

# Business Insurance

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## 11 reinsurers can void contracts with Union Indemnity, judge rules

NEW YORK—Eleven surety bond reinsurers of Union Indemnity Insurance Co. can rescind their contracts with the insolvent insurer, a New York trial judge has ruled.

The 11 reinsurers can void their contracts because the Frank B. Hall & Co. Inc. subsidiary misrepresented its financial condition and methods of operation when it entered into the reinsurance contracts, Judge Ira J. Gammerman ruled last week.

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# Earthquake may turn market

## Reinsurance rates may rise by year-end

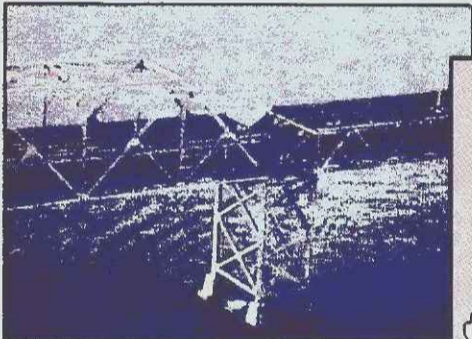
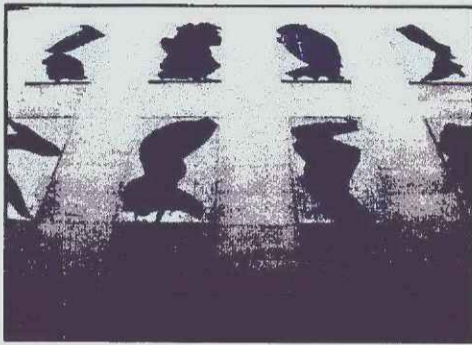
The combination of last week's California earthquake and Hurricane Hugo will lead to higher property insurance prices for U.S. companies, many observers contend.

Even though the earthquake was not the "Big One" long feared by insurers, the combination of two major disasters in less than a month will cause catastrophe property reinsurance rates to increase during year-end renewals, say underwriters and brokers. That, in turn, means U.S. property insurance rates are almost certain to rise next year, if not at the end of this year, they say.

Others agree. For instance, investors, evidently believing the earthquake will cause the commercial property/casualty insurance market to turn, snapped up insurance-related stocks last week (see related story).

Although all observers note that it is far too early to accurately assess the damage from the quake, which registered 6.9 on the Richter scale, most observers say insured losses will not top those caused last month by Hurricane Hugo. Observers originally estimated losses stemming from Hugo at about \$4 billion, but those estimates could increase.

And many pointed out that it was too early to accurately assess market trends, because no solid damage estimates from the quake



The quake damaged businesses and San Francisco Bay Area landmarks.

had been released and because reinsurers and brokers were struggling last week to reinstate reinsurance programs, in some cases for the third time in the past month.

While damage from last week's quake may not be as large as feared, the catas-

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## Insured loss won't top Hugo's

Insured losses from last week's California earthquake probably won't exceed the estimated \$4 billion in insured damages caused by Hurricane Hugo last month, in part because many property owners lack earthquake coverage.

However, almost all observers said last week that it was too early to even attempt to calculate damage from the earthquake, which killed more than 200 people and damaged thousands of businesses and homes in the San Francisco Bay Area.

And, many warn that any early damage estimates may increase as business interruption losses grow and structural damage not visible at first glance is discovered.

The Rahway, N.J.-based Property Claims Services division of the American Insurance Services Group does not expect to have an initial industrywide estimate of insured damages until later this week.

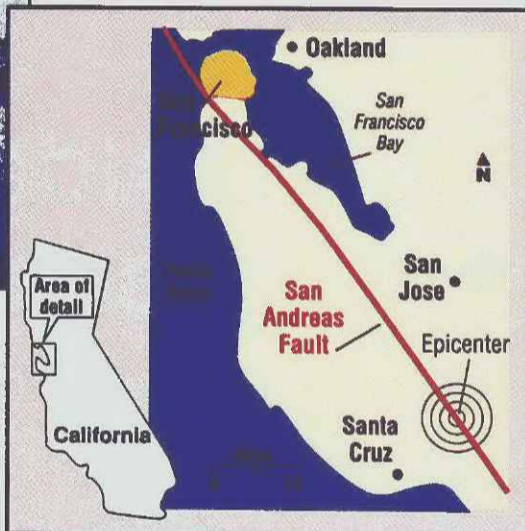
However, the Tustin, Calif.-based Western Insurance Information Service last Friday estimated total insured and uninsured damage from the quake could reach \$10 billion. WIIS based its estimate on extrapolations from previous quakes and reports from throughout the San Francisco Bay Area.

John J. Byrne, chairman and chief executive officer of Fireman's Fund Corp. in Novato, Calif., estimated that insured property damage from the quake would total \$2 billion to \$2.5 billion.

"Our best reasonable estimate is that it will not be as big as Hugo," he said.

In a report released Friday, San Francisco Mayor Art Agnos' office said the city's Department of Public Works estimated that insured and uninsured property damage in San Francisco alone will exceed \$2 billion, excluding damage to the Embarcadero Freeway and Interstate 280. Private homes and businesses account for about \$1.5 billion in damage, while damage to public buildings and the city's infrastructure is pegged at about \$500 million.

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Holly Sequine

## AIG units appeal Oregon suspensions

By MEG FLETCHER

PORTLAND, Ore.—Six American International Group Inc. affiliates are fighting proposed 18-month suspensions that effectively would prohibit the insurers from writing new workers compensation insurance business in Oregon.

The suspensions, now on appeal, were scheduled to go into effect last Friday.

The AIG units' "blatant disregard" for Oregon's record-keeping requirements and failure to promptly pay workers compensation benefits to injured employees led to the proposed suspensions, said Matt Hennessee, administrator of the Workers' Compensation Division of the Oregon Department of Insurance and Finance.

Mr. Hennessee proposed the suspensions under Oregon's workers comp law because regulators repeatedly have fined AIG insurers for such violations during the past six years. Although the insurers have paid the fines, they have not changed their business practices, he charged.

A spokesman for AIG, which is the sixth-largest workers comp insurer in Oregon with 2.15% of the market, declined to discuss the merits of the allegations. However, he emphasized that the proposed suspensions would not affect current policies, which the companies

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## 'Bad news' drives up insurer stock prices

By JUDY GREENWALD

NEW YORK—Insurance industry stocks are rising despite the losses from last week's California earthquake and the Friday the 13th stock market crash.

Investors apparently believe the earthquake, because it struck so soon after Hurricane Hugo, will pressure property/casualty insurers to raise rates, stock analysts and insurer officials say.

"This is a perverse industry. Bad news is what drives the stocks up," said Udayan Ghose, an analyst with Shearson Lehman Hutton in New York.

