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Update

CalFed sells Anglo-American to banking group for $100 million

LONDON—Excess insurer Anglo-American Insurance Co. Ltd. will be purchased by a new affiliate of specialist banking services group John Head & Partners L.P. of New York for 64.5 million pounds ($100.3 million).

Los Angeles-based financial services company CalFed Inc. is selling its London-based insurance company less than three years after it began underwriting.

Capping 10 years of planning, CalFed activated Anglo-American in April 1987

Continued on next page

Hawaii restricts punitive awards

By STACY ADLER

HONOLULU—A sweeping Hawaii Supreme Court ruling that makes it harder for plaintiffs to recover punitive damages is expected to advance a nationwide trend.

The state's high court ruled that plaintiffs must provide "clear and convincing" evidence rather than merely a "preponderance of evidence" that punitive damages are warranted.

The Hawaii court joins a handful of courts in the nation that have raised the standard of proof necessary to award punitive damages.

In addition, about a dozen state legislatures have raised the standard of proof for recovering punitive damages.

Plaintiffs have much more difficulty with "clear and convincing evidence" than with the "preponderance of evidence" standard, which requires only enough evidence to tip the scales in favor of awarding punitive damages.

But, the "clear and convincing" standard is consid-

Continued on page 80

Benefit law changes

Budget bill jammed with proposals

By JERRY GEISEL

WASHINGTON—The outcome of a rancorous Senate debate over a budget reconciliation bill will determine the fate of sweeping proposals to amend employee benefits law.

Benefit provisions stuffed into the 13-pound budget reconciliation bill include total repeal of Section 89, an increase in termination insurance premiums charged by the Pension Benefit Guaranty Corp. and a virtual ban on employers' recovery of excess assets from terminated overfunded pension plans.

Other provisions would allow employers to take excess assets out of their overfunded pension plans—without terminating the plans—to fund retiree health care expenses.

The measure also would curb certain tax advantages of employee stock ownership plans, extend the tax-free status of employer-provided educational assistance benefits and encourage the transfer of employees' pension benefits to individual retirement accounts after employment is terminated.

And, the measure includes a cornucopia of technical provisions that would, among other things, assure that certain tax-exempt organizations can sponsor 401(k) salary reduction plans but restrict the ability of national trade associations to sponsor special vehicles, known as Voluntary Employee Beneficiary Assns., to tax-effectively fund health care and disability benefits.

Continued on page 79

Employee benefit issues at stake in budget reconciliation bills

- ✔ *Section 89 repeal*
- ✔ *Repeal of Medicare Catastrophic Act*
- ✔ *Higher PBGC premiums*
- ✔ *Pension reversions*
- ✔ *Retiree health account transfers*
- ✔ *Loans to Employee Stock Ownership Plans*
- ✔ *Taxation of Educational Assistance benefits*
- ✔ *Pension portability*

Sex discrimination OK to protect fetus: Court

By MEG FLETCHER

CHICAGO—An employer may prohibit all fertile women from holding jobs that pose a significant risk to the health of an unborn child, even if a woman does not intend to become pregnant, according to a recent federal appeals court decision.

The 7th U.S. Circuit Court of Appeals found that the fetal protection policy adopted by Johnson Controls Inc., a Milwaukee-based manufacturer of lead-filled batteries, did not unfairly discriminate against fertile female employees.

As a result, more employers may be willing to adopt such policies to protect themselves from lawsuits that could be brought by employees' injured offspring, experts say.

However, dissenting judges, as well as representatives of labor and women's rights groups, are concerned that fetal protection policies can be used to exclude large numbers of women from higher-paying—but hazardous—jobs even though they do not intend to become pregnant.

"This is the most important sex-discrimination case this circuit has decided. It is likely the most important sex-discrimination case in any court since 1964, when Congress enacted Title VII," said Circuit Judge Frank Easterbrook, who was joined by Judge Joel Flaum in a dissent from the 7th Circuit's 7-4 decision late last month.

The 7th Circuit upheld a decision by the U.S. District Court for the Eastern District of Wisconsin in Milwaukee granting summary judgment to Johnson Controls and dismissing a lawsuit brought by union representatives on behalf of union members at nine of the company's battery division operations where workers are exposed to lead.

The 7th Circuit became the third federal appellate court to uphold a fetal protection policy.

The lawsuit was filed in April 1984 by the international and local units representing members of the United Auto Workers union in nine plants across the United States. The UAW suit alleged that Johnson Controls' fetal protection policy constituted sex discrimination in violation of Title VII of the Civil Rights Act of 1964.

Johnson Controls' current policy, which was adopted in 1982, states that women with childbearing capacity will not be hired for, or allowed to transfer into, jobs involving lead exposure.

The company "was motivated by a concern for the children of employees," said a Johnson Controls spokeswoman.

The policy "does not apply to those women who have medical confirmation that they cannot bear children," according to court records. However, the company expressly advised women against seeking sterilization.

Johnson Controls said that it adopted this policy as part of its longstanding efforts to monitor and protect the health of employees who work with lead. The company, for example, samples employees' blood to ensure that lead levels are acceptable and provides protective clothing.

The company has spent more than $15 million since 1978 on the effort, primarily on equipment to reduce lead levels, according to court records.

Johnson Controls said it adopted a mandatory policy because of increased medical understanding of the risk lead poses to a fetus. Lead can be absorbed into the mother's blood, cross the placenta and mix with the blood of the fetus. Such exposure could cause irreversible learning disabilities, lower birth weight, premature delivery and stillbirths, according to medical

Continued on page 78

Two insurers settle Texas antitrust suit

By JUDY GREENWALD

AUSTIN, Texas—Two insurance company defendants in the Texas state antitrust litigation are settling for a total of $1 million to cap their expenses.

Travelers Insurance Co. and St. Paul Fire & Marine Insurance Co. said last week that they have reached settlement agreements with the state attorney general.

Both insurers, which admitted no wrongdoing, said they wanted to cap their legal costs.

The settlement agreements were signed Thursday by 261st District Court Judge Peter Lowry.

Neither insurer was a defendant in the federal antitrust litigation, which was dismissed by U.S. District Court Judge William Schwarzer last month (*BI*, Sept. 25).

Although the federal and Texas antitrust lawsuits are similar, the Texas complaint contains broader allegations of wrongdoing. In addition to charging insurers with boycotting certain lines of coverage, as both suits do, the Texas suit also accuses insurers of conduct to artificially inflate rates (*BI*, Nov. 7, 1988).

Meanwhile, other defendants in the Texas litigation that were contacted by *Business Insurance* said they intend to defend themselves against the charges and are preparing motions seeking its dismissal. The motions are expected to be filed shortly.

Under the similarly worded agreements, Travelers and St. Paul each agreed to pay $500,000 in attorneys' fees and investigative costs. Both insurers stressed that the sum was neither a fine nor a penalty.

Other provisions of the settlement agreements include:

- Neither insurer will serve on four committees of the Insurance

Continued on page 4

French AXA seeks leading role in worldwide insurance market Page 3

401(k) plans weather new federal rules: Survey Page 3

Judge takes new approach to finding pollution coverage Page 2

Update

CalFed to sell Anglo-American

Continued from previous page
with 50 million pounds ($80 million at appropriate exchange rates) in capital and surplus. Anglo-American's policies were underwritten by H.S. Weavers (Underwriting) Agencies Ltd. (*BI*, April 13, 1987).

Anglo-American accounts for 45% of Weavers' line slip, while Weavers' sister company, Walbrook Insurance Co. Ltd., writes 55% of the slip (*BI*, May 1; April 24).

Weavers' five-year underwriting agency agreement with Anglo-American lasts until April 1992. Either party may cancel with a one-year notice.

Head says it will discuss with Weavers' parent, London United Investments P.L.C., the "long-term future of this relationship. It is too early to assess what changes, if any, to this relationship may be appropriate and the implications of any such changes for the structure of LUI and Anglo-American."

LUI announced last week that it "looks forward to a continuing relationship between (Weavers) and Anglo and to the development of Anglo's business in London, which it believes will strengthen the Weavers' stamp and hence LUI."

Anglo-American reported 1988 total pretax profit of 4.4 million pounds ($8.0 million at year-end exchange rates) and capital of 50 million pounds ($94 million).

The purchase by the new affiliate of Head, which has not been named, will be financed by the Head Insurance Fund, an investment fund controlled by Head and composed of European and American institutions, said Rory Macnamara, finance director of investment bank Morgan Grenfell & Co. Ltd., which arranged the acquisition.

The acquisition is subject to British Department of Trade and Industry approval.

Bank of America sells brokers

LONDON—Bank of America has sold its London brokerage subsidiaries to broker Leslie & Godwin Ltd. for an undisclosed sum.

BankAmerica Insurance Services Ltd. and its Lloyd's of London brokerage subsidiary, BankAmerica Insurance Brokers Ltd., have specialized in credit and political risk insurance since their formation following the San Francisco-based bank's 1985 acquisition of Lloyd's broker G.N. Bishop (London) Ltd.

Leslie & Godwin Chairman Antony A.M. Pinsent would not disclose the brokerages' revenues, although he said they employed about seven people.

The sold brokerages will become part of Leslie & Godwin Financial Risks Ltd., a unit of Leslie & Godwin's non-marine division. Chairman Michael Eve once headed the BankAmerica brokerages.

Farmers can raise rates: Judge

LOS ANGELES—A Los Angeles Superior Court judge last week upheld a six-month rate freeze on private passenger automobile insurance in the state but allowed Farmers Group Inc. to raise rates next month.

Farmers had sought a stay of the rate freeze, but Judge Miriam Vogel denied the request on the basis that Insurance Commissioner Roxani Gillespie has the authority to impose a freeze. Ms. Gillespie ordered the freeze earlier this month partly in response to an announcement by Los Angeles-based Farmers that it would increase rates 5.9% on Nov. 1 (*BI*, Oct. 9).

But, the judge agreed to let Farmers raise rates Dec. 1, according to a spokeswoman for Ms. Gillespie. If Farmers' rates are increased, they will be subject to the state's new prior rate approval system, established by Proposition 103, the spokeswoman said.

Proposition 103 requires the state on Nov. 8 to switch to a prior approval system from the file-and-use system currently in effect.

However, Farmers contends that the judge's ruling not only allows Farmers to increase rates 5.9% on Nov. 30, but also that the file-and-use system will apply, a spokesman said. That approach would subject the rate increase to less immediate review.

Farmers, which is the second-largest auto insurer in the state with 13% of the market, is seeking the higher rates on new and renewal policies to offset a projected $100 million loss resulting from its 1989 experience in the state's assigned risk plan.

Meanwhile, Ms. Gillespie will begin hearings Oct. 30 on new rating criteria and insurers' rates of return, a spokeswoman said. The commissioner agreed during court proceedings last week to issue the new rating factors by Nov. 30.

N.Y.'s Corcoran denies rumors

NEW YORK—New York Insurance Superintendent James P. Corcoran says he is not leaving the department "under any circumstances" to become a partner with Kroll & Tract in New York.

According to rumors, Mr. Corcoran had planned to resign from the department soon to become a partner with the firm and specialize in international matters but that he delayed his resignation at the urging of Gov. Mario Cuomo.

"I'm not going to the law firm of Kroll & Tract," Mr. Corcoran said. "I'm not leaving. That's definite. I'm staying here for a while."

Mr. Corcoran also denied that the governor asked him to stay on. "The governor has not been pleading with me at any time during my career," Mr. Corcoran said.

But, the regulator refused to say whether Kroll & Tract offered him a position. "That's not an issue," he said.

Mr. Corcoran explained that "many" law firms approach him and that he informs the department about those offers immediately to avoid the appearance of a conflict of interest.

While he said he has no plans to leave office "at this point," Mr. Corcoran refused to discuss what might happen over the long term. "I can't tell you what happens next week," he said.

Harold Tract, a partner with Kroll & Tract, would not comment.

Continued on page 80

Forged CD uncovered in risk group's assets

By DOUGLAS McLEOD

BATON ROUGE, La.—The Louisiana Insurance Department refused to license a risk retention group after finding that its assets included a forged $2 million certificate of deposit.

Security American Mutual Risk Retention Group of New Orleans had applied for a certificate of authority in Louisiana earlier this year to write truck liability insurance.

The group reported as its major asset a $2 million CD purportedly issued by Swiss Bank Corp. of Zurich, Switzerland, and held in a trust account at Sun Bank/Miami N.A. of Miami.

In an Aug. 1 letter to the Louisiana department, an official of Sun Bank confirmed it was holding the $2 million CD "to serve as surplus capital as required of an insurance company pursuant to Louisiana state law."

Sun Bank then sent a letter to Swiss Bank seeking confirmation of the CD.

However, on Sept. 14, Sun Bank received a telex from a Swiss Bank official saying that Swiss Bank had never issued the CD.

"The document sent to us is an obvious forgery," the telex said.

Sun Bank wrote to the Louisiana department the next day infori2ing the department of the forgery.

"Please disregard our confirmation letter of Aug. 1, 1989," Sun Bank's letter said. "Sun Bank intends to return the certificate of deposit to the party who presented it."

The Louisiana department subsequently denied Security American's license application.

Security American's financing was arranged by Gary Bennett, president of Truck Writers Insurance Agency Inc. of Cincinnati, which was to have acted as a managing general agent for the risk retention group.

In an interview, Mr. Bennett said he obtained the CD

Continued on page 80

Pollution exclusion overturned

Damage 'unintentional': Court

By STACY ADLER

DENVER—The pollution exclusion does not bar coverage if the policyholder did not intend to contaminate third-party property even though it intentionally placed the contaminants in unlined basins, a federal judge has ruled.

The decision marks the first time a court has interpreted the introductory language of the pollution exclusion that says the clause applies to the "discharge, dispersal, release or escape" of pollutants.

In an Oct. 4 bench ruling, U.S. District Judge Zita L. Weinshienk in Denver ruled that the phrase applies to the moment in time when toxic chemicals damage third-party property. The judge denied insurer arguments that this language should be interpreted to apply to the moment in time when the policyholder placed hazardous wastes into unlined waste basins.

The two policyholder attorneys involved in the case are cheering the judge's decision and say it could influence pollution coverage disputes in courts nationwide.

"This is a landmark ruling," asserted attorney Brooke Jackson of Holland & Hart in Denver, who represented policyholder Broderick Investment Co. of Denver in the litigation.

"This is the first court in the country to rule" on this aspect of the pollution exclusion, Mr. Jackson said.

Other courts have focused only on the meaning of the phrase "sudden and accidental," he noted.

"By focusing on whether the policyholder intended to cause third-party damage, the court has made it easier for insureds to get coverage," Mr. Jackson observed.

"If the pollution exclusion was interpreted to apply to the initial discharge of contaminants, it would be almost impossible for an insured to win," he explained.

Continued on page 74

HMO/PPO directory

Business Insurance will publish its third annual special issue in December containing directories of health maintenance organizations and preferred provider organizations, along with reports on the state of the alternative health care market.

The directories will be published as a special 53rd issue in addition to the regular weekly edition of *BI*. All *BI* subscribers will receive this special 53rd issue of the year free of charge.

In addition to addresses and phone numbers, the directory will provide a wealth of information on individual HMOs, including federal and state qualification, model type, number of participating primary physicians, number of participating hospitals, pharmacies and diagnostic labs, service areas, services offered and rating options, and the number of employers contracting with the HMO.

The PPO directory will contain similar information.

The special issue also will feature an in-depth report on the managed health care market.

The directories are published as an editorial service. There is no charge for companies to be included, but those that wish to be listed must complete and return a *BI* questionnaire by Oct. 30.

HMOs that have not yet received a questionnaire should contact Sara Harty, Editorial Assistant, at 312-380-3195. PPOs should contact Marilou Jones, Directory Editor, at 312-649-5279.

Inside

- A Senate committee's increase of PBGC premiums is an outrage, says this week's editorial. **PAGE 8**
- Primary insurers—not excess insurers—are responsible for post-judgment interest, an Illinois court ruled. **PAGE 10**
- Zurich Insurance Group plans to expand its European operations to take advantage of 1992. **PAGE 14**
- New York's College of Insurance is undergoing a metamorphosis, say the school's trustees and its top administrator. **PAGE 20**
- An action plan aimed at perceptions and realities of the insurance industry is needed to restore its credibility, says Sam H. McGoun of Corroon & Black. **PAGE 49**
- Employers, insurers and other third-party payers should negotiate directly for mental health care, says psychologist Leo H. Bradman. **PAGE 50**
- In light of tax reform's impact on insurers, perhaps a new tax form is needed, muses Franklin W. Nutter of the Alliance of American Insurers. **PAGE 52**
- Risk retention groups must actively plan tailor-made investment strategies with their managers, an investment adviser tells the National Risk Retention Assn. **PAGE 62**
- The strength of insurance brokerage shares will have to persist in the 1990s if current stock valuations are to prevail, says analyst Leonard M. Wilson. **PAGE 81**

Departments

Advertiser index 62
Around the states 75
At issue 10
Benefit beat 6
Bermuda briefs 34
Classifieds 76
Comings & goings: buyers 26
Comings & goings: industry 21
Datebook 64
Insurance services guide 80
Legal briefs 52
Letters 8
London 18
Markets 30
Opinions 8
Perspectives 49
Products & services 22
Speaking out 49
Ticker 81
Washington 71

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Global market

French AXA targets leading role

By STACY SHAPIRO

PARIS—The AXA Group and its principal insurance subsidiary, AXA Midi Assurances S.A., will become one of the 20 largest insurance groups in the world by the year 2000 if aggressive Chairman Claude Bebear has his way.

And he usually does.

Mr. Bebear (pronounced bay-bay-are, with accents over both e's) has been building an insurance empire by acquisitions since 1974. While most of the acquisitions have been friendly, one ended in a boardroom battle earlier this year. He won.

Paris-based AXA is now the second-largest insurer in France, based on premiums of 41.9 billion French francs at year-end 1988 ($6.9 billion at year-end exchange rates).

AXA reported a net profit of 2.1 billion French francs ($346.5 million) in 1988 and unrealized capital gains at year-end 1988 of 123.4 billion French francs ($20.4 billion).

Now, Mr. Bebear, who loves to hunt wild game, is stalking Los Angeles-based Farmers Group Inc. to increase the U.S. presence of his group's main insurance subsidiary, AXA-Midi Assurances. It is part of an overall plan to become more international.

AXA-Midi and an AXA Group unit plan to buy Farmers for $4.5 billion from Sir James Goldsmith's Hoylake Investments Ltd. if Hoylake is successful in its bid to acquire B.A.T Industries P.L.C., the London-based parent of Farmers.

Hoylake's bid, though, is on the back burner until nine state insurance commissioners, including Roxani Gillespie in California, decide whether AXA-Midi is a suitable buyer for one of the largest U.S. personal lines insurers.

Once the commissioners decide, which Mr. Bebear says could take "months," Hoylake's unfriendly bid that lapsed earlier this month will be allowed to be redrafted and offered again to B.A.T shareholders, according to a decision by the British Takeover Panel this month.

After the Farmers bid is decided, AXA will look for new acquisitions in Europe and also at new possibilities in the Far East, in all classes of business, says AXA's chairman.

And, in the future, AXA may look at additional acquisitions in the United States, though it would be up to Farmers' management to decide, he said.

"I have always been convinced that the market would become international and that in every country you will have very big players—American players, Japanese players, European players," Mr. Bebear told *Business Insurance* during an interview in his spacious Parisian office. A guest knows this is an office of a hunter: It is decorated with a black leather couch and chairs, water colors of wild

Continued on page 73

Stacy Shapiro

The AXA Group Chairman Claude Bebear is forging joint ventures with Italy's Assicurazioni Generali.

401(k) plans weather new rules: Survey

By DONNA DiBLASE

Despite recent federal restrictions on defined contribution plans, 401(k) savings plans remain popular among employers, a new survey shows.

About three-quarters of more than 500 employers surveyed now offer or expect to offer a 401(k) plan in the next year, according to Buck Consultants Inc. of New York.

"We were gratified to see that 401(k) plans are still so popular" despite the restrictions on maximum contributions and other plan provisions, said Frederick Rumack, director of Buck's tax and legal consulting services in New York.

"Employers and employees still see 401(k) plans as the best game in town. When you consider the employer matching contributions and the advantages of saving on a pretax basis, you can't go wrong," he said.

The plans also are perceived positively by employees, especially highly compensated employees, the survey found.

The survey also illustrated the effects of recent federal regulations on hundreds of 401(k) plans.

In its January 1989 survey of 508 employers, Buck found that 367—or 72.2% of respondents—have 401(k) plans, and 14 anticipate installing a plan within a year. Four respondents had terminated their plans and 123 said they never had a 401(k) plan.

Most current plans were installed in 1984 and 1985. The four employers that terminated their plans did so in 1987 and 1988.

Low participation was the major reason given for terminations, though employers also cited government regulation, administrative burdens and a union request to terminate the plan.

The desire to supplement another retirement plan was the most popular reason for implementing a 401(k) plan, cited by 67.3% of the respondents. And 63.5% also cited perceived employee interest.

Competitors having a plan was cited by 35.2% of respondents and 28.3% said they installed a plan as a conversion from a thrift or profit sharing plan.

Also, 9.3% wanted to establish a defined contribution pension plan as part of their overall benefit package; 7.4% installed a 401(k) as a conversion from a defined benefit plan; and 6.3% said they installed the plan to establish a sole retirement plan, the survey found.

Of the companies without plans, 35.2% cited the administrative burdens of installing and maintaining a 401(k) plan and 19.5% mentioned low participation rates.

Non-discrimination tests required by the federal Tax Reform Act of 1986 also were noted as reasons for not having a plan: 11.5% cited the 401(m) Actual Contribution Percentage test and 10.6% gave the 401(k) Actual Deferral Percentage test as reasons why they didn't have plans.

The plans are far more popular among highly paid employees, the survey found. Perception of 401(k) plans "very positively" was nearly three times higher—56.6% to 20.6%—among highly paid employees than among those who are non-highly paid.

And, 57.5% of management perceived 401(k) plans very positively, the employers reported.

Participation rates in the 401(k) plans also varied.

For example, 57.1% of the employers with plans had an employee participation rate of between 67% and 100% of eligible employees; 32.5% of the employers had a participation rate of between 34% and 66% of eligible employees; and 10.4% had a participation rate of 33% or less among eligible employees.

Eligibility requirements like age and years

Continued on page 72

D&O claims in Canada cost less than in U.S.

By DONNA DiBLASE

TORONTO—Most Canadian directors and officers liability insurance policyholders face less costly and far fewer D&O claims than their U.S. counterparts and have little trouble finding the coverage, a new survey says.

The cost of settling D&O claims—including those that did not result in a payment to a claimant—averaged $371,571 per claim over a 10-year period for Canadian respondents to the "1989 Wyatt Canadian Directors and Officers Liability Survey."

That figure is less than half of the $805,000 cost per D&O claim against U.S. companies that responded to a 1988 survey, Wyatt notes.

And, the 501 Canadian companies in The Wyatt Co. survey faced a 0.074 claim frequency in the 1979-1988 period, only about one-sixth of the 0.45 claim frequency reported by the 1,708 U.S. companies over a similar period in a survey conducted by the consultant last year (*BI*, Dec. 19, 1988).

Canadian firms that faced the greatest chance of being hit with D&O claims, according to the survey, were: large, in terms of assets and number of stockholders; owners of U.S. subsidiaries; involved in merger activities; and did not report an aftertax loss.

However, only 57% of the Canadian survey participants reported buying D&O coverage, much lower than the 74% of U.S. companies last year that reported buying the coverage.

Of those respondents that did not purchase D&O coverage, only 5% said it was because the coverage was not available to them.

The Canadian legal environment, though, could soon become more difficult for corporate directors and officers, cautioned Vince Brewerton, a consultant in Wyatt's Toronto office.

For example, "there have been some rumblings about two things in Ontario: the introduction of legislation that would allow contingency fees for lawyers and legislation that would facilitate class-

Continued on page 70

Domino's unveils custom program on safer driving

By MARK A. HOFMANN

ANN ARBOR, Mich.—Domino's Pizza Inc. is implementing a new program to encourage safe driving by its delivery crews, but some loss control experts question whether the program can be effective as long as Domino's offers its quick delivery guarantee.

Ann Arbor, Mich.-based Domino's has been engulfed in a firestorm of criticism of its guarantee to deliver orders within 30 minutes or slice $3 off the price of the order after an Indiana teen-ager was killed earlier this year while making a delivery for Domino's (*BI*, June 26).

That death led to a petition drive by the youth's neighbors seeking a federal law to ban guarantees such as Domino's. However, no legislative action has been taken.

And, Domino's currently faces a lawsuit from a Pittsburgh couple who claim a Domino's driver struck their station wagon. The suit, which seeks damages in excess of $25,000, is scheduled to go to court in Pittsburgh on Nov. 16.

At the time of the Indiana driver's death, Domino's revealed that 20 of its drivers had been involved in fatalities in 1988. And, the toll thus far this year is six or seven, according to the Domino's spokeswoman.

But, Domino's contends that its driver safety program had been on the drawing board for some time prior to these events and was launched on a trial basis in Florida in June.

Domino's instituted the program nationally in early August, a spokeswoman said.

The Domino's safety program centers on a 63-page, 14-lesson handbook with an accompanying videotape that details various aspects of safe driving.

The 14 lessons are: Safe Driving Formula; Price of Unsafe Driving; Weather; Light; Traffic; Driver; Avoiding Collisions; Backing and Parking; Yielding to Pedestrians; Entering Intersections; Saving Your Life; Maintaining Your Vehicle; Putting it All Together; and From the Top.

According to the Domino's spokeswoman, all drivers for corpo-

Continued on page 74

Antitrust suit

Continued from page 1

Services Offices Inc. for three years. The committees are the executive committee, board of directors, commercial lines committee and nominating committee.

A St. Paul spokeswoman said the company does not currently serve on any of those committees.

An ISO spokesman said Travelers is on the board of directors, but does not serve on the nominating or executive committees. He wouldn't comment on the commercial lines committee.

- Both insurers agreed not to use joint gatherings of the industry to do anything in restraint of trade.

St. Paul and Travelers both contended that neither had ever done so in any case.

- Both insurers agreed to report on a quarterly basis for three years any meetings they attend of the Alliance of American Insurers, the National Assn. of Independent Insurers or ISO where commercial general liability insurance forms and coverages are discussed

The Travelers spokesman said the insurer had already spent about $500,000 defending the case. Pursuing it, he said, would have meant legal costs of "several times that."

The St. Paul spokeswoman refused to reveal the insurer's legal costs, although she commented that the $500,000 it has agreed to pay "is undoubtedly much less than we would have to pay if we continued."

Both insurers objected to language in a press release issued by the office of Texas Attorney General Jim Mattox, who also announced his candidacy for governor last week.

The press release quoted Mr. Mattox as stating that "in essence these companies have entered a nolo contendre plea and have agreed to testify for the state as the lawsuit continues against other defendants."

Both insurers object to Mr. Mattox's reference to "nolo contendre" or "no contest," emphasizing that although they agreed to settle to reduce their legal costs, they continue to assert their innocence of any of the charges against them.

It is a "ridiculous assertion," said the Travelers spokesman. "In no way can this settlement be equated to that type of criminal plea."

The St. Paul spokeswoman said: "What we're doing is settling a lawsuit for economic reasons. It's just a faulty analogy for him to use. We're not admitting guilt in any way. We've always denied it and still do."

A spokesman for the Texas attorney general's office said objections to the use of the term nolo contendre were "picky."

"As far as I'm concerned it's the same as nolo contendre. They're not admitting or denying anything. They're not contesting it."

The St. Paul settlement agreement states that "it shall not be construed as an admission of liability by defendant. Defendant specifically denies any liability or wrongdoing by it, said consideration being given solely by way of compromise to avoid expenses and terminate the controversies as to all parties to this agreement."

The Travelers agreement includes similar language.

Both insurers also said it was misleading to say they had agreed to testify on the state's behalf against the other defendants.

"We have agreed to testify fully and truthfully in whatever remaining cases there are, and that's our obligation in any lawsuit," said the St. Paul spokeswoman.

No testimony by St. Paul witnesses or documents could be used against any of the other defendants simply because there is no evidence against them, she said.

"That's another gross misinterpretation," agreed the Travelers spokesman. "Travelers has said it will testify truthfully, which we will do anyway." He noted that although the insurer's willingness to testify is noted in the agreement, Travelers would have been obligated to do so under the "normal subpoena process."

"There is no information out there" that supports the Texas attorney general's conspiracy charge, the spokesman added. "It doesn't exist."

But the spokesman for the attorney general's office countered: "If they testify truthfully, then they will be testifying for us. It will benefit the state. That is our opinion."

Asked if the Texas settlements were related in some way to the federal case, the attorney general's spokesman said: "Obviously not. The California case is totally different."

The Texas case is "much further along" than the federal case because the state attorney general has already started the discovery process, which was not started in the federal case before it was dismissed.

The Travelers spokesman said the insurer had approached the state attorney general about reaching a settlement "as part of a standard procedure." Negotiations had taken several months, he said.

The St. Paul spokeswoman could not provide any information on the settlement negotiations.

The attorney general spokesman refused to comment on whether additional settlement agreements could be expected.

Other defendants in the Texas case contacted by *Business Insurance* said they were not negotiating settlements. And most refused to comment on St. Paul's and the Travelers' decision to settle.

A spokeswoman for the Hartford Fire Insurance Co., which is named in both the Texas and federal suits, said the settlement agreements come "as a complete surprise to us. We're not aware of any settlement discussions with other companies and have not participated in any discussions. We have no plans to discuss a settlement with the Texas attorney general's office."

Hartford has not been approached about a settlement agreement, she added.

A spokesman for CIGNA Corp., which also is named in both suits, said that CIGNA expects to participate in a motion seeking dismissal of the suit shortly. CIGNA is confident that it ultimately will be vindicated, he said.

When asked if there was a possibility of Fireman's Fund Insurance Cos., which is named only in the Texas suit, reaching a settlement, a spokesman said, "Not at the moment. Possibly not ever."

However, he added: "We really can't project what the future of litigation will be, especially when we're in the middle of it."

"The suit against us is groundless," he added.

He also said that the Travelers and St. Paul settlements will "absolutely not" have a negative impact on Fireman's Fund's defense.

A spokesman for Aetna Casualty & Surety Co., which is named as a defendant in both suits, also said it had no plans to settle. "We're confident that we will be exonerated in the Texas courts, just as we were in the federal courts," he said.

Commenting on Traveler's and St. Paul's decision to settle, the spokesman said that given the cost of litigation, "it shouldn't come as a surprise that some companies would want to settle."

But, he added, companies involved in both the federal and Texas suits "feel very confident" in going forward with the case.

An ISO spokesman said: "We think that the settlement has absolutely no effect on our position in the case." The charges against ISO are "baseless and without merit," he said.

The Texas antitrust action is considered by some to be the more difficult for the insurance industry to win, partly because Texas juries are known for being tough on companies from northern states.

In addition, the Texas case charges that the defendants violated state antitrust law, from which insurers do not enjoy the same limited immunity as from federal antitrust statutes. ■

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Retailer mulls ESOP as tax vote nears

Benefit beat

By MICHAEL SCHACHNER

Dayton Hudson Corp. is awaiting Congress' vote on curbing tax advantages for employee stock ownership plans before it implements a $400 million leveraged ESOP that would own about 9% of the company.

The Minneapolis-based retailer wants to "evaluate the tax advantages afforded by Congress" before creating the ESOP, said Stephen Kowalke, director of long-term financing.

Dayton Hudson also has not decided where to go for financing, he added.

If Congress preserves existing tax advantages, Dayton Hudson will establish the ESOP and replace the company's 401(k) cash contributions—currently 50 cents on the dollar—with preferred stock contributions, Mr. Kowalke explained.

Pending legislation would also, in some cases, prohibit employers from taking income tax deductions for dividends paid on company stock held by ESOPs (see story page 1).

However, because Dayton Hudson is now buying back 7 million common shares, Mr. Kowalke said he could not estimate the eventual converted preferred stock holdings of the ESOP.

The company offers employees in its 401(k) plan three investment options: company stock; shares in an equity portfolio; or a guaranteed investment contract.

EAP survey

Slightly more than half the nation's public employers have employee assistance programs, according to a poll of public sector risk managers.

Of those with EAPs, 95% are satisfied with them, according to the Public Risk Management Assn. survey of its members.

Between May 1988 and June 1989, 509 of PRIMA's 1,381 members, including municipalities, counties, school systems and park districts, responded. The survey was partially funded by an Occupational Safety and Health Administration grant on drug abuse assistance programs.

Risk managers based assessments on three "subjective quantifiers," said Tom Phillips, city risk manager for Santa Monica, Calif., and chairman of the technical advisory committee that oversaw the survey.

The public entities were asked about the following aspects of their EAPs: utilization, success rate of treatment and feedback from employees and labor groups.

Some respondents also said they had evaluated their own EAPs to determine usage rates and effectiveness.

Of the respondents with EAPs:

- 11% have done a cost-effectiveness, cost-benefit or cost-impact study.
- 19% have a provision for independent third-party review of treatments received by employees.
- 27% have an EAP review committee.
- 46% have a method for participant rating of the EAP.

These percentages exceed 100 because some respondents used more than one evaluation method.

Ninety-nine percent of respondents' EAPs provide referral to community resources, the most common service. Short-term counseling was the next most common service, provided by 93%.

Other popular EAP services included:

- Diagnostic assessment, offered by 86%.
- Crisis intervention, offered by 84%.
- Educational seminars, offered by 80%.
- 24-hour crisis line, offered by 67%.

Respondents' EAPs all offered services or referrals for alcoholism and drug abuse.

Most EAPs also offered services or referrals for a wide range of other disabling problems often linked to drug and alcohol abuse, including:

- Emotional problems, offered by 99%.
- Family/marital/relationship problems, offered by 99%.
- Physical/sexual abuse, offered by 97%.
- Stress, offered by 97%.
- Occupational/job problems, offered by 95%.
- Compulsive gambling, offered by 95%.
- Financial problems, offered by 95%.
- Legal problems, offered by 88%.

About 75% of respondents with EAPs contracted out for services, with 64% of those using outside providers going to independent private EAP providers.

Sixty-one percent of the responding entities pay on a per-employee basis.

The remainder pay either a flat monthly, quarterly or annual fee or on a fee-for-service basis.

A health insurance plan covers all or most of the EAPs' treatment costs, according to 86% of the survey respondents.

The survey also found the average utilization rate for respondents' EAPs was 9%, with a range of 0.02% to 84%.

The rate indicates that generally few employees may use an EAP, but "the impact on those employees, and thus on the organization, may be large," the survey concluded.

Although the survey concentrated on public entities, private sector employers also can benefit from analyzing the results, according to Mr. Phillips.

"The issues in the public sector are the same as in the private sector even though we in the public sector may have different constraints," he said.

"The basic concept of an EAP is to work with dysfunction," observed Mr. Phillips. "These dysfunctions are wide-ranging, and they confront all employers."

Copies of the 300-page study, "Employee Assistance Programs: Strategies for Local Government Workplaces," are available from PRIMA at 1117 N. 19th St., Suite 900, Arlington, Va. 22209; 703-528-7701.

The cost is $35 for members of PRIMA and is $55 for non-members.

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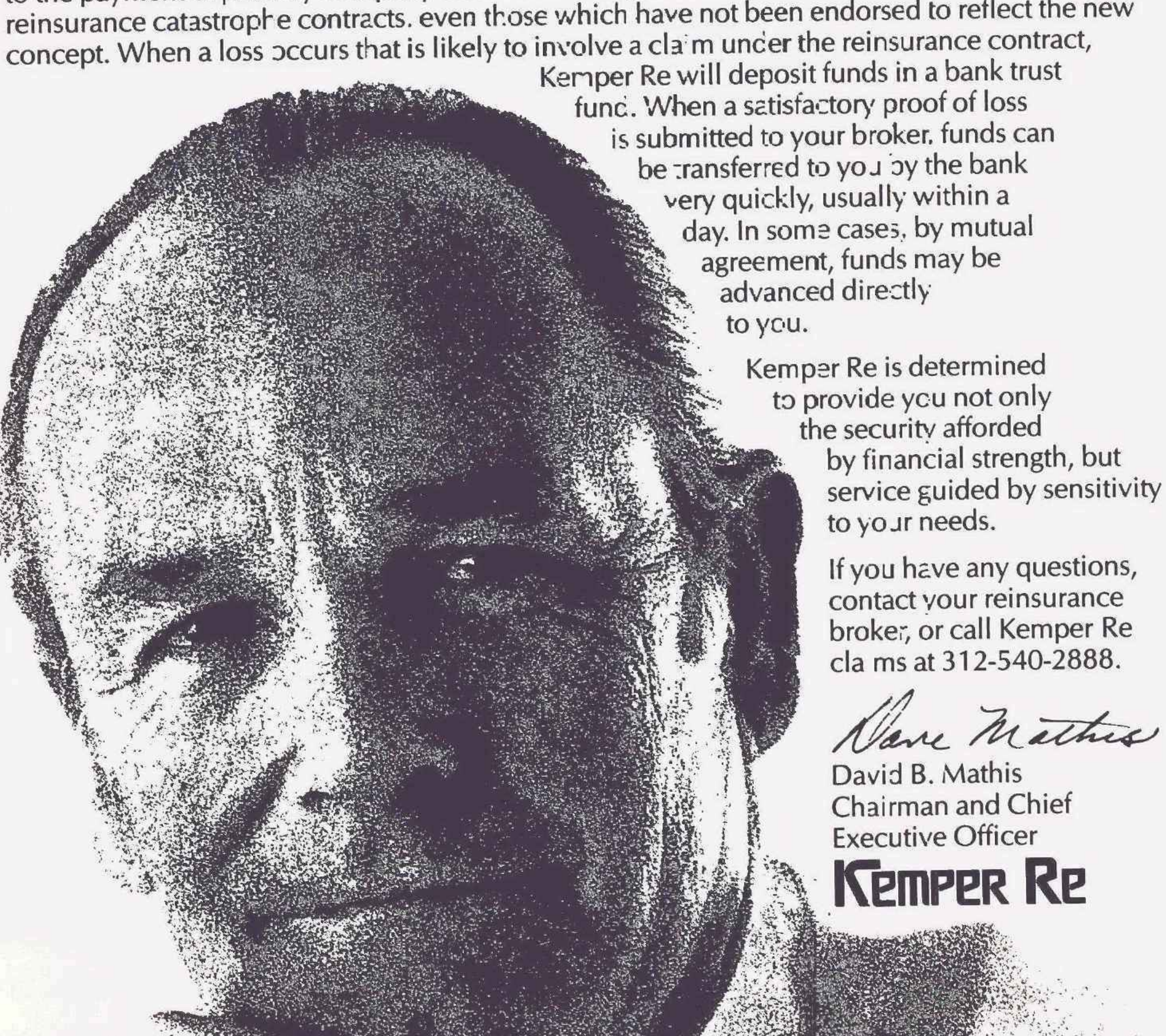
Made any benefit changes? Write Michael Schachner, Associate Editor, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017-5806; 212-210-0143.



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Opinions

Looking for a cash cow

THERE IS ONLY ONE WAY to describe the decision of a Senate panel to raise premiums charged by the Pension Benefit Guaranty Corp.: outrageous.

Earlier this month, the Senate Labor and Human Resources Committee approved a proposal to increase to $18 from $16 the annual minimum premium per plan participant that employers with defined benefit pension plans pay the PBGC.

This $2 per participant increase, tacked onto a revised budget reconciliation bill approved by the committee, would be imposed only on employers with plans that are at least fully funded. PBGC premiums, under the committee's proposal, would not rise for companies with underfunded plans—those plans that lack sufficient assets to pay promised benefits.

Premiums for employers with underfunded plans would continue to be based on a variable-rate premium structure that went into effect last year. Under that schedule, employers with plans that are in the poorest financial condition pay the highest PBGC premiums, up to an annual maximum of $50 per plan participant.

In attempting to justify the proposed increase, the Labor and Human Resources Committee described the PBGC's deficit as an excessive burden on the government that must be reduced.

Anyone who believes that reducing the PBGC's deficit is the real reason behind the committee's proposal also believes in the tooth fairy.

The PBGC, which ought to know, says there is no need for yet another premium increase. Indeed, the agency says it is making steady progress in reducing its deficit because of improved investment income results and substantially higher income generated by the last big premium increase in 1988.

In fact, the proposed PBGC premium increase has little to do with helping the PBGC and a lot to do with the obsession of some committee members, most notably Sen. Howard Metzenbaum, D-Ohio, to stop employers from recovering excess assets after terminating overfunded pension plans.

Restricting asset reversions, though, costs the federal government money. That's because employers that terminate overfunded pension plans pay both income taxes and a special 15% excise tax on excess pension assets they recover.

And, in the politics of budget reconciliation legislation, if a congressman backs a proposal that loses revenue, such as restricting terminations of overfunded pension plans, he or she generally must come up with another proposal to offset those lost revenues.

In July, the Labor and Human Resources Committee thought it had the answer to this problem. It came up with another outrageous idea: imposing stiff fees on employers filing federally required annual pension and welfare reports. It was commonly acknowledged that revenues from filing fees would be used to pay for restricting asset reversions.

But the filing fee proposal ran aground in the face of determined opposition from members of the Senate Finance Committee.

Hence, the PBGC premium increase and higher fees for violations of federal safety and pension laws were proposed as a last-minute substitute for the derailed filing fees proposal.

The higher PBGC premium proposal sends a terrible message to employers. The variable rate premium structure was a congressional promise that employers that properly funded their pension plans would be rewarded with lower PBGC premiums.

By jacking up the PBGC premium for well-funded plans, the Labor and Human Resources Committee would vitiate that promise and essentially punish employers for properly funding their pension plans.

And, if a premium increase is imposed when it is not needed, employers will have to ask themselves how long it will be until legislators will use the PBGC premium as a tool to pay for other pet projects.

Faced with a political system that punishes responsible pension funding, it would not be surprising if companies reduced pension contributions to the lowest level allowed by law or even terminated their plans.

We hope Congress does not allow that to happen and that it kills the PBGC premium increase.

Letters

Put worries about the next hard market aside

To the editor: "There they go again!"—President Ronald Reagan.

When, oh when, will this industry learn some basic political horse sense?

Ladies and gentlemen, with all the bad press we are getting, with consumers literally tearing us to pieces, with politicians legislating us into oblivion, and with a respect rating two notches below vacuum cleaner salesmen, why in heaven's name would anyone ever speak of—nay, even think or whisper of—the "next hard market?"

Gloat not about, nor encourage, the next hard market, because it may truly be the *last* hard market!

And again, when will we ever learn?

Dennis W. Jeff
President
Glenn E. Orndorf Inc.
Lancaster, Pa.

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Cost of COBRA cover beats conversion cover

To the editor: In reply to the Oct. 2 At Issue question—"Are COBRA's Health Care Coverage Provisions Meeting Their Objectives?"—two benefits professionals said that the ill and disabled who really need COBRA coverage don't take it because the cost is prohibitive. I'm confused!

At 102% of the employer's cost, COBRA coverage appears to be a much better deal than a conversion plan, which was about the only option available before the Consolidated Omnibus Budget Reconciliation Act. Conversion plans often have more limited benefits than the employer plan and, where the benefits are the same, costs are often at least 300% higher than the employer's cost. There's no comparison!

The actual cost is probably somewhere between 102% (according to Congress) and 300% (per actuaries, I presume). Thus, it's hard to disagree with the only reply that voted to allow employers to charge more than 102% to individuals who are mostly users of the benefits. Makes sense to me.

Dale Snellbaker
Triangle Employee Benefits
Raleigh, N.C.

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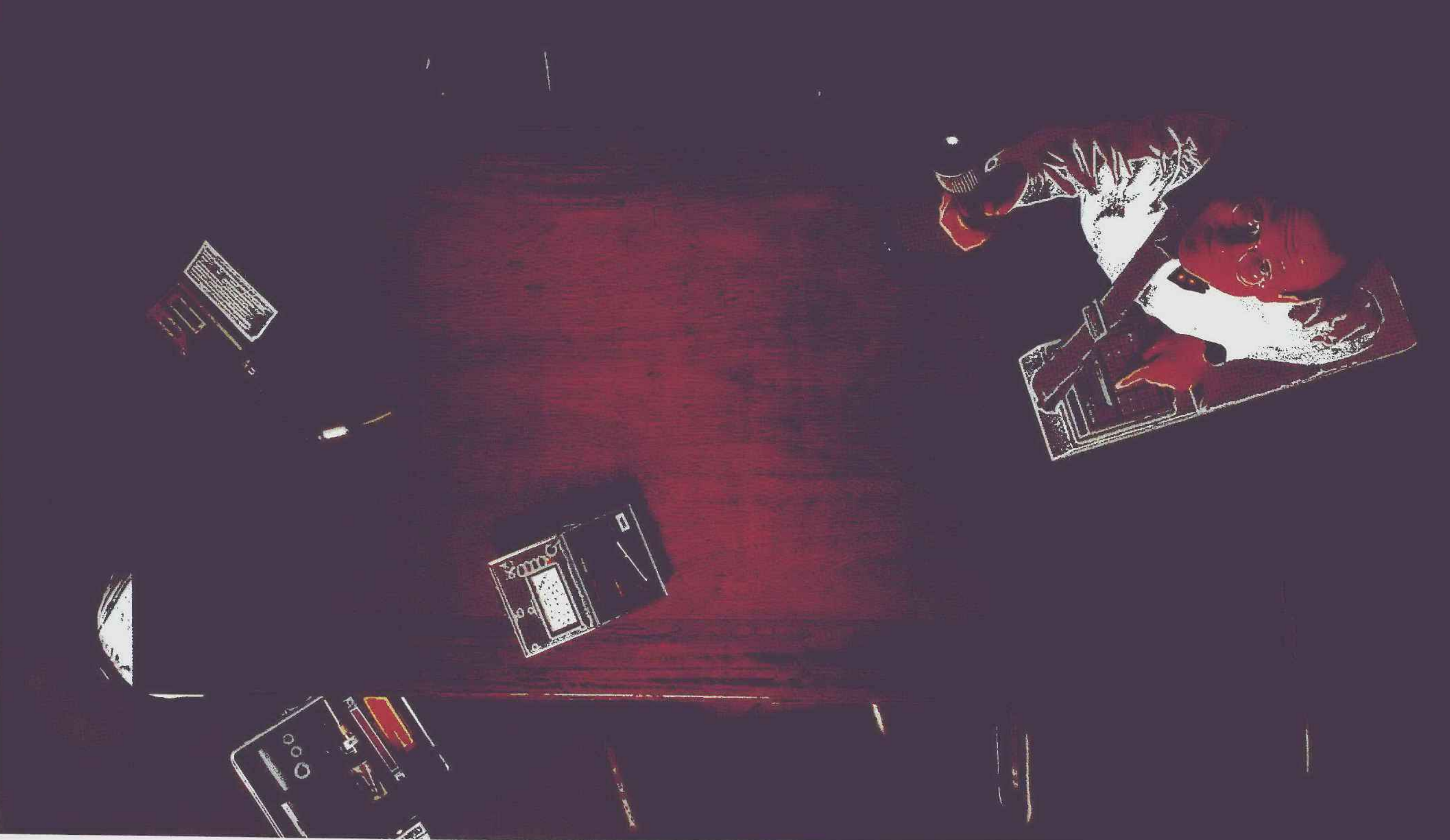

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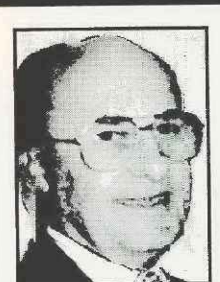
At issue

Should federal safety laws pre-empt state criminal prosecution of job safety violations?



