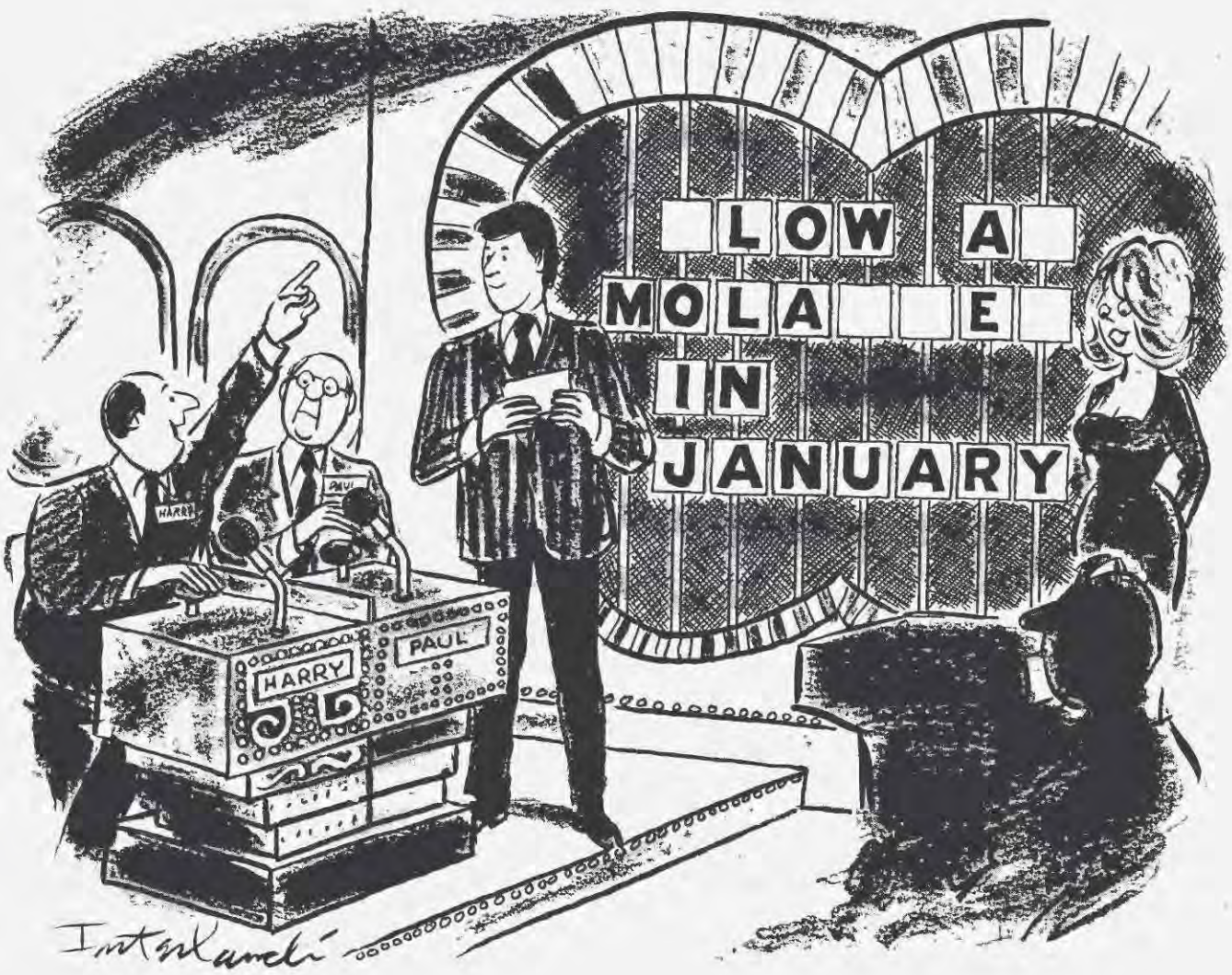
Although the multistate system would work best if adopted by all 50 states, theoretically it would be workable on an incremental basis, she said.

The NAIC points out that uniform information, such as name, address, business address, educational level and insurance background best facilitated by the single licensing process, is practically a prerequisite for multistate licensing.

But right now various state insurance departments are all operating at different levels of automation, said Ms. Bennett.

*Continued on next page*

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*Continued from previous page*

Streamlining the licensing system can benefit not only agents but insurers and regulators as well, said Ms. Borowski. Ongoing problems with most insurance departments' current operating systems include overflowing paperwork, up to 60 days for processing, and the fact that agents can't write business for a newly represented insurer until the paperwork is done.

The NAIC's Agents Licensing Study Task Force draft proposal of a multistate licensing plan includes details about how records could be set up, choices of hardware and software, and a timeframe within which the system could be established. Assuming that a uniform licensing procedure were presented and accepted, the committee estimated that development and implementation of a pilot program—involving Illinois, Missouri, Tennessee, Iowa and Montana—could begin as early as Jan. 1, 1990, added Ms. Bennett.

The NAIC is expected to discuss the multistate issue at its winter meeting in December.

States participating in the multistate pilot program would be required to have a standardized automation system, similar to the type currently used by securities dealers, said Ms. Bennett. The computer vendor would be the central depository of information and would provide each state with a terminal. Administration would be handled by the vendor, and the cost would be defrayed by increasing licensing fees for agents and companies, she added.

However, many questions need to be answered by state regulators and other participants before implementation of the multistate program can begin, said Ms. Borowski. These include:

- Is there any software on the market that can run the system?
- Can the system be run by a network, or must a central data system administrator be utilized?
- How would the proposal tie in with the NAIC's current system and existing systems in the states?
- What would the potential costs be—upfront and ongoing?

To determine how best to implement the model, the committee must carefully analyze the mechanics, or how to set it up; as well as the underlying philosophy behind such changes, i.e., what they hope to accomplish; and the environment needed to best implement such changes (e.g., uniform forms, etc.), said Ms. Borowski. ■

## Letters

# Remarks not made by ex-PIA official

To the editor: The article about the possibility of a merger between the Independent Insurance Agents of America and the National Assn. of Professional Insurance Agents, "Standing Their Ground," in the Oct. 3 issue of *Agent/Broker Topics* included a quotation that was indirectly attributed to me:

" 'I tried to get them together in New York State when I was president (of the PIA state association) in 1970,' a New York agency principal wrote. 'I believed then and still do, that the roadblock (to a merger) is the paid professional staff of both associations. No one wants to get kicked off the gravy train, and a gravy train it is!' "

I was honored to serve as president of the New York PIA during the 1969-70 term. However, I never said or wrote the excerpt that you published. I have never subscribed to the sentiment or import of this quotation.

As a past president of the New York PIA and as a longtime member of both the PIA and the IIAA, I have felt and always advocated, publicly and privately, that the competition engendered by the two separate organizations is healthy and beneficial to independent insurance agents and their agencies. The quality of service we enjoy today is due in large measure to the hard-working staffs from the two fine organizations attempting to outperform each other.

In light of this positive effect, I do not now endorse, nor have I ever supported, the merger of these associations.

**Jerome B. True**
J.B. True Co. Inc.
Ithaca, N.Y.

■ *Editor's note: The remarks indirectly attributed to Mr. True were submitted with a reply to an anonymous survey mailed to agents and brokers around the country. There is no way to identify the author of the remarks. We regret any inconvenience suffered by Mr. True.*

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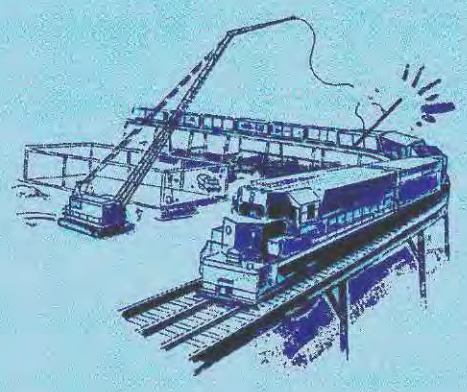
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AGENA Corp. of Seattle, a consortium of seven insurance companies offering automation solutions to independent agents, is now offering full policy conversion capability on both its AGENA/Premier and its AGENA/MicroVAX systems.

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The homeowners policy conversion system is currently available through American States Insurance Co. of Indianapolis; Atlantic Mutual Cos. of New York; General Accident Insurance Cos. of America in Philadelphia; Royal Insurance Co. of America in Chicago; SAFECO Insurance Cos. of Seattle; and Westfield Cos. of Westfield Center, Ohio.

Auto policy conversion is currently available through American States, Atlantic Cos., General Accident and SAFECO.

Auto policy conversion capability with additional insurers is forthcoming.

AGENA estimates that it takes a computer operator an average of nine minutes per policy to manually convert this information to another system, compared with an average 15-second conversion capability through AGENA's automated system.

For further information contact Janene Osborne, Marketing Department, AGENA Corp., 9709 Third Ave. N.E., Seattle, Wash. 98115; 206-547-5244.

## A/BT products & services

### PC software

Personal computer software that gives marketing specialists a close-up look at commercial lines markets by county across the United States is now being offered by the Market Planning Group, a Boston-based agency marketing consulting firm.

The MPG Database-Personal Computer Release contains estimated written premiums for 900 Standard Industrial Classification categories of businesses and not-for-profit organizations in each county of a given state, further broken down into 12 commercial lines of insurance.

For example, an agent or broker could use the software to determine estimated total premiums for drug stores in San Diego County.

The software can then break down estimated premiums into 12 commercial lines categories: commercial multiperil, property, workers compensation, general liability, commercial auto, inland marine, ocean marine, fidelity, surety, aircraft, medical malpractice, and boiler and machinery.

Also included in the data base are the total number of SIC code businesses in each county, average premium per establishment, number of establishments by employment size and estimated premium by employment size. This information is updated on a biannual basis.

The cost of the software, which is sold on a state-by-state basis, ranges from $695 to $1,795.

For more information contact The Market Planning Group, 80 Boylston St., Suite 1207, Boston, Mass. 02116; 617-542-4417.

### Commercial lines

The Commercial Producer's Library, a five-volume set of books compiled by the International Risk Management Institute, is written for agents and brokers interested in achieving a competitive edge in marketing commercial lines business.

The set provides a thorough evaluation of commercial lines exposures, recommended insurance coverages and a complete set of workers compensation classification guidelines by industry, including state-by-state variations.

The five volumes are:

- The Manual of Insurance Checklists, designed to help agents and brokers evaluate the risks of a client and tailor coverage to specific client needs.
- The Exposure Survey Questionnaire, which provides a step-by-step format of how an agent or broker can conduct interviews with the management team of a commercial client or prospect to help reveal that organization's major risks.
- The Manual of Rules, Classifications and Interpretations for Workers Compensation Insurance, which provides workers compensation classifications, rule interpretations and state variations.
- The Classification Cross-Reference cross-indexes comprehensive general liability policies and workers compensation codes.
- The Guide to Workers Compensation Insurance, which contains practical policy interpretations and analyses of the most important workers compensation endorsements.

The cost for the complete set is $212; however, books can be ordered separately.

For additional information contact the International Risk Management Institute Inc., 12222 Merit Drive, Suite 1660, Dallas, Texas. 75251-2217; 214-960-7693 or 800-527-2580.

### Inland marine book

The Insurance Institute of America, based in Malvern, Pa., has published a new textbook on inland marine insurance, developed for the IIA's new Associate in Marine Insurance Management program.

The text—Inland Marine Insurance—provides a comprehensive discussion of the inland marine field. It covers the classes of insurance, including contractors equipment, motor truck cargo, electronic data processing equipment, builders risks, differences in conditions, dealers, personal articles and more.

For each of these classes of insurance, the textbook analyzes loss exposures, describes policy provisions and explains underwriting considerations and loss control techniques.

The two-volume text costs $44, plus shipping and handling.

For more information contact the Insurance Institute of America, Order Department, 720 Providence Road, Malvern, Pa. 19355-0770; 215-644-2100. ■

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## Marcon

*Continued from page 3*

needed, we have—at best—a normal recovery," he said.

Specifically, net written premiums increased 4.8% to $197.2 billion for the year ended June 30 compared with the 12-month period ending June 30, 1986.

In contrast, for the year ending Dec. 31, 1987, net written premiums grew 9.4% to $193.7 billion compared with the 12-month period ending Dec. 31, 1986, Mr. Marcon said.

"The slowdown in written premium growth is even sharper for certain segments of the industry," said Mr. Marcon, who became ISO president in January.

For the year ended June 30, general liability net written premiums declined 4% from the previous year, while net written premiums for all commercial lines increased only 2.2% to $87.7 billion, substantially less than the 20.2% increase in net written premiums for commercial lines for the period ending June 30, 1987.

Personal lines premiums increased 9.7% to $85.9 billion for the year ended June 30, but the rate of increase is slowing down from the 13.5% increase for the year ended June 30, 1987, Mr. Marcon said.

And, the underwriting results for personal lines writings during the same period have been worse than commercial lines' results, he pointed out.

ISO is predicting only a 3.5% increase in overall net written premium for 1988, with no real improvement in 1989, he said.

"With premium growth falling off sharply since 1986, the industry's return on net worth has now begun to deteriorate," Mr. Marcon said.

The return on net worth—or earnings on surplus and equity—of 11.4% for the year ended June 30 was down 1.8 points from 13.2% for same period a year earlier, he said.

And, of 999 property/casualty companies ISO reviewed, 120 posted negative returns on net worth for the year ended June 30.

The industry's 104.8% combined ratio for all lines during the first half of 1988 shows a slight deterioration from the 104.1% recorded for the first half of 1987, Mr. Marcon said.

But, some property/casualty insurers had no recovery at all, Mr. Marcon pointed out. "Even as the industrywide recovery began, 55 insurers covered by guaranty funds became insolvent, including 11 in 1987 and six more so far this year," he said.

"The principles of cost-based pricing are hard-learned lessons for more than a few players in the property/casualty marketplace," he said.

As insurers grapple with the challenges of a rapidly softening marketplace, they face some added burdens, he said, including:

- A deeper federal tax bite. The changes in the Tax Reform Act of 1986 resulted in an effective industrywide tax rate averaging 23%. However, companies that write chiefly long-tail commercial business were hit even harder with a 40% effective tax.

Since tax reform took effect in the first quarter of 1987, federal and foreign income taxes for insurers has averaged $900 million per quarter, according to ISO.

In the first half of 1988, the $2.1 billion in income taxes paid by insurers represented 23.1% of pretax net income. In the first half of 1986, when the industry recorded $5.6 billion of pretax net income, the industry recorded a tax credit of $200 million.

Also, under provisions of the new tax law, even companies with negative statutory operating income pay tax, unlike under the old law.

Net income will be squeezed even tighter during 1990 when more stringent rules about changes in the alternative minimum tax will go into effect.

