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update

GAF wants tobacco firms included in asbestos suits

SAN FRANCISCO—GAF Corp., a defendant in hundreds of asbestos injury lawsuits, has filed cross-complaints in several courts asking that tobacco companies be named as co-defendants in the suits.

GAF, based in Wayne, N.J., filed approximately 170 cross-complaints in San Francisco-area county courts in cases where plaintiffs claiming asbestos injuries smoked cigarettes.

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Photo: Japan National Tourist Organization

Marine underwriters joined the crowds on Tokyo streets during the last month's IUMI conference.

Marine underwriters say rates must be increased

By STACY SHAPIRO

TOKYO—Marine underwriters—noting the higher rates, reduced capacity and tougher policy conditions in other lines of commercial property/casualty insurance—say it's time for the hull and cargo insurance markets to harden.

The underwriters, who gathered in Tokyo last month for the annual International Union of Marine Insurance conference, say quick action is needed to get marine underwriting back on track.

Besides increasing hull rates beyond the current 6% annual price hikes, hull insurers say they must exercise more control over the way hull risks are written.

For instance, some suggest that the insured values of hulls should be cut to the ship's current value in the now-depressed world shipping market, rather than the value of the ship at the time it was constructed.

In addition, hull underwriters say they may take part in the evaluation of the condition of a vessel. Currently, various classification societies around the world determine the condition of a ship, and insurers base their underwriting decisions on that criteria.

Cargo underwriters have similar concerns. They note that the marine cargo insurance market has not yet begun to tighten, with insurers still offering low rates and high levels of capacity.

Cargo insurers also say they should restrict the

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RIMS says changes to claims-made form still not adequate

By ROBERT A. FINLAYSON

The Risk & Insurance Management Society says recent major revisions to the proposed claims-made commercial general liability policy still do not make the form acceptable to insurance buyers.

The five revisions, which are still only in draft form, change the trigger of coverage; establish a five-year, automatic extended claims reporting period for known occurrences; limit when an insurer can advance the retroactive date of a policy; provide for the reinstatement of the aggregate limits of the policy for tail coverage; and control how tail coverage can be priced.

While RIMS welcomes the changes announced Oct. 4 by the Insurance Services Office, "what's on the table is not acceptable to RIMS," said Jon Harkavy, the society's director of governmental affairs. RIMS hopes to negotiate further changes in the policy at a meeting with ISO on Oct. 21, he said.

Meanwhile, insurance regulators, noting that ISO did not make all of the changes they had requested, have not endorsed or rejected the new revisions, pending the outcome of an Oct. 17 meeting with ISO officials.

Robert F. Heisler, assistant deputy director of the Illinois Department of Insurance, says as many as 27 state insurance commissioners may attend that meeting, which is being organized by Illinois Insurance Director John E. Washburn.

Despite these upcoming discussions with buyers and regulators and the fact that its CGL proposals have only been approved in 27 states so far, ISO says both its new claims-made and occurrence policy forms will be implemented on schedule on Jan. 1, 1986, without any further revision of the forms before that date.

There is "no way further changes or modifications or enhancements are going to be made before the program goes into effect Jan. 1," said an ISO spokesman. "Further refinements, if any, would have to come after the program is implemented."

Although ISO is still drafting the exact language of the final forms—and will not likely file the newest forms with state insurance departments until the end of the month—ISO says the revisions will include:

- Changing the claims-made coverage trigger to provide coverage for claims made verbally during the policy period. This removes the requirement that claims be made in writing to the policyholder or insurer.
- Automatic tail coverage for claims made within five years of the policy period for claims stemming from occurrences that are reported to the

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NAIC to study conduct of three insurers

By CAROL CAIN

DENVER—Three Pennsylvania-domiciled insurers are being targeted for special market conduct examinations by the National Assn. of Insurance Commissioners.

The examinations are an unprecedented move by state insurance regulators, who are under pressure from legislators and consumers to solve the property/casualty insurance availability problems.

The special market conduct exams will look into several controversial insurer practices, including midterm cancellation of policies, cancellation of entire books of business and inadequate notices of non-renewal.

"We're not looking at insurers in financial difficulty that are trying to survive," explained David Gates, Nevada's insurance commissioner and chairman of the NAIC's Western Zone.

"We are afraid that some insurers have shown a marked lack of thought in underwriting guidelines and their application," Mr. Gates added.

"We will be looking at their cancellation practices in addition to the existence and quality of their reinsurance programs," he said.

The three insurers targeted for the special exams are:

- Insurance Co. of North America in Philadelphia, a CIGNA Corp. subsidiary.
- National Union Fire Insurance Co. of Pittsburgh, Pa., a New York-based unit of American International Group Inc. that is domiciled in Pennsylvania.
- Colonial Penn Insurance Co. of Philadelphia, a subsidiary of The Colonial Penn Group Inc.

These three insurers were chosen based on a survey of 16 state insurance departments in the NAIC's Western Zone, which includes Alaska, American Samoa, Arizona, California, Colorado, Guam, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Texas, Utah, Washington and Wyoming.

The Western Zone members met Oct. 2-3 in Denver to focus on management of state insurance departments.

However, NAIC President Bruce Foudree, who also is Iowa's insurance commissioner, asked that part of the meeting be spent developing a consensus on appropriate responses by the states to the increase in midterm policy cancellations, midterm premium increases and the unavailability of some 15 to 20 lines of insurance. The lines of coverage include day-care liability, municipal liability, liquor liability, commercial auto and medical malpractice coverages.

During that discussion, regulators agreed to call for the special market conduct exams, which are slated to begin Dec. 2 and should take about four weeks to complete.

The Western Zone members will meet again during the NAIC's annual winter

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NEWSPAPER

update

GAF acts to name tobacco firms

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Arguing that smokers who are exposed to asbestos are more vulnerable to lung disease, the cross-complaints ask that the tobacco companies be liable for a percentage of any awards against GAF.

Tobacco companies named in the cross-complaints include American Brands Inc., American Tobacco Co., Philip Morris Inc., Brown & Williamson Tobacco Co., Liggett Group Inc. and R.J. Reynolds Tobacco Co.

The cross-complaints also seek to bring in other, as yet unidentified co-defendants, including tobacco retailers, advertising agencies and tobacco company employees.

GAF was not joined in the cross-complaints by other asbestos defendants and didn't discuss the actions with other defendants, said Warren George, a San Francisco lawyer representing GAF.

A GAF spokesman refused to comment on whether the company would file similar cross-complaints in asbestos injury suits pending in courts outside the San Francisco area.

Illinois acts on insurance crisis

CHICAGO—Illinois House Speaker Michael Madigan, D-Chicago, and the Illinois State Chamber of Commerce are taking separate steps to deal with the rapidly increasing costs and limited availability of certain lines of property/casualty insurance.

Rep. Madigan earlier this month named three state representatives as co-chairmen of a task force to be formed to examine complaints from individual and commercial insurance buyers.

The task force is expected to make recommendations when the Illinois Legislature reconvenes in January. However, some observers say the urgency voiced by muncipalities and small businesses could spur the Legislature to take some action this week during a special session to consider legislation vetoed by the governor.

Meanwhile, the Illinois State Chamber of Commerce is developing a program to help its 6,000 members with insurance-related problems. The program will include initiatives in tort reform and the close monitoring of insurance-related legislation. Seminars and direct services to help businesses with insurance problems also are planned, with the first seminar scheduled for Jan. 22 in Chicago.

ISCC President Lester W. Brann Jr. said that if the thrust of the state government's action "is getting some reins on the civil justice system," the chamber would add its support.

"But we would be concerned if the task force would propose a need to control insurance rates," Mr. Brann said, noting a survey of ISCC members released last week in which 67% of the respondents said they want no government regulation of insurance rates.

Gloria losses set at $340 million

NEW YORK—The insured property damage from Hurricane Gloria has been estimated at $340 million by the Property Claim Services division of the American Insurance Services Group Inc.

And, as a result of the losses from Gloria, catastrophe losses through the first nine months of 1985 are estimated at $2.45 billion. The insurance industry designates an event a catastrophe when the insured loss is expected to exceed $5 million.

With the Gloria losses, 1985 becomes the worst year ever for catastrophe losses, topping the previous record of $2.3 billion set in 1983. Last year, catastrophe losses totaled $1.55 billion.

Gloria hit North Carolina, Virginia, Maryland, Delaware, Pennsylvania, New Jersey, New York, Connecticut, Rhode Island, Massachusetts, New Hampshire, Vermont and Maine on Sept. 26 and 27 (*BI*, Oct. 7).

The damage estimate does not include losses insured under the National Flood Insurance Program.

Manville, Keene settle suits

DENVER—Manville Corp. has settled with another of its liability insurers with which it is litigating in a San Francisco state court over insurance coverage for asbestos claims.

The company reached agreement Sept. 27 with Highlands Insurance Co., which agreed to pay $2.6 million to Manville. The settlement brings to approximately $430 million the amount of coverage on which Manville has agreed with its insurers.

The agreement calls for Highlands to pay Manville on Dec. 31 or five days following confirmation of a reorganization plan in Manville's reorganization proceedings, whichever is later.

Manville and Highlands will dismiss the claims and defenses against each other in the San Francisco litigation pending approval of the settlement by the bankruptcy court.

Payment by Highlands will be in full satisfaction of all of Manville's claims against the insurer. The effectiveness of the settlement is conditional upon entry of a final order approving a reorganization

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More buyers joining forces to create casualty capacity

By STEVE TARAVELLA

Risk managers in various industries continue to create their own casualty insurance capacity to counteract the restrictive prices and limits of liability coverage available in the commercial market.

More than 20 companies, whose business ranges from chemical manufacturing to paper production to heavy manufacturing, are contributing about $150,000 each to capitalize an excess casualty underwriting pool, named Tortuga Casualty Co.

This will make them shareholders as well as policyholders of Tortuga, which initially will provide coverage of $25 million excess of $50 million.

The insurer, which will be domiciled in the Cayman Islands, is expected to open its doors in January with $3 million to $4 million in capital, according to Jack Ryan, senior vp at American Risk Management Inc. in Fort Lee, N.J.

ARM is the U.S. subsidiary of The Reiss Organization; Tortuga will be managed by Reiss' Cayman Island subsidiary, Transnational Risk Management Ltd.

By pooling the resources of its shareholder companies, Tortuga (Spanish for *turtle*, an animal often associated with the Caymans) will amass an initial capacity of at least $25 million, Mr. Ryan reports.

It hopes to increase that to $50 million by attracting outside reinsurance support, perhaps by the end of its first year of operation, he says.

Participation in the pool is limited to Reiss clients. Also, a company must be a shareholder of Tortuga to insure its risks with it and, conversely, cannot invest in the pool if it does not purchase insurance from it.

All but one or two of the companies that were committed to join the pool as of last week were U.S.-based and will participate in the pool through their captive insurance company subsidiaries, Mr. Ryan says.

Tortuga will write excess umbrella liability coverage on a claims-made basis, and it will cover such hard-to-insure exposures as third-party damage from sudden and accidental pollution.

Such coverage is to be excluded under the new commercial general liability forms to be introduced by the Insurance Services Office next year.

The new pool will not, however, cover gradual pollution losses, Mr. Ryan says.

While the pool initially will not provide directors and officers liability coverage—another headache for risk managers—it may in the future, Mr. Ryan speculates.

Premiums will be based on individual companies' exposure and loss history. Underwriting will be done by Transnational in Grand Cayman.

Meanwhile, 18 businesses in the chemical industry have commissioned Risk Planning Group in Darien,

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California to deny AIDS exclusion

By STEVE TARAVELLA

SAN FRANCISCO—The California Insurance Department says it will deny a request by Blue Cross of California to offer a group health insurance policy that would exclude coverage for AIDS and other sexually transmitted diseases.

The department last week was formulating its official response to Blue Cross, reports Peter Groom, an attorney for the department in San Francisco. Such changes in group insurance contracts must be approved by the department, he said.

The clause was to be applied only to those policyholders that requested it, not to all policyholders statewide, according to Blue Cross.

"We believe someone eligible for benefits shouldn't be denied them just because it happens to be AIDS or because he got it through circumstances that (someone doesn't) approve of," says Mr. Groom.

"There is no justified reason for excluding coverage for this while covering lung cancer and alcohol-related diseases, which can be related to lifestyle."

He says it is the department's understanding that Blue Cross was reluctant to submit the exclusion for approval, but the insurer was pressured into the filing by several policyholders that threatened to self-insure their benefit programs if AIDS claims were not excluded by Blue Cross.

According to Blue Cross Vp Leona Butler, a Central California business whose employees are enrolled in BC's Prudent Buyer Plan was "very disturbed" at the AIDS-related expenses of an employee's son and "pretty much demanded that we exclude it (in the future)."

The man's treatment cost the plan about $59,000, Ms. Butler said.

Blue Cross does not endorse an AIDS exclusion, she said, adding "to say we won't cover AIDS is like saying we won't cover cancer." However, the insurer suspected it would lose the account if it didn't seek approval for the exclusion, she explained, declining to identify the employer.

When told of the department's decision last week, Ms. Butler replied, "Good for them!"

Excluding a life-threatening or terminal illness from group health policies in California would be "unprecedented," says the department's Mr. Groom.

An AIDS patient is expected to incur an average of $140,000 in medical bills between the time the patient is diagnosed with the illness and his or her death, which usually comes within two years of diagnosis (*BI*, Sept. 30).

House panel votes to retain comp benefits' tax-free status

By JERRY GEISEL and CAROL CAIN

WASHINGTON—The House Ways and Means Committee is apparently charting its own course as it considers the risk management and employee benefit provisions of a tax reform bill.

In its first major decision since it began closed sessions on the tax bill earlier this month, the committee rejected proposals by the Reagan administration and the committee's staff to tax workers compensation and black lung disability benefits.

Instead, the panel adopted an amendment by Rep. Ronnie Flippo, D-Ala., that will retain the tax-free status of these benefits.

In addition, committee members approved an amendment by Rep. Barbara Kennelly, D-Conn., to place a $5,000 cap on the amount of tax-free dependent care contributions an employee can annually receive from an employer.

By contrast, the Ways and Means Committee staff last month proposed taxing all employer-provided dependent care benefits, while the Reagan administration in May recommended that these benefits should remain tax-free.

Meanwhile, benefit experts say the committee staff's proposals to establish uniform non-discrimination rules for benefit plans could cause massive problems for employers, although they concede these rules are probably less burdensome than the Reagan administration's earlier non-discrimination proposals.

The adoption of Rep. Flippo's workers compensation benefit amendment is a major victory for employers, insurers and unions, but members of a loosely formed coalition that opposes the taxation of work comp benefits say they are keeping up their guard.

"We were certainly pleased with the committee and the leadership by Congressman Flippo.

"However, under the rules of the committee, any action (vote) can be revisited," explained Robert Rus-

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BI buyers directory ready

The third edition of the *Business Insurance Directory of Corporate Buyers of Insurance, Benefit Plans and Risk Management Services* is on sale.

The updated 1985 edition contains information on more than 2,000 U.S. corporations. Each listing contains the company address and phone number, number of employees and 1984 gross revenues, as well as the names and titles of the chief financial officer and of executives in charge of risk management, employee benefits, personnel and pension/retirement plans.

Many firms also listed personnel with related responsibilities, such as international employee benefits and risk management, insurance management and workers compensation.

An index ranking companies by number of employees and a geographic index are included.

Copies of the *BI* Directory are $50 each, or $40 each for five or more copies. To order, write *Business Insurance*, Single Copy Sales Department, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5425.

Borg-Warner seeks dismissal of Mission claim

By STEVE TARAVELLA

CHICAGO—Borg-Warner Corp. is asking a federal court to dismiss a suit that seeks to hold it liable for reinsurance payments owed by its Centaur Insurance Co. subsidiary to three Mission Insurance Group Inc. units.

The Mission companies, which filed the suit Aug. 9 in U.S. District Court in Chicago, say Borg-Warner—as Centaur's ultimate parent—should be held responsible for Centaur's obligations to the Mission companies under seven reinsurance, reinsurance management and MGA agreements in effect from 1974 to 1984 (*BI*, Sept. 2).

The suit does not seek a determination of the amount Centaur owes—which is currently disputed—but only seeks to hold Borg-Warner responsible for whatever amount Centaur owes.

Borg-Warner responded to the Mission suit Sept. 30, accusing the Mission companies of engaging in "tactical gamesmanship."

It asked the court to dismiss the suit as a matter of law or "sound judicial discretion." Borg-Warner asserts that whether it should be held liable for Centaur's debts is "a purely hypothetical issue" since Centaur's exact liability is not known.

"Borg-Warner contends that as a matter of law, there is no subject matter jurisdiction and the complaint fails to state a claim upon which relief can be granted," the response says.

Borg-Warner also points out the amount Centaur owes to the MIG units is at issue in two other legal actions.

Centaur filed suit in a state court in Chicago in July seeking an accounting of how much it owes. And, the MIG units asked a federal court in Los Angeles in August to order arbitration of their disputes with Centaur (see story, page 33).

Given these pending actions, "nothing is added by an ancillary determination of the abstract question of whether the corporate veil should be pierced," Borg-Warner's response says.

Centaur and Borg-Warner officials would not comment on the Mission suit or Borg-Warner's response.

The three MIG companies that filed suit against Borg-Warner are Mission Insurance Co., Sayre & Toso Inc. and Pacific Reinsurance Management Corp., a reinsurance pool manager that is now running off its business.

The Mission companies contended in their suit that Borg-Warner has "so dominated, controlled and directed the affairs and destiny of Centaur" and "so used Centaur for its own purposes" that Borg-Warner has become Centaur's "alter ego."

The suit says Borg-Warner created Centaur as its captive insurance company in 1973, primarily to insure or reinsure risks related to Borg-Warner or its affiliates. This arrangement permits it to deduct insurance premiums paid to Centaur as a business expense, the suit maintains.

As evidence of the ties between Borg-Warner and Centaur, the MIG units also charge that, within the past two years, Borg-Warner has "taken extraordinary measures to attempt to prevent the Department of Insurance of the state of Illinois from taking action to liquidate Centaur" or to otherwise prohibit Centaur from operating.

They claim Borg-Warner's actions prompted the Insurance Department to permit Centaur to continue operating, "thereby allowing (Borg-Warner) to continue enjoying the economic benefits conferred by Centaur's activities as (Borg-Warner's) 'captive' insurance company, while Centaur has simultaneously become and remained in default on its payment obligations."

The suit alleges that Borg-Warner gave Centaur funds it needed to keep operating; that it proposed that Centaur use certain accounting principles not approved by the Insurance Department that would permit Centaur to boost its reported assets by $30 million as of December 1984; and that Borg-Warner agreed to guarantee to the department the collectability of "certain substantial doubtful

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Top risk manager

Time to nominate the best in the field

The deadline is Dec. 6 for submitting nominations for the annual *Business Insurance* Risk Manager of the Year competition.

Besides the Risk Manager of the Year, a Risk Management Honor Roll will be named.

This year a new category has been added for risk managers for financial institutions, such as banks and bank holding companies, savings institutions, insurance companies, securities and commodities brokers and their holding companies.

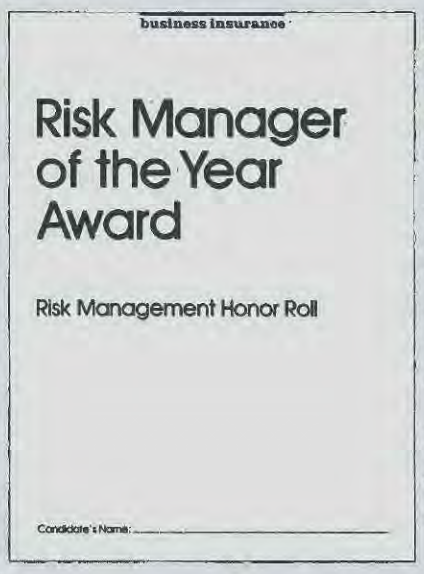
The other categories are risk managers at corporations with sales exceeding $300 million annually, corporations with sales less than $300 million annually, government entities and tax-exempt or non-profit institutions.

To nominate a candidate, you must receive a nominating packet from *Business Insurance* and supply the requested information. A panel of 10 independent judges will evaluate the nominations and choose the 1986 Risk Manager of the Year and the members of the Risk Management Honor Roll.

The winners will be announced in the April 14, 1986, issue of Business Insurance, which is published to coincide with the annual meeting of the Risk & Insurance Management Society.

Anyone knowledgeable about a risk manager's work can nominate a candidate. Any employee or group of employees can nominate their company's risk manager; a broker, consultant or other service supplier can nominate a client; and a risk manager can nominate a colleague.

To be eligible for nomination, a person must be in charge of the risk management function for a corporation, government entity, financial institution or non-profit institution.



The candidate need not spend full time handling risk management tasks but must be a full-time employee of the organization or company for which he or she handles the risk management function.

The 1986 award will be the ninth *Business Insurance* has presented since creating the competition in 1977 on the 10th anniversary of the magazine.

The previous Risk Managers of the Year are:

- Harold C. Lang, director of insurance and risk management at Leaseway Transportation Corp. in Cleveland, in 1985.
- Richard M. Inserra, director of insurance and risk management at American Can Co. in Greenwich, Conn., in 1984.
- John A. O'Connell, executive director/risk manager of Holy Cross Shared Services Inc. in Notre Dame, Ind., in 1983.
- Eckart Russell, then risk and insurance manager at Alcan Aluminium Ltd. in Montreal, in 1982, and now Alcan's manager of foreign exchange risks.
- Duane E. Allen, then assistant treasurer at Hanna Mining Corp. in Cleveland, in 1981. He since has formed Applied Risk Funding Services in Mission Viejo, Calif.
- Thomas V. Hallett, then risk manager of General Motors Corp. in Detroit in 1980. He is now senior vp with Frank B. Hall & Co. Inc. in Briarcliff, N.Y., and president of Adjustco, a Hall unit.
- Edward L. Erickson, director of insurance at American Broadcasting Cos. Inc. in New York, in 1979.
- Howard T. Weber, director of insurance at 3M Corp. in St. Paul, Minn., in 1978.