Observers point out that insurance brokers' and reinsurance stocks fared particularly well.

Brokers, they note, benefit from higher insurance rates without

having to be concerned about underwriting losses. And stock market investors anticipate that the earthquake and Hurricane Hugo will help reinsurers by encouraging insurers to buy more catastrophic reinsurance coverage.

In addition, most insurer stocks were not severely hurt by the Oct. 13 stock debacle, during which the Dow Jones 30 Industrials slid 190 points, observers point out.

"I think the whole thing was a kind of a blip," said Jeffrey Cohen, an analyst with Goldman Sachs in New York.

Insurers' own stock market portfolios were not severely hurt Oct. 13, analysts say. Common stocks account for only a minor portion of insurers' stock portfolios and any stock losses were more than offset by the improvement in insurers'

bond holdings, they say.

"It's minor league, no impact," said Gerald E. Lewinsohn, a vp and analyst with Merrill Lynch Capital Markets in New York.

Investors' interest in property/casualty stocks after the earthquake is a reaction that "bad news is good news as far as how it could affect the insurance cycle," said Michael Lewis, first vp with Dean Witter Reynolds in New York.

Even the stocks of insurers with widespread earthquake exposures did well last week because the exposure is a defined loss in terms of absolute dollars and the quake is viewed as a pressure that will help stabilize the cycle, if not actually turn rates upward, said Mr. Lewis.

People are seeing the earthquake

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2nd Circuit finds coverage for state-ordered cleanup  
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**Update**

**Union Indemnity reinsurers win**

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The reinsurers estimate that losses from Union Indemnity's surety bond business could total \$160 million to \$200 million.

The reinsurers used as evidence information contained in the New York Insurance Department's lawsuit against Hall, which charged the broker was responsible for Union Indemnity's collapse. Hall will pay \$48.5 million to settle that suit (*BI*, June 5).

Among other things, Judge Gammerman said that "material omissions as well as misrepresentations occurred, that Union officers and directors were aware of the operations and financial condition of the company" and that "had a reinsurer been aware of insolvency, it certainly would not have underwritten the sum encompassed by reinsuring the bankrupt company."

The reinsurers are: Allianz Syndicate of the defunct New York Insurance Exchange; American Centennial Insurance Co.; Atlas Assurance Co. of America; First Horizon Insurance Co. Ltd.; GTE REinsurance Ltd.; KCC New York Syndicate Corp., also an NYIE syndicate; Kansa Reinsurance Co.; The 1792 Co., also an NYIE syndicate; Puritan Insurance Co.; Republic Insurance Co.; and Simcoe & Erie General Insurance Co.

Union Indemnity was found insolvent by \$138.5 million as of year-end 1984 and ordered into liquidation in July 1985.

**Mutual Fire sues auditor**

HARRISBURG, Pa.—Mutual Fire, Marine & Inland Insurance Co.'s rehabilitator has filed a \$300 million lawsuit against Peat Marwick Main & Co., the insurer's former auditor.

The suit, filed Oct. 4 in Commonwealth Court of Pennsylvania in Harrisburg, charges that Peat Marwick was negligent in its audits of Mutual Fire, which was ordered into rehabilitation in December 1986. A Pennsylvania Insurance Department audit found Mutual Fire insolvent by \$441.5 million as of year-end 1988.

Lawyers for the Pennsylvania department last week also sought to have a federal court in Philadelphia dismiss a separate lawsuit filed against Peat Marwick by Mutual Fire policyholders (*BI*, Sept. 4), arguing that the department has sole authority as Mutual Fire's rehabilitator to bring such an action.

The department also has asked a Commonwealth Court judge to hold lawyers for the Mutual Fire policyholders' committee in contempt for allegedly breaching several court orders, including a confidentiality order covering information the policyholders' lawyers used in filing the class-action suit against Peat Marwick.

"Neither I nor my firm has ever violated a single order of the Commonwealth Court," said Richard Brown, a lawyer with the Washington, D.C., firm of Spiegel & McDiarmid representing the policyholders committee.

Mr. Brown added that he will fight the department's efforts to intervene in the policyholders' suit.

**Forum Re merger abandoned**

CONCORD, Mass.—After floating three successive reorganization proposals over the last year, Forum Re Group Inc. and Forum Re Group (Bermuda) Ltd. have scrapped plans to merge.

Forum Re Group Inc. directors announced the decision last week after determining that the merger could not be consummated by the end of the year as proposed.

Under the last merger plan, which was announced in July, shareholders of Forum Re (Bermuda) were to receive shares of Forum Re Group Inc., which then would change its name to Aneco Group Inc. Aneco Group was to have been headed by Jonathan Crawley, current president of Aneco Reinsurance Underwriting Ltd., a Forum Re (Bermuda) affiliate.

Mr. Crawley said delays in obtaining opinion letters from investment bankers—and the likelihood the Securities and Exchange Commission would require audited year-end 1989 financial information before clearing the merger—meant the deal probably could not have been concluded before August 1990. That kind of delay would have caused "the marketplace to throw up their hands in despair and say 'good heavens, this is never going to happen' " Mr. Crawley said.

Forum Re (Bermuda) directors were scheduled to meet Friday to discuss future plans, Mr. Crawley said. An announcement on those plans is expected to be made today, he said.

Forum Re (Bermuda) is controlled by Forum Reinsurance Co. Ltd., a Bermuda reinsurer controlled by Mark G. Hardy, who is also the controlling shareholder and chairman of Forum Re Group Inc., a holding company for several U.S. property/casualty insurers.

**Briefly noted**

The U.S. Supreme Court has refused to hear an appeal of a lower court's dismissal of a racketeering lawsuit filed by the liquidators of Bermuda-based **Mentor Insurance Ltd.** against Mentor parent Ocean Drilling & Exploration Co. and 10 other defendants. . . **Risk retention groups** will write \$399.1 million in premiums in 1989, up nearly 60% from the \$250.2 million they wrote last year, estimates a recent survey. Of 66 risk retention groups formed to date, 14 have been formed this year, according to the survey by the Pasadena, Calif.-based Risk Retention Reporter. . . The Louisiana Insurance Department has succeeded in freezing a Swiss bank account containing more than \$1 million in assets of the insolvent **New England International Surety of America Inc.** The Louisiana department also has seized control of Omne Re, a Belgium-based affiliate of New England International. . . The Senate has confirmed David Ball, former senior vp with AMAX Inc. in Greenwich, Conn., as the new chief of the Labor Department's **Pension and Welfare Benefits Administration.**

**Errors and omissions**

• Health maintenance organizations that have not received a questionnaire to be listed in the *Business Insurance* Directory of HMOs and PPOs should call Sara Harty at 312-280-3195. An incorrect phone number was given in the Oct. 16 issue.