Kenneth J. Kortz
risk manager
Holiday Cos.,
Minneapolis

Yes. There should be uniform applications of OSHA because most companies cross state lines. Companies should be able to operate uniformly, and an employee working in one state should not have to do a job differently in another state. And employers should not be subject to state criminal prosecutions if they have complied with the federal safety standards.

Art Bostwick
risk manager
Stone Container Corp.,
Chicago

No. In general, I would prefer the lowest level of the government to respond to this issue. A federal pre-emption would be more detrimental than the wisdom of the people closest to the scene. It should be a power reserved to the states.

Joseph V. Yancoli
vp-risk management
Columbia Gas Systems Service Corp.,
Wilmington, Del.

Yes. I don't think there would be equity among interstate employers if each state could set its own criminal penalties. Some states may be more severe, so employers would follow strict rules there, but could be lax elsewhere. Also, it's a political issue; if one is looking to make political hay or make points with the unions, state OSHA laws would be affected.

Craig Gibons
risk manager
city of Springfield,
Springfield, Ore.

There are two issues here pre-emption and criminal prosecution. If an employer is acting in a criminal manner, then criminal prosecution should take priority over pre-emption. An employer has an obligation, just like a citizen, to act responsibly. Both the Michigan and Illinois Supreme Courts' decisions were right.

Compiled by Christine Woolsey

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Hartford wins case in Illinois

By STACY ADLER

SPRINGFIELD, Ill.—Primary insurance companies—not excess insurers—are responsible for interest that accrues on an appealed judgment, unless a primary policy explicitly says otherwise, the Illinois Supreme Court has ruled.

"We will not rewrite the parties' policies for them to impose" a new obligation to apportion liability for post-judgment interest, the court said in a Sept. 27 case stemming from a wrongful death claim.

Aetna Insurance Co., a CIGNA Corp. unit now called CIGNA Property & Casualty Insurance Co. of Bloomfield, Conn., wrote $1 million in primary liability coverage for an Illinois firm which also had a $2 million excess liability policy from Hartford Accident & Indemnity Co. of Hartford, Conn.

After settlement of a wrongful death suit against the policyholder, Aetna sued Hartford to pay a portion of post-judgment interest accruing while an appeal was pending.

This was the Supreme Court's first ruling on the issue, said Hartford attorney Norman J. Barry of Rothschild, Barry & Myers in Chicago.

"This was a case of first impression," he said. "That is why the Supreme Court took this case."

Wisconsin and Florida courts have issued similar rulings, while courts in Michigan and Louisiana have found for primary insurers, he said.

Though the decision cannot be appealed, Aetna may ask the court to reconsider its ruling. Aetna attorneys could not be reached for comment.

On April 10, 1984, a jury ordered Cuomo & Son Cartage Co. of Lemont, Ill., to pay $1.5 million in a wrongful death case. In October 1986, while its appeal was pending, Cuomo & Son settled the suit for $1.2 million, the amount of the firm's primary policy limit plus interest.

Both primary and excess policies stipulated payment of post-judgment interest. As a result, Aetna sued Hartford claiming the excess insurer should pay a pro rata portion the accrued interest—$121,500 of the total $191,667—on the settlement.

But Hartford argued that Aetna, as the primary insurer, should cover all post-judgment interest.

Aetna's primary policy read: "In addition to our limit of liability, we will pay for you: All interest accruing after entry of a judgment in a suit we defend. Our duty to pay interest ends when we pay or tender our limit of liability."

Hartford's umbrella policy said: "The company shall pay. . .all interest accruing after entry of judgment until the company has paid or tendered or deposited in court such part of judgment as does not exceed the company's liability thereon."

The trial court ordered Hartford to pay the pro rata portion of the interest and Hartford appealed.

An Illinois appellate court reversed, saying the burden of post-judgment interest falls on the primary insurer unless the primary policy explicitly apportions the liability.

Aetna then appealed to the state Supreme Court, where the decision was upheld and Aetna was ordered to pay the full $191,667.

For the majority, Justice Horace Calvo said: "If Aetna had wanted to limit its liability for post-judgment interest in the event that its insured purchased excess coverage, it could have so indicated in its policy. It can hardly be argued that Aetna lacks the legal sophistication to limit its liability as it sees fit."

•

Hartford Accident & Indemnity Co. vs. Aetna Insurance Co. No. 67649

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Zurich introduces network, policies for 1992

By STACY SHAPIRO

ZURICH, Switzerland—Zurich Insurance Group plans to expand its European operations to take advantage of the cross-border freedom of insurance services that will take effect next year in the European Community, according to the group's executives.

"At the Zurich, the expected developments have caused us to reinforce our business and organizational strategy," said Rolf Huppi, Zurich president and chief operating officer, at the company's "Europe 1992" broker symposium earlier this month.

"Rather than a specific date," 1992 signifies the evolution of a unified European insurance market, Mr. Huppi said.

The date is derived from the European Community's effort to implement most of its 300 free-trade directives that will create a single insurance market by the end of 1992.

Eight of the 12 EC nations are to adopt the freedom of insurance measure next year.

In response to the impending cross-border freedom to provide insurance services, Zurich announced plans to:

- Create a Europewide network of locally based companies to offer local and international commercial business coverages. The network will be known as "Zurich International."
- Offer international clients a "EuroZurich" insurance policy to cover corporate risks throughout the EC.
- Maintain its global insurance program, which allows clients to buy local policies and cover differences-in-conditions under a master policy.
- Expand personal lines underwriting in Europe.

"For the consumer, (1992) holds the idea of immediate economic benefit," Mr. Huppi said.

"But for the insurer, unlike the manufacturer, cross border activities appear at least on the surface not to bring too many advantages."

For example, some insurance companies may find expansion throughout the European Community too costly.

As a result, there will be bigger and fewer insurers in the marketplace after 1992, Mr. Huppi predicted.

"Price competition for the commercial business will increase and, in some European insurance markets, a major part of our market will become less profitable" because of competition, he said.

"Premium increases for social, cultural reasons will not be able to" keep up with increased exposures, he added.

Even after 1992, different local customs, cultures, languages and some domestic regulations will slow the process of a unified European insurance market, according to Mr. Huppi.

Mr. Huppi

Nevertheless, a unified Europe "with a population of some 320 million people and a total premium income that lags only behind the U.S. market, we do have the potential of becoming a formidable insurance market," Mr. Huppi asserted.

For its part, Zurich will continue to focus on international corporate clients.

The insurance company "intends to expand the existing business units of the Zurich Group," according to Charles Wyniger, general manager of the Zurich, Switzerland-based insurer.

"The Zurich expects to expand our already strong and broad presence in Europe," Mr. Wyniger continued.

Zurich's expansion will result both from internal growth and acquisitions, he said.

However, "our existing presence allows us to be selective," he added.

"We do enjoy an advantage of not having to buy into the (targeted) markets at exorbitant prices," he noted.

The insurance company's expansion will focus on "Germany, the United Kingdom, France, the Netherlands, Italy and Beligium—legally and in terms of personnel and infrastructure so that they can satisfy the international insurance needs of their owns clients as well as possible," Mr. Wyniger said.

Mr. Wyniger explained that the Zurich International unit will be a network of "locally rooted" companies administering local and international commercial insurance programs.

The Zurich-based international division will oversee the network, he said.

Naming it Zurich International gives the group "a uniform, coordinated appearance, especially in the fields of marketing, contact and cooperation with brokers and clients and advertising while maintaining their Europe-wide independence," Mr. Wyniger explained.

In addition, Zurich's "Euro-policy" or "EuroZurich" policy is designed to take advantage of the

Continued on page 16

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Zurich plans

Continued from page 14

cross-border insurance trading that will begin throughout the EC next year.

"We view the Euro-policy as an addition to our palette of products," said International Division Manager Claude Perret.

"We do not see it as a substitute for the traditional master policy supported by local policies, but as an alternative to national policies within Europe where the client can choose the country that he finds most suitable for his needs," said Mr. Perret.

Under the Euro-policy, which would be worded in an insurance buyer's native language, the buyer would pay one premium for all its risks in Europe covered by that policy, according to Mr. Perret.

However, risk managers for companies operating in 40 or 50 countries may not find the Euro-policy ideal because it would amalgamate coverages in only eight nations next year, Mr. Perret pointed out.

And, some risk managers will have problems with a policy written in a specific foreign currency that will be hit by exchange rate fluctuations until cross-border financial controls are abolished in the EC, he said.

Still, Mr. Perret describes the Euro-policy as a "good tool to solve some of the problems attached to interdependency, such as those regarding business interruption, and to enable greater flexibility."

Symposium participants applauded Zurich's plans but also raised some concerns.

"It is a very good idea and a logical extension" of 1992, said Michael Barrett, chief executive of Alexander Stenhouse Europe Ltd. in London, a subsidiary of Alexander & Alexander Services Inc. in New York.

"It brings another competitive factor to the scene. Brokers react to what's available," Mr. Barrett said.

"A Euro-policy provides the competitive advantage to the underwriter provided he can provide the rest of the servicing for the contract," Mr. Barrett also observed.

"It is a sexy new product and a tremendous new product," said Frank Gunderson, managing director of New York-based Marsh & McLennan Worldwide, a subsidiary of Marsh & McLennan Cos. Inc., during a symposium panel discussion.

"But, until some issues are satisfied, such as claims handling and tax issues, in the EC, it is a point of rhetoric. Until the problems can be overcome, I don't know if we (as brokers) would be able to mass market it."

Another member of the audience worried that a Euro-policy would present a large errors and omissions problem for insurance brokers.

"Is a single European policy going to cover every single idiosyncrasy that would be covered under local policies? If not, then our E&O (insurance) would come into play" because brokers would be offering a policy that does not cover all the risks it was intended to cover, said the participant, who did not want to be identified.

Mr. Huppi responded that the Euro-policy will continue to evolve as the EC becomes a freer market.

'We view the Euro-policy as an addition to our palette of products,' says Zurich's International Division Manager Claude Perret. 'We do not see it as a substitute for the traditional master policy supported by local policies.'

Meanwhile, Zurich Group also will still offer global insurance programs, through which a parent company purchases a master insurance policy to cover the differences in coverage provided by the local insurance policies its subsidiaries buy in their home countries, the Zurich executives pointed out.

"Essential" local services such as claims handling, risk engineering, consulting and administrative services also will remain, Zurich officials said.

And, Zurich's personal lines business will be written by separate locally owned companies that will retain their own names and identities, Mr. Huppi said.

The commercial and personal distinction is part of the company's program to differentiate its divisions by the kinds of business written in Europe rather than by the countries in which they operate, Mr. Huppi pointed out.

"Over time, as the industry learns better to play either the European or global markets, the lines of coverage such as personal lines, life, non-life, etc. may replace the traditional lines of segmentation governed by national boundaries."

Mr. Huppi said he would like to see Zurich expand both commercial and personal lines business. ■

Symposiums attract firms with '92 plans

ZURICH, Switzerland— Zurich Insurance Group hosted two annual invitation-only symposiums earlier this month addressing the topic of "Europe in 1992."

More than 100 clients of the Zurich, Switzerland-based insurer met with company executives beginning on Oct. 2 at the International Hotel in Zurich. And, about 140 brokers from around the world met with Zurich executives later in the week.

Zurich executives used the forum to announce new products the company will offer and changes it is making as a result of the easing of cross-border trade barriers beginning next year.

Participants also discussed some of the obstacles in the way of a truly free European insurance market and how brokers view the challenge of 1992, when all trade barriers are scheduled to be withdrawn.

Three brokerage guests traveled all the way from Australia and other guests came from the United States, Scandinavia and throughout Europe.

About 30 people representing the various partners of the UNISON network of brokers, which is expected to make major announcements about its plans in Europe before year-end, attended the symposium.

Also attending were other brokers that plan to expand in Europe to take advantage of 1992, such as Munich-based Oskar Schunk K.G., which is soon opening an office in Innsbruck, Austria, and plans to open offices in Spain, France and Switzerland in the near future.

—By Stacy Shapiro

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Obstacles remain to EC insurance market

By STACY SHAPIRO

ZURICH, Switzerland—Major tax and legislative obstacles, including widely varying premium taxes and allowable contract durations, will delay implementation of the European Community's freedom of insurance directive, observers say.

The directive, scheduled to be adopted next July, is designed to allow corporate insurance buyers to place coverages across national borders without restrictions, now allowed only in The Netherlands and the United Kingdom.

Eight countries are expected to approve the directive in July. But Portugal, Spain, Greece and Ireland won't have to incorporate new rules until as late as 1997 under a timetable established by the European Commission.

"Everything which comes from Brussels is very complicated," said Charles Wyniger, a Zurich Insurance Group general manager, referring to directives from the commission's headquarters.

"I think this means that we don't have to expect a big bang" in July, said Hans-Peter Karlen, another general manager with the Zurich, Switzerland-based insurer. "It will be rather a relatively slow process."

The outlook is "good" that all EC countries will eventually follow the freedom of insurance guidelines, according to Anton K. Schnyder, legal consultant to the group management of Zurich Insurance Co., parent company of Zurich Insurance Group.

Despite four countries delaying implementation until 1997, "almost all of the EC member states within five to 10 years will follow the spirit of the wordings of the directive," he said.

However, he warned brokers at Zurich's "Europe 1992" symposium Oct. 5 that other legal tangles may hinder true freedom of insurance for large commercial risks.

"We don't know how exactly the duration of an insurance contract will be regulated," he said. Italy allows 10-year terms, while other EC nations allow shorter ones.

Also, "we don't know yet what regulations there will be for mandatory insurance by" EC countries, said Mr. Schnyder. For example, employers liability and third-party auto liability insurance are required in some countries, but not in others.

In addition, "there might be some problems as far as cross-border claims handling is concerned," said Mr. Schnyder.

"We do not know yet how claims-handling regulation will function" since it hasn't been decided yet whether countries will permit foreign insurers' branch offices handle claims, he added.

The role of brokers as underwriting agents also has not been addressed by each EC country, according to Mr. Schnyder.

It remains to be seen whether brokers with affiliations to specific insurers may hinder the movement to freedom of services, he said.

Meanwhile, there is no uniform, EC-wide tax policy, and there won't likely be one "before the end of this millennium," said Alfred Reichmuth, tax counselor to the Zurich Group.

"Everyone agrees on one thing: the creation of a unified European market without politically motivated trade barriers and obstacles distorting competition. . .(requires) harmonization of taxes," he said. "This, however, is where the unanimity ends."

Nations, for example, have yet to solve their major insurance-related problem—how to tax premiums paid on cross-border policies—Mr. Reichmuth told brokers. Currently Spain, Ireland and the United Kingdom do not tax premiums; France taxes some up to 30%; and Denmark levies up to a 50% tax on auto liability premiums.

Under the directive, premium taxes must be split between the nations involved in the transaction according to their local tax rates, Mr. Reichmuth said.

For example, a Danish company underwriting a French risk would apportion its premium tax on coverage between Denmark and France according to the countries' individual laws, despite the freedom of insurance directive.

"This should not be too big a problem with regard to master policies with local policies for each individual risk," he said.

However, he said, a single-premium "Europolicy" poses problems because each country where risks are based will have to be notified for tax purposes, and a premium tax would be split among countries where risks are located.

"Due to the nature of insurance, efficient control of the collection of taxes will be extremely difficult," said Mr. Reichmuth. "The absence of a harmonization of premium taxes will increase the risk of fraud. . .and also increase the risk of competitive distortion (because) insurance contracts will be concluded in those member states with no or little indirect taxes. In other words, without harmonization there is no efficient control." ■

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Shell UK cited under new pollution law

London

By CAROLYN ALDRED

LONDON—In the first case brought by a British government pollution monitoring group under a new pollution law, Shell UK Ltd. is being prosecuted over a 150-ton crude oil spill in the River Mersey near Liverpool Aug. 19.

If the case is heard in High Court, as the National Rivers Assn. will request, the oil company could face unlimited fines under the new Control of Pollution Act. The maximum fine in a lower Magistrate Court is 2,000 pounds ($3,120).

Shell estimates the cost of the spill at 2 million pounds ($3.12 million), including the cost to clean up the river and its estuary, property damage and consequential losses, such as loss of business earnings, a spokesman said.

The rivers association was formed this year as a regulatory agency to prepare for the privatization of Britain's water and sewage industry.

"We have carefully considered our Pollution Control Officers' reports, together with the company's version of events. On this basis we feel it is appropriate to take legal action," said Chris Harpley, an NRA regional general manager.

Losses will be paid by Shell's London-based captive insurance company, Mytilus Insurance Co. Ltd., a spokesman said.

Neither Shell nor the NRA would comment further on the litigation.

Lloyd's liabilities

About 50 Lloyd's of London members have approached Lloyd's for help in meeting their liabilities, according to Lloyd's Chief Executive Alan Lord.

Lloyd's last month announced plans to form a special committee to review cases of members that have difficulty paying syndicate losses (*BI*, Sept. 11).

"At the moment, about 50 Names at Lloyd's have got in touch and said they may be interested in taking advantage of the arrangements," Mr. Lord said at a press conference.

The Council of Lloyd's on Oct. 15 appointed Mary Archer chairwoman of the review committee that will "examine the cases of Lloyd's members who are willing to meet their underwriting losses but are unable to do so," Mr. Lord said.

Ms. Archer, who is a Cambridge scientist, is an external member of the Council of Lloyd's and wife of the former Conservative party chairman, novelist and playwright Jeffrey Archer.

The review committee will have three Council members, including one external, one working and one nominated by the Bank of England.

"It isn't our policy to bankrupt people," Mr. Lord noted. "We have set up the committee to deal—case by case—with those names who are prepared to meet their obligations but who need some help."

Members' unpaid liabilities to syndicates are drawn down from the Lloyd's Central Fund. Lloyd's then may sue those names who have not met their liabilities.

However, Lloyd's has agreed to postpone legal action against members who are willing, but unable, to meet their obligations, Mr. Lord pointed out.

The association drew from the central fund to cover liabilities of about 200 members of the 1986 underwriting year, the year just closed under Lloyd's three-year accounting system, he said.

Many of these members were members of syndicates formerly managed by PCW Underwriting Agencies Ltd. and the number next year will be "significantly less," he said.

Lloyd's currently is suing only "a small number" of members for non-payment of losses, he said.

PWS bonuses

London broker PWS Holdings P.L.C. is making up to 10% of its equity available as "additional incentives" to key employees, according to Deputy Chairman David Springbett.

About 30 to 40 people likely will be eligible for the shareholding options and not all shares will be released simultaneously, he said.

The brokerage also plans to cut about 25 of its 300 jobs in an effort to cut costs, Mr. Springbett confirmed.

Mr. Springbett also confirmed the resignation of PWS Treaty Ltd. Chairman John Lane and the treaty department's merger into PWS International Ltd.

In addition, six PWS brokers specializing in U.S. life, accident and health business resigned to join rival broker Ballantyne, McKean & Sullivan Ltd.

Charles Norton-Smith, John Spencer, Paul Daly and three others left PWS and formed BMS Special Accident Ltd under terms agreed to by BMS and PWS Holdings P.L.C., including transfer of the brokers' portfolios, Mr. Spencer said.

The team had left London broker Dewey Warren & Co. Ltd. to join PWS in spring 1988.

Captive management

German reinsurer Gerling-Konzern Insurance A.G. is setting up a captive management operation in Dublin, Ireland.

Gerling Security Risk Consulting & Management Company (Ireland) Ltd. will be the Cologne-based company's second captive management concern. Gerling-Konzern established a Luxembourg captive manager early this year.

"Internationally active industrial companies are increasingly inclined to seek cross-border solutions for the management and control of their activities," a company statement noted. "With the creation of the liberalized European insurance market, the build-up of captives has become overdue."

Meanwhile, as the use of captives increases, the need for risk management consultancy also will increase, Gerling predicts.

"A greater financial involvement of industry in its own risks via captives results in an improved awareness of risk management," the statement noted.

Liquidation stir

A South African reinsurance company owned by a group of large British and multinational insurers is in liquidation.

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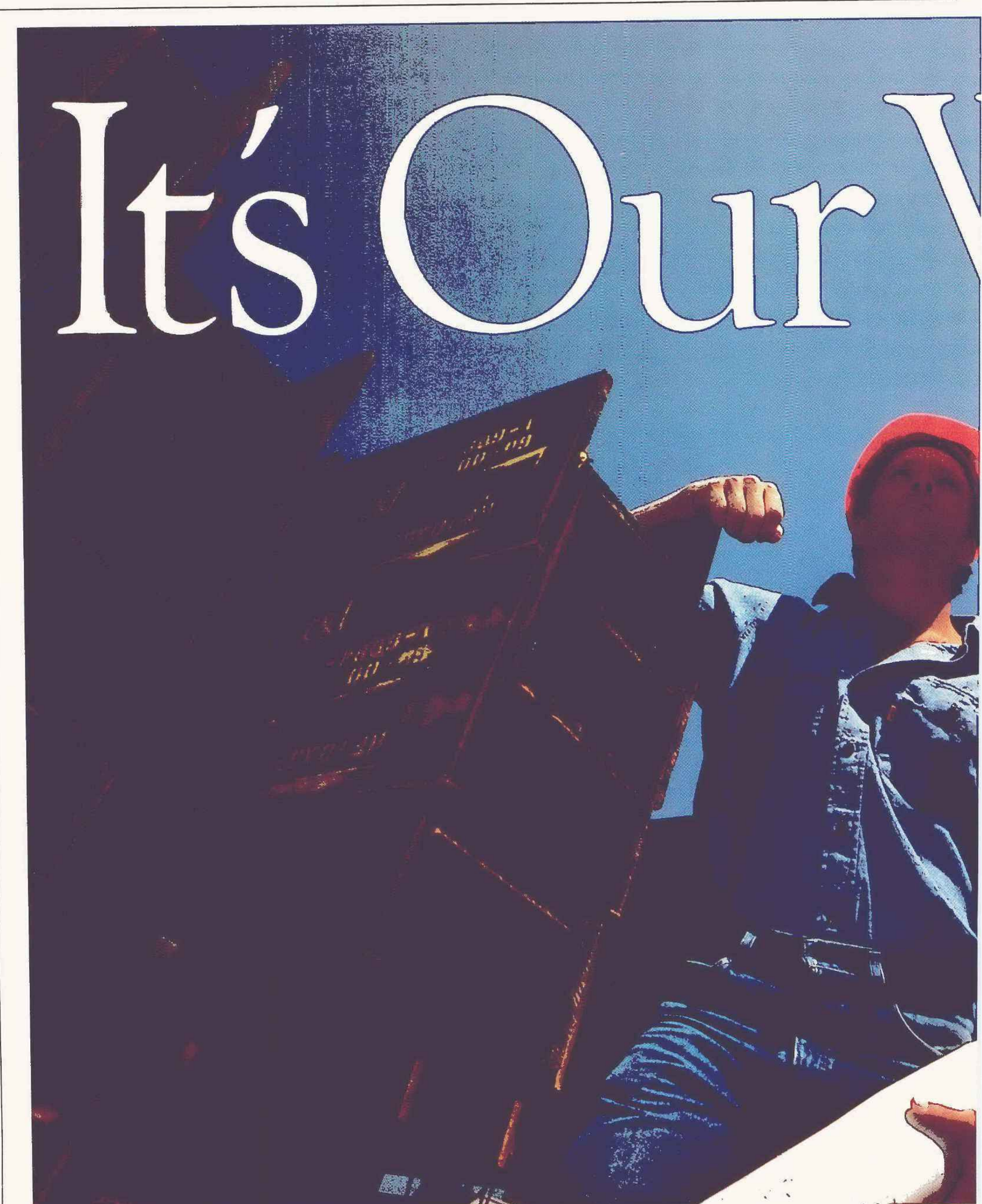

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The liabilities of Reinsurance Union Ltd. of South Africa are estimated at several million pounds, too little to justify liquidation of a company owned by major multinational insurers, a creditor contends.

The company was formed in the 1950s by a consortium of insurers operating in South Africa. It wrote property/casualty, automobile and marine reinsurance until it stopped writing business in 1985 and was put into run-off.

Reinsurance Union Ltd. shareholders include South African subsidiaries and interests of Swiss Reinsurance Co. and major British multiline companies, including Eagle Star Holdings P.L.C., Commercial Union Assurance Co. P.L.C. and Guardian Royal Exchange Assurance P.L.C.

"From a security point of view, which is very important when placing reinsurance, Reinsurance Union looked sound with major shareholders widely spread around the world," said the reinsurance creditor who spoke on the condition of anonymity.

"I am concerned that major and reputable companies in the world are walking away from the debt," the Reinsurance Union creditor said.

Local directors, rather than parent companies, made the decision to liquidate, said a spokesman for one shareholder.

Cater Allen Holdings

London-based financial group Cater Allen Holdings P.L.C. is broadening its Lloyd's of London interests with the proposed purchase of its sixth managing agency.

Cater Allen, which has acquired several agencies in recent years, plans to buy Birrell Smith Underwriting Agencies Ltd., manager of marine syndicate 363 and non-marine syndicate 660.

The two have a stamp capacity of about 25 million pounds ($39 million).

Birrell Smith also has a members agency with 44 Lloyd's members.

Cater Allen will put up 800,000 pounds ($1.3 million) in cash and Cater Allen shares to purchase the agency, according to Deputy Chairman David White.

With the acquisition of Birrell Smith, the financial group would own six managing agencies and two members' agencies, which together manage eight syndicates with a combined underwriting capacity of 290 million pounds ($452.4 million). Members agencies would have 563 Lloyd's members.

New syndicates

Lloyd's of London has approved at least seven new syndicates for the 1990 underwriting year.

But many are having a tougher time obtaining association approval this year due to more rigorous examinations of a syndicate's managing agency and its expected stamp capacity, several sources say.

For example, bylaws now require new syndicates to meet a minimum provisional stamp capacity—capacity committed by legally bound members of Lloyd's—before they can start writing.

Among the newly approved syndicates, provided each meets minimum capacity, are:

- A non-marine syndicate underwritten by John Prestage and managed by Spreckley Villers Hunt & Co. Ltd.

With an expected premium capacity of 10 million pounds ($15.6 million), it will write property insurance worldwide, but mainly outside the United States, kidnap and ransom insurance, medical expense coverage and personal accident insurance (*BI*, July 3).

- A specialist personal accident syndicate underwritten by John Darling and managed by Gresham Underwriting Agencies Ltd.

It hopes to have a stamp capacity of about 3.5 million pounds ($5.5 million) and will write mainly U.K. business.

But, it also will write personal accident coverage worldwide, including a maximum of 35%-40% U.S. business, Mr. Darling said.

- A professional liability syndicate underwritten by David Lowe and managed by Boncaster Ltd., a sister company of underwriting agency Christopherson Heath Ltd. (*BI*, Aug. 28).

- A non-marine syndicate underwritten by Patrick Gage and managed by F.L.P. Secretan & Co. Ltd.

It will have a capacity of about 5 million pounds ($7.8 million) and will write U.K. commercial short-tail business (*BI*, Aug. 28).

- A non-marine syndicate specializing in British, Irish and international liability insurance.

The syndicate, which is expected to have a stamp capacity of about 12 million pounds ($18.7 million), will be underwritten by John Murphy and managed by Bankside Syndicates Ltd. (*BI*, Sept. 11).

- A non-marine syndicate underwritten by John Ball and managed by A.J. Archer & Co. Ltd.

It is expected to start underwriting when it reaches a minimum premium capacity of 4 million pounds ($6.2 million) in mid- to late-October, said Archer Joint Managing Director David Tudor Williams.

It has been promised a total of 6 million pounds ($9.4 million) capacity, according to Mr. Williams.

- A non-marine excess-of-loss reinsurance syndicate underwritten by Richard Jessel.

The syndicate will be managed by London Wall Holdings P.L.C. Mr. Jessel had proposed setting up a new managing agency called Gresham & Jessel Underwriting Ltd. to manage the syndicate (*BI*, Aug. 28).

However, "the syndicate was more likely to be approved (by Lloyd's) if managed by London Wall," he said.

Lloyd's losing Rawlins

The Lloyd's of London market will lose one of its more farsighted executives when Peter J. Rawlins leaves to becomes chief executive at the International Stock Exchange in London Nov. 27.

Mr. Rawlins was managing director of Lloyd's largest underwriting group, Sturge Holdings P.L.C.

At Sturge, and previously as a personal assistant to former Lloyd's Chief Executive Ian Hay Davison, Mr. Rawlins was at the forefront of much new thinking in the Lloyd's market.

He was a particularly ardent supporter of increasing use of computer technology and new trading methods.

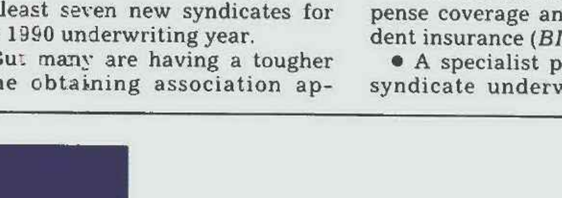
Mr. Rawlins had been deputy chairman of the Lloyd's Underwriting Agents Assn. and had served on several Lloyd's committees.

Unafraid of controversy, he found fault with many London market practices, and at the same time he proposed constructive methods of overcoming what he regarded as old fashioned, labor-intensive or, often, illogical practices.

Comings & goings

Cliff Pearce promoted to a director of Nicholson Chamberlain Colls Financial Institutions Ltd.

Callum Stewart appointed chairman of C.E. Heath (North America) Holdings Ltd., a new holding company to coordinate the activities of C.E. Heath (North America) Ltd. and Heath North American Reinsurance Broking Ltd. ■



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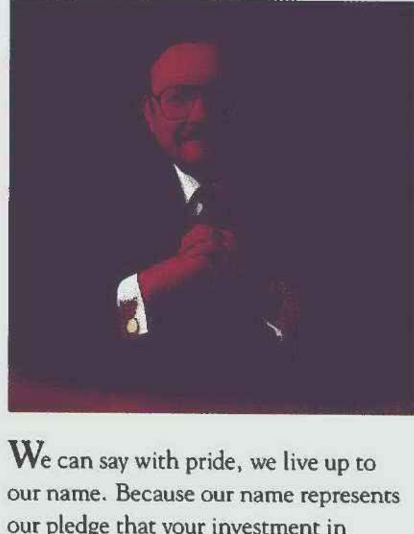

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College of Insurance blooms

Enrollment, donations increasing

By MARK A. HOFMANN

NEW YORK—New York's College of Insurance, bolstered by a new administration and increased insurance industry support, is undergoing a metamorphosis, say the school's trustees and its top administrator.

Enrollment on both the graduate and undergraduate levels has increased for the first time since 1982, and is expected to increase further with the addition of two new master of business administration degree programs.

In addition, a "leadership campaign" that has not yet been officially announced already has raised $1.7 million in cash and pledges toward a three-year goal of $4.5 million.

The largest single pledge to the leadership drive came from the New York-based Starr Foundation, a philanthropic organization established by C.V. Starr, whose operations in Shanghai, China, during the early part of this century became the basis of New York-based American International Group Inc.

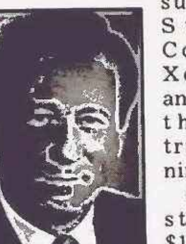
Mr. Greenberg

The Starr Foundation pledged $600,000 to the college over three years, AIG Chairman Maurice R. Greenberg recently announced. Mr. Greenberg also serves as a trustee of the college.

And, New York-based broker Johnson & Higgins pledged $300,000 for the same period, said Robert V. Hatcher Jr., chairman and chief executive officer.

The College of Insurance is "an uncut diamond" offering such a wide variety of courses—liberal arts as well as insurance and general business—that its name may be changed in the future," said Mr. Hatcher, who has served as chairman of the college's board of trustees since June.

"I think we've got a great future. We're all involved," said Robert J. Vairo, chairman and chief executive officer of Basking Ridge, N.J.-based Crum & Forster Corp., a subsidiary of Stamford, Conn.-based Xerox Corp., and chairman of the college trustees' planning committee.


Mr. Hatcher

Crum & Forster pledged $150,000, as did The Home Insurance Co. of New York, the college announced.

"The college is kind of going through a renaissance," agreed Robert J. Smith Jr., president of Alexander & Alexander of New York Inc. and a trustee of the college.

"I suppose like a lot of institutions, the college has had its ups and downs. The college is very much in a recovery mode," said William E. Thiele, a college trustee and senior executive vp of New York-based Continental Insurance Co.

"We've turned a corner," said Mr. Hatcher, giving much of the credit for the school's turnaround to Ellen Thrower, who took over as the school's president on July 1, 1988.

Ms. Thrower, who had taught at Drake University in Des Moines, Iowa, before assuming her current position, attributed the college's renewed vigor to "active and committed" trustees.

Among other trustees elected in June are: Norman A. Baglini, president of Malvern, Pa.-based American Institute for Property and Liability Underwriters; William J. Flynn, chairman and chief executive officer of Mutual of America Life Insurance Co. in New York; David A. Kocker, president-commercial insurance division of Aetna Life & Casualty Co. in Hartford, Conn.; Richard M. Page, chairman of Fred S. James & Co. in New York; and Dennis B. Williams, vp of General Re Corp. in Stamford.

The college plans to launch two new MBA programs early next year.

One MBA program, in actuarial science, is "designed for the people in the industry with a strong undergraduate foundation in mathematics," Ms. Thrower said.

The other MBA program will be a non-residence program in risk management.

Although some of the course work will have to be completed at the college's New York campus, some of the requirements would be met by completing the Malvern, Pa.-based Insurance Institute of America's program for the Associate in Risk Management designation, Ms. Thrower said.

"One of the areas we're concentrating on is actuarial science," because the insurance industry needs more actuaries than are currently available, Mr. Vairo observed.

The college also is concentrating on attracting minority students to insurance careers, noted A&A's Mr. Smith, who praised the college's recently launched minority honors program.

The program, which began this fall, allows college juniors to spend a semester at the College of Insurance while taking part in internships offered by brokers and insurers (*BI*, Feb. 6).

Nine participating students are spending 20 hours per week on the job. A&A currently employs two of the interns—one in its energy division, and the other in its casualty division.

The college also is reaching out to overseas students, said Ms. Thrower. Thirty-eight students from 19 foreign countries currently attend the college, with the majority enrolled in MBA programs. Japan, South Korea and the Peoples' Republic of China are the countries with the largest representation.

The foreign students are part of a student body that currently numbers about 1,400. Overall registration this fall represented a 12% growth over that of last fall, said a spokeswoman for the college. In addition, MBA enrollment increased by 62%, she said.

"I expect to see enrollment broaden," said Continental's Mr. Thiele. ■

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Murray named chairman of Minet unit

Richard H. Murray will assume the duties of chairman and chief executive officer of New York-based professional liability insurance broker Minet International Professional Indemnity Ltd. on Jan. 1.

Mr. Murray, who previously was executive director of Touche Ross International, assumes the duties at MIPI from Peter S. Christie, who will remain chairman of parent company Minet Specialty Management. Minet Specialty is a unit of London-based Minet Holdings P.L.C., which is a unit of St. Paul Cos. Inc. of St. Paul, Minn.

Mr. Murray will report to Mr. Christie.

In other broker changes:

Vincent H. Trapani promoted to chief of staff at American Business Insurance Inc. in San Francisco. Mr. Trapani will remain senior vp and chief financial officer.

Joel J. Buschmann named senior vp of The Reeves Co. Inc., a unit of American Business Insurance Inc. located in Lodi, Calif. He also will coordinate surety operations for other ABI Western subsidiaries.

Arthur J. Forenza Jr. promoted to president and chief operating officer of Glanvill Special Risk Insurance Brokers, the surplus lines brokerage subsidiary of Jardine Emett & Chandler Inc. Mr. Forenza, who will be based in San Francisco, previously was an executive vp.

Penn Independent Corp. and two wholly owned subsidiaries, Penn-America Insurance Co. and Delaware Valley Underwriting Agency Inc. of Hatboro, Pa., announced the following changes: **Charles Ellman** named vice chairman of Penn Independent Corp. from executive vp of DVUA; **Leroy Ellman** promoted to president and chief operating officer of Penn Independent Corp. from executive vp and chief operating officer; **Charles Conway** promoted to president and chief operating officer of DVUA from senior vp; and **Jon Saltzman** promoted to president and chief operating officer of Penn-America from executive vp.

Insurers

F. Herbert Brantlinger appointed first executive vp of United Community Insurance Co. in Albany, N.Y., a division of Lawrence Group Inc. Mr. Brantlinger had been vp-marketing with the Hartford Insurance Group in Hartford, Conn.

Paul D. Curioli has been elected regional vp and regional underwriting manager at Arkwright Mutual Insurance Co. He is based in the Norwalk, Conn., office.

David M. Tilford named vp-administration for the large group services division of Blue Cross of California in Woodland Hills, Calif. Mr. Tilford most recently was second vp and conversion project manager in the group operations division of The Provident Life & Accident Insurance Co. in Los Angeles.

Anne Bossi and **James G. Carlson** named vps at The Prudential Insurance Co. of America. Ms. Bossi, vp-Southwestern group operations, will be responsible for employee benefit products in Arkansas, Kansas, Louisiana, Missouri, Oklahoma and Texas. She is based in Houston. Ms. Bossi formerly was vp for corporate development at Prudential-Bache Securities Inc. in New York. Mr. Carlson, vp-Western group operations, will be responsible for Alaska, Arizona, California, Hawaii, Idaho, New Mexico, Nevada, Oregon, Utah and Washington state. He is based in Woodland Hills, Calif. Mr. Carlson previously was vp-health care management for Western group operations.

Comings & goings: industry

Reinsurance

Michael S. Abesamis promoted to vp for business development in Southeast Asia from assistant vp at Pearson & Georgi International Inc. of Hoboken, N.J.

David W. Tritton promoted to vp and branch manager of the treaty division's eastern region at American Re-Insurance Co. of Princeton, N.J.

Excess/surplus

John A. Dunbar promoted to senior vp of the wholesale brokerage group of Markel Service Inc. in Richmond, Va. He will direct the company's special risk, excess/surplus and transportation divisions.

In addition, **T. Davis Thrift** and **Nancy A. Horn** named vp of Markel Service's wholesale brokerage unit. Mr. Thrift will assume Mr. Dunbar's responsibilities as manager of the special risk division.

Other suppliers

Lynn L. Schenck named executive vp of The Center for Corporate Health Promotion in Reston, Va., a Travelers Corp. subsidiary that markets wellness and other health care cost containment programs. She had been a vp at Travelers.

Patricia M. Owens named vp in the Tarrytown, N.Y., office of Thomas L. Jacobs & Associates, a third-party administrator specializing in disability claims and a subsidiary of UNUM Corp. Ms. Owens formerly was associate commissioner for disability with the Social Security Administration.

Margaret-Ann Cole named manager of defined contribution consulting services at Touche Ross & Co. in New York. She formerly was vp of communication and recordkeeping services at Pension Plan Co. in New York.

Charles W. Dawson named senior vp-employee benefit consulting services at Benetech Corp. in Birmingham, Mich. Mr. Dawson most recently was vp with Johnson & Higgins of Michigan.

Michael J. Lewis named president and chief operating officer at August International Corp. in Orange, Calif., a health care cost management company. Mr. Lewis formerly was chief financial officer of Emulex Corp. in Costa Mesa, Calif.

Mark A. Straus joined the group/flex practice at The Wyatt Co. in Los Angeles as a consultant. Mr. Straus formerly was group practice leader for Alexander Consulting Group in Los Angeles.

Terrence M. O'Brien promoted to partner of Coopers & Lybrand in Chicago.

Robert L. Posnak promoted to national director of Ernst & Young's insurance industry group in New York. Also at Ernst & Young, **Robert W. Stein** promoted to national director of actuarial services. ■

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Referral service links buyers, vendors

Products & services

Employers that do not have an in-house risk management department can now locate outside risk management vendors through an independent risk management vendor information service.

Risk Management Referral Service, based in Newport Beach, Calif., functions as an independent organization that links buyers with vendors of risk management services.

It does not sell risk management services.

"It's amazing that in a market this big, the way risk managers still find vendors is still very 'catch if you can,'" said Andrew J. Cmiel, president and chief executive officer of the company.

"It's the kind of thing the market desperately needs," he said.

Mr. Cmiel explained the idea for the service occurred to him because of his experiences at conferences like those held by the Risk & Insurance Management Society Inc.

"You've got 450 exhibitors hawking their wares, and risk managers don't know which end is up," he said.

Mr. Cmiel described the referral service as an in-house information source for buyers to use whenever they want to.

"There isn't a catch. You have buyers out there looking for the right vendors and you have vendors out there looking for buyers; all we do is put them together," he explained.

The service can be accessed by mail, telephone or facsimile machine.

The buyer chooses the services he or she specifically needs from a menu, which is then compared to a list of vendors that may fit the bill.

The referral service has identified 34 major risk management services and has categorized the services into seven vendor types:

- Consulting services.
- Claims administration services.
- Medical cost containment services.
- Group benefit services.
- Automated systems.
- Underwriting services.
- Other services, including international specialities, structured settlement services, audits, recreation safety programs, professional liability specialties and legal cost containment.

Mr. Cmiel said the service usually finds two or three close matches. Then, a vendor miniprofile is sent to the buyer and a copy of the service request is sent to the appropriate vendor or vendors.

Use of the referral service is free to buyers, and buyers are under no obligation to use any of the vendors highlighted by the company.

Vendors pay the service a percentage of the business they get through the referral service.

Basically, "we are a marketing vehicle for the vendors," Mr. Cmiel explained.

But, he stressed, his service is more than a directory for buyers.

"We follow up to see whether the suggested vendors did contact the buyer, and we make sure everything is satisfactory," Mr. Cmiel said.

For more information, contact Andrew J. Cmiel, President, Risk Management Referral Service, P.O. Box 8104, Newport Beach, Calif.; 714-768-0334.

Aetna expands D&O

Aetna Casualty & Surety Co. is extending its Independent Directors Liability policy to provide coverage for all members of qualified corporate boards.

The IDL policy previously was available only to outside or non-management directors and was tailored to specific non-indemnifiable risks, such as shareholder derivative suits, said Stephen Sills, director of underwriting-financial institutions.

The extended policy is designed to enhance rather than replace traditional D&O liability coverage, and it indemnifies all directors and officers for personal financial loss up to limits of $10 million.

The policy covers such exposures as hostile takeovers, leveraged buyouts and failure to maintain insurance—all of which are excluded from standard D&O policies.

In addition, the policy advances defense costs rather than reimbursing them.

The extended policy was developed in response to increasing corporate board vulnerability created by the pervasive merger/takeover environment, Mr. Sills explained.

Among the exclusions are criminal acts and bodily injury/property damage.

The policy, which is written on a claims-made basis, also includes a one-year automatic extended discovery period, or tail coverage, if it is not renewed.

Premiums, which are determined according to the policyholder's asset size, start at $10,000 per $1 million of coverage.

The IDL policy is available through independent agents and brokers in most states except Florida, Indiana, North Carolina, New York, Ohio, Virginia and Wisconsin.

For more information, contact Stephen Sills, director of underwriting-financial institutions, Aetna Casualty & Surety Co., 82 Hopmeadow St., P.O. Box 2002, Simsbury, Conn. 06070; 203-244-8922.

Strike, tamper policies

Johnson and Higgins is now marketing two previously difficult-to-obtain coverages: strike insurance and malicious product tamper insurance.

The strike insurance policy, underwritten by syndicates at Lloyd's of London, indemnifies policyholders for 90% of all losses attributable to strikes by parties other than employees, such as suppliers, up to $10 million.

Premiums vary according to the type of company insured.

The product tamper insurance "protects against losses from either an actual or threatened product contamination, including loss of income from decreased sales, the costs of recall and the costs of rehabilitating a product's damaged reputation," a J&H spokesman said.

The policy is underwritten by Lloyd's underwriters and American International Underwriters, a unit of American International Group Inc. Limits of up to $30 million are available.

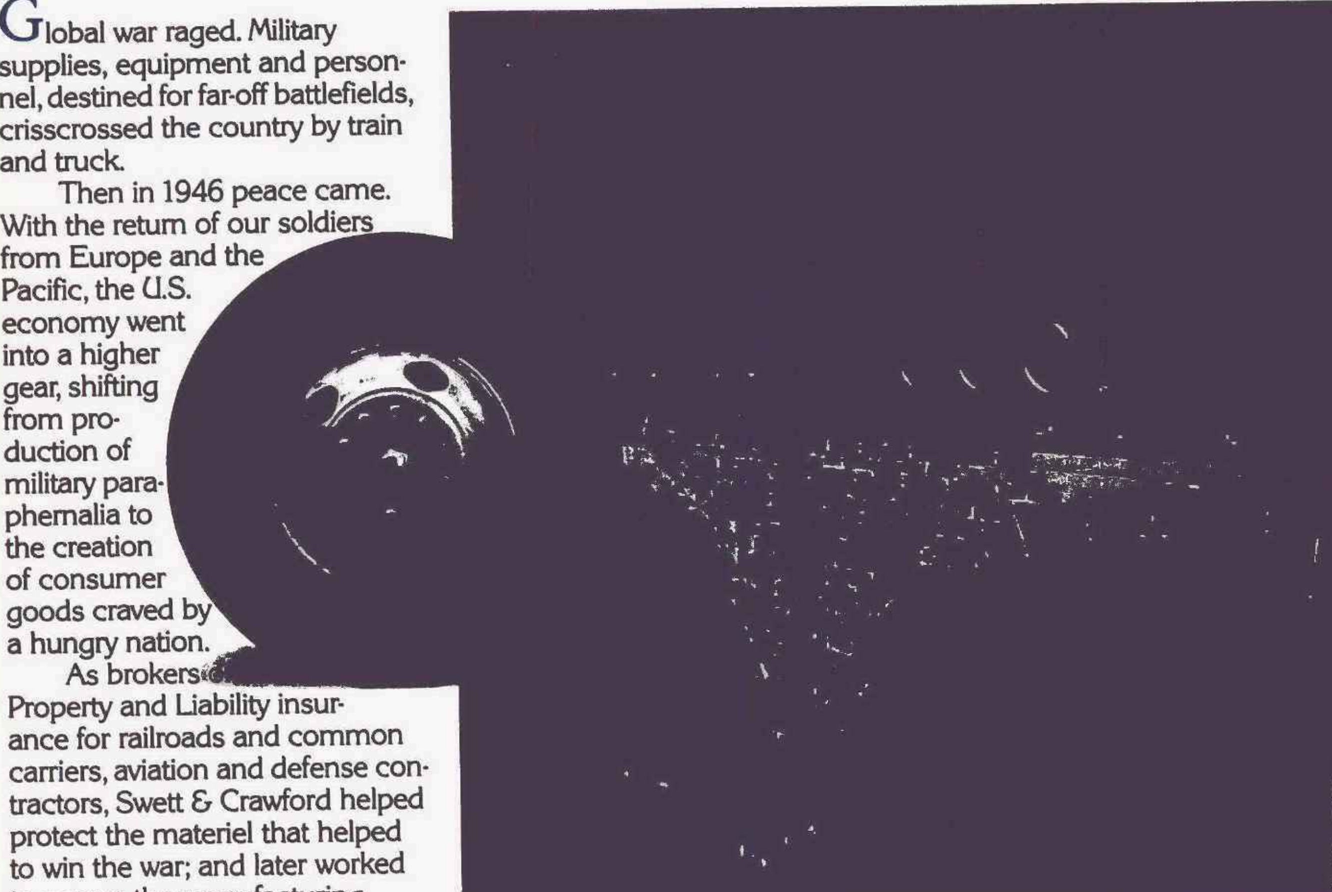
Exclusions include unintentional contamination.

Policyholders also receive for no extra charge consultation in loss prevention, anti-terrorist measures and crisis management.