To request a nominating packet, write *Business Insurance*, Risk Manager of the Year, 740 N. Rush St., Chicago, Ill. 60611.

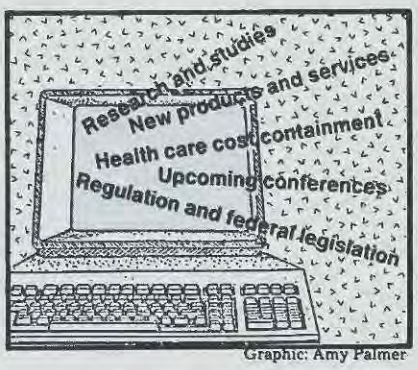
Computer network gives benefit news at touch of a button

By DIANE LYNN KASTIEL

Employee benefit managers who are buried under piles of work-related reading can now keep up with the latest benefit developments simply by pressing a button—on their personal computers.

The Employee Benefits Information Network, a network of "electronic bulletin boards" sponsored by Personnel Research Associates in Verona, N.J., gives benefit managers access to information from more than 25 different sources.

EBIN is the brainchild of Richard D. Quinn, a benefit manager himself and the president of Personnel Research, a company specializing in employee benefits information.



Graphic: Amy Palmer

The system capsulizes employee benefits issues in 50 lines or less. And, the "bulletin board" entries include the source of the information, so the benefit manager can refer to the source for more complete information.

Mr. Quinn started the bulletin board to help streamline the work of benefit managers who find themselves inundated with reams of printed information to read every day.

In addition to his position at Personnel Research, which he founded, Mr. Quinn is the employee benefits manager for Public Service Electric & Gas Co. in Newark, N.J.

"In my own work, I see volumes of material coming across my desk," Mr. Quinn said. "And, with the growing complexity of employee benefits, it's very difficult—almost impossible—for the benefit manager to keep up with the latest information."

All employee benefit managers need to tap into EBIN is a personal computer with a telephone modem, Mr. Quinn said. Users pay $50 every six months to maintain a password, which provides unlimited access to all the information in the network.

Currently, the network is accessible Tuesdays, Wednesdays and Thursdays between 7 a.m. and 3 p.m. EST. But, when the need increases, the network will become available on Mondays and Fridays.

"That will depend on how the number of users grows and how often

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Bill would allow workers to delay asset reversions

By JERRY GEISEL

WASHINGTON—The Senate this week will consider legislation that would give employees the right to temporarily block corporations from terminating overfunded pension plans to obtain the plans' excess assets.

If as few as 10 employees file an objection with the federal Pension Benefit Guaranty Corp., the termination could be delayed as long as three months under the legislation.

Employer lobbyists who oppose this restriction warn it could serve as a forerunner to legislation that establishes lengthier delays or totally prohibits reversions of excess pension assets.

In addition, they say that delaying plan terminations could increase the chances that employers would be liable for a proposed excise tax on asset reversions.

The restriction is tacked on to legislation intended to shore up the financial base of the PBGC, the federal agency that guarantees employees' pension benefits.

The legislation would boost the insurance premiums employers with defined benefit plans pay to the PBGC and would make it more difficult and expensive for companies to shift unfunded pension liabilities onto the agency.

The PBGC proposals are attached to a major Senate budget bill, S. 1730. A comparable House budget bill, H.R. 3500, which also could be voted on this week, contains similar proposals to shore up the PBGC, though the House bill does not include a so-called "moratorium" provision that allows employees to delay the termination of an overfunded plan.

That provision was added to the PBGC legislation as part of political maneuvering between Sen. Howard Metzenbaum, D-Ohio, and Republican leaders on the Senate Labor and Human Resources Committee, sources say.

The provision was intended to assure that Sen. Metzenbaum, a long-standing critic of pension reversions, would not block the PBGC proposals when they were pending in the Labor and Human Resources Committee, sources added.

"It was the price that had to be paid to get the bill out of committee," observed Richard Fay, a partner with the law firm of Reed, Smith, Shaw & McClay in Washington.

"It is a compromise that had to be made," added a Reagan administration official who asked not to be identified.

But, the "compromise" has outraged employer lobbying groups, which say the provision could endanger their support for the PBGC proposals.

In a strongly worded letter mailed last week to senators, the ERISA Industry Committee, also known as ERIC, and the Assn. of Private Pension & Welfare Plans urged the Senate to strip the provision from the budget bill.

The ERIC-APPWP letter warns that employers will interpret the provision "as a threat to their ability to ever retrieve excess assets and will cause many employers—who had not previously considered it—to reduce their plan contribution or to terminate their plans."

"The provision is mischievous and obnoxious," adds Mark J. Ugoretz, ERIC's executive director. Employers could inter-

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NAIC examinations

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meeting, to be held Dec. 8-12 in Reno, Nev., to discuss the possibility of a second round of examinations, according to Mr. Gates.

"This is not your typical market conduct exam," Mr. Gates noted. "We're looking for specifics: if they're engaged in midterm cancellations and why. They will have to document, to give us their rationale.

"If the insurers say the cancellations were because of poor loss ratios in a particular line, we'd better see some numbers," Mr. Gates said.

The three insurers were notified of the NAIC's Western Zone action through letters mailed to their presidents on Oct. 7, said Thomas E. Power, chief examiner and chief actuary of the Wyoming Insurance Department, which serves as secretary to the Western Zone.

However, when contacted by *Business Insurance* last week, spokesmen from all three insurers said they had not yet received any official notice and therefore could not comment.

'We're looking for specifics: if they're engaged in midterm cancellations and why. . . .If the insurers say the cancellations were because of poor loss ratios in a particular line, we'd better see some numbers,' says Mr. Gates.

A spokesman for one of the insurers, Colonial Penn, did say: "We have done nothing illegal. We have done nothing improper. We conducted our business in keeping with insurance industry practices. . . .

"There is no reason why we should have a market conduct exam against us," the spokesman said.

Although the examinations currently are expected to take four weeks, they could be completed more quickly if several states respond to a call for examiners, according to Mr. Power.

He explained that the examination teams will be composed of five to six examiners from various state insurance departments who have received special training in insurance topics from the Society of Financial Examiners.

"We will look at cancellation practices, their cancel and rewrite practices. . .and any evidence of unfair trade practices," Mr. Power said.

"The examiners who will be assigned are experts in ferreting out information," he added.

The three insurers targeted for this exam are licensed to do business in all states and, thus, all state insurance departments have an interest in the insurers' affairs and would be responsible for the activities of the insurer within their boundaries.

Any remedial actions against the insurers would be up to individual insurance departments, based on individual state law, Mr. Power said.

Although the three insurers are domiciled in Pennsylvania, the Pennsylvania Insurance Department does not automatically have to be represented on the teams, Mr. Power noted.

In fact, the Pennsylvania department has not yet decided whether it will participate on the team, a spokeswoman from the department said.

The spokeswoman also noted that one of the targeted insurers—Colonial Penn—hardly writes any commercial liability coverages in Pennsylvania.

Colonial Penn, which reported $314.3 million in direct written premiums in 1984, primarily writes automobile liability and physical damage policies. However, the insurer also writes general liability, ocean marine and commercial multiperil coverages.

INA, which reported $2.2 billion in direct written premiums in 1984, writes almost all lines of commercial property and casualty coverages, as does National Union, which reported direct written premiums of almost $1.56 billion last year.

The examination reports on the three insurers will be written "on the job," Mr. Power said, explaining that the reports will be complete at the close of the examination process.

They will not be made public, however, until after the individual insurers have a chance to examine the reports and respond.

Mr. Power wouldn't speculate as to the possible findings of the examination.

"I want to make decisions (as a regulator) based on facts, not rumors," Mr. Power said, explaining the main rationale for the examination.

"There is a problem," he added. "We have to determine as regulators how to solve it.

"And we may not have all the tools. . .we may need help from legislators for those tools and for additional staff," according to Mr. Power.

Legislators are expected to take up problems associated with the hardening property/casualty market next month at the annual meeting of the Conference of Insurance Legislators, slated Nov. 21-24 in Phoenix, Ariz.

Individual legislators reported to COIL headquarters that they have received several calls each week about the "availability crisis," said Charles O. Davis, COIL's executive director.

In addition to agreeing on the market conduct exams, regulators attending the NAIC's Denver meeting decided to begin gathering information on regulatory and legislative responses to the current market situation. This information, in turn, will be used in developing model guidelines.

The model is expected to be ready in draft form for adoption by the full NAIC during its winter meeting in Reno.

"In our discussion in Denver, we were able to identify four or five things that could be done to tighten up cancellations and non-renewal (practices)," Mr. Gates said.

"We need to tailor regulatory responses to the needs of the market," Mr. Gates added, explaining that regulators are trying to identify which actions currently taken by insurers are warranted by the tight market.

In the past several months, state regulators—as well as legislators and governors—have taken aggressive steps to curtail insurers from canceling policies midterm or giving policyholders inadequate notices of non-renewal.

Bulletins, orders, letters to chief executive officers and emergency rules have been among the procedures used in the various states (*BI*, Oct. 7, Sept. 16, Aug. 12, July 1).

"There is a general sense of urgency among regulators," said Mr. Foudree, the NAIC president. "We all are in a bit of a quandry how to deal with these."

He noted that cancellation of policies by some insurers is a step of survival, but it also serves as a "red flag" to regulators.

"On the other side is a recognition that not everybody has a right to insurance. . .It's a recognition that some of these risks could be uninsurable," Mr. Foudree concluded. ■

Claims-made form

Continued from page 1

insurer during the policy period, subject to the policy's retroactive date.

- Specifying only four conditions under which an insurer is permitted to advance the retroactive date of a claims-made policy.
- Providing an optional endorsement that will allow insurers to reinstate a policy's aggregate limits when the policyholder buys the optional tail coverage. These new limits, however, would not apply to occurrences reported during the policy period.
- Providing rating guidelines for the tail endorsement based on the various sublines of coverage, such as products/completed operations or personal and advertising injury, and the number of years a policyholder has had claims-made coverage.

These policy revisions were sketched out at a Sept. 30 meeting between ISO officials and insurance commissioners from Illinois, New York, Connecticut and Nebraska and at an Oct. 1 meeting between ISO and members of the National Assn. of Professional Insurance Agents and the Independent Insurance Agents of America.

RIMS had met previously with ISO to discuss its concerns.

One of the major concerns of these groups was the trigger of coverage provided under the claims-made form.

As currently filed with state insurance departments, coverage under the claims-made policy can only be triggered when a written claim for damages is made against the policy by a claimant.

However, the contract requires policyholders to notify their insurer of all incidents that may result in a claim.

Buyers and agents argued that under this coverage trigger, insurers would be free to cancel the policy or exclude a particular incident from coverage using a so-called laser endorsement before any claims stemming from the announced incident were filed in writing.

This would force the policyholder to purchase extended reporting period or tail coverage at up to 200% of the original policy premium to cover such claims or go without coverage.

The revisions announced by ISO address this concern in two ways. The requirement that claims be submitted in writing will be dropped from the claims-made policy. The revised policy language will allow a verbal claim against the policy to trigger coverage. This, according to agents, is more in line with the way in which 95% of all claims are made.

Forcing the public to file a claim in writing is simply inviting litigation, the agents contend, because most claimants will seek the services of an attorney when they are told they must put their claim in writing.

The revisions also provide an automatic, five-year extended reporting period for all occurrences reported to the insurer during the policy period, provided the occurrence took place after the policy's retroactive date.

ISO says this removes the incentive for an unscrupulous insurer to attempt to exclude coverage for a reported occurrence by using a laser endorsement, canceling the policy or advancing the retroactive date at renewal past the date of the occurrence.

Such actions would prove ineffective in eliminating coverage for the occurrence because every policyholder would automatically have coverage for occurrences reported during the policy period, provided the claims are filed within five years of the termination of the policy.

However, this automatic tail coverage does not apply if other insurance is in place to cover the claim or if the aggregate policy limits are exhausted.

In most cases, ISO officials explain, this automatic tail will not be necessary, because claims would be picked up by the policyholder's current claims-made policy.

The automatic tail would only become important if the policyholder goes out of business and therefore does not purchase new insurance or if the retroactive date is advanced and the policyholder chooses not to buy the unlimited, optional tail coverage provided under the claims-made policy, ISO says.

The new policy revisions also make it much more difficult for an insurer to advance a policy's retroactive date. ISO says it will change the manual rules to specify that an insurer may advance the retroactive date only under four specific circumstances:

- When a policyholder changes insurers.
- When the policyholder changes operations in such a way as to present a substantial new hazard.
- If the policyholder fails to disclose information about his operations that would materially affect the risk.
- When both the policyholder and insurer agree to the change.

ISO officials contend this change responds directly to concerns raised by buyers and agents that an insurer would advance the retroactive date on a claims-made policy to force the policyholder to purchase extended reporting period coverage to prevent any gaps in coverage.

ISO also responded to a related concern that insurers would routinely charge 200% of the expiring policy's original premium for the tail coverage. The 200% figure was designed to be the maximum cost of the tail coverage, ISO officials say, but buyers and brokers feared it would become the accepted standard premium, regardless of the aggregate limits remaining in the policy.

ISO now plans to provide rating guidelines for the tail endorsement, based on the sublines of coverage and the number of years a policyholder has had claims-made coverage.

Such guidelines will bring the price of the tail in line with expected claims, ISO officials say. However, the guidelines, which will take the form of a matrix, will not factor in the aggregate limits remaining in the policy, they add.

In a somewhat unexpected move, ISO also decided to offer an optional endorsement that would allow the reinstatement of a policy's aggregate limits when the optional extended reporting period or

Continued on next page

Continued from previous page
tail coverage is purchased.

Buyers and agents have repeatedly voiced their concern that tail coverage is of little value if an insured has nearly exhausted aggregate limits of a policy.

The new endorsement would effectively eliminate this problem, but only for claims arising out of occurrences unknown and unreported when the endorsement takes effect. The reinstated aggregate limits would not apply to reported occurrences.

Bill Blick, assistant treasurer and corporate risk manager for Allen Group Inc. in Mellville, N.Y., and chairman of RIMS' ISO liaison committee, says that while ISO's revisions do address some of the concerns raised by buyers, "I have not changed my opinion that the occurrence policy can be modified to be acceptable to all segments of the insurance community."

Generally, Mr. Blick says ISO's latest revisions in the claims-made policy fail to address the problem of unknown incidents that result in future claims. "All these revisions refer to incidents known and reported," he maintains.

He also says the restrictions on when an insurer can advance the retroactive date of a claims-made policy fall short of answering buyers' concerns.

Because the changing of insurers is one of the authorized reasons for advancing the retroactive date of a policy, buyers' fear that they will be locked into one insurer unless they are willing to purchase expensive tail coverage for unknown incidents is not alleviated, he said.

"I applaud ISO for starting to recognize they need to do something," said RIMS President Richard Hackenburg, staff vp and assistant treasurer at Allegheny International Inc., who heard about the changes while attending an international risk management conference in Monte Carlo last week and had not seen official notice of the changes.

But like Mr. Blick, Mr. Hackenburg still is opposed to the claims-made form replacing occurrence coverage.

"Why can't we take the occurrence form, modify it so you don't stack limits and clean up the issue of sudden and accidental pollution?" he asked.

"We ought to get the lawyers and judiciary to help us so we can achieve a clear understanding of what the words mean for one solid contract for all insureds."

Mr. Hackenburg also does not believe the new revisions will eliminate situations in which a buyer is locked into one insurer because of the threat of the creation of a coverage gap or being forced to buy tail coverage if the buyer changes insurers and the retroactive date is advanced.

RIMS' Mr. Harkavy adds that while ISO has attempted to improve the trigger of coverage under the claims-made policy, the recent revisions still fail to address the basic question of what constitutes notification of an occurrence.

"What happens if 10 or 11 months into the policy, I inform the insurer that I just manufactured defective widgets and that claims could arise from those defective widgets?" Mr. Harkavy asks. "Does that constitute an occurrence and trigger coverage under the automatic tail provision?"

However, ISO officials are hopeful that the latest revision of the claims-made form will answer the concerns raised by regulators, buyers and agents and get the state approval process back on track.

The approval process slowed down over the summer when buyers and agents succeeded in getting regulators to focus their attention on perceived problems in the claims-made form.

"It is a fact that our claims-made policy, at this stage, is approved in only 27 jurisdictions, and very few major ones," ISO President Daniel J. McNamara told participants at last week's conference of the National Assn. of Casualty & Surety Agents and the National Assn. of Casualty & Surety Executives.

"It is also a fact that we in no way are going to change the advisory effective date of Jan. 1, 1986," he added. "While we have not yet met every real or perceived regulatory concern, we have walked the extra mile to meet the interests of the regulators."

Mr. McNamara added that he is hopeful regulators will approve the new forms after the revisions are explained to them Oct. 17 and that agents and brokers now will support the form.

"I am hopeful that what we have done will meet with prompt regulatory approval and endorsement by producer forces, and will prompt utilization over time by insurers."

However, RIMS' Mr. Hackenburg and others do not believe a Jan. 1 implementation date is feasible for the new CGL forms.

"They're never going to get 1-1-86," Mr. Harkavy said. "It is impossible. People aren't going to be educated; the intermediaries can't represent the policy to clients.

"The industry can't respond to the need of consumers if it insists on putting in a program before it can be understood and implemented properly. It is craziness."

The Independent Insurance Agents of America, which likely will endorse the new forms, also plans to ask insurers and reinsurers to back off from the Jan. 1 implementation date, said C. Courtney Wood, a vp with Marsh & McLennan Inc. in Oklahoma City and a member of the IIAA's commercial lines committee.

But, he does concede that the new forms are a significant step forward. "I feel much more disposed to say this form will (now) fly."

While RIMS still hopes to negotiate more changes with ISO, the National Assn. of Professional Insurance Agents, which has not yet announced its position on the revised form, does not believe ISO will make any more changes.

"ISO has made it clear that while Christmas came early this year, it still comes but once a year," says Patricia Borowski, the PIA's vp of government and industry affairs. "We've got to make a decision now one way or the other" to support or oppose the claims made policy, she says.

The executive committee of the PIA plans to meet Oct. 26 to develop a position on the ISO revisions.

Also contributing to this report were Editor Kathryn J. McIntyre from Monte Carlo and Associate Editor Linda J. Collins from White Sulphur Springs, W.Va.

opinions

Jan. 1 is just too soon

WHILE WE UNDERSTAND the pressure on insurers from the reinsurance community to adopt a claims-made liability form and the insurers' own eagerness to introduce a policy form that will let them properly price the liability coverages they write, the implementation date for the new commercial general liability forms cannot be Jan. 1, 1986.

If the forms are to be introduced in an orderly fashion by insurers that have upgraded their computer systems to process policies written under the new forms and trained their underwriting and claims staffs in the intricacies of the new forms, the implementation date cannot be Jan. 1.

If policyholders are to be fully informed of the dramatic changes in their liability coverage by well-trained agents and brokers before the new forms are used, the implementation date cannot be Jan. 1.

If umbrella insurers are to be ready with a product that meshes well with the new primary CGL forms, the implementation date cannot be Jan. 1.

The Insurance Services Office last week—after much pressure from buyers, agents and regulators—introduced several significant changes to the claims-made form, less than three months before the date it wants to start using the new form.

In sticking to its Jan. 1 implementation date, ISO is assuming that these most recent changes will satisfy buyers', agents' and regulators' concerns.

That is a big assumption on ISO's part.

As Los Angeles Bureau Chief Robert A. Finlayson reports this week, all these groups are scrutinizing the newest changes to the form, and some already have scheduled further discussions with ISO.

But, even if there were no more debate over the forms, is it realistic to believe that insurers' computers and staffs will be ready in 2½ months to implement policy wording that has not yet been finalized by ISO? That brokers will be trained? And, that the forms will be approved by insurance regulators in all states?

We think not.

We find it objectionable that ISO could wait until less than three months before the targeted implementation date of the new forms to respond to major concerns expressed by buyers and brokers for the last several months.

But, since it did, ISO should be prepared also to postpone the implementation date of the new forms—if it is interested in an effective and smooth introduction of the most significant liability policy changes in history.

We believe insurers and brokers need at least six months to prepare for the transition to the new policy forms—once the final forms are agreed on.

All things considered, we don't see how the new forms could be introduced before July 1, 1986, at the earliest.

ISO would be wise to consider all things, too.

letters

Insurance prices controlled by underwriter, not agent

To the editor: The article "Market turn differs from previous cycles" (*BI*, Sept. 9), written by Michael Bradford, was thought-provoking and well-written. It brought out many issues that make this cycle different from those of the past and should give the entire industry cause for concern.

I could not, however, help being struck by the remarks attributed to David Seifer, vp at First Boston Corp., specifically his audacious, erroneous statement that, "As everyone knows, the agent represents himself first and the customer second." Perhaps it's the striking verbiage, but I not only disagree with that remark, I take umbrage!

Mr. Seifer goes on to say, "The key thing is, most of the time, the agents control the business and the companies don't. We just watched a cycle where the agents held up the companies, played them one against the other. . . ." Again, the verbiage is strong and misleading.

It must first be remembered that an agent, who is really a broker if he is doing his job, is obligated to provide the finest combination of coverage and cost for his client. It is ludicrous to elevate the agent to the exalted position of being able to dictate, individually or collectively, price and coverage to a professional underwriter.

While I agree that there are several sides to this story, and that the insurance companies are not alone responsible for the recent soft market that grew beyond reasonableness, I have never encountered the theory, even by implication, that the agent was somehow the root cause of the problem; and if he were, it certainly would not be a case of representing "himself first and the customer second."

Playing one company against another is counterproductive to an agent's best interest in both maintaining relationships and making a profit. I draw a clear distinction between an agent's appointed duty to foster competitive zeal among underwriters on behalf of the client he represents and playing them "one against the other."