**U.S. court finds cover for state cleanup order**

By STACY ADLER

NEW YORK—The costs of responding to a government order to clean up polluted property are insurable, according to the 2nd U.S. Circuit Court of Appeals.

In a unanimous decision, the three-judge panel ruled Wednesday that the term "damages" in comprehensive general liability policies applies to the costs of complying with government-mandated cleanups.

The decision marks the first time a federal appellate court has ruled that a letter from a state environmental protection agency naming a policyholder as potentially responsible for a hazardous waste site is the equivalent of a lawsuit for insurance purposes.

Attorneys say the 2nd Circuit's decision will tremendously help policyholders nationwide litigating with insurers over coverage for the costs of complying with government-mandated cleanups.

Previously, both the 8th U.S. Circuit Court of Appeals and the 4th U.S. Circuit Court of Appeals ruled that the costs of complying with government-mandated cleanups are not insurable under CGL policies (*BI*, March 7, 1988; July 27, 1987).

In the case before the 2nd Circuit, Hartford, Conn.-based Travelers Indemnity Co. argued that

the CGL insurance it wrote for New Orleans-based Avondale Industries Inc. does not cover the costs of complying with a cleanup order from the Louisiana State Department of Environmental Quality. The agency named the policyholder as potentially responsible for a multimillion-dollar cleanup of petroleum products and chemical compounds that Avondale handled.

**'We have little trouble viewing this administrative proceeding as a suit,' says the court.**

The Travelers Corp. unit insured Avondale from 1975 to 1984, providing approximately \$2 million in coverage each year, according to Avondale attorney Hugh Fryer of Fryer, Ross & Gowen in New York.

Whether the policy limits are to be applied on a per-occurrence basis or on a per-year basis is being disputed.

The Travelers CGL policy states that Travelers "will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages."

Travelers and several amicus curiae briefs strenuously argued that the term "damages" in Avondale's policy means only monetary judgments awarded by a court.

But the 2nd Circuit disagreed. "The term damages is not defined in Travelers' policy. Damages not being given any more limited definition in the policy must be construed to include the remedial costs that may be imposed on Avondale by the State of Louisiana," the court said.

"Moreover, viewed from the insured's perspective, we think an ordinary businessman reading this policy would have believed himself covered for the demands and potential damage claims now being asserted in the Department of Environmental Quality administrative proceeding," the court concluded.

Travelers also argued that the Louisiana Department of Environmental Quality's letter was not a lawsuit and thus did not obligate the insurer to defend Avondale.

But, the court disagreed: "We have little trouble viewing this administrative proceeding as a suit," the court said.

The court noted that the letter from the Louisiana department was more than an invitation to Avondale to voluntarily participate in the cleanup. The letter was

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**Budget debate imperils some benefit proposals**

By JERRY GEISEL

WASHINGTON—The Senate's decision this month to strip hundreds of provisions from a budget reconciliation bill could stall or even kill benefit-related proposals eagerly sought by employers.

The most important benefit provisions deleted from the budget reconciliation bill, later passed by the Senate on a 87-7 vote, include total repeal of Section 89 and a provision allowing companies to use excess assets from overfunded pension plans to pay for retiree health care expenses.

Even though Section 89 repeal and pension asset transfers are included in a budget reconciliation bill passed earlier by the House of Representatives, benefit experts are skeptical that these provisions will survive when congressional conferees meet this month to work

out differences between the two bills.

Meanwhile, because certain other benefit provisions also are included in only the House or the Senate budget bill—not both—the fate of those provisions is not yet clear, experts say. Those provisions include:

- Repeal of the Medicare Catastrophic Act. The House last month, as part of its budget reconciliation bill, voted to repeal the 1988 law that substantially expanded both hospital and physician benefits for retirees. The Senate, though, voted as part of a separate bill to retain the expanded hospital benefits.

- Higher PBGC premiums. The Senate budget bill would increase the annual base premium the Pension Benefit Guaranty Corp. charges employers with fully and overfunded pension plans. The

House budget bill lacks a comparable provision.

- Pension asset reversions. The House budget bill would bar employers from recovering surplus assets after terminating overfunded pension plans. Instead, any surplus assets would go to participants following a plan termination. A comparable provision was stripped from the Senate bill.

- Educational assistance benefits. The House bill would retroactively extend through 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 budget bill had an identical extension of tax-free educational assistance benefits, but that provision was deleted.

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**Inside**

✓ This week's editorial expresses hope that the removal of extraneous benefit provisions in the budget bill signals an end to what has become a scandalous tradition. **PAGE 8**

✓ A national health care policy can succeed only if myriad state and local rules governing health plans are preempted, a multiemployer plan lobbyist says. **PAGE 21**

✓ The drive to contain costs is behind the merger of EBIS and RMIS systems, says consultant David A. Tweedy in RMIS Commentary. **PAGE 23**

✓ Self-insured employers do not need a TPA to shield them from employee complaints, an employer says at the Self-Insurance Institute of America conference. **PAGE 28**

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# House panel seeks Miro probe

## Feds asked to investigate former Transit MGA

By DOUGLAS McLEOD

WASHINGTON—A congressional subcommittee is asking the Justice Department to launch a criminal fraud investigation of Carlos I. Miro in the wake of allegations that he plundered Transit Casualty Co. and Anglo-American Insurance Co. of Louisiana.

In an Oct. 10 letter to U.S. Attorney General Richard L. Thornburgh, the House Oversight and Investigations subcommittee alleges that Mr. Miro, a former Transit managing general agent, diverted millions of dollars in Transit premiums to his Dallas-based agency and to an offshore reinsurer he controlled.

After Transit failed in 1985, Mr. Miro formed Anglo-American and diverted millions of dollars more through high salaries, lavish expense accounts, loans and other means, the subcommittee's letter alleges.

Mr. Miro's activities—and those of four associates also named in the letter—may involve violations of federal mail and wire fraud statutes and other federal criminal laws, according to the letter, which was signed by subcommittee Chairman John D. Dingell, D-Mich., and ranking minority member Thomas J. Bliley Jr., R-Va.

Separately, the Cuban-born, 35-year-old Mr. Miro—a non-U.S. citizen who travels on a Mexican passport—is the subject of investigations by the Immigration and Naturalization Service and the Internal Revenue Service.

Mr. Miro could not be reached for comment on this story. J. Albert Kroemer, Mr. Miro's attorney and one of the Miro

associates named in the subcommittee's letter, said: "It's fairly clear what the subcommittee wants to do is try Carlos in the press."

In a subsequent written statement, Mr. Kroemer said: "It is a sad day when the arrogance of power exercised by a single congressman like Mr. Dingell... results in a media campaign which negatively impacts so many innocent people."

Mr. Kroemer's statement also expressed confidence that the allegations against Mr. Miro and his associates—including Mr. Kroemer himself—will be found to be unsubstantiated.