- Threats to the industry's limited immunity from antitrust laws. One threat comes from federal legislation that would modify or repeal the McCarran-Ferguson Act, which grants the industry limited immunity from antitrust laws.

Mr. Marcon asked members of the group to disseminate information that "if opponents succeed in repealing or substantially modifying the McCarran-Ferguson Act, they'll cast a pall of uncertainly over many beneficial industry activities, ultimately to the detriment of consumers."

The other threat stems from the antitrust suits pending against ISO and several other property/casualty insurance industry defendants in which state attorneys general and several private parties allege defendants conspired to manipulate the U.S. commercial liability insurance market (see story, page 1).

**'If opponents succeed in repealing or substantially modifying the McCarran-Ferguson Act, they'll cast a pall of uncertainly over many beneficial industry activities, ultimately to the detriment of consumers,' Mr. Marcon says.**

"The charges against ISO are totally without merit," Mr. Marcon said.

In addition to fighting those accusations, ISO plans to do whatever it can to inform lawmakers, regulators, risk managers and consumers that ISO's collective activities are beneficial. Such activities include: standardizing contract wording; issuing advisory price information that allows more insurers to compete in more markets; and encouraging insurers to jointly provide coverage for large risks like nuclear power plants.

- Other serious threats to the stability of state regulation, which include propositions on California's Nov. 8 ballot calling for mandatory rate rollbacks among other things (*BI*, Oct. 24).
- Continuing escalation of guaranty fund assessments and insurers' potential obligation to fund insolvent insurers' unpaid claims.

Between 1969 and 1983, insurers were assessed more than $450 million to cover the cost of insolvencies. But between 1984 and 1987, insurers were assessed $1.4 billion, or three times as much.

There also are other threats to insurer profitability, Mr. Marcon said.

"Most residual markets, joint underwriting associations and involuntary pools are reeling from losses and expenses that have historically outstripped and will continue to exceed revenues. Collectively, the industry will be forced to shoulder an increasingly heavy burden to pay for these mechanisms," he said.

In addition, Mr. Marcon noted the unpredictable nature of catastrophe losses.

The $1.1 billion in catastrophe losses in the first nine months of 1988 are 20% greater than the $905 million of catastrophe losses recorded for all of 1987.

But the insurance industry can withstand catastrophes if it is "fundamentally strong and strong on the fundamentals" of a sound underwriting policy of cost-based pricing, Mr. Marcon said. ■


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Reaching a target audience of 36,752* insurance and reinsurance company executives, Insurer Topics reports on issues of special interest to insurance and reinsurance company executives. This section covers specific issues such as commercial underwriting techniques, reserving practice, relationships with insurance distribution systems and policyholders, and techniques used by other companies.

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# Brokers to expand global presence: Exec

**By JUDY GREENWALD**

NEW YORK—Globalization and specialization will be among the keys to success for large insurance brokers in the 1990s, a brokerage executive says.

"Globalization is the hot buzzword in our industry," explained Lawrence E. Burk, president and chief executive officer of the greater New York division of Alexander & Alexander Inc.

But, at the same time, "I think we're going to have to become more specialized" in serving clients' needs, he said.

Mr. Burk was among the members of a panel who discussed the brokerage business in the 1990s at the Insurance Information Institute's 13th annual research seminar last month, which was cosponsored by the National Assn. of Insurance Brokers.

Other topics the panel discussed during the wide-ranging session included:

- The future of alternative risk-financing mechanisms.
- How brokers will be compensated in the 1990s.
- The pros and cons of state vs. federal regulation.

Mr. Burk said globalization is one concept that large brokers will have to take into account to be successful in the 1990s. A&A, he noted, now has more employees working abroad than it has in its U.S. offices.

And many observers believe that by the mid-1990s there will only be a handful of global brokers competing on a worldwide basis, he said.

"The insurance world is obviously becoming increasingly interdependent," Mr. Burk noted.

Pricing and coverage are being determined on a worldwide basis, he said. And, a broker must help his clients develop a uniform risk management philosophy, said Mr. Burk, referring to the breakdown of trade barriers among European Common Market countries in 1992.

The most successful brokers, he said, will be those large enough to offer a full range of services in all EC member states. Mr. Burk noted the European Community has a total population of 320 million, as opposed to only 285 million in the United States, though insurance expenditures total only $600 per person in EC nations, compared with $1,700 per person in the United States.

While Europe is not expected to reach the U.S. per-capita level of insurance expenditures, "Obviously over time they're going to move closer to it," said Mr. Burk. "The potential opportunity over there is tremendous for the global broker."

He noted that a local presence in overseas nations is also needed to handle matters such as local customs and individual services. Globalization requires the large broker to provide worldwide capabilities "backed by local expertise," he explained.

**Risk-financing facilities 'will be a real force' in the 1990s, says Alan G. Page, senior vp at Johnson & Higgins. However, these facilities must have access to capital markets and the ability to raise 'vast amounts of money.'**

"I don't see how a major broker can maximize growth in the 1990s without a massive global strategy," he said, noting that two-thirds of the world's largest companies are now located outside the United States, a trend that will continue in the 1990s.

Brokers also must become specialized, said Mr. Burk. A&A, for instance, has set up a national marketing group to focus on aviation, aerospace and other specialized areas, while other brokers have established "similar but slightly different" organizational structures as well.

The third concept on which brokers must focus is "value-added" services, including risk analysis and risk management services, he said.

Brokers must offer a range of services to solve client problems, providing clients with "more value for their dollars," he explained.

Mr. Burk added that the "biggest challenge" facing the large broker is recruiting good personnel. "We can't possibility be efficient without good, quality people," he said.

Traditionally, he said, brokers could acquire agencies or hire workers from insurance companies. But "these approaches are no longer able to fulfill our needs," he said.

Large brokers must figure out ways to attract and retain quality people, offering them a challenging workplace, good compensation and ample opportunity for development, he explained.

Companies can no longer count on fulfilling their personnel needs during a soft market. While there used to be an "overabundance" of people available in the soft market, today "the demand for people far exceeds the supply."

In his remarks, Alan G. Page, senior vp for Johnson & Higgins in New York, noted that the development of alternative risk-financing facilities is "real exciting and something that will be a real force" in the 1990s.

However, these facilities must have access to capital markets and the ability to raise "vast amounts of money," Mr. Page said.

The last hard market cycle, he explained, saw an unprecedented alliance of investment bankers and brokers that helped establish these facilities, and a similar effort can be expected to continue in the 1990s, with perhaps even more capital being generated by the brokers themselves.

Mr. Page said that alternative facilities that set realistic goals and do not try to compete with better-capitalized entities will survive the soft market.

But those that are overly ambitious and try to accomplish things they are insufficiently capitalized to attain will fail. "These people are to be discouraged," he said.

Mr. Page called it ironic that some insurers fear the development of alternative markets because commercial insurers "have all they tools they need to compete with alternative markets."

"Innovation and being ahead of the times—that is one way to compete with alternative markets," he said.

Alternative markets hold an appeal when coverage is either unavailable or so restricted that policyholders feel there is, in effect, no coverage. The availability of insurance, even at a higher price, is a "very powerful alternative to alternative markets," said Mr. Page.

Panelist Philip F. Petronis, managing director for Marsh & McLennan Inc. in New York, pointed to alternative markets partly sponsored by brokers, such as A.C.E. Insurance Co. and X.L. Insurance Co., and posed the question of whether brokers will encroach on underwriters "turf" more in the 1990s than in the past.

"I think the answer is 'absolutely not' from an underwriting standpoint," he said. "I certainly don't see us going to their turf on the underwriting side."

The role of brokers in creating these alternative markets was a response to a market dysfunction, said Mr. Petronis.

Mr. Petronis also pointed out that a "fundamental issue" in the brokerage industry—providing risk management and insurance advice and transactional skills—will not change in the 1990s.

Full-service brokers, he said, must establish worldwide services companies that offer specialization as well as centralization. This will involve offering marketing specialization, which is close to brokers' traditional skills; client specialization in areas such as aviation and financial institutions; and technical specialization skills in areas such as loss control and risk management information systems.

"The qualities that I think will characterize an organization in the 1990s as respects these services will reflect increased specialization and increased centralization," he said. This need is demonstrated by a number of issues, he added, including the complexity of the insurance product and buyers' size, sophistication and globalization.

"This specialization certainly is what differentiates" an alphabet broker like M&M "from the independent broker," said Mr. Petronis. While an independent broker can be as successful as an alphabet house on a regional basis, it cannot offer the centralization and specialization offered by brokers like M&M, he said.

"It's a strategy for organization of services in the 1990s that we think reflects our strength as a large organization," he added.

However, Mr. Petronis said that it is important that the services offered by a broker support brokerage activity. M&M sees itself as a broker, not a consultant, he stressed.

Mr. Petronis said any strategy for the 1990s should consider brokers' remuneration.

"On a general basis, I don't see a fundamental shift in commission as a proper compensation for brokers' activities," he said. "However, I think it's clear that commissions don't always make sense," particularly for large account business or those that involve a substantial level of risk management services.

On the other hand, he said, fees "haven't always made sense either," Mr. Petronis remarked.

An alternative form of compensation should be found that takes into account the value of brokers' services, Mr. Petronis said, "though I don't necessarily have the answer to what that is at the moment."

Barbara A. Guernsey, executive vp of San Francisco-based DSI Insurance Services, who represented regional brokers on the panel, focused on regulation, noting that it is expensive for a broker to deal with 50 different state insurance departments as opposed to one federal agency.

However, she said, there is also the question of whether it is preferable to deal with one gorilla "rather than 50 little monkeys running around."

"I'm not sure which we want to be involved with," she said.

And, she added, it would be a "real concern" if federal regulation affected the availability and affordability of insurance and led to a reduction in competition.

From insurers' standpoint, there is also the question of whether under federal regulation they would be forced to change their procedures, which would lead to increased cost of distribution, said Ms. Guernsey, adding that she was not sure it would be fair to pass this on to the consumer.

"I don't really think there's any answer, black or white," on the question of state vs. federal regulation, she said, adding that there are benefits and disadvantages to both forms of regulation. The ultimate concern, she said, is that "distribution cost must be reduced." ■

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# Los Angeles building fire spawns safety fines

SAN FRANCISCO—Four companies have been cited and fined for alleged safety violations related to the May 4 fire that raged through five floors of a 62-story office building in downtown Los Angeles.

The federal Occupational Safety and Health Administration is seeking penalties against Pedus Services Inc., Equitable Real Estate and American Building Maintenance Engineering Service, all of Los Angeles, and Commercial Building Co. of Glendale, Calif.

The companies, which face a total of $82,500 in penalties, have until Nov. 11 to either pay the fines and comply with OSHA standards or to contest the citations.

A maintenance worker was killed and about 40 others suffered smoke inhalation in the blaze at the First Interstate Bank Corp. (*BI*, May 9).

Pedus Services, Equitable Real Estate and American Building Maintenance were cited for two willful violations: one for a silenced fire alarm and one for lack of designated fire wardens, no emergency evacuation plan made available to employees, and no employee training for fire extinguisher use. Commercial Building was cited for the second set of violations.

The companies were also cited for several other serious penalties such as use of an elevator during the fire, delayed warning to people in the buildings and lack of water for use by firefighters.

Total penalties for each company are: Pedus Services, $23,100; Equitable Real Estate, $23,900; American Building Maintenance, $23,900; and Commercial Building, $11,600.

*—By Glenn Huntley*

# Balboa will fight $1 million state fine

By DOUGLAS McLEOD

BOSTON—Balboa Insurance Co. plans to fight an attempt by the Massachusetts Insurance Division to fine the insurer $1 million and bar it from doing business in the state for five years.

In an administrative complaint filed Oct. 24, the Insurance Division charges that Irvine, Calif.-based Balboa has engaged in unfair and deceptive business practices in its underwriting of four general liability insurance and auto warranty programs.

Noting that Balboa has been the object of more than 350 consumer complaints since 1984, the administrative action charges that Balboa has failed to pay valid claims, delayed claim payments, attempted midterm cancellation of an entire commercial liability insurance program, failed to make required rate filings and used unlicensed agents to market programs.

In addition to the $1 million fine and the five-year exclusion from the state, the Insurance Division complaint seeks official revocation of Balboa's license in Massachusetts.

Herbert F. Smith, senior vp and general counsel for Balboa, said the insurer surrendered its license Oct. 12 after a year of talks failed to resolve the Insurance Division's complaints.

"We just chose to turn it in and not continue doing business in the state," Mr. Smith said.

He added that Balboa will fight the Insurance Division's order to show cause why the insurer should not be fined and barred from the state.

"We believe they are totally without merit," Mr. Smith said of the allegations in the administrative complaint.

"We intend to resist the order to show cause vigorously," he continued.

A hearing on the complaint has been scheduled for Jan. 23.

One of the programs cited in the complaint was an automobile warranty program in which Balboa offered mechanical breakdown insurance to auto dealers who then sold auto warranty certificates to buyers of new and used cars.

Prior to year-end 1984, the program had been underwritten by Occidental Fire & Casualty Co. through a managing general agent, Corporate Underwriters Agency Inc., according to the complaint.

In late 1984, however, Balboa agreed to take over as the insurer of the program through its own MGA, Continental Benefit Industries Inc.

Harley Carlson, president of Corporate Underwriters, then formed a new company, C.W.C. Marketing Corp., to administer the auto warranty business, the complaint states.

More than 2,400 Massachusetts auto buyers were enrolled in the C.W.C. warranty program by two Massachusetts agents after January 1985, according to the complaint.

In May 1986, though, the Insurance Division started receiving complaints from auto dealers and warranty certificate holders who charged that Balboa had failed to pay their claims.

Since that time, the Insurance Division has been notified of more than 300 claims totaling more than $120,000 that Balboa has refused to pay, according to the complaint.

Mr. Smith denied that Balboa ever insured Massachusetts risks through the C.W.C. warranty program, adding that the two Massachusetts agents who allegedly marketed the coverage were not authorized to accept business on Balboa's behalf.

In mid-1985, Balboa started selling auto warranty coverage through a second program administered by another MGA, Autotech Services Inc. of Shawnee Mission, Kan., the Insurance Division's complaint says.

Warranty coverage under this program was sold by Autotech representatives who were not licensed as agents or brokers in Massachusetts, the complaint alleges.

Balboa also failed to pay claims promptly on this program, often delaying payments until it was contacted by auto dealers or Insurance Division officials, the complaint charges.

Meanwhile, the Insurance Division also accuses Balboa of violating state law in connection with a national liability program for taxi companies.

Balboa offered the program in early 1983 through a Texas MGA, Southern Underwriting Managers Inc., and was 100% reinsured by Omaha Indemnity Co. through Omaha Indemnity's MGA, World American Underwriters Inc.