Let me state the issue succinctly: The agent's or broker's job is to provide the finest reasonable combination of coverage and cost for his client, who happens to be the insurance buyer—all done within the framework and confines of the insurance bargaining and delivery system. All three entities—the underwriter, the agent and the client—have a hand in determining the conditions of the playing field, but it is the underwriter whose presence is most exalted. And this is as it should be!

Richard B. Willis Jr.
Senior Vp
Johnson, Kendall & Johnson Inc.
Langhorne, Pa.

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Various tax rules govern Far East pension plans

To the editor: S. Robert Beane's Perspective article "Far East pension programs vary" (*BI*, Sept. 9) pointed out the growing pension market in the Far East.

However, I want to point out that in Taiwan, for retirement plans funded via the book-reserve method, the maximum tax deductibility is only 4% of payroll. Only plans with external funding are allowed a tax deduction up to 8% of payroll.

Secondly, the new Labor Standards Law mandates the external funding of the retirement plans with "a financial institution designated jointly by the central competent authority and the Ministry of Finance." There is no requirement for funding the termination indemnities externally.

Finally, in Thailand, the government passed a law in January 1984 granting tax-exempt status to employer contributions to defined contribution plans (Provident Fund plans).

Arthur Koo
Vp-Group Insurance
American International
Assurance Co. Ltd.
New York

PBGC flat premium really a tax, reader says

To the editor: Bravo to Kathleen P. Utgoff, executive director of the Pension Benefit Guaranty Corp., for endorsing the concept of risk-related premiums (*BI*, Sept. 16). To continue the current flat premium arrangement is merely a tax, and a regressive one at that.

I suggest a low uniform premium (such as $1) with an additional premium to be assessed according to risk. However, there should be some incentive to avoid this additional premium. For example, if the sponsor makes a contribution on the ERISA-maximum basis, the additional risk premium could be waived. Thus, the sponsor's funds would be put to the best use; that is, funding of the plan.

There are methods for accomplishing such a risk premium and incentive. The important aspect is the philosophy that such premiums and incentives exist.

David Rigby
Administrative Consultant
Retirement and Stock Plans
Contel Service Corp.
Atlanta

IRS stance on participating annuities explained

To the editor: I agree that participating annuities could be a viable solution to the capacity crunch life insurance companies face because of the increase in pension plan terminations, as noted in the article "Plan Terminations Spark Capacity Concerns" (*BI*, Sept. 23). While your article is correct in pointing out that the Pension Benefit Guaranty Corp. has approved these annuities, the article neglected to mention that the Internal Revenue Service has reservations and has, in fact, put a hold on plan terminations involving participating annuities.

It is unfortunate that employers face this inter-agency conflict. Hopefully, the IRS and PBGC will agree on a joint policy that is acceptable to all parties.

Thomas D. Ucko
Manager of Technical Analysis
Frank B. Hall Consulting Co.
Briarcliff Manor, N.Y.

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More municipalities seeking outside counsel: Attorney

By MEG FLETCHER

CHICAGO—Many local governments are encountering increasing difficulties handling complicated litigation without the aid of outside counsel, according to a former city attorney for Richmond, Va.

"There is an increasing need for outside counsel in today's city attorney's office," said William H. Hefty at a seminar sponsored recently in Chicago by The Defense Research Institute Inc.

Usually, a local government's legal staff is neither large enough nor experienced enough to cope with complex litigation involving antitrust issues, securities law, technical environmental requirements, mass tort and class-action employment suits, Mr. Hefty said.

Yet, local government attorneys can save taxpayers money by doing as much basic litigation as possible in-house, he said. As their expertise grows, many local government legal officers are negotiating with insurance companies to allow their offices to represent the local government policyholder. he said.

"This is being done either for a reduced premium, with the local government attorney providing the defense at no charge, or by the local government attorney charging a relatively low hourly fee for the defense," he said.

Still, in many cases the insurer wishes to have outside counsel represent the policyholder, Mr. Hefty said.

In addition, conflicts of interest may make it impossible for a local government's attorney to represent all defendants in a particular case.

That was the situation Mr. Hefty faced as city attorney for Richmond, when the city was sued for $240 million in 1981 for allegedly violating antitrust and civil rights laws by denying a developer's zoning request.

Richmond Hilton Associates sued after city officials voted 5-4 to deny the developer permission to build a franchise hotel. Permission was denied because the new hotel would compete with a hotel that officials had earlier approved as part of a city-sponsored downtown renovation plan, Mr. Hefty said.

Richmond paid $1.3 million for outside attorneys' services in the case, which was settled in 1983, Mr. Hefty said. At that time, the city approved the developer's zoning request and loaned him $4.5 million, which the plaintiff had to match 50 cents on the dollar.

The loans and the developer's contribution had to be invested in the downtown area, Mr. Hefty said.

"We spent much more time in the Hilton case on who defends whom than on the antitrust issue," he said.

Three important questions emerged during the case:

- How should the conflict between representation of the individual defendants and the city be handled?

"Conflicts of interest. . .may make it impossible for the local government attorney's office to represent all defendants in a particular case," he said. That is because lawsuits alleging violations of civil rights may be brought against the municipality and public officials or against employees as both public and private persons.

"Courts have recognized that there is a conflict of interest where the government is arguing that there is no official custom, policy or practice which the employee, such as the policeman, was following when the alleged act occurred, even though the government may admit that the employee was acting within the scope of his employment," he said.

To avoid liability, a local government often argues that the litigated act is not in accord with a local policy. On the other hand, the individual defendant usually argues the opposite, he said.

"In these cases, outside counsel may be used to represent some or all of the defendants, to serve as settlement counsel or simply to give advice as to the conflict issue," Mr. Hefty said.

- How many lawyers should there be?

The defense was simplified in the Richmond case because all elected officials were represented by the same law firm, Mr. Hefty said.

However, if these officials had hired individual attorneys, some of those lawyers may have argued that the city or other city officials acted wrongly, which would have fragmented the defense, he said.

Depending on a city's coverage, an insurer could be required to provide each public official with his or her own attorney, he said.

That situation can provide a useful bargaining chip in negotiating with an insurer, Mr. Hefty and other conference speakers agreed. If a city attorney can persuade defendants to agree to a single defense attorney, he may be able to get the insurer to waive any reservation of rights.

Continued on page 12

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Outside counsel

Continued from page 10

Before consolidating the defense, it is essential to obtain waivers from the public officials or employees involved, Mr. Hefty said. He suggested a city attorney call in an outside attorney to discuss this with the individuals so the city attorney does not put himself in legal jeopardy.

● Who should pick the lawyers?

Insurers may dictate who the lawyers will be.

However, when an individual's attorney expense may be borne by a local government, allowing an individual defendant to choose his attorney is inefficient. It also does not guarantee that the attorney will have the needed expertise in civil rights litigation, Mr. Hefty said.

Mr. Hefty chose the attorneys in the Richmond case, with council members' approval. Although his authority to do so was challenged, it was upheld on appeal, he said.

Mr. Hefty said one option is to let an employee named in the suit choose an attorney from a list.

The defense situation was complicated by the board's split vote in the Richmond case. The five officials who opposed the rezoning were pitted against the four who would have approved it.

However, the composition of the council changed during the lawsuit. Persons sympathetic to the council members who voted against the rezoning became the majority. As a result, one outside law firm was fired and another was hired, he said.

An "interesting" way to get around the question of who should select the attorneys to be used is to allow each employee who is a party to a suit to choose an attorney from a list of three, Mr. Hefty said. This approach was upheld earlier this year by the 2nd U.S. Circuit Court of Appeals in *Suffolk County Patrolmen's Benevolent Assn. Inc. vs. County of Suffolk*, he added.

In dealing with outside counsel, the local government needs to keep control of the case by requiring briefings and receiving copies of all pleadings.

It is also important to clearly delineate fee arrangements and mesh them with the local government attorney's budgetary process so bills are presented before allocated funds revert to the general budget fund. ■

Employee reports are sticky issue

CHICAGO—Some risk managers may be going too far to preserve the confidentiality of employee reports on potentially loss-causing events, defense attorneys warn.

Some risk managers ask employees to submit accident reports in a letter to the employer's attorney. The idea is to cloak that report with attorney-client privilege and prevent a plaintiff's attorney from later having access to it.

However, a judge would probably rule such an effort a "sham," said Robert W. Fioretti, senior attorney and supervisor in the general litigation division of Chicago's corporation counsel's office. Mr. Fioretti participated in a conference in Chicago last month sponsored by The Defense Research Institute Inc.

After a few cases like that, the employer's attorney may be facing charges of conspiracy and have to hire an attorney to defend himself, added Joseph D. McDevitt, an attorney with the firm of Borgelt, Powell, Peterson & Frauen, S.C., in Milwaukee.

Eliminating as much paperwork as possible is better than trying to hide it, Mr. McDevitt explained.

Employees should be trained to write only objective comments in reports, because subjective comments often create problems in liability cases, he added.

Reports should be open because the long-term effects of covering up a law enforcement officer's inappropriate actions, for example, would be worse, said Eugene F. Pigott, county attorney for Erie County, N.Y., in Buffalo.

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N.Y. county bullish on cutting claim costs

By MEG FLETCHER

CHICAGO—A New York county government is facing reduced liability exposures and claims costs because of the aggressive use of risk management techniques and other cost-cutting practices, the county attorney says.

Erie County, which spends about $700 million annually to provide services for 1 million residents, faces liability exposures for such diverse risks as recreational facilities to 1,000 miles of roads, says County Attorney Eugene F. Pigott Jr.

The county is also responsible for a public hospital, a convention center and a professional football stadium in Buffalo, Mr. Pigott told participants recently at a seminar sponsored by The Defense Research Institute Inc. in Chicago.

Among the techniques and practices the county uses to hold down liability exposures and claims costs are:

- Handling liability claims in-house.

More and more cases are being handled in-house because the county found that outside counsel lacked the necessary expertise to properly defend the county on a cost-efficient basis, Mr. Pigott said.

"The county made the determined effort to gradually wean itself away from the use of outside counsel, first with respect to the more straightforward cases, and leaving for the last the complex medical malpractice claims and multidefendant general liability claims," Mr. Pigott said in his written presentation.

"In addition, more attoneys were hired on a gradual basis to assume more and more of these duties as they were brought inside."

The county attorney's office can defend claims against the county with little interference from liability underwriters because the county in 1978 established a funded, self-insurance program for its automobile, general liability and medical malpractice claims.

Although the county had initially supplemented the self-insured program with the purchase of umbrella liability coverage, it decided during the current tight market to become totally self-insured, said Mr. Pigott.

The county attorney's office has "broad" discretion to settle any claims brought against the county, he said. His office can settle most cases independently. However, he must notify the county budget office of any settlement in excess of $25,000 and receive approval from the county executive to settle claims in excess of $100,000, he said.

- Limiting liability for contracted services.

The county has been a "bully" about protecting itself by limiting its liability for contracted services, Mr. Pigott said.

Erie County requires any contractor wanting to do business with it to certify that it meets the county's minimum insurance requirements.

In addition, all county contracts provide that the contractor will "hold harmless, indemnify, defend and pay any judgment" for any action arising out of the contract.

However, the tight insurance market has made it difficult for some contractors and other municipalities, which plow some Erie County roads, to find insurance. Under certain circumstances, the county attorney's office will waive insurance certification requirements for such a contractor, Mr. Pigott said.

- Controlling risks.

A risk management specialist operates out of the county attorney's office, Mr. Pigott explains. The specialist assigns risk management duties to designated individuals within each department that has major liability exposures.

Incident reports are filed on a form prepared by the county's law department, Mr. Pigott adds. Potentially serious claims are reviewed weekly by investigators from the county attorney's office.

Minor incidents may result in a "no-fault" form being sent to the claimant to fill out and return for routine handling. That type of expeditious handling would be used if, for example, a few motorists complained that loose stones at a county road construction site bounced up and cracked their windshields, he said.

"We are very sensitive to the needs of our citizens in that regard," Mr. Pigott said.

But the risk management process wouldn't end with payment of the claim. The road crew would

Continued on next page

Lawyers' group holds seminar

CHICAGO—About 50 people attended a seminar on defending liability suits against government entities, held Sept. 26-27 at the Knickerbocker Hotel in Chicago.

The seminar was sponsored by The Defense Research Institute Inc., a Chicago-based national organization for defense attorneys.

Upcoming conferences to be sponsored by DRI include seminars on asbestos, equal employment law, workers compensation, toxic waste, bad faith, trial tactics, product liability, medical malpractice and drug liability.

For more information, contact The Defense Research Institute Inc., 750 N. Lake Shore Drive, Suite 5000, Chicago, Ill. 60611; 312-944-0575.

Continued from previous page
be contacted about the damage complaints to prevent future losses.

- Handling lawsuits.

A New York state law makes the county attorney's job easier by requiring that anyone suing a municipality must file a notice of claim within 90 days of the accident describing the incident and the plaintiff's alleged injuries, he said.

The law also allows the county attorney to depose the claimant soon afterwards and require him or her to submit to a medical examination.

The county attorney's office also defends the county's public hospital for all claims, except those in which a private patient sues a doctor. However, the county attorney sometimes encounters difficulties determining whether or not the patient is a private, fee-paying one, Mr. Pigott said. It also is determined whether a conflict of interest exists in cases when the county attorney's office is defending a doctor and the hospital. Outside counsel is appointed as needed.

- Paying judgments.

Mr. Pigott said the county has used structured settlements in which it purchases annuities from commercial insurers to pay judgments, whenever possible

The county also may be able to "self-structure" settlements because of its bonding capability, but has not done so, he added. ■

High court bucks precedent in municipal antitrust ruling

By MEG FLETCHER

CHICAGO—A U.S. Supreme Court ruling that "substantially liberalized" the ability of municipalities to restrict competition and still escape liability in antitrust suits may be short-lived, according to a legal expert.

"The pendulum is going to swing back in the direction from which it has come," said Stanley M. Lipnick, an attorney with Arnstein, Gluck, Lehr, Barron & Milligan in Chicago.

Mr. Lipnick predicted the reversal during a seminar sponsored in Chicago by The Defense Research Institute Inc., a Chicago-based organization for defense attorneys. His projection is based on previous antitrust actions against municipalities where lower courts have ruled very differently in cases involving similar facts.

Before the high court's ruling, plaintiffs had successfully challenged the authority of municipalities to deny access to municipal services, grant cable television franchises, require Sunday closings of businesses and implement zoning restrictions, he said.

But, the Supreme Court's ruling earlier this year in *Town of Hallie vs. City of Eau Claire* (Wisconsin) altered that precedent. The case concerned a municipality that constructed sewage treatment facilities but refused to serve nearby towns unless they agreed to be annexed by the municipality.

"State statutes authorized the municipality to construct the facilities and to determine the areas to be served by them, implicitly authorizing refusals to serve certain areas," Mr. Lipnick said.

Because of that implicit authorization, the court said, a municipality claiming a "state action" exemption does not have to show that state law requires its anti-competitive conduct or that the state supervises that conduct, he added.

Mr. Lipnick said the ruling modified law made in two earlier cases:

- In 1978, *City of Lafayette vs. Louisiana Power & Light Co.* determined that local governments do not have the same exemption from federal antitrust laws that states do.
- And, in 1982, *Community Communication Co. Inc. vs. City of Boulder* (Colorado) held that political subdivisions of a state enjoy the state's federal antitrust exemption only if they are following a specifically expressed state policy of displacing competition by regulation or by monopoly public service.

Such court interpretations led to, among other things, a $9.5 million antitrust judgment—later tripled to $28.5 million under then-current antitrust laws—against Grayslake, Ill. in 1984. Here, the city had denied a sewer tie-in to a developer (*BI*, July 1; Aug. 13, 1984).

That verdict prompted the filing of about 200 antitrust cases against municipalities nationwide, Mr. Lipnick said. It also prompted municipalities to urgently appeal for federal statutory relief.

The federal Local Government Antitrust Act of 1984 conferred partial immunity for local governments and their officials and employees and exempted them from triple damages in future cases.

However, the prohibition against triple damages applies only to cases filed after the law took effect on Sept. 25, 1984, unless a defendant convinces the court that it would be inequitable not to apply the law retroactively, Mr. Lipkin said.

And, there is a "clear" trend that courts are ruling favorably on municipal requests for retroactive application, he said.

Still, in antitrust actions against municipalities, courts have made very different decisions in cases with similar facts, he said.

That has raised "nagging" questions and uncertainty about an area of law where there exists "inherent tension between the antitrust goal of economic freedom and (the) regulation and exclusion of competitors through exercise of governmental functions such as licensing, zoning and franchising," he said.

Municipalities should be aware of rapid changes in court rulings in cases involving municipal antitrust issues and that there may be more in the future, he said.

Municipalities should be prepared to answer antitrust charges, he said. "The best thing that a city can do to defend itself is to have some real governmental rationale for its action," he said. ■

System forecasts, analyzes comp losses for self-insurers

products & services

California Interactive Computing Inc. is offering a loss-forecasting and analysis system to companies that self-insure or self-administer their workers compensation or property/casualty insurance programs.

The system, called FORECAST PLUS, provides forecasts of ultimate aggregate losses by insurance layer and predicts when losses will be paid or reported. It can analyze losses in terms of exposures, like the number of employees or amount of merchandise sold, and identify loss trends that may suggest changes in claims administration practices.

The system was developed by Risk Management Inc., a subsidiary of broker Emett & Chandler Cos. Inc., and is being marketed, installed and supported by North Hollywood, Calif.-based California Interactive Computing

Run off a mainframe computer, the system can be used as a stand-alone system or with CIC's claims and data base management system.

The cost of the system varies with how the system is used, a CIC spokesman said.

For more information, contact Gary Smart, California Interactive Computing Inc., 12517 Chandler Blvd., North Hollywood, Calif. 91607; 818-985-2680.

Nurses' legal issues

Nurses have not escaped unscathed from the recent move toward liability suits. In fact, many nurses are increasingly concerned about their legal rights and responsibilities in the current health care delivery system.

The Virginia Hospital Research and Education Foundation and the Virginia Insurance Reciprocal are offering a 17-minute videotape presentation called, "Legal Issues for Nurses. . .A Case Study."

The video, which consists of several vignettes, covers a variety of legal issues concerning nurses, including consent, negligence, responsibility for actions of supervisors, physicians' orders, administering medications and documentation.

The videotape is available in ½-inch or ¾-inch tape, and comes with a discussion leader's guide and a participant's training guide.

The package costs $350, including shipping. Order from Carrol B. Longest-Gray, Virginia Hospital Research & Education Foundation, P.O. Box 31394, Richmond, Va. 23294; 804-747-8600, ext. 213 or 280.

Punitive damages

Both plaintiffs' and defendants' lawyers may find what they are looking for in "Punitive Damages: Law and Practice," published by Callaghan & Co. in Wilmette, Ill.

The two-volume set covers background and current elements of punitive damage law and precedent-setting cases. Specific topics covered include:

- State-specific discussions of punitive damage laws nationwide.
- Analysis of a variety of cases.
- An in-depth examination of punitive damage insurance policies.
- Pleading forms in three major areas: product liability, bad faith and intentional torts.
- Practical suggestions about presenting proof, evidence, precedents, etc.

"Punitive Damages" is written by James D. Ghiardi and John J. Kircher, both law professors at Marquette University Law School.

The two-volume set is available for $116 from Callaghan & Co., 3201 Old Glenview Road, Wilmette, Ill. 60091; 800-323-1336; 800-624-8525 in Illinois. ■

Product liability suits in federal courts rise

The number of product liability suits filed in federal courts around the country is rising.

Product liability complaints filed in federal courts increased 26.1% in fiscal 1985 compared with fiscal 1984, according to statistics compiled by the Administrative Office of the U.S. Courts in Washington.

Some 13,554 product liability suits were filed in fiscal 1985, which ended June 30, compared with 10,745 suits in fiscal 1984.

The states with the most federal product liability suits filed in 1985 are: Texas, 1,485 cases, up 62.1% from 916 in fiscal 1984; Massachusetts, 1,216 cases, up 47.4% from 825; Ohio, 1,018 cases, up 51.7% from 671; Pennsylvania, 908 cases, up 3.9% from 874; and Mississippi, 787 cases, up 10.4% from 713.

Wyoming had the fewest product liability cases—12—filed in 1985. ■

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Benefits network

Continued from page 3

they access it," Mr. Quinn said.

About 50 companies and organizations nationwide currently have access to the network, and the number "has been growing weekly," Mr. Quinn said.

Among the users are the Employee Benefits Research Institute, an employee benefits think tank in Washington, and the U.S. Department of Health and Human Services, he said.

Mr. Quinn said he receives 15 to 20 requests a week for information about the EBIN.

However, he said, "Many companies don't have all the equipment they need," he said. "They don't have a modem or a PC and they re trying to get approval for one."

The network, which is edited by Mr. Quinn and an associate writer, consists of nine separate bulletin boards: Research and Studies; Upcoming Conferences; Employer's Health Benefits Newsletter Summary; HOTOPICS—Employee Benefit Innovation Summary; Consultants Corner; New Products and Services; Health Care Cost-Containment Issues: Regulation and Federal Legislation; and the User Message Board, which allows users to communicate with each other by asking questions and leaving answers or messages on the bulletin board.

'Oftentimes, I don't have the time to read a whole article in a paper, but it's easy for me to scan the information on my computer,' says Charles Miracola of Public Service Electric & Gas Co.

The network's information comes from a variety of sources, including articles in daily newspapers and trade publications; reports from insurance companies; newsletters from employee benefit consultants, and information gathered by EBRI and the Department of Health and Human Services.

Two of the bulletin boards—Employers Health Benefits Newsletter and HOTOPICS—are summaries of the two newsletters published by Personnel Research.

The brevity of the items is one of the system s advantages, Mr. Quinn said.

"It's kept purposely small so people can scan the system in a short period of time and print out whatever they want," Mr. Quinn said.

"The material is constantly changing. When it becomes old or has been accessed by most people, we delete it. And, we add something new almost every day," he explained.

The 50 users, most of whom are non-corporate entities such as research institutes and information clearinghouses, use the network in varying amounts.

"Some of them call the computer every couple of weeks, some of them call twice a week," Mr. Quinn said.