For more information, contact Dan Bartonick, Manager-New York property department, Johnson & Higgins, 25 Broad St., New York, N.Y. 10004; 212-574-8523.

Continued on page 24

In the 1940's we helped keep America moving. Today we're still on a roll.



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Products & services

Continued from page 22

Peer review costs

An architects and engineers professional liability insurer will fully reimburse its policyholders for the cost of operational peer reviews.

The new peer review reimbursement program offered by Design Professionals Insurance Co. of Monterey, Calif., replaces the DPIC peer review credit program that had awarded policyholders a one-time, 5% premium reduction.

DPIC, a unit of Orion Capital Corp., markets architects and engineers professional liability insurance underwritten by Orion units Security Insurance Co. of Hartford, The Connecticut Indemnity Co. and DPIC.

The reimbursement program, administered by the American Consulting Engineers Council, is available in all states except Nebraska, Alabama and Georgia, where the previous peer review credit program remains in place.

"Our goal is to promote wider participation in organizational peer review because we are convinced that this process can reduce a design professional's exposure to loss," explained Bernard P. Engles, senior vp of DPIC.

"Therefore, DPIC Cos. will now fully reimburse its policyholders for the cost of the review, up to a maximum of $6,000."

An operational peer review assesses a company's policies and procedures pertaining to overall management, business development, human resources, financial management, project management and maintenance of technical competence.

Reviews take between one and three days depending on a company's size.

To initiate a peer review, an interested firm must contact the ACEC, which sends a communications package containing:

- Application forms.
- A Reviewer Profile Report containing background data, such as the prospective reviewers' discipline, firm location and size.
- A brochure explaining the review process.
- A manual detailing the six areas to be reviewed.

After completing the application form, the firm selects several possible dates for a review as well as a reviewer.

The ACEC program administrator also may select the reviewer based on criteria set by the company being studied.

After the review, a verbal report of the review findings—which are not compared to other companies or national standards—is issued to the firm along with all notes and background material.

Review fees for ACEC member firms are: $125 plus $25 per reviewer per day, as well as all reviewer expenses, including travel and meals. Non-member firms pay $250 plus $50 per reviewer per day, plus expenses.

The organizational peer review program has been endorsed by several insurers and industry associations, including the American Institute of Architects and the National Society of Professional Engineers.

For more information, contact Pam Frye, Peer Review Director, American Consulting Engineers Council, 1015 15th St. N.W., Suite 802, Washington, D.C. 20005; 202-347-7474.

Disability policy

UNUM Life Insurance Co. is now offering an individual disability insurance program for small business owners between the ages of 18 and 60.

The CUSTOMAX Owner-Manager policy is targeted to full or partial owners of commercial, industrial, manufacturing and retail businesses who spend 20% or less of their time performing manual labor.

"Knowing that most small business owners occasionally perform some manual duties—or supervise employees who do—we developed the CUSTOMAX Owner-Manager policy," explained Cheryl A. Stewart, second vp in UNUM's individual disability market/product development department.

"For years, small business owners who do any manual labor on the job have had great difficulty purchasing top of the line disability coverage," she said.

CUSTOMAX benefits are computed according to the individual policyholder's income level and financial needs and flexible plan designs are available, said Jane Langelier, individual disability product manager. Premiums are set accordingly.

CUSTOMAX is available through UNUM's offices in all states except Minnesota, New Jersey, New York, Pennsylvania, South Carolina, Virginia and Iowa.

For more information, contact Jane Langelier, Individual Disability Manager, UNUM Life Insurance Co., 2211 Congress St., Portland, Maine 04122; 207-770-8022.

Books/videos

"European Insurance Strategies," published by Evandale Publishing Ltd., gives insurance buyers, insurers and brokers monthly updates on developments affecting insurance markets as **trade barriers fall between European Community nations**. The newsletter also provides detailed analyses and studies of successful businesses, focusing on their strategies and tactics. The normal subscription rate to "European Insurance Strategies" is 315 pounds ($580). However, a reduced rate of 285 pounds ($525) is available for a limited time. Contact Evandale Publishing Ltd., Oriel Buildings, Suite 17, 10 Margaret St., London W1N 7Lf, United Kingdom.

The "Law of Chemical Regulation and Hazardous Waste," published by Clark Boardman Co. Ltd. of New York, helps risk managers and their attorneys see their way through the **complex maze of environmental regulations**. The volume is part of the Environmental Law Series that also includes "Managing Environmental Risk: Real Estate and Business Transactions," "Law of Environmental Protection" and "Law of Toxic Torts." Purchasers of "Law of Chemical Regulation and Hazardous Waste" receive periodic page revisions reflecting the latest statutory, regulatory and judicial developments. The publication, which costs $185, is available for a free 30-day examination. For information on other volumes in the series or to order, contact Clark Boardman Co. Ltd., 435 Hudson St., New York, N.Y. 10014; 800-221-9428 outside New York; 212-645-0215 inside New York; or fax to 212-924-0460.

Two new health care training videos from Industrial Training Systems Corp. teach employees **how to handle chemicals and waste in the hospital environment**. "Keeping Health Care Healthy: Handling Chemicals in the Hospital Environment" introduces hospital employees to the Occupational Safety and Health Administration's newly expanded hazard communication worker right-to-know regulations. "Waste Handling Practices in the Health Care Industry," videotaped in a hospital environment, discusses the five major waste streams: chemical, infectious, pharmaceutical, radioactive and general. "Keeping Health Care Healthy" runs 23 minutes and "Waste Handling" runs 22 minutes. Both videos cost $495 and are available in various video formats, including half-inch VHS and Beta formats. For more information, contact Doug Batezel, Industrial Training Systems Corp., 9 E. Stow Road, Marlton, N.J. 08053; 609-983-7300 or 800-727-2487. ■

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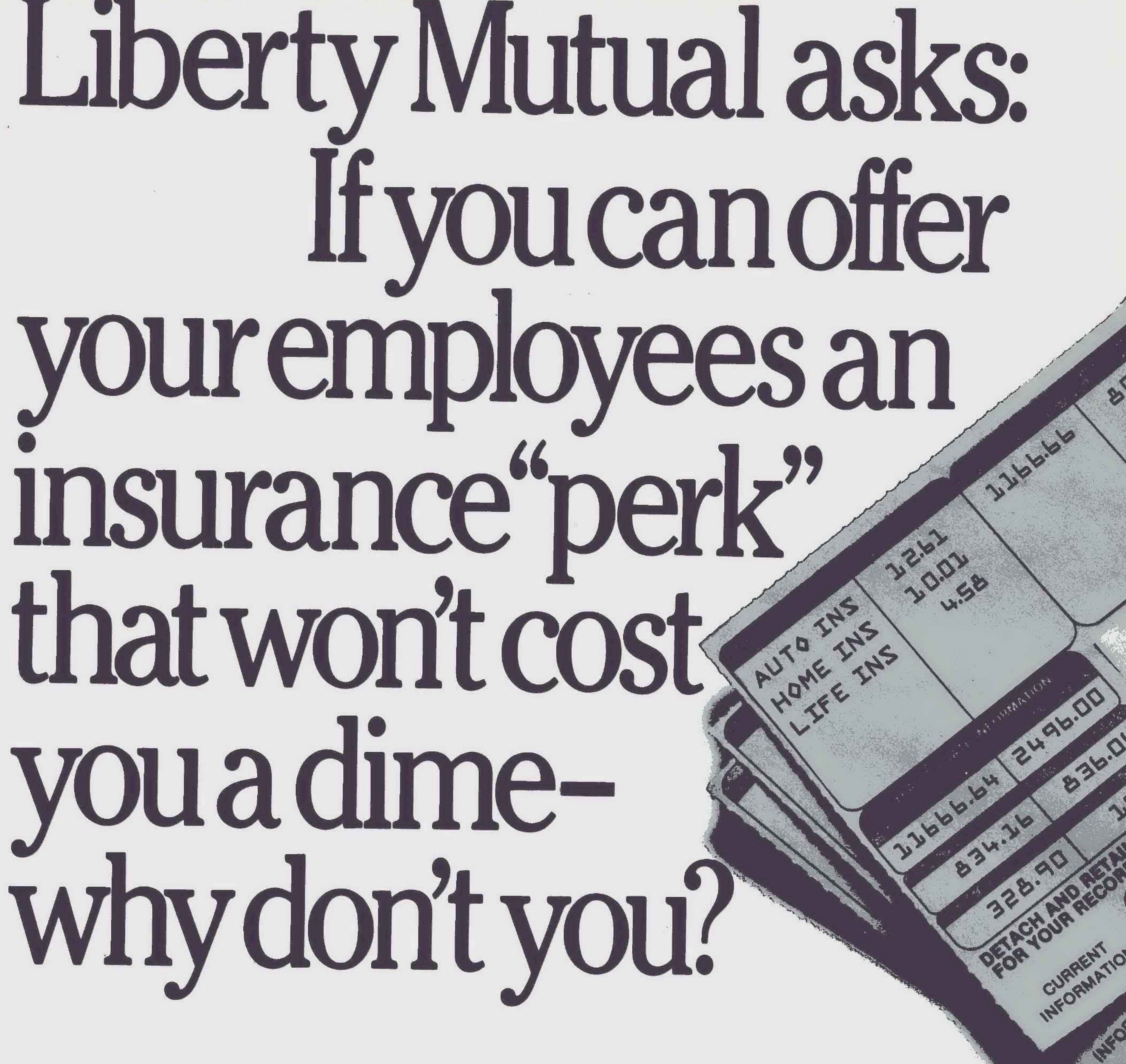

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Time Warner taps Mallia to oversee risk management

Comings & goings: buyers

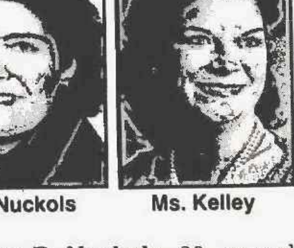
Joseph C. Mallia has been named director of corporate risk management at Time Warner Inc. in New York. In this newly created position, he will oversee the combined risk management departments of Warner Communications Inc. and Time Inc., which are merging to form a multinational publishing and entertainment conglomerate. Mr. Mallia reports to Glenn A. Britt, vp-finance and treasurer. Previously, Mr. Mallia was director of risk management for Warner Communications. Prior to that he was a senior consultant with EBASCO Risk Management Consultants Inc. in New York. Mr. Mallia received a bachelor of business administration degree from St. John's University in Jamaica, N.Y. He holds the Certified Property & Casualty Underwriter designation and is a member of the Society of CPCU. He also holds the Associate in Risk Management designation and has taught insurance and risk management courses at The College of Insurance in New York.

* * *

Carol S. Barnes, 43, named risk manager of Entertainment One Inc. in Houston. In this newly created position, she oversees property/casualty insurance, risk control and safety for the recently reorganized company, which manages 34 restaurants and lounges. Ms. Barnes reports to Maria Attilio, chief financial officer. Prior to joining Entertainment One, Ms. Barnes was risk manager of United Gas Pipe Lines Co. in Houston. She received the Associate in Risk Management designation and is a deputy member of the Risk & Insurance Management Society.

* * *

Ms. Nuckols



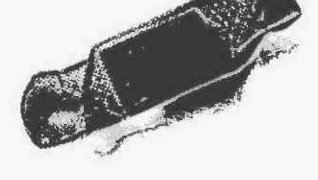
Ms. Kelley

Karen F. Nuckols, 29, named senior insurance administrator at Reynolds Metals Co. in Richmond, Va. In this position, she is responsible for managing the insurance and claims of Reynolds' blanket property, ocean cargo, marine and aviation programs. She reports to R. Kemper Smith, manager of insurance administration. Prior to joining Reynolds, Ms. Nuckols held marketing and claims positions with Alexander & Alexander of Virginia Inc. in Richmond. She holds a bachelor of business administration and management degree, with specialization in insurance, from Virginia Commonwealth University in Richmond.

Also at Reynolds Metals Co., **Vicki Kelley** named insurance administrator. In this position, she administers the company's bond program, self-insured workers compensation programs and various special coverages. She reports to R. Kemper Smith, manager of insurance administration. Ms. Kelley, who joined the company in 1979, previously served as a secretary within the risk management department.

•

We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Just drop a note to Paul Winston, Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, or call 312-649-5442. Please send a photograph, too.



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Unit targets firms without risk manager

Corporate Policyholders Council Inc. in Park Ridge, Ill., has formed a new unit to provide risk management services to companies that do not employ a full-time risk manager.

Duncan Randall, a former risk manager, is director of risk management service for the new unit, called CPC Risk Management.

"We see a great market out there. A number of companies need risk management services and have considered hiring a risk manager but feel that they don't have enough activities to keep somebody active on a full-time basis," Mr. Randall explained.

"We are able to manage their risk management program with our staff of professionals at probably one-fifth the cost of hiring a full-time risk manager and at the same level of competency," he said.

CPC Risk Management is targeting as clients companies with annual property/casualty insurance premiums ranging from $500,000 to $2 million.

While concentrating on companies in the Chicago area now, CPC Risk Management eventually expects to expand nationally.

Mr. Randall most recently was director of risk management for Homart Development Co., a real estate management and development firm in Chicago. Prior to that, he was vp-corporate insurance for Aon Corp. in Chicago.

For more information, contact Duncan Randall, Director of Risk Management Service, CPC Risk Management, 1460 Renaissance Drive, Park Ridge, Ill. 60068; 312-298-1770.

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PROPERTY

Markets

New EIL insurer

Front Royal Group Inc. of McLean, Va., has formed a new stock property/casualty insurance company subsidiary that will specialize in environmental impairment liability insurance, particularly for underground storage tank owners and operators.

The new Virginia-domiciled insurer, the Front Royal Insurance Co., has initial combined capital and surplus of $6 million and is seeking regulatory approval in all other states.

The company has arranged quota share reinsurance treaty support through domestic reinsurers that have combined policyholder surplus exceeding $1 billion.

"Our ability to attract quality domestic reinsurance support for a start-up operation is evidence of our management team's solid underwriting plan and operational expertise," said John J. Metelski, chairman of Front Royal Group.

The insurance company will offer owners and operators of underground petroleum storage tank systems EIL claims-made coverage of up to $1 million, with $1 million to $2 million in aggregate coverage, in accordance with U.S. Environmental Protection Agency requirements.

In addition to underwriting and administering claims, the company will also provide "ongoing risk management services to assist policyholders in complying with technical upgrading requirements," Mr. Metelski pointed out.

The company will introduce additional environmental insurance products as different underwriting opportunities are explored and reinsurance support obtained, he added.

For more information, contact Myra Anderson, Front Royal Group Inc., 7900 Westpark Drive, A300, McLean, Va. 22102; 703-893-0900.

Aetna buys HMO

Aetna Life Insurance Co has acquired Delta Health HMO Inc., a New Orleans-based health maintenance organization.

Delta Health will be managed by PARTNERS National Health Plans, which will market the plan under the name PARTNERS Health Plan of Louisiana.

PARTNERS National Health Plans is a joint venture of Aetna Life Insurance Co. and VHA Enterprises Inc., a subsidiary of Voluntary Hospitals of America Inc.

Partners Health Plan of Louisiana, an individual practice association HMO, will provide medical care to members in seven New Orleans parishes through about 625 physicians and six area hospitals: East Jefferson General Hospital, West Jefferson Medical Center, Touro Infirmary, Slidell Memorial Hospital, St. Tammany Parish Hospital and Pendleton Memorial Methodist Hospital.

"Since PARTNERS (National Health Plans) was launched four years ago, we've grown nationwide to 2.5 million members," said Deke Ellwanger, executive director of PARTNERS Health Plan of Louisiana. "That is a clear tribute to the strength of our provider network."

For more information, contact Deke Ellwanger, Executive Director, PARTNERS Health Plan of Louisiana, 3838 N. Causeway Blvd., Suite 1919, Metairie, La. 70002; 214-504-4344.

Atlantic Mutual unit

New York-based Atlantic Mutual Insurance Co. has created a new unit that specializes in developing and marketing property/casualty insurance programs for groups, associations and franchises.

The new group marketing unit can arrange property/casualty, auto, umbrella and workers compensation insurance programs for members of trade and professional associations, religious denominations, franchise operations and purchasing groups.

"Currently, we insure nearly 30 groups, including more than 45,000 policyholders," said David A. Jordan, manager and head of the new unit. "With this new unit, we are sharpening our corporate focus on this business line."

For more information, contact David A. Jordan, Manager-Group Marketing, Atlantic Mutual Insurance Co., 430 Mountain Ave., Murray Hill, N.J. 07974; 201-771-0660.

Associated Insurance

Associated Insurance Cos. Inc. of Indianapolis acquired three Dallas-based group life and health insurance companies from American General Corp. of Houston.

The acquisition reinforces the company's plan to diversify its product line and expand geographically, said L. Ben Lytle, president and chief executive officer of Associated.

The acquired companies will maintain their agency relationships throughout the South and West and there are no plans to relocate the Dallas offices, according to Mr. Lytle.

Associated will pay up to $195 million for the three units, collectively called American General Group Life Insurance Cos., and the transaction should be completed by year-end, said James S. D'Agostino, Jr., vp and treasurer at American General.

American General's divestitures are part of the company's "overall strategy to focus on the marketing of products and services directly to the consumer" rather than through independent agents and brokers, Mr. D'Agostino said.

Kendall merges

Rochester, N.H.-based agency Kendall Insurance Inc., the 44th-largest U.S. broker, plans to merge with New York-based Corroon & Black Corp., the fifth-largest broker in the United States.

"Kendall is a well-established

Continued on page 30

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Markets

Continued from page 28

agency that has gained national recognition for expertise in the specialized field of ski resorts and related business," said Richard M. Miller, president and chief executive officer of Corroon & Black.

The merger will "enhance Corroon & Black's penetration of a region and an industry that hold excellent potential for growth," he said.

Kendall also provides risk management services for commercial clients and designs and administers self-insured employee benefits and workers compensation programs.

Corroon & Black posted 1988 gross revenues of $425 million, while Kendall had $13.7 million in gross revenues in 1988 (*BI*, June 26).

The Kendall Agency, founded in 1867, has 165 employees.

Consultant acquired

Independent commercial insurance brokerage Engler, Hundhausen & Lockos Insurance Group Inc. has acquired Insurance Management Group Inc., a St. Louis-based consulting firm that specializes in developing custom programs for franchise networks and associations.

Engler, also based in St. Louis, offers risk analysis, program development, financing as well as insurance placement for associations and non-profit organizations, distributors and firms in the construction, manufacturing and health care industries.

IMG, begun in 1983, set up programs for franchise networks including Sparks Tune-Up centers, Car-X, Speedy and Meineke muffler shops.

"By acquiring IMG, our organization can boast exceptional knowledge in the automotive aftermarket and other automotive services," said J. Curtis Engler, EHL chairman and chief financial officer.

Jeffrey A. Combs, former president of IMG, will be senior vp-franchise program development at EHL.

Benefits merger

Miller Mason & Dickenson Inc., an employee benefits consulting subsidiary of Aon Corp., will acquire Clayton, Mo.-based Compensation Management Inc., a benefits firm specializing in general consulting and administration of qualified benefit plans.

CMI will continue to service and expand its own client base, said Daniel T. Cox, president of Chicago-based Miller Mason & Dickenson.

"CMI is a dominant factor in its profession for mid-size companies within the St. Louis area" and will further enhance "our ability to provide a wide range of professional benefit services to our clients nationwide," Mr. Cox said.

Paul Robberson, president of CMI and one of its founding principals, will become a managing director of Miller Mason & Dickenson and continue to manage the St. Louis operation.

Poe acquisition

Tampa, Fla.-based Poe & Associates Inc. will acquire the business of Insurance Administration Center Inc.

IAC, based in Park Ridge, Ill., acts as the insurance consultant and plan administrator for the National Assn. of Wholesaler-Distributors and its member associations.

"We are delighted with this joining of forces because it will bring increased capacity and capability in serving our members," said Dirk Van Dongen, president of NAWD.

"The addition of this professional group considerably enhances Poe's position in the area of association and affinity group insurance marketing," noted William F. Poe, chairman of Poe & Associates, the 15th-largest U.S. insurance broker with 1988 gross revenues totaling $35.1 million.

IAC President Robert L. Larsen will remain on staff, he added.

Surplus lines

Providence, R.I.-based PW Group, a group of independent property/casualty insurers, has formed PWN Underwriting Managers Inc., located in Boston.

The new company will serve as a surplus lines management division of the PW Group and will specialize in traditional property-oriented surplus lines products as well as in programs for the mortgage banking industry.

For more information, call Christopher C. Dawson, president, PWN Underwriting Managers Inc., 4 Liberty Square, Boston, Mass. 02109; 617-482-0600

New wholesaler opens

Delta States Underwriters Inc., a new managing general agent in Metairie, La., will offer "a complete line" of coverages and other services to insurance agents primarily in Mississippi and Louisiana, as well as in other Southern states.

"The knowledge and experience offered by our staff combined with the range of insurance companies we represent will be a major resource for insurance agents throughout the region," said President C. Russell Wilson Jr.

Mr. Wilson, who has worked in the insurance industry for nearly 20 years, most recently served as vp and general manager of American Guardian Insurance Underwriters of Dallas.

Delta States Underwriters is located at 111 Heritage Plaza, Suite 1424, Metairie, La. 70005; 504-832-7922.

Trucking risk specialty

Burnett Insurance Corp. of Mississippi in Jackson is a new agency specializing in insurance for the transportation industry.

The agency also will offer a complete line of commercial insurance coverages, but it has determined that it "could fill a need in Jackson's insurance market for an agency specializing in trucking coverages," explained Terry Burnett, president of parent company, Burnett Insurance Corp.

The new agency is located at 807 Northside Drive, Clinton, Miss. The mailing address is P.O. Box 397, Jackson, Miss. 39205.

Skandia expands

Skandia International Holding A.B. is beefing up its U.S. presence with the purchase of the Charter Gros4up in Dallas.

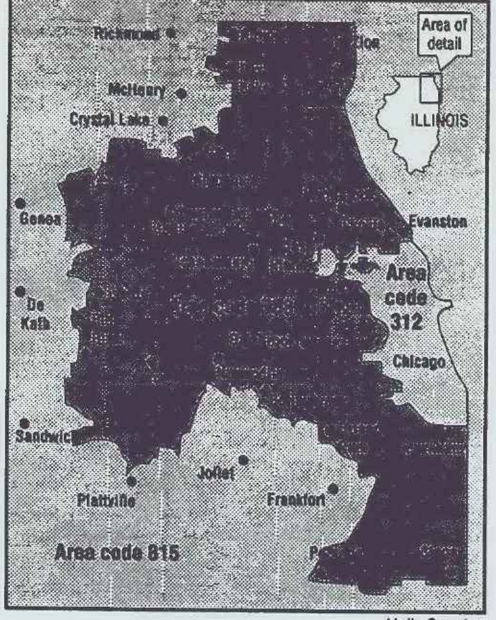
The Charter Group includes managing general agent Charter General Agency Inc.: excess and surplus lines broker Charter Special Risks Inc.; Monarch Premium Financing Inc., a premium finance company; and Charter Indemnity Co. Inc., a property/casualty insurer. All the companies are based in Dallas.

The purchase, for an undisclosed sum, is subject to regulatory approvals and is expected to be finalized by the end of the year, according to a spokeswoman for Skandia, which is a unit of international insurer and reinsurer Skandia Group of Stockholm, Sweden.

The purchase "is consistent with our strategic plan to increase our presence in the U.S. direct insurance market by acquiring insurance facilities with strong positions in their respective markets," explained Arne Benroth, executive vp of Skandia International.

Continued on next page

...al 708 to reach Chicago suburbs



Holly Seguine

Callers trying to reach insurers, consultants and colleagues in the Chicago suburbs may find their patience wearing thin late this fall.

Beginning Nov. 11, all suburban Chicago telephone numbers will change to area code 708 from area code 312.

However, the phone company has announced that it will allow a limited grace period during which it will complete calls to suburban locations made using either area code.

But, in December, the unconnected calls and recordings begin for callers using the wrong area code.

The phone company explains that the change is necessary because it has run out of prefixes to give customers.

To avoid months of annoying telephone recordings, start updating your Rolodex now.

Continued from previous page

MBIA acquires BIG

MBIA Inc. has reached an agreement in principle to buy all the common stock of Bond Investors Group Inc., parent of Bond Investors Guaranty Insurance Co., for about $275 million in cash.

BIG is jointly owned by American International Group Inc., Bankers Trust New York Corp., Government Employees Insurance Co., Salomon Inc. and Xerox Credit Corp., each of which controls 20%.

MBIA has about a 37% share of the municipal bond insurance industry, while BIG has a 13% share, according to an MBIA spokesman.

The agreement, which may be consummated by year-end, subject to regulatory approvals, calls for MBIA to reinsure BIG's $30 billion municipal bond insurance portfolio.

BIG will cede its unearned premium reserve and contingency reserves to MBIA.

The acquisition will give MBIA a capital base of $650 million and policyholders' reserves of about $1.5 billion.

The spokesman noted there are no significant differences between MBIA's and BIG's bond portfolios.

BIG has about 90 employees, some of whom may be offered employment at MBIA depending on staffing needs, according to the MBIA spokesman.

Robert Barbanell, managing director of BT Securities, a Bankers Trust unit, said BIG's owners decided to sell its stock because of differing views among them on the direction of the insurer's business. He would not elaborate further.

New claims manager

Claims Service Corp. of America has been formed by a group of insurance and claims executives in Richmond, Va., to perform independent claims adjusting, claims management and auditing services.

Roy C. Hinton, president, said he and four other partners who had been affiliated with other claims service companies wanted to form a smaller operation in Richmond.

The company plans to eventually have 25 offices in the Mid-Atlantic states, he said. Currently, about 19 employees work in offices in Virginia and Maryland.

For more information, contact Mr. Hinton at Claims Service Corp. of America, 1910 Byrd Ave., Suite 224, Richmond, Va. 23230; 804-282-7800.

Hilb, Rogal mergers

Hilb, Rogal & Hamilton Co. of Richmond, Va., has reached a tentative agreement to acquire all of the outstanding shares of **Lasher-Cowie Agency Inc.** of Phoenix, Ariz., in a pooling agreement.

Lasher-Cowie also has retail brokerage branch offices in Tucson and Flagstaff, Ariz. Lasher-Cowie reported $5.9 million of gross revenues in 1988.

Meanwhile, **Trupp-McGinty Insurance Services Inc.** of St. Simons Island, Ga., has merged with Hilb, Rogal and **Lee & Short Insurance Agency Inc.**, an independent agent in Charlotte, Va., has merged with the The Charlottesville, Va., office of Hilb, Rogal.

Mergers/acquisitions

New York-based **Lawrence Agency Group Inc.** will acquire **United Republic Reinsurance Co.**, a property & casualty reinsurance company based in Houston.

HCX Inc., a subsidiary of Washington, D.C.-based investment partnership TEI Medical L.P., has acquired **Republic-RSB Cos. Inc.** in Naperville, Ill.

Republic provides hospital bill audits and medical utilization management services to self-insurers and insurance companies. The new company will operate under the Republic-RSB name.

Pacific Compensation Capital Corp. of San Bruno, Calif., will acquire San Francisco-based **Beaver Pacific Corp.** and its principal operating susidiaries, Beaver Insurance Co. and David Corp.

Zenith Administrators Inc. of Washington, D.C., has acquired two third-party administrators: **Kelly & Associates Inc.** of Chicago and **United Administrators Inc.** of Seattle.

Laub Group Inc., a Milwaukee-based regional insurance agency, has acquired **W.R. Russell Hummel Co. Inc.** of Rolling Meadows, Ill., and **R.N. Crawford & Co.** of Chicago. Hummel and Crawford will become affiliates of the Laub Group and will operate under the name **Hummel Cos. Inc.**

Tower Special Facilities Inc. of Milwaukee and **Specialty Insurance Brokers of Wisconsin**

Continued on next page

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Markets

Continued from previous page

Inc. in Pewaukee have merged and offices will be combined in Milwaukee. Tower Special Facilities will assume all the commercial business of Specialty Insurance Brokers in Wisconsin, although SIB will be maintained for certain selected contracts and operations.

Near North Insurance Group Inc. of Chicago has acquired **Cohen Insurance** of New York. Near North's Entertainment Division combined with Cohen will provide clients specialized coverages for independent film, video and television productions.

ALTA Health Strategies Inc., an independent health care cost management company, has acquired Salt Lake City-based Smith Administrators Inc., a third-party administrator.

New England Critical Care, a Westborough, Mass.-based infusion therapy company, plans to acquire **Integrated Care Systems Inc.,** a home infusion therapy company based in Gardena, Calif. ICS will become a wholly owned subsidiary of NECC and will continue to operate its six regional centers in San Francisco, Sacramento, Bakersfield, Santa Barbara, Van Nuys and Orange County, Calif. A seventh regional center is planned to open in Upland, Calif.

Kinney-Pike/Hartford, a unit of independent insurance agency Kinney, Pike, Bell & Conner Inc. of Rutland, Vt., has acquired **Barwood Insurance Agency** of White River Junction, Vt.

HCM Claim Management Corp., a claims administrator in Park Ridge, N.J., acquired **Bierly & Associates Inc.**, a third-party administrator in Pasadena, Calif. Also acquired were Bierly & Associates' two subsidiaries: Page One Adjusters, which investigates work comp claims; and Best Impressions, which provides photocopies for medical and legal adjustments.

Name change

NWNL Reinsurance Co. of Minneapolis changed its name to **Chartwell Reinsurance Co.**

The name change is designed to strengthen the company's market image as an independent professional reinsurance company, said President and Chief Executive Officer Angus Robinson Jr.

The reinsurer is now directly owned by a newly created holding company, Chartwell Re Corp., domiciled in Wilmington, Del. However, Northwestern National Life Insurance Co. in Minneapolis continues as Chartwell's sponsor and majority shareholder.

New offices

National Benefit Resources has opened a new office at 600 W. Cummings Park, Suite 1500, Woburn, Mass. 01801; 617-937-0410.

Portland, Maine-based **Maine Health Plan Inc.** has moved to 778 Main St., Suite 5, South Portland, Maine 04106; 207-774-2824.

Nemirow Financial Services, a risk and insurance management consulting and accounting/tax services firm, has opened an office at 3690 Daisy St., Seal Beach, Calif. 90740; 213-430-8231.

O'Mara & Associates, a risk management consulting firm that specializes in the health care industry, opened an office at 3731 Wilshire Blvd., Suite 770, Los Angeles, Calif. 90010; 213-480-7734.

ECS Inc., a Downington, Pa.-managing general agent for Reliance Group Holdings Inc. insurers underwriting a nationwide environmental insurance program, including environmental impairment liability insurance, has moved to 1 E. Uwchlan Ave., Suite 300, Exton, Pa. 19341; 215-269-6731.

San Mateo, Calif.-based **Andreini & Co.**, an insurance, risk management and employee benefits consulting firm, opened a new office in Portland, Ore. Andreini & Co. of Oregon is located at 1500 S.W. First, Suite 1050, Portland, Ore. 97201; 503-221-9595.

Lindsey & Newsom Claim Services Inc. of Tyler, Texas, has opened a new branch office in Baton Rouge, La. The new office is located at 4127 S. Sherwood Forest Blvd., Suite 240, Baton Rouge, La. 70816; 504-296-5896. The mailing address is P.O. Box 40416, Baton Rouge, La. 70835.

New York-based **Atlantic Mutual Insurance Co.** opened a new marketing center for commerci[al] lines insurance at 5300 W. C[...] St., Suite 120, Cypres[s...] Tampa, Fla. 3360[...]

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Mentor liquidators defend their record

HAMILTON, Bermuda—The liquidators of Mentor Insurance Ltd., who are under attack by dissident creditors owed $160 million, are refusing to resign without a fight.

The dissident creditors, represented by the London law firm of Clyde & Co., filed 16 resolutions in September calling for the resignation of Mentor liquidators Charles Kempe and Michael Arnold, and other changes in the handling of the liquidation.

While the resolutions will be on the agenda for the Nov. 1 creditors meeting, the Mentor liquidators say there is no justification for their resignations.

In an 11-page rebuttal sent to all creditors, Messrs. Kempe and Arnold say the dissident creditors' criticism is "based upon fundamental misconceptions and misunderstandings of the liquidation process."

The dissatisfied creditors have asked for the liquidators' resignations, but "the joint liquidators do not believe that there is any cause why one or both of them should resign or be removed by the court," the liquidators say.

The liquidators' rebuttal is among 32 pages of documents sent to all Mentor creditors Oct. 4. Also included is the agenda for the Nov. 1 meeting to be held in Bermuda; a summary supporting Clyde & Co.'s resolutions; a statement from the committee of inspection; and a proxy to vote for or against the 16 resolutions.

According to the agenda filed with the Bermuda Supreme Court last month, the creditors are being asked to vote, among other things, on the following resolutions:

- That Mr. Kempe, partner with Ernst & Young, be asked to tender his resignation, and if he refuses, that the creditors vote to file an application with the Supreme Court of Bermuda to have him removed as liquidator.
- That Mr. Kempe be replaced by David Lines, a Bermuda-based partner of Coopers & Lybrand (International).
- That Mr. Arnold, former partner of Ernst & Young, be asked to explain whether he plans to continue as liquidator of Mentor. Mr. Arnold left Ernst & Young following the merger of Ernst & Whinney with Arthur Young earlier this year, but remains as a consultant to Ernst & Young. His departure from the accounting firm has raised doubts among creditors about his position as liquidator of Mentor.
- That if Mr. Arnold is not prepared to remain as liquidator, that he also be asked to tender his resignation.
- That if Mr. Arnold does leave, he is replaced by Michael Jordan, a partner at Cork Gully, which is affiliated with Coopers & Lybrand (International).

Messrs. Lines and Jordan already are working together as joint liquidators of River Plate Reinsurance Ltd., a Bermuda reinsurer that collapsed in 1988.

- That the creditors vote whether to retain the current members of the Committee of Inspection or to elect new members.
- That four other creditors, to be selected at the meeting, be appointed additional members of the Committee of Inspection.

A larger Committee of Inspection would have a wider range of insurance market expertise from which the new liquidators could draw, the dissident creditors say.

The creditors represented by Clyde & Co., who represent 10% to 20% of the value of all creditors' claims against the company, say that the present liquidation strategy is "predominantly litigation-oriented and substantially influenced by the concept of being a contentious runoff," according to a 2½-page summary of their objections that all Mentor creditors have received.

The dissident creditors claim that over the first three years of the liquidation, this strategy has cost more than the value of the assets collected.

And "this situation has not improved over the last 12 months," the dissatisfied creditors claim.

The dissatisfied creditors "believe that their interests, and those of the general body of creditors, will be best served if a more conventional approach becomes the dominant influence in the strategy—i.e., marshaling in and distributing the assets of the company and taking all necessary steps as efficiently and expeditiously as possible to wind up the company's affairs," says the summary.

The dissident creditors would like Mr. Lines and a senior partner of Ernst & Young, or Mr. Jordan of Cork Gully, to take over the management of the Mentor liquidation "with renewed vigor and enthusiasm. Such a team of new joint liquidators would be independent and thus have fresh and new ideas, but would also bring about the minimum of disruption to the continuing administration of the estate," says the summary.

The new liquidators could draw upon the support of the Mentor staff in Bermuda for assistance.

If new liquidators are appointed, a review of the present liquidation process, its administration and strategy would be conducted by the new liquidators, the Committee of Inspection and appropriate outside professionals, says the summary.

Meanwhile, Messrs. Kempe and Arnold have no objection to a larger Committee of Inspection, according to the documents sent to creditors earlier this month. But they say that the arguments made by the dissident creditors to remove them as liquidators—particularly Mr. Kempe—are "based on a number of fundamental misconceptions."

For example, "the liquidation is not predominantly litigation orientated," say the liquidators in their 11-page rebuttal.

To date, the liquidators have only filed five legal actions "of any significance." Most of the actions are mainly against Mentor's parent, Ocean Drilling & Exploration Co., and Mentor's auditor, KPMG Peat Marwick, which "represent very substantial, if not the most valuable, assets" of the defunct company.

The liquidators are trying to pierce the corporate veil and hold ODECO responsible for Mentor's debts. They also are charging that Peat Marwick did not do a proper job of auditing Mentor's accounts (*BI*, Sept. 25).

Messrs. Kempe and Arnold also say that they have been advised by lawyers that they are under a "duty" to pursue these actions in the interests of the majority of the creditors. In particular, the liqui-

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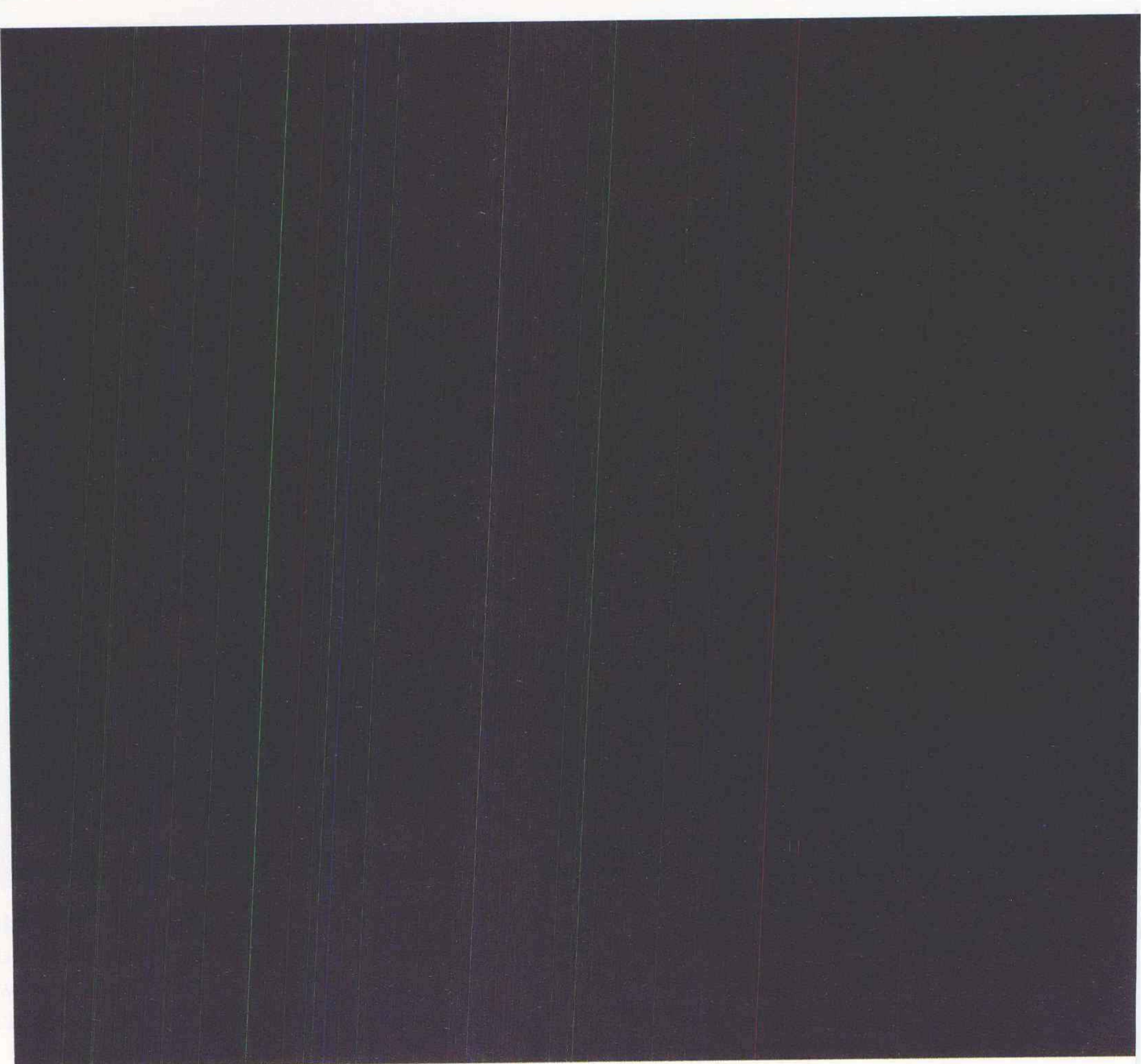
Bermuda briefs



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...ay they sought advice from ...muda law firm of Appleby, ...g & Kempe and London-... ...ovell White Durrant when ...ed their Oct. 3 action in the Supreme Court of Bermuda against ODECO, Pinnacle Reinsurance Co. and several current and former ODECO and Mentor officers.

"Faced with such advice, no professional insolvency practitioner acting in the best interest of creditors would 'drop hands' on this litigation," said the liquidators. "That is not to say that a substantial offer to settle would not receive proper consideration."

The Bermuda action substantially repeats the allegations contained in the suit the liquidators filed in U.S. federal court, which was dismissed on the grounds of forum non conveniens (*BI*, April 25, 1988). However, the liquidators have asked the U.S. Supreme Court to review the dismissal.

Messrs. Kempe and Arnold also say that they are using a conventional approach to liquidate Mentor, which is what the dissident creditors led by Clyde & Co. want. As of Sept. 30 this year, Mentor liquidators have collected $92.2 million, including $51.7 million in investment income.

"In addition, steps are being taken to distribute the assets as expeditiously as possible," say the liquidators.

And it is false to say that the cost of the liquidation exceeds the amount of assets collected, the liquidators say.

"The net assets available to creditors have increased by $59.8 million after costs" in the last 12 months, they say.

Messrs. Kempe and Arnold believe that they can "substantially complete" the Mentor liquidation without disruption within the next two to three years. But creditors should be aware that if the liquidators are removed, there is no guarantee that the Mentor employees will stay, a possibility which would postpone the liquidation.

Messrs. Kempe and Arnold also point out that Mr. Lines, who has been proposed to replace Mr. Kempe, is not independent of the proceedings.

They claim that Mr. Lines' parent firm, Coopers & Lybrand, is the auditor of American International Group Inc., which underwrote directors and officers liability insurance for ODECO officers and directors, some of whom are defendants in litigation. In addition, ODECO has sought advice from Coopers & Lybrand (International), the liquidators contend.

As for Mr. Arnold's position, the liquidators explain that after the merger of Ernst & Whinney and Arthur Young, Mr. Arnold has served as a "consultant" to Ernst & Young "with a considerable time commitment on his part to Mentor's liquidation in order that the investment in his expertise so far borne by creditors should not be lost."

Meanwhile, Ernst & Young will not agree to be appointed joint liquidators with another accounting firm, because having joint liquidators from two different accounting firms "is not in the creditors' interests given that it will only cause additional cost and delay to the rapid progress being achieved."

Creditors also should be aware that Messrs. Kempe and Arnold are by Bermudian law the officers of the court and can only be removed by the court with just cause. Despite Clyde & Co.'s lengthy 12-month correspondence with the court, the dissident creditors have not offered any just cause why the current Mentor liquidators should be removed, says the rebuttal document.

"The statement in support of the resolutions is based on a number of fundamental misconceptions, is not supported by the facts and does not show any 'cause' why one or both of the joint liquidators should resign or be removed by the Court," say the liquidators.

—*By Stacy Shapiro*

Norad liquidation

Creditors of Norad Reinsurance Co. Ltd., an insolvent Bermuda captive insurer owned by privately held conglomerate Berwind Corp. of Philadelphia, will receive a first and final cash payment in April 1990, says Norad's liquidator.

If current estimates of liabilities and assets prove accurate, however, 50 creditors will receive only 10 cents on the dollar.

A filing deadline of Dec. 29 has been set for the return of proof of debt forms now being sent to Norad creditors, said Chris Whittle, a partner with the accounting firm Ernst & Young, who was appointed Norad's liquidator last year when the company filed a voluntary winding-up petition (*BI*, Oct. 17, 1988).

He predicts the liquidation could be completed by next summer.

"We have garnered about $5 million in assets of the company under our control and we've explored all the options open to us," said Mr. Whittle.

"There is a basic desire to get this liquidation completed at minimal expense and we can see no reason why we need to take years to wind up a fairly straightforward reinsurance company. It makes good business sense to do it as quickly as possible so that creditors can take their money and invest it," he said.

Norad, which had been managed by James Bermuda Ltd., now a unit of Sedgwick Group P.L.C., stopped underwriting in 1985. The decision to liquidate was made at an October 1988 creditors' meeting.

Norad's biggest creditor is the insolvent Mutual Fire, Marine & Insurance Co. of Philadelphia, which is in rehabilitation in Pennsylvania. Alex Bratic, special deputy rehabilitator with the Pennsylvania Insurance Department, last month filed suit against Berwind in Pennsylvania Commonwealth Court, seeking to pierce the corporate veil and hold the conglomerate responsible for Norad's liabilities (*BI*, Sept. 25).

Norad owes Mutual Fire, Marine "at least $25 million," said Ralph Jacobs, an attorney for the rehabilitator with the Philadelphia law form of Hoyle, Morris & Kerr.

Berwind is seeking to have the suit moved to federal court.

"We understand Berwind is filing motions in the U.S. District Court for the Middle District of Pennsylvania for the suit to be dismissed on the grounds of forum non conveniens," said Mr. Jacobs. "We have not seen briefs in support of this motion yet, but we believe that Berwind is saying the case should be brought in Bermuda."

The Mutual Fire, Marine complaint charges that Berwind managed and controlled Norad and is liable, under Pennsylvania law, for the captive's liability to Mutual Fire, Marine, Mr. Jacobs said. The action alleges that key decisions affecting Norad were made by Berwind's management in Philadelphia, he said. The suit also claims that Mutual Fire, Marine employees had "direct dealing with Berwind staff over Norad matters."

Mr. Whittle, Norad's liquidator, said Norad is not joining Mutual Fire, Marine's action against Berwind, though he is not ruling out any possibility of recovering additional sums owed to the failed Bermuda captive.

In a Sept. 5 letter to Norad creditors, Mr. Whittle said that although he intends to distribute all of Norad's estate in the April dividend, "unanticipated situations" may arise before then.

"Therefore, I reserve the right to retain funds of the estate for a longer period should it prove nec-

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Bermuda briefs

Continued from previous page

retention of assets prove appropriate, a further distribution may be made at a future date."

Mr. Whittle's letter warned that creditors who fail to complete and return required proof of debt forms by the Dec. 29 deadline will not qualify for the proposed April payment.

—By Roger Scotton

Bercanus petition

Legal proceedings stemming from the collapse of Bermuda-based Bercanus Insurance Co. Ltd. were put on hold last month after owners of the insolvent company filed for protection under Chapter 11 of the U.S. bankruptcy code.

However, Bercanus liquidator Chris Whittle, an Ernst & Young partner in Bermuda, says he has no intention of dropping the litigation he began in January 1988 against Bercanus President Neill Portermain and Florence Portermain, his wife and a Bercanus co-director.

According to Jeff Ford, a Dallas attorney representing Mr. Whittle, the Portermains filed for bankruptcy Sept. 18, three weeks before a jury trial in Mr. Whittle's suit was to begin in Texas District Court in Dallas.

Mr. Whittle's suit against the Portermains includes allegations of fraud, negligence, breach of fiduciary duty and violations of the Racketeer Influenced and Corrupt Organizations law.

The Portermains' bankruptcy filing "means there will be an automatic stay of the Bercanus suit pending a hearing of the Portermains' bankruptcy filing," said Mr. Ford. "My guess is that things will now be postponed for a number of months, after which we will either reach a settlement or obtain an order in the bankruptcy filing."

Mr. Ford said he would object to any attempt by the Portermains, who live in McKinney, Texas, to have Mr. Whittle's suit discharged.

"We were ready to proceed with the trial and believed we had a very strong case," Mr. Ford explained. "We still believe that."

The suit seeks the recovery of about $10 million that Mr. Whittle believes was illegally diverted from Bercanus by the Portermains (*BI*, May 9, 1988). The suit also demands payment for damages that crippled the insurer and left it with an estimated $38 million in liabilities when it collapsed in March 1985.