World American later changed its name to Royal American Managers Inc. Omaha Indemnity canceled RAM's MGA contract in 1985 and currently is arbitrating claims that RAM failed to report millions of dollars in premiums and failed to arrange adequate reinsurance for Omaha Indemnity (*BI*, April 28, 1986).

According to the complaint, Balboa and RAM discovered in early 1984 that one of the principals of Southern Underwriting Managers had misappropriated more than $1 million in premiums.

Two other Southern officials then joined with officials of Jacques & Co. Insurance Agency Inc., a Massachusetts agency marketing taxi coverage, to form a new MGA, Frontier Management Co. Inc., to take over the Balboa taxi program,

**'We believe they are totally without merit,' says Balboa's general counsel, Herbert F. Smith.**

the complaint says.

Jacques & Co. then became the exclusive New England subproducer for the Frontier-Balboa program.

Frontier eventually provided coverage for 45% of the total taxi market in Massachusetts and 80% to 90% of the Boston taxi market. Gross premiums for the program nationally amounted to $45 million between July 1984 and May 1987, with the New England region accounting for about $7 million of this, the complaint says.

In September 1985, however, Balboa notified Frontier that it was terminating its MGA agreement as of Dec. 31, 1985. Shortly before this, Omaha Indemnity had terminated its MGA agreement with RAM, the complaint says.

"Balboa's withdrawal from the taxi market in Massachusetts caused confusion and anxiety in the market, and further strained an already overburdened Massachusetts automobile insurance market," the complaint says, noting that taxi owners either had to find other insurance on short notice or enter the state's residual market mechanism.

Once Omaha Indemnity decided to non-renew its reinsurance of Balboa, "Balboa attempted to escape liability by non-renewing all its insureds," the complaint alleges.

In addition, Balboa failed to provide required statistical data on the taxi program, including loss information, to Commonwealth Automobile Reinsurers, the state residual market mechanism. As a result, the Massachusetts Automobile Rating and Accident Prevention Bureau, a rate-making organization that uses C.A.R. data for rate filings, was not able to include Balboa loss information in its rate-making calculations, the complaint alleges.

Balboa also failed to file adequate information regarding its own rating plans despite requests by the Insurance Division to do so, the complaint charges.

Balboa currently is arbitrating a dispute with Omaha Indemnity over reinsurance coverage for the Frontier taxi program, according to Mr. Smith. However, Balboa took a $20 million charge in the first quarter of 1988, reflecting the insurer's best estimate of its ultimate liabilities in connection with the arbitration, Mr. Smith said. The charge represents reimbursements Balboa probably will have to make to Omaha Indemnity for claims it already has paid on the taxi program, he said.

Mr. Smith added that when Balboa became aware that statistical data had not been filed on the taxi program, it notified C.A.R.

A fourth Balboa program offered liability coverage to roller-skating rinks and amusement parks through Allied Specialty Insurance Inc., a Florida MGA appointed to manage the program in March 1983. Balboa was reinsured on the program by Insurance Corp. of Ireland, the complaint says.

Balboa insured eight Massachusetts roller-skating rinks during 1985, generating more than $40,000 in premiums.

By early 1985, ICI was approaching insolvency and was taken over by the Irish government, the complaint notes.

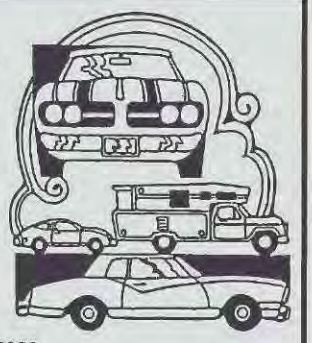
In October 1985, Balboa canceled the roller rink policies midterm, but reinstated them after being told by the Insurance Division that the midterm cancellations were illegal.

The complaint charges that the attempted cancellations, in addition to being illegal, were also premature, since ICI had never canceled its reinsurance of Balboa.

The Insurance Division charges that alleged mismanagement by Balboa has led to "substantial consumer confusion, market disruption and (has) caused Balboa's policyholders and competitors to incur substantial losses."

Balboa, a unit of Avco Financial Services Inc., posted premium volume of $99.4 million in 1987, a 57.1% decline from $231.6 million in 1986. The company discontinued writing non-standard automobile business through MGAs last year, according to A.M. Best Co. ■


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# Broker results

*Continued from page 1*

"In the third quarter, the property/casualty market was very competitive," said Robert P. Cuthbert, vp and comptroller of Corroon & Black Corp. in New York. Discussions with managers of the C&B offices throughout the country indicate that rates in the fourth quarter will be even softer, he said.

Securities analyst Ira H. Malis with Alex Brown & Sons Inc. in Baltimore attributed the "almost non-existent" revenue growth among the brokers to property/casualty rate competition and predicted that current market pressures "will continue through 1989."

"Rates are in a freefall out there and brokers are getting clobbered for their efforts," said analyst Michael A. Smith, vp of Shearson Lehman Hutton Inc. in New York. While many underwriters vowed over the last several months that they could not cut rates further, that was "clearly not true," he stressed.

There is "no end in sight" to property/casualty price competition," according to analyst Thomas G. Rosencrants, senior vp of Johnson Lane Space Smith & Co. Inc. in Atlanta. "Most insurers in the industry are back to playing the same sorts of market-share games they did in the early to mid-1980s, and I don't think there will be any change for the better for the next several quarters."

While most brokers are doing a good job of keeping the reins on operating expenses in response to lagging revenue growth, "I think (they) are about at the point where they can no longer cut expenses without endangering their revenues," said Mr. Smith.

In fact, brokers may begin to selectively hire producers in 1989 "in anticipation of a harder market," Mr. Malis stated. He noted that over the past year-and-a-half, most brokers have either selectively cut back on personnel or have been slow to replace employees lost through attrition to keep their expenses in line with revenues.

Mr. Rosencrants disagrees, however.

"Expense controls are good, but expenses are still outpacing revenue gains," he said. "Brokers could tighten expenses more, frankly, but they are somewhat reluctant to do that and (risk cutting) some of the muscle they need when the market tightens."

Employee benefit consulting revenues have provided the strongest revenue growth for the publicly held brokers, analysts pointed out.

Employee benefits work "is helping everybody," Mr. Rosencrants stressed.

"The growth of that segment is the fastest for any broker," said Mr. Smith. "They are all looking at that business as a growth opportunity," he added.

"We're seeing some real nice growth" in consulting revenues, Mr. Malis agreed. "Any kind of change in the tax laws really helps these guys." He also pointed out that while employee benefits consulting is a "lower-margin business," it provides a good revenue balance to the swings of the property/casualty brokerage business.

Consulting revenues were responsible for all of Marsh & McLennan's revenue growth in both the third quarter and the first nine months of 1988.

In the first nine months of 1988, Marsh & McLennan's gross revenues rose 5.8% to $1.73 billion from $1.63 billion in the comparable period of 1987. Net income for the period dropped 1.5% to $245.7 million from $249.5 million in 1987.

M&M's 1988 third-quarter revenues rose 5.4% to $562.7 million from $533.7 million in 1987, while third-quarter net income dropped 4% to $74.6 million from $77.7 million in 1987.

**'Rates are in a freefall out there and brokers are getting clobbered for their efforts,' says Michael A. Smith. While many underwriters vowed over the last several months that they could not cut rates further, that was 'clearly not true.'**

For the nine-month period, consulting revenues rose 34.4% to $466 million from $346.8 million in 1987, and in the third quarter they rose 30.7% to $161.8 million from $123.8 million in third-quarter 1987.

While some of this growth is attributable to acquisitions made in the employee benefits area, Mr. Bischoff noted that, excluding acquisitions, consulting revenues were up about 20% in the third quarter.

Marsh & McLennan's "big winner has been and continues to be employee benefits consulting," Mr. Rosencrants said.

M&M's consulting operations "continue to show beautiful growth," Mr. Malis agreed.

Insurance services revenues—including retail and reinsurance brokerage—declined by 0.7% in the third quarter to $334.8 million from $337.2 million in the third quarter of 1987. Insurance services revenues were virtually unchanged in the first nine months.

Investment management revenues were down 9.1% in the quarter—to $66.1 million from $72.7 million—and down 10.2% in the first nine months of 1988—to $196.4 million from $218.8 million—from the comparable periods of 1987.

Excluding acquisition costs and the addition of employees in the employee benefits area, which boosted expenses 9.6% in the quarter from the comparable quarter of 1987, M&M's expenses remained essentially unchanged from a year ago, according to Mr. Bischoff.

The broker's "expenses are under control and they are doing about as well as can be expected" in the current marketplace, Mr. Smith stressed.

"We prepared for a very competitive operating environment and we are doing everything we can during this period to improve services to our clients and be cognizant of our expenses," Mr. Bischoff agreed.

New York-based Alexander & Alexander reported nine-month operating revenues of $857.3 million, a 2.4% increase from $837.6 million in 1987. Nine-month net income dropped 8% to $53.1 million from $57.7 million in 1987.

In the third quarter, A&A's revenues rose 1.5% to $277.5 million from $273.4 million in the third quarter of 1987, while net income rose 7.1% to $16.5 million from $15.4 million in 1987.

A&A's operating expenses rose 1.9% in the first nine months of 1988 to $799.7 million from $785 million in 1987. In the third quarter, expenses rose only 1.5% to $263.6 million from $259.6 million in the third quarter of 1987.

"Any time you can hold expenses to a 2% to 3% increase, that's kind of a nice feat," Mr. Wieczynski said. He also noted that A&A's new business production was strong in the quarter—up about 15%—while lost business was in the 6% to 7% range.

Third-quarter 1988 results include a $3.3 million loss primarily attributable to the sale of a South African subsidiary (*BI*, Oct. 17). Results for the third quarter of 1987 include a $10 million loss on disposal of London-based Sphere Drake Insurance Group P.L.C. as well as a non-recurring gain related to A&A's $11 million sale of a Montreal-based personal lines brokerage, Optimum Financial Corp. Ltd., which it acquired in 1985 with Canadian brokerage Reed Stenhouse Cos. Ltd.

Revenues from A&A's consulting business grew 15.7% in the first nine months of 1988 to $98.7 million from $85.3 million in the first nine months of 1987, Mr. Wieczynski said.

According to Mr. Rosencrants, A&A's insurance services revenues—including retail and reinsurance brokerage—were up about 2% in the quarter, excluding foreign currency and divestitures.

"They're clearly not performing to their potential, but they are performing in line with our expectations and their expenses are being held pretty well in control," Mr. Rosencrants observed.

"They are doing a really good job of controlling expenses," agreed Mr. Malis.

The broker's "results were very much as I had anticipated," Mr. Smith said.

Corroon & Black's nine-month gross revenues rose 5.6% to $318.3 million in 1988 from $301.5 million in the first nine months of 1987.

Net income for the same period was up 182.9% to $107.9 million from $38.1 million, but much of that growth is attributable to a non-recurring aftertax gain of $73.9 million from the sale of Corroon & Black's 29.9% holding in Lloyd's of London broker Minet Holdings P.L.C. to The St. Paul Cos. Inc. (*BI*, Feb. 1).

In the third quarter of 1988, Corroon & Black's gross revenues rose 6% to $111.7 million from $105.3 million in the third quarter of 1987. Net income dropped 16.1% in the quarter to $12.6 million from slightly under $15 million in the third quarter of 1987.

Because of an aggressive stock repurchase program—the broker has bought back about 20% of its stock in a little more than a year—Securities and Exchange Commission requirements prohibit Corroon & Black from making acquisitions on a pooling basis—as it had normally done in the past—for either two years from the last stock repurchase or until the company reissues the repurchased shares.

Since acquisitions in the quarter were instead made on a purchase basis, financial results of the acquired companies were included only in Corroon & Black's 1988 results. Thus, the broker reported a 12.1% increase in expenses in the third quarter to $90.1 million from $80.4 million in the comparable quarter of 1987.

However, Mr. Cuthbert pointed out, without the effect of the acquisitions, expense growth for the quarter would have been up only 5%. "We are satisfied with our expense increase," Mr. Cuthbert said.

"Our revenues were disappointing because of rate competition, but within this (rating) environment we feel we are doing an adequate job," he added.

Mr. Cuthbert said Corroon & Black's benefit consulting business "is doing quite fine, thanks to government benefit changes." The brokerage has also made two employee benefits acquisitions so far in 1988 and is looking for additional opportunities in that area," he said.

Because of the amount of cash on Corroon & Black's balance sheet after the sale of its Minet stock, it frequently has been cited as an attractive acquisition candidate by analysts.

Mr. Cuthbert said that the broker will not make any snap decisions on how to spend the excess cash.

"It would be somewhat imprudent for the cash to burn a hole in our pockets," he commented. Instead, Corroon & Black will take its time in order to come up with a solution "that will maximize shareholders' value."

Corroon & Black is a "class operation," but, like other brokers, it is having a "tough time" in the current market, Mr. Malis said. "We're looking for flat earnings in 1989."

Both Mr. Smith and Mr. Rosencrants said that Corroon & Black's earnings were right in line with their expectations.

Rolling Meadows, Ill.-based Arthur J. Gallagher & Co. reported gross revenues of $117.9 million in the first nine months of 1988, an 8.8% increase from $108.3 million in the first nine months of 1987. Net income dropped 1.1% to $13.6 million from $13.8 million.

Gallagher's 1988 third-quarter revenues rose 5.8% to $44.3 million from $41.8 million in the third quarter of 1987, while third-quarter net income rose 5.5% to $7.8 million from $7.4 million.

Expenses grew 15.1% to $99.1 million in the first nine months of 1988 from $86.1 million in 1987, and 16.9% in the third quarter of 1988 to $35 million from $29.9 million in 1987.

Because of Gallagher's focus on total risk management services and its higher percentage of more labor-intensive, fee-based income, "they can't hold their expenses like other brokers," said Mr. Malis.

Michael Cloherty, Gallagher's vp-finance, pointed out that the company's expenses rose in the third quarter due to the completion of two acquisitions. "We are watching our expenses in light of softening market conditions," which Mr. Cloherty expects will continue "right through next year."

Mr. Cloherty said Gallagher "finalized an outstanding tax audit," resulting in "about $2 million of tax relief in the quarter," which helped third-quarter results. The broker has seen significant growth in new business and an improvement in business retention, though it continues to be hurt by rate competition, he added.

Mr. Malis expressed disappointment in Gallagher's results for the quarter, while praising the broker's management team.

However, Mr. Rosencrants said that it is difficult to compare Gallagher's third-quarter 1988 results with the previous year's because Gallagher reported "an extremely strong third quarter in 1987."

Richmond, Va.-based Hilb, Rogal & Hamilton Co. reported revenue growth of 17.6% to $32.1 million in the first nine months of 1988 from $27.3 million in 1987. Net income for the period rose 35.8% to $3.5 million from $2.6 million in 1987.