To gain access to the network, a user simply inputs his or her password into the computer and selects a bulletin board. The computer responds with a list of summaries of recent information on the topic the user has chosen.

To save time, the user can ask the computer to list only those items that he or she has not previously reviewed, according to Mr. Quinn.

Public Service Electric & Gas has used EBIN since mid-July "basically to try to get as much benefits information as soon as possible," said Charles Miracola, senior employee benefits representative for the utility.

"Oftentimes, I don't have the time to read a whole article in a paper, but it's easy for me to scan the information on my computer," he said. "Most of my work is done on a personal computer anyway, so it is easy for me to scan the system to see what's new while I'm working on it."

The utility company's headquarters and its Salem, N.J., office both have access to the network through IBM Personal Computers.

Mr. Miracola said he uses the system two or three days a week, adding that he would like to have more access.

"I would like to see it (accessible) more often, especially on Mondays, being the first day after the weekend," he said. "It saves me a lot of time, particularly when I have to look up statistics or studies. I can get up-to-date information very quickly without having to weed through piles of reports. I use all the bulletin boards quite a bit."

Before the company was linked to EBIN, Mr. Miracola said, he had to read four different benefits publications, the local newspapers, The Wall Street Journal and other periodicals to keep up with employee benefits developments.

"I still scan them, but I don't spend as much time on them as I normally would," he said.

The Nyhart Co. Inc., an employee benefits consulting company in Indianapolis, started using EBIN in early September. The company has about 1,000 clients, most of whom are located in the Midwest.

Nyhart is hoping the network will give it a jump on information —especially information on legislative developments—that it normally gets through regular mail.

"(We hope to) get information on what's being discussed earlier," said Daryl Dean, president of Nyhart. "It's a matter of speeding up the lobbying response, which we participate in" on behalf of the Assn. of Private Pension and Welfare Plans.

Mr. Dean is hoping the network, which all Nyhart employees may tap into using IBM Personal Computers, will streamline his review of all the benefit-related material he sees each week. But, he is reserving final judgment on the network for the moment.

"I probably have 100 to 150 pages of material weekly to scan," he said. "I'm still looking at what I used to look at and will continue to do so until this is proven."

But, he said, "the cost is minimal and my philosophy is the concept of the electronic bulletin board is long overdue."

Nyhart currently is training its employees to use the network, Mr. Dean said. In the meantime, each employee receives a printout once a week listing new items that were added to the network during the week.

"If they have further questions about the article, they can call up the summary and see if that article really covers the topic they're interested in, without having to go and hunt down the original source," Mr. Dean said.

So far, the company is using the system about two or three times a week, Mr. Dean said, adding that he expects usage to pick up as employees become more familiar with it.

"If it proves to be accurate and quicker, it'll get a lot more use in the future," he said.

However, Mr. Pear cautioned, "If it doesn't prove to be more accurate and quicker, it'll die on the vine."

For more information on EBIN, contact Mr. Quinn at Personnel Research Associates, 49 Oakridge Road, Verona, N.J. 07044; 201-239-6154. ■

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BI 10/85

UCCEL Corp. offers a flexible benefit plan

benefit beat

UCCEL Corp. in Dallas has introduced a flexible benefit package it hopes will better meet employees' benefit needs while containing benefit costs.

Currently, UCCEL pays $35 in benefits for every $100 it pays in salaries.

"We wanted to contain future costs, and we wanted an innovative benefits package to better meet employees' needs," said Stuart Gill, the computer software company's benefits manager.

The new program, called "UCCELECT," took effect earlier this year and covers UCCEL's 1,400 full-time employees. The program, which offers 83 possible coverage options, was designed with the help of two consultants: Hewitt Associates in Lincolnshire, Ill. and Towers, Perrin, Forster & Crosby in Dallas. Under UCCELECT, employees can choose from among the following:

- Two levels of traditional fee-for-service medical coverage.
- Health maintenance organizations in Dallas, Chicago and Minneapolis, which cover about 90% of UCCEL's employees.
- Two dental plans.
- Three levels of individual life insurance and two levels of dependent life insurance.
- Ten levels of accidental death and dismemberment coverage with employee and dependent options.
- Two levels of long-term disability coverage.
- A flexible spending account for medical expenses not covered under the employee's medical plan and for child care expenses.
- A 401(k) savings plan allowing pretax and aftertax investments with three investment vehicles and a company match.

UCCELECT provides a basic benefit package at no cost to employees. The basic insured benefits are individual medical, life and business travel accident insurance.

However, employees can "buy" other benefits with "selection dollars," which the company adds to the employees' bi-monthly paychecks. Employees also can use their selection dollars to make contributions to the 401(k) plan.

The amount of selection dollars an employee receives depends on his or her pay level and seniority.

If an employee's benefit choices cost more than he or she gets in benefits dollars, the employee pays the difference in pretax dollars; if the cost of the chosen benefits is less than the amount of selection dollars, the employee receives the difference in aftertax dollars.

Employees have three medical coverage options: the basic plan, the high-level plan and HMOs. The basic plan and the high-level plan are underwritten by Aetna Life Insurance Co. of Hartford, Conn.

The basic plan requires employees to pay a $500 individual and $1,000 family deductible and 30% of expenses above the deductible, up to an annual out-of-pocket maximum of $2,000 for individuals and $4,000 for family coverage.

The high-option plan provides coverage equivalent to UCCEL's previous medical plan, which also was underwritten by Aetna. The high-option plan requires employees to pay a $200 individual or $400 family deductible and 20% of expenses exceeding the deductible, up to an annual out-of-pocket maximum of $1,000 for individuals and $2,000 for family coverage.

Both plans waive the deductible and pay 100% of expenses for outpatient surgery, pre-admission testing and second surgical opinions.

Both plans also require employees to get a second, concurring opinion for 15 selected non-emergency surgical procedures. If the employee fails to do so, the plan only pays 50% of the surgeon's fee. It pays the regular reimbursement for hospital and other related fees.

Both plans also deny reimbursement for hospital expenses incurred on Fridays or Saturdays, except for emergency admissions.

And, both plans provide up to 120 days' coverage in an extended care facility and 30 days of hospice care or the cost of outpatient care for terminally ill participants, to a maximum of $3,000.

UCCEL pays the entire premium —$23.34 per pay period—for employees who select basic individual coverage. Employees who choose coverage for themselves and one dependent pay $12.46 each pay period; UCCEL contributes $40.72.

Employees who choose coverage for themselves and two or more dependents pay $18.46 per pay period; UCCEL pays $54.88.

Employees who select high-option individual coverage pay $4.61 per pay period; UCCEL pays $25.89 toward the coverage. Employees who select high-option coverage for themselves and one dependent pay $23.07; UCCEL pays $45.08.

Employees who select high-option coverage for themselves and two or more dependents pay $30; UCCEL contributes $65.79.

Previously, employees paid $56.75 for dependent health care coverage only, which included the cost of their dental coverage.

Employees in Dallas, Chicago and Minneapolis also may choose to enroll in one of five HMOs. The cost of each HMO varies, but UCCEL contributes the same amount toward HMO coverage as it does toward basic coverage.

Or, employees may waive medical coverage and receive $9.62 in selection dollars each pay period.

The flexible plan also offers employees individual or family dental coverage, neither of which is included in their basic benefits. Employee elections under the dental coverage are effective for two years. The dental coverage is underwritten by Aetna.

The dental options require a $50 annual deductible for individual coverage and a $100 deductible for family coverage. In addition, employees must pay 20% of their basic dental expenses, such as exams and cleanings, and 50% of major dental expenses, such as oral surgery.

The plan pays a maximum of $1,000 a year per participant.

The plan also requires employees to get pre-treatment review if the cost of a procedure is expected to exceed $150.

Employees who select individual dental coverage pay $1.38 per pay period; UCCEL contributes $2.78. Employees who select dental coverage for themselves and one family member pay $3.06; UCCEL pays $6.23. Employees who select dental coverage for themselves and two or more dependents pay $4.38; UCCEL pays $8.69.

Previously, dental care was covered under the medical plan.

Continued on next page

Continued from previous page

Under the UCCELECT program's basic benefits, employees receive $10,000 of life insurance, which is underwritten by Aetna.

Employees may choose supplemental individual life insurance options equal to one, two or three times their annual salary, rounded to the next-highest $1,000, up to $750,000. The cost depends on an employee's salary and age.

Employees also have two choices for dependent life insurance. The standard option provides $5,000 in insurance for spouses and $2,500 for each child. The high option provides $10,000 in life insurance for spouses and $5,000 for each child.

The cost of dependent life insurance is 55 cents each pay period for standard coverage and $1.10 each pay period for high-level coverage.

Previously, employees had company-provided life insurance equal to twice their salary, up to $150,000. The coverage was written by Aetna.

UCCELECT gives employees a choice of 10 levels of accidental death and dismemberment coverage, starting at $25,000 and increasing in $25,000 increments to $250,000. The cost of the coverage, underwritten by The Home Insurance Co. in New York, ranges from 34 cents to $3.46 per pay period.

Previously, the company provided AD&D coverage equal to twice an employee's salary, up to $50,000. Employees also could buy additional coverage in increments of $20,000, up to $100,000. The cost ranged from 96 cents to $4.80 a month, and Aetna Life underwrote that plan.

Employees also can select from a variety of options under dependent AD&D. The cost and the benefits depend on the specific items covered and the employee's family status. The cost ranges from 50 cents to $5.07 per pay period.

Previously, employees could purchase AD&D coverage for their spouse for $1.20 a month for $25,000 in coverage, and for children for 5 cents per child per month for $1,000 in coverage for each child.

Two levels of long-term disability coverage are available, and employees must choose one unless they have waived medical coverage. The LTD coverage is written by Union Mutual Life Insurance Co. of Portland, Maine.

The standard option provides a benefit equal to 50% of base pay, up to $7,000 a month. It starts after an employee has been disabled for 90 days and continues for up to 60 months, depending on age.

Previously, most employees paid 100% of the cost of LTD coverage, which was equal to the high-level coverage. The cost depended on the employee's salary. But, if the cost exceeded $15 a month, UCCEL paid the balance of the premium. That program also was underwritten by Union Mutual.

In addition to these insured benefits, UCCEL's new program offers employees a flexible spending account to pay for child care expenses and unreimbursable health care expenses. Employees can contribute from $130 to $3,000 a year to the account, but they must forfeit any unused contributions at the end of the year to comply with Internal Revenue Service requirements.

The flexible plan also offers a 401(k) savings plan, into which employees can deposit up to 10% of their pretax earnings and 10% of their aftertax earnings.

UCCEL matches the first 4% of earnings contributed on a pretax basis with 25 cents, 30 cents or 35 cents on the dollar, depending on the employee's years of service. Employees can choose from three investment vehicles.

UCCEL terminated its defined benefit pension plan and rolled over its accruals into employees' 401(k) plans.

The company also canceled its thrift savings plan, which allowed employees to contribute from 2% to 8% of aftertax pay. ■

washington

IRS dropping REA spousal consent rule

By JERRY GEISEL

WASHINGTON—The Internal Revenue Service says final regulations implementing the 1984 Retirement Equity Act will not require employees to get consent of their spouses before they can collect early retirement benefits.

The regulations will allow employees—without spousal consent—to retire early if they opt for an annuity that provides joint and survivor benefits, the IRS said in a recent news release.

The news release nullifies a much-criticized provision in temporary regulations issued by the IRS during the summer that said spousal consent was needed before employees could collect early retirement benefits (*BI*, Aug. 19).

The IRS said employers can rely on the news release in amending their plans.

Superfund extension

The House of Representatives has approved a 45-day extension of the federal Superfund law after congressional committees failed to act on a bigger reauthorization bill.

The extension was needed so the federal government can continue to collect taxes to pay for hazardous-waste cleanups.

The Senate has already passed a five-year $7.5 billion Superfund reauthorization bill (*BI*, Sept. 30), but several House committees still must act on pending proposals.

In addition, both the House and Senate have approved resolutions to continue the Federal Crime Insurance Program through Nov. 14. Statutory authority for that program expired on Sept. 30.

It isn't clear if Congress will continue the program beyond Nov. 14. The Senate wants to terminate the program, but the House is more inclined to a one-year extension, congressional committee staffers say.

The program provides federally subsidized coverage to 39,000 policyholders, about half of which are small employers in New York.

Meanwhile, the federal Overseas Private Investment Corp. is waiting for the Senate to pass a reauthorization bill so it can continue to write new political risk policies. OPIC's authority to write new policies expired Sept. 30. The House has already passed a reauthorization bill allowing OPIC to write policies for four more years.

OPIC says existing policies will remain in force and it will process applications.

Carbide fines

The Occupational Safety and Health Administration has proposed fining Union Carbide Corp. $32,100 for alleged safety violations at the company's pesticide producing plant in Institute, W.Va.

The proposed penalties result from an OSHA investigation of an Aug. 11 leak at the plant that left 141 people hospitalized, OSHA said.

OSHA said violations at the plant include:

- Failure to store in a control room a sufficient amount of emergency respiratory protective equipment. The equipment also was not quickly accessible to employees.
- Improper slicing and location of electrical cords.
- Engineering controls to prevent air contamination were not implemented.

Carbide will contest the penalties, a spokesman said. ■

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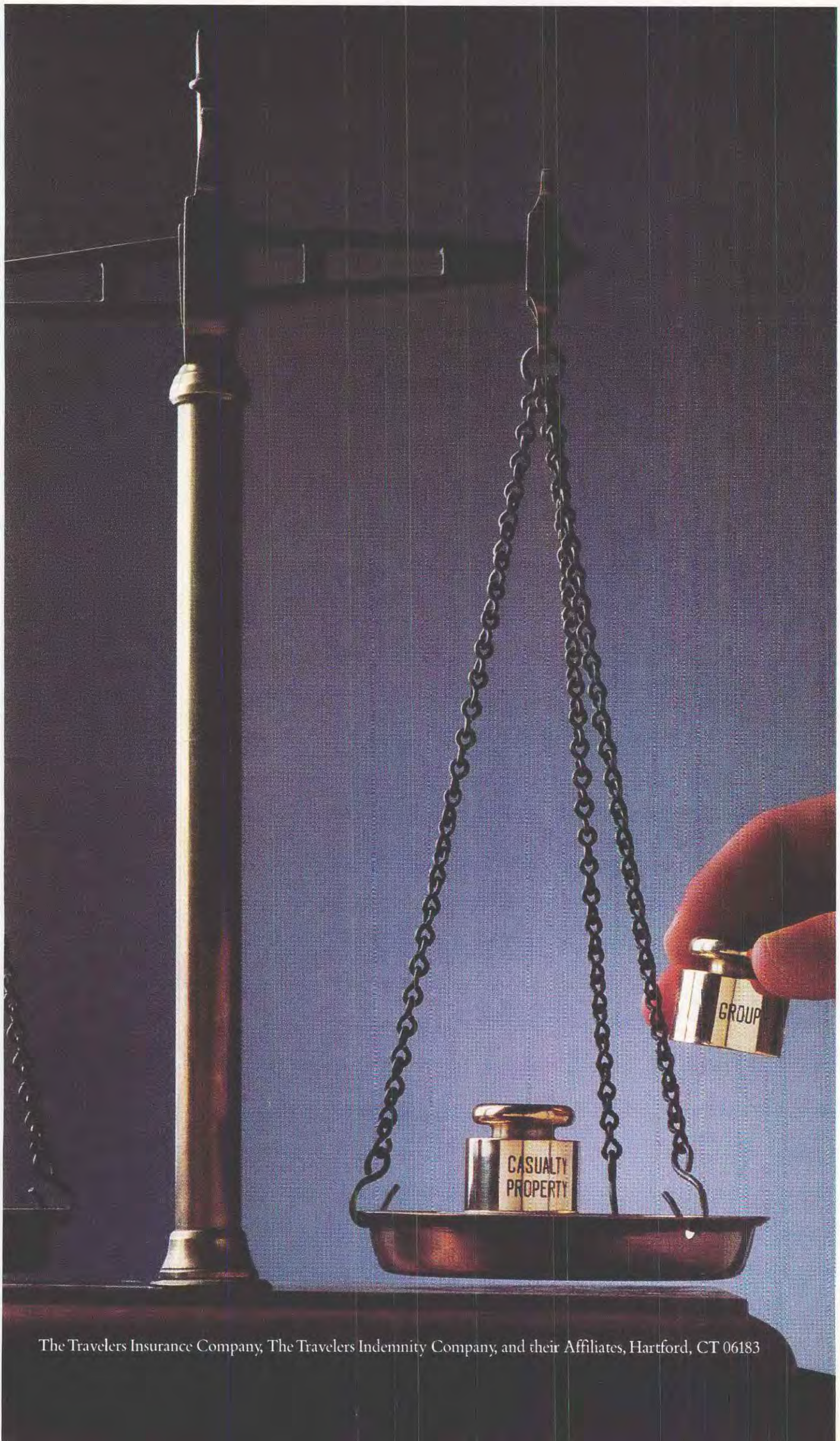

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WEIGHING CHOICES

Risk managers should use care in selecting a claims service

By Thomas S. Owens

WERE I TO BECOME the newly appointed casualty risk manager of a large corporation with multiple business locations nationwide, I would ask myself a number of questions at the outset of that job:

- Should I insure or self-insure the level of exposure within which expected losses are presumed to fall?
- How much risk, per occurrence and annually, can the corporation afford to retain?
- Would I be better off dealing directly with primary and/or excess insurers or would I do better retaining a broker?
- What organization is best positioned to provide casualty claims service? The options would be the claims facility of the insurer issuing the policies, some other insurer's claims facility, a nationally based independent claims service provider, a number of regional or local independent companies or internalizing some or all of the claims handling.

The answers to these basic questions are all of extreme importance in constructing a casualty risk management program that's right for a particular organization.

It's arguable which of these issues is the most important.

However, since I know that 80% to 85% of my insurance costs will be represented by the claim and allocated loss adjustment expense dollars paid on losses, I'm going to concentrate, in this article, on the criteria that I would consider in the selection of a claims-service provider.

The process can and should be lengthy. It should involve several interviews with management-level representatives.

For the sake of efficiency, before that process begins, two fundamental questions should be answered to narrow the list of possible options to those most attractive to my corporation.

'All claims management and disposition authority could be delegated to the provider. Or I could retain all of it. The third choice is that some authority be delegated and some retained.'

The first question is whether I want to exercise claims control. I could elect to resolve this issue in any one of three ways.

All claims management and disposition authority could be delegated to the provider.

Or, in contrast, I could retain all of it and accept the responsibility for managing or supervising the provider and the claims results.

The third choice is that some authority be delegated and some retained.

The authority break point could be represented by line of insurance, level of exposure, per claim or a particular line of cases representing high sensitivity to my corporation, like product liability claims, personal injury claims or claims from indemnitors.

Should I decide to insure my program with a self-retention level in the primary layer, it's reasonable to expect most underwriters to consent to my control of losses falling somewhere within this self-retention level, contingent on acceptance of this arrangement by any reinsurers or excess insurers involved. However, some may not.

Regardless of the risk-funding alternative selected, if I decide to retain all claims authority, I must be prepared to actively supervise the work of my provider's claims representatives.

This is because if the provider has no authority, it will expect to work at my direction and its representatives will be unlikely to initiate claims management techniques, resulting in higher expenses associated with the final outcome of the claims.

I must determine whether I have the time and the staff support—or whether I can acquire these necessary elements—to perform this essential supervisory function.

If I am to operate without the staff supervisory resources, then I will search for the provider that is believed to be best equipped to supervise its own work and apply claims cost-control techniques of its own volition.

The consideration is deciding whether independent service providers—compared with underwriters' claims facilities or subsidiaries—have the most basic precept that claims results are the single most important element of the independent service providers' existence.

The answer might well be obtained by asking the question, "Whose claim employees spend the most time managing and concluding losses on which some or all of the risk is borne by their employer?"

'I would not solicit service fee quotations until after the initial interviews because I wouldn't want the difference in quotes to affect my judgment of the final selection—at this point. At a later date that will matter, but not now.'

The second issue involves the matter of uniformity vs. fragmentation: I must ask, do I want single or multiple providers?

Historically, self-insurance provided the risk manager with the option to select the most attractive service provider if the decision was made not to internalize or self-administer losses.

Today, that same option exists in insured programs because most major property/casualty underwriters have accepted the fact that the unbundling concept is not a passing fad but that it is here to stay, and they have adjusted accordingly.

Given the unbundling option in insured programs, the choice then becomes that of selecting single vs. multiple providers.

The advantages of using a single provider seem obvious. I would have just one service contract to negotiate.

The number of key provider representatives I would work with would be limited. Only one set of claims service specifications would be necessary.

One service provider, large enough to handle my entire casualty program, would be less susceptible to acquisition or dissolution.

When service problems arise—and even in the very best of circumstances these problems inevitably will arise—the value of my entire account to the provider with all my business will give me greater leverage to get the soft spots strengthened.

And finally, let's consider the management information I'll require. This final point is a very important one.

In terms of management information I desire, I will want to know about incurred and paid amounts, projections of ultimate values and any variety of claims data for loss-control and allocation purposes.

It will be much more easily integrated into my operation if I can depend on this information coming from a single source, produced at the same time and in a uniform format for easier interpretation.

Were I to opt for fragmentation, I would contract with multiple providers and could break out these assignments on a number of bases: by line of exposure, by geographic region or by subsidiary and division within my own organization.

As a matter of fact, if one's desire is to have a complex program, any combination of multiples thereof is possible.

Proponents of fragmentation might argue that the biggest advantage to be derived is the ability to replace one provider of the group whose performance is not satisfactory and not disrupt the entire service program in the process.

But, I'd have to be convinced I'd be satisfied with performance before any service contracts were executed.

I don't believe in organizing solely to take care of the unexpected contingency, and that seems to me to be the only advantage to fragmentation.

Depending on the answers to the questions of claims control and uniformity vs. fragmentation, I now would be in a position to interview a reasonable number of providers.