However, Mr. Whittle says that liabilities are much higher than first thought and could total about $60 million. Assets are now estimated at about $1.5 million.

Bercanus' main creditors are Fremont Insurance Co. of Los Angeles, American Centennial Insurance Co. of Wilmington, Del., and members of the American Podiatry Assn., who purchased medical malpractice insurance policies from Bercanus.

The suit notes that Bercanus was incorporated in Bermuda in April 1970 to write U.S. medical malpractice insurance and excess-of-loss reinsurance. It was a wholly owned subsidiary of United Nebraska Investors, a company the suit says was owned and controlled by Mr. Portermain.

The suit alleges that Mr. Portermain in June 1978 organized a producer agreement between Bercanus and South Rock Ltd., another Bermuda-based company controlled by Mr. Portermain. The agreement required Bercanus to pay South Rock commissions of 20%-30% on business South Rock placed with Bercanus. However, the suit alleges, Mr. Portermain did not disclose his interest in South Rock to Bercanus' board of director[s]

In October 1979, Mr. Porter[main] arranged another agreement [be]tween Bercanus and South Ro[ck] which South Rock received a [...] year contract as Bercanus' ma[nag]ing general agent, the suit alleges. Bercanus was to pay South Rock an annual fee equal to 5% of gross premiums, plus commissions, the suit says.

The liquidator charges that these payments were privately fixed at $1 million a year irrespective of the level of underlying business.

Between May 1978 and December 1983, Bercanus paid South Rock a total of $4.8 million in commissions and fees, the suit alleges. South Rock, in turn, directly or indirectly paid the Portermains dividends of $3.4 million, the suit says, adding that the company paid another $600,000 to other South Rock directors and shareholders.

"Both the producer agreement and the management agreement were shams contrived and used by Mr. and Mrs. Portermain and other conspirators to loot Bercanus and to steer funds rightfully belonging to Bercanus to South Rock," the suit charges.

"These funds were then passed through South Rock as dividends or other payments to Mr. and Mrs. Portermain. South Rock did not, nor at any time was it in the position to, render any genuine services of any substantial worth to Bercanus," the suit says.

Mr. Whittle maintains in the suit that rather than carrying on any insurance business, South Rock merely acted as a conduit for business already destined for Bercanus, adding that Bercanus' payments to South Rock were misappropriations for the sole benefit of the Portermains.

The suit also charges that the scheme to loot Bercanus also included fraudulent quota-share reinsurance deals.

The deals, which allegedly took place in 1978 and 1979, were agreed to by Bercanus and shell corporations in the Cayman Islands and Panama controlled by the Portermains, the suit says. The companies included Avis Insurance, Security Exchange Co. and other companies owned by Plan Real Property Investments Inc., a Texas company controlled by the Portermains, the suit claims.

The complaint says that $1.2 million was funneled from Bercanus through the bogus reinsurance deals.

The suit also alleges that Bercanus' money was used to establish a limited partnership agreement for the acquisition and development of real estate in Dallas and Collin counties in Texas.

The suit's racketeering charges maintain that the Portermains repeatedly used the U.S. mail, telephone, telex and air links with their offices in Richardson, Texas, to rob Bercanus.

Mr. Portermain, who is an actuary, also has been accused of allowing Bercanus to be stripped of its assets and of knowingly and intentionally misrepresenting Bercanus' financial condition to Bermuda insurance regulators.

Mr. Portermain could not be reached for comment.

The Portermains' bankruptcy filing, though not entirely unexpected, is a "real blow" and came after significant time and money had been spent pursuing Bercanus' former owners, Mr. Whittle said. However, he firmly rejects any suggestion that Bercanus' resources could have been better applied or that the lawsuit against the Portermains was ill-advised.

"We satisfied ourselves two years ago that the Portermains had sufficient assets to pursue. And don't forget that they still have to convince a U.S. bankruptcy court they are bankrupt," Mr. Whittle said.

—By Roger Scotton

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Year-end GIC demand could outstrip supply

By JUDY GREENWALD

PRINCETON, N.J.—Benefit plan sponsors could face a shortage of guaranteed investment contracts later this year as demand outstrips capacity, says benefit consultant A. Foster Higgins & Co. Inc.

A study of 45 insurers—accounting for an estimated 99% of 1988 GIC sales—shows demand for GICs up 25% to $40 billion in 1989 but insurers' capacity rising only 14% to $36.5 billion.

Increasing demand may be met by bank investment contracts, a form of deposit similar to GICs, said Brian Ternoey, a principal and head of Foster Higgins' investment services practice in Princeton, N.J.

BICs and other alternative investments absorbed about 10% of GIC demand in the first half of 1989, he said. "It really does seem they have balanced the equation pretty comfortably this year."

With current factors constant, the market could "turn the corner" with no major capacity problems, he said.

GICs promise a specific return rate on capital over the life of the contract. They account for an estimated 75%-85% of funds invested by defined contribution pension plans.

Two factors could cause a capacity shortage this year, said Mr. Ternoey:

- The possibility of a normal yield curve, which means higher rates of return on longer contracts.

With shorter maturities, BICs offer higher yields because banks have more experience with short-term investments.

Earlier this year, the GIC market was marked by an inverted yield curve, with the shorter maturities offering higher rates (*BI*, May 22). As a result, BICs were in high demand.

Recently, however, the yield curve has flattened and banks are not "writing the kind of business they were in the first half of this year," said Mr. Ternoey. "It really looks like the banks needed that inverted yield curve" on GICs to be more competitive, he said.

- Diminished capacity by insurers, many of which are limiting the amount of GIC business they write, in a variety of ways.

Forty percent of survey respondents say they are rationing supply or limiting sales, primarily by increasing profit margins, using general sales limits and tightening underwriting requirements.

If both trends develop, plan sponsors could face year-end capacity shortages as investment contracts expire and sponsors seek to reinvest in new contracts, Mr. Ternoey said. "If banks sell less and carriers sell less, capacity could run out."

Even without a serious supply problem, plan sponsors could have trouble securing GICs, Mr. Ternoey said.

Among potential problems:

- Offering defined benefit pension plan investment options that insurers consider risky, and therefore undesirable, to service. For instance, an insurer may be unwilling to write a GIC on a plan that offers competing investment options, such as a money market fund, out of concern that plan participants will not select the GIC. Plan sponsors could be forced to change their plan design.
- Large cash flows or large maturing proceeds to invest, which could prevent sponsors from finding a single insurer to work with them.
- Problems placing GICs with shorter maturities, although BICs could be purchased.
- Finding only a few bidders willing to give quotes on business, forcing plan sponsors to lower their standards for the type of insurers they want to issue GICs.

Among other survey findings:

- 37.5% of insurers said 1989 sales were ahead of their 1988 pace, as of June 30; 37.5% matched last year's pace; and 25% were behind.
- 19% of the insurers said some maturities, primarily in the one-to-three-year range, are in tight supply or unavailable.
- 23% said maturities in the five-to-eight-year range are more abundant than last year.
- 40% of the insurers said BICs hurt their sales results, particularly GICs with maturities of three years or less.

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Copies of the survey, "1989 GIC Carrier Capacity Survey," are available free of charge from A. Foster Higgins & Co. Inc., 212 Carnegie Center, Princeton, N.J. 08543, Attn.: Investment Services Group.

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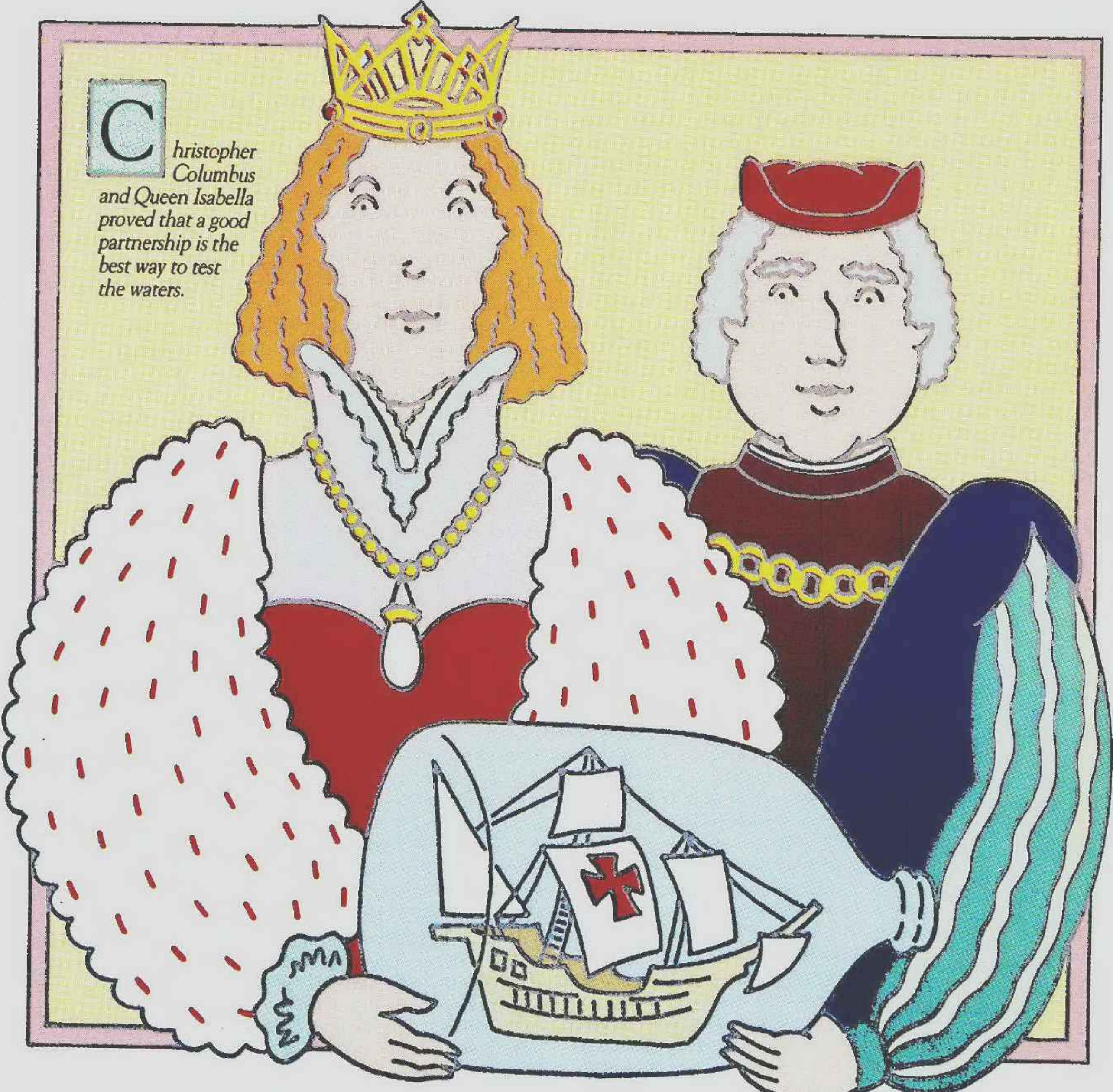

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Improving the industry

Education is key to change

Speaking out

By Sam H. McGoun

THE EVER ESCALATING frustration of insurance industry leaders with the barrage of criticism being heaped on the industry has been evident in recent articles in *Business Insurance*.

Criticism of the insurance industry has been addressed in remarks by National Assn. of Insurance Brokers President C. Richard Peterson (*BI*, June 12), with retorts by H. Felix Kloman, vp and principal at the Tillinghast division of Towers, Perrin, Forster & Crosby (*BI*, July 10), and John P. Mascotte, chairman and chief executive officer of Continental Corp. (*BI*, June 12).

Mr. Peterson is concerned with the image of the industry and public misunderstanding of the function of the business, whereas Mr. Kloman is concerned with the non-performance of the industry and its inability to serve its intended purpose. Mr. Mascotte would opt for not worrying about the image of the industry on the premise that the image is the image, we're not about to change it so let's get on with it.

All these comments—from the brokerage, consultant and insurance company perspective—reflect the frustration level that exists in the insurance industry as it attempts to fend off criticism from just about the entire world.

Realistically, all of this is part of a self-examination, which as Mr. Kloman so appropriately points out, is necessary and will produce positive change, hopefully sooner rather than later. There is no doubt in my mind that the business is going to have to change in order to regain the respect and understanding it sorely needs and to resume functioning as people and industry expect.

Whatever the result of all this gnashing of teeth, there is no doubt that an action plan aimed at perceptions and realities of the industry is needed to restore its credibility.

Implementation of that action plan—individually, through our professional societies or by whatever method—is absolutely imperative.

Otherwise, change will be made for us by those who have a totally different perspective on the business than we do—a perspective that has been developed through listening to the legitimate concerns of educated buyers of insurance but also by listening to the uninformed whinings of special interest groups and individuals and businesses who buy insurance with the same degree of care with which they purchase pencils and paper clips.

As we enter the fray and attempt to shape the change in our own way, there are three essential concerns that I feel must be understood and addressed and which Messrs. Peterson, Kloman and Mascotte have omitted or overlooked.

First, the cost of risk. How do you price a product today that often has to perform for years in the future? How do you deal with the risks, in terms of identifying and evaluating their potential magnitude? You can only deal with these from empirical data and it has been proved, time and again, that data alone is not sufficient to give us a reliable cost basis for our product. How much in loss dollars was factored into premiums to cover asbestos and the triple trigger; pollution; cumulative trauma; occupational disease; etc.?

In other words, whether it's insurance, self-insurance, an alternative market mechanism, no insurance or whatever method is used to predict and finance risk, the outcome will always be uncertain at best and volatile at worst.

Secondly, whether the insurance mechanism or some other risk financing method is chosen, only its successful management will "insure" to the greatest extent possible the long-term financial stability of whatever has been selected. So, like anything else, management is the key.

Realistically, the success of alternative market facilities, to a large extent, has not stood the test of time. It's accurate, I believe, to say that those alternative market facilities that are managed well will survive and will serve their constituents. Those that are not managed well will go the way of Transit Casualty Co., Mission Insurance Co. and others.

Lastly, we have to be mindful of the buyer of insurance, specifically, the buyer's habits and our ability to influence those buying habits. Some of the success of captives and alternative market facilities that have stood the test of time is attributable to the fact that they have served the needs of a group of buyers of insurance and risk protection that buy on a perspective of what's good for them.

Realistically, however, the industry deals with the legions of individuals and businesses who buy insurance carelessly and on price alone. As I see it, we have two choices: one is to let them buy somewhere else and the other is to try to change their buying habits. Contrary to what Mr. Mascotte has said, I think we are making some progress in this latter area, as we educate our buyers on the techniques of purchasing this professional product and service.

Professional agents, brokers, consultants and others are engaged in an educational process to convince buyers to look long term. They must look at the product, the attendant services that go with it, the professional qualifications of the deliverer of those services and other qualitative evaluations. All of these elements are to be received for a *fair* price, of course. In other words, buy the product based on its value, not on price alone. Anyone who doubts that this educational process is taking place or doubts its effectiveness is out of touch with reality.

At the same time we educate our buyers, we have to also educate our sellers. Long term is a two-way proposition. I would like to see us sell more and underwrite more on the basis of how well a risk is managed. By that, I mean how well a business is run, rather than what kind of business it is.

Whether you evaluate the ills of our business along the lines of Mr. Peterson or Mr. Kloman or Mr. Mascotte or myself isn't really the issue. The issue is that every facet of our industry requires an internal self-examination in the context of what is reality for the 1990s. On the basis of that critical self-examination, we must take it upon ourselves individually—or collectively, if possible—to help shape this needed change.

Let's not worry about identifying the problem because we all know what it is. We're just not doing anything about it and, as Mr. Kloman says, "Let's quit this self-flagellation." We have to go out and do something to improve our industry. We have to educate our clients, our legislators and, most importantly, ourselves.

Let's do it now, today. We'd better get going because our detractors are eating our lunch. And what do they *really* know about this business?

Sam H. McGoun is president and chief executive officer of Corroon & Black of Michigan Inc. in Detroit.

Contract directly for mental health care

By Leo H. Bradman

MUCH HAS BEEN WRITTEN about the spiraling costs of mental health and substance abuse benefits. It is well known that many providers tailor treatment plans to exhaust insurance benefits. It is also obvious that many providers are aggressive marketers and profit seekers. There has been considerable commentary regarding particular populations that are especially vulnerable to the abuse of benefits, such as adolescents and participants in the now infamous "28-day programs" for substance abusers. The mental health and substance abuse field is beset by unethical business practices such as fraudulent billing and payoffs.

Less well known and rarely discussed are the serious problems associated with many of the cost-cutting measures instituted over the past several years. Some of these measures have resulted in underutilization of benefits forced by management companies and utilization managers. They have opened the way for poor quality of care, lawsuits, consumer complaints and provider resistance. This article is an attempt both to shed some light on these problems and to offer some solutions.

Most attempts to control mental health costs fall into one or more of five approaches:

- The "management only" approach is the most common approach now in use. This is the situation in which independent providers are supposed to be managed or controlled by utilization reviewers. Often, utilization reviewers function through forms, letters and telephone calls and do not have any contact with the patient.

Needless to say, providers quickly learn how to manipulate this type of system and are often able to exploit it. In other cases, intense battles ensue between case managers and providers as each is pushing for opposite goals: The case manager wants to drive down costs while the provider, quickly citing ambiguous quality of care issues, is pushing to drive up utilization. The fact that utilization managers usually have fewer credentials and less training than many providers adds to the difficulties.

Some management companies and utilization managers go a step further and provide some on-site contact with patients, particularly in hospital settings. While this is an improvement over "blind reviews," it still creates problems and conflicts as the case manager confronts a situation where the attending psychiatrist and hospital staff may be working at cross purposes and influencing the patient into more expensive and unnecessary treatment regimes.

The management-only approach comes in many forms, including a variety of mental health case management companies and some health maintenance organizations and preferred provider organizations. The fundamental weakness that they all share is a failure to fully integrate the independent provider into a smooth running system of cost-effective quality care. Some of the more stringent approaches simply deny care regardless of the benefit package and many restrict care to inadequate levels.

Continued on next page

Mental health care

Continued from previous page

I know of several lawsuits that are based on improper denials of care. There are countless situations in which a hospital or doctor has continued treatment past the cutoff in coverage imposed by a utilization manager because to discontinue treatment would have constituted malpractice. At the other extreme, there are situations in which the only "management" that is taking place is a simple selection of a list of preferred providers, which obviously does little to control costs.

- The second approach I call the "limited staff clinic" approach. A management company or similar organization sets up a number of strategically located, wholly owned clinics staffed by salaried mental health professionals. The main problem associated with this approach is poor quality of care.

This can come in the form of inadequate or poorly trained staff, restriction in range of services, insufficient locations, etc. Since the management company has to pay the overhead, the clinicians on salary are usually less than top-notch, and the number of locations is usually insufficient. Associated problems include poor emergency services, poor interaction with employers and their employee assistance programs and lack of motivation on the part of the staff.

- The third approach is what I call the "expanded EAP." In this situation, an EAP, which could be either internal or external, is given total power to run a comprehensive mental health and substance abuse program. While I strongly value EAPs in their traditional roles, expanding an EAP to control doctors and hospitals can lead to tensions with providers, liability problems and ethical implications when the welfare of the patient may be compromised in order to save employer dollars.

Expanded EAPs use some of the other approaches listed here to control costs. When an EAP sets up provider clinics, it puts itself in the questionable position of funneling patients and insurance dollars back into itself. I am often amused to see EAP companies suddenly advertise as managed care companies without any additional preparation in this area. Unfortunately, some of the same EAP companies that push to increase services when acting in a traditional role tend to severely restrict services when in the expanded "managed care" role.

- The fourth approach to cutting costs is what I call the "Procrustean" approach because there is an obvious attempt to make patients fit some predetermined treatment modality, often in an indiscriminate assembly line manner because the insurance covers it.

For example, I am often amused to see proponents of traditional inpatient care battle with the new wave of outpatient enthusiasts who see no need for hospital admissions except in the most extreme emergencies. A third rapidly forming group views partial hospitalization as the panacea. I am also seeing the biological approach making a comeback where medicines and esoteric lab tests are being touted and hospital units are being marketed as "biological psychiatry" programs.

The problem with the Procrustean approach is the failure to provide individualized treatment for each unique person who needs help.

The best clinical approach is always eclectic and the full range of available treatments should be considered to ensure a good prognosis. Patients should not be forced to fit a particular treatment approach. Rather, the treatment should fit the patient. In its worst form, the Procrustean approach leads to "cookbook medicine" where clinicians are reduced to technicians following a menu of procedures and criteria.

- The fifth and most obvious approach is to simply reduce, modify, or eliminate mental health and substance abuse benefits. Some plans are so inadequate as to seems ridiculous (e.g., one visit a year maximum; up to $20 covered per session).

Other plans are unreachable by the average employee due to high deductibles and copayments. Some plans encourage misutilization as a result of their poor design, such as when coverage for inpatient treatment is much better than for outpatient.

The problem with this approach is that it is short-sighted and temporary. Cutting costs in this manner is certain to increase costs in the future when employees and dependents become more mentally and physically ill. Many of these people will be "dumped" into the public sector, driving up taxes and forcing hospitals to charge their paying patients even more. It should be noted that it is becoming increasingly difficult to transfer patients to public facilities. Most are generally filled while others are becoming more sophisticated at distinguishing truly needy patients from those who have had their coverage unjustly reduced by utilization reviews.

All of these cost cutting approaches ultimately will increase costs. They will increase costs primarily due to the failure to deliver timely and proper treatment at the appropriate level and intensity. This will result in further deterioration of the patient and increase treatment costs. Also, the costs of lawsuits and consumer complaints will be significant. In addition, one should not underestimate the fact that providers who are overburdened with unnecessary paper work and procedures will ultimately be forced to raise their costs to cover these extra services. As inadequate and insufficient care reaches crisis levels, direct federal intervention may occur.

I believe that the best solution to all of these problems is to return to private enterprise on a person-to-person level.

Employers, insurance companies and other third-party payers should negotiate directly with community-based group private practices consisting of qualified professionals who stand above any exploitation of patients or payers and who always deliver ethical, quality and cost-effective services. Economically, the payers and providers should assume some type of risk-sharing arrangement to further consolidate a trusting and mutually beneficial relationship. Making the contract exclusive or semi-exclusive further solidifies the bond and assures the provider high volume in exchange for meaningful discounts.

The group practice should contract directly with the payer and should be a large enough group to ensure comprehensive services. The practice should have stability, a good reputation and the willingness to experiment with innovative arrangements until the perfect one is found. When the group practice lacks the management or administrative expertise to handle direct contacts, it should secure the services of consultants in the areas of computers, management information systems, actuarial and statistical analyses and utilization review procedures.

While I strongly value EAPs in their traditional roles, expanding an EAP to control doctors and hospitals can lead to tensions with providers, liability problems and ethical implications when the welfare of the patient may be compromised in order to save employer dollars.

Specialized attorneys can assist in specific areas such as confidentiality issues and drafting contracts that "carve out" mental health and substance abuse services from the general medical/surgical benefit packages.

This type of arrangement will result in higher quality but lower cost than many of the managed care products now dominating the market. A group private practice has the advantage of existing referral bases that will dilute the costs of setting up a direct contract.

Often, a management company will establish an entire operation just to serve one or a few contracts. An existing group practice has many of the necessary elements already in place.

In addition, a group private practice has sufficiently diverse sources of revenue to provide for an economically sound and equitable priced arrangement. Group private practices can negotiate good discounts with hospitals because of their large and mixed referral bases.

Finally, group private practices do not have the large advertising and marketing budgets of some of the other approaches I have discussed.

I see my recommendation as a "win-win-win" situation. The payer wins by having quality care at a reasonably low cost. The patients win because they are being treated by a community-based resource that they probably would go to anyway out of choice rather than contractual obligation.

Finally, let us not forget the providers themselves, who are currently a very frustrated lot. Doctors would win because they enjoy and are most comfortable in a private practice setting where the full extent of their skills can be utilized.

The only drawback I can see for the system that I am proposing is that it would take extra work and sophistication on the part of benefits managers to investigate and explore what their community has to offer. Very often they will have to be very astute at separating appearances from substance and selecting the one group private practice that is ethical, competent, caring and properly priced. Although difficult to do, it can be done and the rewards would be many. An outside, impartial consultant may be of valuable assistance in the selection process.

An open bidding process should be used to make the selection. The most successful, popular or politically powerful private practice may not be the best choice.

Request references from different sectors such as insurers, employers, hospitals, EAP counselors and business and professional leaders.

Inspect the quality assurance and utilization review procedures in use as well as the billing patterns and accounting practices. See that the practice consists of only licensed and insured professionals, a high percentage of whom should hold doctorate degrees.

There should be assurance that all patients receive the same quality of care regardless of the payer. The group should have contracts with high quality, fully accredited inpatient facilities but no vested interest in filling beds.

Above all, establish an open and comfortable working relationship with the provider so that any problems can be addressed and resolved in a timely and productive manner. Ongoing feedback and sophisticated utilization reports should be a fundamental part of any arrangement.

Many factors can legitimately influence costs, for example, including utilization history of the membership, deductibles and copayments, provisions, limitations and exclusions. Also, good traditional EAPs can usually reduce costs and improve services. While regional variations exist, I have found that costs for a typical yearly acute care benefit package of 20 outpatient visits and 30 inpatient days should be in the mid $2 per member per month range. This is a simple guideline for assessing pricing arrangements.

Risk should be involved for both outpatient and inpatient services in order to assure full control and avoid cost shifting. The more parties that are involved between or around the payer and provider, the higher the expected costs.

Leo H. Bradman is chairman of Bradman Therapy Centers in North Miami Beach, Fla.

Di

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The impact of tax reform

Insurer tax revenues outstrip estimates made by Congress

By Franklin W. Nutter

As WITH MANY OTHER individuals and businesses, property/casualty insurers were subject to major changes due to the 1986 Tax Reform Act. Along with a lower corporate tax rate, the most notable changes for insurers were the requirements to reduce loss reserves for future claims to present value, include a percentage of tax-exempt income to taxable income and phase in unearned premium into income.

The industry, which invests heavily in tax-exempt obligations, experienced significant operating losses and was not a major taxpayer in the 1980s. With the 1986 Tax Reform Act changes and the availability of net operating losses to offset gains in taxable income reduced, the tax picture markedly changed.

Projections at the time of enactment of the 1986 Tax Reform Act called for a $7.5 billion increase in tax revenues in five years. However, a recent report by the Insurance Services Offices Inc. estimates that the tax law will have raised taxes by more than $10 billion in its first five years.

The ISO report estimates the property/casualty industry will pay $12.2 billion in federal income taxes for 1987-1990, $7.8 billion more than it would have paid under the prior tax law.

Most of this tax revenue is clearly due to the 1986 tax changes. Regrettably the changes will likely have an antigrowth impact on insurers and thus be counterproductive to the marketplace.

In light of the tax changes and the unintended consequences from which the IRS benefits, a new, more realistic property/casualty tax form may need to be considered. I offer the accompanying form.

Franklin W. Nutter is president of the Alliance of American Insurers in Schaumburg, Ill.

1120-PC **1989**

PROPERTY/CASUALTY INSURER INCOME TAX RETURN

For Paperwork Reduction Act, see page 852 of the draft instructions.

Please type or print (no cursive writing)

Company Name ______
Household Name ______
City/State/Zip Code

A Employer I.D. No. ______
B Date Incorporated ______
C Date of Annual Picnic ______
D Check this box ☐

E Check applicable boxes: (1) ☐ Final return
(2) ☐ Change in country of domicile
(3) ☐ Amended return

F Check box if a section 953(c)(3)(C)(i)37(d) election has been made. ☐
Why not?

G Check box for kind of company:
(1) ☐ National
(2) ☐ Regional
(3) ☐ Good Company
(4) ☐ Bad Company
(5) ☐ International
(6) ☐ Intergalactic

If your tax year includes June 30, 1989, complete line 23. If not, please explain here: ______

TAXABLE INCOME AND TAX COMPUTATION

Income
Premiums written (report these for this year) ______
Unearned premiums (too bad, report these this year too) ______
Taxable investment income ______
Taxable tax-exempt income (i.e., oxymoron tax) ______

Deductions
Compensation of officers ______
Do you compensate other employees? ☐ Yes ☐ No How much? ______
Worthless agency balances and bills receivable ______
Less: Worthless officer salaries ______
Hours officers worked times minimum wage preferred by President Bush ______
Pension, employee benefit programs
Check here ☐ if you understand IRC section 89
Call us toll free if you checked the box.
Losses incurred ______
Claim reserves (Prop. 103 tax: roll back amount by 20%, then arbitrarily discount to present value)
Expenses of doing business (report these on next year's return)
Dividends to policyholders (in the margin, explain again to us again why you do this) ______
Have you used all prior years net operating losses?
☐ Yes ☐ No Amount unused ______
Do you plan to lose money again this year? ☐ Yes ☐ Probably
How much? ______

Tax
Enter the share of your income earned you would like to keep ______
Enter our share of your net income IRS USE ONLY
Your income tax if Congress had not changed the law in 1986 IRS USE ONLY ☺ ☹ ______
1984-1986 underpayment of tax
1988 refund ______ Our error, send it back

ALTERNATIVE MINIMUM TAX (AMT)
AMT tax will probably be greater next year. To avoid penalty, you may prepay 1990 AMT tax
If we missed taxing anything, add it in here ______
AMT rate: 100% x line 17
TAX DUE: Add all income less most deductions times tax rate (see draft Schedule 2) ______
Do the Hokey Pokey
Taxes owed ______ THANKS

Under penalty of perjury, extradition, prosecution, persecution, and IRS audit, I have read and understood this form and all instruction manuals and believe them to be true and correct.

PLEASE SIGN HERE ______
Signature of Officer and of Company Founder

Data loss covered by CGL insurer: Court

Legal briefs

A Minnesota appellate court has declared that a comprehensive general liability insurer was responsible for indemnifying a policyholder for a loss of use claim arising from the accidental or mistaken erasure of computer information.

Magnetic Data Inc. is a computer company whose principal business is the inspection and repair of computer disk cartridges. In February 1984, Sanger Corp. arranged with Control Data Corp. to have Magnetic inspect 22 computer disk cartridges for defects. Twelve of the cartridges were to be visually inspected and gauge tested only and not subjected to electronic inspection, which would erase all data.

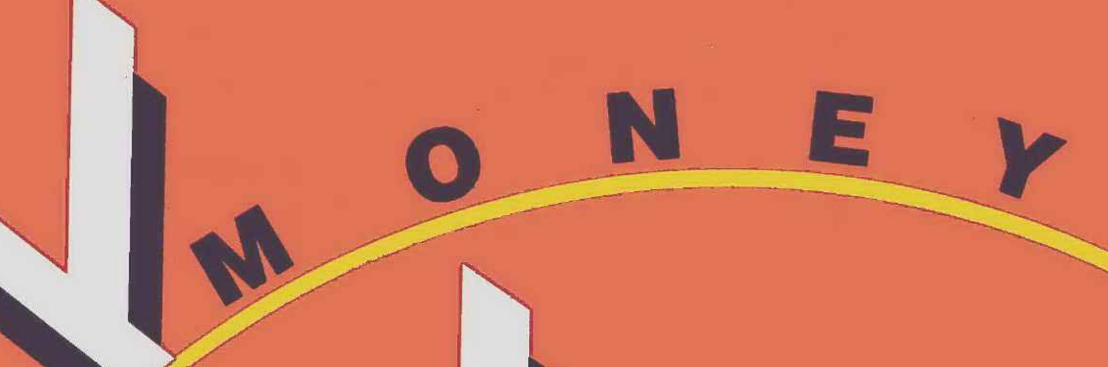
For reasons not disclosed in the record, Magnetic employees electronically inspected all of the cartridges thereby erasing valuable client information from Sanger's cartridges. Sanger sued Magnetic and Control Data. Magnetic tendered the defense to its comprehensive general liability insurer, St. Paul Fire & Marine Insurance Co., which refused to defend claiming no coverage.

Magnetic brought this action seeking to have the court declare St. Paul had a duty to defend. The trial court ruled for Magnetic.

The appellate court concluded that the loss of use claim here arising from the accidental or mistaken erasure of the computer information constituted "property damage" that was caused by an "accidental event" within the coverage of the policy. Furthermore, the court said that such a claim was not excluded under a "work product or business risk" exclusion. The trial court decision was affirmed.

Magnetic Data Inc. vs. St. Paul Fire & Marine Insurance Co., Court of Appeals of Minnesota, Oct. 18, 1988 (*BI*/03/July-$10).

This abstract was prepared by Cases Unlimited Inc. Copies of the decision are available by sending a $10 check payable to Cases Unlimited to Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*



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41 states revise workers comp laws

Workers compensation systems in 41 states are operating under more than 150 new laws that legislatures enacted during the last half of 1988 and the first seven months of 1989.

Thus far, 1989 has been "very active" for state workers compensation legislation, according to a recent report of the International Assn. of Industrial Accident Boards and Commissions' Legislative Committee.

More new laws were enacted during the first seven months of this year than in the latter half of last year, which is a byproduct of legislative cycles.

The committee's report, which was presented at the IAIABC's convention Sept. 16-20 in Baltimore, highlighted state-level changes, including:

- Benefit changes.

Twenty-four states raised benefit levels for disability and death benefits, the committee reports.

Twenty-one states authorized the increases through the use of automatic adjustments in the states' average weekly wage, while the remaining three states did so statutorily.

In addition, Maine and Montana lifted the cap on weekly benefit levels as of July 1. However, Montana restored the freeze until July 1991, following a special session of the Legislature.

The only other state with frozen benefits is Oklahoma, the committee reported.

In related benefit developments, burial allowances were raised in Arizona, Maryland and Nevada.

- Medical deductibles.

"Several states now authorize inclusion of medical deductibles in workers compensation policies as a cost savings mechanism," the committee reported.

- Self-insurers.

Some states expanded employers' ability to use letters of credit, in lieu of bonds and other security, as proof of an employer's financial capability to self-insure its workers compensation coverage.

In addition, Alabama established the Alabama Workmen's Compensation Self-Insurers Guaranty Assn., a non-profit corporation to establish a guaranty association.

- Reorganization of Hawaii's State Workers' Compensation Fund.

Now called the State Compensation Mutual Insurance Fund, it will operate as a non-profit independent mutual insurance corporation instead of a state agency.

Following is a summary of significant legislative changes enacted between July 1, 1988, and July 30, 1989. It was prepared from information reported to the U.S. Labor Department's Division of State Workers' Compensation Programs, Office of Liaison and Legislative Analysis, Employment Standards Administration.

The following state legislatures either did not pass significant workers compensation-related legislation during this time frame or did not report it: Kentucky, Massachusetts, Minnesota, Mississippi, New Jersey, Oklahoma, Pennsylvania, Vermont and Wisconsin. Ohio enacted legislation in late July (*BI*, Aug. 21, Aug. 7).

Alabama

- **S. 326** (1989)

□ Creates the Alabama Workmen's Compensation Self-Insurers Guaranty Assn. as a non-profit corporation to establish and fund an insolvency fund to assure payment of disability and death claims against any member who becomes insolvent. Requires all non-government self-insurers to be insured with the association as a condition of their authority to self-insure.

Alaska

- **S. 93** (1989)

□ Provides that in computing compensation benefits for members of the state's organized militia, earnings will be based on the pay and allowances authorized for a member of the U.S. Armed Forces in the same grade and rank.

Arizona

- **S. 1055** (1989)

□ Increases burial expenses to $3,000 from $1,000.

Arkansas

- **S. 271** (1989)

□ Makes various appropriations to cover the costs for personal services and operating expenses of the Workers' Compensation Commission for the biennial period ending June 30, 1991.

- **H. 1087** (1989)

□ Provides lump-sum compensation payments when it is determined to be in the best interest of the person who is entitled to receive compensation, at a 10% discount, compounded annually.

California

- **S. 1787** (1988)

□ Raises the maximum allowance for burial expenses of employees of local public agencies to $2,000 from $1,500.

- **S. 2667** (1988)

□ Excludes from coverage any law enforcement officer who is regularly employed by a local or state law enforcement agency in another state but serving as a deputy peace officer in California.

Colorado

- **S. 172** (1989)

□ Authorizes a $1,500 deductible per claim in contracts for workers compensation insurance.

- **S. 195** (1989)

□ Establishes new procedures for resolving disputes. Provides that claimants are responsible for proving entitlement to benefits by a preponderance of the evidence.

- **H. 1311** (1989)

□ Requires all insurers, including the State Compensation Insurance Authority, to notify employ-

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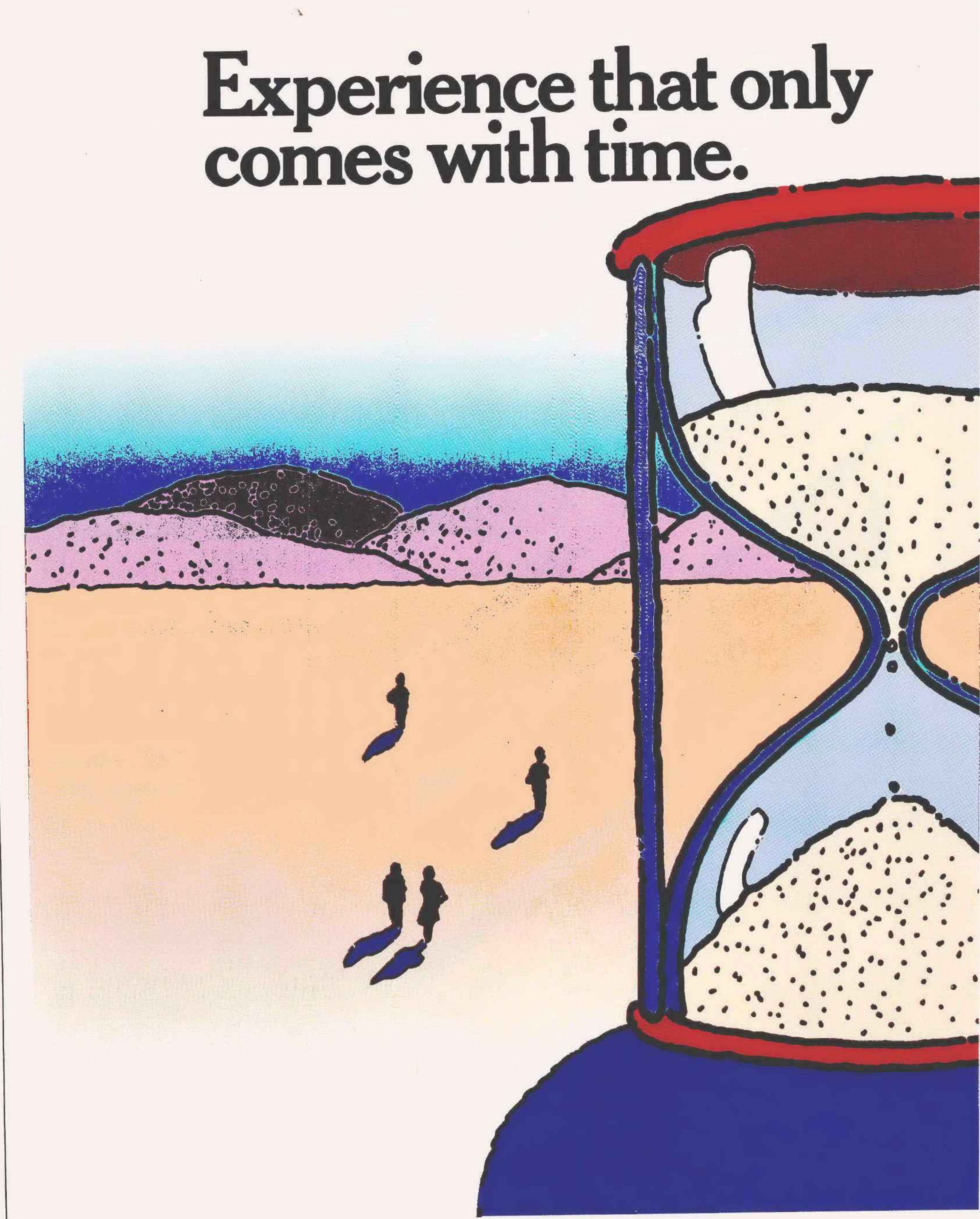

Continued from previous page
ers within 30 days regarding any cancellation of insurance or changes in rates by classification.

□ Eliminates extraterritoriality coverage for out-of-state employers or employees while temporarily employed in Colorado.

• **H. 1322** (1989)

□ Removes coverage of persons confined in a city or county jail or in any department of corrections facilities as inmates who, as part of their confinement work, perform services or participate in training, rehabilitation or work release programs. Excludes, for coverage purposes, volunteer ski patrol personnel, ski instructors, or any race crew members or passenger tramway operators from the definition of "employee."

□ Redefines "wages" to include reportable tips, as well as costs to the employee for converting a health insurance plan.

□ Increases benefits for temporary total disability to 91% from 80% of the state average weekly wage.

□ Changes the waiting period from three days to three regular working days before compensation is paid for temporary total disability.

□ Adds a new provision that specifies that under no circumstances is a provider of medical care allowed to seek recovery of costs or fees from an employee after the employer or insurer is found liable for payment of such expenses.

□ Specifies that compensation for permanent total disability may be reduced by 50% of any federal Social Security benefits at age 65, or if the employee is receiving retirement benefits, the reduction is based on the amount of the employer's contribution to the retirement fund as a percentage of total contributions to the retirement fund over the entire period of covered employment if a work-related injury occurs after age 45.

• **H. 1323** (1989)

□ Creates the "Workmen's Compensation Cost Containment Act" to assist employers in reducing costs related to coverage of injuries.

Connecticut

• **S. 6279 & H. 7106** (1989)

□ Increases the interest in compensation cases to 10% from 6% in cases where payments or adjustments in payments have been unduly delayed or neglected.

• **H. 6897** (1989)

□ Provides that the health insurance coverage for a claimant will be continued by the Second Injury Fund where the employer has relocated or shut down business.

• **H. 7183** (1989)

□ Authorizes retroactive compensation payments for the dependents of any deceased employee who was injured on or after Jan. 1, 1974, and who died not later than Dec. 31, 1981.

• **H. 7184** (1989)

□ Covers volunteer fire department personnel while performing fire duties under an agreement established between municipalities.

• **H. 7186** (1989)

□ Raises the minimum weekly benefits in certain cases of partial disability to $50 from $20.

• **H. 5852** (1988)

□ Reduces specified benefits in cases where voluntary agreements have been established.

Delaware

• **H. 130** (1989)

□ Authorizes discounts on workers compensation premiums for employers that meet certain criteria that promote and maintain safety in the workplace.

• **H. 403** (1988)

□ Sets a minimum notification period of 60 days prior to non-renewal of an employer's workers compensation insurance policy.

Florida

• **S. 1025** (1988)

□ Increases maximum weekly compensation for periods of additional temporary total disability to $700 from $400.

• **S. 1028** (1988)

Exempts government group self-insurance pools from regulations that apply to other employers that group self-insure.

• **H. 1288** (1988)

□ Extends the immunity granted employers from liability for injury or death to any sole proprietor, partner, corporate officer or director, supervisor or other person acting in a managerial or policy-making capacity at the time of the injury.

• **H. 1329** (1988)

□ Establishes criteria for use in calculating the value of a non-professional attendant or custodial care provided to an injured employee by a family member.

Georgia

• **H. 274** (1989)

□ Prohibits a rehabilitation supplier from directly billing an employee for authorized services rendered.

Hawaii

• **S. 833** (1989)

□ Changes the "Hawaii Workers' Compensation State Fund" to the "Hawaii State Compensation Mutual Insurance Fund" and authorizes the fund to operate as a non-profit independent mutual insurance corporation, not as an agency of the state.

□ Further requires the fund to sell workers compensation insurance at the lowest actuarially responsible price as determined by its board of directors. Provides that all assets of the fund will be used exclusively for administration of the fund.

• **S. 1508** (1989)

□ Raises the maximum amount that may be taken as a deductible for medical benefits to $2,500 from $500.

• **S. 1938** (1989)

□ Requires the state to cover an exceptional child while working for a private employer as part of the child's instructional program.

Idaho

• **S. 1163** (1989)

□ Changes the "Workmen's Compensation Law" to "Workers' Compensation Law." All references to "workmen's" have been changed to

Continued on next page

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Work comp laws

Continued from previous page

"workers" throughout the law.

• **S. 1164** (1989)
□ Entitles a widower to receive benefits under the same conditions as a widow; previously widowers were eligible for benefits only if actually dependent on the deceased employee.

• **S. 1165** (1989)
□ Clarifies the time within which an application for a hearing may be filed in cases where compensation has been paid and discontinued.

• **H. 8** (1989)
□ Covers members of the Idaho National Guard for injuries or deaths not covered by federal law.

Illinois

• **S. 1676** (1988)
□ Establishes procedures relating to an initial application or application to renew self-insurance privileges. Creates a Self-Insurers Administration Fund. Provides for a custodian and for funding of the fund and establishes payment methods.

Indiana

• **S. 543** (1989)
□ Provides that an injured employee, who as a result of injury or occupational disease is unable to perform work for which the employee has previous training or experience, is entitled to vocational rehabilitative services necessary to restore employee to useful employment.

Iowa

• **S. 444** (1989)
□ Specifies that settlements in contested cases are not acceptable unless there is evidence of a bona fide dispute regarding a substantial portion of the claim.

• **H. 655** (1989)
□ Raises assessments to the second injury fund to $4,000 from $2,000 in death cases where there are dependents, and to $15,000 from $5,000 in cases with no dependents.

Kansas

• **S. 354** (1989)
□ Authorizes vocational rehabilitation services for employees who are unable to work for the same employer at a comparable wage and for employees who are unable to enter the open labor market and earn a comparable wage because of injury or occupational disease.

Louisiana

• **S. 3** (1989)
□ Provides coverage for legislative assistants as state employees, immediately upon employment.

• **S. 318** (1989)
□ Relates to resolution of claims disputes by the Office of Workers' Compensation with review of determinations in state district courts.

• **S. 322** (1989)
□ Authorizes a 24% penalty in cases involving overdue benefit payments, unless an appeal order is made as provided by law.

• **S. 323** (1989)
□ Clarifies the provision concerning the resolution of disputes between health care providers and the employee, employer or the insurer.

• **S. 325** (1989)
□ Newly requires prehearing conferences concerning the resolution of disputed claims. Provides new procedures for appealing hearing officers' decisions.

• **S. 331** (1989)
□ Specifies that a self-insured employer that defaults in paying benefits to an employee will forfeit the security posted with the Director of the Office of Workers' Compensation and, in the case of the surety bond, the director may institute suit.

• **S. 335** (1989)
□ Eliminates the requirement for security of benefits to be deposited by foreign (out-of-state) employers.

• **S. 943** (1988)
□ Provides for a $20,000 lump sum payable to the surviving parents of a deceased employee, when there are no other legal dependents entitled to such benefits.
□ Requires the director of the Office of Workers' Compensation Administration to establish and promulgate a reimbursement schedule for drugs, supplies, hospital care and services, medical and surgical treatment, and any non-medical treatment recognized by law. Provides that compensation claims will be dismissed and barred forever, unless within five years after initiation the claimant requests a hearing and final determination. Makes other revisions regarding claims procedures.
□ Adds a penalty for any employer who fails to secure compensation.

• **H. 1444** (1988)
□ Permits an employee to change his or her physician to one in another field or specialty without first obtaining approval.
□ Reduces costs for non-emergency diagnostic testing or treatment to $750; formerly, costs were limited to $1,000. However, if the payer has denied that an injury is compensable, no prior approval for treatment or testing is required.