Mr. Miro himself had issued a press release on Sept. 27 rebutting the charges.

"I have been, in essence, depicted as some evil wizard or whiz-kid responsible for all of the insurance industry's woes, basically the 'Ollie North' of the Transit Casualty demise and the 'Jim Bakker' of Anglo-American Insurance Co.," Mr. Miro's statement said. "This is ridiculous."

The subcommittee's letter to the Justice Department follows a series of hearings earlier this year on the 1985 collapse of Transit Casualty and the January 1989 failure of Anglo-American, which is unrelated to a London-based insurer of the same name managed by H.S. Weavers (Underwriting) Agencies Ltd.

One hearing focused on Mr. Miro's activities as an MGA for Transit and later as the founder of Anglo-American and ma-

majority shareholder of its parent company (BI, April 10).

Missouri-domiciled Transit is now estimated to be insolvent by as much as \$2.5 billion, while Anglo-American was declared insolvent by \$19 million.

This year's hearings were the latest in an ongoing subcommittee inquiry into insurer insolvencies and the adequacy of insurance company regulation.

Hearings last year on the collapse of Mission Insurance Co resulted in a similar request for a Justice Department investigation into possible mail fraud violations by Mission executives (BI, Dec. 19, 1988; Sept. 19, 1988).

However, prosecutors dropped the Mission inquiry after finding that statutes of limitations on possible charges had expired, according to subcommittee correspondence.

At an April 5 subcommittee hearing, Transit's receiver testified that Mr. Miro's tenure as an MGA was marked by abuses of underwriting authority and the disappearance of millions of dollars in ceded reinsurance premiums into three offshore reinsurers, all named Lafayette Reinsurance Co. Ltd.

A Louisiana Insurance Department representative also testified that Mr. Miro systematically looted Anglo-American through a combination of management fees, loans to affiliates, reinsurance ceded to an Irish company Mr. Miro is believed to control and lavish salaries and expense allowances.

For example, Anglo-American ceded \$5 million to Anglo-American International Reinsurance Co. Ltd. of Dublin, Ireland, which has since failed to pay any of the more than \$3.7

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Mr. Miro

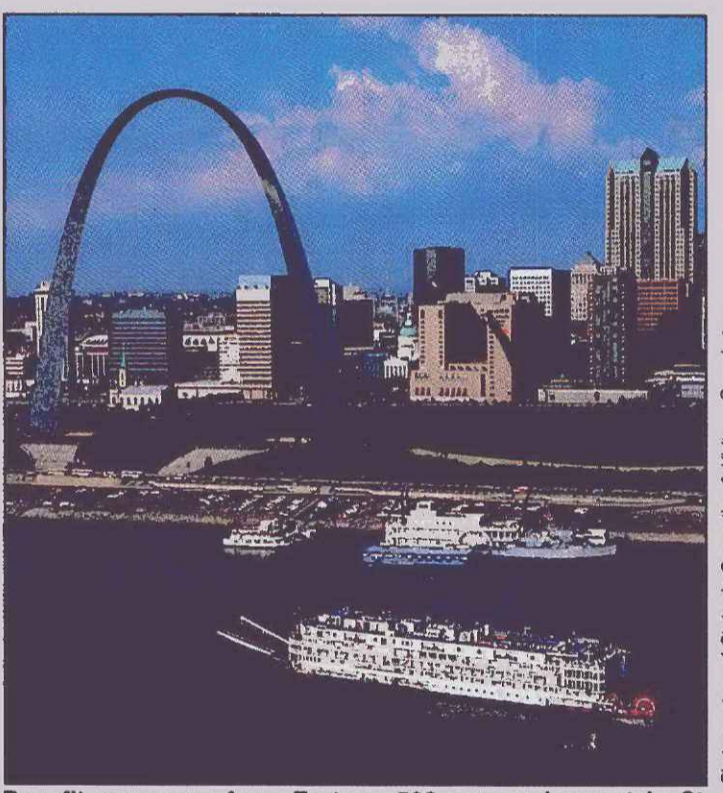


Photo courtesy of St. Louis Convention & Visitors Commission

Benefit managers from Fortune 500 companies met in St. Louis for the Council on Employee Benefits conference.

## Managed care to be norm in '90s, health experts say

By CHRISTINE WOOLSEY

ST. LOUIS—Employers battling continuously rising health care costs will have some innovative weapons at their disposal as they enter the 1990s, employee benefit experts say.

Increased emphasis on managed care, the introduction of practice guidelines or protocols for health care providers and improving how health care providers are selected by employers and employees will augment other tools in employers' health care cost control arsenal.

The 1990s will be the decade of managed care, said several speakers at the Council on Employee Benefits' 43rd annual fall conference, held Oct. 11-13 in St. Louis.

"I think we all know that the point-of-service indemnity plans are dead," said Joseph W. Duva, corporate director of employee benefits at Morristown, N.J.-based Allied-Signal Inc. and president of CEB.

Dr. Paul M. Ellwood Jr., chairman of Interstudy, a health care research firm in Excelsior, Minn., agreed, telling the nearly 300 benefit managers attending the conference that "in the next five years, you will experience more change in health care than the

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## New vesting schedules 'non-issue' for employers

By MICHAEL SCHACHNER

Faster pension plan vesting schedules that go into effect this year under the 1986 tax reform law will mean only small additional costs for employers' pension plans, according to benefit managers and consultants.

Most employers' and pension plans' costs will increase only from 0.5% to 5% because there will not be a significant number of additional plan participants vesting under the faster vesting schedules due to high employee turnover rates, benefit managers and consultants explain.

In fact, faster vesting schedules are such a "non-issue," as one benefit consultant put it, that employers are not conducting full-scale communication blitzes to inform pension plan participants of vesting changes, consultants and benefit managers note.

Indeed, the administrative hassles associated with the faster vesting schedules—such as complying with new pension plan and Social Security integration rules—concern employers more than the cost increases, experts point out.

"Vesting cost increases are less of an issue than the administrative hassles associated with tracking down who is vested and who isn't, especially in a financial institution like ours with a high rate of turnover," observed Lew Garner, vp-employee benefits with Barnett Banks Inc. in Jacksonville, Fla.

The sweeping Tax Reform Act of 1986 requires employers to fully vest pension plan participants within seven years. Previously, employers had been able to vest pension plan participants over as long as 15 years, with many employers opting for 10-year graded or cliff schedules.

Under the new vesting requirements, employers can choose to vest plan participants under a variation of any two minimum vesting schedules:

- Under a seven-year graded schedule, the employer must vest participants at 20% after three years and by an additional 20% in each subsequent year.

- Under the five-year vesting schedule, plan participants must be fully vested after five years.

Under the minimum five-year vesting schedule, employers can opt to for either graded vesting, similar to the seven-year vesting schedule, or cliff vesting, under which plan participants are not vested at all until the fifth year, when they become 100% vested.