In the third quarter, HRH's revenues rose 19.9% to $10.8 million from $9 million in the third quarter of 1987, while net income rose 31.6% to $1 million from $771,000 in 1987.

The broker's third-quarter 1988 income includes an aftertax gain of about $218,000 from its sale in September of Hilb, Rogal & Hamilton Co. of Goldsboro (N.C.) Inc.

While HRH does not break out its operating expenses, President Robert H. Hilb said expenses were up 19% in the quarter, primarily due to acquisitions.

While HRH has made several recent acquisitions, its acquisition last week of Savannah, Ga.-based Jones, Hill & Mercer Inc. will significantly enhance HRH's employee benefits capabilities and bring it a sizeable third-party administration business.

"We feel this expansion in the benefits area was one we needed and were lacking," Mr. Hilb commented, noting that its offices can now provide clients with services

*Continued on facing page*


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# HMO survey

*Continued from page 3*

about the HMOs they are enrolled in, the survey results will assist employers in the coalition in developing comprehensive managed health care strategies for the future, Ms. Weinstein said.

The idea of surveying employees about their satisfaction with HMOs was proposed by the HMO Task Force within the coalition, Ms. Weinstein said.

But, the task force first wanted to "respond to the fact that employees were dissatisfied with HMOs because they really didn't understand what they were getting when they enrolled in an HMO. There was an enormous consensus that employee education about HMOs was necessary," she explained.

So, the coalition developed and distributed to its company members last year an employee handbook on HMOs called "Playing Your Cards Right," which was then distributed to the employees.

After the handbooks were distributed, "employers saw a lot of movement between HMOs. So, they then wanted to look at being able to reduce the number of HMOs they offered. The feeling was that if they could survey their employees collectively, they could identify any common problems with any one of the 13 HMOs in the area," she added.

After studying the survey results, however, the employers "didn't see any reason to take any joint action in trying to initiate any changes with any one HMO," said Ms. Weinstein.

However, the employers do plan to use the results to eventually reduce the number of HMOs they contract with, according to Ms. Weinstein.

The survey found that the largest percentage of respondents, 33%, said they chose their present HMO because of its reasonable cost. The next highest group of respondents, 28%, said they chose an HMO because it offered broad coverage of medical services.

In addition, 9% of those surveyed said the convenience of HMO locations was a major factor in their choice of HMOs, while another 9% said the choice of primary physicians was important. Some 5% said the fact that their family physician was a member of the HMO was important, while others cited reasons such as the reputation of the HMO, that enrollees did not have to file claim forms, and the overall quality of services provided.

In the area of services provided, 48% said they were very satisfied with the medical and surgical services provided by their HMO, while 44% said they were fairly satisfied with those services. Only 5% said they were fairly dissatisfied and 3% said they were very dissatisfied.

In addition, 45% reported that they were fairly satisfied with the HMO's handling of emergency procedures, while 38% said they were very satisfied. Some 10% were fairly dissatisfied and 7% said they were very dissatisfied with these services.

Regarding the length of time it takes enrollees to get an appointment for non-emergency services, 38% said they were fairly satisfied, while 36% said they were very satisfied. However, 15% reported that they were fairly dissatisfied and 12% were very dissatisfied.

Some 40% said they had to wait an average of three days or less to get an appointment for non-emergency services. However, 22% said they had to wait more than 14 days, while 21% said they waited an average of four to seven days; 9% waited eight to 11 days; and 7% waited 11 to 14 days.

On the issue of waiting time when they went to the HMO for a scheduled appointment, 48% said they were fairly satisfied; 35% were very satisfied; 11% fairly dissatisfied; and only 6% said they were very dissatisfied.

Some 47% said they waited an average of 15 to 20 minutes when they went to the HMO for a scheduled appointment, while 20% said they waited 10 minutes or less. However, 20% said they waited about 30 minutes, while only 7% waited about 45 minutes; 3% waited about an hour; and only 2% waited more than an hour.

Survey results show that respondents on the average are low utilizers of health care services.

For example, 46% reported that in the last 12 months, they and members of their families visited the HMO only one to five times. Another 26% said they had six to 10 visits, while 11% said they had 11 to 15 visits and another 11% said they had more than 15 visits. Only 6% said they had no visits.

However, these results could be skewed by the possibility that the employee completing the survey was not the family member usually responsible for taking children to the doctor, or that respondents simply underestimated the frequency of visits, according to both Ms. Weinstein and Mr. Nalli.

In addition to an apparent low utilization of outpatient services, the survey results also indicate that respondents are low utilizers of hospital services.

For example, 73% reported that they or members of their families that were enrolled in the HMO required no hospitalization for anything other than normal child delivery during the past 12 months. Another 22% said they or their family members were hospitalized one or two times; 3% reported three or four hospitalizations; and 1% reported five to seven hospitalizations.

Most survey respondents—42%—also reported that there were no health care services that they needed that were not provided by their HMO. However, 26% said they needed dental services, but these were not provided by their HMO, while 19% said they needed vision care services not provided by the HMO.

But, contrary to common complaints that HMOs do not provide adequate mental health and substance abuse services, only 3% of the respondents reported that they needed and could not receive these services from their HMOs.

"The raps that HMOs get about not doing all they can in this area seem to be untrue according to the answers of this group of enrollees," said Ms. Weinstein of the coalition.

However, Mr. Nalli offered two possible reasons for the survey results on this issue: "People who need these types of services may not opt to join HMOs because of the limited mental health benefits provided or that survey respondents did not want to acknowledge their need for or use of these services in the survey."

In terms of choice of primary physicians and physician-patient contact, respondents reported satisfaction with availability and services rendered.

For example, 67% said they got all of their first choices for physicians for themselves and members of their families, while 23% said they got some of their first choices, but not all. Only 9% said they didn't get any of their first choices for physicians.

And, 73% said they have never been required by the HMO to change any of their primary doctors.

In addition, 52% of the respondents said their primary physician is always or almost always available, while 24% reported their physician is usually available. Only 5% said their physicians were never or almost never available, while 10% said their physicians were available about half the time and another 10% said their physicians were available less than half the time.

Some 64% of respondents said they are almost always seen by their primary care physician, instead of by someone other than a physician, when they visit the HMO. Another 17% said this is the case about half the time and only 6% said they almost always have to see someone other than a physician.

However, when enrollees had to see someone other than a physician, 30% said they were fairly satisfied with the services and 17% said they were very satisfied. Only 3% said they were very dissatisfied.

Also, 57% said they never or almost never have trouble reaching their physician by telephone; 23% had trouble sometimes or less than half the time; and only 6% said they always or almost always have trouble.

As far as receiving information about the HMO's procedures and services before they enrolled, 47% said they agreed somewhat that they had received enough of this information, while 44% said they agreed strongly. Only 7% disagreed somewhat and 2% disagreed strongly.

When asked about the biggest problems enrollees had with their current HMOs, the majority, 27%, reported they had no problems with their HMOs.

However, 16% reported their biggest problem was that it takes too long to get an appointment. Other problems cited by small percentages of respondents include: the HMO doesn't cover the services needed; locations are inconvenient; the physician the patient wants is no longer with the HMO.

And, 38% said they would definitely re-enroll in their present HMO, while 35% said they would probably re-enroll in their present HMO. Another 7% said they would probably not re-enroll; 5% said they would definitely not re-enroll; and 15% said they didn't know what they would do.

Some 24% of those surveyed have been enrolled in their current HMO for less than one year; 11% for one year; 27% of those surveyed have been enrolled for two years; 17% for three years; and 20% for four years or more.

The major reason given for switching from one HMO to another was a dissatisfaction with the quality of services. Some 19% cited this reason, with 18% citing that the coverage costs too much. Another 14% said they switched because they were no longer eligible because of a job change.

The majority of the employees surveyed were between the ages of 25 and 44 and had total household incomes of between $30,000 or more.

Thirty-seven percent have employee-only coverage, while 20% have coverage for themselves plus one dependent. Another 17% have coverage for themselves plus two dependents; 18% have coverage for themselves and three dependents; and 9% have coverage for themselves and four or more dependents.

"Their (the coalition's) task for 1989 will be to design a model benefits package, send out requests for proposals and have the area HMOs bid on the program. Then they will contract with those HMOs to offer a managed care plan" to the coalition members' employees, Ms. Weinstein said. ■

# Broker results

*Continued from facing page*

they "were not able to provide before."

The employee benefits presence of Jones, Hill & Mercer "will help Hilb significantly," Mr. Rosencrants agreed.

"The market is tougher than nails out there and our people are doing a phenomenal job of bringing in new business," Mr. Hilb added.

"I think (Mr. Hilb) is doing a wonderful job," Mr. Malis stressed.

Tampa, Fla.-based Poe & Associates Inc. reported revenue gains of 13% in the first nine months of 1988 to $27.2 million from $24.1 million in 1987. Nine-month net income rose 95.7% to $3.7 million from $1.9 million in 1987.

Poe's revenues grew 10.7% in the third quarter to $8.8 million from $7.9 million in the third quarter of 1987, while net income jumped to $938,000 from $40,000 in the third quarter of 1987.

Poe's 1987 third-quarter and nine-month earnings reflected a loss for discontinued operations related to an indemnity agreement between Poe and a ceding insurer involving Poe's discontinued Whiting National Insurance Co. unit (*BI*, Nov. 16, 1987). The amount of the loss was not disclosed.

Poe Chairman William F. Poe said that Poe's total expenses, including salaries, rose 4.3% to $21.6 million in the first nine months of 1988 from $20.7 million in the first nine months of 1987.

The executive said that revenue growth for Poe came primarily from its wholesale brokerage operations, partially because of slightly larger commission levels on that book of business. Revenues from its retail brokerage business were up about 3%, he estimated. Given the competitive rating environment, Poe was "pleased" to show retail business revenue growth, Mr. Poe said. On the retail side, he estimates "rate levels have dropped about 15% off last year on the same book of business."

Financial results of Briarcliff Manor, N.Y.-based Frank B. Hall & Co. Inc. will not be released until mid-November. ■


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# Texas antitrust suit

*Continued from page 1*

cases and the forums.

One of the most significant differences is the nature of the juries that will hear the cases, observers say.

"There is a lot of thought that Texas juries are different than in other places," said George L. Priest, John M. Olin professor of law and economics at Yale Law School in New Haven, Conn. "Texas juries have a reputation of being more skeptical of corporate enterprises."

"The specter of a Texas jury could be perhaps even more intimidating than a San Francisco jury," speculated California Deputy Attorney General Thomas Dove.

"A few folks who are not Texans by birth, from the northeastern part of the United States, might find some concern with the good people of Texas that are on juries. Texaco-Getty comes to mind," said Mr. Dove, referring to the mammoth litigation between Texaco Inc. and Pennzoil Co. over Texaco's 1984 acquisition of Getty Oil Co.

A Texas jury in 1985 ordered New York-based Texaco Inc. to pay $11.1 billion to Houston-based Pennzoil. The case eventually was settled for $3 billion after Texaco filed for reorganization under Chapter 11 of the U.S. bankruptcy code (*BI*, Aug. 29; Feb. 22).

Besides Texas juries, defendants in that state may have to face a state Supreme Court, the highest court in Texas whose actions would be much less predictable than those of the U.S. Supreme Court if the federal litigation moved that far, according to Mr. Priest.

"I think if (the federal case) ever goes to the (U.S.) Supreme Court, there will be a summary judgment in favor of the defendants," Mr. Priest predicted. "The practices complained about don't make sense on antitrust grounds."

But, he noted: "The Texas Supreme Court has not had to make many antitrust decisions. It is certainly more difficult to predict what it would do than what the U.S. Supreme Court would do."

In addition, the presiding judge in Texas state court, Judge Peter Lowry of the 261st District Court of Travis County in Austin, admits he has little experience in trying antitrust cases (see story, page 60).

"There might be some validity to the concern from a defendant's perspective as to the Texas suit," agreed Eugene Pavalon of the Chicago firm of Asher, Pavalon, Gittler & Greenfield Ltd. and immediate past president of the Assn. of Trial Lawyers of America.

"The Texas case might provide more problems and difficulties than the federal case," he said.

Like the federal suit, the Texas suit accuses the defendants

*Continued on facing page*

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| **Sub-total** | **24,719** |
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| **Commercial Consumers** | |
| **Sub-total** | **26,175** |
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| Insurance Companies | 7,380 |
| Actuaries, Attorneys, Adjusters, Appraisers and Consultants | 3,843 |
| Others Allied to the Field | 2,991 |
| **TOTAL** | **50,946** |

* Source Business/Occupational breakdown of qualified circulation, May 30, 1988 issue, as submitted to BPA for June 1988 BPA Publisher's Statement.

*Continued from facing page*
of an illegal boycott.

The suit charges that the defendants "illegally agreed to boycott particular lines of coverage by artificially reducing and constricting industrywide capacity, in order to create a crisis atmosphere in which to more favorably promote two of the defendants' goals. . . ."

Those goals are listed as "industry, consumer and regulatory acceptance of industrywide implementation of the claims-made trigger of coverage" and "state-by-state adoption of 'tort reform' measures."

The suit states that the chief executives of major insurance companies by 1986 "were not only calling publicly for additional rate increases, but also for the property/casualty industry to withdraw from certain politically sensitive lines of insurance.

"These actions were intended to increase the pressure on regulators for approval of the claims-made form and on legislators for changes in the tort system."

But, Mr. Pavalon pointed out, the Texas suit, while alleging many of the same antitrust complaints contained in the federal suits, is broader in scope.

"I think it takes a different thrust," said Mr. Pavalon, who withdrew a class-action suit he had filed on behalf of Chicago-based Pickens-Kane Moving & Storage Co. after he learned the lead plaintiff's liability coverage was written on an occurrence rather than a claims-made form (*BI*, June 20).

He noted that the Texas suit zeroes in on the "pricing mechanism and rate structures that resulted during the insurance crisis and whether they were justified."

The Texas suit seeks to determine whether "the conduct of insurance companies was to artificially inflate rates," he said.

"These issues are not part of the federal case. The federal case deals primarily with whether there was illegal boycott, so the issues are somewhat narrower."

Among other allegations, the federal suit contends that defendants conspired to eliminate occurrence-based commercial general liability policy forms (*BI*, June 20; April 11).

In addition, the Texas suit alleges the defendants violated state antitrust law, the Texas Free Enterprise & Antitrust Act of 1983.

The Texas antitrust law does not offer insurers the limited immunity granted nationally under the McCarran-Ferguson Act, the 1945 federal law that also grants states primary regulatory authority over the industry.

Mr. Priest noted that "it is a complicated issue whether a ruling by the Texas Supreme Court" would pre-empt federal antitrust statutes.

The Texas law virtually is a carbon copy of the Sherman Antitrust Act of 1890, the federal legislation that prohibits acts or contracts tended to create monopoly. The Texas statute reads that the law "shall be construed in harmony with federal judicial interpretations of comparable federal antitrust statutes."