Maine

• **S. 339** (1989)
□ Requires an employer with 250 or more workers to reinstate an injured worker within two years after maximum medical improvement.

• **S. 396** (1989)
□ Simplifies reporting requirements for insurers and self-insurers.

• **S. 550** (1989)
□ Clarifies the definition of "seasonal workers."

• **S. 473** (1989)
□ Amends the workers compensation self-insurance law.

• **H. 675** (1989)
□ Clarifies the method of obtaining benefits for incapacity.

• **H. 1176** (1989)
□ Strengthens the statutes concerning an injured worker's rights to rehabilitation and provides for improvements in the rehab system.

Maryland

• **S. 167** (1989)
□ Provides for funding the subsequent injury fund through assessments on permanent disability and death awards, including disfigurement and mutilations, and on settlements.

• **S. 213** (1989)
□ Requires the adjutant general to maintain coverage for members of the Maryland State Guard during training.

• **S. 430** (1989)
□ Revises the definition of "public safety officer" to include certain volunteer firefighters or volunteer ambulance personnel for coverage purposes.

• **S. 825** (1989)
□ Exempts certain owner-operators of motor vehicles who enter into contracts with motor carriers from coverage.

• **H. 274** (1989)
□ Increases the maximum payable for funeral expenses to $2,500 from $1,200 and extends the benefit period from five to seven years after injury.

• **H. 634** (1989)
□ Transfers the responsibility for determining the state average weekly wage from the Department of Employment and Training to the Department of Economic and Employment Development.

• **H. 941** (1989)
□ Changes elective coverage of volunteer firefighters and rescue squad members to mandatory coverage.

Michigan

• **S. 419** (1989)
□ Creates a 45-member workers compensation appeals board, effective July 1, 1989.

• **S. 422** (1989)
□ Provides for changes relating to efficiency in claims administration. Creates the Board of Workers' Compensation Magistrates and the Appellate Commission, and provides procedures concerning claims resolution through mediation and arbitration.

• **H. 4415** (1989)
□ Adds criteria to protect the confidentiality of certain claimant files and records in applications of employers for self-insurance; however, certain exceptions exist.

• **H. 4220** (1988)
□ Authorizes group self-insurers to obtain employer liability insurance that secures payment of compensation and benefits.

Missouri

• **H. 1073** (1988)
□ Eliminates coverage of inmates in a state, county or municipal prison or jail and patients or residents of a state mental facility, except where the inmate, patient, or resident was hired after direct competition with persons who are not the same and employment is not contingent or affected by the worker's status.
□ Eliminates volunteers of a tax-exempt organization from coverage.

• **H. 1277** (1988)
□ Broadens coverage to include the services of chiropractors for treating injuries of workers.

Montana

• **S. 218** (1989)
□ Waives the time requirement and extends the filing period for claims an additional 24 months for cases of a latent injury or equitable estoppel.

• **S. 278** (1989)
□ Creates a guaranty fund to guarantee payment of claims against self-insured employers that become insolvent and unable to pay claims.

• **S. 315** (1989)
□ Newly requires the state Workers' Compensation Fund and private insurance companies to provide a medical deductible item in

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Work comp laws

Continued from previous page

any workers compensation policy issued after Sept. 30, 1989. Requires the deductible to be in $500 increments, not to exceed $2,500 per claim.

• **S. 421** (1989)
□ Authorizes the governor to arrange agreements with any Canadian province for reciprocal application of its workers compensation laws to ensure coverage of Montana's employers and workers while temporarily employed in Canada. Establishes conditions for such reciprocity.

• **S. 428** (1989)
□ Authorizes the creation of a state fund to operate as a non-profit independent public corporation. Requires the fund to insure every employer that requests such coverage unless an assigned risk plan is established within the state. Gives the commissioner of the Department of Labor and Industry authority to establish an assigned risk plan for workers compensation.

• **H. 21** (1989)
□ Exempts any dependent member of an employer's family from coverage if an exemption can be claimed for such person by the employer under the federal Internal Revenue Code.

• **H. 155** (1989)
□ States that an insurer is not responsible for providing additional benefits for a subsequent non-work-related injury to the same body part after the injured employee has reached maximum healing.

• **H. 214** (1989)
□ Allows the Division of Workers' Compensation to appoint a representative for the claimant, or the beneficiaries, who will apply for and receive benefits on behalf of the claimant if the division determines it to be in the best interest of such person.

• **H. 347** (1989)
□ Provides that benefits for total rehabilitation will begin after the healing period and will continue for up to 26 weeks.
□ Permits an injured worker to be reimbursed for reasonable costs for travel and medical treatment at rates permitted for state employees.
□ Provides that no compensation is payable for the first 48 hours, or six days of loss of wages, for total disability, whichever is less. Formerly, compensation was not paid for the first six days of wage loss due to an injury.
□ Establishes a penalty not exceeding $200 that may be assessed on an employer for giving an improper notification regarding the cancellation of an insurance policy. Adds another penalty of not less than $200, nor more than $500, for each offense of refusal or negligence in submitting required reports to the Division of Workers' Compensation for proper review of a claim.
□ Establishes a penalty not exceeding $200 which may be assessed on an employer for giving an improper notification regarding the cancellation of an insurance policy. Adds another penalty of not less than $200, nor more than $500, for each offense of refusal or negligence in submitting required reports to the Division of Workers' Compensation for proper review of a claim.
□ Provides that weekly compensation benefits must now be based on the amount of elected wages, (not less than $900 per month) not exceeding 1½ times the average weekly wage of all employees under covered employment, as established annually by the Montana Department of Labor and Industry.
□ Permits the division to retroactively apply modification factors to the experience rating systems of employers enrolled under plan 3, when the factor is delayed because the rating bureau has not received sufficient data to calculate a final modification factor.

Nebraska

• **L.B. 261** (1989)
□ Permits hearings to be held at the discretion of the court, anywhere in Nebraska where the accident occurred outside of the state, unless otherwise stipulated.

• **L.B. 410** (1989)
□ Amends provisions relating to modification of agreements or awards.

Nevada

• **S. 121** (1989)
□ Prohibits an insurer from entering into exclusive agreements or contracts for therapy treatment, or with any particular pharmacy for filling prescriptions, if such arrangement would prevent the injured employee from receiving prompt professional care.

• **S. 241** (1989)
□ Authorizes insurers to deduct from the benefits of an employee any amounts obtained by the employee through misrepresentation or concealment of a material fact. Requires repayment of any benefits received in this manner.

• **S. 258** (1989)
□ Allows the Commissioner of Insurance to withdraw the certification of any self-insured employer who intentionally or repeatedly violates the law.

• **A. 141** (1989)
□ Increases the burial allowance to $5,000 from $2,500. Extends to 60 days from 30 days the time for filing a request for a hearing concerning the proposed closing of a claim.

• **A. 681** (1989)
□ Enacts new provisions concerning fraudulent claims for payment of services rendered to workers compensation claimants.

• **A. 755** (1989)
□ Adds a presumption that a disease of the lung is conclusively presumed to be work-related for a person who has been employed continuously and full-time as a police officer or firefighter for five years or more prior to disablement.

• **A. 790** (1989)
□ Provides that compensation may be received in a lump sum for injuries occurring on or after July 1, 1981 (formerly 1987), for permanent partial disability exceeding 25%.

New Hampshire

• **S. 8** (1989)
□ Eliminates the requirement that a call or volunteer firefighter must be a member of the New Hampshire Fireman's Assn. for coverage purposes.

• **H. 615** (1989)
□ Creates a pilot program involving a study of medical, hospital and remedial care in workers compensation.

New Mexico

• **S. 432** (1989)
□ Amends coverage by excluding qualified real estate salespersons.
□ Permits employers to implement a safety program and provides for bonuses based on 10% of a worker's wages if all criteria to receive the bonuses are met.

New York

• **S. 8120** (1989)
□ Makes the employer responsible for replacing a lost or damaged prosthesis that causes no bodily injury to the employee. Clarifies that damage to, or the loss of, a prosthetic device is deemed to be an injury, except that no disability benefits are payable for such injury.

• **S. 7571** (1989)
□ Increases various fines and pen-

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Continued from previous page
alties concerning untimely payments, notices and undue delays under the workers compensation system.

• **S. 7624** (1989)
□ Provides for certain procedures to be employed when a private insolvent self-insured employer defaults on compensation payments.

• **S. 8677** (1988)
□ Provides that any county electing self-insurance may also elect to cover voluntary ambulance companies under the same terms and conditions applicable to firefighters.

North Carolina

• **S. 1202** (1989)
□ Clarifies coverage of contractors and permits an exemption for any subcontractor who has no employees.

• **H. 1926** (1989)
□ Authorizes the Insurance Commissioner to use experience modifiers to calculate a self-insured employer's maintenance fund tax assessment. Also increases assessments to the stock and mutual workers compensation security funds.

North Dakota

• **S. 2173** (1989)
□ Establishes, by administrative rule, an hourly rate for compensating claimant attorneys for legal services following constructive denial of a claim or issuance of an administrative order reducing or denying benefits. Adds a definition for "constructive denial." Further clarifies rights and obligations under the law for payment of attorney fees.

• **S. 2237** (1989)
□ Raises dependency allowances in death cases to $10 from $7 per week for each dependent child.
□ Newly permits injured employees to select a physician of their initial choice for treatment; however, no change may be made without prior approval of the Workers' Compensation Bureau.
□ Allows recovery of costs for travel and other personal expenses related to an employee obtaining medical care only if a request is made by the employee. Authorizes mileage of at least 50 miles one way, unless total mileage equals or exceeds 200 miles in a calendar month, in order to receive reimbursement.
□ Requires an employee to submit to an independent medical examination by a physician designated or approved by the Workers' Compensation Bureau and upon request of the bureau.
□ Exempts all compensation from claims of creditors, except the Workers' Compensation Bureau may recover any overpayments due to clerical errors or any other circumstances unrelated to fraud. Clarifies compensation awards for aggravated injuries. Adds new provisions relative to offset of permanent total disability benefits when an employee is also entitled to Social Security retirement benefits. Makes other changes.

• **S. 2256** (1989)
□ Establishes that the state average weekly wage will now be computed to the next highest dollar. Permits lump sum payment of permanent impairment benefits, based on 33⅓% of the state average weekly wage rounded to the next highest dollar; previously, compensation was limited to $60 per week for a total of 500 weeks.
□ Broadens the term "artificial members" to include coverage of eyeglasses or contact lenses under certain conditions. Modifies and adds other definitions under the law, including coverage of "mental injury" precipitated by mental stimulus.

• **S. 2323** (1989)
□ Creates a State Workers' Compensation Advisory Council to assist the Workers' Compensation Bureau in formulating policies related to administration and in assuming impartiality and freedom from political influence. The council will further assist the bureau in establishing various fees, determining employer premium rates, maintaining the solvency of the workers compensation fund and in other matters as necessary.

• **S. 2324** (1989)
□ Gives the governor authority to appoint a Director of the Workers Compensation Bureau who will serve under the direct supervision of the governor. Formerly, the bureau was composed of three commissioners who served for a period of six years.

• **H. 1119** (1989)
□ Prohibits medical providers from billing a claimant directly for the difference between the usual and customary charges and amounts allowed by the Workers' Compensation Bureau fee schedule for services.
□ Establishes a maximum of $10,000 for injured workers who sustain catastrophic injuries for making permanent additions, for remodeling or for adaptations to real estate.
□ Requires the bureau to establish a system of peer review in cases involving medical care.

• **H. 1128** (1989)
□ Disallows compensation in cases of total or partial disability where duration is less than five consecutive calendar days, formerly five days.
□ Suspends all compensation and benefits to any person confined to a correctional institution, unless the worker has a spouse or child eligible for such benefits.
□ Offsets benefit payments for total or partial disability where the worker fails to report wages received from any part-time or full-time employment.
□ Provides that compensation, or any combination of compensation, or dependency awards may not exceed the weekly wage of the employee after deductions are made for Social Security and federal taxes.
□ Removes coverage of volunteer firefighters and disaster emergency trainees from the law. Adds a new section which provides that if a claimant is entitled to permanent total disability benefits and Social Security retirement benefits, the average wage loss benefits must be determined according to provisions of the workers compensation law. Provides that an offset of compensation may not exceed 40% of the employee's weekly Social Security retirement benefits.

• **H. 1191** (1989)
□ Defines "substantial gainful employment." Adds a calculated list of options for returning the injured employee to substantial gainful employment.
□ Provides for the appointment of medical assessment teams to review an injured worker's physical restrictions and limitations.
□ Limits rehabilitation benefits to 104 weeks, except in cases of catastrophic injury where benefits may continue beyond five years; however, additional benefits may be authorized to assist the worker with work search after successful completion of a rehabilitation program.
□ Specifies that eligibility for partial disability benefits continues successfully up to two years after the injured worker has completed a rehabilitation program and acquires substantial gainful employment.

• **H. 1364** (1989)
□ Increases weekly benefit payments for temporary or permanent total disability to $160 from $150; and to $100 from $90 for death in cases where a claimant is eligible for supplementary benefits.

Ohio

• **Sub. H.B. 222** (1989)
□ Limits the authority of the five-member Industrial Commission to adjudicating claims and moves oversight of the state's non adjudicatory operations to a new 12-member Workers Compensation Board composed of equal numbers of employers, labor representatives and legislators.

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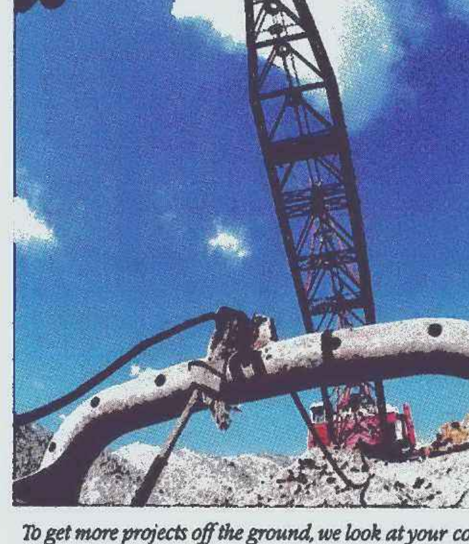

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Work comp laws

Continued from previous page

The Board will be responsible for setting operational policy; overseeing implementation of the law by the existing Bureau of Workers Compensation; and selecting the administrator of the Bureau of Workers' Compensation. Previously, the governor appointed the administrator.

In other provisions, the law, effective Nov. 3, establishes a medical section within the state's Bureau of Workers' Compensation to assist in developing policies that medical providers must follow.

The law also entitles employers to reimbursement from the state's Surplus Fund when compensation has been paid for a claim that is subsequently disallowed either in whole or in part.

It also requires employers that self-insure workers compensation risks to be assessed for state-mandated contributions to special funds on the basis of workers compensation payouts rather than payroll.

Oregon

- **H. 2320** (1989)
  - Clarifies the term "independent contractor" by creating a universal definition applicable to income taxes, workers compensation, unemployment compensation, and the registering of residential builders.
- **H. 2461** (1989)
  - Allows up to one-fourth of a worker's disability payments to be recovered for child and spousal support in certain cases.
- **H. 2533** (1989)
  - Requires insurers, upon request of the Department of Insurance and Finance, to provide a report of their expenditures for safety and health loss control activities. Previously, insurers were required to submit annual reports.
- **H. 2684** (1989)
  - Modifies the list of qualified government group self-insurers to include an employer of a Public Housing Authority.
- **H. 3176** (1989)
  - Clarifies that employers and their workers from another state are exempt from coverage while the employer has a temporary workplace within the state, provided certain conditions are met. Formerly, the exemption was applicable only to a worker. Adds a new definition for "temporary workplace."

Rhode Island

- **S. 194** (1989)
  - Creates a Special Legislative Commission to investigate occupational diseases in the workplace. Requires the commission to submit a report on its investigation to the General Assembly on or before April 3, 1991.
- **S. 736** (1989)
  - Authorizes the workers compensation director to present educational seminars and publications in a special volume containing provisions of the workers compensation law. Provides that all fees received from seminars must be used to further educate the public.
- **S. 1235** (1989)
  - Relates to workers compensation claims for medical care.
- **H. 5634** (1989)
  - Provides for any eligible state employee to utilize the treatment facilities at the Donley Rehabilitation Center, regardless of date of injury.
- **H. 5653** (1989)
  - Provides for increases in dependency allowances for permanent total disability when the number of dependents increases.
- **H. 5903** (1989)
  - Establishes a new education unit within the Department of Workers' Compensation with offices around the state. Provides for services concerning prevention of occupational diseases and injuries, provides training for non-management employees and employers concerning procedures and rights under the workers compensation law, and provides information to employers and employees concerning known and suspected workplace hazards.

South Carolina

- **S. 253** (1989)
  - Provides new procedures relative to administration of claims filed by members of the Workers' Compensation Commission and their families or by employees of the commission; however claims filed for medical benefits only are not included.
- **H. 3014** (1989)
  - Provides that surviving nondependent children are eligible for death benefits when a deceased employee leaves no dependent survivors. Requires that any remaining benefits of a deceased employee must be divided equally among all children when the last child is no longer enrolled in an accredited educational institution; previously any remaining benefits were terminated.
- **H. 3195** (1989)
  - Reduces the maintenance tax assessment to 3.5% from 4.5% of actual operating costs for fiscal year 1990-91; and for fiscal year 1991-92 and afterward, the reduction will be at 2.5%.
- **H. 3448** (1989)
  - Specifies that a report of injury, excluding injury to the back, may be filed in summary if there is no compensable lost time or permanency and the medical treatment does not exceed an amount established by regulation of the Workers' Compensation Commission.
- **H. 3657** (1989)
  - Raises minimum weekly benefits for death to $75 from $25, not to exceed the employee's average weekly wage.
- **H. 3762** (1989)
  - Provides for a 5% penalty on maintenance taxes unpaid within 15 days of due date. Establishes percentages for maintenance tax assessments for fiscal years 1991-92, and thereafter.
- **H. 4198** (1988)
  - Requires employers to provide and enforce the use of safety appliances, and adopt and enforce safety rules and regulations; previously the Workers' Compensation Commission was responsible for workplace safety regulations. Provides that employees who violate safety rules and regulations are ineligible to receive compensation for occupational disease.

South Dakota

- **S. 44** (1989)
  - Transfers the administration of the Subsequent Injury Fund from the Department of Labor to the Division of Insurance.
- **S. 160** (1989)
  - Sets a 60-day limit on compensation payments for temporary total disability in cases where an employee is unable to return to his or her usual and customary line of employment, provided the employee is pursuing rehabilitation.
- **H. 1356** (1989)
  - Allows a self-insurer, or a renewing self-insurer, to secure compensation with a surety bond, cash, certificate of deposit, approved government securities or an irrevocable letter of credit in a total amount equal to the greater of: $250,000; twice the amount of compensation claims paid by the employer during the preceding calendar year; or the amount designated by the employer as a reserve for workers compensation claims. Adds other relative terms and definitions.

Tennessee

- **S. 426** (1989)
  - Permits government group self-insurers to participate in the Second Injury Fund.
- **S. 1095** (1989)
  - Provides that disbursements from the Second Injury Fund will be made only in accordance with the decree, instead of through the court clerk.

Texas

- **SCR 66** (1989)
  - Resolves that the 71st Legislature direct schools in Texas to require course instruction in industrial hygiene, safety and occupational medicine and nursing since these specified health fields would have a significant impact on medical cost containment.
- **HCR 123** (1989)
  - Resolves that the 71st Legislature instruct the State Board of Insurance to reassign furniture stores to more accurate classifications since many of these businesses are suffering from unjustified economic losses.

Utah

- **HJR 34** (1989)
  - Creates an interim committee to study the mechanics of establishing a rehabilitation program for industrially injured workers.
- **S. 163** (1989)
  - Increases the solvency level of the uninsured employers fund reserve to $2 million from $500,000.
- **S. 219** (1989)
  - Provides that payment of compensation must commence within 30 days, formerly 90 days, after a final award of the Industrial Commission.
- **H. 160** (1989)
  - Specifies that volunteer firefighters will be covered as employees of local government entities.
- **H. 3-XX** (1988)
  - Newly establishes a $3,000 limit to cover rehabilitation and training of a permanently and totally disabled employee.
  - Changes the title "Vocational Rehabilitation Agency" to "Utah State Office of Rehabilitation."
- **S. 106** (1988)
  - Creates a state self-insurance program for workers compensation. Requires that all state agencies, departments, boards and commissions be participants in the program and contribute to the fund.

Virginia

- **S. 301** (1989)
  - Clarifies the provision regarding the tolling of the statute of limita-

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tions.

• **S. 472** (1989)
□ Provides that when disputes arise over vocational rehabilitation training services being provided to an employee, a request may be made to the Industrial Commission for approval of such services.

• **H. 1577** (1989)
□ Exempts taxicab drivers from coverage, provided the Industrial Commission has been furnished evidence that such individual is excluded from taxation by the federal Unemployment Tax Act.

• **H. 1578** (1989)
□ Authorizes the Industrial Commission to make an award within 36 months from the date of accident in cases where no compensation has been paid and where review of an award is based on a change in condition.

• **H. 1654** (1989)
□ Newly provides that hearings convened by the Industrial Commission are considered public proceedings and may be video recorded at the discretion of the commission, subject only to the same limitations and conditions that apply to other court proceedings in the commonwealth.

• **H. 1657** (1989)
□ Allows an employer to elect coverage for an independent contractor under his or her policy as an employee of the employer, if agreement has been reached between the independent contractor and the insurer.

• **H. 1659** (1989)
□ Authorizes the Industrial Commission to fine an employer or insurer $1,000, or apply other sanctions against an employer, for failure to file a memorandum of agreement with the commission within 14 calendar days of execution.

• **H. 1972** (1989)
□ Amends conditions under which an ordinary disease of life is considered an occupational disease for coverage purposes, to include any infectious or contagious disease contracted in the direct delivery of health care in the course of employment. States that claims for symptomatic or asymptomatic infection with human immunodeficiency virus, including acquired immunodeficiency syndrome, will be forever barred if not filed within two years after a positive test of such infection.

Washington

• **S. 5679** (1989)
□ Transfers certain functions regarding the Reserve Fund and the State Fund from the State Insurance Commissioner to the Department of Labor and Industries.

• **H. 1518** (1989)
□ Requires that any common or contract carrier doing business (formerly domiciled in the state) in the state exclusively in interstate or foreign commerce, or in any combination, to provide coverage for their Washington employees, unless coverage has been established for such employees under the laws of another state. Provides that any common or contract carrier or its successor who was formerly covered, and by virtue of being exclusively engaged in such business, withdrew its liability for workers compensation coverage will be governed by the provisions of this section in effect as of that date.

• **H. 1709** (1989)
□ Appropriates a minimum of $300,000 from the Medical Aid Fund to the Department of Labor and Industries for the biennium ending June 30, 1991, to carry out the purposes of this act.

West Virginia

• **SCR 22** (1989)
□ Urges the U.S. Congress to enact legislation to restore interim black lung benefits to disabled coal miners whose benefits were put in jeopardy by a recent U.S. Supreme Court decision.

• **S. 576** (1989)
□ Provides that the Workers' Compensation Commissioner is responsible for establishing fee schedules, for making payments and taking any other appropriate action as required or allowed by law regarding state health care. Clarifies the law is not intended to prohibit an employer from participating in a preferred provider organization or program, or a health maintenance organization, or other medical cost containment relationship with providers of medical, hospital, or other health care.

• **H. 2672** (1989)
□ Makes state employees ineligible for workers compensation while receiving sick leave benefits; however, this provision does not apply to a permanent disability.

Wyoming

• **S. 28** (1989)
□ Changes the statute of limitations for benefits previously paid by providing that a claim for disability or medical benefits must be filed within a four-year time frame or any rights to benefits will be terminated. Notwithstanding the statute, medical claims may be accepted if certain conditions are met.

• **S. 29** (1989)
□ Revises compensation payments for temporary total disability to be based on two-thirds of the employee's actual monthly earnings at the time of injury, not to exceed the state's average monthly wage. Previously, benefit payments were based on two-thirds the employee's monthly earnings for 12 months immediately preceding the injury.
□ Provides that the confidentiality provision now covers information obtained from employers and employees regarding reporting requirements and information concerning enforcement activities of the Workers' Compensation Division.
□ Prohibits an employee who is receiving unemployment compensation from receiving workers compensation disability benefits. Attorney fees are now set by hearing examiners based on an hourly rate and all services must be itemized and verified.
□ Creates the Office of Independent Hearing Examiners as a separate independent agency funded by the workers compensation account. Further amends the law concerning review and settlement of initial compensation claims and any subsequent claims.

• **S. 122** (1989)
□ Classifies mine rescue teams as extrahazardous employment for coverage purposes. Defines "mine rescue team" as covered employees while engaged in mine rescue operations work and training.

• **H. 28** (1989)
□ Redefines "employer" for coverage purposes to include any person who employs an employee engaged in an extrahazardous occupation. Provides that an employer must be qualified as a resident employer or as a non-resident employer. Clarifies "non-resident employer or employee" as a person who is temporarily employed in Wyoming, but not covered by the state's workers compensation law.

• **H. 29** (1989)
□ Enacts new coverage for volunteer peace officers and for volunteers who are trained to handle or work with hazardous substances. Further clarifies, modifies and expands the coverage of extrahazardous occupations.

• **H. 72** (1989)
□ Permits surcharges to be assessed on employers if revenues in the Workers' Compensation Account are projected to be inadequate to pay benefits and repay any loans. ■

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Active role urged for RRG investors

By ADRIENNE C. LOCKE

ARLINGTON, Va.—Risk retention groups must actively plan tailor-made investment strategies with their managers, according to an investment advisory executive.

Plans should match investment objectives with business needs and should consider a group's financial limitations, according to Laura R. Estes, president of Aetna Financial Services Inc. in Hartford, Conn., an Aetna Life & Casualty Co. subsidiary that provides investment advisory and investment banking services.

Investment tactics should differ depending on whether a group is looking for funds to pay claims or to build up surplus, Ms. Estes told the National Risk Retention Assn.'s annual meeting Oct. 3-5.

For example, when selecting investments whose returns will be used to pay claims, liquidity is vital to ensure that the group has money to settle promptly, she said.

A portfolio, she said, should also be structured to ensure that investment proceeds are available to pay future claims. She advises groups to invest, for example, in bonds with different maturity dates.

Risk retention groups' investments should at least guarantee the return of the initial cash outlay, said Ms. Estes, cautioning that high-risk, high-yield junk bonds are too volatile.

When a risk retention group begins formulating a strategy, it should make clear to its investment manager what sort of investments it is willing to make, she cautioned.

A manager and group should also discuss the risks involved in each investment being considered before selecting a plan, she said.

According to Ms. Estes, the pros and cons of several investment vehicles include:

- Near-cash and equivalent investments.

These investment vehicles include money market accounts, U.S. Treasury bills, short-term bank certificates of deposit and short-term municipal bonds.

These investment options are accessible, easily liquidated and are a good choice if the funds and the returns on these investments are used for everyday business, according Ms. Estes.

However, returns would be higher on corporate or municipal bonds.

- Corporate bonds.

They are designed for consistent, long-term returns. Agencies rate each bond from AAA to BBB.

Typically, corporate bond face values are $1 million to $10 million, but face values are available from $250,000 to $1 million. However, commissions on lower face value bonds are greater than those on bonds of typical face value.

Corporate bond returns can be ¼% to ½% higher than those on U.S. Treasury bonds with an equal maturity.

Marketability of corporate bonds is uneven, with older bonds being traded far less often than new ones, "so you want to know when the bond was issued," said Ms. Estes.

- Municipal bonds.

Differences in accounting practices may make them riskier than corporate bonds, even when municipalities and corporations have equal bond ratings.

Municipal bonds also may be difficult to sell and demand can fluctuate greatly.

However, returns can be ½% to 1½% higher than U.S. Treasury bonds with similar maturities.

- Mortgage pass-through pools.

A bank packages a pool of individual home mortgages, which is guaranteed by the Government National Mortgage Assn., the Federal National Mortgage Assn. or the Federal Home Loan Mortgage Corp. Pool investors purchase participations and receive income from payments made by the mortgagees.

They have a high cash flow and the government guarantee makes them top-rated credit risks. And returns can be 1% to 1½% higher than those of U.S. Treasury bonds with equal maturities.

However, mortgage pass-throughs are vulnerable to fluctuating interest rates. For example, if a risk retention group purchases a pass-through of 10 30-year mortgages with an 11% interest rate and rates fall to 7%, mortgages may be refinanced and paid off in less than 30 years.

Prepayment funds are passed on to investors but the overall cash return decreases with each prepayment.

And lower rates could hamper a group that has based future claims funding on investments returning 11%.

After choosing its investment path and observing its returns, a risk retention group next should evaluate the performance of its portfolio relative to the group's short-term and long-term goals, Ms. Estes said. ■

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Issue of October 16

READER SERVICE #	ADVERTISER	PAGE #
—	Aetna Life and Casualty	9
—	Affiliated FM/Appalachian	54-55
—	Allstate Insurance Companies	20
—	American International Group	26
1	American Re-insurance	34-35
2	Argonaut Insurance Co.	58-59
—	Atlantic Star Intermediaries	60
3	Blue Cross Blue Shield	37-44
4	Blue Cross Blue Shield	45-46
5	Brownyard Brothers	26
—	Carnegie Insurance Services	70
6	CIGNA	15
—	Coopers & Lybrand	28
7	Cover X	65
8	Crawford & Company	4
—	CRC	28
9	Employers Reinsurance	47
10	Equicor Health Plans	32
11	Erisco	72
12	Erisco	73
13	Erisco	74
14	Erisco	75
—	Essex Insurance Company	24
15	Fidelity & Deposit	14
—5	Front Royal Group	62
—	GENERALI US Branch	27
—	General Reinsurance	29
—	IBM/WINS Incorporated	51
—	Industrial Insurance Mgmt.	32
—	IRI	56
—	Fred S. James	60
16	Kemper Insurance Group	6
—	Kornreich Organization	56
17	Liberty Mutual	25
18	Mass Mutual Insurance	30-31
19	Media/Professional Ins.	61
—	Merrill Lynch	11
—	Merrill Lynch	12-13
20	Metropolitan Life Ins. Co.	10
21	National Reinsurance	53
—	Northfield Insurance	64
—	Partner's Health Plan	57
22	Pharmaceutical Card System	7
—	Pitney Bowes	23
23	Protection Mutual Ins. Co.	18-19
—	Reliance Insurance Company	33
24	Reliance National Risk Spec.	48
25	Resource Inform Mgmt. Systems	36
—	Scor Reinsurance	66-67
—	Sherwood Insurance Service	65
—	Skandia America Group	16-17
26	Swett & Crawford Group	22
—	Tillinghast	71
—	Travis Pedersen & Associates	68
27	Wausau Insurance Company	5
28	Zurich-American Insurance Co.	82

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16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70	71	72	73	74	75
76	77	78	79	80	81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	100	101	102	103	104	105
106	107	108	109	110	111	112	113	114	115	116	117	118	119	120
121	122	123	124	125	126	127	128	129	130	131	132	133	134	135
136	137	138	139	140	141	142	143	144	145	146	147	148	149	150

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Insurer Topics

A special editorial section sent exclusively to insurers and reinsurers

Claims technology advances

Policyholders' wishes are insurers' commands

By MARK A. HOFMANN

Technological advances are making it easier for insurers to satisfy policyholders' demands for better and faster claims processing.

Insurance buyers, whether consumers of personal or commercial coverage, want more than to simply receive a check in the shortest possible time. They also want to know why they've been paid what they've been paid. And, in some cases, commercial insurance customers often want to have instant access to their claims files as well.

In response, insurers have begun concentrating on using automated claims systems to enhance customer satisfaction as well as speed up processing.

For example, the development of relational data bases has given insurers access to large amounts of information with simpler programming compared with structured data bases, which had required much more complicated programming for data retrieval.

In addition, technologies that are barely off the drawing board, such as image processing and expert systems, may further smooth the claims handling process.

Insurers must look more closely at improving customer service through claims handling if they are to defuse consumer resentment, some insurance automation experts say.

"In my opinion, automation and customer service go hand in hand," said David L. Mullen, president and chief executive officer of Chicago-based CCC Information Services Inc.

Claims handling, he said, "is no longer the poor cousin of underwriting and marketing."

CCC Information Services maintains a vehicle data base of the inventories of more than 3,000 automobile dealers in the United States and Canada. The information, which is updated at least weekly, is used by about 200 property/casualty insurance companies to determine the value of insured automobiles that are deemed a total loss.

In an address to a symposium on claims and customer service in Chicago this fall, Mr. Mullen said that passage in California of Proposition 103, an insurance regulation reform measure, should force insurers to change the way they handle claims.

"Whether we want to admit it or not, Proposition 103 is only the tip of the iceberg with regard to consumer disenchantment and misunderstanding of the industry," said Mr. Mullen, referring to the California voter initiative that mandated premium rollbacks and other regulatory changes.

"Whether it remains in its present form or not is irrelevant; Proposition 103 as a reflection of an attitude is not going away, and we have to face up to the fact that we've done a poor job of educating the public about the basic concepts and realities of insurance and also—and perhaps more importantly—we can and have to do a much better job of running our business."

Mr. Mullen said that "traditional thinking with respect to claims" is not necessarily going to work. "There is more to running your business" than simply cutting expenses, he said.

"Good customer service in claims requires an investment, but that investment is worth a great deal in meeting the most important business task any insurer has: retaining the customer," Mr. Mullen said.

He used as an example an imaginary company with 1 million policies. The average cost of marketing and underwriting each policy is $125, which makes the total investment $125 million, he said. But the company loses 12% of it customers each year, Mr. Mullen said.

"Industry statistics suggest that approximately half of this total leave because of price; the balance were disappointed in service," he said. "Approximately one-third of the 12% have had a claims experience," he said.

The company has to pay out $15 million in costs related to generating business just to stay even, Mr. Mullen said.

"If your customer service can influence that lapse rate by a mere 1%, you can save your company in excess of $1 million a year. And that savings doesn't come from claims department expenses. It comes from lower marketing and underwriting costs," he said.

The illustration demonstrated that "there is more today to managing claims than just managing costs," Mr. Mullen said. "You have to invest in customer service and make sure that the rest of your company understands the payoff."

An investment in automated claims handling should pay dividends in customer satisfaction as well as in streamlined operations, asserts Larry Mihalik, senior manager-claims automation for the companies of the Schaumburg, Ill.-based Zurich-American Insurance Co.

Five years ago, most insurers looked at automation primarily as a means of increasing efficiency, but now insurers have begun to look at automation from a slightly different perspective.

Wausau, Wis.-based Wausau Insurance Co. developed a system dubbed DIAL Wausau that allows large corporate policyholders to review their claims files by phone. So far 70 commercial policyholders are online (see story, page 62G).

Insurers now seek "not only to improve operating efficiency, but also to enhance our ability to provide enhanced service to our policyholders," said Mr. Mihalik of Zurich-American, which has developed a similar system.

Zurich-American developed ACCESS—or "Advanced Computerized Claims Entry and Service System"—with the idea that "everything should be user-friendly," he said.

Ease of use helps when a policyholder is reviewing its claims record, he added. Five of Zurich-American's large commercial clients currently make inquiries about their claims service through computer terminals, he said.

One of the best features of ACCESS is that it allows "real-time updating," which means that claims information can be retrieved as soon as it is entered into the system, said Mr. Mihalik.

If a client wishes to receive all claims made since a certain time, an up-to-date list that includes information entered only moments earlier also can be prepared, he added.

The use of automation also has improved claims handling at Hartford, Conn.-based Aetna Life Insurance Co., said John L. Ruggiero, director—claims services. The system—AECCLAIMS for "Aetna's Computerized Claims System"—is a real-time, interactive system that operates 14 hours a day, he said.

The system links roughly 6,500 terminals in 35 Aetna offices throughout the country with three International Business Machines Corp. 3033-200E computers at the insurer's data center in Middletown, Conn., said Mr. Ruggiero. It handles more than 250,000 claims a day and pays out more than $40 million in benefits daily, he added.

For example, the system has permitted Aetna to beat its goal of paying group dental claims within 10 days of submission. The actual average is now 9½ days, he said.

Automation has improved the quality

Continued on next page

Claims advances

Continued from previous page

chief advantages of expert systems used in underwriting, Mr. Roberts added (*IT*, May 15).

In addition, an expert system could audit a claim as it is being processed, Mr. Roberts said.

Expert systems also could speed up claims processing, he said.

"The time requirement would be greatly reduced," because some routine types of claims—such as those for certain types of tests that detect certain diseases—really don't require a great deal of human oversight.

An expert system could audit a claim as it is being processed, says Mr. Roberts of Gateway Information.

Sunnyvale, Calif.-based Syntelligence Inc. is considering the creation of an expert system for claims-handling, said Lynn Edwards, product marketing manager-insurance. Syntelligence already has developed expert systems for underwriting.

A claims-oriented expert system probably would be most useful in determining the value of liability claims, Ms. Edwards said. It could help answer, for example, what a particular pain and suffering claim is worth.

However, not all automation experts are sold on the idea that expert systems will enhance insurance claims handling.

As the Insurance Institute of America's Mr. Gatza noted, no matter how good the system might be, people will still be needed to make claims-handling decisions.

"You don't capture all of a person's expertise in an expert system," he said.

Expert systems would provide "very few if any advantages to a claims system," said Zurich-American's Mr. Mihalik. "The information expert systems could provide, I could provide with my data base," he said.

While individual technological advances should enhance claims handling, the integration of the various technologies—e.g., telephone access, imaging and artificial intelligence—into one system would be the best of all worlds, said Warner's Mr. Hameyer.

John Woolery, vp-marketing for Indianapolis-based Pallm Property & Casualty Inc., another Swiss Re affiliate that provides service and software to the property/casualty insurance industry, agreed.

"We are moving toward integrating these systems into our PallmWise Workstation," Mr. Woolery said. ■

Imaging replaces files to save insurers millions

By MICHAEL BRADFORD

Insurers are saving millions of dollars by replacing folders full of paper with electronic images of claims forms and policies.

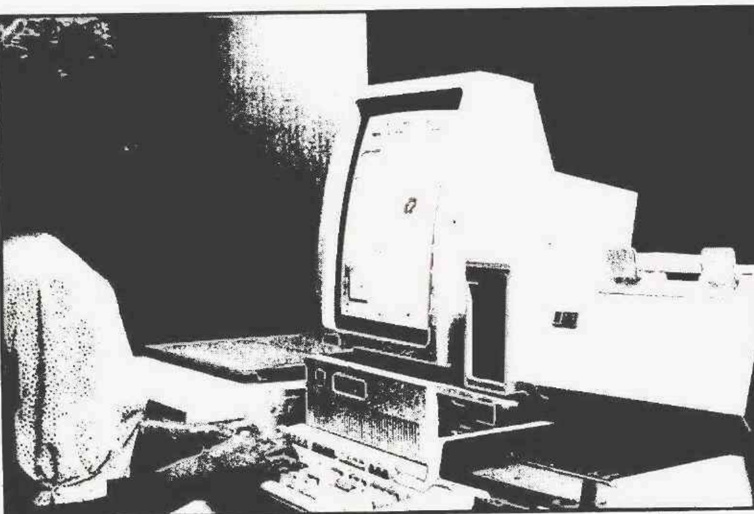
"Imaging," the hottest trend in company automation, has vendors and users singing its praises.

"In five years, image processing will be where word processing is now," predicts a spokesman for Metafile Information Systems Inc., a Rochester, Minn.-based vendor of imaging systems.

The paper-intensive business of insurance seems ideally suited to the technology.

"Insurance is a key market for us. There is a tremendous amount of activity," said Roger K. Sullivan, director and program manager at Lowell, Mass.-based Wang Laboratories Inc.

It "is the most closely matched application for the system," said Robert Ellis, president of Electronic Document Management Systems in Houston. His company has been particularly busy recently installing imaging equipment in insurance offices, he said.



Imaging systems, like this one from Metafile in Rochester, Minn., can speed information retrieval and service and save insurers millions.

Insurance accounts for about 10% of the imaging industry's 1988 total revenue of $3.35 billion (including imaging, microfilm and microfiche systems and vendor services) and 7.5% of the $800 million in revenues generated solely by imaging, according to a consultant's study for the Assn. for Information & Image Management in Silver Spring, Md.

Total imaging revenue is predicted to more than double—to $6.8 billion—by 1993, though the study does not say how much growth could come from sales to insurance companies.

Pinning down a single definition of this relatively new technology is not easy. Increasingly popular since 1984, it is alternately referred to as image processing, image management, forms management and document storage and retrieval systems, depending on users and vendors.

By whatever moniker, imaging involves scanning a document and

Continued on next page

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Insurer Topics

Continued from previous page
storing the image in a computer system. Once stored, an image can be manipulated or data added and the documents electronically processed along the same route as paper forms.

Some systems scan components of a document, like logos or signatures, and electronically place them onto boilerplate forms.

Vendors and users say the advantages include:

- Quicker processing.

Several computer operators in different departments can simultaneously process from a single document.

- Lower printing costs.

Firms no longer need large volumes of duplicate blank forms.

- Improved service.

Information can be retrieved immediately for an agent or policyholder, rather than waiting for a clerk to physically retrieve papers.

- Fewer lost documents.
- Improved work flow and productivity from employees no longer bogged down in paper-intensive work.
- Freeing up space formerly used for file cabinets.

Scanned documents are stored efficiently on optical disks, dozens of which fit in a single "jukebox." Each jukebox can replace 140 four-drawer file cabinets, according to an imaging system vendor.

Potential savings to insurers and other firms can be large, vendors say.

"I would stand up in front of the president of any insurance company and say there is no investment he can make that will give him anywhere close to the rate of return or have as dramatic an impact on the bottom line over the next 12 to 24 months," as an imaging system, said Tom Scott, manager of the insurance market group of Carrollton, Texas-based Electronic Form Systems.

CIGNA Corp. customers are expected to quickly realize the advantages of the Wang imaging system used to administer pension benefits, said Scott Kania, assistant director of the group pension division in Hartford, Conn.

"One of our philosophies is to lead with our technology," he said. "Our existing clients will certainly see the advantages. . and we expect they will measure our competitors against our capabilities."

With 60 work stations, CIGNA plans to cut response time on client inquiries and to recoup its $2.5 million investment in about 2½ years. "Our goal is to answer a client inquiry while the client is on the phone," rather than return his call, Mr. Kania noted.

All paper documents should be converted by next year and microfiche in 1991, he said.

The company also will clear out

Continued on next page

Letters

Determined efforts required to recruit recent graduates

To the editor: As a college recruitment consultant and former director of staffing at Aetna Life & Casualty Co., I am confused by and concerned about several statements contained in "College Students No Longer Avoid Insurance Careers" (*IT*, Aug. 21).

While it is certainly true that some insurers have been able to compete more effectively on campus the past few years, the article mistakenly attributes their success to some nebulous change in student attitudes about business careers.

What the article understates and perhaps underestimates is the tremendous *effort* required of insurance companies to overcome industry stereotypes and to educate young people about career opportunities. The companies that have upgraded the professionalism of their campus programs and have invested the resources to target, recruit and retain talented college grads are the ones that will be better positioned to select from the dwindling pool of applicants over the next decade.

To conclude that the challenge of attracting students to the industry has abated fails to recognize the growing imbalance in the supply of and demand for new grads and the increasingly sophisticated recruitment methods that employers use to compete for entry-level staff.

Mary E. Scott
President
M.E. Scott & Co.
West Hartford, Conn.

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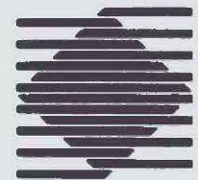

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Insurer Topics

Imaging

Continued from previous page

"an enormous amount of floor space" when it replaces filing cabinets with two 89-disk jukeboxes that together will store 80,000 documents, Mr. Kania said. The space will help accommodate a growing Hartford operation, he said.

Other insurers aim to save money spent on developing and printing commonly used forms.

"The difference in stocking plain paper vs. buying the forms paid for the system," said Gary Tobiason, vp and director of information services for Federated Life Insurance Co. in Owatonna, Minn., which uses imaging to print workers comp policies.

With Metafile's imaging system—called MetaView—Federated scans logos and common signatures on an optical disk. Those components, plus information from the company mainframe, are loaded onto boilerplate forms.

Electronic forms can then be processed by underwriting and rating personnel and printed at the main office or any Federated branch equipped with printers.

The system automatically assigns information to any of the 36 boilerplate forms required by regulators in the 36 states where Federated writes workers compensation insurance, he said.

Federated may eventually add a full-blown imaging system to scan and store all company documents, he said.

In "forms management," companies save time and money with imaging, said Mr. Scott of EFS.

At $50,000-$150,000, the EFS system lets users develop documents like claims or policy forms on IBM mainframes or microcomputers. "Since we have customers with several hundred printing locations, they can centrally develop the forms and distribute them electronically," he said.

"Instead of going to a commercial printer and having hundreds of thousands of forms printed and stored in a warehouse, you can go into the system and order 500 at a time," Mr. Scott said.

Vendors stress the convenience of adding imaging systems to work with existing personal computers.

For example, PCs with memories as small as 640K can work with mainframes and minicomputers in the MetaView program, a company spokesman says.

"Our software moves computing from the mainframe to the PC," he said. "The mainframe hands out the information the PC needs to do the computing."

Sigma Imaging Systems Inc. in New York also touts use of its OmniDesk system with PCs already linked to a mainframe.

Prices are kept down in part by its ability to work with an existing mainframe, said Adrienne Gans, a Sigma marketing and sales representative.

Depending on application, a full work station costs $30,000-$35,000, including a proportional share peripheral imaging equipment expenses.

Integration into existing systems should be a key for insurers considering imaging systems, Ms. Gans said.

Users "shouldn't have to learn to change their jobs. They're used to the way they do their work, and imaging doesn't alter the claims-handling process," she said.

Integration into existing systems is important to insurers considering imaging, says Adrienne Gans.

Sigma developed and installed OmniDesk for Empire Blue Cross & Blue Shield of New York, and the system now processes 2,000 claims daily at the insurer's Yorktown Heights, N.Y., offices. When fully operational in 1990, it is expected to handle 125,000 a day.

Empire plans to recoup its $2.5 million outlay two years later.

Marilyn T. Kanas, director of insurance sales for New York-based Image Systems Corp., said her firm's ImageSystem allows "seamless integration" of new and existing technology.

Centering on an IBM PS 2 Model 70 work station, the $2 million system of 53 work stations is used by the Texas State Board of Insurance in Austin to store documents for several departments.

It should pay for itself in about two years, according to Ms. Kanas.

An insurer could recoup the cost of installing a Wang system in about the same time, said Mr. Sullivan. An average Wang imaging system—including about 20 work stations and peripheral equipment—costs $500,000-$600,000, he said.

Wary of installing "technology islands," at least half of Wang customers have integrated imaging and other data processing systems, Mr. Sullivan explained.

Mr. Ellis of Electronic Document Management Systems said the Data General Corp. hardware provided with the EDMS system can be used in tandem with a company's existing PCs.

For example, PCs already in place can be used as viewing terminals and the Data General hardware to input and process data, he noted.

Mr. Ellis said the EDMS system, at about $42,000 for a terminal and peripherals, usually pays for itself in nine to 12 months, with underwriting being "one of the first areas where we see insurers recouping their investment."

Without imaging systems, underwriters often play the role of file clerk and searcher, losing 40% to 50% of time that could be better spent generating new business, he said.

Northwestern Mutual Life Insurance Co. plans to upgrade its present MetaView system for data processing to handle imaging, said Armin Gumerman, director of information systems for the Milwaukee-based insurer.

The imaging capability will be "strictly an underwriting application, to support life underwriting," he said.

Vendors and users also point to imaging's competitive advantages.