Employers do not have the option of a seven-year cliff vesting schedule.

Employers also can implement faster vesting schedules.

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## Hurricane Jerry hits Texas

# Storm's damage limited

By MICHAEL BRADFORD

GALVESTON, Texas—Property insurers, facing billions of dollars of claims from Hurricane Hugo and last week's California earthquake, aren't anticipating a heavy hit from a storm that struck the Texas coast just three weeks later.

Hurricane Jerry blew ashore on Galveston Island Oct. 15 with sustained winds of about 80 mph and, after raking that resort community, moved north striking Galveston, Texas City and Baytown.

Galveston was the hardest hit, with an estimated \$8.25 million in insured and uninsured damage, say city officials.

Damage in Baytown, including the cost of overtime for city workers, is expected to be less than \$2 million, said a city spokeswoman. Texas City officials estimate repair costs at \$500,000.

The relatively light damage follows the fury of Hugo, which left an estimated \$4 billion in insured property damage in the Caribbean and along the East Coast (BI, Oct. 2; Sept. 25).

State Farm Mutual Automobile Insurance Co. and its affiliates will apparently pay the majority of claims from Hurricane Jerry. An estimated 7,500 claims will

cost about \$5.7 million, said a spokesman.

That amount pales when compared to the estimated \$475 million in claims Bloomington, Ill.-based State Farm expects from Hugo.

"As hurricanes go, this was not a real strong one. We didn't need another huge hurricane right after Hugo. We're not happy about another \$5.7 million, but compared with Hugo, that is small," the spokesman said last week before the earthquake rocked northern California.

State Farm did not set up a "special disaster operation" following Jerry, he said, but sent some Texas-based adjusters who were working on claims in the Carolinas to assess damage "in their own back yard."

Claims payments are expected to be "quite light" for Hartford, Conn.-based Travelers Corp., according to a spokesman. "We're quite pleased."

"This one was concentrated in one area and didn't cause the damage that it could have if it had been more spread out," said the Travelers spokesman. A few adjusters were sent to the scene, he said.

"Losses will be rather light," said a spokesman for Nationwide Mutual Insurance Co. of Columbus, Ohio. Figures for Jerry-related damage were unavailable.

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## Insurer stocks

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"as another event in the demise of the soft market," agreed Gordon D. Luce, an assistant manager with Brown Bros. Harriman & Co. in New York.

"As a stand-alone event, I don't think this earthquake is terribly meaningful," but it is significant because it follows Hugo and other catastrophes, said Mr. Ghose.

The two natural disasters are viewed as removing excess capital that has been "sloshing around" the property/casualty insurance industry, said Gloria Vogel, an associate director at Bear Stearns & Co. Inc. in New York.

The feeling is that the earthquake will turn the cycle, said Merrill Lynch's Mr. Lewinsohn, who added, though, that he does not see why it should as long as insurers continue to have reasonable profit levels and excess capital. "You're talking psychology

more than anything else," he said.

A good proportion of stock analysts and portfolio managers have missed the good market the property/casualty stocks have enjoyed all year and are now looking for a reason to get back into the stocks, according to Robert Branche of the Branche Research Group in Morrisville, Pa.

"I think they seized on the argument that rates will now turn up, he said. "I think they're using it basically as a reason for buying the stocks."

Investors are predicting on their own that rates will rise, said a CIGNA Corp. spokesman. "I have not heard of any company spokesmen say that they will increase prices because of this," he said.

The earthquake and Hugo "underscore the need for long-term adequate rates to cover these unusual events," he said.

"We're a little nervous about" the insurer stock rally, said Joanne Morrissey, a principal and analyst

with Firemark in Morristown, N.J. Prices will tighten as a result of the catastrophes, she conceded, adding that Firemark believes that "reinsurance companies are the way to look right now."

However, because the earthquake's final toll is unknown, "I think the stock market may have overreacted a bit," especially on prices for the "bread-and-butter" property/casualty companies, said Ms. Morrissey.

"Until anybody knows for sure, I think it's a little foolhardy to pump a lot of money into property/casualty stocks unless you're ready to pull out at a moment's notice," Ms. Morrissey said.

Brokerage and reinsurance stocks did particularly well last week, observers note.

Several insurance-related stocks hit 52-week highs on Thursday, including Chubb Corp., up \$1.75 in trading Wednesday and Thursday to close at \$82.25; Arthur J. Gallagher & Co., up \$3, to \$26.13;

General Re Corp., up \$5.88 to \$89.63; Marsh & McLennan Cos. Inc., up \$7 to \$79.75; and NAC Re Corp., up \$3.25 to \$39.

Other insurance-related stock that increased on Wednesday and Thursday included American International Group Inc., up \$7.25 to \$106.63; Alexander & Alexander Services Inc., up \$3 to \$33; and Corroon & Black Corp., up \$2.88 to \$38.50.

It is "pretty clear" that "anything that's good for pricing is good for the brokers, and there's no offset in terms of losses they've got to pay," said Goldman Sachs' Mr. Cohen.

Reinsurers are doing well because investors expect primary insurers to buy more reinsurance in light of the catastrophes, he said.

The gains in insurance industry stocks last week come on top of the sector's above-average performance amid the Friday the 13th market turmoil.

"They certainly did do well rela-

tive to the market, and in most cases the insurance stocks did a whole lot better than the market," said Ms. Morrissey.

She noted, for instance, that W.R. Berkeley Co., which is traded over the counter, went up 25 cents on Oct. 13 to \$42.25.

"I think insurance stocks reacted very well when the market had its so-called crash," said Ms. Morrissey.

Mr. Luce said insurance stocks outperformed the market overall because the Federal Reserve Board indicated it may ease the money supply and bring down interest rates.

Insurance companies thrive on low rates because they boost the value of insurers' bond portfolios and there is less temptation to engage in cash-flow underwriting, said Mr. Luce.

However, some insurers were hit particularly hard Oct. 13, including AIG, which dropped \$7.25 to \$97 but rebounded to \$106.63 by Oct. 19.

An AIG spokesman noted that because AIG is part of the Standard & Poor's 500, it is subject to program trading and was automatically sold in some cases when the market dropped.

Ms. Vogel noted that General Re Corp. and Marsh & McLennan Cos. Inc. also are often included in program trades.

Some stocks like AIG "were selling off highs," said Mr. Lewis, noting the stocks did not come "anywhere near" losing all their 1989 gains.

Mr. Luce also attributed the AIG drop to profit taking, because the stock had enjoyed a "good run" in the couple of weeks before the crash.

Analysts and insurance officials point out that the stock market plunge had a minimal effect on insurers' own portfolios.

Common stocks only account for about 17% of insurers' total invested assets, said Sean Mooney, an economist with the Insurance Information Institute in New York.