"The Texas antitrust statutes have always been more stringent than the national statutes, so I believe the most serious problem the insurance companies face is with the Texas action," said Eugene Anderson, a partner in the New York law firm of Anderson Russell Kill & Olick.

The Texas suit and the federal suit seek comparable monetary and other penalties, including calling for some defendants to keep detailed records for the next 10 years of any meetings in which competitors or other members of the insurance industry are present.

The Texas suit, however, also seeks to bar ISO from operating in the state. The suit charges that ISO, the insurance policy and rate-making organization, violated the Texas Deceptive Trade Practices Act.

Barring ISO from operating in Texas could cause a "major disruption of the marketplace and would deny the Texas insurance commission of critical information it needs to review the appropriateness of rates," said Craig Barrington, general counsel for the American Insurance Assn. in Washington, D.C.

"There is no way you can responsibly make judgments to the actuarial adequacy of rates" without gathering large amounts of data from insurers, he said. "ISO is the only way to do that."

Mr. Barrington added that "more so, ISO provides consumers with protection through standardized policy forms." If insurers are forced to produce their own forms, "consumers will have a difficult time determining what insurance they are buying and comparing rates."

Barring ISO from Texas is an "extraordinarily reckless idea in my view," Mr. Barrington said.

The remedies called for in the Texas suit "would make it impossible for any collective ratemaking organization to exist," said Patricia A. Borowski, vp-government and industry affairs for the Assn. of Professional Insurance Agents in Alexandria, Va.

Most observers speculate that the outcome of the case that is settled first—whether it is the federal court litigation or the state court suit—will not impact the decision in the other. The defendants may win one case but lose the other, they say.

"It could be that the narrow, arcane little discrepancies in the Texas and federal laws may be significant enough to allow the defendants to win the federal case and lose in Texas," suggested David J. Brummond, assistant vp and assistant general counsel at the National Assn. of Independent Insurers.

"You're looking at basically the same allegations," Mr. Brummond said, referring to the antitrust allegations in both cases. "It would be unusual to have different results, but there would be explanations for it."

Yale's Mr. Priest agreed that it is "well within the realm of possibility" and, indeed, "highly likely" that the defendants could prevail in the U.S. suit and lose in Texas.

But, Mr. Dove of the California attorney general's office disagrees. "If the insurers are stung by Texas, they're dead in the water in California and vice versa."

Jon Harkavy, director of governmental affairs for the Risk & Insurance Management Society Inc. in New York, said he believes that if the insurers win one case and lose the other, they would be better off winning the federal case.

"If I had to choose one to lose, I would want to lose the Texas suit as opposed to the federal suit," Mr. Harkavy said, explaining that the impact nationally on insurers might be greater if they are defeated in federal rather than state court. He said that anyone considering future suits against insurers might be more inclined to file based on a federal action.

Meanwhile, defendants in the Texas case are pressing forward with their efforts to remove the litigation from the state court.

After Attorney General Mattox filed the suit in March, the defendants—arguing that it raised questions of federal law—succeeded in getting the case transferred to federal court (*BI*, Aug. 8).

However, U.S. District Court Judge James Nowlin in August returned the case to the state court, citing a 1987 case he said shows federal antitrust laws do not preempt or supercede state antitrust laws.

In October, the defendants began

*Continued on next page*


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# Judge in position to make landmark ruling

**By MICHAEL BRADFORD**

AUSTIN, Texas—The state court judge who will preside over the antitrust litigation against the property/casualty insurance industry in Texas is a former federal district court appointee with admittedly little experience in antitrust cases.

However, defense attorneys say they do not know much about 261st District Court Judge Peter Lowry, the jurist they expect to see quite a bit more of in the coming months. They offer only the assessment that the 47-year-old judge is "fair and honest."

Judge Lowry has served as a state district court judge in Austin since 1977. Before that, he was a partner in the Austin law firm of McGinnis, Lochridge & Kilgore for eight years. Prior to joining the firm, he was a briefing attorney for the Supreme Court of Texas for a year.

And, if Ronald Reagan had not been elected president in 1980, the antitrust case would be going before another judge.

"In 1980, just before the elections, I was (nominated) by President Carter to serve as a federal district court judge," Judge Lowry explained.

However, "the Senate Judiciary Committee held up the appointments to see what would happen in the election," he said. "When Reagan won, that was the end of my appointment."

Judge Lowry currently is presiding over the litigation filed by Texas Attorney General Jim Mattox that charges insurance industry defendants with violating state antitrust and deceptive trade practices laws by intentionally limiting insurance coverages and driving up the price of insurance (see story, page 1).

The judge says antitrust cases are not common in Travis County District Court and that his experience with that type of lawsuit is limited. "We don't have very many, certainly nothing quite of this magnitude, although we do see a lot of substantial litigation."

Of the major cases Judge Lowry has heard in recent years, he refers to one in which he eventually ruled as unconstitutional a state law that established changes in property valuations for tax purposes. If the law had stood, it would have significantly decreased the amount of tax due on some residential property owned by real estate developers.

In another case Judge Lowry characterizes as noteworthy, he became the hero of oystermen by ordering the Texas Parks and Wildlife Commission to open the 1987-88 oyster season. The commission, which wanted to cancel that season, argued that oyster levels were almost depleted in Texas bays, but fishermen countered that the state's economy would lose billions of dollars if there were no season.

And, last June, the judge ruled that heirs of a West Texas oilman could continue to receive about $400,000 in monthly oil and gas royalties while a suit filed against them by the state's land commissioner is pending. The state, in its attempt to stop the payments, did not prove its case of irreparable harm, Judge Lowry ruled.

Judge Lowry said he will not approach the antitrust case any differently than other large cases he has heard.

"The only thing unusual about this case is that there are so many lawyers involved in it," he remarked. "During the pre-trial conference there were 39 lawyers in the courtroom. I've never had a case with that many lawyers."

If the case goes to trial, it could be the longest case over which he has presided, Judge Lowry noted.

"I don't expect it to go to trial until at least a year and a half from now," he said. And, the trial itself would likely take another three months.

An appeal, if any, could take at least two more years, he said. ■

## Texas antitrust suit

*Continued from previous page*

a different tact to steer the case away from state court.

Last month, Judge Lowry gave the defendants permission to prepare briefs that argue the Texas State Board of Insurance should have primary jurisdiction in the case. Judge Lowry granted a pretrial scheduling order that stays all discovery in the case until the primary jurisdiction issue and other pretrial issues are settled.

In granting the scheduling order, Judge Lowry gave the defendants 30 days to submit briefs on the primary jurisdiction issue and other pretrial issues.

The attorney general has 14 days to respond to the briefs, and then the defendants will be allowed another 14 days to reply to those briefs. At that time, the court will schedule oral arguments on the issues.

In their motion requesting the scheduling order, defendants' attorneys indicated they intend to argue "that under the doctrine of primary jurisdiction and related doctrines, this court should dismiss or abate this case until the (Insurance) Board has had the opportunity to consider the plaintiff's allegations and evidence. Defendants seek a reasonable period of time in which to research and fully brief those doctrines for the court."

The defendants say the State Board of Insurance should have primary jurisdiction because of its technical expertise in insurance matters. "By virtue of its continuous involvement with the business of insurance, the State Board of Insurance has special knowledge and experience that is directly relevant to the matters at issue in this case," the court filing states.

"(We) are eager to defend ourselves as vigorously as possible and raise the defenses available to us," said Frank Bruton, vp in Aetna's law department.

Mr. Bruton added that because the board has regulatory authority over the defendants, it also should have authority to determine whether the attorney general's allegations have merit.

The defendants' effort "seems to be a rational position to take. There is a question of primary jurisdiction here," he said.

The notion that defendants may be concerned with facing a Texas jury is irrelevant, according to Mr. Bruton. "Our view is that it won't get to a jury. The issue of juries comes later. And we believe that the arguments we have prior to that time are significant and should be persuasive."

Pete Schenkkan, an attorney with the Austin firm of Vinson & Elkins and the Texas counsel for Mr. Jackson and the Merrett syndicate, said the State Board of Insurance possibly could resolve the case, preventing it from going to a trial court.

Even if a hearing by the board does not lead to a resolution of the case, the state court could use in its proceedings the information that comes out in a Board hearing, Mr. Schenkkan noted. In any event, a hearing by the board would reveal that insurers abided by board regulations, he said.

However, Deputy Commissioner John Hamje of the State Board of Insurance said he was unaware that the defendants were trying to transfer jurisdiction to the agency.

"The attorney general's office took this action without coordinating things with our various regulatory departments," Mr. Hamje said, referring to the suit filed last March.

"We're not actually monitoring it at this stage of the game. We're curious and interested, but other things are taking up our time," Mr. Hamje said. ■


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# Rand study

*Continued from page 3*

U.S. airline disasters between 1970 and 1984. ATRA argues that the methodology and data used in the survey are flawed (see story, page 62).

The results also have been criticized by the aviation industry, even though $440,000 of the funding for the $1.3 million study was provided by the Aerospace Industries Assn. and the Air Transport Assn.

Rand, however, calls its study "one of the first systematic comparisons of compensation and economic loss for a specific class of litigation and the most comprehensive examination of the legal aftermath of air crashes ever undertaken."

But while the mean compensation of about $363,680 per death represented about 49% of the actual economic loss to the victim's survivors, it represented only about 26% of the full economic loss represented by the death of the victim, according to the study.

"The key differences between computing full economic loss and computing loss to survivors are that the decedent's own expenses and consumption are not included in the loss to survivors, and the effects of taxes must be considered," the authors explain.

The survivors' economic losses were computed according to a method that takes into account seven elements, including the victims' incomes at the time of death, how fast their incomes would have increased, how long they would have worked, the household services they contributed, their personal consumption and the effect of taxes and discount rates.

From the average of $363,680 in compensation paid the survivors, the plaintiffs paid an average of about $72,000 in legal fees and expenses, leaving them with about $291,000 in net compensation.

Defendants' litigation expenses averaged $49,000 per death, according to the study.

The combined plaintiff and defendant transaction costs represented 29% of the total $412,680 in expenditures per death. Rand notes that this is substantially below the 50% average for all tort cases closed in 1985.

The study also shows a significant increase in average compensation during the latter years of the study period.

In the first half of the period—1970 through 1976—compensation averaged $321,300 per victim; in the second half, the average was $408,500.

This is consistent with other Rand studies that indicate a strong upturn in the value of tort awards during the 1980s.

However, the Rand study emphasizes that even the higher compensation awarded during the second half of the study fell far short of the actual losses of the survivors of airline crashes.

Even during the 1980s, compensation awarded amounted to only 59% of survivors' actual losses, the study said.

About 35% of the claimants in the airline crashes settled their claims without filing a lawsuit. Of those who filed lawsuits, about 86% settled before a trial.

About 90% of the claimants retained a lawyer and, Rand says, "Claimants who retained attorneys won higher awards and settlements than the 10% of plaintiffs who did without, but the amounts at stake were greater as well. In fact, the overall ratio of compensation to economic loss was virtually the same for cases with and without lawyers."

The cases that were settled before a lawsuit was filed represented the smallest losses to survivors—an average of $536,237; the losses to survivors were highest in those cases that proceeded to trial: $1.4 million.

**'The air-death victims represent an economic elite. Not only were a much higher percentage of them (than of the general population) in professional occupation brackets, but within those brackets they tended to earn more,' the survey says**

In fact, the Rand survey notes, "Relative to the typical American worker, the air-death victims represent an economic elite. Not only were a much higher percentage of them (than of the general population) in professional occupation brackets, but within those brackets they tended to earn more."

This fact led to some very high individual awards and settlements, according to the survey. Eight percent of the cases resulted in payments of more than $1 million, and about half the total compensation for all the deaths went to survivors of one-sixth of the victims.

However, despite the fact that the survivors of more-affluent victims got such a large share of the total pie, they received a smaller percentage of their actual losses than did the survivors of less-affluent victims, according to the study.

Survivors of the least-affluent victims received compensation that represented 100%—and occasionally more—of their actual losses. However, survivors whose losses exceeded $2 million received compensation equal to less than 25% of that loss.

In addition to income levels, several other factors influenced the amount and level of compensation paid to survivors of the airline disasters studied, as well as the disposition of the claim or lawsuit, according to Rand.

These factors included:

- Limits on compensation.

About 40% of the victims were holding international tickets and thus were covered under the Warsaw Convention and Montreal Agreement, which limit an airline's liability in death cases to $75,000 per victim.

However, the liability limits do not apply to any other defendants that might be included in a claim or suit.

The study found that when the airline is the only defendant, the likelihood of litigation increased with the amount of loss; in other words, survivors of victims with substantially more than $75,000 in losses were substantially more likely to sue.

However, when there was more than one defendant, survivors of victims covered by these international agreements were no more likely to sue than other survivors.

The international agreements actually limited that total compensation received by the survivor of a crash victim in about 25% of the cases in which the agreements applied; in the remaining 75% of the cases, the agreements did not effect total compensation, usually because there were defendants other than the airline.

- Sex of the victim.

There is no difference on the likelihood of litigation, or on the course of that litigation, resulting from the death of an American man or an American woman.

However, according to the survey authors, "At low levels of economic loss, compensation was higher for U.S. female decedents than for U.S. male decedents. The reverse was true at high levels of economic loss. Recovery rates for U.S. women were lowest where losses exceeded the $2 million mark."

- Citizenship of the victim.

The authors say, "Our estimates indicate that foreigners were not treated equitably in compensation. In their cases, compensation was 29% lower than compensation for U.S. males."

- Temporary survival.

Cases involving victims who lived for a brief time after the crash are more likely to involve litigation.

"When the victim temporarily survived after the accident, the time to closure increased by 36%, the probability of a suit increased by 10% and the likelihood of a trial increased by 16%, when we condition on a lawsuit being filed," the survey authors reported.

"Indeed, those deaths where the victims temporarily survived the crash are among those most likely to proceed to trial," they added.

These deaths also result in higher payments, according to the study: Compensation was about 47% higher in deaths in which the victim survived for a brief period.

The authors suggest that both the increased possibility of litigation and the higher awards result because such cases are more likely to involve complex questions about pain and suffering.

The study concludes that because of the low level of compensation and because of the wide variations in compensation, the current tort system is neither a deterrent to unsafe practices nor a means of providing fair and equitable compensation to victims of airline disasters.

On the question of deterrence, the authors say, "The compensation paid falls far short of imposing effective financial incentives to invest in air safety."

However, they note, "Deterrence is not the sole objective of the tort system, and perhaps should not be a major objective."

And, the survey authors say, airlines have other incentives for investing in safety, including regulatory agencies and market forces.

"The only conclusion this study can reach unambiguously is that the present system of compensation does not by itself add any significant financial incentives for safety that are commensurate with the full cost of accidents."