I would select those to be interviewed based on my own general knowledge of their reputation and how I thought their facilities would fit the needs of my corporation. And, I also would weigh the recommendations of my staff members or friends in the risk management business.

I would not solicit service fee quotations until after the initial interviews were conducted.

This is because I would not want the difference in quotes to affect my judgment of the final selection—at this point.

At a later date that will matter, but it will not at this juncture.

Remember, the unallocated loss adjustment expenses are going to represent only 10% or less of my overall risk management costs.

What I want to concentrate on at this point is determining which of the providers in which I'm interested are able to distinguish themselves by describing how these providers' claims-management and cost-control techniques will derive the best possible results: fair claims payment at minimum claims-handling costs.

It also is important to learn to what extent the competing providers can quantify the results of their cost-control programs.

Each representative from the providers I interview will present some boiler-plate monologue of their company's basic philosophies, demographics and dimensions: number of people employed, number of business locations, volume of cases handled, total dollars paid in claims settlements, etc.

In addition, each representative can be counted on to distribute some glossy, professionally prepared literature.

Although this information may sound and may appear impressive, it really is not going to tell me very much about each provider's claims-handling capabilities.

To learn about that, I am going to need specific answers to specific questions.

For the sake of clarity, I would segregate them by major line of exposure—workers compensation and general liability—and ask questions on litigation cost control.

The box on page 24 shows the questions that I would ask in each area.

The purpose of the interviews is solely to obtain sufficient specific information to review carefully and make an assessment of the claim capability of each provider.

Continued on next page

Thomas S. Owens is director of casualty-property claims at The Travelers Corp. in Hartford, Conn.

Care is needed in choosing a claims service

Continued from previous page

Then—and only from the providers that I felt had exhibited the greatest capability of providing me with high-quality service—would I solicit quotations.

As I request quotations, I would ask that they be itemized as follows:

- Identify the items that constitute unallocated expenses included in the basic claims-service fee.
- Identify the items that constitute allocated expenses not included in the basic claims-service fee.
- Identify how independent adjuster expenses are handled when the fees incurred pertain to the entire claims-adjustment process.
- Describe the methods used to structure the claims-service fee.

And now, finally, comes the time to exercise sound business judgment.

In my opinion, a basic tenet is that the low bidder doesn't automatically receive my business. I'll pay more for quality, because what I'm seeking to control is the vast majority of total risk dollars represented by claims and allocated expense payments.

I agree with others that, when it comes to services, one gets what one pays for.

Questions to ask in weighing claims-handling firms

Workers compensation:

- What medical expertise do you have on your staff?
- How do you match the complexity and exposure levels of cases to the experience and expertise of your staff?
- What control do you exert over use of outside vendors for rehabilitation?
- What in-house facility do you have to make use of transferable skills for employees who can't return to work with the same employer?
- What are your criteria for making outside assignments?
- How do you handle cost control in medical fee-schedule states?
- How do you handle cost control in usual-and-customary states?
- What is your procedure for handling dental claims?
- How do you handle subrogation and employers' liability cases?
- How do you estimate future exposure on cases?
- What actuarial facilities do you have on total disability cases?
- What procedure do you have for handling hearings and appeals?

Litigation cost control:

- Do you have a formal program for managing lawsuits and litigation expense?
- Do you directly employ lawyers to defend your policyholders?
- How many practicing attorneys do you employ? Will you provide their educational and work experience backgrounds?
- At how many of your field offices do you provide on-staff legal service?
- What percentage of newly reported litigation do your directly employed lawyers handle?
- Do you maintain a list of independen law firms to represent your policyholders? How many?
- How do your directly employed lawyers charge for their services?
- Do you have a formal program for handling fees charged by independent law firms?
- How much have you paid for legal expenses in each of the last three years?
- How many litigation cases were reported to you and settled in each of the last three years?

Liability:

- How do you match the complexity and exposure levels of cases to the experience and expertise of the members of your staff?
- Do the very highest exposure liability cases receive special handling from your firm?
- What kind of special training was given to your highest-level technical experts?
- What medical experts do you have on your own staff?
- What kind of process do you have for effecting structured settlement agreements?
- What use do you make of rehabilitation of liability cases?
- What kinds of controls do you exert over use of outside vendors for rehabilitation?
- Do you have a process for estimating future economic loss on liability cases?
- How do you control claims exposure on larger, more complex property damage cases?
- How closely are less severe, more routine cases supervised?

New book charts surplus lines market

"Surplus Lines Insurance: The Misunderstood Market"
By Samuel H. Weese, Ph.D.
Published by the National Assn. of Independent Insurers, 2600 River Road, Des Plaines, Ill. 60018-3286
69 pages, $6 softcover

By Carol Cain

THE IMPACT of surplus lines insurers on the insurance marketplace is explored in a new book written by a surplus lines expert.

"The surplus lines insurance business has been an important part of the property-liability insurance market since the industry's beginning in this country," Professor Samuel H. Weese says in the opening chapter of his new book: "Surplus Lines Insurance: The Misunderstood Market."

Mr. Weese, who is considered an expert on the subject of surplus lines, is a professor of insurance studies at Eastern Kentucky University in Richmond.

In the book, Mr. Weese discusses the history and the future of the surplus lines market, making it an excellent reference for anyone dealing in this market.

Chapters concentrate on surplus lines insurance in the current insurance environment, the regulation of surplus lines insurance and the surplus lines marketing structure. There also are sections on the major surplus lines insurance sources, like Lloyd's of London, the U.S. insurance exchanges and other alien and domestic surplus lines insurers.

books & ideas

In the chapter on the regulation of surplus lines insurance, Mr. Weese notes that this job "has long been a difficult and perplexing problem for regulators.

Regulators "recognize the need for a surplus lines market, but they disagree over the degree of regulatory freedom this market needs to best serve the insurance buying public," Mr. Weese says, adding that "the debate continues."

In discussing the surplus lines marketing structure, Mr. Weese explains the roles of the various intermediaries used and how the intermediary is the focal point of activity, from both an underwriting and a regulatory standpoint.

And, Mr. Weese also recognized the importance of another of the key players in the surplus lines market—the corporate buyer.

"Insurers recognize that they are dealing with a more sophisticated buyer, who has become more demanding, not only on prices but on services, too," he says.

"One of the strongest influences on the competition for commercial lines property-liability insurance has been the movement by major industrial and commercial businesses of this country into self-insurance and captive insurer programs," he says.

"While risk managers and the risk management concept have brought major changes to the operational and underwriting policies of the admitted property-liability insurance industry, the risk managers have probably been a positive factor for surplus lines insurers and required little change in the way they have done business in recent years," Mr. Weese says.

The book was researched and written during 1984, which Mr. Weese classifies as "perhaps one of the most dynamic (years) on record for the property-liability insurance business." It also contains an epilogue to recap some of the events of 1985.

All of these perspectives on the surplus lines market—the history, the current dynamics and the future—are written in a compact and clear manner by Mr. Weese, making the book a 69-page gem that should be on the mandatory reading list for both newcomers and veterans in the surplus lines marketplace.

Mr. Weese was commissioned to write the book by three trade associations: the American Assn. of Managing General Agents in Washington; the National Assn. of Independent Insurers in Des Plaines, Ill.; and the National Assn. of Professional Surplus Lines Offices in Roswell, Ga.

"The book is a complete review of the surplus lines market—a broad analysis," said Richard M. Bouhan, government relations director for NAPSLO, adding it can be used as a resource, reference document or text.

Surgical procedure for impotence found compensable

legal briefs

An Arkansas appellate court ruled that the implantation of a prosthetic penile for an employee who sustained a back injury followed by impotence was reasonable and necessary.

Jimmy Rogers injured his back while working for Crain Burton Ford Co. and underwent surgery in 1973. Later, he developed bladder and bowel incontinence and impotence.

It was found that Mr. Rogers was suffering from a demyelinating disease, which had either been precipitated or aggravated by the back injury and was compensable.

Treatment began for impotence and a penile implant was recommended.

Mr. Rogers' claim for compensation for the procedure was approved by the Workers' Compensation Commission; however, his employer appealed.

The appellate court said that it was not essential that the causal relationship between the accident and the disability be established by medical evidence or that the evidence be medically certain.

The appellate court was satisfied that there was substantial evidence to support the finding of a causal relationship between Mr. Rogers' injury and his impotence.

Furthermore, the appellate court also rejected the employer's argument that the procedure was not reasonable or necessary.

The court said there was satisfactory evidence that the procedure was "necessary" to restore Mr. Rogers, as far as predictable, to his physical condition before the back injury. *Crain Burton Ford Co. v. Rogers*, Court of Appeals of Arkansas, Sept. 5, 1984 (*BI*/05/).-$5).

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

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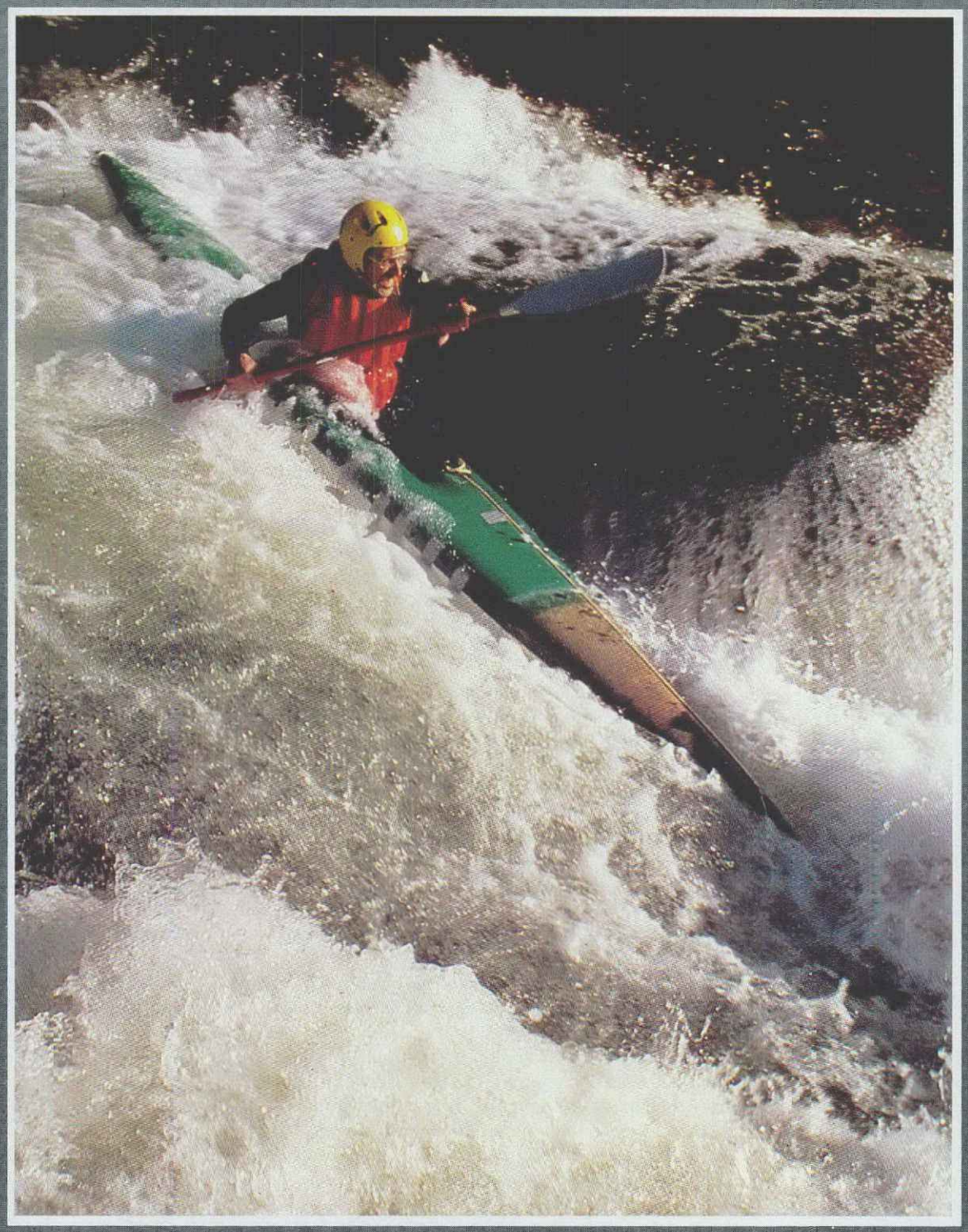

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ASK A RISK MANAGER

There are advantages to 'shopping' for cover

Q **What are the advantages and disadvantages for a firm and its risk manager of shopping an insurance program, say every three years?**

A In today's marketplace, the "shopping" that is being done is almost exclusively to find a market for the account. In many cases, it is just to secure the limit and coverage terms desired.

If we return to a competitive marketplace, the advantages to both the firm and the risk manager are measurable, provided the risk is a desirable class of business with a good loss record.

The market environment and quality of risk being offered are key issues in determining the frequency of shopping a program.

From personal experience, though, staying with one or two financially stable markets for more than 10 years has been most beneficial for our company and for me. During this time, we enhanced the terms and policy conditions, adjusting the premium as the risk changed—on an annual basis.

My experience involved our property program, which provided broad coverage at reasonable cost in financially secure markets. We suffered a catastrophic loss in excess of $30 million. The coverage was there, while some companies in the same business had none. Our loss was paid quickly and in full.

At renewal, even in this disturbed marketplace, premium increases were reasonable, along with the policy terms and conditions.

The disadvantages of shopping today are obvious. Many markets will not take the time to quote on any favorable terms, and they may not be ready to pay your loss without considerable conversation.

Reports can answer profit center questions

Q **After my insurance and risk management budget has been sent out to our profit centers, the phone rings continuously for explanations about the increased premium expense. Most of the heated requests are directed toward our retrospective charges in the workers compensation, general and auto liability programs. How do you handle these questions and this problem?**

A I will assume the questions to this seemingly ever-present problem involve large, self-insured programs.

While there are two easy answers to the problem, in my experience, very few of us use them. The first answer is to forecast your premium accurately so it equals ultimate claim and expense costs; the second is to combine last year's retrospective adjustment with next year's forecast.

We work hard to be accurate in our projections with actuarial help, but have yet to attain an ultimate accurate projection of expense. Secondly, our auditors have persuaded us not to combine our prior adjustment with next year's expense.

I believe that most large, self-insured programs seek outside actuarial help in setting prospective rates for forecasting premium expense, based on the account's prior loss history.

We do this for our combined workers compensation, general and auto liability program.

In the beginning, the actuaries were hired to satisfy outside accountants' questions about the adequacy of our reserves.

However, with a good history of losses, their help in setting prospective rates became beneficial and more accurate.

We continually experience escalating jury awards. With medical expenses and statutory benefit levels increasing at a rate exceeding inflation, an actuarial program that looks at your loss records frequently is necessary. We now ask them to do a report twice a year, by profit center.

Although we use the actuarial report as a basis for premium forecasting, we also can identify reserve changes in the previous year's loss history that can cause the retrospective adjustment and numerous questions.

Here are the reports we issue for profit center use to help identify, by line, major reserve changes and then zero in on the claim causing the major dollar change. Our standard reports are issued quarterly, by profit center.

Our first report is a large-claim report listing workers compensation claims of $50,000 and above and general and auto liability claims of $25,000 and above. This permits quick identification of large claims, so visible to the senior management. It does not show those smaller claims that collectively may have a greater impact on costs.

The second report is called a Claim Variance Report, which quarterly shows all reserve changes of $100 or more. This report also can be issued monthly.

We find profit centers consider this the more valuable report in tracking reserve changes, by quarter, in total and individual, including when the reserve change was recorded. Provided they keep a record of these changes each quarter, it is possible in our program to determine the approximate expected retro.

If individual claim reserves change substantially, we expect the profit center to ask questions about that claim.

We encourage direct contact with the adjuster, as well as with ourselves. Occasionally, claim payment detail is requested about an individual claim.

We secure this information from our on-line Corporate Systems computer in the form of a claim abstract. This detail is printed at the time we request it and shows the claim date, location, each payment by date, reserves and reserve changes by date for medical, indemnity and claim expense.

Lack of manuscript form problem on liability risks

Q **In this down marketplace, how do you handle the changes you must make from broadly written contracts or manuscript forms to the more traditional forms being offered by insurance companies?**

A This can be a frustrating experience, particularly if you and your broker have labored hard during past years at broadening your coverage and policy terms.

Our experience has been less traumatic with our property coverage than with the liability forms. Perhaps this has been due to the long-term relationship built up with property underwriters over time and to some consideration for our acceptance of reasonable pricing.

While our property coverage lacks some refinements—such as a no claim bonus—and we would buy some higher limits, if they were available, the basic structure of coverage is still intact.

However, our liability program suffered a serious blow when the manuscript form was eliminated. Coverage, terms and limits were reduced, and the price increased more than 50%.

Our immediate concern was to notify our operations people of reductions and restrictions, as well as any new contractual obligations imposed upon us. This exercise was hampered by delays in completing limits and agreeing to form and term conditions.

The concern in communicating these coverage modifications to our legal and operations people sometimes cannot be clearly understood by your broker or the market.

Specifically we have begun, as we did many years back, with a standard company form. We have requested broadening features that can be added by printed endorsements.

The next step—for us and for you—will be to attempt further revisions by special endorsements that will provide some coverage or eliminate exclusions and bring your forms closer to those you had in the past.

Advantage of stop-loss is capping year's losses

Q **What are the advantages and disadvantages for a firm and its risk manager of having a "stop-loss" in the retrospective rating plan?**

A The advantage is that you "cap" your losses in any one year so your company knows the maximum cost of its program. This could be profitable for a new company or one entering a new business with little experience in the type and frequency of insurance claims expected.

Capping your losses if you work in a corporate environment with very tight financial controls may be worthwhile.

The disadvantages are cost of the coverage, particularly in the first several years, and the need, depending on the lines of insurance involved, to record and keep accurate account of claims on a paid and incurred basis.

Good recordkeeping is mandatory, since your casualty claims can take up to 10 years or more to close.

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

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

Mr. Perry

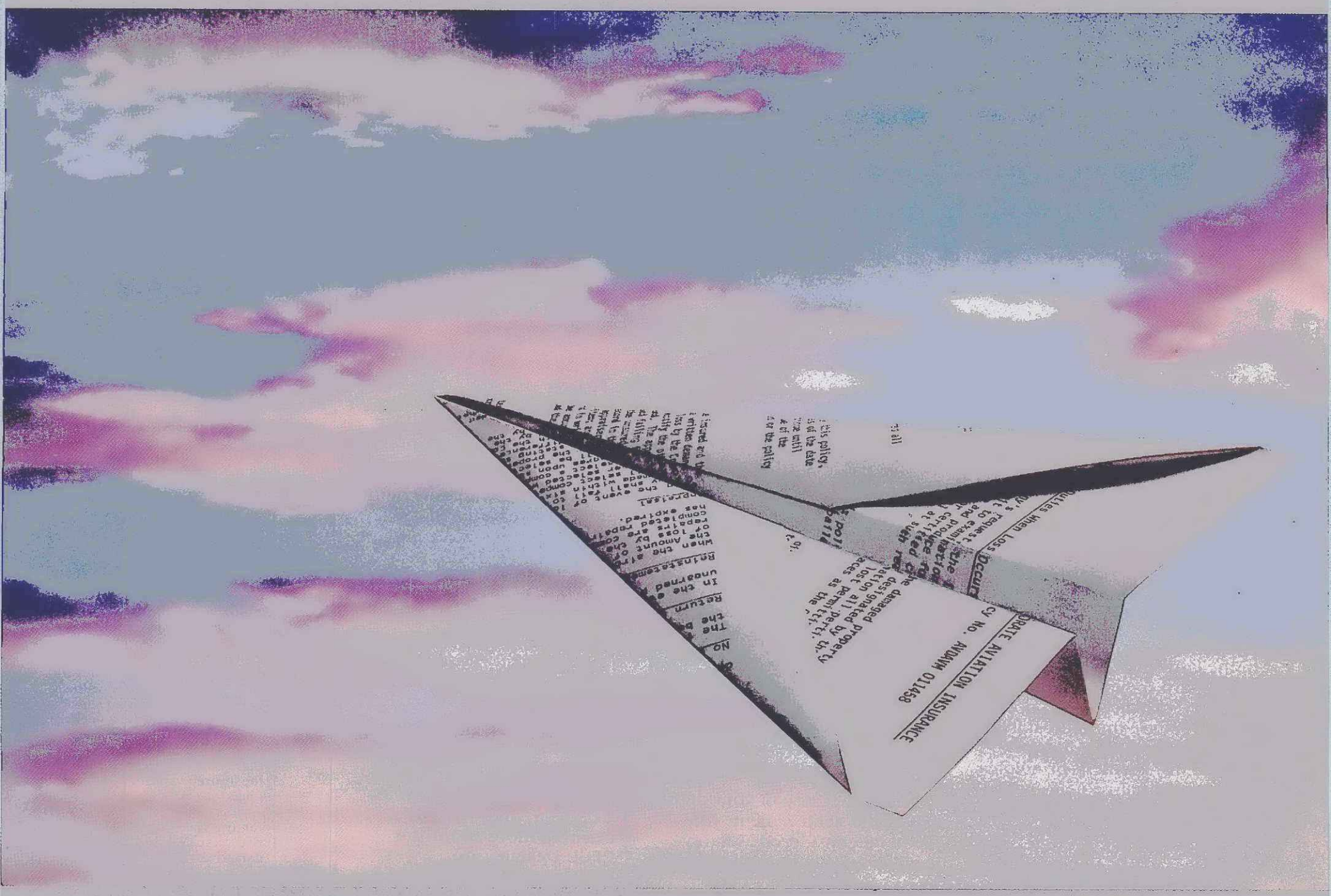
This month's column on risk management issues is written by Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco. Joseph Duva, director of employee benefits and compensation at SCM Corp. in New York, answers benefit management questions. And, William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions.

Mr. Duva's and Mr. Perry's columns appear alternately on the second Monday of each month. Mr. Miner's column appears four times a year on the first Monday of the month. Mr. Perry's next column will appear in December.

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.