An overall 8% decline in the market translates into only a 1% to 2% drop in insurers' portfolio value, he said. "The overall portfolio impact of the decline on Friday is pretty minimal," said Mr. Mooney.

"They've lost some money in the stock market, obviously, but not a tremendous amount and, after all, they made an awful lot this year," said Goldman Sachs' Mr. Cohen.

Analysts also point out that any declines in insurer stock holdings probably were offset by improvements in their bond portfolios. However, since insurers report bonds at book, not market, value, any gains are not reflected in insurers' results until the bonds are actually sold.

"The hit in the stock market has been more than offset by the gains in the bond market," said Shearson's Mr. Ghose.

"It's probably a wash," commented Mr. Branche.

Ms. Vogel noted that junk bonds, which have come under pressure, account for probably no more than 5% of insurers' portfolios. But "you've got to wonder" whether a negative turn in the junk bond market could affect the quality bonds insurers hold, she said.

While insurers say they could not pinpoint the net impact of the stock market slump on their portfolios, they do not believe it is significant.

For instance, Sentry Insurance Cos. of Stevens Point, Wis., may have lost less than 0.5% of its surplus when the market plunged, said Sentry Vp and Treasurer Bernard Hlavac.

"We just don't have that much in the way of equities and equity exposure," he said, adding that Sentry's equity market involvement has been "very modest" since the company pulled back in 1985. ■

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# CNA employees embrace LTC benefit

By MICHAEL SCHACHNER

## Benefit beat

An "overwhelming" 22.6% of Chicago-based CNA Financial Corp. employees have enrolled in a new employee-paid long-term care insurance program, company officials say.

CNA credits lower group rates for the response.

"Our employees are able to take advantage of group rates that are lower than individual plans," said Paul Rego, vp of CNA's Special Risk Division in Chicago.

Long-term care insurance coverage is an "increasingly attractive benefit for employees," Mr. Rego said.

Group rates vary according to plan the plan option selected, but the group plan offers savings of 10% to 15% on average, said a CNA

spokeswoman.

The long-term care plan also offers portability: Employees who leave the company can retain coverage at the group rates through direct payments.

In addition, when a participant pulls out of the LTC program, he or she will receive benefits accrued during the time of enrollment.

Nearly 3,300 of 14,500 eligible CNA employees signed up for the coverage, which is written by CNA subsidiary Continental Casualty Co. of Chicago.

More than 1,600 spouses of employees also enrolled.

The response rate is more than

double the initial enrollment in any other announced LTC program, according to the company spokeswoman.

Retirees and parents of employees and spouses up to age 79 also are eligible for the company's coverage.

The group long-term care plan provides participants with the option of home health care coverage, adult day care center coverage and nursing home coverage.

There is no prior hospitalization requirement.

Coverage for home health care and adult day care do not require any previous stay in a long-term care facility.

However, a participant must pay for the first 15 days of home health care services before benefits are payable.

Plan participants may choose from three benefit levels for nursing home and adult day care center coverage: a \$60 daily benefit, with a \$120,000 lifetime maximum benefit; an \$80 daily benefit, with a \$160,000 lifetime maximum; or \$100 daily benefit, with a \$200,000 lifetime maximum.

The maximum benefit available for home health care coverage is 50% of the applicable maximum benefit for nursing home coverage.

For example, the maximum benefit for home health care would be \$50 per day up to \$18,250 per year with a lifetime maximum of \$100,000.

The cost of coverage varies by age of the policyholder and the coverage selected.

In the case of a 45-year-old employee, the premium for a \$60 daily nursing home or adult day care benefit would be \$14.46 per month under the group plan; the monthly premium for an \$80 daily benefit would be \$19.28 per month; and the monthly premium for a \$100 daily benefit would be \$24.10 per month.

For plan enrollees aged 35-39, the premium for a \$60 daily nursing home or adult day care benefit would be \$9.02 per month; the premium for an \$80 daily benefit would be \$12.02 per month; and the premium for a \$100 daily benefit would be \$15.02 per month.

Payments are deducted directly from payroll for employee coverage and for spousal coverage.

Of the CNA employees who enrolled in the long-term care plan, 57% are between the ages of 30 and 45, and 25% are age 45-60.

Employees younger than 30 accounted for 15% of the plan enrollees, and those over 60 years old accounted for 3%.

An enrollee's age on average is 39.

Women account for 70% of those obtaining coverage under the CNA program.

## Daycare benefit

The city of Southfield, Mich., is the first municipality in the state and one of only a few in the country to open a child care center for city employees.

The Southfield Employee Child Care Center, which opened Oct. 16, offers care for up to 39 preschool children as young as 6 months old. The facility can handle up to 15 children aged 6 months to 3 years, according to Jef Farland, deputy director of the city parks and recreation department.

The center, which is owned by the Detroit suburb and operated by the parks and recreation department, charges parents of children aged 6 months to 3 years \$110 per week and parents of older preschool children \$85 per week.

Mr. Farland said the rates are "about middle-of-the-road compared with what the private sector charges."

However, he acknowledged that the rates are somewhat higher than "one might expect" for a city-owned facility because the ratio of counselors to children is better than required by the state's day-care center law.

The Southfield facility offers one counselor for every three children aged 6 months to 3 years and one counselor for every eight older preschool children.

State required ratios are 1-to-4 for infant/toddlers and 1-to-10 for preschoolers.

The city's child care facility has \$10 million of occurrence-based general liability and public officials' errors and omissions liability coverage, with no aggregate, written by the Michigan Municipal Risk Management Authority, a pool consisting of between 75 and 100 Michigan municipalities, according to insurance agent Chris Bowles, a principal with Bowles & Foster Inc. in Southfield.

The facility's property coverage is written by Great American Insurance Co. The facility is covered for replacement value, Mr. Bowles said.

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

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## Opinions

## The kitchen sink, too

WHAT WAS THE DEFINITION of a Vidalia onion doing tucked away in a budget reconciliation bill that the Senate was about to consider? Sen. Phil Gramm, R-Texas, recently asked.

The same question could have been asked of hundreds of other provisions, including restrictions on pension plan asset reversions, which also found a home in the budget bill.

Perhaps senators later agreed to jettison many of those proposals, including those dealing with Vidalia onions and pension reversions, because they were embarrassed that a bill intended to reduce the federal deficit had attracted so many provisions that had little to do with deficit reduction.

And, the leadership of the House of Representatives has indicated that it would be willing to abandon many provisions unrelated to deficit reduction that now are in its bloated budget reconciliation bill.

We hope that these words and deeds are signs that legislators are in fact serious about stopping what has become a scandalous situation: stuffing, without any hearings or consideration, every idea under the sun into what has become monster budget reconciliation bills.

Indeed, these measures have terrorized employers since the mid-1980s.