For example, many insurers expedite claims processing for commercial clients with express service, for which they charge extra, Mr. Sullivan said. But segregating "express" clients' claims from others is expensive without an imaging system, he said.

With such a system, he said, an insurer can better separate the claims and thus offer faster claims payment at lower costs.

Vendors and users are hard-pressed to come up with any disadvantages associated with image processing.

But converting paper files and microfiche to imaging systems has a "downside," says Mr. Kania of CIGNA: "It's expensive and takes time."

Mr. Scott of EFS said companies often don't consider the long-term implications of document processing, factors like how easily a system can be upgraded, whether it can print to remote locations and what type of image processing system the business will need in three to five years.

"Many companies are building themselves into a corner because they are solving one short-term need" rather than anticipating future needs, he said. ■

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Technology changes image of processing

Pity the poor mail room clerk.

No more leisurely strolls through the office with that big wire basket on wheels. Now, he just stands beside the high-speed scanner, feeding it insurance claims forms that are gobbled up and spit out on screens all over the building.

The big wire basket has been converted into a planter and now the dour lad spends his free time tending to his mail room garden.

Socializing is limited to the company picnic.

Well, the consequences of image processing may not be that severe, but it does portend significant changes in the way insurance companies and other businesses conduct their inter-office affairs.

Actually, the mail room clerk is likely to be quite happy at the prospect of his domain being renamed a "document capture room," as some imaging system users are calling their old mail rooms.

To illustrate the flow of a document through an imaging system, Roger Sullivan, director and program manager of Wang Laboratories Inc. in Lowell, Mass., traced a claim through a company that processes automobile, dental and medical claims.

The document capture room is where the flow of electronic imaging begins.

"When a claim is received, it is scanned into a kind of imaging in-box," Mr. Sullivan explained. "The system recognizes whether it is a medical, dental or auto claim and routes it to the proper department."

An employee checks the claim to determine whether supporting documentation, like prescription forms or documents from doctors, are needed to continue processing the claim.

When supporting documents arrive in the mail room, they, too, are scanned into the system and automatically routed to the electronic file that is holding the claim.

"Only when all the information is complete does it move to the next station," said Mr. Sullivan, eliminating the need for a worker to continually check a paper file to see if supporting documents have arrived.

If irregularities are found and a claim processor needs more information from a doctor or someone else associated with a claim, the system operator has the ability to automatically send a letter via facsimile machine.

"Through all this, you're not passing paper through the office, but moving images through the system," Mr. Sullivan emphasized.

Claims with no irregularities make it swiftly through the system and checks are printed.

At that point, the mail room clerk is pressed into service and the checks are turned over to the U.S. Postal Service.

—*By Michael Bradford*

Insurer Topics

Wausau insureds get on-line access to their claims files

By MARK A. HOFMANN

WAUSAU, Wis.—Wausau Insurance Co. commercial policyholders can now let their fingers do the walking to review claims files.

A system—dubbed "DIAL Wausau"—gives policyholders access to specific property and casualty claims information, said Ron Fisher, assistant vp-risk management services for the Wausau, Wis.-based affiliate of Nationwide Insurance Co. of Columbus, Ohio.

Ever-larger information requests from major customers and the inordinate amount of time required to process the data prompted creation of the service, he explained.

"It struck us that since we were getting so many calls about claims, and the technology was there, could the customer tap in?" Mr. Fisher said.

Wausau does not charge for the service, but users need a personal computer, printer, Touch-Tone telephone and some specialized hardware and software. Wausau supplies the software, which allows a PC to communicate with the Wausau computer.

DIAL Wausau began as a pilot program in the spring of 1987, Mr. Fisher said, with the first accounts on-line a year later. Currently 70 commercial policyholders are on-line.

Even before the pilot program ended, Wausau simplified procedures while trying to maintain data security, he said. Originally a "dial-back" system required policyholders to call, dial in codes, hang up and wait for the computer to call back. But that proved too onerous, Mr. Fisher said.

And limiting access by account number keeps the data so secure that stealing it would be like worrying about someone stealing the front yard while a person is sleeping, he said. However, thefts are unlikely, he said, adding that the data would probably be of little value to a thief.

Available information includes:

- Electronic claim record, including policy number, accident date, claimant information, description of an accident, total paid to date and outstanding reserves.
- Lists of individual payments and information about them.
- A claim summary inquiry.
- Special handling instructions.
- Loss location code listing.
- Employee/claimant name search allowing users to find a claim number knowing only a claimant's name.
- Electronic mail service.

While the phone service has no account-size minimum, it appeals primarily to large accounts, such as those with annual premiums exceeding $250,000, Mr. Fisher said.

A client with only four claims a year may find access pointless, but multilocation firms employing thousands may need to regularly review their claims files, he said.

The service also may promote loss control, he said. For example, a customer that notices an unusually high number of slip-and-fall accidents at one facility can request advice from Wausau on how to reduce them.

The service has proved appealing to prospective policyholders, said Mr. Fisher. Before even asking about underwriting, he said, many would-be customers want to know more about an insurer's claims, computer and loss control services.

DIAL Wausau is not designed to turn the his claim system into a risk management information system where the risk manager can manipulate the data, he stressed.

"This particular system only allows people to look at the claims files," said Mr. Fisher. "It's an enhancement of claims service."

The system is designed not only for risk managers, but also for "people at the level in a policyholder organization that deal with us on a daily basis," said Mr. Fisher.

Several users will be asked to assess the system at a Wausau focus group later this year. ■

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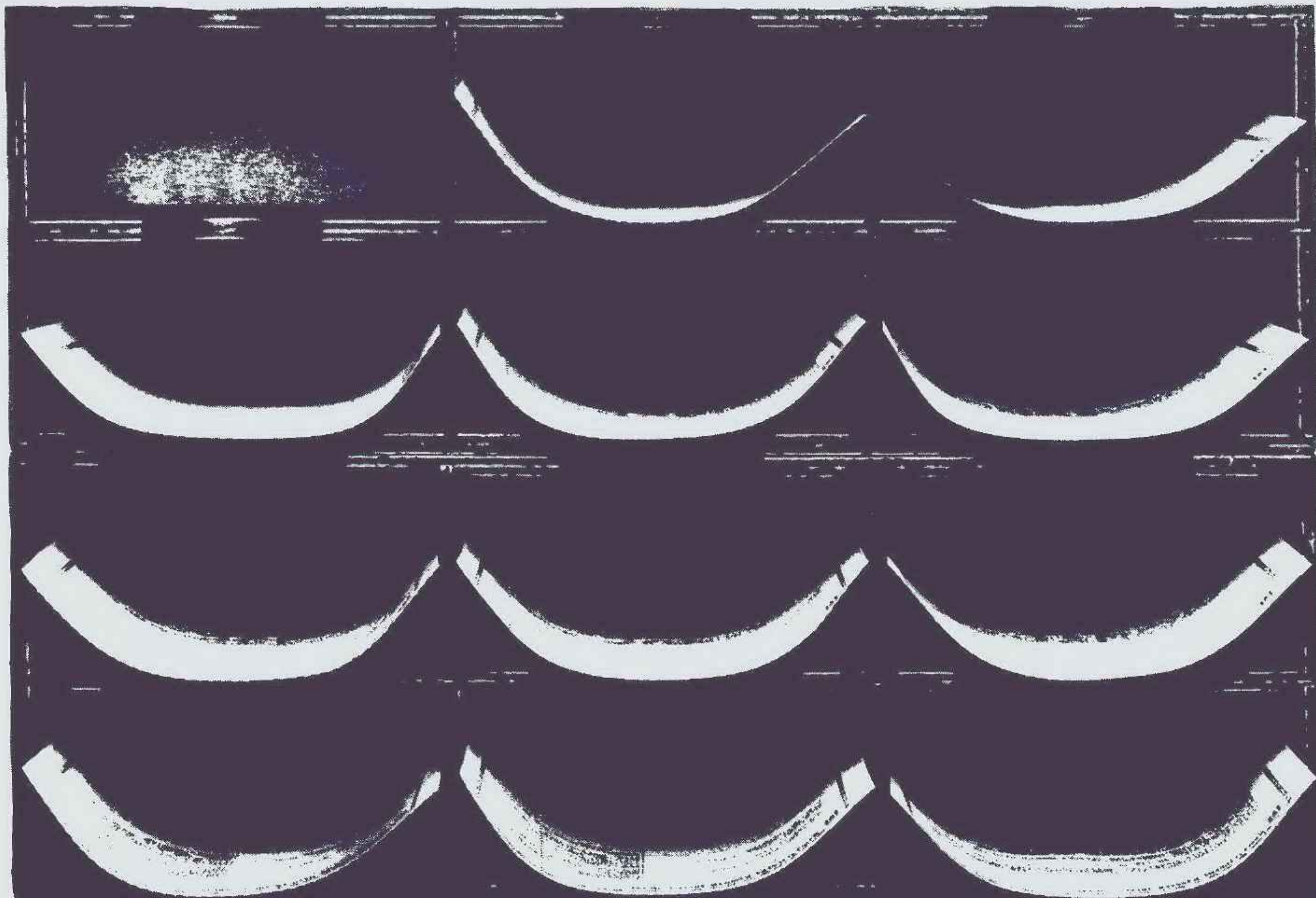

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Insurer Topics

Computer models predicted Hugo's toll

By MARK A. HOFMANN

Thanks to a pair of computer loss forecasting models, some insurers had a rough idea of the damage caused by Hurricane Hugo even before adjusters could reach the scene.

Among them were about 50 subscribers to CATALYST, a service of reinsurance broker E.W. Blanch Inc., based in Minneapolis, and companies buying disaster information services from Hartford, Conn.-based Travelers Corp.'s Natural Hazard Research Service unit (*BI*, Aug. 22, 1988).

Both models draw on similar historical data to forecast insured damage, but they produced widely disparate estimates of Hugo's ultimate toll: more than $5.5 billion according to CATALYST; slightly less than one-third that amount, says the Travelers service.

However, both services warn that the models are set up to service individual firms, rather than provide that type of industrywide estimate.

The computer models are designed to help reinsurance buyers decide on levels of coverage.

The Rahway, N.J.-based Property Claims Services division of the New York-based American Insurance Services Group Inc., calculated Hugo's damage to the continental United States, Puerto Rico and the U.S. Virgin Islands at $3.984 billion (*BI*, Oct. 2).

Like the Travelers model, CATALYST, which was begun in 1987, simulates thousands of storms by varying factors such as wind velocity and storm paths to produce a series of snapshots of likely impact, said Jean Taylor, vp-actuarial services at Blanch.

Buyers have long focused on the worst-possible loss, but if the worst-possible storm is likely to hit only once every other millenium, buyers may be overinsured, she said.

Hugo projections began long before the storm hit land, says Travelers' Mr. Friedman, but low wind expectations kept estimates down. Forecasters initially projected maximum gusts of 125 mph, but Hugo's winds eventually exceeded 150 mph, he says, and 'just by chance, it hit a major metropolitan area.'

In addition, "If we give them an idea of the range of the size of the storm, they can have an idea of how many people to send out there," said Ms. Taylor.

The Travelers system simulates hurricanes since 1871 with current property data and hypothetical storms.

Don G. Friedman, a meteorologist with a Massachusetts Institute of Technology doctorate, began developing the model while working on the National Flood Insurance Plan in the 1960s. His early programs estimated possible flood damage to property at 5,500 locations.

Because Hugo's point of landfall was unknown, damage estimates varied widely, with CATALYST's early projections swinging between $1 billion and $9 billion, said Ms. Taylor. She adds that the model is not designed for industrywide estimates, but rather to service individual companies.

Hugo projections began long before the storm hit land, said Mr. Friedman, but low wind expectations kept estimates down. Forecasters initially projected maximum gusts of 125 mph, but Hugo's winds eventually exceeded 150 mph, he said, and "just by chance, it hit a major metropolitan area."

Both Mr. Friedman and Ms. Taylor said that even their sophisticated models could not consider every variable. CATALYST, for example, bases its forecasts on only six storm characteristics: severity, speed, radius, direction, tide and point of landfall; and the Travelers model uses similar information.

Disparity of nearly $4 billion in their industrywide estimates surprised neither forecaster.

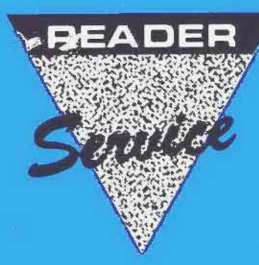
The Travelers model does not take into account business interruption losses or damages to the contents of homes. "You just can't cover all these things," said Mr. Friedman.

Nor does the Travelers model take into consideration the damage likely to be done by falling trees, which turned out to be extensive as Hugo devastated low-lying sections of the Carolinas.

Sixty mile-per-hour winds turned trees into "battering rams," he said. Compounding the severity was the Southeast's extremely wet summer and the vulnerable root systems of pines, the region's most common trees, he said.

For comparison he notes that Hurricane Gracie, which in 1959 hit a far less developed area about 40 miles southwest of Charleston, caused $14 million to $17 million in damage. Adjusted for inflation, the toll was only $170 million, he said.

Inherent limitations of forecasting and the disparities with other models notwithstanding, Mr. Friedman praised his system. "It did a very good job," he said. ■



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Insurer Topics

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READER SERVICE #	ADVERTISER	PAGE #
—	Alliance Capital Management	62C
130	Apex Data Systems	62E
131	Chemical Bank	62B
—	Kernan & Assoc. Re Inc.	62G
132	Manufacturers Hanover Trust	62G
—	Munich Reinsurance Co.	62E
133	Society of CPCU	62D

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16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70	71	72	73	74	75
76	77	78	79	80	81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	100	101	102	103	104	105
106	107	108	109	110	111	112	113	114	115	116	117	118	119	120
121	122	123	124	125	126	127	128	129	130	131	132	133	134	135
136	137	138	139	140	141	142	143	144	145	146	147	148	149	150

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Computer firms help trim costs of JUA operation

FAIR LAWN, N.J.—Some New Jersey drivers now carry insurance policies that bear the names of computer companies rather than insurers as part of an attempt by the Garden State to cut the cost of its deficit-riddled Joint Underwriting Assn.

Insurance Commissioner Kenneth Merin's decision to transform computer companies into quasi insurers is a logical one, according to Hellmut Hameyer, executive vp of Fair Lawn, N.J.-based Warner Computer Systems Inc.

Under the JUA, "insurers don't really take risk—they just administer," he said.

The state pays insurers to handle claims, applications, renewals and other services for the JUA, which last year issued about 2 million personal auto policies—roughly half of the personal auto policies issued in the state, Mr. Hameyer explained.

Under the former system, insurers were paid as much as 20.8% of premiums for providing policy application, renewal and claims-handling services.

However, under the commissioner's new plan, the computer companies will receive an average of only 16.6% of premiums for providing the same services.

Warner is the smallest of the four computer firms and one insurer that are servicing the JUA.

The other three firms are: Computer Science Corp. of El Segundo, Calif.; Electronic Data Systems Corp. of Dallas; and Policy Management Systems Corp. of Blythewood, S.C.

Worcester, Mass.-based Hanover Insurance Co. is the only one of 12 insurers that had been servicing the JUA to continue the administrative task this year.

Warner received a contract to service about 175,000 JUA policies, Mr. Hameyer said. In addition, the computer company provides processing services for Hanover's 300,000 JUA policies.

"The only difference is, we have something of a different attitude than insurance companies," Mr. Hameyer said.

While insurance companies often follow procedures established a century ago, Warner follows procedures established in the early 1970s, when it was founded, he explained.

'The only difference is, we have something of a different attitude than insurance companies.'
— Hellmut Hameyer
Warner executive vp

In addition, because Warner was founded as a data-processing firm rather than as an insurer, it has emphasized processing the applications and endorsements as quickly as possible instead of underwriting.

"We have no real underwriting—we have to follow the underwriting rules of the JUA," he said.

Warner also does not process claims. Instead, the company subcontracts that task to Material Damage Adjustment Corp., which maintains its operations in the same Fair Lawn, N.J., building as Warner. Material Damage Adjustment Corp.'s automated system is integrated with Warner's, he said.

Warner can turn an application into a policy within 10 days, Mr. Hameyer said.

—By Mark A. Hofmann

Lawyers offer RRGs claims handling tips

By ADRIENNE C. LOCKE

ARLINGTON, Va.—The effectiveness of a risk retention group's claims handling department depends in large part on the department's relationship with its legal counsel, according to two attorneys.

Compatibility between the claims department and legal counsel is a key factor to smooth-running claims handling, the attorneys said

"The team approach is the better approach," said Michael Merlo, an attorney with Pretzel, Stouffer, Nolan & Rooney in Chicago, at the National Risk Retention Assn.'s annual meeting Oct. 3-5.

The first step in establishing this relationship is selecting legal counsel with a similar litigation philosophy, according to James Ebel, an attorney at Toplis & Harding in Chicago.

Mr. Ebel said many risk retention groups use personal referrals to find their lawyers, while others seek advice about a counsel from other attorneys they work with or from referral services.

However a group goes about selecting legal counsel, it should inquire about the reputations of candidates, he stressed.

When interviewing a prospective attorney, there are several questions the risk retention group should ask, according to Mr. Ebel.

For example, the risk retention group must inquire about whether any conflicts of interest would arise if the attorney were selected as legal counsel for the group's claims handling department.

The attorney's expertise also should be discussed. The group should inquire about the attorney's experience and—most importantly—whether the attorney is a trial lawyer, Mr. Ebel said, noting that not all lawyers are capable of arguing a case in court.

In addition, the personality of an attorney is important, he pointed out. The claims department should be able to get along with its counsel and agree with his or her style of handling a case, he said.

For example, some attorneys are more aggressive than others and may want to make the final decisions on how a case is handled.

Another factor that should be considered in the selection process is an attorney's billing practice, Mr. Ebel pointed out. For example, is billing done hourly, and are there extra charges for certain services?

A risk retention group also should ensure it will not be charged extra for additional hours of research or other work done by a young attorney that a more experienced colleague could have done more efficiently, he said. However, Mr. Ebel added, the age of an attorney is not the most important factor in deciding on counsel, because age does not guarantee competent legal help. But younger attorneys should be supervised by senior members of a firm, he said.

Mr. Ebel also observed that there are differences between large and small law firms that risk retention groups should weigh.

For example, larger firms have more lawyers that could work on a case and can provide more resources.

However, larger firms usually are more expensive, he said.

In contrast, smaller firms usually are less expensive and can offer more personalized service, like having day-to-day legal paperwork handled by the assigned counsel, Mr. Ebel said.

In all cases, though, ask for references, he cautioned.

The claims department and its legal counsel should function as partners and work together to establish a litigation plan that is specific, yet flexible, according to Mr. Ebel. The claims department and counsel should be accessible to each other and have regular meetings, he added.

When a claim develops, the risk retention group will also have to decide when it is prudent to settle a claim and when it is better to take a claim to trial, said Mr. Merlo.

Working together on a case is important, he stressed. The risk retention group should inform its counsel that it intends to be a participating member in the case and during its planning stages, Mr. Merlo added.

The claims department and its attorney should discuss such budgetary considerations as the cost of taking a case to trial, Mr. Ebel suggested.

Mr. Merlo noted that large companies tend to settle general liability claims but will fight product liability claims because they involve the reputation of their products.

Overall, Mr. Merlo observed, 30% of the cases he has seen go to trial should have been settled. He blames what he thinks is excessive litigation of claims on a lack of management decision-making or uncertainty over whether settling a claim is the best route to take.

And, when a risk retention group decides to settle a claim, it should be done quickly and while the plaintiff is still with the family lawyer, he advised.

Family counsel is much easier to deal with than a liability lawyer "because the family lawyer has a better relationship with the plaintiff and has the best interest of the plaintiff in mind," he said.

Mr. Merlo strongly urged risk retention groups to contact their counsel whenever they suspect they may be hit with a lawsuit so that counsel will have as much time as possible to prepare. ■

NRRA re-elects president

ARLINGTON, Va.—Robert L. Larsen will serve a second one-year term as president of the National Risk Retention Assn.

Mr. Larsen, who was re-elected at the group's annual meeting Oct. 3-5 at the Stouffers Concourse Hotel in Arlington, Va., is president of the Insurance Administration Center Inc., a Park Ridge, Ill.-based firm that specializes in developing insurance programs for members of trade organizations.

Also at the meeting, three new vps were elected: James A. Anderson, senior director of government relations for the National Assn. of Wholesaler-Distributors in Washington, D.C.; Joseph Peloso, vp of American Re-Insurance Co. in Princeton, N.J.; and Leslea Dummer, president of Donner Specialty Markets Inc. in Salt Lake City, Utah, which specializes in forming and managing risk retention groups.

The new treasurer is William Hurlman, director of Continental Retention & Specialty Managers in New York, a Continental Corp. unit providing reinsurance and other services to risk retention groups.

And, the new secretary is Rosita Steele, vp of sales and product development of Meadowbrook Insurance Group, a Southfield, Mich.-based insurance services and brokerage group.

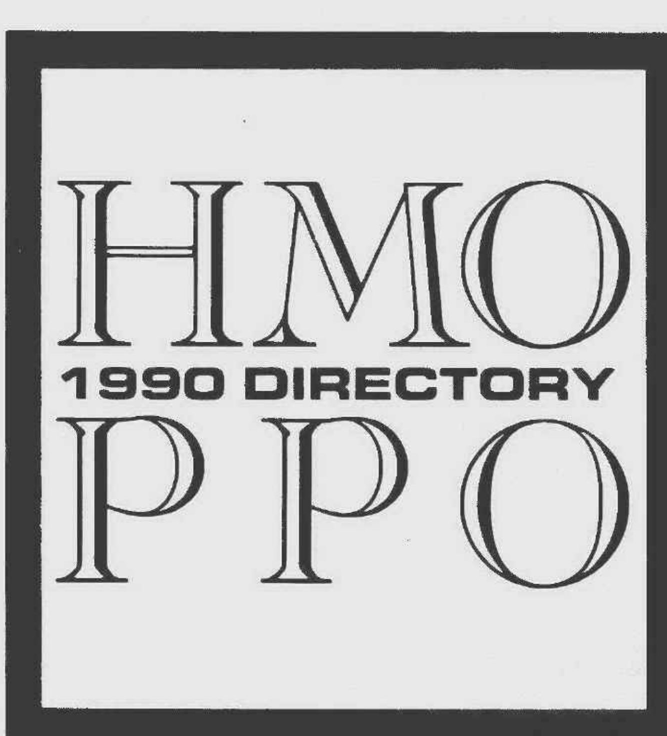
More than 200 people attended the annual meeting of the NRRA, a non-profit group whose membership includes risk retention and risk purchasing groups, insurance brokers, insurers, reinsurers, law firms and service providers.

The NRRA seeks to develop and promote the use of alternative risk sharing mechanisms under the Risk Retention Act.

The group also seeks to improve the regulatory environment under which risk retention and purchasing groups must operate and to encourage the establishment of high performance standards for these groups.

The NRRA board will meet in November, when it is expected to schedule the next annual meeting.

For more information about the NRRA, contact Leslea Dummer at Donner Specialty Markets Inc., 4505 S. Wasatch Blvd., Suite 310; Salt Lake City, Utah 84124; 800-999-4505 or 801-277-4747.



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members; $295 for non-members. National Assn. of Health Data Organizations, 316 Pennsylvania Ave. S.E., Suite 202, Washington, D.C. 20003; 202-546-5881.

NOV. 9-10. Legal Malpractice Litigation institute in San Francisco, sponsored by the American Bar Assn.'s Section of Tort and Insurance and Division for Professional Education; $395 for TIPS members; $345 for ABA Young Lawyers Division, $425 for other ABA members; $450 for non-members; $75 for law students. ABA Division for Professional Education, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

NOV. 9-10. Third International Reinsurance Congress in Hamilton, Bermuda, co-sponsored by Hawksmere Ltd. and Coopers & Lybrand; $750; $720 for each additional registrant from same organization. Hawksmere Ltd., 12-18 Grosvenor Gardens, London, England SW1W ODH; 01-824-8257.

NOV. 10. Assessing Vendors Workshop in San Summit, N.J., sponsored by Health Research Institute; $250. **Also Dec. 7** in Chicago. HRI, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

NOV. 10. Retiree/Catastrophic Workshop in Summit, N.J., sponsored by Health Research Institute; $250. **Also Dec. 8** in Chicago. HRI, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

NOV. 11-12. Medical Staff Law Update in Chicago, sponsored by the American Bar Assn.'s Section of Tort & Insurance Practice and Division for Professional Education; $390 for TIPS members; $350 for members of the ABA Young Lawyers Division; $425 for other ABA members; $200 for government employees; $75 for law students. ABA Division for Professional Education, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

NOV. 11-15. 21st Annual National Conference of Insurance Legislators Conference in Austin, Texas; $150 for legislators and staff; $25 for spouses. LaVerne Cantwell, NCOIL, 1776 Church View Drive, P.O. Box 217, Brookfield, Wis. 53008; 414-782-6669.

NOV. 12-15. 13th Annual Conference of the Assn. of Risk & Insurance Managers of Australia in Sydney, New South Wales; $575 Australian ($452) for IFRIMA members; $625 Australian ($531) for non-members. Dart Associates, P.O. Box 1197, North Sydney, New South Wales 2059; telephone 02-929-3628; fax 02-929-0446.

NOV. 13-14. Understanding Reinsurance Contract Language course in New York City, sponsored by Executive Enterprises Inc.; $990. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

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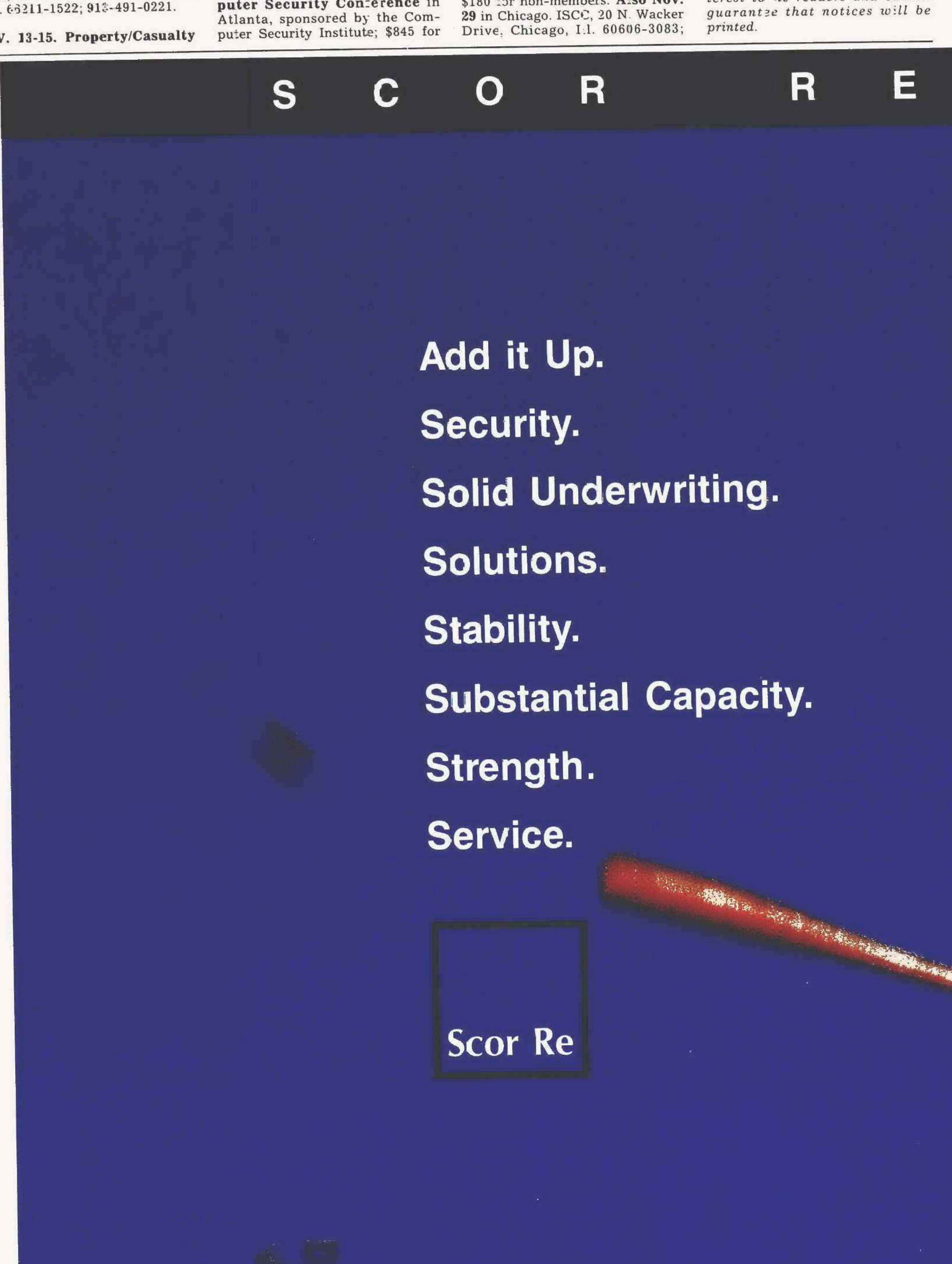

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Amtrak wins guaranty fund coverage

By JUDY GREENWALD

WASHINGTON—The District of Columbia Insurance Guaranty Assn. is appealing a federal court ruling that quota-share excess insurers do not have to cover the liabilities of an insolvent quota-share insurer on the same policy.

The guaranty association must pay Amtrak $367,000 for two claims covered by an excess insurance policy that was partially underwritten by insolvent Transit Casualty Co., according to a summary judgment order by U.S. District Court Judge Stanley S. Harris.

The guaranty fund had argued that Amtrak should have tried to force the other quota-share insurers to cover Transit's obligation.

If it is upheld, the ruling probably will lead to an additional assessment of insurers, said Paul Gulko, president of Guaranty Fund Management Services in Boston, which manages the Washington, D.C., guaranty fund.

The case stems from two train accidents, one March 5, 1984 in Kittrell, N.C., the other July 7, 1984 in Essex Junction, Vt. (*BI* July 30, 1984; *BI* July 16, 1984).

At the time, Amtrak self-insured the first $1 million of loss. Losses up to $3.5 million were insured by Mutual Fire Marine Inland Insurance Co., National Union Fire Insurance Co. of Pittsburgh and International Surplus Lines Insurance Co.

A layer to $6 million excess of $3.5 million was insured by Transit Casualty (30%), Royal Group (30%), National Union (25%) and underwriters at Lloyd's of London (15%).

Amtrak submitted proofs of losses totalling $3.7 million for the Kittrell accident and $5.6 million for Essex Junction. In October 1985, the insurers agreed to pay their shares of the losses, but Transit Casualty was placed into receivership shortly thereafter (*BI*, Dec. 2, 1985).

Mutual Fire had paid before it was put into rehabilitation.

The guaranty association was asked to pay about $67,000 in connection with the Kittrell loss and $300,000, its maximum permissible claim, on the Essex Junction loss.

The guaranty fund refused, arguing that:

- Amtrak should have recovered up to the policy limits from solvent insurers on the second excess layer.
- Amtrak's recoveries from first excess insurers, plus the amount it should have recovered from second-layer excess insurers, would eliminate any guaranty fund obligation.

The guaranty association argued that "by failing to demand, to the extent of litigation, if necessary," that other second excess layer policies pay up to their policy limits to cover Transit's obligations, Amtrak "did not exhaust its rights under such other policies."

Though he found that phrases in the policies supported that position, Judge Harris wrote, "In looking at the entire contract and the entire context of the policies at issue, the Court concludes that the second level policies do not require that the other second level insurers increase their contracted-for-percentages of loss by assuming the loss originally covered by Transit."

For example, the policies "expressly state that the underwriters are 'severally and not jointly liable,' " for losses, the judge wrote.

As association members, the insurers also knew that the guaranty fund takes on the obligations of an insolvent insurer, said Judge Harris. "Given this factor, plaintiff's reading of the contracts is illogical. To construe it in such a manner would be totally to re-create the risk that each underwriter agreed to bear."

Payments by other first or second excess layer insurers do not reduce the association's obligation, he held.

Praising the ruling's "solid legal reasoning," Amtrak's deputy general counsel, Mike Kerrine, said the ruling was "right on target."

The court "misinterpreted the excess policies," said Joseph Tanski, of Hutchins & Wheeler in Boston, who represented the guaranty association. Both policies "clearly provide" that other insurers on an excess layer "move over and pay what an insolvent insurer would pay," he contends.

He compares the Amtrak case to others in which excess insurers have been required to "drop down" to cover the claims of insolvent insurers.

The Massachusetts Supreme Judicial Court ruled in 1987 that two umbrella insurers must pay losses of two policyholders whose primary insurers became insolvent (*BI*, June 1, 1987).

"The principle's the same," he said. "I think that the court misinterpreted the guaranty association statute by refusing to hold that other insurance recoveries reduce guaranty association obligations."

Other state courts, including California's, have ruled that excess insurers do not have to drop down to cover liabilities of insolvent primary insurers. The California state court ruling, however, involved claims for long-latent disease, leading the court to conclude that all primary policies should pay before the excess insurers (*BI*, May 16, 1988).

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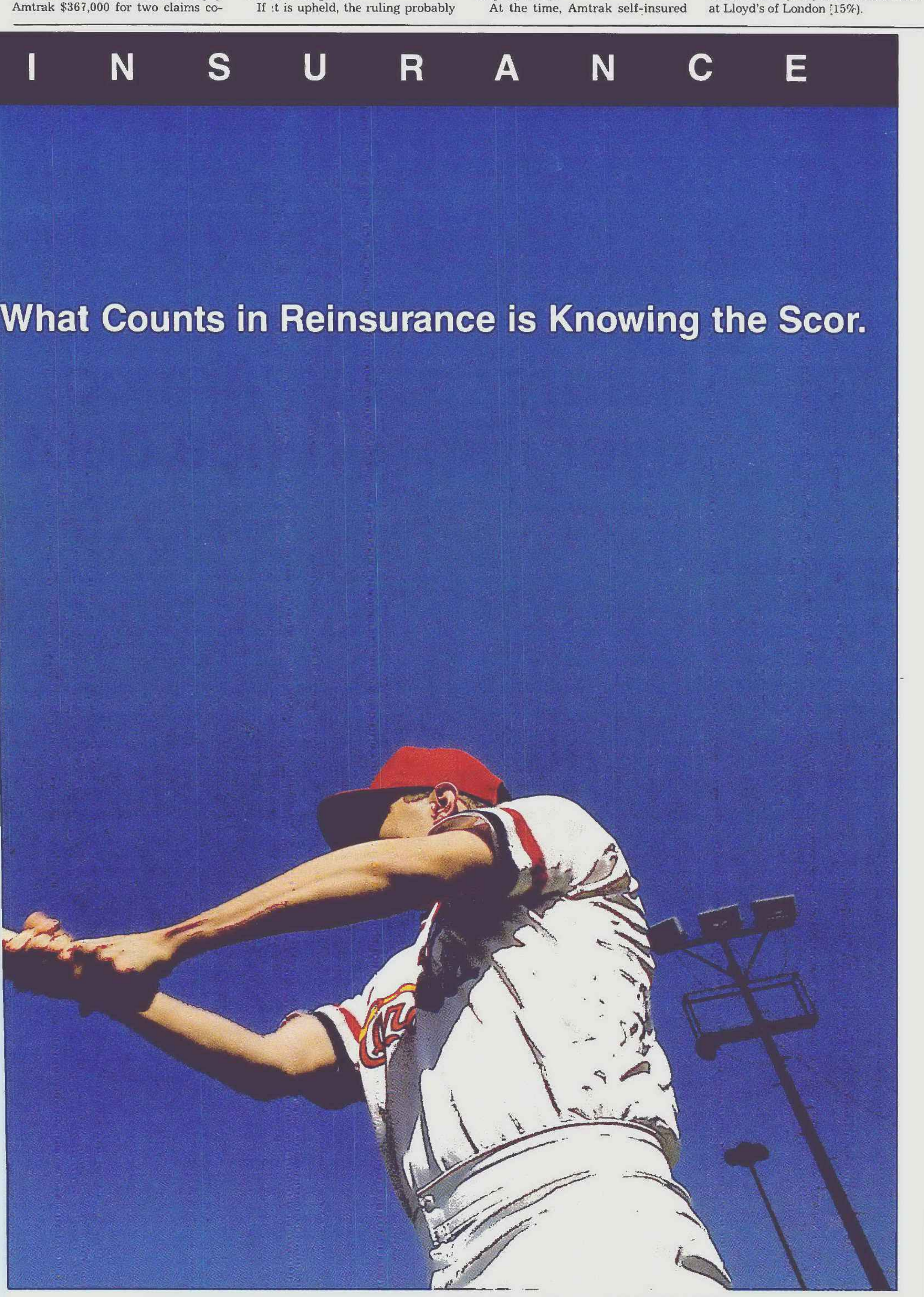
District of Columbia Insurance Guaranty Assn. vs. National Railroad Passenger Corp., U.S. District Court for the District of Columbia; No. 87-3169.



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Canadian D&O study

Continued from page 3

action suits. The advent of those two items could increase litigation" against directors and officers, he said.

In addition, the Canadian legal environment could become more volatile as the number of large investors in corporations increase. This could generate more shareholder-initiated suits against directors and officers, Mr. Brewerton said.

And, the survey notes that Canadians in general are becoming more aggressive litigants.

Survey respondents also reported on the source of D&O claims; policy limits, deductibles, retentions and premiums; changes in policy conditions in 1989 compared with 1988 policies; and insurers.

A total of 626 corporations and trade associations were surveyed by Wyatt in the first quarter of 1989. Of these, 501 completed the survey.

This was the first year Wyatt surveyed Canadian companies separately from U.S. companies.

The most prevalent types of business among the participants in the Canadian survey were banking, finance and leasing, 23%; manufacturing, 20.7%; insurance, 8.8%; and merchandising, 6%.

Of the 501 Canadian survey respondents, only 25 reported that they were hit with D&O claims between 1979 and 1988, and only 37 claims were filed against the companies.

Of these 37 claims, 21 were closed as of the first quarter of 1989, and only eight of the closed claims, or 38%, involved payments to claimants.

U.S. companies fared nearly as well over the 1979-1987 period, reporting that 40% of D&O settlements involved payments to claimants.

The largest D&O settlement among Canadian respondents was $4.5 million and the smallest settlement was $25,000, with settlements resulting in payments averaging $975,375 per settlement.

However, when all claims were considered, the average settlement was $371,571.

The survey of U.S. firms found that settlements resulting in payments to claimants averaged nearly $2 million per settlement, about twice as large as the Canadian average.

The average cost per claim in the United States when all closed claims were considered was $804,869.

Legal expenses to defend claims were incurred for 19 of the 37 claims in the survey, and the average cost to defend a Canadian D&O claim was $344,412.

Mr. Brewerton said the average defense cost figure includes cases in which no payment was made to a claimant.

The U.S. survey found defense costs on closed claims averaged $336,000.

The Canadian survey found that larger companies tend to have more claims.

For example, the smallest 200 of the survey participants in terms of assets reported only four claims, while the largest 134 participants reported 27 claims.

According to the survey, while 20% of the Canadian companies with $1.5 billion to $5 billion in assets were hit with D&O claims and nearly 2.5 claims on average were filed per 100 companies in this category, only 8% of the next largest group of companies in terms of assets—$600 million to $1.5 billion—were hit with claims, and fewer than 1.5 claims were filed per 100 companies in this category.

However, D&O claims were filed against 12% of the largest Canadian companies surveyed—those with more than $5 billion in assets—and about 2.25 claims on average were filed per 100 companies in this category (see chart, page 3).

Publicly traded Canadian companies reported a much higher D&O claim frequency than nonpublicly traded companies, according to the survey. Twenty-eight publicly traded companies incurred the 37 reported D&O claims for the 10-year period, while privately held companies reported no claims.

Meanwhile, nearly 9% of the surveyed Canadian companies with wholly owned U.S. subsidiaries were hit with a D&O claim, and slightly more than 12 claims were filed per 100 companies in this category, the survey reports.

By contrast, only slightly more than 3% of the surveyed Canadian firms without a U.S. subsidiary were hit with D&O claims, and about five claims were reported per 100 companies in this category.

Canadian firms that were involved in merger and acquisition or other corporate restructuring activities over the last five years also reported a greater claims frequency than companies that did not restructure in any way.

For example, 7% of the surveyed companies that were involved in merger or other restructuring activities between 1984 and 1988 were hit by D&O claims, the study reports. And, 11 D&O claims on average were filed per 100 companies involved in some sort of restructuring activities in the five-year period, according to the survey.

By contrast, about 2½% of the surveyed Canadian firms that were not involved in restructuring activities during this period were hit with D&O claims, and about 3 claims on average were filed per 100 companies in this category.

Surprisingly, the survey reports that D&O claims were filed against a greater percentage of companies that did not report an aftertax loss between 1984 and 1988—6.5%—than those companies that reported an aftertax losses—4.5%.

However, 9.2 claims on average were filed per 100 companies with aftertax losses, while only 8.7 claims on average were filed per 100 companies with no aftertax losses, the survey points out.

Canadian firms in the oil and gas industry reported the highest susceptibility to D&O claims among various industry groups surveyed, with about 24% of the oil and gas firms being hit with D&O claims between 1979 and 1983.

In addition, D&O claims were filed against about 20% of the utilities, about 17% of transportation companies, and 10% of the forest industry and professional services companies surveyed.

Canadian survey respondents identified the source of 20 of the 37 D&O claims they were hit with over the 10-year period.

Of the 20 claims, shareholders generated 13, or 65%; customers generated four, or 20%; and competitors filed three claims, or 15%.

The survey found that slightly more than half of the Canadian respondents—286, or 57%—purchased D&O liability insurance.

The likelihood of purchasing D&O coverage varied according to the type of business involved.

Among banking, finance and leasing businesses, 82% purchased D&O coverage; among professional services firms, 80% purchased coverage; utilities, 73%; and forest industries, 70%.

By type of ownership, 72% of the publicly traded participants purchased D&O coverage, while 95% of non-publicly traded companies purchased coverage. Of the government-owned participants, 15% reported purchasing D&O coverage.

The reasons for not purchasing D&O coverage cited by the 215 respondents were varied.

Thirty-nine percent reported that they saw no need for D&O coverage; 21% thought the cost of coverage was too expensive; 12% were advised by legal counsel not to buy the coverage; 6% found the terms of the coverage too limited and 5% said the coverage was not available.

The remaining 17% listed other reasons or did not respond.

"What really brought to light the fact that the Canadian D&O market is soft is the small percentage of companies that said availability was the reason they didn't purchase coverage," Mr. Brewerton said.

'What really brought to light the fact that the Canadian D&O market is soft is the small percentage of companies (5%) that said availability was the reason they didn't purchase coverage,' says Wyatt's Mr. Brewerton.

Canadian respondents purchased D&O policies with limits ranging from $250,000 to $110 million, and respondents on average purchased $8.9 million in limits.

Surveyed companies purchasing the highest limits were transportation companies, which purchased $25.4 million in limits on average; forestry companies, which purchased $25 million in limits on average; utility companies, which purchased $20.7 million in limits on average; and oil and gas companies, which purchased $20.5 million in limits on average.

By types of ownership, publicly traded Canadian companies with more than 500 shareholders purchased the highest average limit: $17.5 million. Publicly-traded companies with fewer than 500 shareholders purchased $8.7 million of D&O limits on average; government-owned concerns purchased $7.3 million in D&O limits; and non-publicly traded companies purchased $3.7 million in limits.

Canadian respondents paid about $75,000 on average for both personal director and corporate reimbursement D&O coverage. All but 40 of the 286 Canadian companies that purchased D&O coverage said they purchased both personal director and corporate reimbursement coverage.

The other 40 companies purchased only personal director coverage and paid an average premium of $51,168.

Companies with more than $5 billion in assets paid the highest D&O premiums: about $460,000 on average.

Companies with $1.5 billion-$5 billion in assets paid about $250,000 in premiums on average; companies with $600 million-$1.5 billion paid slightly more than $100,000 on average; and companies with $600 million or less in assets paid $50,000 in premiums or less on average.

Transportation companies reported paying the highest premium among Canadian industries: $312,833 on average.

Companies in the oil and gas industry paid $209,556 on average and utility companies paid $154,192 on average.

Trade associations reported paying the lowest premium: $1,966 on average.

The survey also shows average premiums paid for selected primary coverage limits.

For example, for a personal and corporate reimbursement D&O policy with $1 million in primary limits, the surveyed companies paid $7,072 on average.

For $5 million in limits, companies paid $42,350 on average, or $8,470 per $1 million of limits.

For a policy with $10 million in primary limits, the companies paid $83,147 on average, or $8,315 per $1 million in limits.

For a policy with a primary limit of $25 million, the companies paid $259,522 on average, or $10,381 per $1 million in limits.

The survey notes that of the Canadian companies that provided information about premium changes in 1989 from the previous year, 61% reported a reduction, 22% reported an increase and 17% reported no change in their annual D&O premium.

The survey noted that premiums for both types of coverage paid by Canadian companies of equal asset size and in the same industry vary widely according to, among other things, the limits purchased and claims experience.

A deductible of $15,834 for personal director coverage was reported by 77% of the companies that bought D&O coverage.

And, only 10% of the companies reported an aggregate retention for personal director coverage, which was $23,571 on average.

Approximately 93% of the survey respondents that purchased corporate reimbursement coverage reported a $300,000 deductible on average.

Only 3% of the companies also reported having an aggregate retention on their corporate reimbursement policies.

The companies also reported that coverage exclusions either were narrowed or remained unchanged.

For the companies in Wyatt's survey, Chubb Insurance Co. of Canada wrote both the greatest percentage of D&O policies and the highest percentage of premium: 22% and 35%, respectively.

By premium volume alone, American Home Assurance Co. ranked second, writing 20% of the Canadian respondents' premium.

Insurers represented by ENCON Insurance Managers Inc., a D&O underwriting facility, and Guarantee Co. of North America wrote 7% of the premium volume.

Stewart, Smith (Canada) Ltd. placed 4% of the premium volume; Kansa General Insurance Co. wrote 3%; and Reliance Insurance Co. wrote 2%.

The remaining 22% was written by various other insurers.

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Copies of the "1989 Wyatt Canadian Directors and Officers Liability Survey" are available for $500 from Tracy Leach, The Wyatt Co., Suite 1700, 150 York St., Toronto, Ontario M5H3S5; 416-862-0393.

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Tax breaks pushed for long-term care

Washington

By ADRIENNE C. LOCKE

Existing tax laws are not clear on the treatment of employer-provided long-term health care benefits, says the president of a life insurance trade association.

Clarification and possible changes in tax laws are needed to encourage employers to provide workers with long-term health care benefits, Richard S. Schweiker of the American Council of Life Insurance in Washington, D.C., testified before the U.S. Bipartisan Commission on Comprehensive Health Care.

Businesses are "ready and able to provide innovative cost-effective insurance arrangements" to help meet the increasing need for long-term health care financing but current tax laws make it difficult to do so, he said.

Mr. Schweiker also called for allowing individual retirement funds to pay for needed long-term care without taxing the withdrawal of funds.

Some of the needed tax clarifications and changes according to Mr. Schweiker, are:

- Ensuring that employer contributions to long-term care benefits are not included in determining an employee's pay.
- Allowing the use of IRA assets and pension payments to purchase long-term care insurance without a tax liability.
- Allowing coverage under long-term care policies as a benefit under cafeteria plan provisions so employees can pay for the insurance with pretax dollars.

The health care commission, also known as the Claude Pepper Commission, is seeking public opinion on the problems of the health care delivery system.

Chevron fined

The Labor Department last month proposed $877,000 in fines against a subsidiary of San Francisco-based Chevron Corp. for 109 alleged willful safety violations and five alleged serious violations following an investigation into a fire at a California refinery earlier this year.