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

SOME AVIATION POLICIES FLY BETTER THAN OTHERS.



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Hull, cargo rates

Continued from page 1

types of risks they write, noting that many ocean cargo policies now include coverage for land-based risks without additional premium.

In fact, the cargo underwriters attending the IUMI conference passed a resolution decrying the low rates being charged for cargo risks and calling for a halt to coverage "for losses which are inevitable."

Although the hull insurance underwriters attending the conference discussed many topics, the need for higher rates was on everyone's mind.

"The hull rates are generally too low," said Lars Lindfelt, managing director of the Swedish Mutual Hull Club, a Swedish hull insurer that was criticized last year for undercutting rates to attract new U.S. business (see story, page 32).

"The danger is that for so many years, underwriters have relied on investment income to make ends meet. But, now claims must be covered by premiums, so, bluntly, rates should come up," he said.

Hull rates should reflect loss experience and the quality of the fleets being insured, Mr. Lindfelt added. If a "good" shipowner with a quality fleet pays a rate of 0.5% of the insured value, then a "bad" owner with a poor-quality fleet should pay 1.5%, he said.

"Rates are too low. But, the answer is that you should help the good owner by giving adequate rates and penalize the bad owner. Then maybe the bad owner will get out of the market and his ships will be scrapped," Mr. Lindfelt said, adding, "I am surprised that some ships are insured at all."

"There is a significant defect in the current rating of hull insurance," Derek Wills, Lloyd's of London marine underwriter for syndicate 633 managed by Barder & Marsh, told a IUMI hull committee workshop.

"Surely there has to be a better way than the way we are dealing with it today," he added.

Although delegations from several nations—including Australia, Canada, Denmark and France—reported at the conference that hull rates are hardening, rates are still not high enough, said Tony Nunn, chairman of IUMI hull committee and manager, director and marine underwriter for Malvern Insurance Co. Ltd. in London.

"Do not leave this conference with the idea that we have reached an adequate level of premium for hull risks to which underwriters are exposed," he warned. "Deductibles have not generally followed inflation and the currency situations. Numerous special owners' or brokers' clauses are exposing underwriters to eventualities, not risks."

Mr. Nunn also said that underwriters must ask for more information from policyholders to calculate hull premiums.

He said underwriters should:

- Pay more attention to the condition of vessels established by the classification societies.
- Pay "continual" attention to management and crew, which consistently aggravate or minimize hull losses.
- Discontinue giving wide coverage to "substandard" vessels, "particularly if this cover is indirectly subsidized by the reputable and successful owner."
- Give premium discounts only to those fleets that deserve the discounts, not across-the-board.

"Unless we recognize now how appalling in real underwriting this hull account has been, how long will we continue to write this portfolio?" asked Mr. Nunn. "We are walking a tightrope over a deep cavity. . .and we are just halfway across the chasm to safety."

Most of the underwriters attending a question-and-answer session following the hull committee workshop also seemed to agree that there should be some changes in the way underwriters evaluate risks before quoting a premium rate.

For example, Mr. Wills suggested that underwriters rather than shipowners should determine the insured value of a vessel.

"As an underwriter, I have always felt that the value of a ship is the owner's business," Mr. Wills said. "But today I am concerned that the banking system is getting shored up by insurance coverage values that are not anything like the real value of the vessel."

Mr. Lindfelt agreed. Before the current depressed condition of the shipping market, some ships were worth $30 million to $40 million, but they now are worth only $5 million to $10 million, he said.

However, these ships are still financed by loans at their original value, and banks require owners to have insurance, he said.

As an example, Mr. Lindfelt said the Swedish Club insured for $27 million a ship originally valued at $34 million. When the ship suffered a partial loss, it cost $15 million for repairs, even though by then the ship was worth only $7 million on the open market.

The Swedish Club paid the $15 million claim, he said.

"These large amounts should not be insured by marine hull coverage, but by bankers' coverage (for the financing)," he said.

"My own view is that underwriters should take an independent view of rating risks," said Mr. Wills. "I do not see the need for inflating the insured value, because it only inflates your claim."

Ryota Fujimoto, executive director of the Japanese Hull Insurers' Union, told the hull committee workshop that in Japan, the insured value of the vessel actually is determined by underwriters.

But, in the United States, the insured value of ships is determined by the shipowners and their financiers, said Allen E. Schumacher, chairman of the American Hull Insurance Syndicate in New York.

So, he warned, "We do have to be on guard and should be kept in front of the situation at all times."

Some underwriters suggested that if insurers get the right price, the insured value of a ship is not an important factor in hull rating.

"It is more getting the right price for the risk than worrying about the insured value," one underwriter at the workshop commented.

Hull underwriters also expressed concern about depending on classification societies to ascertain the condition of the ships they insure. Classification societies, including one at Lloyd's, survey the condition of the vessels and log this information for underwriters.

However, when the ownership of a vessel changes, the classification society report on the condition of the vessel is not always up-to-date, and underwriters are concerned about the effect this has on their underwriting decisions.

Meanwhile, the cargo underwriters attending the IUMI meeting were so concerned about the state of the current cargo insurance market that they passed a resolution decrying low rates.

The resolution states: "There is abundant evidence to support the repeated assertion that cargo underwriting has been unprofitable in recent years on both a national and international scale. . . .The number of national markets to which this does not apply are very small.

"The (IUMI) Council believes that underwriting practice has gone too far in the granting of insurance cover for losses which are inevitable and that a reversal of this trend is an essential prerequisite to any program designed to im-

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prove the underwriting results of international cargo insurance.

"Obviously, premium levels should reflect the risk exposures and immediate past experience," the resolution concludes.

One reason that cargo rates have not ballooned is that reinsurance capacity has not contracted for cargo coverage like it has for other property/casualty risks, said David C. Beebe Jr., senior vp for Chubb & Sons Inc. in New York.

In addition, he noted that cargo insurance underwriters have markedly different attitudes than do property/casualty underwriters.

"The property/casualty correction in the U.S. was a groundswell, with reinsurance contracting and other factors all pointing in the same direction," Mr. Beebe said. "There isn't that groundswell in the marine cargo market.

"Cargo and hull (insurance) cycles, in fact, are different than property/casualty cycles, and they almost seem to me to be opposite cycles to each other," he observed.

Mr. Beebe also noted that cargo underwriters have stretched ocean marine cargo policies to include overland transit risks, warehouse-to-warehouse coverage and other extensions without any additional exclusions or premiums.

In fact, in the face of increasing competition, cargo insurers have included risks about which they know nothing, he said.

"From an insurance buyer's viewpoint, there are obvious advantages to this type of placement," he said. "He is able to negotiate with a single underwriter who has the flexibility to make his coverage and pricing decisions on a judgmental basis. . . .It makes the few difficult segments easier to place as part of the overall ocean marine program and is usually more advantageous on a total price basis."

But, this kind of broad-based underwriting without proper knowledge of the risk is "dangerous" to the underwriter, he said.

Although the underwriter may be very knowledgeable about the risks of cargo on the seas—losses from stranding, sinking, burning or collision—he or she may not know anything about the onshore risks that the policy has been extended to include.

"How many are truly comfortable when asked to include a processing exposure or, alternatively, a rigging risk at the delivery end which includes a lengthy installation of equipment and a complex testing requirement?" Mr. Beebe asked conference attendees.

Marine underwriters have faced costly losses because they have extended their ocean marine cargo coverage to include on-land risks, Mr. Beebe said. Recent losses in which cargo insurers have shared include the $100 million loss of goods from a fire at a K mart Corp. warehouse in 1982 (*BI*, July 19, 1982) and a loss of as much as $200 million of goods in a fire at a Port Elizabeth, N.J., warehouse complex last February (*BI*, May 13).

"I believe that we cargo underwriters must now, before it is too late, reassess the complex risk facing us," Mr. Beebe said.

"We must take appropriate action to assure that cargo underwriting continues to be a profitable —and therefore effective—adjunct to international trade."

Specifically, Mr. Beebe advised cargo insurers to:

- Learn more from property underwriters.

Property underwriters traditionally provide a separate limit for earthquake coverage and reduced limits for flood losses, he said. They also request, in certain instances, deductibles and coinsurance.

But, marine underwriters seldom have invoked such limitations or conditions, Mr. Beebe said.

- Analyze and reconsider the rationale for offering extensions and other frills on marine cargo policies. This may mean asking detailed questions of policyholders, Mr. Beebe said.

"Quite naturally, our policyholders may complain and resist such time-consuming activities—particularly if they sense that the outcome may result in higher premium bills," he said. "Nevertheless, the re-evaluation process must take place, and it must occur under the totally reasonable premise that the underwriter has a right to know all."

- Find out more about the financial condition of the policyholder. "Statistics show a marked correlation between an insured's unstable financial condition and the incidence of fraud and arson," he said.

Mr. Beebe said he believes that, with today's computerized information sources, underwriters will have no difficulty finding the information they need to write sound cargo insurance coverage. ■

Attempt to lower hull war risk rates worries insurers

By STACY SHAPIRO

TOKYO—Lloyd's of London hull war risk underwriters are cutting standard worldwide hull war risk rates, to the dismay of some other marine underwriters.

According to Lloyd's underwriters attending the International Union of Marine Insurance conference in Tokyo last month, standard war risk rates are being reduced by some Lloyd's underwriters to .025% of insured value from 0.1% due to competition within the London market over the past year for war risks.

This follows efforts by leading Lloyd's underwriters and U.S. insurers a year ago to boost the standard hull war risk rate from .025% to 0.1% (*BI*, Sept. 19, 1983).

Several underwriters led by IUMI Hull Committee Chairman Tony Nunn said Lloyd's move to reduce hull war risk rates is ill-timed. Mr. Nunn noted at the conference that tension in the Persian Gulf is rising because of the Iran-Iraq War, threats are being made to close the Straits of Hormuz—which could trap up to 40 tankers—and Iraq has successfully attacked Kharg Island, Iran's main Persian Gulf oil terminal.

In addition, marine underwriters have paid more than $1 billion in hull war risk losses since the beginning of the Iran-Iraq War in 1980, said Mr. Nunn, who is also manager, marine underwriter and director for Malvern Insurance Co. Ltd. in London.

In summarizing the latest hull loss statistics compiled by the Liverpool Underwriters' Assn. and the Institute of London Underwriters, Mr. Nunn noted that from June 1981 to June 1985, more than 150 vessels have been damaged, destroyed or trapped in the Persian Gulf as a result of the Iran-Iraq War.

In 1984, war risk losses, primarily in the Persian Gulf, cost underwriters $142.5 million. And, from January to June of this year, 31 vessels have been damaged, costing underwriters $8.4 million, along with another five vessels for which losses aren't known.

At the conference, Mr. Nunn read a telex pertaining to the most recent hull war risk loss: The North Korean crude oil carrier Son Bong was hit Sept. 23 by an Iraqi missile while loading crude oil at Kharg Island. The size of the loss is not known.

Besides focusing on war risk losses, Mr. Nunn also gave an overview of other hull losses at the IUMI conference.

In 1984, 215 ships were lost, compared with 209 ships in 1983, he said. Among major casualties was the total loss of passenger vessel Sundancer, grounded off Canada's western coast. The vessel, which sailed under a Bahamian flag, had a value of $40 million, said Mr. Nunn.

The French roll on/roll off vessel Mont Louis also sunk off the French coast in 1984. The hull loss cost underwriters $2.3 million. No cargo losses were paid because the cargo of uranium hexaflouride was recovered and the French coast suffered no pollution.

Mr. Nunn noted that more than 70% of all hull losses in 1984 involved ships that were 15 years or older.

About 39% of hull losses, excluding war risks, are weather-related, the hull casualty statistics released by Mr. Nunn note. About 31% of hull losses are caused by fire and/or explosion and the rest by stranding, collision and contact—"which shows a marked increase in human error," said Mr. Nunn.

Underwriters are encouraged by some of the statistics in the report, however, Mr. Nunn said.

In the past, up to 12.5% of the world's tonnage has been idle because of the slump in world shipping. However, in 1985, only 8.0% of the world's tonnage is laid up, compared with 9.4% last year, said Mr. Nunn.

This may reflect shipowners' move to break up older vessels that are causing losses for underwriters, Mr. Nunn reflected. "Break-up is being encouraged in many quarters," he said. ■

World offshore risk premiums could be depleted by one loss

By STACY SHAPIRO

TOKYO—A single major catastrophe in the North Sea offshore oil fields could wipe out the worldwide premium base for offshore oil rig coverages, says Jean-Claude Mace, marine underwriter for Companie d'Assurances Maritimes Aerriennes & Terrestres (CAMAR) in France.

Total worldwide premiums generated by offshore risks on an annual basis reach $1 billion today, Mr. Mace told the International Union of Marine Insurance conference in Tokyo last month.

Of this, about $300 million of premium is written on the London Master Oil Rig Slip and about $200 million more is written in the London market, about $150 million is written in the U.S. insurance market and about $100 million in the Scandinavian insurance market. The remainder is written by other world markets, he said.

"A major loss of an (oil drilling) platform over $1 billion would dry, at one go, the premium of the year and would have dramatic effects on the offshore, the marine and other insurance markets in the world," said Mr. Mace. "What would be the effects of a catastrophic loss involving several platforms?"

Mr. Mace noted that underwriters are currently facing at least one offshore loss that may exceed $200 million as a result of efforts to control a blowout last year near Canada's Sable Island, off the coast of Nova Scotia. That "represents more than 20% of the total premium," he said.

Underwriters, too, are concerned about the subsidence of a North Sea oil rig in the Ekofisk field, though no loss estimates were mentioned at the conference.

"If we consider the premium volume compared with the exposure represented by a single unit, we have to ask ourselves where will we find the money in case of a catastrophic loss," said Mr. Mace.

Marine underwriters mute on Swedish Club expansion

By STACY SHAPIRO

TOKYO—The expansion of a Swedish mutual hull association into the U.S. marine insurance market—a hot topic at last year's International Union of Marine Insurance conference—is now apparently taken for granted.

U.S. and London underwriters charged at last year's conference in Helsinki, Finland, that the Swedish Mutual Hull Club had undercut standard marine hull insurance rates when it grabbed three large U.S. accounts that previously had been underwritten in London and the United States (*BI*, Sept. 24, 1984). Representatives of the Swedish Club were not on hand at the conference to answer these charges.

Swedish Club Managing Director Lars Lindfelt attended last month's IUMI conference in Tokyo to answer questions underwriters might raise, but the Swedish Club's critics were silent this year.

"One of the reasons I came to Japan is to answer any comments like those that were made last year," Mr. Lindfelt said. "But we are steadily increasing our business without any criticism."

Competing hull underwriters seem to have taken the Swedish Club's moves for granted, said Mr. Lindfelt, addig that some underwriters said they also would have aggressively sought new U.S. business if they could.

"Until 1974 we had no need to leave Sweden to find new risks because the Swedish shipping market was booming," Mr. Lindfelt explained. "But when that stopped, we had to go into international. We have made mistakes, but now we have the machinery working to write the business. And last year, we were able to put our plans into action."

The Swedish Club, founded in 1672, now insures about 550 ocean-going hulls totaling 12 million tons in weight. It retains the entire risk of about 93% of the ships that it insures, while it retains at least 75% of the other risks it writes, he said. Mr. Lindfelt did not comment on the club's premium volume.

Now that it has expanded to include U.S. business, the Swedish Club is increasing its interests in the Far East, Mr. Lindfelt added.

Meanwhile, a U.S. hull underwriter that lost two large clients—U.S. Lines Inc. of New York and Sealand Service Inc. of Iselin, N.J.—says it someday will write these accounts again.

"The real impact on us regarding the Swedish Club is the loss of position we have had with Sealand," said Allen E. Schumacher, chairman of the American Hull Insurance Syndicate. "But I am confident that the fleet will return to us.

"Shipowners today are pressed for operations and insurance costs to be lower. If they can get better deductibles and a better deal, it's too much not to experiment with," Mr. Schumacher said. "I don't think it's going to be a permanent arrangement with the Swedish Club," he added. "It offered lower rates. It thinks it's right and we think we are right."

The American Hull Insurance Syndicate has refused over the years to follow hull rates down just to retain business, explained Mr. Schumacher. The syndicate, which is backed by 50 U.S. insurers, retains 100% of its risk.

"That integrity, plus the philosophy of looking at claims with a positive view, gives us the reputation of quality—the Tiffany's impression, if you like," Mr. Schumacher said.

"We haven't been prepared to bend to hold business over the past years or go beyond the level of our underwriting judgment. Our combined ratio over the last five years has been around 108%....Last year our combined ratio was 97%."

The syndicate has raised its hull rates an average of 6% annually for several years, Mr. Schumacher said. "Certainly a bigger increase is needed," he said. "We are prepared to wait around."

But because of this attitude, the syndicate's premium volume has been cut in half from $100 million in 1974 to $50 million this year.

"We are mean and lean," said Mr. Schumacher. "But we don't want to go further...." ■

Marine insurance conference attracts 450 participants

By STACY SHAPIRO

TOKYO—More than 450 marine underwriters, reinsurers and underwriting agents attended the conference of the International Union of Marine Insurance, held Sept. 22-26 at the Okura Hotel in Tokyo.

Delegates from 40 countries attended this year's conference, which was hosted by the Marine & Fire Insurance Assn. of Japan. In addition, this year non-delegate underwriters, reinsurers and underwriting agents also were allowed to participate in the conference, although they could not vote on IUMI issues.

The IUMI allows non-delegate underwriters, reinsurers and underwriting agents to attend the conference every other year, although brokers are never allowed to attend the gathering.

As in the past, this year one of the largest contingents of delegates was from Great Britain, whose underwriters write about 40% of the world's marine insurance and reinsurance.

As usual, Great Britain was represented by two delegations: one from the Institute of London Underwriters and one from Lloyd's of London.

Also, as in past years, the U.S. delegation, made up of representatives from different organizations, started the proceedings by reading what conference members fondly call "the Lord's Prayer"—a fixed speech that says American delegates cannot discuss rates or terms and conditions during conference proceedings because of U.S. antitrust laws.

Underwriters say they attend the IUMI conference because it gives them a chance to see what is happening in marine insurance markets elsewhere in the world. For example, this year they learned of serious losses caused by ice in Canada and problems involved in the export of automobiles from Japan.

But most of all, they discussed the state of the world's cargo and hull insurance markets (see stories, pages 1 and 30).

The underwriters talked shop while they visited the shrines or the Imperial Palace in Tokyo, dined or kept appointments with other underwriters.

"We can cross-pollinate ideas," one underwriter said. "Usually it is the broker who travels, but this conference gives us a chance to see for ourselves what is happening in other markets," another underwriter said.

The underwriters also enjoyed the hospitality of their Japanese hosts. Women dressed in kimonos opened elevator doors and bowed as the doors shut. Flowers and gifts adorned the rooms. And, hot tea sometimes awaited the weary delegates in their rooms at night.

At Japanese Night at the Chinzan-so Center, the delegates feasted on Japanese delicacies such as sushi, tempura and sashimi as they attempted to master the art of eating with chopsticks.

Marine cargo ranges from autos to wild pig

By STACY SHAPIRO

TOKYO—Practically any commodity can be covered under a marine cargo insurance policy, as evidenced by the loss reports released by national delegations at the International Union of Marine Insurance conference in Tokyo last month.

For example, the U.S. market report noted concern about its "fair share of rejection claims"—meaning merchandise that was rejected by the buyer—caused when refrigeration broke down and ruined seafood.

Beef fillets shipped from the United States to Switzerland also were deemed a loss when they became frozen together during transport, according to the Swiss market report.

Stranded soybeans meant a $3.9 million claim for British cargo underwriters, according to the British report.

And, a fire during a voyage singed $2.3 million worth of frozen octopus and cuttlefish bound for Japan, the Japanese market report said.

In Australia, a container of wild pig meat overturned while en route to a ship, making the pig meat unusable for pet food and causing a loss valued at $52,000.

Australia also reported a variety of other cargo losses, including frozen cheese, electrical switching gear for a satellite station, a $300,000 cigarette machine, paper pulp and vegetable oil.

A Canadian buyer rejected canned oysters from South Korea, and the rejection resulted in a $400,000 loss to the South Korean cargo market.

Soviet insurers had to pay a $3.5 million claim after raw sugar was contaminated by sea water, the Soviet report said.

And, walnuts arrived from West Germany "with a peculiar flavor causing indisposition when eating," according to the West German market report. The "peculiar" walnuts caused a reported loss of about $63,000.

But, by far the largest cargo losses involve the theft or "disappearance" of gold, securities, diamonds and other jewelry, the British market report said.

For example, in July 1984, $3.8 million of gold was stolen from a Brinks-MAT warehouse in Eureka, Calif.

Securities worth $6 million were stolen from Brinks Inc. while they were in transit between Portland, Ore., and Los Angeles in January 1984.

And, in March 1984, about $18 million in cash and securities was stolen from Brinks Securmat SPA's Operations Center in Rome (*BI*, April 2, 1984).

The British market also reported 15 separate diamond or jewelry thefts, including the theft of a diamond necklace valued at $2.5 million.

But, some markets—especially Japan—are learning to prevent cargo losses.

In 1984, the Japanese exported more than 4 million new cars and 2 million new trucks and buses, said Tadashi Arakawa, general manager of the marine claims department of Taisho Marine & Fire Insurance Co. Ltd.

The Japanese found that the vehicles frequently were damaged when they were being loaded onto ships for export, according to Mr. Arakawa.

Walnuts 'with a peculiar flavor causing indisposition when eating' caused a cargo loss.

However, after studying the problem, they discovered that the rate of vehicle damage could be cut to two cars per 100 from seven cars per 100 by loading the cars backward and leaving less space between cars aboard the ship to prevent damage from doors swinging into other cars when they are opened. ■

Centaur, MIG units' dispute spawns three suits

By STEVE TARAVELLA

CHICAGO—The dispute between Centaur Insurance Co. and several Mission Insurance Group Inc. units is being litigated in three separate cases.