Several years have passed, but employers still remember how legislators recklessly included health care continuation provisions in the 1985 budget reconciliation bill, which aptly became known as COBRA. With virtually no advance warning, employers were expected to open up their health care programs to millions of former employees and spouses.

And, if an employer made just the slightest inadvertent mistake in extending COBRA coverage, even though the error was quickly corrected, the company still would have lost its federal tax deduction for that year's health care expenses.

Eventually, after an intense employer lobbying campaign, legislators saw the utter insanity of the COBRA penalties and scaled back those penalties to more reasonable levels.

But, the ease with which the health care provisions became part of the huge 1985 budget reconciliation bill no doubt has inspired representatives and their staffers to try their luck at sneaking other benefit proposals—which never could pass Congress as freestanding bills—into subsequent budget bills.

For example, this year's budget reconciliation bills have included such ill-considered proposals as slapping employers with fees for filing federally required pension and welfare plan reports and re-



quiring employers to share control of their defined benefit and defined contribution pension plan assets with employees.

Fortunately, the filing fee and pension asset control proposals were killed after employers alerted legislators to the damage the proposals would inflict on the nation's pension plan network.

But unless Congress reforms the budget reconciliation process, the potential for future damaging proposals, especially in the employee benefit arena, remains.

A few simple steps would go a long way toward cleaning up the budget reconciliation mess:

- Tighten rules so that, generally, only provisions that relate to deficit reduction could be made a part of the legislation. It is impossible for legislators and their staffs to give careful consideration to every provision in measures that number well over 1,000 pages.

- Allow non-deficit reduction provisions to be added to a bill only if the provisions are approved by a majority of the Senate and the House of Representatives. This measure not only would reduce the likelihood that obscure—but potentially damaging—provisions would be made part of the legislation, but they also would allow proposals that have great congressional support—but are blocked by powerful committee chairmen—to obtain serious consideration.

If these changes are adopted, budget reconciliation legislation can become an important vehicle to reduce the deficit rather than an object of terror for employee benefit programs.

## Letters

## Insurers rewrite intent of pollution exclusion

To the editor: As a lawyer representing policyholders in coverage litigation, I read with great interest your recent editorial, "Revisionist History," discussing how insurer arguments today about the effect of the so-called pollution exclusion are inconsistent with the underwriting history of the exclusion (*BI*, Sept. 25).

I thought you might be interested in the

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enclosed articles from *Business Insurance* in the early days of the pollution exclusion.

Apparently Insurance Co. of North America told your reporter that its exclusion excluded coverage only "for companies that knowingly pollute water and the atmosphere" (*BI*, May 11, 1970).

This is consistent both with the company's earlier representation that intentionally "pumping waste materials" into watercourses was "beyond the realm of insurance" (*BI*, June 9, 1969) and with a *BI* editorial the following year which suggested that the exclusion bars coverage for "willful polluters" (*BI*, June 3, 1970).

As the Insurance Rating Board represented to *BI* (and to state regulators), the exclusion "clarifies the situation to avoid any misunderstanding" (*BI*, June 8,

1970).

Of course, the extensive drafting history demonstrating the underwriting intent of the exclusions show that the insurance industry represented that only a "clarification" of coverage was intended—and thus no return premium to policyholders was warranted.

I, like *Business Insurance*, look forward to the insurers' statements in the Allied-Signal case, in which I hope the insurers will own up to the underwriting intent of the policy language.

Neither the courts nor the insurance-buying public should countenance insurer efforts at rewriting history or, for that matter, rewriting policies retroactively.

Marc S. Mayerson  
Covington & Burling  
Washington, D.C.

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## CEB conference

Continued from page 3  
previous 50 years."

In discussing how private sector health care initiatives will interact with public policy in the 1990s to contain costs and bring more value to health care, Dr. Ellwood predicted that the federal government will institute a "triple cap" on federally financed health care programs, like Medicare.

Under the triple cap:

- The government would set a fee schedule for physicians that would effectively shift some remuneration from surgeons to family practitioners and pediatricians, for example.

- Physicians would be limited in the amount they could bill patients beyond the reimbursement they receive from the government.

- The government would "treat the physicians under Medicare like a great big IPA" or individual practice association health maintenance organization. Under this provision, the government would put a target on the amount of money Medicare spends on physician services. If the target is not met, fee schedules would be modified in ensuing years.

However, Mr. Ellwood pointed out that if the government asks physicians to tighten their belts under a triple cap, there will "be a massive cost shifting to the private sector."

"If you think you saw cost shifting when hospitals were put on a lean diet, wait until they try to put doctors on a lean diet," he warned.

At the same time, costs also will continue to be shifted onto employers with indemnity health care plans as more and more companies turn to HMOs and other managed care networks, he said.

"The result will be the end of indemnity insurance and we'll see a total shift in the private sector to use some form of managed care," he said.

He also predicted that only insurers and managed care organizations with adequate market share and an ability to work effectively with providers will remain competitive.

Dr. Ellwood, who was a major influence in the development of the HMO movement, said: "When we first proposed the idea, our assumption was the market would work if employers were selective about providers." However, "they have not been up until very, very recently," he said.

The managed care approach can still work, he said. "We can still reduce hospital utilization by 25% to 30% across the country," he said, pointing out that part of the reason for high hospital utilization rates is because not enough disincentives to hospitalization were incorporated into HMOs or other managed care plans.

And, despite the establishment of utilization guidelines, many inappropriate health care procedures still are being ordered by providers, Dr. Ellwood said.

"There is not enough consensus about what works in medical care, and no amount of changes in structure or incentives for benefits will get around this problem," he said.

In addition, during the next several years, employers will see growing employee dissatisfaction because of the limited choices inherent in managed care plans, Dr. Ellwood said. And, many companies will be increasingly criticized by doctors who accuse employers of attempting to practice medicine.

"The full-blown application of managed care really blurs the distinction between doctor, payer and patient," he explained, noting that "everyone is practicing medicine to some degree."

For example, when an employer selects the doctors its employees can use, it is influencing the patient's behavior. And, because employers provide different levels of reimbursement to employees based on the provider selected by the employees,

Continued on next page

## At issue

### Would you consider offering an employee-paid long-term care plan?



**Thomas S. Roos**  
corporate director-employee benefits  
**Parker-Hannifin Corp.,**  
Cleveland

I would be very hesitant to recommend that our company get involved with long-term care. It is a huge issue, and there are too many unknowns. It's so new that we're really not sure what it represents in total costs. And we're so busy trying to manage benefits for our active employees that, for now, the proper means of addressing the issue is on an individual basis.



**Martin S. Solhaug**  
director-benefits services  
**General Mills Inc.,**  
Minneapolis

Yes. We will introduce a long-term care plan on Jan. 1, 1990. Our employees have become increasingly aware of the risks of being uninsured and the financial strain of long-term care costs. Therefore, we're offering a long-term care insurance policy which delivers cost-effective protection for our employees.