Occupational Health and Safety Administration inspectors discovered the alleged safety violations at a Richmond, Calif., facility after an April blast in a hydrogen gas reactor seriously burned three workers.

The workers were not wearing fire resistant clothing at the time.

"Chevron knew of the need for protective equipment and clothing for employees," yet failed to provide even the most basic protection, said Secretary of Labor Elizabeth Dole in a statement announcing the proposed fines.

As a result of other fires at the refinery, workers and union representatives have requested protective fire equipment for several years, OSHA contends.

Chevron has until Wednesday to contest the citation and penalties. ■

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401(k) survey

Continued from page 3

of service also varied among employers.

Nearly two-thirds said they had no minimum age requirement for participants and 28.7% said they required participants to be at least 21. Another 4.1% said they required participants to be at least 18 years old; 0.5% had a minimum age requirement of 19 years of age; and 0.5% required participants to be at least 20 years of age.

More than half of the employers —55.6%—require participants to have at least one year of service; 18% said they had no minimum service requirement; and 17.5% require at least six months.

Buck found that 8% of employers believed they would need to expand eligibility requirements to meet new federal non-discrimination standards. The remainder said no changes would be needed.

In response to government restrictions on employers' abilities to expand contribution provisions, Buck also queried the employers on plan contribution provisions.

Nearly all respondents—99.2%—said deferral amounts were based on a percentage of base pay; 62.3% also used an overtime or shift differential; 52.3% also based amounts on commissions; 48.5% also based amounts on incentive compensation; and 9.8% cited other factors.

In addition, 71.7% said their 401(k) plans accepted rollover contributions from employees' other retirement plans and 28.4% said theirs did not.

Employers increasingly are limiting or eliminating employees' ability to make aftertax contributions to 401(k) plans, the survey found.

For example, 56.5% of employers said their 401(k) plans do not allow employees to make aftertax contributions, up from 46.2% two years earlier.

In determining employer matching contributions to 401(k) accounts, 62.7% of employers match employees' pretax deferrals only. Another 18.5% match both pretax deferrals and aftertax contributions; 10.8% use a mixed approach; 4.8% contribute without regard to employees' contributions or deferrals; and 3.2% contribute by matching employees' aftertax contributions only.

'Employers and employees still see 401(k) plans as the best game in town. When you consider the employer matching contributions and the advantages of saving on a pretax basis, you can't go wrong,' says Frederick Rumack of Buck.

The most popular employer matching contribution—used by 39.2% of respondents—is 50 cents per dollar of employee pretax deferrals. Another 20.3% match at a rate of 25 cents on the dollar, while 15.8% use a special formula and 12.2% match 100% of employee deferrals. Only 10% match at less than 25 cents on the dollar and 2.3% match at 75 cents on the dollar.

On employee aftertax contributions, 38.5% of the employers match at a rate of 50 cents on the dollar; 20.5% use a special formula; 12.8% match at 25 cents on the dollar; 11.5% match at less than 25 cents on the dollar; and 9% match 100%.

Just over half the employers—51.1%—reported matching a maximum of 6% of employees' pretax deferrals. Likewise, the most popular maximum percentage of aftertax contributions matched by employers is 6%, as reported by 62.5% of the employers.

And 79% of employers said they make contributions in cash; 14.4% make them in stock; and 6.6% use a combination of the two.

The new ADP and ACP testing rules in the Tax Reform Act of 1986 on 401(k) deferrals caused a cutback in contributions by highly compensated employees at 49% of the employers in 1988, up slightly from 48.6% in 1987.

Most of the employers, 38.1%, monitor employee deferrals on a quarterly basis to ensure passage of the ADP test.

And 38.6% of employers also monitor on a quarterly basis employee aftertax and employer matching contributions to ensure passage of the 401(m) contribution percentage tests.

Nearly 60% of employers said their plans currently meet the nondiscrimination tests; 19.3% said their plans failed, and 21.8% said they didn't know.

Likewise, 60.2% of the employers said their plans passed the ACP test, while 14.2% said their plans failed and 25.5% didn't know.

Along with various contribution provisions, investment vehicles under 401(k) plans were surveyed.

The survey found that 34% of employers offer a total of three investment options; 24.5% offer four options; and 19.2% offer two.

Forty percent of employers permit plan members to change investment elections quarterly; 30.3% of companies allow semiannual changes; and 10.6% permit changes on an annual basis.

"Adding a loan feature to the plan is a big component" in making plans more attractive under new federal restrictions, said Mr. Rumack.

Adding a loan feature to 401(k) plans more often increased participation by non-highly compensated employees than by highly compensated employees, the survey shows.

About 45% of employers reported that plan participation by non-highly compensated employees increased as a result of adding a loan provision, double the increase for highly paid employees.

Contribution levels to 401(k) plans also were more likely to increase for non-highly compensated employees than for highly compensated employees when a loan provision was included. One-third of respondents reported higher contribution levels by non-highly compensated employees, compared with 20.1% for highly compensated employees.

Most employers—90.7%—do not permit loans of more than $50,000, and nearly half do not permit loans of less than $1,000. Fifty-four percent of employers permit loans equal to 50% of an employee's vested account balance.

Among employers with loan provisions, five years is the most popular maximum term for a home loan, offered by 34.3% of employers. Nearly all employers with loan provisions set five years as the maximum length of a non-home loan, the survey found.

A total of 58.2% of employers require employees to repay all loans upon termination of employment.

The greatest percentage—32.9% —of the employers applied an interest rate to 401(k) loans determined by the prime rate plus or minus a number of points.

And, 91.9% of employers reported that interest paid on loans under the plan goes to participants' account; 7.7% treated loan interest as a plan's general investment funds; and 0.4% used the interest in a combination of both ways.

The survey also found that 88.8% of employers permit employees to make hardship withdrawals and 70% of employers restrict these withdrawals to funds accumulated by employees' elective deferrals to 401(k) accounts.

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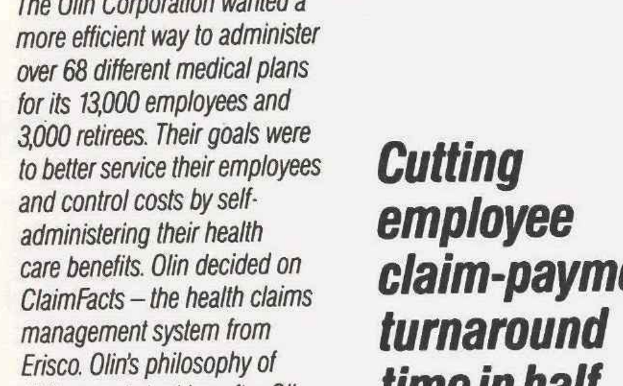
Copies of "Current 401(k) Plan Practices: A Survey Report," can be obtained for $150 each from Carolee Martin, Manager of Marketing, Buck Consultants Inc., 500 Plaza Drive, Secaucus, N.J. 07096; 201-902-2555.



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Most defined benefit plans exceed funding limit: Study

By DONNA DiBLASE

Most defined benefit pension plans exceeded their full funding limitation in 1988, a recent survey shows.

However, nearly 21% had unfunded current vested liabilities, forcing them to pay nearly $3 million in premium surcharges to the federal Pension Benefit Guaranty Corp. in 1988, says the survey by New York-based Buck Consultants Inc.

The survey, "OBRA '87: A Survey Report," examines the funding characteristics of 465 defined benefit pension plans offered by 124 employers in the first year following enactment of the defined benefit pension plan provisions of the Omnibus Budget Reconciliation Act of 1987.

Among many other things, OBRA:

- Increased the flat-dollar PBGC premium paid by defined benefit pension plan sponsors to $16 per participant from $8.50 per participant.
- Established an additional PBGC premium of $6 per $1,000 of unfunded vested current liability.
- Limited employers' annual maximum tax-deductible contributions to their pension plans to 150% of the plan's current liabilities (*BI*, Jan. 25, 1988).

Under the new PBGC rate, annual premiums ranged from $352 to $2.96 million.

The Buck survey found that 53.3% of the plans exceeded the full funding limitation for 1988. As a result, employers were unable to take tax deductions for their contributions to these plans.

"A large percentage of plans have reached or exceeded these levels," said Larry Wiltse, director of forecasting and planning for Buck in New York.

However, 20.9% of the 465 plans paid an additional PBGC premium because they did not meet the full funding limits. These plans were sponsored by 35, or 28%, of the 124 responding companies.

The remaining 25.8% of the plans neither exceeded nor fell short of funding limits.

The total 1988 dollar cost of the flat $16 per-participant PBGC premium for all 465 plans totaled more than $16 million, according to the survey.

Under the old $8.50 per-plan-participant PBGC premium, the total dollar cost for the plans would have been more than $8 million, or slightly less than half of the cost under the new premium rate, the survey notes.

Under the new PBGC rate, annual premiums paid by each plan ranged from as little as $352 to as much as $2.96 million.

A total of $2.8 million was paid by the plans that were underfunded, and thus were required to pay additional PBGC premiums, the survey said.

The additional amount for underfunding paid per plan ranged from $108 to $1.17 million.

Fifty-two percent of the plans reported that they use plan assets to pay PBGC premiums, while 46% use other corporate assets to pay PBGC premiums. Only 2% use both plan and corporate assets to pay the premiums.

"It's interesting to note that half of the plans pay PBGC premiums out of plan assets. Particularly with the high percentage of overfunded plans, many of them are using excess assets to pay PBGC premiums," Mr. Wiltse noted.

The survey also asked the employers if they have made any significant change in their investment practices to reduce the risk of having to pay additional PBGC premiums because of unfunded currently vested liabilities.

"We found that a relatively small percentage of plans have made some changes in investment planning in response to reducing the risk of paying increased PBGC premiums. This is something we will follow," Mr. Wiltse said.

For example, of 115 employers who answered the question, only 3% said they had made any investment planning changes, while 97% reported that they did not make changes in their investment practices.

In addition, the survey asked employers if they took any official action to express to Congress whether they support or oppose OBRA '87.

Of the 116 employers that answered the question, only 7% said they took official action, while 93% said they took no action.

Of the 124 survey respondents, 115 reported the exact number of plans they sponsor.

Of those, 54% sponsor only one plan, while the remaining 46% sponsor more than one plan. The number of plans sponsored by one employer ranged from one to 50.

The number of employees covered by defined benefit pension plans in the survey ranged from 22 to 185,000. The greatest percentage—27%—of the plans covered fewer than 750 employees.

Twenty-four percent of the plans covered between 1,500 and 7,499 employees; 12% covered between 750 and 1,499 employees; another 12% covered between 7,500 and 14,999; 9% covered between 15,000 and 24,999 employees; and 7% covered more than 25,000 employees.

Nine percent of the employers did not respond to the question.

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Copies of "OBRA '87: A Survey Report," can be obtained for $25 each from Carolee Martin, Manager of Marketing, Buck Consultants Inc., 500 Plaza Drive, Secaucus, N.J. 07094; 201-902-2555.

AXA Group

Continued from page 3

animals and a plaque displaying small tusks.

"And, as a small company you either have to stay in a niche or you have to disappear or you have to become big," said Mr. Bebear. "So my strategy has been to try and become more international and bigger," he said. "We want to be more international and have more than 50% of our business outside of France."

Currently, two-third's of AXA's premiums are written in France, according to Mr. Bebear, even though the company controls 42 insurance and reinsurance companies throughout Europe and North America.

"But I don't want 50% of our business done in one country," he said.

"So we try to buy something in North America" and continue to search in the Far East and Europe.

"I know that the Far East will be a very big market in 20 years' time, but you have to be there now in order to do business when the market will explode," he explained.

"We want to be among the Top 20 insurers, because I think you will have 20 companies which will dominate the world, and I want to be one of those companies."

The group will write life and non-life lines and commercial and personal lines, Mr. Bebear said.

"When you are a big international group, you have to be in all kinds of insurance businesses. You cannot specialize, or it will be a mistake."

Currently, AXA's business is about 58% property/casualty/marine/aviation, 37% life and 5% reinsurance.

Mr. Bebear is considered by many insurance executives to be one of the main architects in Europe of the large, international insurance conglomerates that are developing worldwide.

"Perhaps I saw this trend (in France) before the others did," he said.

"I think I contributed in France to putting that idea into their heads. You know, I have been saying to them for more than 10 years that they have to become bigger and bigger; that the market will become more and more international.

"And, at the beginning, they said, 'He's mad,' but now everyone is saying the same thing."

From the time he was studying at L'Ecole Polytechnique—considered the Massachusetts Institute of Technology of France—to be an actuary, Mr. Bebear knew that he wanted to be in the insurance business—a career which many people fall into rather than choose.

His father had suggested that he choose insurance because he had a mathematical mind. "In those days, you didn't argue with your parents," Mr. Bebear said.

In 1958, at age 23, Mr. Bebear joined Ancienne Mutuelle Group of Paris with his career track to chief executive set.

Founded in 1817 as Compagnie d'Assurances Mutuelle contre l'Incendie dans le Departements de la Seine Inverieure et de L'Eure, the company grew by merging with other mutuals and creating new mutual companies. By 1946, the group was a federation of eight mutual companies known as Ancienne Mutuelle.

Before Mr. Bebear became chief executive of Ancienne Mutuelle group in 1974, the company was involved in two transactions: the purchase of Provinces Unies in Canada in 1966 and the entry of the Mutuelle Saint-Christophe into the Ancienne Mutuelle Group.

After Mr. Bebear moved into top management, however, major expansion occurred.

"I knew at that time (in 1974) already that it was necessary to become bigger and bigger because I was convinced that the market would become international," Mr. Bebear recalled.

In 1976, the group created AMRe (pronounced am-ray) reinsurance company in Paris. In 1978, the group changed its name to Mutuelles Unie and acquired French company Mutuelle Parisienne de Garantie. And in 1979, the group created Gamma Re in the United States.

But "the first big jump" was in 1982, when the group bought 83.6% of the Drouot Group in France and its life insurance subsidiary La Vie Nouvelle and foreign subsidiaries to form the largest publicly held insurance group in France and the fourth-largest in the country after three companies controlled by the government, according to Mr. Bebear.

"It was losing a lot of money. But I knew (Drouot) was a very good company, with very good (middle) management but a poor top management," he recalled. "So I changed the top management and in two years it went from $40 million in the red to $40 million in the black."

In 1984, the expanded group—including Mutuelle Unies, Compagnie Financiere Drouot and all of the insurance subsidiaries—decided to call itself "The AXA Group". The name "AXA" serves as corporate name for all the operations which Mr. Bebear controls, even though it is not the legal name of any ultimate holding company.

Mr. Bebear was appointed chairman of AXA and its various units.

The directors thought of the name "AXA" because it is short and can be understood in any language, Mr. Bebear explained. He did not know at the time, however, that there was a racy comic book published in France also called "AXA" featuring a half naked woman on the front cover. However, Mr. Bebear now has a copy of the comic book in his large bookcase in his office.

Two years later, in 1986, AXA launched a successful takeover bid for French insurer Providence et Secours, also called the Presence Group. "And, at the time we became the third-largest French insurance group," Mr. Bebear recalled.

Also, "we started to become more international" and created AXA International, a holding company for all of the group's foreign subsidiaries, he said.

Last April, AXA created UNI Europe to specialize in the sale of insurance through brokers. Up until then, AXA primarily sold its insurance through its thousands of underwriting agents in the country.

In June 1988, AXA bought 28.6% of financial conglomerate Compagnie du Midi, which owned one of the largest private insurance companies in France, Assurances Group de Paris S.A., and U.K.-based Equity & Law Life Assurance Society P.L.C.

AXA and Compagnie du Midi merged their insurance and reinsurance operations to form AXA-Midi Assurances S.A., with Compagnie du Midi owning 99.7% of the new insurance holding company.

AXA has increased its stake in Compagnie du Midi and now owns 43% of the company and therefore around 43% of AXA-Midi, which is the controlling interest.

The merger, which created the second-largest French insurance company, was partially a defense on Midi's part to avoid an unfriendly takeover from Italy's largest insurer, Assicurazioni Generali S.p.A., which currently has a 17% stake in Compagnie du Midi and therefore around 17% in AXA-Midi.

The other 40% of Compagnie du Midi is owned by minority shareholders including institutional shareholders.

Midi Chairman Bernard Pagezy —known in France to have been an arch rival of Mr. Bebear—was reported to have been happy with the AXA-Midi merger.

However, "we merged with the idea that we would refocus the company toward insurance," Mr. Bebear said. Midi until then was 60% insurance and 40% in industry, real estate and other financial services.

"But after the merger, the chairman of Midi changed his mind and decided to continue to diversify the company out of insurance," Mr. Bebear said. A proxy fight took place in the boardroom of AXA with Compagnie du Midi shareholders present and Mr. Pagezy lost. "We had a big fight together and he was obliged to resign at the beginning of this year on Feb. 28," said Mr. Bebear, who became chairman of AXA-Midi.

"So now I am trying to continue to develop our business in insurance; to become more international, which means to increase our business out of France," he explained.

The AXA Group plans to sell most of Compagnie du Midi's non-insurance related operations, except its wineries because Mr. Bebear is very fond of fine wine. "I was born close to the Bordeaux region," he said. And although the wineries only count for 0.2% of the company's profits, "we talk a lot about them. It would be interesting to buy a winery in California someday," he mused.

Also last year, AXA-Midi bought Canadian-based Home Insurance Co.

Meanwhile, Generali and The AXA Group are expected at the end of the year to form a new holding company, 60%-owned by AXA and 40%-owned by Generali, to hold 60% of Compagnie du Midi and therefore about 60% of the insurance unit AXA-Midi.

Generali and AXA also will form another holding company, in which Generali will have a 60% share and AXA will have a 40% share, to make other acquisitions around the world, he said.

Meanwhile, Mr. Bebear waits for the state insurance commissioners in the United States to decide whether AXA-Midi Assurances and AXA unit La Paternelle Risques Divers will be allowed to purchase Farmers.

'My strategy has been to try and become more international and bigger,' says AXA Group Chairman Claude Bebear. 'We want to be more international and have more than 50% of our business outside of France.'

AXA-Midi reported net worth and reserves totaling 17.6 billion French francs ($2.9 billion) at year-end 1988 while La Paternelle reported net worth and reserves totaling 5.4 billion French francs ($891 million) at year-end 1988.

Last month, Mr. Bebear flew 9,000 miles in the United States, landed 12 times and met about 57 people—including senators, governors, commissioners and journalists—to lobby for the Farmers bid.

However, he has so far not met with the Farmers executives, who are only just getting over the nine-month battle they lost to B.A.T last year. "They know that when they are ready, I am willing to talk with them," he said of the Farmers' executives.

Mr. Bebear will explain to whomever will listen that while Sir James Goldsmith is a raider, AXA-Midi is not.

Further, Mr. Bebear has asked Sir James to drop his lawsuit against the insurance commissioners, which is intended to stop them from barring the Hoylake bid of B.A.T.

"I have asked him to stop the lawsuits because I need to be on good terms with the commissioners," Mr. Bebear said. "I have not been involved in any way with those lawsuits."

If Farmers is acquired, it will be run by the same American management that it has today, Mr. Bebear said. In each country, the day-to-day business must be run according to the laws and practices of the country, he explained.

Mr. Bebear learned the hard way in the United States, however, when he was asked to file the last five to 10 years of accounts of his group's insurance companies with the insurance commissioners and could only file the information in French. "But now we have everything translated in English and put in dollars," he said.

Mr. Bebear said that if AXA-Midi acquires Farmers, "our business would be only to define strategy with them, to help them if they need something to develop their business—to develop synergies between the Farmers Group and us," he said.

"We have things to learn from Farmers and they have things to learn from us because we are in personal lines business, too, and life and commercial business, and we have business in Europe. We perhaps can offer them a network in order to follow their clients out of America, if necessary." ■

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Driver safety program

Continued from page 3
rate-owned outlets—roughly 1,700 of the chain's 5,100 outlets—must complete the safe driving program and pass a 20-question, multiple-choice examination by answering at least 17 questions correctly.

"We have given the program to 25,000 drivers," the spokeswoman said.

At any given time, Domino's has between 70,000 and 80,000 pizza delivery drivers, so roughly one-third of the drivers have completed the program, she noted.

In addition, Domino's "strongly" advises owners of franchised outlets to institute the program, she said.

The spokeswoman noted that many franchise owners have their own driving programs.

As an example of a successful franchise-required safe driving program, she cited a Nevada franchise owner who requires the completion of a driver safety course as a condition of employment and requires drivers who commit a traffic offense to enroll in driving school.

Drivers with second offenses lose their jobs, she said.

However, Domino's has no plans to discontinue its 30-minute delivery guarantee, a company spokeswoman said.

Domino's contends that the speed in the delivery process does not occur on the highway but in the franchise outlet, where pizzas can be made in a few minutes.

Experts, though, are divided as to how effective a driver safety program will be for Domino's.

"It's one thing to say something. It's quite another to" make it operational, said Joseph Kinney, director of the Chicago-based National Safe Workplace Institute and a particularly vocal critic of Domino's safety record.

Steve Oesch, assistant general counsel for the Arlington, Va.-based Insurance Institute for Highway Safety, questioned whether any safety program could overcome what he called "an inherent conflict" in the guarantee.

As long as there is perceived pressure to deliver a pizza within a specified time, drivers—particularly young, inexperienced drivers—will feel that they have to make the deadline even though the $3 penalty does not come out of their pocket, Mr. Oesch contends. That pressure will tempt them to break driving laws, he said.

"The most difficult thing in the safety field is to change behavior," said Dave Ploss, an independent safety and environmental compliance consultant in Northboro, Mass.

Mr. Ploss—formerly safety director of Norton Co. in Worcester, Mass.—could not comment on Domino's particular program. But, he said his experience with safety programs indicates that they can be effective when they are bolstered by follow-up talks, pamphlets and posters.

Jim Solomon, administrator of training for driver improvement programs at the Chicago-based National Safety Council, agreed.

Any successful safety program "has to be ongoing—it has to be continual," he said. Such an ongoing program would feature constant safety reminders, such as posters, pay envelope stuffers that stress safety themes and occasional safety talks, he said.

Because he has not seen the new Domino's program, Mr. Solomon said he could not comment on it. However, he noted that the NSC has "trained scads of trainers for Domino's" over the years.

The Domino's spokeswoman said that all Domino's outlets are required to display a poster where drivers can see it as part of the company's commitment to safe driving.

In addition, E. Scott Geller, a professor of psychology at Virginia Polytechnic Institute in Blacksburg, Va., and one of the authors of the program, said that he and the other authors have urged Domino's to establish a follow-up program.

Domino's new driver safety program features a 63-page booklet.

Mr. Geller said that although the company has not committed to doing so yet, preferring instead to concentrate on getting the current program up and running, the initial reaction to a follow-up program "was not negative."

The National Safety Council's Mr. Solomon stressed that management commitment to safe driving is the most critical component of a successful safety program.

"It must start with upper management. It must start at the top and permeate the entire program," he said, noting that even employees who do not deliver pizzas should participate in the courses.

The final lesson in the Domino's safe driving handbook, "From the Top," is a letter from Michael L. Orcutt, vp-operations, in which he stresses that there is no room for unsafe drivers in the Domino's organization.

"Speeding, careless driving, inattention behind the wheel and any unlawful operation of a motor vehicle are not part of the Domino's Pizza delivery policy and have no place in the Domino's Pizza system. You must drive courteously, professionally and, above all else, safely while you work for Domino's Pizza," Mr. Orcutt wrote.

In addition, "the manager himself must be beyond reproach," said Jerry Zwaga, fleet specialist with Aetna Life & Casualty Corp. in Hartford, Conn.

For example, managers should not peel out of store parking lots, Mr. Zwaga said.

In addition, managers should recognize safe drivers, Mr. Zwaga suggested.

"There's always something to be gained by recognizing that person," Mr. Zwaga said. For example, employees with exemplary driving records could receive a bonus or extra time off, he said.

Mr. Geller, one of the co-authors of Domino's new driving safety program, said he has encouraged the pizza maker to "reward safe driving."

For example, drivers who complete the safety course and have no violations could eventually be made driver trainers, he said. Money alone may not be a sufficient reward, he said.

Indeed, negative reinforcement had been cited as one of the reasons for fatalities involving Domino's drivers.

Some outlets had established "King of Lates" badges that were awarded weekly to the driver who most often missed the 30-minute deadline.

Critics said that this encouraged unsafe driving.

However, the Domino's spokeswoman stressed that these mocking awards were not authorized by the chain.

"We have been working real hard to make sure all of our franchises understand that this is unacceptable," she said.

In addition, the giant pizza maker has instituted a toll-free number for drivers to register complaints with Domino's corporate headquarters if they feel they are being pressured to hurry while on the road, the spokeswoman said.

But, rather than the 30-minute guarantee and the unauthorized mock awards, "Domino's real problem is plain and simple—it's turnover," Aetna's Mr. Zwaga asserted.

He pointed out that high turnover bedevils fast food chains and most businesses that depend on young employees who have just entered the job market.

The Domino's spokeswoman said that the company had no information on turnover.

But, according to Mr. Geller, a Domino's competitor had only nine drivers out of an initial pool of 300 still on the job after a period of three years.

And in Mr. Geller's home town of Blacksburg, Va., Domino's franchise operators have estimated their annual turnover rate at 300%, he said. ■

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Pollution ruling

Continued from page 2
For example, in this case, the policyholder intended to place hazardous chemicals into an unlined waste pond, but the policyholder did not intend for the chemicals to leak into the groundwater or onto third-party property, Mr. Jackson said.

If the judge instead had focused on Broderick's act of placing the hazardous chemicals into the pond, the pollution exclusion would bar coverage, he said.

Because the judge focused on whether the spread of chemicals onto third-party property was unexpected or unintended, there is coverage, he said.

Prior to this decision, all other courts focused on the meaning of the language in the pollution exclusion that states there is no coverage unless the event that causes pollution is "sudden and accidental."

Insurers vigorously argue that the language should be given a temporal meaning, such as happening quickly.

Policyholders nationwide, though, argue the phrase should be interpreted to mean "unexpected" or "unintended," which is how the judge in the Broderick case interpreted it.

Judge Weinshienk interpreted "sudden and accidental" to mean unexpected or unintended.

The ruling is very beneficial to policyholders, Mr. Jackson said.

The ruling could make it easier for policyholders nationwide to win pollution insurance disputes, he said.

Policyholder attorney Nicholas Zoogman of Anderson Kill Olick & Oshinsky in New York agreed: "This ruling will be very favorable to policyholders."

Mr. Zoogman, who also represented the policyholder in the case, predicted that the court's ruling would influence other courts interpreting the pollution exclusion.

"It is an absolute and complete win for policyholders," Mr. Zoogman cheered.

The ruling involved a dispute between Broderick Investment, formerly Broderick Woods Products Co., and its primary liability insurer, Hartford Accident & Indemnity Co. in Hartford, Conn., a unit of the Hartford Insurance Group.

A spokesman from Hartford said the insurer disagrees with the ruling but would not comment further.

A jury trial is expected to begin today in the same court to determine whether Broderick is insured for a government-mandated multimillion hazardous waste cleanup of the pollution. The jury will decide if the pollution was an accident or deliberate.

Broderick is seeking coverage for the cost of cleaning up toxic waste contamination at a former wood treatment facility it owned and operated from 1947 to 1981. Toxic chemicals used to treat the wood at the plant were placed into waste ponds that have since leaked, allowing chemicals to contaminate the groundwater and third-party property.

The U.S. Environmental Protection Agency has ordered Broderick to clean the site under provisions of the Comprehensive Environmental Response, Compensation and Liability Act of 1980, or Superfund.

There are no clear estimates of how much it will cost to clean the site. However, it clearly is a multi-million dollar cleanup, attorneys say.

Broderick had primary comprehensive general liability coverage and umbrella coverage with Hartford from 1976 to 1984. The primary limits varied from $50,000 per occurrence to $1 million per occurrence. The umbrella limits varied from $1 million per occurrence to $2 million per occurrence.

Broderick is claiming coverage in each policy year from 1976 to 1984, arguing that there was third-party property damage in each policy year.

The Broderick case also is noteworthy because the policyholder was able to introduce into evidence the infamous brief involving First State Insurance Co., a subsidiary of Hartford, in which First State argued that the pollution exclusion does not bar coverage for gradual pollution incidents (*BI*, Sept. 11; June 12).

While Judge Weinshienk allowed the policyholder to submit the First State brief as evidence, it is not clear what impact the brief had on her ultimate decision.

Mr. Zoogman speculated that Judge Weinshienk concluded that the First State brief was proof that the policyholder's interpretation of the pollution exclusion was at least a reasonable interpretation.

However, Mr. Jackson said the First State brief was a "minor factor" in Judge Weinshienk's decision.

Meanwhile, the controllers of the two trusts which have held Broderick Investment Co. since the early 1960s have settled with their insurers in the case.

The owner of the company had placed all company stock in two trusts for his children. One trust is controlled by The Colorado National Bank of Denver and the other is controlled by The First Interstate Bank of Denver.

Each bank has liability insurance that responds to claims stemming from trust properties, such as the Broderick property.

Early in the litigation all of the bank's insurers settled for approximately $1.7 million.

The banks' insurers include: USF&G Corp.; Travelers Insurance Co. and Phoenix Insurance Co., units of The Travelers Corp.; Federal Insurance Co., a Chubb Corp. unit; Farmers Insurance Co.; and Aetna Life & Casualty Co.

These types of settlements are usually confidential. But because trust settlements in Colorado must be approved by a probate court, the value of many of the settlements was disclosed.

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Broderick Investment Co. vs. Hartford Accident & Indemnity Co., U.S. District Court for the District of Colorado, No. 86-Z-1033.

Illinois regulator maps approach

Continuing projects to get incoming chief's attention

Mr. Stamp

The new designated director of the Illinois Insurance Department has three projects in mind as he awaits approval of his appointment.

Zack Stamp, the state's designated director of insurance, still has to undergo scrutiny by the Illinois Senate's Executive Appointments Committee.

But having been the governor's chief lobbyist in the General Assembly for the past three years, he says: "I don't really have a problem about meeting anybody (in the committee) for the first time."

Gov. James Thompson tapped Mr. Stamp, 35, to lead the department in September. The governor promoted Mr. Stamp's predecessor, John E. Washburn, to deputy governor after he had served as insurance director for six years.

Although he is in a job that probably will end when the governor leaves office in 1991, Mr. Stamp said he doesn't see himself as just a caretaker.

In fact, there's plenty left over from Mr. Washburn's tenure as the state's chief insurance regulator. Mr. Stamp says he'll begin working on three main priorities as soon as he is confirmed by the Legislature:

• To fully implement the state's Comprehensive Health Insurance Program, the publicly financed insurance plan for the medically uninsurable that was approved by the Legislature in 1986 but has not attracted much public interest since then.

• To carry out Illinois' mandatory auto insurance program, which will go into effect in January.

• To improve monitoring of financially troubled insurance companies doing business in the state.

However, he added, "I think we do a pretty good job" of financial regulation.

In addition, Mr. Stamp must tend to the embers of other issues.

He expects consumer advocates to continue their efforts to persuade the Illinois Legislature to enact Proposition 103-type measures in Illinois, although such a measure failed earlier this year (*BI*, June 12).

The failed measure had called for repealing the insurance industry's limited antitrust immunity in Illinois, rolling back of some insurance rates and changing the regulator's post to an elected—rather than appointed—job.

"I don't see the problems and that is why (such proposals) aren't going anywhere," Mr. Stamp said.

In addition, Mr. Stamp plans to pursue adoption of voluntary standards developed by the National Assn. of Insurance Commissioners to regulate insurer solvency. Those standards were spearheaded by his predecessor and adopted by the NAIC this summer (*BI*, June 19).

The program also lays the groundwork for the NAIC to consider accrediting each state's insurance department, which Mr. Stamp favors.

In addition, he plans to continue the active involvement of Illinois Insurance Department personnel in the NAIC, of which Mr. Washburn was chairman.

Mr. Stamp admits he has no significant experience in the insurance field, with his only previous exposure being a 1981 job with the Illinois Senate's Insurance Committee. But he says the state's hands-off approach to rate regulation "is the best system," and he doesn't intend to tamper with it.

Mr. Stamp earned his spurs in state government through tough business politics and legislative wrangling. He got his first exposure in 1976 as a coordinator in West Central Illinois for Gov. Thompson's first gubernatorial campaign.

After receiving a law degree from Southern Illinois University in 1980, Mr. Stamp joined the Senate Republican staff. He joined the governor's office as Senate liaison in 1985 and was appointed director of legislative affairs the following year.

As Gov. Thompson's chief liaison with the General Assembly, his job was to advise the governor on legislative strategies, keep tabs on the votes for crucial issues "and, really, just communicate—make sure the right people got the word at the right time."

Despite an $8,000 cut in pay, to $60,349, Mr. Stamp is calling his new assignment "the opportunity of a lifetime."

Though a Republican, Mr. Stamp drew praise from Democrats with whom he worked.

"He was very organized, and he didn't make any promises he couldn't keep." said Gary LaPaille, chief of staff to House majority leader Michael Madigan.

James Reilly, former deputy governor and now chief executive officer at McCormick Place, a major Chicago convention center, said: "Zack is a good choice for insurance director because you need somebody who understands government and how it works and who, as regulator, does not necessarily agree with what the industry wants."

Mr. Stamp says he'll vacate the office in 1991, after Gov. Thompson leaves. But he adds: If (Republican candidate) Jim Edgar wins in the next election, I wouldn't want to send a signal that I won't take this job if it's offered."

—Crain News Service

Around the states

Louisiana court upholds damage cap

NEW ORLEANS—The Louisiana State Supreme Court has upheld the constitutionality of a state-imposed cap on non-economic damage awards in medical malpractice cases, making Louisiana the fifth state to uphold such a law.

The law sets a $100,000 limit on the amount of non-economic damages that plaintiffs can recover from doctors, hospitals or other health care providers.

However, plaintiffs can recover as much as $400,000 more from a state-operated insurance fund, the Patients Compensation Fund.

But, plaintiffs' attorney Joseph W. Thomas argued that the cap is unconstitutional because it discriminates between less seriously injured victims, who can be fully compensated within the cap, and those for whom the maximum award allowed is insufficient compensation.

The Supreme Court rejected that argument, noting that courts in four other states—Indiana, California, Nebraska and Virginia—have upheld such caps.

However, the court noted that six states have declared such caps unconstitutional: Idaho, Illinois, Kansas, New Hampshire, North Dakota and Texas.

The Patients Compensation Fund was established in 1975 in response to the growing concern over medical malpractice insurance availability in Louisiana, an Insurance Department spokeswoman said. Its primary purpose is to provide supplemental compensation for more seriously injured victims.

"More than 90% of doctors in Louisiana participate in the fund," she added.

The fund is financed by surcharges applied to medical malpractice insurance premiums paid by doctors, hospitals and other health care providers. The surcharge is a percentage of premium, which varies depending upon the classification of the provider.

For instance, since an obstetrician is considered a higher than average risk, "he'd pay more than a general practitioner," the spokeswoman explained.

A $15 million surplus must be maintained in the fund, she said. However, if the fund exceeds $15 million after all claims and expenses are paid, the Louisiana Insurance Rating Commission and the state attorney general can file to reduce the surcharge.

—By Christine Woolsey

FAIR Plan refunds

NEW YORK—The New York Property Insurance Underwriting Assn., which operates the state's pool for high-risk property insurance, plans to refund nearly $5.2 million to thousands of commercial policyholders in the next few weeks, according to the New York Insurance Department.

The payments from the Fair Access to Insurance Requirements Plan are "a result of better-than-expected results from its book of business," a department statement explained. The scheduled distribution marks the third consecutive year that the plan has returned excess funds to its commercial policyholders.

To date, the FAIR Plan has refunded about $23 million.

The FAIR plan will distribute checks ranging from about $65 to $301 to 31,000 policyholders in four classes of business:

• Small retail establishments.

• Charitable or philanthropic organizations.

• Owners of apartment buildings containing eight or more units.

• Others.

"The only commercial classification not qualifying for the experienced-based distribution this year was the 'Apartments of Eight Units or Fewer' class," said a department spokesman.

Superintendent of Insurance James P. Corcoran said the FAIR plan refunds in recent years should persuade insurers in the voluntary market to offer affordable coverage to plan policyholders. "We urge fire and property insurers in New York to underwrite more business at lower rates in the voluntary market, and thus obviate the need for further NYPIUA policyholder distributions," Mr. Corcoran said.

The FAIR Plan provides fire insurance and other extended coverages to commercial and residential policyholders unable to obtain coverage in the voluntary market.

—By Collin Nash

Health cover pool

COLUMBIA, S.C.—The directors of South Carolina's new health insurance pool will meet Oct. 31 to hammer out a plan of operation.

The South Carolina Health Insurance Pool will "provide health insurance for medically uninsurable people" at a rate initially set at 200% of the "standard premium" when it begins operations on Jan. 1, 1990, said Chief Deputy Insurance Commissioner Suzanne Murphy.

The standard premium will be determined by the rates charged by the five largest health insurers in the state, she said. However, the law establishing the pool does not spell out whether the rate is to be an average.

The pool is not designed to provide health coverage for the indigent uninsured, she noted.

Health insurers doing business in South Carolina will fund the pool through assessments on the amount of major medical insurance they write in the state. However, they will receive dollar for dollar premium tax relief to compensate them for the assessment for the first $5 million in losses suffered by the pool.

If annual losses exceed that $5 million, the premiums will be increased.

The pool's coverage will include a $500 deductible and require a 20% copayment until another $1,500 in out-of-pocket expenses is reached, Ms. Murphy explained.

The pool is governed by an eight-member board of directors. Five of the directors are elected by insurers doing business in the state and three serve by gubernatorial appointment. Two of the governor's appointees must be from outside the insurance industry and one must represent consumers.

—By Mark A. Hofmann

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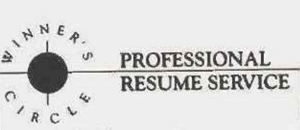

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Vice-Presidents, General Managers and Other Administrative Personnel 4,006

Financial:
Chief Financial Officers and Vice-presidents of Finance 2,795
Secretaries, Treasurers, controllers and other Financial Personnel .. 3,842

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 10,719

Sub-total **24,021**

Associations 554
Government, Unions and Educational Institutions 1,417

Commercial Consumers
Sub-total **25,992**

Insurance Agents and Brokers 10,515
Insurance Companies 7,673
Actuaries, Consultants, Attorneys, Adjusters, Appraisers and Third Party Administrators 3,800
Others Allied to the Field 2,771

TOTAL **50,751**

* Source Business/Occupational breakdown of qualified circulation, May 29, 1989 issue, as submitted to BPA for June 1989 BPA Publisher's Statement.

Promote image with clients: CPCU chief

By LINDA J. COLLINS

NEW ORLEANS—The merits of the insurance industry should be evident in insurers' and producers' everyday contacts with clients, asserts the incoming president of the Society of Chartered Property & Casualty Underwriters.

"We need to put the insurance industry in a better light and help people understand how it operates," said Richard L. Katten, executive vp of The Ferd. Marks Insurance Agency Ltd. in New Orleans.

Mr. Katten will assume the Society of CPCU presidency this week at the group's annual meeting in Anaheim, Calif.

The goal for his tenure is to encourage members to "not only explain why we're a good industry, but to demonstrate why we are a good industry," Mr. Katten said.

For example, "every underwriter, before he makes a decision, ought to think about how that decision would be made if it affected him personally," he explained.

Proposals such as those to amend or repeal the McCarran-Ferguson Act and the passage of California's Proposition 103 have arisen because of the insurance industry's failure to explain its usefulness to the public, Mr. Katten said.

"Getting rid of McCarran-Ferguson will not solve the industry's problems. . . .We tried to throw money at the problem in California with Proposition 103" through advertising and public relations campaigns, but that approach also was unsuccessful, he observed.

"The only thing that will solve the industry's problems is for us to be more responsive to the public—talk to them and explain how we operate" on a one-on-one level, he stressed.

The insurance industry "doesn't have anything to defend or anything to apologize for. We have helped to build the economy, we just need to explain the things we've done" to the public, Mr. Katten added.

Mr. Katten

Most risk managers "know there are good sides and bad sides to the industry," but many consumers do not know that, he said.

Mr. Katten said that the Society of CPCU provides a good forum for different insurance disciplines to get together and discuss industry issues. In addition to insurer and producer members, it also counts risk managers and defense attorneys among its ranks.

And, he pointed out that the Society of CPCU's Intra-Industry Committee has just published a series of guidelines that Society of CPCU chapters throughout the United States can use in planning joint activities with local chapters of the Risk & Insurance Management Society Inc., the organization representing risk and employee benefit managers.

For example, the guidelines state that "chapters may consider the development of joint educational workshops and seminars to be designed and sponsored locally, and/or they may want to consider programs already developed by the Society's Continuing Education Department or Risk Management Section on a national level."

The guidelines also instruct chapters to "consider sharing public relations efforts, profits or losses on the proposed workshops."

Furthermore, the guidelines encourage Society of CPCU chapters to consider tapping the expertise available through local RIMS chapters when selecting research topics.

Another item on the Society of CPCU's agenda for the coming year is a pilot project to show a specific industry what the insurance industry has to offer.

The group will promote itself to that targeted industry and advertise the availability of its members as speakers on various insurance industry topics in an attempt to increase communications with that group. He expects the target industry to be selected before year-end.

If the pilot program proves successful, "we will branch it out into other industries," he said. ■

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1. Sales through Dealers and Carriers, Street Vendors and Counter Sales	23	5
2. Mail Subscriptions	35,692	35,910
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Fetal protection

Continued from page 1

experts.

"The overwhelming evidence in this record establishes that an unborn child's exposure to lead creates a substantial health risk involving a danger of permanent harm," experts on both sides concluded, according to the 7th Circuit's 97-page decision.

In addition, a mandatory policy was necessary because Johnson's previous voluntary policy was not effective, as demonstrated by the fact that at least six women working in high lead exposure areas became pregnant between 1979 and 1983, according to the company.

At least one of those babies had an elevated blood lead level and suffered from some medical problems, including hyperactivity, according to one of Johnson Control's medical experts.

In addition, the company considered—but rejected—the alternative of removing a woman from the high lead area once she became pregnant. That was deemed ineffective because of the frequent time-lag in reporting a pregnancy and the fact that high residual lead levels could damage an unborn child.

However, the company tried to ease the impact of the policy on existing battery division workers, including assuring transferred employees they would not lose pay or benefits.

The UAW lawsuit challenged this policy on behalf of several plaintiffs, including a 50-year-old divorcee and another woman who said that she was voluntarily sterilized to keep her battery division job.

About 135 of the 2,000 UAW members at Johnson Controls' nine plants were women, said Ralph Jones, the UAW's associate general counsel.

Johnson Controls requested summary judgment of the suit, which U.S. District Court Judge Robert Warren granted in January of 1988.

"Society has an interest in protecting fetal safety," he wrote in his decision. The potential abnormalities in female employees' offspring are "too serious for this court to find unimportant," he added.

The UAW appealed the lower court's decision in February 1988. The Allied Industrial Workers of America, which represents employees in a 10th Johnson Controls' battery division facility in Milwaukee, was allowed to intervene as plaintiffs in the appeal. That unit included 110 women.

A three-judge panel of the 7th Circuit heard the appeal and circulated its opinion among all the judges prior to its publication.

That resulted in the full 11-member panel hearing the case, apparently because of a disagreement among the judges over the appropriate ruling.

"Johnson Controls has demonstrated that its fetal protection policy is reasonably necessary to industrial safety," the majority of judges said in their decision.

The company produced facts that demonstrate that it could defend its policy as a business necessity if the case would go to trial, the majority said.

In reaching its conclusion, the majority rejected testimony from UAW medical experts who challenged the findings of Johnson Controls experts and emphasized that the offspring of male employees could also face potential injury.

The UAW "has failed to carry its burden of persuasion" in showing that there were factual questions to challenge such a business necessity defense, the majority wrote.

In addition, the court majority found that being an individual incapable of bearing children is "a bona fide occupational qualification" for the high-lead exposure jobs that supports a fetal protection policy against claims of discrimination.

Attorneys for the UAW are currently considering whether to ask the U.S. Supreme Court to review the case.

Attorneys disagree on whether the U.S. Supreme Court would consider the case.

Stanley Jaspan, Johnson Controls' attorney, emphasizes that the 7th Circuit followed the same standards as previous courts in reviewing whether a fetal protection policy was valid.

Two other U.S. Courts of Appeal—the 4th Circuit and the 11th Circuit—have upheld fetal protection policies. However, the 5th Circuit struck down a fetal protection policy because the employer discharged a pregnant employee rather than placing the employee on leave.

Courts have considered fetal protection policies valid if the employer proves that there was a significant risk of harm to unborn children, that the potential harm was confined to the offspring of one sex and that the company was unable to devise a less discriminatory alternative, said Mr. Jaspan, who is with Foley & Ladner in Milwaukee.

But some legal experts and dissenting judges are concerned by the majority's decision and the effect is could ultimately have in other companies.

"This decision is materially different from other federal (court) decisions," said Joan Bertin, associate director of the Women's Rights Project for the American Civil Liberties Union in New York City.

In the three other federal cases, a "high" burden was put on employers to prove that such a policy was an essential last resort because there were no feasible alternatives, she said.

This decision relaxes the burden on the employer and places a heavier burden on the plaintiff to show why a policy is discriminatory, explained Ms. Bertin.

Mary Becker, a University of Chicago law professor who has written about fetal protection policies, agrees.

"This will immunize a large number of traditionally male jobs from women's ability to integrate them," said Ms. Becker.

In addition, more employers are likely to adopt fetal protection policies in the future as a result of this ruling, according to Ms. Becker and Ms. Bertin.

However, Ms. Bertin says that if the U.S. Supreme Court were to review the case, it would be because there was no trial and the conflicting medical evidence was not sufficiently debated.

On these grounds, she says, the 7th Circuit decision is "very vulnerable to reversal."

Currently, dozens—and perhaps hundreds—of employers have some type of fetal protection policy that applies to women, Ms. Bertin estimated.

However, she knows of no fetal-exposure lawsuits brought by the offspring of female employees, although she is aware of unsuccessful lawsuits by the offspring of male employees.

Judge Richard Posner noted in his dissent from the 7th Circuit decision that "there is a solid medical basis for concern with fetal injury from airborne lead in the concentration found in battery plants, and this concern could in turn cause the employer to worry about being sued by injured children of his employees.

"Such a suit would not be preempted by workers compensation law," he added.

As a result, "the employer would therefore be exposed to full common law damages, punitive as well as compensatory."

In addition, the mother's own negligence in ignoring employer warnings and becoming pregnant while doing hazardous work would not be imputed to the child and therefore would not reduce the employer's liability, he said.

Johnson Controls did not discuss the liability issue in its court documents and its spokeswoman later declined to comment on the issue.

'Johnson Controls has demonstrated that its fetal protection policy is reasonably necessary to industrial safety,' a 7th Circuit majority says in upholding a policy barring fertile women from the battery division.

The majority decision also prompted strong comment from some of the four dissenting judges.