The disputes between Centaur, a subsidiary of Borg-Warner Corp., and the MIG units stem from seven reinsurance, reinsurance management and MGA agreements entered into between 1974 and 1984. All had expired by July 1984 (*BI*, Sept. 2).

After Mission asked Centaur in June to pay $9 million in reinsurance claims stemming from the agreements, Centaur filed suit in Cook County Circuit Court here, asking for an accounting of what the Mission companies said Centaur owed. The suit later was moved to U.S. District Court in Chicago.

Centaur in this suit does not deny that it owes money, but disputes the amount and questions how certain Mission reinsurance pools in which it participated operated.

Centaur's suit names Los Angeles-based MIG and four subsidiaries: Pacific Reinsurance Management Corp. and Mission Reinsurance Management Corp., reinsurance pool underwriting managers now running off their business; Mission Insurance Co. (MIC); and Sayre & Toso Inc., MIG's MGA affiliate.

Two weeks later, MIC, Sayre & Toso and Pacific filed a separate suit against Borg-Warner Corp., Centaur's parent, seeking to hold it liable for Centaur's debts (see story, page 3). The Mission units do not seek to determine the amount of Centaur's debt, but seek to hold Borg-Warner responsibile for those debts may be.

In the third case, the MIG units on Aug. 22 asked a U.S. District Court in Los Angeles to order arbitration of their disputes with Centaur in that city. But, Centaur filed an objection to arbitration this month, an attorney involved says.

Centaur is opposing arbitration on both factual and legal grounds, including questioning whether arbitration is appropriate since the contracts no longer are in effect.

Six of the seven contracts between Centaur and the MIG companies require binding arbitration to settle disputes, according to court papers filed by Mission. These are:

- Quota-share retrocessional contracts with MIC in 1977 and 1980, in which Centaur reinsured business through a pool managed by Mission Re.
- A 1975 quota-share retrocessional contract with MIC, in which Centaur reinsured business through another pool managed by Pacific.
- Reinsurance management contracts with Pacific in 1978 and 1979.
- A 1983 MGA contract with Sayre & Toso, in which S&T bound Centaur to reinsurance on business written on a direct basis by MIC and Holland America Insurance Co., another MIG affiliate.

The seventh, not requiring arbitration, is a 1974 MGA contract between Centaur and S&T.

While the Los Angeles court considers ordering arbitration, the Mission units are asking the court in Chicago to stay Centaur's suit, pending possible arbitration.

In addition, Mission Re and MIG are asking the Chicago court to remove them from the suit filed by Centaur in July. Mission Re and MIG claim in papers filed Sept. 10 in the Chicago court that they are not party to any reinsurance agreements with Centaur, have no dispute with Centaur and are not seeking any funds from Centaur.

Centaur now owes the three other Mission units at least $10 million for payments made on its behalf, says Lawrence G. Becker, MIG vp and general counsel.

And, MIC, Sayre & Toso and Pacific say in their suit against Centaur that Centaur soon will owe at least $14 million for case loss reserves and an estimated $25 million for losses incurred but not reported. ■

Borg-Warner

Continued from page 3

receivables of Centaur" to permit it to continue operating.

Borg-Warner's response only briefly refers to these allegations, noting that "presumably Mission is likewise regulated by the California Department of Insurance."

"If we accept Mission's complaint as being true, it likely will obtain a money judgment at some time in the future, either in arbitration or in other litigation," Borg-Warner continues. "Can anyone say at this time that Centaur could not satisfy the judgment?"

An official of the Illinois Insurance Department says the department reached an agreement with Centaur last year that required Borg-Warner to inject $10 million into Centaur, increasing Centaur's year-end surplus to $15.2 million.

If Borg-Warner had not contributed those funds, the department probably would have permitted Centaur to continue operating, but only on a limited basis, says Norman Koefoed, supervisor in financial analysis for the Insurance Department in Springfield.

Under a prior agreement with the department, Centaur was running off existing business and only writing new business related to its parent before the $10 million infusion last year, he says.

But Centaur was allowed to write some outside business after the infusion, he says.

The department also permitted Centaur to discount its loss reserves, an exception to customary departmental practice, Mr. Koefoed adds. At year-end 1984, Centaur was able to discount its loss reserves by 7% which reduced Centaur's liabilities by $30 million. However, as of June 30, the effect of the discount was reduced to $26 million, he says.

The discounting was permitted in part because of the long-tail nature of much of Centaur's business, Mr. Koefoed says.

In lieu of a letter of credit or the posting of securities, the department also agreed to let Borg-Warner guarantee 46% of Centaur's reinsurance recoverable from unauthorized reinsurers, Mr. Koefoed reports. That percentage is equal to the federal income tax benefit Borg-Warner realized from underwriting losses at Centaur.

Mr. Koefoed says the department is monitoring Centaur, but no more closely than 150 other companies asked to submit financial results quarterly. Most insurers licensed in Illinois must submit results to the department annually.

He notes that Centaur officials have been "very cooperative."

Centaur reported $10.6 million in net written premiums for the first six months of this year, Mr. Koefoed says. It reported $28.9 million in net written premiums for 1984. ■

Pension plan terminations

Continued from page 3

pret the provision as a forerunner to even more drastic congressional restrictions on reversions of pension assets, Mr. Ugoretz fears, adding that those companies might rush to terminate their plans while they can.

"It creates a great deal of uncertainty," Mr. Ugoretz adds.

The lobbyists' concern about the provision is understandable given the importance and scope of reversions.

According to the PBGC, 569 employers have terminated overfunded pension plans and recovered $5.2 billion in excess pension assets since 1980. Most of those companies have set up either new defined benefit or defined contribution plans to replace the terminated programs.

In addition, the PBGC has 199 pending applications from employers that are seeking to terminate pension plans and recover $2.9 billion in excess assets.

Those pending applications and others that could follow could be delayed if the provision is adopted.

The length of the delay would depend on how long the application has been pending with the PBGC.

For termination notices received after the moratorium is enacted, the reversion would be held up for three months beyond the date the PBGC normally would have approved the termination if 10 employees or 10% of all employees, whichever is less, objects to the reversion.

The employees would have to file their complaint within 45 days of the time the company filed for permission to terminate the plan.

Pending applications for terminations that are less than 3 months old at the time the moratorium is enacted also would be held up for three months if employees object.

Their objections would have to be filed within 15 days of the time the moratorium is enacted.

Terminations that have been pending for more than 90 days could be held up for a maximum of two weeks.

In that situation, the objections would also have to be filed within 15 days of enactment of the moratorium.

The moratorium provision would expire on March 1, 1986.

The provision could reduce some of the attractiveness of terminating plans, observers say.

For instance, a special excise tax that companies would have to pay on reversions from overfunded pension plans could be in effect by the time the reversion could be made.

Both the Reagan administration and congressional tax committee staffers have proposed, as part of a tax reform bill, to place excise taxes on these reversions. The administration wants a 10% tax while Ways and Means Committee and Joint Committee on Taxation staffers have proposed a 15% excise on the amount a company recoups after it terminates a plan.

Both proposals call for imposing the excise tax on reversions that occur after Dec. 31 of this year.

In addition to the moratorium provision in the Senate bill, both the House and the Senate bills would increase costs for companies that don't terminate their pension plans.

The PBGC proposals would boost 'benefit guarantees beyond what an employer contemplated when it set up a pension plan,' says Lawrence Franklin, a benefit consultant in the Dallas office of Buck Consultants Inc.

For example, the Senate bill would boost the annual PBGC premium to $8.10 per plan participant, while the House budget bill calls for an annual premium of $8.50.

In addition, a separate measure, H.R. 3128, earlier passed by the House Ways and Means Committee, calls for a premium increase to $8, but would rescind that increase after three years.

The current premium is $2.60 per plan participant.

In addition, under the House and Senate PBGC proposals, companies that terminate underfunded plans will find that it is more costly to do so.

Under current law, a company can terminate an underfunded plan anytime it chooses. If the plan doesn't have sufficient assets to pay benefits guaranteed by the PBGC, the agency can take up to 30% of the company's net worth to pay guaranteed benefits.

(Guaranteed benefits, among other things, do not include non-vested benefits or recent benefit improvements. Guaranteed benefits are generally equal to about 85% of vested benefits.)

Under both the House and Senate bills, employers generally would not be allowed to unilaterally terminate underfunded plans.

The House version would not allow an employer to terminate a plan until all vested benefits have been funded, while the Senate bill would require funding of all accrued vested *and* non-vested benefits.

Some critics say this new expanded liability should be deleted from the bills because it has nothing to do with shoring up the PBGC since these provisions would force an employer to fund benefits beyond the amount guaranteed by the PBGC.

"It is boosting benefit guarantees beyond what an employer contemplated when it set up a pension plan," observed Lawrence Franklin, a benefit consultant in the Dallas office of Buck Consultants Inc.

But Kevin Putt, the PBGC's assistant executive director, notes that the PBGC insurance program should not be used to reduce a company's obligation to pay promised benefits.

"The participants should not be the losers in such a situation," Mr. Putt said.

For companies that have to terminate underfunded pension plans because they are in financial "distress," the proposals would continue to require companies to pay the PBGC up to 30% of their net worth to pay for unfunded liabilities. Also, these companies would be forced to pay 10% of their pretax profits—if any—to the PBGC over the next 10 years or until their debt to the PBGC is paid.

In addition, the Senate bill would require companies in "distress" situations to contribute another 5% of pretax profits over the next 10 years to pay plan participants the difference between the guaranteed benefits paid by the PBGC and their total accrued benefits.

The House bill would also require the payment of an additional 5% of pretax profits. This would be used to pay the difference—if any—between guaranteed benefits and the plan participants' vested benefits.

In addition, the House bill gives the Internal Revenue Service the right to demand security, like a surety bond, from an employer that receives IRS permission to waive making minimum required contributions to a plan. The Senate bill does not contain a similar provision.

In addition, the House bill would make a parent company liable for a former subsidiary's pension benefits for up to five years after it sells the subsidiary to another company.

This "transfer liability" provision would come into play if the subsidiary later collapsed and the PBGC could prove that a company's purpose in selling a unit was to evade paying for the subsidiary's pension liabilities.

The Senate bill does not contain a comparable provision. ■

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Business Insurance

Circulation Breakdown*

Commercial Consumers

Administrative:

CEO's presidents and owners...2,531
Vice-presidents, general managers and other administrative personnel 2,547

Financial:

Chief financial officers and vice-presidents of finance 2,075
Secretaries, treasurers, controllers and other financial personnel ...6,886

Risk/employee benefits:

Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 8,048

Sub-total 22,087

Associations 804
Government, unions and educational systems 1,030

Commercial Consumers
Sub-total 23,921

Insurance agents and brokers 9,548
Insurance companies 6,089
Financial institutions 536
Actuaries, attorneys, adjusters, appraisers and consultants 3,464
Others allied to the field 1,320

TOTAL 44,878

* Source: Business/Occupational breakdown of qualified circulation, May 6, 1985 issue, as submitted to BPA for June 1985. BPA Publisher's Statement.

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Louisville, KY
Lexington, KY
Kansas City, KS
Columbus, OH
Chicago, IL
Springfield, IL
Corpus Christi, TX
San Antonio, TX
Dallas, TX
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Tax bill provisions

Continued from page 2

buldt, legislative director in the Washington office of the American Insurance Assn., a coalition member. He and others note that a tax on workers compensation benefits could also be reintroduced on the House floor or by the Senate Finance Committee.

"Members of the coalition will continue their efforts to seek to ensure that the final version of tax reform legislation reported out of the Ways and Means Committee, and eventually passed by the Congress, will not include a tax on these benefits," said Robert E. Vagley, a Washington attorney whose law firm was hired by the National Council on Compensation Insurance to represent the broad-based coalition (*BI*, Oct. 7).

"Since benefits are considerably less than an injured worker's actual pay, the taxation of those benefits would place an unfair and unnecessary burden on beneficiaries and their families, " said Rep. Flippo, whose interest in work comp issues is a personal one.

Rep. Flippo suffered serious injuries in the early 1960s when he was an ironworker at a Tennessee Valley Authority power plant in Colbert County, Ala., says Mike Adcock, an aide to Rep. Flippo.

Rep. Flippo was hospitalized and received work comp benefits for several months after the injury and began taking college accounting classes during this time. He later received bachelor's and master's degrees.

While the elimination of the proposed tax on workers compensation benefits is a major victory for business, benefit experts say the proposed $5,000 cap on tax-free employer-provided dependent care benefits would have a minimal impact on employers.

Relatively few companies offer dependent care benefits, and when they are offered, few employees take advantage of the benefits, consultants say.

Dependent care benefits are often offered by employers through a salary-reduction feature in a flexible benefit plan or through a flexible spending account, explains Peter Hutchings, a partner with Kwasha Lipton in Fort Lee, N.J. Under tax law, the amount of salary an employee contributes to such a plan is considered an employer contribution and would be affected by the amendment.

Consultants note that employers already generally place caps—between $4,000 and $6,000—on the maximum salary reduction an employee may take to pay for dependent care expenses. They note the average employee salary reduction is between $2,000 and $3,000.

In addition, when an FSA option is offered, only 3% to 6% of participating employees reduce their salaries to pay for dependent care expenses, consultants say.

The percentage is low because lower-paid employees may find it more financially advantageous to take federal tax credits for their child-care expenses rather than pay the costs with pretax dollars through an FSA, said Lance Tane, manager of The Wyatt Co.'s flexible compensation team in Washington.

Still, consultants say the $5,000 cap will cause administrative problems for some companies, especially those that provide and subsidize on-site day-care programs.

These companies will find it difficult to place a dollar value on the cost of the benefit, Mr. Tane explains.

While experts generally say they do not expect the child-care benefit cap to be a burden on employers, an option proposed by staff members of the Ways and Means Committee and the Joint Committee on Taxation that sets uniform non-discrimination rules for benefit plans has severe shortcomings, they contend.

Under this option, a benefit plan covering 100 employees at a company with "separate lines of business or operating units" would be considered non-discriminatory as long as 90% of a unit's employees were eligible to participate and no more than 25% of the participants were highly compensated.

In general, a highly compensated employee is defined as someone earning more than $50,000 a year.

Many companies will flunk this 90% test, consultants say, especially companies that offer different benefit plans based on where employees work.

For example, a food store chain might offer a richer health care plan for employees in the Northeast than for employees working in the South, points out Gerald Uslander, a principal in the Louisville, Ky., office of William M. Mercer-Meidinger Inc. Each plan might cover 50% of employees, he explains.

Since the more generous health care benefits do not cover at least 90% of the company's employees, the plan would flunk the discrimination test, he explained.

To retain the plan's tax-favored status, the company therefore would have to offer a uniform health care plan to all employees of the subsidiary, but that would not end the company's problems, consultants say.

If the company covered Southern employees in the more generous health care plan, its benefit costs would be uncompetitive with other stores with which it competes in the South, consultants add. And, if Northern employees' benefits were the same as those in the less generous Southern plan, it might have difficulty recruiting employees in that part of the country.

A company could also fail the 90% test if it bought another company that is engaged in the same type of business and the acquired company retains a separate benefit plan, said Sophie Korczyk, director of benefits research in the Washington office of Peat Marwick Mitchell & Co. "The test could interfere with corporate acquisitions," Ms. Korczyk said.

Under the Reagan administration's proposed nondiscrimination test, the percentage of the corporation's highly compensated non-union employees covered by a benefit plan would be computed. That percentage would be compared with the percentage of other nonunion employees covered by the plan.

In order for the plan to receive favorable tax qualification, the percentage of highly compensated employees could not exceed 125% of the percentage of other employees covered by the plan. ■

update

Manville, Keene settle suits

Continued from page 2

plan in Manville's bankruptcy proceedings in New York.

Highlands provided insurance to Manville from July 1, 1976, until July 1, 1977.

Manville contends it has more than $600 million in liability coverage. It already has settled with seven other insurers but still is litigating with 19 insurers in the San Francisco case. The company is continuing settlement discussions with those remaining insurers.

Meanwhile, a longstanding dispute between Keene Corp. and four of its insurers over insurance coverage for asbestos bodily injury claims has finally come to an end after seven years of litigation.

District of Columbia U.S. District Court Judge June L. Green recently entered orders dismissing remaining claims in the litigation because they were superseded by the Wellington agreement, a settlement among some producers and insurers on asbestos coverage litigation (*BI*, June 24).

The litigation is known for the 1981 landmark decision of *Keene Corp. v. Insurance Co. of North America*, the first to grant broad coverage to asbestos producers hit with thousands of claims.

In addition to INA, Aetna Casualty & Surety Co., Hartford Accident & Indemnity Co. and Liberty Mutual Insurance Co. also were defendants in the litigation.

Keene still has suits pending against various insurers for coverage for asbestos property damage and bodily injury claims.

Some Ideal policies assumed

NEW YORK—Dart & Kraft Inc. in Northbrook, Ill., has reached a "partial" assumption agreement with the New York Insurance Department concerning some of the policies it had with Ideal Mutual Insurance Co., which is now in liquidation in New York, says a department spokesman.

The spokesman says the agreement provides that Aetna Casualty & Surety Co. in Hartford, Conn., would take over Ideal's outstanding liabilities for Dart & Kraft's workers compensation, general liability and corporate auto policies for certain unspecified years.

A Dart & Kraft spokesman could not be reached for comment.

Michigan comp director ousted

LANSING, Mich.—Rudy Redmond, who has been director of the Michigan Bureau of Workers' Disability Compensation since February 1983, is expected to leave that post this week.

Mr. Redmond said he was asked to resign by Elizabeth Howe, the new Labor Department director. The workers compensation bureau is part of the state Labor Department.

He noted that the workers compensation system in Michigan currently is involved in "a lot of litigation, emotion and political deals being cut. And I got caught up in that. Workers compensation has always been the political battleground," he added (*BI*, Sept. 9).

A replacement for Mr. Redmond has not been named.

New capacity

Continued from page 2

Conn., a division of Tillinghast, Nelson & Warren Inc., to study the feasibility of a similar excess facility for their risks.

Among the companies funding the Chemical Insurance Group study are Diamond Shamrock Corp. in Dallas, Monsanto Co. in St. Louis, American Cyanamid Co. in Wayne, N.J., and Dow Corning Corp. in Midland, Mich.

The companies are hoping to set up a facility to provide coverage of $50 million excess of $50 million, sources say. Organizers of the study refuse to comment on its objectives or scope until the research is further along.

Tortuga and the Chemical Insurance Group's facility would fill a big coverage gap for some buyers, who say $50 million is the most capacity they can find now in the commercial market for casualty risks.

If Tortuga or the Chemical Insurance Group can provide a facility for $50 million in coverage excess of $50 million, buyers in need of more coverage could then turn to American Casualty Excess Insurance Co. Ltd.

ACE, an investor-owned insurer being formed to write high excess casualty limits, is expected to offer coverage excess of $100 million to its investors. ACE, which will be managed by Marsh & McLennan Cos. Inc.—a driving force behind its formation—will operate from Bermuda although it is incorporated in the Caymans (*BI*, May 6).

Dow Chemical Co. is considering participating in the Tortuga or the Chemical Insurance Group to plug the gap between the liability coverage it expects to find in the market at its Dec. 1 renewal and the coverage it can obtain from ACE, in which it recently decided to participate, explains Philip Roels, vp with Dorinco Reinsurance Co., Dow Chemical Co.'s captive in Midland, Mich.

Dow, which is working on its Dec. 1 casualty renewal, will be "lucky" to obtain $50 million from commercial insurers and may only get $35 million, Mr. Roels speculates.

When Dow renewed its coverage on Dec. 1, 1984—just prior to the tragic toxic gas leak at the Union Carbide Corp. plant in Bhopal, India—it was able to secure $150 million in coverage.

The previous year, Dow purchased about $220 million in coverage, Mr. Roels says.

As of last month, 18 major U.S. corporations had agreed to contribute to ACE's $200 million authorized capital. Industry kingpin John Cox, former executive vp-property/casualty at CIGNA Corp., will serve as chairman of ACE and its holding company, ACE Holdings Ltd.

Several trade and professional organizations also are pursuing ways they can insure or self-insure their environmental impairment liability exposures (*BI*, Sept. 9). The EIL insurance market is one of the most difficult for today's risk managers.

And, some of the nation's leading financial institutions are studying ways they can pool their funds to provide bankers blanket bonds and upper limits of directors and officers liability coverage (*BI*, July 22).

New York Bureau Chief Douglas McLeod also contributed to this story.

Former Reed Stenhouse chief named chairman of A&A unit

comings & goings: industry

William M. Wilson, former president of Toronto-based Reed Stenhouse Cos. Ltd., has been named chairman and chief executive officer of Alexander & Alexander International Inc. in New York.

Mr. Wilson

Mr. Wilson, who maintains offices in Toronto and New York, succeeds **John C. Sienkiewicz**, who continues as president of A&A's international operation and also has been given the additional title of director of multinational business development. Mr. Sienkiewicz is based in New York and oversees Middle East, African and Central and South American operations.

In addition, two other executive appointments were made as a result of A&A's recent acquisition of Reed Stenhouse.

John B. Devine, former chairman and chief executive of Reed Stenhouse & Partners Ltd., was named to the newly created position of chief executive responsible for A&A's United Kingdom and European retail operations. He is based in London.

And, **David C. French**, former Reed Stenhouse Inc. chief executive and former chairman of Reed Stenhouse's Asia Pacific region, was named to the newly created position of chairman and chief executive officer of the combined Asia Pacific region. He will be based in Sydney, Australia.

In addition, A&A announced that A&A International's retail brokerage operations will be known in Britain as Alexander Stenhouse, effective Jan. 1.

Other agent/broker changes:

Fred S. James & Co. Inc. named **Geoffrey W. Kennedy** senior vp and managing director of James International, a newly formed subsidiary that will work with James' U.S. offices on overseas accounts and will develop international insurance programs. He will be based at James' New York headquarters. Mr. Kennedy was most recently director of Sedgwick Group Services Inc., the U.S. liaison office for Sedgwick Group P.L.C., with which James merged earlier this year.