And, the study authors say, the tort system does not provide fair or adequate compensation to air-crash victims.

But, they add, changes that occurred from the beginning of the Rand study to the end "indicate that the tort system performance is evolving. Compensation and recovery rates have risen dramatically, even for cases with the same loss."

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*Any or all of the five volumes of the study of aviation accidents can be ordered from the Rand Corp., Publications Department, 1700 Main St., P.O. Box 2138, Santa Monica, Calif. 90406-2138; 213-393-0411. The titles, series numbers and prices of the volumes are: "Costs and Compensation Paid in Aviation Accident Litigation" (R-3421-ICJ), $10; "Computing Economic Loss in Case of Wrongful Death" (R-3549-ICJ), $10; "Economic Loss and Compensation in Aviation Accidents" (R-3551-ICJ), $10; "Dispute Resolution Following Airplane Crashes" (R-3585-ICJ), $10; and "Executive Summaries of the Aviation Accident Study" (R-3684-ICJ), $7.50.*

# Update

## PRMC seeks court confirmation

*Continued from page 2*

Under the decision Ohio Reinsurance Corp. must pay $24.9 million; Abeille-Paix Reassurances must pay $18.5 million; Hamburg International Reinsurance Co. must pay $14.7 million; Hassneh Insurance of Israel Ltd. must pay $16.7 million; Seguros America S.A. must pay $13.1 million; and Compagnie Transcontinentale de Reassurance must pay $5.9 million.

The panel also found that PRMC "may have breached the agreements" it had with the reinsurers and awarded compensatory damages to the reinsurers. However, the reinsurers cannot offset any amounts owed to Mission by amounts due from PRMC. The amount of compensatory damages owed to the reinsurers will be determined following an audit of the pool's business.

## Judge pulls out of Bhopal case

NEW DELHI, India—An Indian Supreme Court judge last week withdrew from the litigation between the Indian government and Union Carbide Corp. over compensation for victims of the December 1984 Bhopal poison gas leak after revealing that he held stock in Union Carbide India Ltd.

Another judge has been named to replace Justice M.H. Kania, a Union Carbide official said.

Union Carbide owned 50.9% of Union Carbide India stock at the time of the disaster. About 2,500 citizens were killed and hundreds of thousands more were injured in the incident. Union Carbide India is not involved in the litigation.

Judge Kania's withdrawal comes just a few weeks after India's highest court replaced the lower court judge who had been presiding over the litigation (*BI*, Oct. 24).

The Supreme Court is hearing appeals by attorneys for Union Carbide and the Indian government over the complex legal maneuverings that have resulted in two courts imposing judgments against Union Carbide.

A Union Carbide spokesman noted that Judge Kania is the fifth judge to withdraw from the case.

Meanwhile, neither Union Carbide spokesmen nor attorneys for both Union Carbide and the Indian government said they could confirm reports that the Supreme Court has asked the two parties to reach a settlement in the case.

## Judge amends E&O settlement

PHILADELPHIA—A Philadelphia law firm is awaiting a response from the Federal Savings & Loan Insurance Corp. to a ruling that a record $50 million settlement between the firm and the FSLIC stemming from the failure of a Florida thrift should reduce the liability of other defendants on a proportional basis.

Judge Thomas N. O'Neill Jr. said Oct. 28 that the $50 million settlement reached in August between Blank, Rome, Comisky & McCauley and the FSLIC should not be used to reduce the future liability of other defendants by $50 million as called for by the FSLIC and the firm.

Instead, he said, the liability of other defendants should be reduced by the proportion of liability assigned to the law firm. For instance, if a jury later finds that Blank, Rome was 50% liable for the thrift's failure, other defendants' liability would be reduced by 50%, no matter what effect that reduction would have on the size of a damage award.

The judge concluded "it is better to put the risk of a potentially low settlement (with Blank, Rome) on the FSLIC than on the non-settling defendants," said John G. Harkins Jr., an attorney with Pepper, Hamilton & Scheetz in Philadelphia, which is representing Blank, Rome.

FSLIC officials could not be reached for comment.

The case involves Sunrise Savings & Loan Assn. of Boynton Beach, Fla., which Blank, Rome partners created in 1980 as a state-chartered stock association (*BI*, Aug. 15).

Under the proposed settlement, the FSLIC would have received $29 million, Sunrise shareholders would have received $10 million and $11 million would have been set aside for claims from other parties. Blank, Rome says the settlement is fully insured, but would not name the firm's professional liability insurer.

## A&A completes TIFCO sale

NEW YORK—New York-based Alexander & Alexander Services Inc. has completed the sale of its insurance premium financing subsidiary, Baltimore-based TIFCO Inc., to Los Angeles-based Transamerica Financial Corp., the lending subsidiary of Transamerica Corp.

The sale was completed for $73.75 million (*BI*, Sept. 5).

TIFCO is the second-largest U.S. insurance premium financing company with assets of about $400 million, according to A&A.

Insurance financial analyst Thomas G. Rosencrants, senior vp of Johnson Lane Space Smith & Co. Inc. in Atlanta, estimated that A&A's fourth-quarter 1988 results will include a pretax capital gain of $28 million from the TIFCO sale.

## Briefly noted

**Manville Corp.** successfully appealed a lower Canadian court ruling that would have nullified insurance written by Toronto-based Canadian Indemnity Co. from 1970-1975. As a result of the Canadian appeals court ruling on Oct. 27, the Denver-based company has garnered $5 million in asbestos-related personal injury and property damage liability coverage. . . .Pierre D. Croizat, president of **Scor U.S. Corp.** and Francois M. Chavel, executive vp, resigned from the New York-based reinsurance company last week. They will be replaced by executives from Scor U.S.'s parent, Societe Commerciale de Reassurance of Paris. . . .A small percentage of a $226 million settlement of a class-action lawsuit filed by bond holders of the **Washington Public Power Supply System** is insured, according to a defense attorney, who could not provide further details. WPPSS sold $2.25 billion in bonds to fund construction of two nuclear power units, but the project was canceled in 1982. WPPSS defaulted on the bonds in 1983 (*BI*, Aug. 1, 1983).

# ATRA questions validity of Rand study

By ALISON KITTRELL

A Rand Corp. study on airline disaster compensation is misleading because it uses flawed methodology and data, the American Tort Reform Assn. contends.

ATRA, a Washington-based coalition seeking reform of the civil justice system, has asked Rand Corp.'s Institute for Civil Justice to reconsider the report's findings (see story, page 3).

ATRA charges that the study did not take a realistic view of the tort system, but looked at it in terms of what Rand thinks it should be. In addition, ATRA contends that compensation for accidents during the study period do not reflect current crash settlements and judgments.

Rand, however, contends that the study did exactly what it was designed to do: Examine how economic losses should be calculated and measure how close the tort system came to providing compensation.

Robert Willmore, ATRA counsel and a member of Washington law firm Arent, Fox, Kintner, Plotkin & Kahn, says the authors of the Rand study first developed a mathematical model for determining loss and then looked at the aviation accidents in light of that model.

"Then they tried to determine: 'Did the compensation paid in these accidents meet what we feel is fair compensation, based on this model?' " Mr. Willmore said. When compensation did not meet losses according to the model, he said, the Rand authors concluded that the tort system is not fulfilling its responsibilities.

"We argue that that's the wrong conclusion. The right conclusion is that there is something wrong with the model," he said.

"We think there were a number of methodological assumptions that were made that were flawed, and that these methodological assumptions—and they are just assumptions—if they were changed would greatly alter the conclusions of the study," Mr. Willmore said.

For example, the interest rate used to determine the future valuation of compensation was too low—2.75%, he said. "Other studies assume a much higher rate—5% or even 6%—and if you use this higher rate, you get a much different result."

However, ICJ Director Kevin McCarthy said, "We have tested alternative interest rates to see how the results were changed," and while a different interest rate would yield different figures, "it wouldn't change the overall thrust of the survey."

Another objection raised by ATRA is the Rand study's use of "opportunity cost" rather than "replacement cost" to figure the value of household jobs such as child care.

Under a replacement cost approach, the loss is figured as the amount that the survivors would have to pay someone else to do the task that the victim had done. Under an opportunity cost approach, the loss is figured as the victim's hourly wage in the workforce, after taxes.

"The notion here is that if an individual chooses to spend time at home, the time that they are forgoing is time that they could have spent in the market alternatively," the ICJ's Mr. McCarthy explains.

However, ATRA's Mr. Willmore said this approach can yield some unrealistic loss figures. If, for example, a lawyer whose hourly salary was $100 also mowed the lawn, then the loss of his lawn-mowing efforts would be equal to $100 an hour, rather than the much lower amount the survivors actually could pay to have someone mow.

Mr. McCarthy agreed that such an example seems extreme. But, in the case of such an attorney, the loss related to lawn mowing would be so small in comparison with the loss related to the victim's actual work that it would not have a statistical bearing on the total, he said.

But, Mr. Willmore contends, the courts do not use opportunity costs in computing loss. "That's one of the economic assumptions made in the model, and it is not one of the assumptions used in the tort system. So this model isn't telling you how the tort system works; it's telling you how these economists think the tort system ought to work."

To this charge, Mr. McCarthy pleads guilty.

"We do not maintain that the method that we have used to calculate economic loss. . .is exactly what is used in any particular jurisdiction," he said. "What we are trying to do is come up with a single benchmark to assess what has happened during the entire period. . .to see what is the best method for trying to measure loss."

And, "We think this is the general way in which loss should be measured," he said.

ATRA also thinks that the data used "is very misleading, for a number of reasons," Mr. Willmore said.

First, he noted, including deaths covered by the Warsaw Convention and the Montreal Agreement, which limit airlines' liability, lowers average compensation paid.

However, in its study Rand notes that the international agreements limit the liability of the airlines only. Since there often are other defendants in airline litigation, the agreements have limited the compensation of victims in only about 25% of the cases where they applied.

However, Mr. Willmore believes a "more serious problem is the time frame of the study."

Several other Rand studies show that there had been a large increase in the amount of damage awards after 1980, but 23 of the 25 crashes covered in the airline study occurred during the 1970s.

"The data doesn't tell you about how the tort system operates today—it tells you about how it operated in the 1970s," he said.

But Mr. McCarthy explained that the study was designed to be comprehensive, seeking a large enough sample so that no single case could skew the results. Recent catastrophes could not be included in the study because of the time it takes to gather an analyze the data, he said. ■

## Captive taxes

*Continued from page 2*

foreign corporation.

Since most association and group captives were not considered controlled foreign corporations until the Tax Reform Act of 1986 became effective on Jan. 1, 1987, these captives will not be able to claim excise tax refunds for 1986, tax experts point out.

Nevertheless, the tax law changes have been greeted warmly by many.

Reaction in Bermuda "has been very positive both in the insurance sector and outside," said Robert Steinhoff, managing partner with KPMG Peat Marwick in Hamilton (see story, page 12).

"It means that you can have a level playing field if you are onshore or offshore," added Richard S. Betterley, president of Betterley Risk Consultants Inc. of Worcester, Mass.

The domestication election of the technical corrections act is intended to correct problems that arose from changes made in the 1986 tax reform law, tax experts note.

Among other things, the Tax Reform Act broadened the definition of a controlled foreign corporation to include any captive more than 25% owned by U.S. shareholder/policyholders, a test that included most association and group captives.

Under the 1986 act, U.S. shareholders of CFCs were to be taxed on their pro-rata share of "related person insurance income," or RPII.

However, because of the logistical problems involved in taxing the large number of shareholders of some group captives, captives were allowed to elect to be taxed directly on their RPII—as if they were engaged in U.S. trade or business—rather than having their U.S. shareholders taxed.

The Tax Reform Act created another problem for offshore captives engaged in U.S. trade or business, though, and the new domestication election is intended to address this problem, experts note.

In some situations, offshore captives and their U.S. shareholders could theoretically be subjected to three taxes on the same income, including:

- Corporate-level tax on captive income that is "effectively connected" with the captive's U.S. trade or business.
- Branch profits tax. While this tax was not intended to affect U.S.-owned foreign corporations, it could have been applied to captives actually engaged in U.S. trade or business. Thus, a captive might have to pay what amounts to a 30% branch profits tax on distributions to its shareholders.
- A tax on dividends received by shareholders owning less than 10% of the captive.

Under the tax law, a U.S. shareholder could take a deduction for dividends received from a captive only if the shareholder owned 10% or more of the captive.

Most multiple-owner captives, however, had been structured to limit each shareholder's ownership to less than 10%, meaning that these shareholders could not take the dividends-received deduction.

"The gist of it was that people were concerned about the so-called triple taxation problem," noted John W. Weber Jr., a partner with the law firm of LeBoeuf, Lamb, Leiby & MacRae in New York.

Under the new domestication election, though, a captive may choose to pay U.S. income tax on all of its income—RPII and non—RPII—and be exempted from branch profits tax.

U.S. corporate shareholders, meanwhile, would be allowed dividends-received deductions.

In addition, premiums paid to such captives would be exempt from the 4% federal excise tax on direct insurance premiums and the 1% excise tax on reinsurance premiums, tax experts note.

However, a captive choosing to be taxed as a U.S. corporation will have to pay a one-time charge equal to 0.75% of its capital and surplus as of Dec. 31, 1987, up to a maximum charge of $1.5 million.

The new domestication election will cause offshore captives to re-examine their tax positions, Mr. Steinhoff predicted, noting that Bermuda captives may now opt for the old RPII election, the new domestication election or may choose neither election and structure themselves so as not to be deemed engaged in U.S. trade or business at all.

"Each company will now analyze its position and decide which position would be in its best interest based on its expected future operations," Mr. Steinhoff said.

Some experts, however, doubt that many captives will choose the new election.

"If you weren't going to make the old election, you aren't going to make the new election either," observed D. Hugh Rosenbaum, a principal with the Tillinghast division of Towers, Perrin, Forster & Crosby in Darien, Conn.

The Bermuda tax treaty, meanwhile, grants the long-sought exemption from federal excise tax on direct insurance and reinsurance premiums, but only under certain circumstances, Mr. Steinhoff noted.

The excise tax exemption applies only to controlled foreign corporations—those companies otherwise subject to U.S. income taxation—and does not include non-CFCs such as domestic Bermuda insurers.

In addition, the exemption is retroactive to Jan. 1, 1986 or to the date an offshore insurer was first deemed a CFC which for many group captives means the effective date of the Tax Reform Act, Mr. Steinhoff noted.

Meanwhile, the excise tax exemption is due to end as of Dec. 31, 1989.

"The excise tax benefit has really been limited," noted Albert D'Ambrosio, tax manager with Peat Marwick in Bermuda.

One other important feature of the tax treaty is a provision that clarifies when a Bermuda captive will be subject to U.S. income tax or branch tax, Mr. Steinhoff noted.