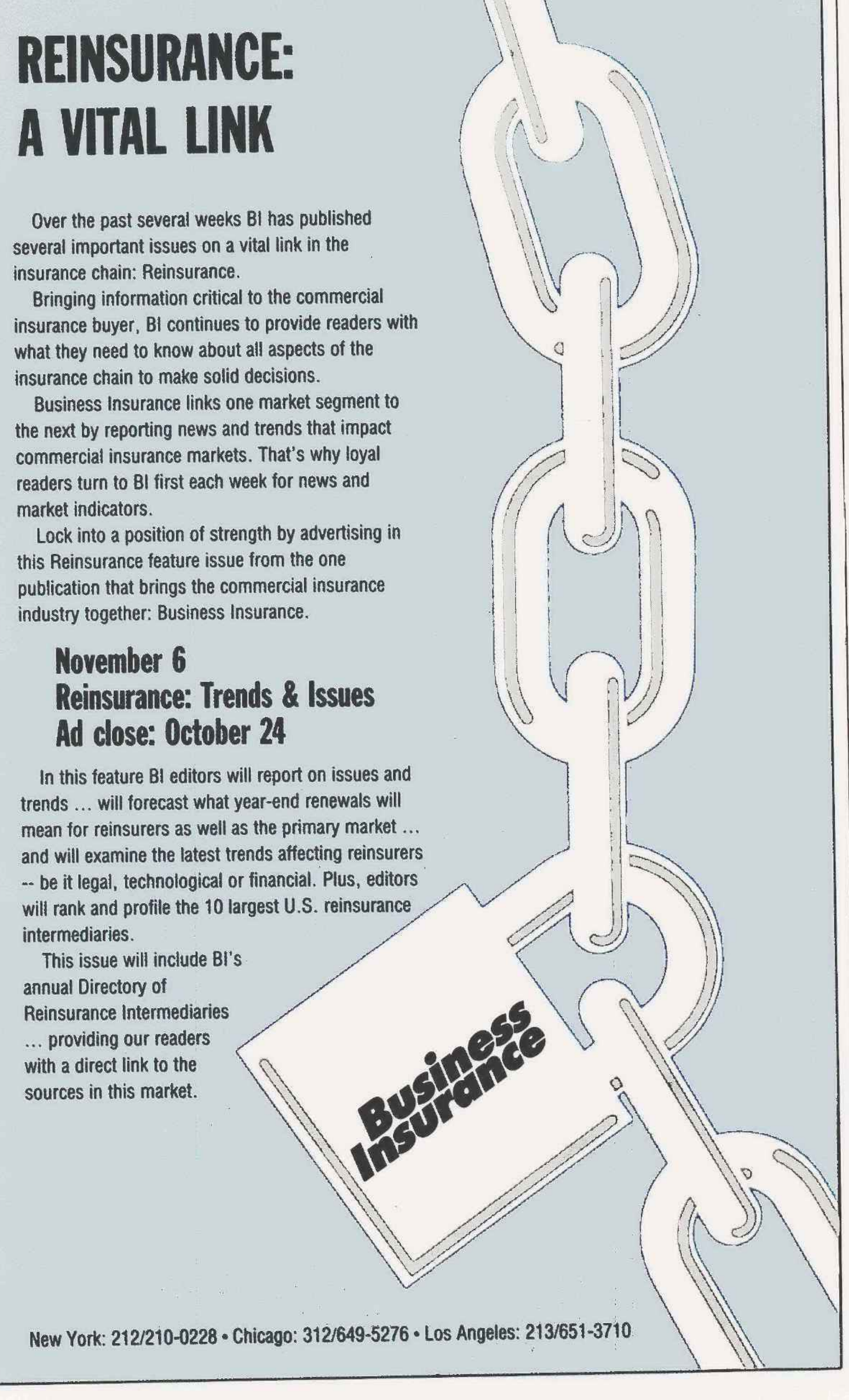
"If the majority is right, then by one estimate 20 million industrial jobs could be closed to women, for many substances in addition to lead pose fetal risks," wrote Judge Easterbrook, quoting the highest estimate of jobs with exposures to hazardous chemicals made by the Bureau of National Affairs in 1987.

"Whether that would happen is of course a separate question; legal entitlements need not translate to action. But the law would allow employers to consign more women to 'women's work' while reserving better-paying but more hazardous jobs for men. Title VII was designed to eliminate rather than perpetuate such matching of sexes to jobs," he wrote.

Judge Posner said "the issue of the legality of fetal protection is as novel and difficult as it is contentious," adding that the appeals court should have required that a trial be held.

"By affirming on this scanty basis we may be encouraging incautious employers to adopt fetal protection policies that could endanger the jobs of millions of women for minor gains in fetal safety and health," the judge said.

In related action, the Allied Industrial Workers union is pursuing similar cases against Johnson Controls before the Wisconsin Equal Rights Division of the Department of Industry, Labor and Human Relations and in state court, said Kenneth Loebel, an attorney with Habush, Habush & Davis, S.C. in Milwaukee, who represents the AIW. ■



Congress

Continued from page 1

These employee benefit measures are crammed into the $14.1 billion deficit reduction bill, which the Senate began debating late last week. How much of the bill will survive, however, was uncertain last week.

Some senators, enraged at the huge girth of the legislation, were attempting to strip provisions that have nothing to do with the bill's purpose: raising revenues and reducing federal expenditures to reduce the federal deficit.

"This trashes the legislative process," declared Sen. William Armstrong, R-Colo. Congressional ignorance of provisions in earlier massive bills led to such "faux pas" as Section 89, he warned.

"Now we are about to do the same thing," Sen. Armstrong complained.

The budget reconciliation process has become an "unmitigated farce," asserted Sen. Orrin Hatch, R-Utah. "What has happened here is atrocious."

Quick congressional approval of the budget reconciliation legislation is essential to meet a deadline—now set for this week—to reduce the federal deficit. If that deadline is not met, automatic federal spending cuts, as required by the Gramm-Rudman law, would take effect.

Legislators want to avoid those spending cuts, which would hit a variety of domestic and military programs.

If the effort to prune the Senate bill is successful, presumably many of the benefit provisions, such as Section 89 repeal, would be removed and would have to be considered at another time.

Regardless of the final shape of the Senate bill when it is approved, congressional conferees still will have to iron out differences between the Senate legislation and another budget reconciliation bill, H.R. 3299, which the House approved earlier this month.

The House bill also is laden with benefit provisions. However, the House budget bill includes an amendment to repeal the 1988 Medicare Catastrophic Act.

The Senate's proposal to curb benefits and taxes set by the 1988 Medicare law was passed as part of a separate bill (see related story).

In addition, some benefit provisions that triggered an outpouring of employer objections already have been removed from the House and Senate budget bills.

For example, the House earlier voted to strip the so-called Visclosky amendment, named after sponsor Rep. Peter Visclosky, D-Ind., that would have required employers to share control of defined benefit and defined contribution pension plan assets with employees.

The Senate budget bill lacked a comparable provision (*BI*, Oct. 2).

In addition, provisions to impose stiff and unprecedented fees on employers filing federally required pension and welfare plan reports were removed from the House and Senate budget bills.

Nonetheless, the budget bills in both chambers of Congress are fraught with employee benefit plan provisions.

"These bills are benefit freight trains with everything under the sun attached to them," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

The most important benefit provision in both the House and Senate budget bills would repeal the detested Section 89, the section of the tax code that has required employers to spend hundreds of millions of dollars to collect data to prove that their health care benefit plans do not discriminate in favor of highly compensated employees.

Section 89, which is scheduled to go into effect Dec. 1, kicked up a storm of protests from employers objecting to the law's nightmarish complex tests.

Even if Section 89 is stripped from the Senate bill, the anger that Congress has felt from employers on Section 89 makes it almost certain that the repeal provision would be restored by conferees or approved by the House and Senate as part of other bills, benefit experts say.

"No matter how you cut it, Section 89 will be repealed. It is a packaging question, not a substantive question," observed Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

But the fate of a provision—only in the Senate bill—to increase PBGC premiums is much less certain.

This provision, opposed by the PBGC as unnecessary, would increase the pension plan premiums paid only by employers whose defined benefit pension plans are at least fully funded.

Their annual premiums would increase to $18 per plan participant from $16.

Premiums paid by employers with underfunded plans, which are based on how badly the plan is underfunded, would not be increased. Under a variable-rate premium structure, which went into effect last year, the annual per participant premium can be as much as $50.

Benefit lobbyists earlier blasted the premium increase, as well as accompanying provisions to boost penalties for violations of federal pension and safety laws, as an underhanded move by Sen. Howard Metzenbaum, D-Ohio, and his allies on the Senate Labor and Human Resources Committee. Critics charged that the fees were proposed to increase revenues to "pay" for another provision advanced by Sen. Metzenbaum to restrict employers from recovering surplus assets after terminating overfunded pension plans (*BI*, Oct. 9).

"To increase the premium willy nilly and have the increase go to pay for restricting reversions borders on the absurd and outrageous," said Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C.

"If the premium increase passes, legislators will be supplying one more reason for employers not to offer defined benefit plans," Mr. Weizmann added.

The PBGC premium increase proposal came out of the blue, making it difficult to predict its chances of remaining in the budget bill.

The House and Senate budget bills also include a hodge-podge of provisions regarding employers' ability to recoup excess assets after terminating overfunded pension plans.

Since 1980, employers have recovered about $20 billion in surplus assets through the terminations of overfunded plans, helping some companies to weather severe economic crises.

Typically, employers establish new pension plans to replace the terminated plans.

But the House and Senate budget bills include provisions that would make it impossible, or at least more expensive, for a company to recover assets from a pension plan.

For example, the House bill would bar an employer from recovering surplus assets after terminating an overfunded plan. Instead, the participants would be entitled to the surplus.

The Senate bill includes two reversion provisions:

- The first, tacked onto the bill by the Senate Finance Committee, would boost to 20% from 15% the excise tax employers generally now must pay on reversions.
- The second, added to the bill by the Labor and Human Resources Committee, is a de facto ban on reversions. So many conditions would be imposed on employers terminating overfunded plans, such as giving participants cost-of-living adjustments, that little or no surplus would likely remain after all the conditions were met, benefit experts have said.

Of the varying reversion restrictions, the increase in the excise tax to 20% is most likely to survive, experts say.

"An increase in the excise tax may be seen as a compromise. It avoids the controversy over whether reversions should be halted, while it would raise revenues for the government," Mr. Saveth said.

While an excise tax increase may be less objectionable than an outright ban on reversions, business groups vehemently oppose hiking the excise tax.

"If the excise tax keeps going up, eventually you reach the point that taxes will eat up most of the reversion," said the APPWP's Mr. Weizmann.

Both the House and Senate bills include varying provisions to allow employers to transfer surplus assets from their pension plans to special accounts, known as 401(h) accounts, to pay for retiree health care expenses.

Under a provision in the House bill, employers would have a one-time opportunity to transfer surplus pension assets to a 401(h) account.

The transfer generally would be limited to assets needed to pay retiree health care expenses paid or incurred in 1990 or 1991, and the transfer would have to be completed by Dec. 31, 1991.

However, as a condition to such a tax-free asset transfer, an employer would have to vest participants' accrued pension benefits and purchase annuities for those benefits.

The Senate bill is more favorable to employers. It would allow employers to annually transfer surplus pension assets to pay for retiree health care expenses paid or incurred between 1989 and 1994. The transfer would have to be completed by Dec. 31, 1994.

Like the House bill, the Senate measure would require employers to vest participants' accrued pension benefits before a transfer would be permitted.

However, unlike the House bill, the Senate bill would not require companies to purchase annuities for those benefits.

The bills "offer some near-term relief for some employers to meet retiree health care liabilities with certain strings attached," said Michael Johnston, a consultant with Hewitt Associates in Lincolnshire, Ill.

But, because so many conditions are attached, benefit experts say the asset transfer provisions will have limited appeal to employers.

For example, the asset transfer mechanism would offer little appeal to companies with few current retirees and a young workforce with high turnover. To take advantage of the asset transfer provision, that company would have to bear the expense of vesting all pension benefits and, in the case of the House bill, buy annuities for those benefits.

However, Hewitt Associates' Mr. Johnston said the Senate provision could be attractive to a company with many retirees and an employee population that is largely already vested in the pension plan.

Both measures also would strip away some of the tax advantages associated with ESOPs.

Under both bills, lenders generally no longer could exclude from their taxable income 50% of interest earned from loans made to ESOPs.

Under the Senate bill, this change generally would apply to loans made after June 6, while the cutoff date in the House bill is July 10.

In addition, the House bill generally would bar an employer from taking a tax deduction for dividends paid on company stock that was acquired by an ESOP after July 10.

However, neither the interest income exclusion nor the ban on tax deductions for dividends on company shares held by an ESOP would apply when an ESOP holds at least 30% of outstanding company stock.

Both measures also would retroactively extend through the end of 1991 Section 127 of the Internal Revenue Code, which had allowed employees to receive up to $5,250 in tax-free educational assistance benefits from their employers.

Section 127 expired on Dec. 31, 1988.

The Senate bill also would encourage pension portability by allowing employers to transfer—without the consent of the employee—lump-sum distributions from pension plans to an employee's individual retirement account when an employee leaves the company.

The Senate measure also would allow companies, regardless of size, to establish a salary reduction feature for simplified employee pension plans. Under the Tax Reform Act of 1986, only employers with 25 or fewer employees may establish a salary reduction feature for SEPs.

Two technical provisions in the Senate bill would provide a limited expansion of 401(k) plans, but would restrict some VEBAs, also known as 501(c)(9) trusts.

The measure would allow certain tax-exempt organizations, such as civic leagues and fraternal societies, to set up 401(k) plans. This would amend a provision in the 1986 tax law that generally barred tax-exempt organizations from setting up 401(k) plans after July 2, 1986.

This provision is aimed at tax-exempt organizations that were not eligible to establish another pension program known as a 403(b) annuity plan.

The 403(b) plan is generally used by educational institutions.

However, the Senate bill would effectively overturn a 1986 U.S. 7th Circuit Court of Appeals decision that said national trade associations could sponsor VEBAs.

That decision reversed Internal Revenue Service rules that said a trade association could offer a VEBA only if members' employees were located in one state (*BI*, July 21, 1986).

The Senate bill would slightly liberalize the IRS rules to allow a trade association to offer a VEBA as long as members' employees are located in no more than three contiguous states. ■

Congress to forge Medicare cutback bill

By JERRY GEISEL

WASHINGTON—A congressional conference committee will decide the fate of the Medicare Catastrophic Act.

The Senate this month voted to kill a controversial surtax and to sharply curtail benefits in the landmark 1988 law that gives retirees more protection from acute catastrophic health care expenses.

But the Senate refused to follow the lead of the House of Representatives, which voted to repeal both expanded benefits and the detested Medicare surtax, under which middle- and upper-income retirees would have to pay as much as $800 to finance the program (*BI*, Oct. 9).

The House voted 360-66 to approve a budget reconciliation bill amendment that would repeal the 1988 law.

The budget bill, H.R. 3299, later approved by the House, also contains provisions that would have a sweeping impact on employee benefit programs (see story, page 1).

The Senate unanimously approved a separate Medicare expansion cutback bill, S. 1726, introduced by Sen. John McCain, R-Ariz.

Conferees will have to iron out differences between the two bills.

The Senate version would retain expanded Part A hospital benefits. Under that expansion, beneficiaries' out-of-pocket expenses for covered hospital services are limited to $560.

Previously, Medicare's high deductibles and coinsurance requirements left beneficiaries potentially liable for thousands of dollars in hospital expenses.

However, the Senate bill would scrap two of the biggest benefits in the 1988 law: limited out-of-pocket expenses for physician charges and a new prescription drug program.

Starting next year, the 1988 law limits retirees' liabilities for physician bills, covered under Medicare Part B, to $1,370. Medicare B currently pays 80% of physician expenses with no stop-loss limit.

The law also establishes, starting in 1991, a prescription drug program under which Medicare would pay 50% of expenses after a $600 deductible.

While the Senate bill would eliminate the expanded Part B benefits, as well as the surtax, it would retain a non-controversial $4 monthly premium paid by beneficiaries that is set to gradually rise over the next several years. That supplemental premium is used to finance the expanded Medicare Part A benefits.

Benefit experts say it is more likely that conferees will accept the Senate Medicare legislation, or something similar, than total repeal.

"Politically, the Senate bill appears more viable. It gets rid of the most onerous provision—the surtax—while salvaging the hospital benefits," said Edward J. Davey, a principal with A. Foster Higgins & Co. Inc. in New York.

"There are indications that House supporters of total repeal could live with the Senate bill," agreed Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

Regardless of how the conferees iron out the differences between the two bills, employers again would have to pick up billions of dollars in retiree health care costs that they had expected expanded Medicare to cover.

Many employer-sponsored retiree health care plans, which cover more than 10 million people, are designed to pay hospital and physician expenses not covered by Medicare. With the expanded Medicare program assuming a much greater share of the costs, employer plans automatically would pay less.

In fact, the General Accounting Office earlier this year estimated that as of 1988, Medicare expansion would reduce employers' accrued retiree health care liabilities by 13.2%, to $197 billion from $227 billion.

Unless employers amended their retiree health care plans to cut back benefits, that $30 billion in liabilities would bounce back to companies if the 1988 expansion law is repealed.

It is not known how much employers will save if the Senate plan is adopted.

Risk group

Continued from page 2

through Avery Stuart Ltd., a Florida corporation that he said acted as a broker in the transaction.

Mr. Bennett said he believed that the Swiss Bank CD was backed by deposits from Argentine investors and that Avery Stuart was authorized to broker the CD to third parties as an "asset enhancement" tool.

He added that he paid Avery Stuart $90,000 in "up-front interest charges" and had agreed to pay an additional $15,000 per month for use of the CD.

Avery Stuart is based in Venice, Fla., according to incorporation papers filed with the Florida secretary of state's office. But, it has no phone listing in Venice.

Robert L. Dailey, an Avery Stuart director, has a Venice phone number, but he could not be reached.

Mr. Bennett declined to comment on who introduced him to Avery Stuart, explaining that he is trying to recover a finders fee he paid for the introduction.

After the CD forgery came to light, Security American lined up nearly $2 million in cash from a group of investors to replace it, and the cash was deposited at two Louisiana banks, Mr. Bennett said.

He said he does not know the names of the investors and referred the question to Security American President William E. Pringle.

Mr. Pringle did not return several phone messages.

Mr. Bennett said that despite the new capital available to Security American, the risk retention group probably will not re-apply for a certificate of authority in Louisiana.

Mr. Bennett said he hoped to form Security American as a replacement market for American Interfidelity Exchange, an Indiana risk retention group that had agreed to act as a fronting insurer for a book of trucking business produced by Mr. Bennett.

In addition to producing business for American Interfidelity, Mr. Bennett was responsible for arranging reinsurance for 100% of the risks assumed by the risk retention group.

However, American Interfidelity terminated its relationship with Mr. Bennett in June after reinsurance he had supposedly arranged with Korean Reinsurance Co. of Seoul, South Korea, turned out to have been bound by a Tokyo-based company that had no binding authority for the reinsurer, according to American Interfidelity Secretary Harold Antonson (*BI*, July 10).

In interviews earlier this year, Mr. Bennett said he had arranged the purported Korean Re coverage through Tokyo-based Nippon Kei Ei Consultant and London-based McDonald Management LBS Forum.

Mr. Bennett said he had been told by Colin Youell, described as McDonald Management's chief executive officer, that Nippon Kei Ei had binding authority for Korean Re and that the Tokyo firm had in turn granted binding authority to McDonald Management as a subagent.

However, Korean Re later announced that neither Nippon Kei Ei nor McDonald Management had binding authority for it.

Mr. Bennett said that by the time these problems came to light, he had already forwarded $300,000 to Nippon Kei Ei for the purported Korean Re coverage.

American Interfidelity filed a lawsuit against Truck Writers and Mr. Bennett in Hamilton County Court of Common Pleas in Cincinnati on July 18, according to James O'Connell, a lawyer with the Cincinnati firm of Lindhorst & Dreidame, who represents American Interfidelity. ■

Update

Tax reform socks insurers: ISO

NEW YORK—The property/casualty insurance industry will pay nearly three times as much federal income tax during 1987-1990 under the Tax Reform Act of 1986 than it would have under the previous tax code, says a study by the Insurance Services Office Inc.

Property/casualty insurers will pay $12.2 billion in federal taxes during this four-year period, or $7.8 billion more than the $4.4 billion they would have paid under previous law, according to "Tax Law Changes and Property/Casualty Insurers: A Comprehensive Analysis." The study was released earlier this month by New York-based ISO.

"If 1991's results are similar to 1990's, the current tax law will have raised taxes by more than $10 billion in its first five years," the report further notes. "That's more than one-third greater than the $7.5 billion increase the U.S. Congress anticipated when it enacted" the law.

Punitive awards

Continued from page 1

ered a middle road between the "preponderance of evidence" applied in most civil trials, and the "beyond-a-reasonable-doubt" standard used in all criminal trials.

This middle road is appropriate in some civil trials because "punitive damages are a form of punishment and can stigmatize the defendant in much the same way as a criminal conviction," the Hawaii court held Sept. 20.

"It is because of the penal character of punitive damages that a standard of proof more akin to that required in criminal trials is appropriate," the court said.

The "clear and convincing" standard "will produce in the mind of the trier of fact a firm belief or conviction as to the allegations sought to be established and requires the existence of a fact to be highly probable," the court explained.

"A more stringent standard of proof will assure that punitive damages are properly awarded," the court concluded.

Praising the decision, product liability scholar Victor Schwartz, an attorney with Crowell & Moring in Washington, D.C., said the "clear and convincing" standard is appropriate when punitive damages are being sought because "the civil jury is transformed into something akin to a criminal jury."

"Punitive damages are quasi-criminal in nature," said attorney David M. Heilbron, who represented General Motors Corp. in the Hawaii litigation.

"The purpose of punitive damages is not to compensate but to punish," said Mr. Heilbron.

However, raising the standard of proof will not have much of an effect because "in most states, plaintiffs must prove outrageous conduct" to recover punitive damages, said Bill Wagner, a partner with Wagner, Cunningham, Vaughan & McLaughlin in Tampa, Fla., and former head of the Assn. of Trial Lawyers of America.

Attorneys predict the Hawaii ruling will prove very influential in other states because the state is considered a pro-plaintiff jurisdiction.

"Hawaii is on the edge of the envelope in rulings for the plaintiff," Mr. Schwartz explained. "This makes a decision that advances a defense argument all the more important."

Mr. Wheeler agreed, noting that other courts can be persuaded when "a traditionally liberal tort court goes in this direction."

As courts and legislatures nationwide grapple with the problem of unrestrained punitive damage awards, raising the standard of proof is one of the most popular reforms.

"There is a big move by courts and legislatures" nationwide to raise the standard of proof required to award punitive damages, said product liability attorney Malcolm Wheeler who is with Mayer, Brown & Platt in Washington, D.C.

Courts and legislatures are recognizing the "need for reform of punitive damages," he said.

"There are drumbeats that are being heard by our courts and our legislatures," Mr. Schwartz concurred.

Its simplicity makes raising the standard of proof "one of the most palliative reforms," Mr. Schwartz explained.

"This is an area where people who are seeking rational reform of the current system of awarding punitive damages have their strongest arguments," he said.

Several prominent legal organizations also support raising the standard of proof necessary to award punitive damages.

The American Bar Assn.'s 1987 Report on the Commission to Improve the Tort Liability System, better known as the McCay Report, endorsed raising the standard of proof necessary to award punitive damages (*BI*, Feb. 23, 1987; Jan. 19, 1987; Jan 12, 1987).

And this year, the American College of Trial Lawyers similarly recommended raising the standard of proof to "clear and convincing" evidence (*BI*, Aug. 7).

'A more stringent standard of proof will assure' punitive awards are proper, the court said.

General Motors attorney Mr. Heilbron predicted that most states eventually will raise the standard of proof for punitive damages to at least "clear and convincing evidence," if not to the even higher "beyond a reasonable doubt." Only Colorado now applies this toughest standard.

Attorneys also predict that the U.S. Supreme Court soon will address the issue of unrestrained punitive damage awards.

In fact, justices last week granted two stays of punitive damage awards, indicating that they are wrestling with this issue, according to attorneys.

The high court stayed a $1.8 million award against a HealthAmerica Corp. unit for fraud and a $2.75 million award in an Alabama car accident case in which a 16-year-old girl was killed.

Although the Supreme Court ruled in June that large punitive damage awards do not violate the Eighth Amendment's excessive fines clause, the justices indicated that they were interested in considering whether large punitive damage awards violate a defendant's 14th Amendment due process rights (*BI*, July 3).

The Hawaii litigation involved an $11.2 million punitive damage award to a 28-year-old auto mechanic who was rendered a quadriplegic when a Chevrolet van he was attempting to repair from underneath rolled backward over him.

The mechanic also was awarded $6.8 million in compensatory damages.

The mechanic, Steven Masaki, and his parents sued General Motors, claiming that the van's transmission was defectively designed.

However, evidence presented during the trial indicated that Mr. Masaki did not set the parking brake and may not have placed the gearshift in park before he began repairing the van.

The jury found Mr. Masaki 40% responsible for his injuries, and the judge cut the compensatory award 40% to $4.1 million.

Jurors may have granted the extraordinarily large $11.2 million punitive damage award in part because evidence presented during the trial showed General Motors could have easily installed a device to warn drivers exiting a vehicle to put it in park.

As a result of the Hawaii Supreme Court's ruling, Mr. Masaki's case will be remanded to the trial court for a new trial to determine what, if any, punitive damages should be awarded.

The compensatory award remains intact, as do the compensatory damages awarded to Mr. Masaki's parents, each of whom will receive $560,000 for loss of consortium and $460,000 for emotional distress.

Loss of consortium is a legal theory under which damages can be awarded to a person for suffering the loss of companionship when a spouse is killed.

But, courts recently have begun expanding the theory to include relationships other than husband and wife and cases of serious injury, not just death.

The Supreme Court of Hawaii is at the forefront of a movement to allow loss of consortium to be awarded to parents for the serious injury of an adult child.

In fact, the ruling marked the first time that the Supreme Court of Hawaii had addressed this issue.

"We find ourselves in agreement with those jurisdictions that have recognized that severe injury may have just as deleterious an impact on filial (parent/child) consortium as death," the court said.

"It would be anomalous to take the position that if a child is injured but does not die the parents may not recover," the Hawaii court added.

"Courts are split on the loss of consortium issue," according to product liability attorney Mr Wheeler.

The position taken in the Hawai case is "very much a minority position," said General Motors attorney Mr. Heilbron. "The decision is apt to give rise to liability that is not warranted."

●

Steven Masaki, Frank Masaki and Sumiye Masaki vs. General Motors Corp. and Servco Pacific Inc. et al. Supreme Court of Hawaii, No 13023.

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Examining brokers' valuations

By LEONARD M. WILSON
Special to Business Insurance

HURRICANE HUGO has come and gone, but some observers were quick to predict a firming in commercial premium rates in its wake. Certainly, insurance brokerage shares have behaved as if something were afoot in the marketplace. Share prices moved ahead smartly over the past two weeks, even though the consensus now suggests that insurance prices may not be greatly affected by Hugo-related losses.

Mr. Wilson

The run-up in share prices has justifiably raised the question of appropriate valuation. Earnings estimates for the group are generally restrained for this year and next. To what extent have insurance brokerage stocks discounted the impact of a firming on their earnings progress? While ascertaining proper value is difficult at best, it seems worthwhile to explore the issue.

We have calculated price-to-earnings ratios for each of the companies in the group, based upon estimates for both 1989 and 1990. Currently, the average price-to-earnings ratio is about 18 for this year and around 16 for next year.

These absolute multiples do not reveal a great deal about valuation. More useful is the so-called relative price-to-earnings ratio that uses the price-to-earnings ratio of the broad market averages as a benchmark for judging the current valuation of individual stocks or industry groups.

For example, the Standard & Poor's Industrial Index now sports price-to-earnings ratios of roughly 14.5 for 1989 and 13.5 for 1990.

If a stock were selling at 14.5 times 1989 earnings, exactly that of the market index, its relative price-to-earnings ratio would be 1.0.

This computation of relative valuation is easily accomplished, and yet it enables the analyst to compare a current valuation with the historical record of valuation. This method, like most approaches to the stock market, is not infallible, but it has proved useful in nourishing the judgment process.

Our numbers indicate that the brokers are selling at relative price-to-earnings ratios of 1.25 for 1989 and 1.18 for 1990. Accordingly, investors think that the earning power of brokerage stocks is worth more than that of common stocks generally. This is not a new phenomenon, though.

Going back to 1970, brokerage shares commonly sold at a relative price-to-earnings ratio in a range of 1.20 to 1.50. Therefore, the current valuation is well within the compass of historical experience.

The relative valuation has varied considerably over the insurance cycle. When brokerage earnings were growing rapidly in hard insurance markets, the valuation tended to be higher. In the tough, soft market of 1979-1984, the relative price-to-earnings ratio dropped.

This variation in valuation is not surprising, since investors are usually willing to pay more for faster growing earnings, and run for cover when results hit a snag.

Is the past prologue? The premium appraisals that are now enjoyed by the brokers cannot be justified only by the historical record.

Rather, future prospects will govern valuations. The fundamental strengths of insurance brokerage will have to persist in the 1990s if the present valuations are to prevail.

We believe that several factors influence investors in insurance brokerage shares. The first, and perhaps most important, is future earnings growth.

The soft market has slowed earnings progress, and even though there is no assurance that premium rates will harden any time soon, we hold to the view that insurance brokerage is a growth business.

This position is supported by the probable growth in premiums both in the United States and internationally, driven by expansion in economic activity.

In addition, the publicly owned brokers have consistently gained market share. We expect the gains in market penetration to spur growth in the future as well.

In our view, insurance brokerage over a full property/casualty cycle should expand close to twice the rate of the gross national product and of the broad market indices. This favorable prospect warrants a premium relative valuation.

Free cash flow is another attribute of insurance brokerage that contributes to growth in earnings per share. Used for share buybacks or acquisitions, free cash flow increases the underlying growth in earnings per share. We calculate that free cash spent wisely can accelerate earnings per share growth by several percentage points over the long term.

Return on equity as a measure of performance also has a bearing on the premium valuation of insurance brokerage. Even in the soft market, returns range from 20% to 30% on shareholder's capital. This compares with a current return on equity of 16% for the Standard & Poor's Index. Moreover, the brokerage rates of return are achieved without much leverage.

Individual brokerage stocks do not carry identical price-to-earnings ratios. Perceived differences account for the variations.

By our estimate, Alexander & Alexander Services Inc. now carries the highest price-to-earnings ratio. Some investors believe that the company has greater potential to expand profit margins in the next cycle of rising prices, and therefore could achieve more pronounced earnings gains. Some investors are drawn to Marsh & McLennan Cos. Inc. for its size and consistently strong record. Corroon & Black Corp.'s cash position is a factor that likely influences the company's appraisal, while Arthur J. Gallagher & Co.'s position in self-insurance continues to be an intriguing source of value.

Our observations provide a rationale for the valuations of the brokers. Whether their prices have moved too far too soon depends on when commercial premium rates firm.

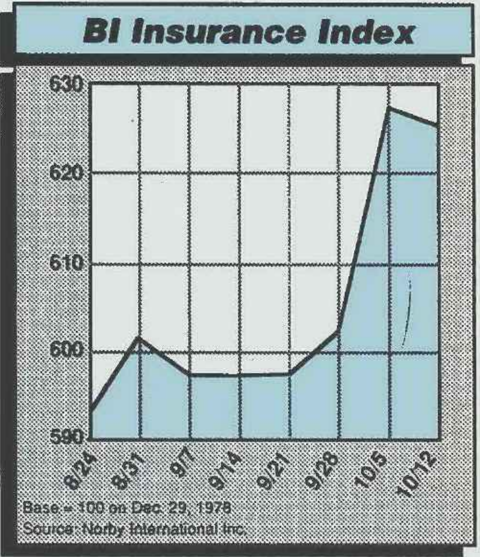
If the soft market drags on almost interminably as it did in the last cycle, investors will lose heart and seek greener pastures.

In that event, price-to-earnings ratios will shrink. On the other side, if premium rates firm in the first half of next year, as some believe, then the impetus to earnings progress might elicit still higher relative valuations.

Ultimately, subjective judgment rules in the bailiwick of value, and for every buyer of stocks, there is a seller with an opposing viewpoint.

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

BI Insurance Index



Insurance industry stocks dropped last week, as the *Business Insurance Index* fell 1.9 points to 625.5 on Oct. 12, from 627.4 on Oct. 6. Advancing issues were led by U.S. Healthcare, up 7.6%; Pacificare Health System, up 6.2%; and Hanover Insurance Co., up 6.1%. Decliners followed RLI Corp., down 7.3%; Tokio Marine & Fire Insurance Co. Ltd., down 7.1%; and Kemper Corp., down 6.0%. The most active issue during the period was Sears, Roebuck & Co. (Allstate), 1.4 million shares traded. The *BI Index* lost 0.30% for the period; the New York Stock Exchange Composite fell 0.54%; the Dow Jones 30 Industrials lost 0.50%; and the Standard & Poor's 500 Index was down 0.44%.

British Issues

Oct. 12 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	444	18.5	29.3	6.6	455—444
Genl Accident	1040	10.3	68.0	6.5	1048—1039
Gdn Royal Exch	220	14.0	15.7	7.1	223—220
Royal	468	14.3	34.0	7.3	468—460
Sun Alliance	285	8.3	17.0	6.0	290-285
Brokers					
Bradstock	195	13.4	10.0	5.1	197—195
CE Heath	485	13.9	34.5	7.1	485—480
Hogg Robinson	143	10.0	9.7	6.7	145—143
Lloyd Thompson	228	15.2	9.3	4.1	230—228
PWS Holdings	39	10.5	3.3	8.5	50—39
Sedgwick Grp	254	17.9	16.7	6.6	265—254
Steel Brrl Jones	230	14.4	15.3	6.7	234—230
Willis Faber	236	16.6	15.3	6.5	245—236

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

OCT. 12, 1989 — 10/6/89 THROUGH 10/12/89

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	32.63	4.80	40.32	33.25	22.63	240	1.00	3.07	20	2.90	11.25
Corroon & Black	NYS	37.38	-0.33	17.72	37.63	29.13	384	1.24	3.32	16	7.52	4.90
Gallagher Arthur J. & Co.	NYS	23.13	1.07	36.03	24.75	15.88	15	0.52	2.25	16	5.33	4.34
Frank B. Hall	NYS	3.00	4.17	0.00	4.63	2.50	119	0.00	0.00	-1	N/A	N/A
Hilb, Rogal & Hamilton	OTC	22.25	2.30	60.51	23.00	10.91	47	0.20	0.90	20	4.60	4.84
Marsh & McLennan	NYS	76.00	1.00	36.94	76.50	55.00	879	2.50	3.29	19	6.48	11.73
Poe & Associates	OTC	8.50	3.03	-2.86	9.75	8.00	3	0.40	4.71	10	1.43	5.94
BROKERS	AVERAGE		2.3	27.0					2.5	14		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	42.00	-1.75	41.77	43.25	27.50	145	0.40	0.95	9	21.28	1.97
Berkshire Hathaway Inc.	NYS	8250.00										
			-5.44	77.42	8900.00	700.00	1	0.00	0.00	11	2468.63	3.34
ITT (Hartford Group)	NYS	61.88	-1.21	23.44	64.50	47.75	1059	1.48	2.39	10	56.33	1.10
Sears (Allstate)	NYS	42.38	-1.45	4.95	48.13	39.00	1422	2.00	4.72	14	36.09	1.17
CONGLOMERATES	AVERAGE		-2.5	36.9					2.0	11		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	59.25	0.42	26.40	60.13	46.00	824	2.76	4.66	9	58.11	1.02
Ambase Corp.	NYS	15.75	0.00	41.57	16.38	10.50	164	0.20	1.27	6	18.66	0.84
American General	NYS	36.38	-1.02	21.25	38.50	29.50	669	1.50	4.12	9	28.04	1.30
American Heritage	NYS	27.75	-0.89	8.82	28.50	25.00	2	1.20	4.32	11	22.47	1.23
American Indemnity/Fin'l	OTC	9.75	-4.88	-7.14	13.00	9.50	7	0.56	5.74	-12	17.38	0.56
American International	NYS	104.25	-2.11	56.47	108.25	61.75	771	0.48	0.46	13	33.55	3.11
Aon Corp.	NYS	35.63	-0.35	28.96	38.00	26.00	137	1.40	3.93	12	16.67	2.14
Argonaut Group	OTC	69.00	1.28	58.62	69.50	42.25	55	1.00	1.45	9	36.83	1.87
AVEMCO Corp.	NYS	26.63	-0.95	3.90	27.50	22.63	10	0.40	1.50	14	9.20	2.89
Baldwin & Lyons Inc.	OTC	21.00	-0.62	44.83	21.38	14.38	21	0.20	0.95	7	17.57	1.20
Belvedere Corp.	ASE	4.75	-2.66	5.56	6.50	4.25	4	0.04	0.84	7	8.43	0.56
Chandler Insurance	OTC	11.63	-0.04	55.00	12.25	6.20	108	0.00	0.00	7	9.53	1.22
Chubb Corp.	NYS	81.25	-0.61	40.69	82.50	53.75	420	2.32	2.86	9	53.50	1.52
CIGNA Corp.	NYS	63.75	-0.20	37.84	64.38	45.75	285	2.96	4.64	11	53.08	1.20
CNA Financial Corp.	NYS	94.50	1.34	60.85	94.88	56.00	81	0.00	0.00	11	54.52	1.73
Continental Corp.	NYS	35.13	-2.43	9.77	45.00	31.50	242	2.60	7.40	-73	42.10	0.83
Durham Corp.	OTC	31.00	-2.36	-3.13	33.00	31.00	18	0.92	2.97	27	26.32	1.18
Fireman's Fund	NYS	38.88	-0.32	33.48	40.75	28.38	411	0.60	1.54	10	32.74	1.19
Fremont General Corp.	OTC	15.50	-1.59	24.00	18.25	10.63	45	0.80	5.16	221	17.61	0.88
Frontier Insurance Group	NYS	19.50	0.00	75.12	21.75	9.55	13	0.00	0.00	10	7.53	2.59
General RE Corp.	NYS	87.25	0.58	58.64	87.50	53.13	545	1.36	1.56	14	29.04	3.00
Hanover Insurance Co.	OTC	32.50	6.11	22.64	32.50	25.50	124	0.44	1.35	-	31.47	1.03
Harleysville Group	OTC	22.88	0.55	28.87	24.13	14.88	19	0.60	2.62	8	18.94	1.21
Hartford Steam Boiler	OTC	57.75	0.87	56.08	58.75	30.63	111	1.60	2.77	15	13.04	4.43
Kansas City Life Ins.	OTC	36.00	0.70	5.11	41.00	29.25	60	1.04	2.89	13	39.22	0.92
Kemper Corp.	NYS	48.63	-6.04	106.91	51.88	22.75	346	0.84	1.73	8	28.91	1.68
Lawrence Insurance Group	ASE	7.75	1.57	-3.13	11.25	6.63	3	0.28	3.61	16	3.19	2.43
Liberty Corp.	NYS	38.75	0.65	6.53	40.50	32.50	11	0.80	2.06	22	21.17	1.83
Lincoln National	NYS	56.00	-1.55	29.48	57.63	42.75	131	2.48	4.43	14	39.21	1.43
NAC Re Corp.	OTC	37.50	-1.96	81.47	38.75	19.50	112	0.20	0.53	17	22.81	1.64
Navigators Group	OTC	27.00	0.00	-31.71	27.75	18.50	13	0.00	0.00	10	15.22	1.77
Nobel Insurance LTD.	OTC	2.25	0.00	-51.35	6.50	1.50	9	-	-	-	7.76	0.29
NWNL Companies	OTC	37.38	1.70	21.54	40.63	26.88	476	1.20	3.21	12	37.50	1.00
Ohio Casualty Corp.	OTC	52.00	2.46	45.45	52.00	33.25	183	2.08	4.00	8	33.30	1.56
Old Republic Int'l	OTC	28.88	-2.55	27.00	30.38	22.62	53	0.74	2.56	14	26.60	1.09
Orion Capital Corp.	NYS	26.75	-4.05	67.19	28.50	13.88	64	0.84	3.14	7	12.93	2.07
Phoenix RE Corp.	OTC	10.88	2.30	11.54	11.00	8.75	147	0.00	0.00	6	12.99	0.84
Protective Life Corp.	OTC	14.13	-0.88	6.60	16.25	12.88	42	0.70	4.96	34	14.54	0.97
Provident Life	OTC	28.88	5.00	49.03	28.88	17.75	383	0.68	2.35	10	12.60	2.29
Re Capital Corp.	ASE	12.00	-2.04	29.73	12.88	8.63	4	0.00	0.00	11	10.71	1.12
RLI Corp.	NYS	8.00	-7.30	4.92	9.38	7.13	4	0.40	5.00	8	23.24	0.34
St. Paul Companies	OTC	60.50	-1.63	40.70	61.75	40.50	433	2.20	3.64	8	32.00	1.89
SAFECO Corp.	OTC	33.13	-1.50	41.71	34.75	23.13	210	1.20	3.62	8	24.88	1.33
SCOR U.S. Corp.	NYS	12.63	1.00	46.38	12.63	6.88	76	0.20	1.58	9	10.35	1.22
Seibels Bruce Group	OTC	10.75	-4.44	-4.44	13.63	10.25	124	0.80	7.44	12	13.42	0.80
Selective Ins. Group	OTC	18.75	1.35	-18.48	18.75	14.50	106	0.96	5.12	6	22.33	0.84
Statesman Group Inc.	OTC	2.63	-4.55	-8.70	4.00	2.38	46	0.05	1.90	26	3.48	0.75
Tokio Marine & Fire	OTC	68.88	-7.09	-24.93	98.00	66.00	28	0.23	0.33	29	N/A	N/A
Torchmark Corp.	NYS	50.13	1.78	64.34	49.50	29.38	173	1.40	2.79	15	12.24	4.10
Transamerica	NYS	46.25	-2.38	38.58	48.00	30.38	502	1.92	4.15	10	30.70	1.51
Trenwick Group Inc.	OTC	18.25	-1.35	28.07	19.50	13.13	3	0.36	1.97	10	16.91	1.08
United Fire & Casualty	OTC	34.25	1.48	12.30	34.50	28.00	48	1.20	3.50	7	22.56	1.52
USF&G Corp.	NYS	30.88	-0.40	6.47	34.00	28.50	489	2.80	9.07	16	22.57	1.37
UNUM Corp.	NYS	41.38	-0.61	54.67	42.00	24.63	639	0.60	1.45	12	30.64	1.35
USLIFE Corp.	NYS	46.13	-1.34	34.18	48.13	32.88	78	1.40	3.04	11	54.27	0.85
Washington National	NYS	27.50	0.92	3.29	29.13	24.00	97	1.08	3.93	-27	32.33	0.85
Zenith National Ins.	NYS	19.13	-0.65	8.51	21.50	18.75	34	0.84	4.39	9	13.61	1.41
INSURERS/REINSURERS	AVERAGE		-0.7	27.7					2.8	13		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	49.50	1.02	321.28	51.00	10.88	245	0.00	0.00	24	3.54	13.98
HMO America Inc.	OTC	8.50	-1.51	806.18	10.63	0.81	204	0.00	0.00	-15	1.12	7.59
Pacificare Health Sys.	OTC	30.00	6.19	140.00	30.38	5.63	61	0.00	0.00	37	6.35	4.72
Safeguard Health Enter.	OTC	11.50	-1.12	113.95	11.50	4.50	55	0.00	0.00	18	2.99	3.85
Sierra Health Services	ASE	7.13	5.56	338.46	8.25	1.25	76	0.00	0.00	-7	1.59	4.48
United Healthcare Corp.	OTC	11.75	-1.09	176.47	12.63	3.88	417	0.00	0.00	-6	0.31	37.90
United Medical Corp.	ASE	6.88	-3.58	27.91	6.88	4.13	9	0.00	0.00	2	4.11	1.67
U.S. Healthcare	OTC	14.25	7.55	153.33	14.25	4.88	764	0.23	1.61	71	2.87	4.97
Western Health Plans	ASE	NA	NA	NA	1.25	0.13	-	0.00	NA	-	0.82	NA
HMOs	AVERAGE		1.4	230.8					0.2	14		
ALL COMPANIES	AVERAGE		-0.5	52					2.4	13		

System design: Nordby International Inc.

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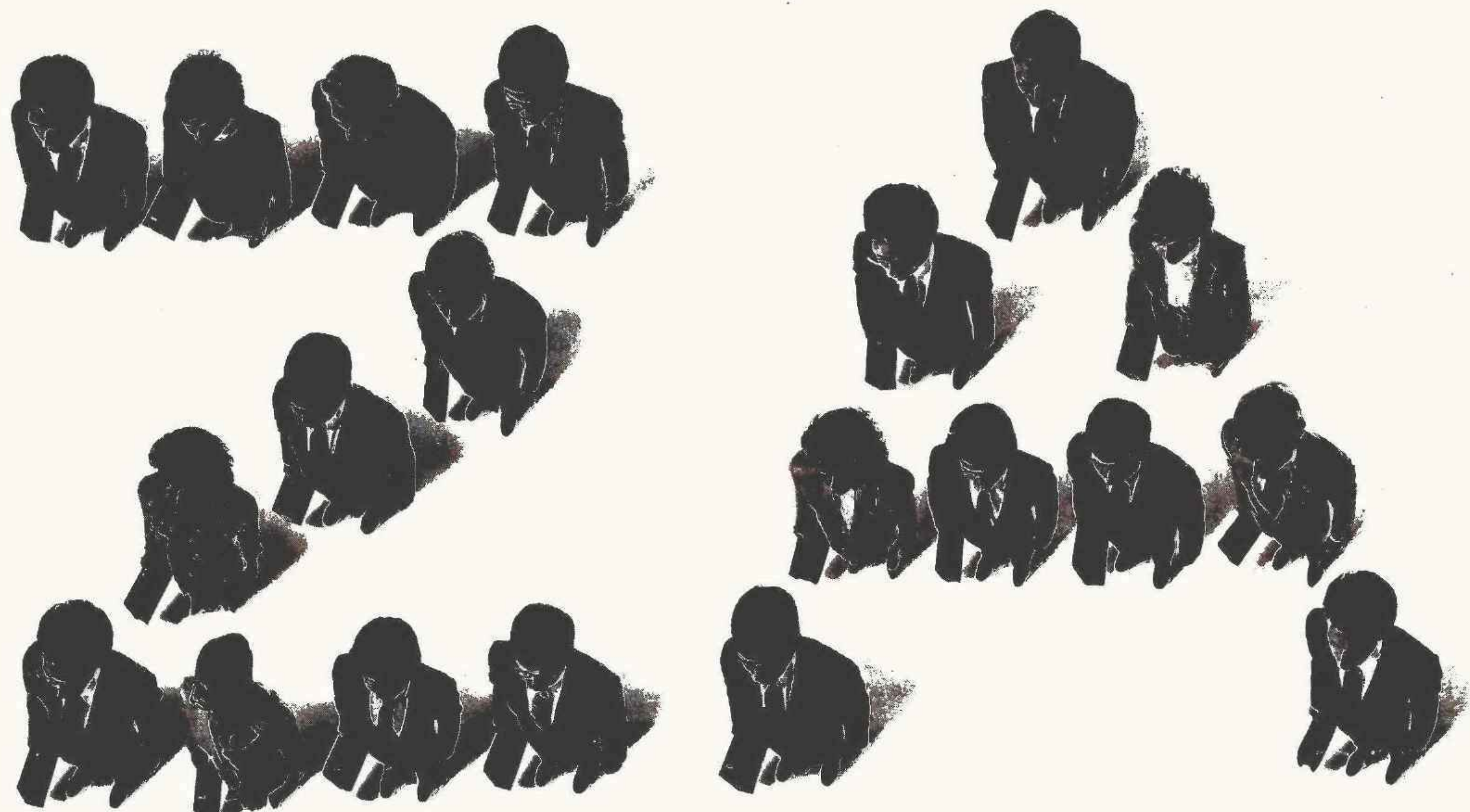

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