Mr. Beane

S. Robert Beane elected senior vp of Johnson & Higgins in New York and appointed administrator of the firm's overseas subsidiaries. Mr. Beane, manager of J&H's New York international department since 1984, will be responsible for administration of overseas subsidiaries and joint ventures. Mr. Beane also writes the "International Issues" column that appears monthly in the Perspective section of *Business Insurance*. Succeeding Mr. Beane as manager of the New York branch's international department will be Vp **Jerome Karter.**

Other suppliers

Larry A. Niemi promoted to senior vp at Claremont, Calif.-based Galaher Settlements & Insurance Services Co. Inc.'s Chicago office.

Richard A. Ensbury named senior vp of BPC Risk Management Services Inc. in Walnut Creek, Calif. Mr. Ensbury, who joined the company in 1984 as vp, is responsible for overseeing operations at the home office, as well as field offices in California, Washington, Oregon, Nevada and Arizona.

Fred Potenza named executive manager-safety, health and loss prevention services at Gallagher Bassett Services Inc. in Rolling Meadows, Ill. Mr. Potenza previously was vp-safety, health and loss control at the National Safety Council. ■

Florida tightens financial rules for insurers

around the states

TALLAHASSEE, Fla.—A new law enhancing the Florida Insurance Department's ability to monitor the financial health of insurers is now in effect.

The measure—S.B. 973—took effect Oct. 1. It requires all insurers that do business in Florida to maintain larger reserves to give policyholders a financial cushion in the event of an insolvency, said an Insurance Department spokeswoman.

According to the new law, insurers must meet the greater of two requirements: that they have a reserve equal to 10% of their capital and surplus, or that they have a combination of $1 million in surplus, $750,000 in capital and $70,000 on deposit with the state.

Previously, insurers only had to have $750,000 in surplus, $500,000 in capital and $50,000 on deposit.

The law also:

- Requires every insurer doing business in Florida to submit an annual independent certified public accountant's audit of assets and liabilities to the department.
- Requires insurers to submit their annual statements to the National Assn. of Insurance Commissioners for solvency tests.
- Requires insurers to file copies of reinsurance treaties with the Insurance Department within 30 days of receiving the treaties.
- Forbids insurers that are controlled by an insurance agency or that control an agency to count uncollected premiums as assets, unless the premiums are held in trust accounts or unless the insurer or agency deposits a letter of credit or guaranty bond in the amount of the premiums with the department.
- Requires that persons performing the functions of a managing general agent be licensed with the Insurance Department. The law also holds an insurer responsible for acts by its MGA.

State Insurance Commissioner Bill Gunter, who initiated the legislation, said the law will better protect Florida policyholders.

"To the extent that we can keep insurance companies financially afloat, we can protect the investment of policyholders," he said.

"Consumers. . .need to know the company that sold them the policy today will be around to pay claims tomorrow."

California comp

SACRAMENTO, Calif.—As he promised, California Gov. George Deukmejian has vetoed a workers compensation package passed this year that would have increased the weekly maximum temporary disability benefits to $273 from $224 (*BI*, Sept. 23).

In his veto message Oct. 2, he said benefit increases should be accompanied by meaningful reforms "to neutralize employer costs, diminish administrative costs and reduce the amount of litigation."

Some 45 groups opposed the package—S.B. 1273—saying it did not meet these objectives, said a spokeswoman for the governor.

Gov. Deukmejian had hoped for a compromise measure and said he would veto any measure if either business or labor asked him to do so. The California Chamber of Commerce requested the veto.

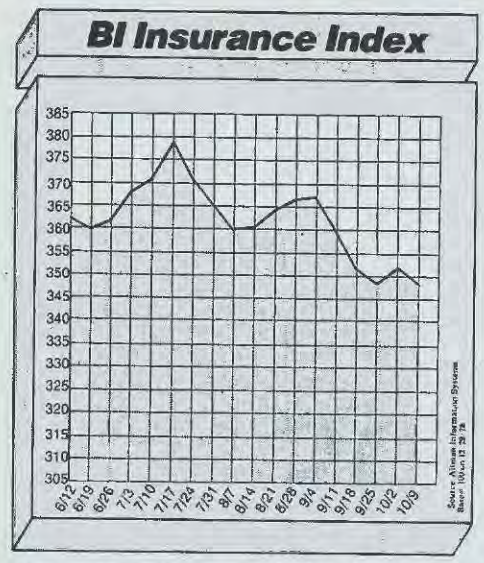
In his veto message, the governor encouraged both sides to try again next year to draft a workers compensation reform measure. But, a coalition of more than 800 employers, local governments and insurers—known as Californians for Compensation Reform—already has introduced its reform package.

Those reform measures were introduced on Sept. 13, the last day of the session, as an amendment to A.B. 1000, a workers comp bill that was introduced by Assemblyman Alister McAlister, D-Milpitas.

The new measure, which automatically is carried over to the second year of the two-year legislative session, is expected to be a starting point for debate when the Legislature reconvenes in January.

A.B. 1000 calls for an increase in benefits, but also calls for a complete restructuring of permanent partial disability benefits.

Under the proposal, there would be two forms of permanent partial benefits: a new lump-sum, tax-free benefit for serious impairment, such as amputation or loss of hearing, and a wage-replacement benefit based on actual wages lost due to the job-related injury. ■



The *Business Insurance* stock index declined during the most recent trading period, following an upward surge two weeks ago that had broken the index's three-week downward plunge. The index closed at 347.8 points on Oct. 9, down 4.4 points from 352.2 points on Oct. 2. A total of 19 stocks posted gains, 31 stocks declined and seven stocks were unchanged. The biggest gains were by Torchmark Corp., up 5.3%; Washington National Corp., also up 5.3%; Monumental Corp., up 3.8%; Nobel Insurance Ltd., up 3.7%; Avemco Corp., up 3.7%; and Baldwin & Lyons Inc., up 3.3%. The biggest losses were posted by Aneco Reinsurance Co. Ltd., down 30.0%; Mission Insurance Group Inc., down 6.0%; Continental Corp., down 5.9%; Frank B. Hall & Co. Inc., down 5.0%; CNA Financial Corp., down 4.9%; and Tokio Marine & Fire Insurance Ltd., down 4.7%. The *Business Insurance* index declined 1.2% for the period. The New York Stock Exchange composite declined 0.8%; the Standard & Poor's 500 index declined 0.8%; and the Dow Jones 30 Industrials index fell 0.5%.

British Issues

8 Oct Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	223	N/M	16.9	7.6	230—223
Genl Accident	603	25.1	31.4	5.2	612—603
Gdn Royal Exch	653	56.8	38.6	5.9	660—653
Royal	665	83.1	35.0	5.3	668—655
Sun Alliance	462	N/M	23.6	5.1	465—458
Brokers					
CE Heath	625	8.1	37.5	6.0	633—625
Hogg Robinson	270	11.3	14.3	5.3	271—270
JH Minet	218	9.9	11.4	5.2	229—218
Sedg Grp	345	13.8	17.8	5.2	353—345
Stew Wrightson	655	12.6	32.8	5.0	662—655
Willis Faber	698	17.9	23.6	3.4	700—695

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Broker stocks still strong, despite recent price drop

By LEONARD M. WILSON

Special to Business Insurance

THE PAUSE THAT refreshes might well be an appropriate description for the recent price action of the publicly owned insurance brokers' shares.

Most of the issues within the group, having posted a sharp run-up in the past six months, have undergone price corrections ranging from about 10% to 30%.

This led an anxious client to ask us if any fundamental problems cropped up among the brokerages. All vital signs seem inordinately robust, so clearly it is not loss of operating momentum that accounts for the price retreat.

Mr. Wilson

In point of fact, we believe that prices for the insurance brokers had gotten a little ahead of themselves. Investors seek to peer into the future and discount developments, both favorable and unfavorable, long before they are evident to the casual observer.

Insurance brokerage stocks started to move even before the premiums rates clearly had begun the current broad-scale advance.

Nothing succeeds like success in the stock market, and rising prices attracted additional buyers, some of whom may lack a grounding in valuation concepts.

The result, which is common enough in other industry groups as well, is temporary overevaluation that—sooner or later—is corrected.

At the recent peak, the insurance brokers as a group were selling at 17 to 18 times their 1985 earnings estimates, a rich appraisal in absolute terms and relative to the stock market in general. For example, Arthur J. Gallagher & Co. was appraised at better than 20 times a plausible earnings expectation for this year.

These lofty valuations dramatically illustrate the altered perceptions that investors hold toward insurance brokerage.

Leonard M. Wilson, a special limited partner at L.F. Rothschild, Unterberg, Towbin in New York, specializes in insurance brokerage stocks. He is a member of the New York Society of Security Analysts.

Indeed, the very qualities that made insurance brokers the rage in the early 1970s now seem once again to be an impetus to valuations.

Of course, we do not belittle the current rate environment as a driving force. The pronounced earnings growth that seems in store for the next several years accounts for a good deal of investor enthusiasm.

Few industrial or financial companies will match the earnings progress of the insurance brokers over the 1985-1987 period. And, stock prices respond almost unfailingly to an acceleration in earnings progress.

Long-term, we think there is renewed recognition that publicly owned insurance brokers are likely to attain growth rates well in excess of the gross national product's. New products, additional services and greater market penetration should generate a rate of progress that exceeds real economic growth and gains registered by most financial services.

The brokers seem largely immune to the uncertainties of budget deficits, trade deficits and exchange fluctuations—all but the most severe economic dislocations.

Investors are worried about a recession in 1986 or 1987, but the earnings outlook for insurance brokers will be not much altered by the state of the economy.

The advance in premium rates is—and will remain—the overriding contributor to operating performance.

If interest rates fall and pare investment income, we can expect some compensation from higher premium rates. In addition, lower interest rates would quite likely foster higher stock prices.

Return on shareholders' equity is a key measure of investor regard. Few companies equaled the profitability of the insurance brokers before ruinous rate competition inflicted its damage.

Once again, the brokers, with a continuing recovery in earnings, should achieve returns in the range of 25% to 30% on shareholders' equity, without leverage, and in some instances with a good deal of excess cash.

Like most service businesses, insurance brokerage is not capital-intensive. High rates of return, slim working capital needs and low fixed-asset requirements translate into copious free cash flow. In the past, this meant generous dividend payout ratios, debt-free balance sheets and cash for external opportunities.

Unfortunately, excess cash was not always committed wisely, but painful lessons have been learned, and we would expect greater discretion in the use of free cash in the future.

We think insurance brokers should be unusually favored beneficiaries of the proposed reduction in the corporate tax rate, if enacted.

The timing of tax legislation is difficult to call, but by 1987 it would be reasonable to expect earnings to receive a shot in the arm from lower tax rates. Thus, earnings estimates based upon operating gains alone could prove to be conservative. So, investors have another basis for optimism.

The prospect of takeovers has receded for the moment, but insurance brokers will remain attractive targets for all the reasons that currently attract investors to the group. Admittedly, unfriendly deals seem to be unlikely.

Then too, the flirtation of underwriters with vertical integration seems to be an idea that has arrived and departed.

However, deregulation of banks may yet bring a massive new force into the insurance industry, and a leading broker would be a quick avenue of entry.

Since acquisition prices invariably are well above market prices, values beyond what the fundamentals justify could be potentially realized.

This collection of attractive characteristics provides almost ironclad assurance that the public brokers will continue to command premium appraisals. If earnings falter, of course, they could again fall into disfavor, but we think the positive outlook will last through the decade, even after premium rates achieve adequacy and some degree of price competition returns to commercial insurance.

For now, the brokerage stocks are catching their wind, but if earnings momentum is sustained, as seems likely, the current easing in share prices could prove to be a temporary phenomenon.

The Crump Cos.

The Crump Cos. Inc. has announced a 2-for-1 split of the company's stock and an increase in its quarterly dividend.

Crump's board of directors recommended the split earlier this year to increase the number of authorized common shares to 20 million from 10 million. Shareholders approved an amendment increasing the number of shares last month.

In addition, the Crump board has increased the quarterly dividend rate by declaring a cash dividend of 6.25 cents per share on the shares outstanding after the split. The increase is the equivalent of raising Crump's annual dividend rate by 14% to 50 cents per share from 44 cents.

The new shares issued pursuant to the split and the cash dividend will be paid simultaneously on Oct. 18 to shareholders of record as of Sept. 30.

Guaranty National

Orion Capital Corp. of New York, a property/casualty insurance holding company, has purchased a 9% convertible subordinated promissory note in the principal amount of $5 million from Englewood, Colo.-based Guaranty National Corp., the immediate parent of Guaranty National Insurance Co.

Proceeds from the sale of the note will be used to increase Guaranty National's capital and allow its commercial business to grow.

Orion Capital currently holds all 5.25 million shares of Guaranty National's 6% convertible preferred stock and has approximately 55% voting control of Guaranty National.

Travelers Corp.

Travelers Corp. has declared a quarterly dividend of 51 cents per share of common stock and $1.04 cents per share on its $4.16 Series A convertible exchangeable preferred stock. Both dividends are payable Dec. 10 to shareholders of record on Oct. 31. ■

BI Industry Stock Report

October 9, 1985 10/3/85 thru 10/9/85

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	27.38	-2.2	0.0	1.00	3.7	27.88	27.13	297.1
Baldwin & Lyons Inc	OTC	62.00	3.3	10.2	0.80	1.3	64.00	60.00	0.3
Corroon & Black Corp	NYSE	45.63	0.3	0.0	1.00	2.2	45.63	45.25	21.0
Crump E H Cos Inc	OTC	29.50	2.2	19.0	0.50	1.7	29.50	28.75	48.0
Emett & Chandler Cos Inc	OTC	13.63	0.9	34.9	0.00	0.0	14.00	13.25	13.6
Gallagher Arthur J & Co	OTC	35.00	1.4	19.6	0.28	0.8	35.00	34.50	25.9
Hall Frank B & Co Inc	NYSE	25.88	-5.0	0.0	1.00	3.9	27.75	25.88	166.9
Marsh & Mclennan Cos Inc	NYSE	66.88	-2.4	17.1	2.68	4.0	68.50	66.75	139.6
Poe & Assoc Inc	OTC	8.00	0.0	0.0	0.80	10.0	8.00	8.00	200.1
Reed Stenhouse Cos Ltd	OTC	21.88	0.0	28.4	0.00	0.0	0.00	0.00	0.0
AGENTS/BROKERS	AVERAGE			36.3		2.4			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	40.63	-2.1	14.1	1.36	3.3	41.88	40.63	2,100.8
Anderson Clayton(Ranger/PanAm)	NYSE	42.75	-1.4	31.4	1.32	3.1	43.75	42.63	64.8
Amaco Inc	NYSE	8.75	0.0	0.0	0.00	0.0	8.75	8.63	251.1
Berkley W R Corp	OTC	19.75	-1.3	58.1	0.32	1.6	20.25	19.75	113.5
CIGNA Corp	NYSE	54.38	0.5	76.6	2.60	4.8	54.38	53.13	661.3
City Investing Co. (Home Ins.)	NYSE	7.25	0.0	1.1	0.00	0.0	0.00	0.00	0.0
CNA Finl Corp (CCNA)	NYSE	48.00	-5.0	16.6	0.00	0.0	49.88	48.00	289.2
General Re Corp	NYSE	80.75	-2.6	128.2	1.56	1.9	81.75	80.75	159.7
ITT (Hartford Group)	NYSE	34.63	1.1	10.0	1.00	2.9	34.88	33.75	4,481.0
Sears Roebuck & Co. (Allstate)	NYSE	32.13	-1.9	8.6	1.76	5.5	32.50	31.88	2,241.6
Teledyne Inc (Argonaut)	NYSE	235.00	-0.9	5.0	0.00	0.0	236.63	234.00	57.7
Transamerica Corp (Occidental & Fred S. James)	NYSE	27.75	-0.4	14.3	1.68	6.1	28.25	27.63	352.2
CONGLOMERATES/HOLDING COS.	AVERAGE			9.6		1.8			
Insurers									
Aetna Life & Cas Co	NYSE	44.25	-1.7	18.2	2.64	6.0	45.00	43.38	2,831.1
American General Corp	NYSE	28.13	-3.8	8.7	1.00	3.6	29.00	28.13	966.4
Amern Heritage Life Invt Co	NYSE	34.25	1.1	10.0	1.20	3.5	34.25	34.00	2.0
American Indty Finl Corp	OTC	17.25	-1.4	0.0	1.12	6.5	18.00	17.25	0.7
American Intl Group Inc	NYSE	82.88	-3.1	22.2	0.44	0.5	84.25	82.88	311.6
Aneco Reins Ltd	OTC	0.88	-30.0	0.0	0.00	0.0	0.88	0.88*	17.5
Avemco Corp	NYSE	31.38	3.7	13.8	0.60	1.9	31.38*	30.25	5.0
Business Mens Assurn Co Amer	OTC	26.38	-0.5	7.6	1.04	3.9	27.00	26.25	22.0
Chubb Corp	NYSE	65.63	-4.5	16.0	2.34	3.6	66.50	65.25	405.7
Combined Intl Corp	NYSE	42.13	-3.7	7.9	2.16	5.1	43.88	42.13	155.9
Continental Corp	NYSE	38.13	-5.9	18.7	2.60	6.8	39.63	37.38	1,129.0
Crown Life Ins Co	OTC	215.00	-4.4	13.0	0.00	0.0	225.00	215.00	0.0
Durham Corp	OTC	37.50	-2.0	6.9	1.28	3.4	38.50	37.50	11.8
Farmers Group Inc	OTC	58.50	-0.8	10.0	1.76	3.0	59.13	58.38	223.8
Fremont Gen Corp	OTC	22.75	-3.7	0.0	0.48	2.1	23.50	22.38	89.9
Great West Life Assurn Co	OTC	430.00	0.0	11.1	1.60	0.4	430.00	430.00	0.0
Hanover Ins Co	OTC	44.25	1.1	60.6	0.56	1.3	44.25	43.75	9.2
Hartford Steam Boiler Insptn	OTC	50.50	0.0	15.9	2.00	4.0	50.50	49.50	7.7
Kans City Life Ins	OTC	23.75	1.1	9.4	0.87	3.7	23.75	23.50	1.9
Kemper Corp	OTC	51.88	-3.0	14.9	1.80	3.5	53.50	51.88	61.3
Liberty Corp S C	NYSE	29.50	1.3	13.0	0.72	2.4	29.50	28.88	24.0
Lincoln Natl Corp Ind	NYSE	42.25	0.3	10.1	1.84	4.4	42.50	42.13	109.7
Mission Ins Group Inc	NYSE	3.88	-6.1	0.0	0.00	0.0	4.25	3.88	74.6
Monumental Corp	OTC	30.75	3.8	11.3	1.40	4.6	30.75	29.75	29.5
Nobel Ins Ltd	OTC	10.50	3.7	13.8	0.25	2.4	11.00	10.25	17.5
Northwestern Natl Life Ins	OTC	21.63	1.8	5.6	0.80	3.7	21.63	21.38	221.8
Ohio Cas Corp	OTC	56.88	-0.7	21.3	2.80	4.9	57.25	56.88	74.3
Old Rep Intl Corp	OTC	29.25	-3.3	7.9	0.74	2.5	29.63	28.75	70.6
Orion Cap Corp	NYSE	24.25	-1.0	0.0	0.76	3.1	24.75	24.25	33.0
Protective Corp	OTC	18.13	0.7	6.7	0.66	3.6	18.25	18.00	922.6
Provident Life & Acc Ins Co	OTC	23.25	-1.1	6.3	0.76	3.3	23.25	23.00	227.1
St Paul Cos Inc	OTC	67.75	-1.1	0.0	3.00	4.4	68.50	67.63	128.0
SAFECO Corp	OTC	37.88	-2.3	12.3	1.60	4.2	38.50	37.00	197.2
Sri Corp	OTC	18.00	-1.4	52.9	0.80	4.4	18.25	18.00	22.0
Seibels Bruce Group Inc	OTC	18.00	-2.7	0.0	0.80	4.4	18.63	18.00	43.5
Statesman Group Inc	OTC	4.25	0.0	0.0	0.15	3.5	4.38	4.25	39.1
Tokio Marine & Fire Ins Co	OTC	219.75	-4.7	41.4	1.05	0.5	234.00*	219.25	42.8
Torchmark Corp	NYSE	20.00	5.3	8.4	0.60	3.0	20.00	18.88	1,071.6
Travelers Corp	NYSE	41.38	-0.9	10.0	2.04	4.9	41.75	41.00	1,085.7
United Fire & Cas Co	OTC	24.50	0.0	21.3	1.20	4.9	24.50	24.50	0.0
United States Fid & Gty Co	NYSE	32.50	-4.1	135.4	2.20	6.8	33.63	32.38	338.3
Usilife Corp	NYSE	34.88	-1.1	7.9	1.04	3.0	35.38	34.88	396.0
Washington Natl Corp	NYSE	25.00	5.3	7.2	1.08	4.3	25.00	24.63	90.5
Zenith Natl Ins Corp	OTC	19.75	2.6	0.0	0.68	3.4	19.75	19.25	60.6
INSURANCE COMPANIES	AVERAGE			17.4		2.4			

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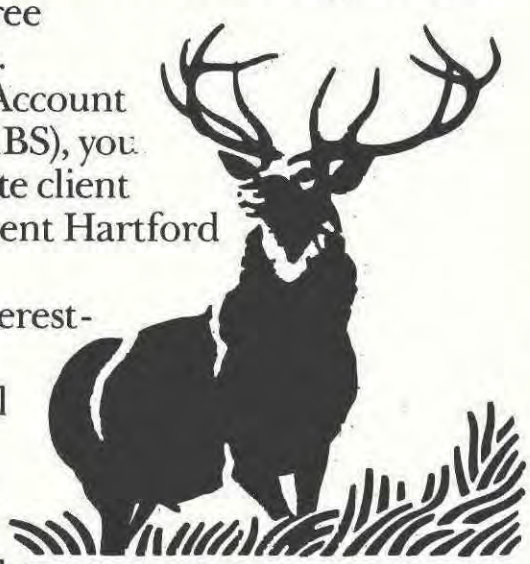

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