Under existing law, these taxes can be imposed if a captive is found to be engaged in trade or business in the United States, though the precise definition of "engaged in trade or business" has not been established, he explained.

The tax treaty provides that Bermuda companies will not be subject to income or branch taxes unless they conduct business in the United States through a "permanent establishment," defined as a regular place of business through which activities in the United States are carried out, he said.

Brokers and independent agents placing business with a Bermuda captive would not be considered permanent establishments, Mr. Steinhoff added.

Therefore, the treaty "raises the level of activity and presence" required in the United States before a Bermuda insurer could be deemed liable for income and branch taxes, he explained.

While the treaty will allow officials of Bermuda companies to hold meetings and perform other functions in the United States that they previously could not, most captives still will "take care" to maintain their permanent establishments in Bermuda, conducting only occasional business in the United States, he said. ■


# Insurance services guide

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# Uninsured survey

*Continued from page 1*

Overall, employers provide health care insurance to 88.1 million, or 74.7%, of the nation's 118 million workers, the study reports.

Although the EBRI study is based on March 1987 Census Bureau figures from the U.S. Department of Commerce, the institute's 1987 and 1988 estimates and its 1989 projections show little change, pointed out Ms. Chollet and Tim Cerino, a research analyst.

"Nothing's going to change," Ms. Chollet asserted. "Further recovery is not going to change the problem. I would expect the proportion (of uninsured people) to remain stable unless we have another major recession."

"There's no evidence that economic growth will change coverage. We're going to need to do something active about the problem," she said.

The EBRI study shows that 171 million of the 208 million non-elderly Americans in 1986, or 82.2%, had health insurance through employer-provided, private or public plans.

Employer-provided insurance covered the greatest percentage of Americans: 136.1 million, or 79.6, of insured Americans—including workers' dependents—were covered by employer-sponsored plans, with 70.2 million receiving coverage directly from their employer and 65.9 million receiving coverage indirectly, such as under a spouse's plan.

Of the nation's 118 million full- and part-time workers, 88.1 million, or 74.7%, were covered by employer-sponsored plans. Of those, 70.3 million, or 79.8%, were covered directly, while 17.8 million, or 20.2%, were indirectly covered.

About 8.2 million more workers, or 7% of the workforce, were covered only by private plans, and 3.6 million, or 3% of the workforce, were covered only under public plans.

About 16.8 million of the 171 million Americans with health insurance, or 9.8%, were covered only by private plans, which is defined as non-employer sponsored private health insurance. In addition, 18.1 million covered Americans, or 10.6%, were covered only by public aid plans, like Medicaid.

The EBRI researchers explained that the personal services and retail trade industries—which have flourished in the economic recovery—account for the greatest proportion of uninsured employees.

Among the industries with the greatest number of workers, there are more employees without health insurance in the retail trade industry than any other industry.

About 4.1 million of the industry's 18 million workers, or 22.8%, are uninsured, according to the study.

Uninsured employees in the retail trade industry accounted for 22.5% of all of the nation's uninsured employees, by far the greatest percentage among all industries.

However, there is an equal number of uninsured employees in several other service-related industries—personal services; entertainment and recreation services; professional and related services; and business and repair services—when those industries are grouped together.

In the retail trade industry, only 41.3% of employees with health care insurance, or 7.4 million workers, are covered directly under employer-sponsored plans.

Another 23.3%, or 4.2 million retail trade workers, are covered indirectly, such as under spouses' plans.

And, 1.3 million retail trade employees, or 7.2% of retail trade workers, are covered only under private health insurance, while 1 million workers, or 5.6%, are covered only by public plans.

Among other major industries, the greatest percentage of workers without health care insurance are in:

- The personal services industry: 32.1% of the industry's 3.5 million employees, or 1.1 million workers, are uninsured.

Uninsured employees in this industry accounted for 6% of the 18.1 million uninsured working Americans.

In addition, a low percentage of personal service employees—29%, or 1 million employees—were insured directly under employer plans. Some 21.8% more—or 800,000 employees—were indirectly covered.

And, 300,000 personal service employees, or 8.6%, are covered only by private plans, while another 300,000 workers are covered by only public plans.

- The construction industry: 27.7% of its 5.9 employees, or 1.6 million workers, are without health insurance.

Uninsured construction workers represent 8.8% of the uninsured working Americans.

However, 51.8%, or 3.1 million, of construction employees with health care coverage were covered directly under employer plans, while 10.6% more, or 600,000 employees, are covered indirectly.

And, 400,000 construction employees, or 6.8%, are covered only by private plans, while 200,000 workers, or 3.4%, are covered by only public plans.

- The entertainment and recreation services industry: 24.5% of the industry's 1.1 million employees, or 300,000 workers, have no health care insurance.

Uninsured employees in this industry account for 1.75% of all uninsured working Americans.

Some 40.6%, or 400,000 entertainment industry employees, are directly covered under employer plans, and 18.4%, or about 200,000 employees, are covered indirectly.

And, 200,000 employees, or 18.1%, are covered only only private plans; practically no employees are covered by only public plans.

- The self-employed: 22.4% of the 11.3 million self-employed Americans, or 2.5 million people, are uninsured.

Of those with coverage, 28.7%, or 3.3 million workers, are covered directly, while 22.3% more, or 2.5 million workers, are indirectly covered.

These workers account for 13.8% of all uninsured working Americans.

And, 2.7 million self-employed people, or 23.9%, are covered only by private plans, while 300,000 of the self-employed, or 2.7%, are covered only by public plans.

In addition, 800,000 of the nation's 2 million agricultural workers—42.4%—do not have health care insurance.

While the manufacturing industry has the third-highest number of uninsured workers behind the retail trade industry and the self-employed, it ranks among the industries with the lowest percentage of workers without health care insurance. Two million of the industry's 21.6 million workers, or 9.1%, do not have health care insurance.

Among the other industries with the lowest percentage of employees without health care insurance are:

- The public sector: Only 1.3 million of its 17.8 million workers, or 7.2%, are uninsured.

Of those insured, 73.8%, or 13.1 million workers, are covered directly under employer-sponsored plans.

- The finance, insurance and real estate industry: Only 8.1%, or about 500,000, of the industry's 6.6 million workers lack health coverage.

Of those insured, 71.2%, or about 4.7 million employees, are covered directly under employer-sponsored plans.

- The mining industry: 9.2%, or about 100,000, of the industry's 900,000 workers are uninsured.

Of those covered, 82.4%, or 800,000 workers, are covered directly under employer plans.

- The transportation, communications and utilities industry: 10.8%, or 700,000, of the industry's 6.1 million workers are without health insurance.

Of those insured, 78.4%, or 4.7 million employees, are covered directly under employer-sponsored plans.

- The wholesale trade industry: 10.8%, or 500,000, of the industry's 4.2 million employees are uninsured.

Of those with coverage, 72.8%, or about 300,000 employees, are directly covered under employer-sponsored plans.

The study also reports that employers in the South are less likely to offer health care insurance than employers in other regions.

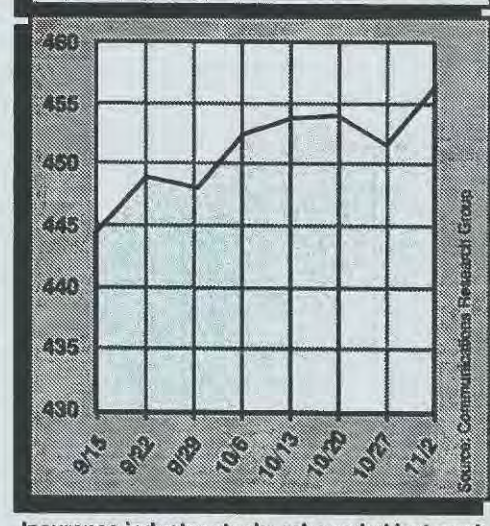
For example, in the East South Central region—which includes Kentucky, Tennessee, Alabama and Mississippi—only 7.7 million of the area's 13 million residents, or 59.1%, are directly or indirectly covered by employer-sponsored plans. About 3 million, or 22.7% of the region's residents do not have health insurance.

In contrast, in New England—which includes Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut—7.9 million, or 72.7% of the 10.9 million residents, are covered either directly or indirectly under employer-sponsored health care plans. About 1.3 million of the area's residents, or 12.2%, do not have health insurance.

•

*Copies of "Uninsured in the United States: The Non-elderly Population without Health Insurance, 1986" is available for $18.95 from EBRI, Books Division, P.O. Box 4866, Hampden Station, Baltimore, Md. 21211; 301-338-6946.*

## BI Insurance Index




**Insurance industry stocks rebounded last week, as the *Business Insurance Index* rose 5 points to 457.1 on Nov. 3, from 452.1 on Oct. 27. Advancing issues were led by a new addition to the stock index, Chandler Insurance Co., up 14.5%; Kansas City Life Insurance Co., up 10.3%; Belvedere Corp., up 8.4%; Frank B. Hall & Co., up 8.3%; Home Group Inc., up 6.8%; and Sears, Roebuck & Co. (Allstate), up 6%. Declining issues were led by AVEMCO Corp., down 5%; Nobel Insurance Ltd., down 4%; Seibels Bruce Group Inc., down 3.9%; Statesman Group Inc., down 3.8%; Continental Corp., down 3.8%; and Protective Life Corp., down 3.6%. Issues showing the most activity during the period were: Sears, Roebuck & Co. (Allstate) 5.8 million shares traded; Farmers Group Inc., 2.1 million shares traded; and American International Group Inc., 1.1 million shares traded. The *Business Insurance Index* gained 1.1% for the period, performing about even with the leading market indicators: The Dow Jones 30 Industrials rose 1.4%, while the Standard & Poor's 500 and New York Stock Exchange Composite each gained 0.6%.**

## British Issues

| Nov. 3 Companies | Price pence | P/E | Div. pence | Yield % | 1 Week High—Low pence | pence |
|---|---|---|---|---|---|---|
| Comml Union | 331 | 10.0 | 25.3 | 7.7 | 334—331 | |
| Gen! Accident | 858 | 8.5 | 58.0 | 6.8 | 870—858 | |
| Gdn Royal Exch | 181 | 9.8 | 13.1 | 7.2 | 185—181 | |
| Royal | 382 | 8.3 | 30.0 | 7.9 | 385—382 | |
| Sun Alliance | 1019 | 7.8 | 54.7 | 5.4 | 1031-1019 | |
| **Brokers** | | | | | | |
| Bredstock | 223 | 12.1 | 8.0 | 3.6 | 223—222 | |
| CE Health | 439 | 14.2 | 34.5 | 7.8 | 445—439 | |
| Hogg Robinson | 149 | 12.6 | 8.0 | 5.4 | 156—149 | |
| Lloyd Thompson | 209 | 16.5 | 8.0 | 3.8 | 209—209 | |
| PWS Holdings | 135 | 19.3 | 6.0 | 3.9 | 135—135 | |
| Sedgwick Grp | 230 | 19.2 | 16.0 | 7.0 | 234—230 | |
| Steel Brit Jones | 221 | 19.7 | 13.3 | 6.0 | 221—221 | |
| Willis Faber | 243 | 13.6 | 16.0 | 6.6 | 246—242 | |

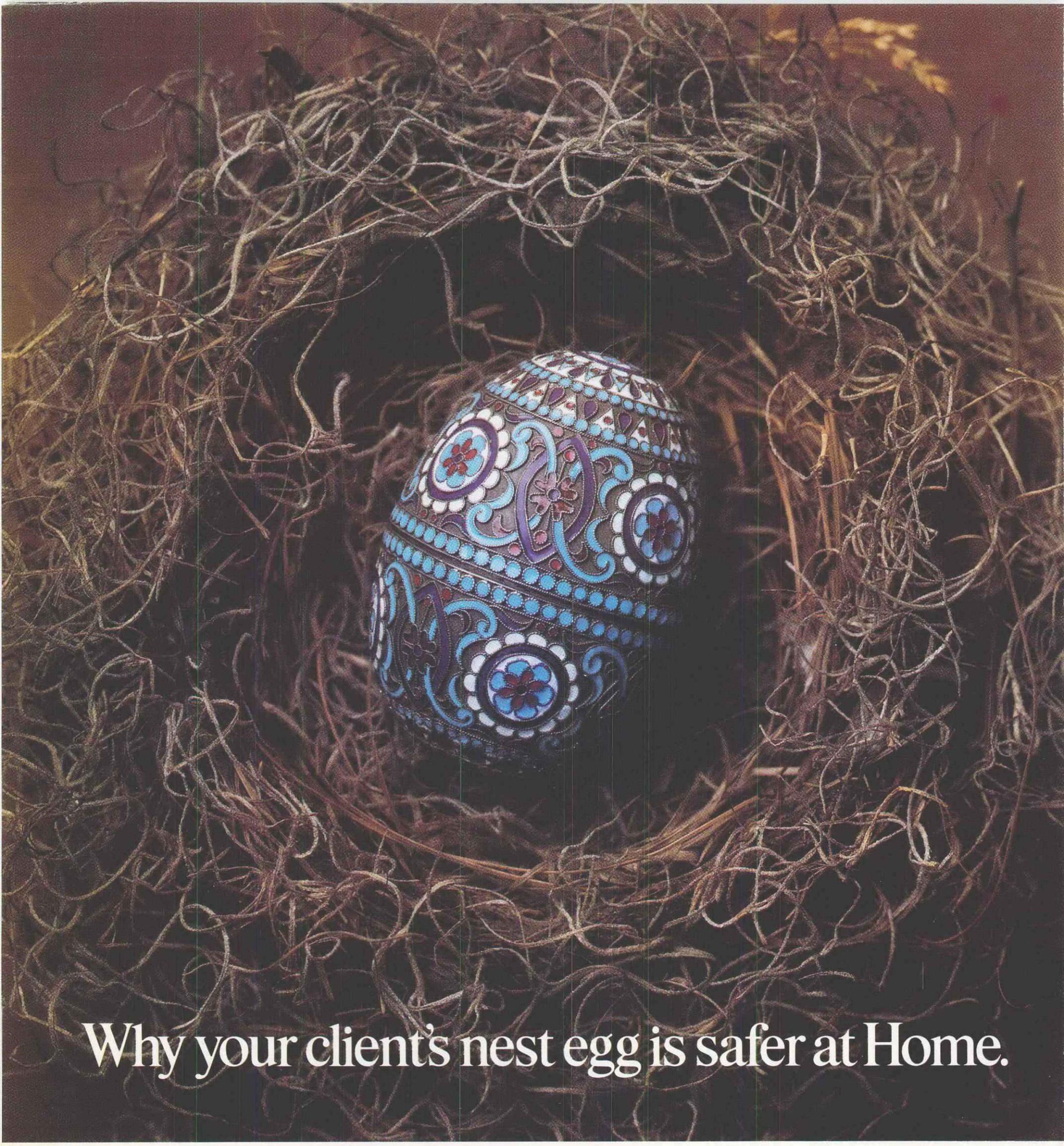
Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

# BI Industry Stock Report

**NOVEMBER 3, 1988** **10/28/88 THRU 11/3/88**

| BROKERS | | Price | Weekly % change | Year to Date % change | Annual High | Annual Low | Vol.(000) | $ Div. | % Yield | P/E | Book value | Mkt/Bk. value |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alexander & Alexander Svcs | NYSE | 24.75 | 0.0 | 39.4 | 28.13 | 17.75 | 388 | 1.00 | 4.0 | 17.0 | 3.71 | 6.67 |
| Corroon & Black Corp | NYSE | 30.50 | 2.5 | 8.0 | 34.75 | 28.00 | 49 | 1.08 | 3.5 | 4.6 | 5.43 | 5.62 |
| Gallagher Arthur J. & Co | NYSE | 17.63 | 3.7 | 10.2 | 18.88 | 13.88 | 29 | 0.48 | 2.7 | 12.2 | 5.16 | 3.42 |
| Hall Frank B. & Co | NYSE | 3.25 | 8.3 | 12.8 | 5.50 | 2.88 | 126 | 0.00 | 0.0 | 12.2 | 0.00 | N/A |
| Hilb, Rogal & Hamilton | OTC | 13.75 | 3.8 | 41.0 | 14.50 | 9.75 | 98 | 0.00 | 0.0 | 12.2 | 0.00 | N/A |
| Marsh & McLennan Cos. Inc | NYSE | 58.75 | 0.9 | 18.7 | 59.63 | 45.25 | 387 | 2.50 | 4.3 | 14.4 | 6.74 | 8.72 |
| Poe & Assoc Inc | OTC | 6.25 | 0.0 | 17.9 | 9.25 | 6.75 | 0 | 0.40 | 4.8 | 12.7 | 0.27 | 30.56 |
| BROKERS | AVERAGE | | 2.7 | 21.1 | | | | | 2.8 | 12.1 | | |
| **CONGLOMERATES & HOLDING COMPANIES** | | | | | | | | | | | | |
| Berkley W.R. Corp. | OTC | 29.38 | 0.4 | 22.4 | 29.50 | 23.50 | 197 | 0.36 | 1.2 | 6.3 | 17.63 | 1.67 |
| Berkshire Hathaway Inc. DEL | OTC | 4775.00 | 0.0 | 61.9 | 5000.00 | 2755.00 | 57 | 0.00 | 0.0 | 21.1 | 77.66 | 1.93 |
| ITT (Hartford Group) | NYSE | 53.00 | 1.9 | 17.8 | 54.88 | 43.25 | 996 | 1.25 | 2.4 | 6.7 | 52.23 | 1.01 |
| Sears Roebuck & Co (Allstate) | NYSE | 46.00 | 6.0 | 36.8 | 46.00 | 32.25 | 5775 | 2.00 | 4.3 | 12.0 | 34.74 | 1.32 |
| CONGLOMERATES | AVERAGE | | 2.1 | 34.7 | | | | | 2.0 | 11.5 | | |
| **INSURERS/REINSURERS** | | | | | | | | | | | | |
| Aetna Life & Cas Co. | NYSE | 50.00 | -0.8 | 10.5 | 52.50 | 39.50 | 1049 | 2.76 | 5.5 | 8.2 | 53.56 | 0.93 |
| American General Corp. | NYSE | 34.00 | 0.7 | 7.1 | 36.38 | 27.50 | 592 | 1.40 | 4.1 | 8.6 | 28.04 | 1.21 |
| Amer Heritage Life Invt | NYSE | 26.63 | -0.9 | 9.8 | 27.00 | 24.00 | 1 | 1.08 | 4.1 | 11.3 | 20.98 | 1.27 |
| Amer Indty Fin'l Corp. | OTC | 10.00 | 2.6 | 11.1 | 12.00 | 8.25 | 14 | 0.56 | 5.6 | 17.5 | 15.26 | 0.66 |
| American Int'l Group | NYSE | 66.13 | 0.2 | 10.2 | 68.75 | 49.00 | 1109 | 0.40 | 0.6 | 10.3 | 33.56 | 1.97 |
| Aon Corp. | NYSE | 28.50 | 0.4 | 24.6 | 28.75 | 21.88 | 290 | 1.28 | 4.5 | 9.7 | 15.13 | 1.88 |
| Argonaut Group | OTC | 43.25 | -0.6 | 45.4 | 49.00 | 29.50 | 57 | 0.00 | 0.0 | 6.0 | 29.19 | 1.48 |
| AVEMCO Corp. | NYSE | 23.63 | -5.0 | 20.4 | 28.75 | 17.88 | 28 | 0.34 | 1.4 | 11.0 | 7.74 | 3.05 |
| Belvedere Corp. | AMEX | 4.75 | 8.4 | 8.4 | 6.00 | 4.00 | 15 | 0.04 | 0.8 | 7.0 | 7.87 | 0.60 |
| Chandler Insurance | OTC | 9.88 | 14.5 | 102.5 | 9.75 | 4.25 | 379 | 0.00 | 0.0 | 4.8 | 7.18 | 1.38 |
| Chubb Corp. | NYSE | 56.25 | -2.2 | 0.7 | 63.38 | 51.25 | 362 | 2.16 | 3.8 | 6.4 | 46.13 | 1.22 |
| CIGNA Corp. | NYSE | 50.38 | 0.0 | 14.8 | 55.38 | 42.75 | 447 | 2.96 | 5.9 | 8.2 | 49.19 | 1.02 |
| CNA Fin'l Corp. | NYSE | 61.00 | -1.6 | 9.7 | 66.13 | 51.00 | 106 | 0.00 | 0.0 | 9.1 | 46.40 | 1.31 |
| Continental Corp. | NYSE | 38.50 | -3.8 | -0.6 | 41.63 | 34.75 | 978 | 2.60 | 6.8 | 12.3 | 42.10 | 0.91 |
| Durham Corp. | OTC | 35.25 | -0.7 | 64.0 | 36.75 | 21.50 | 37 | 0.92 | 2.6 | 33.3 | 26.00 | 1.36 |
| Farmers Group Inc. | OTC | 72.75 | 1.4 | 80.7 | 72.50 | 40.50 | 2103 | 1.44 | 2.0 | 17.1 | 22.02 | 3.30 |
| Fireman's Fund Corp. | NYSE | 30.50 | 0.0 | 17.3 | 33.50 | 25.75 | 624 | 0.50 | 1.6 | 132.6 | 26.17 | 1.17 |
| Forum Re (Bermuda) | OTC | 2.38 | 0.0 | -29.6 | 4.00 | 2.13 | 37 | 0.00 | 0.0 | 6.6 | 2.58 | 0.92 |
| Fremont Gen Corp. | OTC | 11.13 | 2.3 | 15.6 | 13.50 | 8.75 | 115 | 0.60 | 5.4 | 6.6 | 16.24 | 0.69 |
| General Re Corp. | NYSE | 56.38 | -0.4 | 0.9 | 59.38 | 45.50 | 744 | 1.20 | 2.1 | 12.1 | 26.21 | 2.15 |
| Home Group Inc. | NYSE | 11.75 | 6.8 | -1.1 | 14.38 | 10.75 | 398 | 0.20 | 1.7 | 2.9 | 17.76 | 0.66 |
| Hanover Ins Co | OTC | 27.25 | 1.9 | 17.2 | 27.75 | 20.50 | 38 | 0.36 | 1.3 | 5.7 | 25.10 | 1.09 |
| Harleysville Group Inc | OTC | 16.00 | 4.9 | 22.0 | 16.38 | 13.38 | 37 | 0.48 | 3.0 | 6.3 | 16.65 | 0.96 |
| Hartford Steam Boiler | OTC | 32.25 | 4.0 | 40.2 | 32.75 | 22.50 | 73 | 1.20 | 3.7 | 11.0 | 10.65 | 3.03 |
| Kans City Life Ins | OTC | 32.25 | 10.3 | 22.9 | 32.25 | 25.25 | 19 | 0.00 | 0.0 | 11.0 | 29.60 | 1.09 |
| Kemper Corp. | OTC | 24.63 | -1.5 | 20.1 | 27.50 | 20.75 | 246 | 0.72 | 2.9 | 7.8 | 26.50 | 0.93 |
| Lawrence Ins. Group | AMEX | 10.63 | 1.2 | 136.2 | 11.63 | 4.50 | 2 | 0.24 | 2.3 | 17.4 | 2.90 | 3.67 |
| Liberty Corp. S.C. | NYSE | 40.25 | 1.6 | 13.4 | 47.25 | 34.50 | 11 | 0.80 | 2.0 | 13.9 | 17.40 | 2.31 |
| Lincoln Nat'l Corp. | NYSE | 49.88 | 0.8 | 24.3 | 53.50 | 40.25 | 130 | 2.36 | 4.7 | 12.9 | 36.62 | 1.36 |
| NAC Re Corp. | OTC | 30.75 | 2.5 | 73.2 | 31.25 | 18.50 | 121 | 0.00 | 0.0 | 13.7 | 19.92 | 1.54 |
| Navigators Group | OTC | 20.00 | 5.3 | 37.9 | 20.00 | 14.50 | 8 | 0.00 | 0.0 | 9.7 | 12.88 | 1.55 |
| Nobel Ins Ltd | OTC | 6.00 | -4.0 | -31.4 | 9.50 | 4.50 | 22 | 0.44 | 7.3 | 28.6 | 9.37 | 0.64 |
| Northwestern Nat'l Life | OTC | 33.25 | -1.5 | 45.3 | 34.50 | 22.63 | 210 | 1.12 | 3.4 | 7.8 | 35.05 | 0.95 |
| Ohio Cas Corp. | OTC | 36.00 | 0.3 | -0.7 | 38.25 | 32.25 | 54 | 1.88 | 5.2 | 6.7 | 27.86 | 1.29 |
| Old Rep Int'l Corp. | OTC | 24.50 | -1.0 | 22.5 | 25.88 | 19.13 | 78 | 0.74 | 3.0 | 5.8 | 27.82 | 0.88 |
| Orion Cap Corp. | NYSE | 16.00 | 0.0 | 18.5 | 17.63 | 13.13 | 17 | 0.76 | 4.8 | 5.1 | 9.34 | 1.71 |
| Phoenix Re Corp. | OTC | 10.13 | 0.0 | 55.8 | 10.75 | 6.75 | 111 | 0.00 | 0.0 | 5.9 | 11.08 | 0.91 |
| Protective Life Corp. | OTC | 13.25 | -3.6 | 8.2 | 15.13 | 12.25 | 50 | 0.70 | 5.3 | 16.2 | 17.25 | 0.77 |
| Re Capital Corp. | AMEX | 9.50 | 5.6 | -9.5 | 11.75 | 7.88 | 12 | 0.00 | 0.0 | 21.1 | 11.49 | 0.83 |
| Provident Life & Acc Ins Co. | OTC | 22.13 | 0.0 | 77.0 | 25.00 | 15.63 | 369 | 0.67 | 3.0 | 18.6 | 21.96 | 1.01 |
| St. Paul Cos. Inc. | OTC | 43.25 | -1.1 | -6.0 | 51.00 | 38.25 | 1077 | 2.00 | 4.6 | 6.1 | 35.83 | 1.21 |
| SAFECO Corp. | OTC | 25.50 | 1.0 | -8.1 | 30.00 | 22.75 | 637 | 1.08 | 4.2 | 8.1 | 21.39 | 1.19 |
| SCOR US Corp. | NYSE | 8.25 | -1.6 | -10.8 | 9.50 | 6.63 | 78 | 0.10 | 1.2 | 5.7 | 9.39 | 0.88 |
| Seibels Bruce Group Inc. | OTC | 12.25 | -3.9 | 8.9 | 14.25 | 11.00 | 41 | 0.80 | 6.5 | 8.2 | 12.51 | 0.98 |
| Selective Ins Group Inc. | OTC | 25.75 | -1.0 | 35.5 | 26.50 | 19.25 | 45 | 1.24 | 4.8 | 5.7 | 19.52 | 1.32 |
| Statesman Group Inc. | OTC | 3.25 | -3.8 | -30.7 | 5.56 | 3.13 | 17 | 0.05 | 1.5 | 5.7 | 3.48 | 0.93 |
| Tokio Marine & Fire Ins | OTC | 84.00 | 0.9 | 27.5 | 85.88 | 63.25 | 34 | 0.22 | 0.3 | 50.9 | 0.00 | N/A |
| Torchmark Corp. | NYSE | 31.38 | 0.0 | 28.1 | 33.50 | 24.50 | 358 | 1.20 | 3.8 | 10.2 | 12.24 | 2.56 |
| Transamerica Corp. | NYSE | 34.50 | 0.7 | 16.0 | 36.75 | 29.75 | 323 | 1.88 | 5.4 | 7.9 | 24.94 | 1.38 |
| Travelers Corp. | NYSE | 35.88 | -1.4 | 2.1 | 40.00 | 33.00 | 687 | 2.40 | 6.7 | 13.1 | 45.28 | 0.79 |
| Trenwick Group Inc. | OTC | 13.50 | 0.0 | 31.7 | 13.50 | 9.75 | 38 | 0.16 | 1.2 | 13.2 | 15.41 | 0.88 |
| United Fire & Cas Co. | OTC | 29.00 | 1.8 | 11.5 | 29.50 | 24.00 | 3 | 1.08 | 3.7 | 4.8 | 22.56 | 1.29 |
| United States Fid & Gty | NYSE | 31.00 | 1.6 | 8.8 | 34.38 | 28.88 | 748 | 2.64 | 8.5 | 8.3 | 19.53 | 1.59 |
| UNUM Corp. | NYSE | 26.13 | 5.0 | 41.2 | 25.75 | 17.88 | 418 | 0.48 | 1.8 | 10.9 | 28.53 | 0.92 |
| USLIFE Corp. | NYSE | 36.50 | 0.3 | 28.1 | 40.13 | 28.00 | 142 | 1.36 | 3.7 | 9.7 | 46.77 | 0.78 |
| Washington Nat'l Corp. | NYSE | 27.63 | 1.4 | 15.7 | 28.75 | 24.00 | 36 | 1.08 | 3.9 | 12.9 | 32.33 | 0.85 |
| Zenith Nat'l Ins Corp. | NYSE | 17.50 | 0.0 | 16.7 | 23.88 | 15.00 | 95 | 0.80 | 4.6 | 8.2 | 12.53 | 1.40 |
| INSURERS/REINSURERS | AVERAGE | | 0.8 | 21.6 | | | | | 3.1 | 13.5 | | |
| ALL COMPANIES | AVERAGE | | 1.1 | 22.3 | | | | | 3.0 | 13.3 | | |

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