**J.R. Walters**  
consultant manager-compensation & benefits  
**Monsanto Co.,**  
St. Louis

Yes, I would. In fact, on Jan. 1, 1990, we will be offering such a plan, along with a flexible benefits plan, to our salaried and non-union employees in two Monsanto Co. units. We are offering a long-term care plan in response to the employee interest indicated in surveys conducted during the planning stage for the flexible benefits plan.

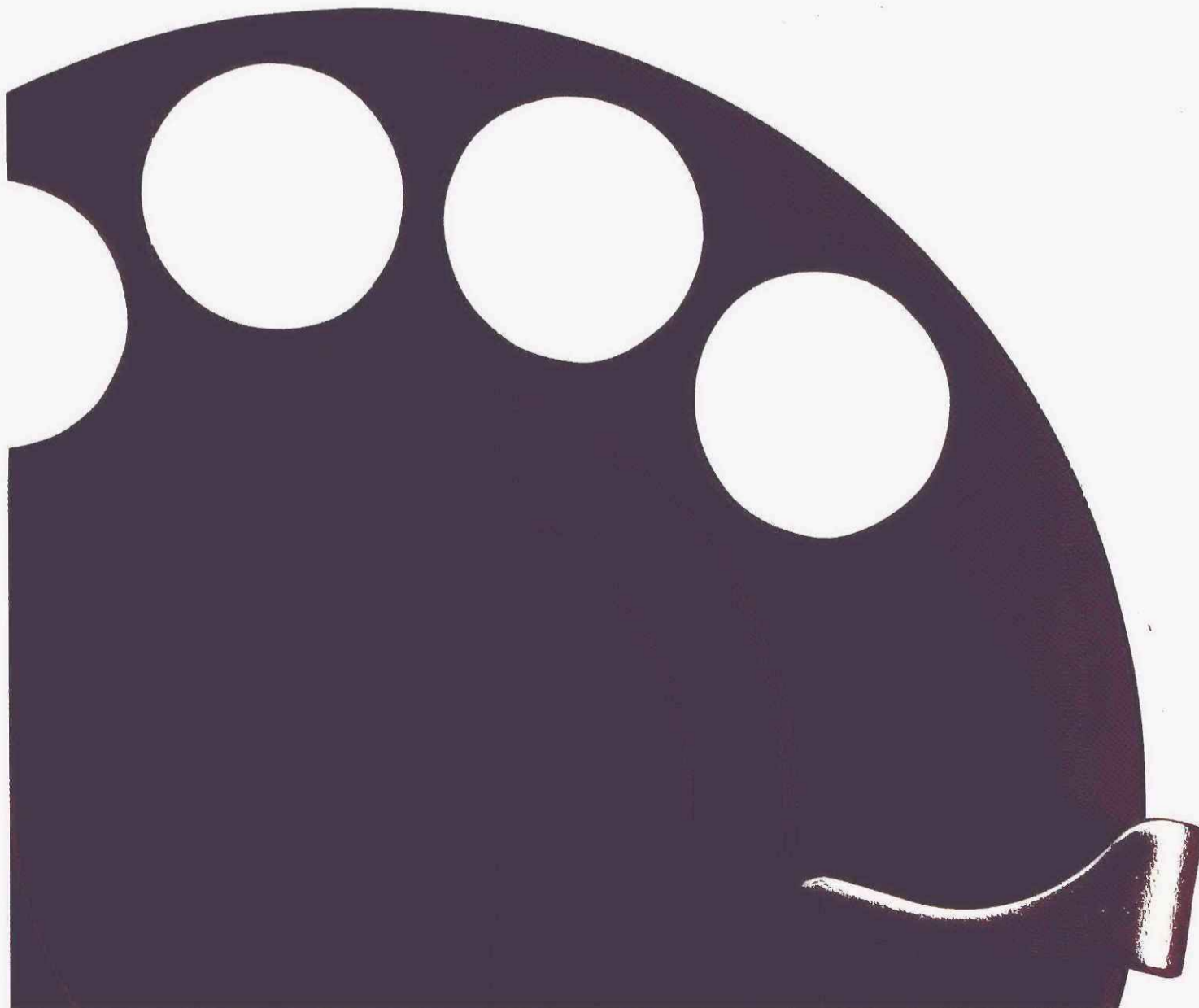


**Teri Edman**  
manager-compensation  
**Century Cos. of America,**  
Waverly, Iowa

We have not considered the possibility of adding a long-term care program at this time. We've needed to use our resources on more pressing areas: health care costs and keeping our other benefit plans in compliance with constantly changing regulations. And, our employees have not expressed a need or an awareness of this benefit.

Compiled by Christine Woolsey

# A lot has changed since C



# Managed care

Continued from previous page  
doctors' behavior may be influenced—namely the type of care they recommend to patients, he said.

Noting that employers and employees still are not obtaining quality health care for the amount of money spent, Dr. Ellwood said there are basically three problems complicating employers' attempts to identify practitioners who provide the highest quality health care at the lowest cost.

First, he said, employers have a difficult time selecting providers to recommend to employees because price or reputation are no longer adequate yardsticks.

And, the providers themselves are having a hard time deciding upon the proper diagnosis and treatment to give patients, he continued.

Some medical procedures only help a small percentage of those patients who undergo a treatment, he said, adding that the medical profession should attempt to pinpoint those pa-

tients most likely to benefit.

"Any kind of real savings in medical care depends on making better choices (and) depends on identifying that patient who is really going to benefit from the treatment," Dr. Ellwood said.

The third problem is that patients, who are increasingly faced with treatment choices that may result in different outcomes, are not given accurate information about how a specific treatment will affect their lifestyle, he said.

This current system "ignores the quality of life" issues, Dr. Ellwood said. But, "we've got to do something about this problem so we can understand—in a statistically sound way—how this process affects people's quality of life."

One way to do this, Dr. Ellwood suggested, is to develop a tool similar to "a financial accounting system that allows us to compare, manage and account for the impact of ordinary medical care on people's clinical status and their quality of life."

"We've been working with the federal government, with pre-eminent physicians and a number of outstanding medical care organizations and I'm convinced we can build and apply a practical health management system" of this sort, he said.

The system would require a huge data base of information in order to produce statistically significant information about the efficiency of various health care providers and the quality of their work, he admitted.

However, he said employers can play a major part in gathering this information. For example, employee benefit managers should require all health care providers to supply them with outcome information, including utilization and consumer satisfaction data, for employees they treat.

The data base will have to be in the public domain and in a form that is easily understood by benefit managers, insurers and managed care organizations, he said.

Success also will depend on getting providers to agree on the terms they

will use to describe a patient's condition in order to come up with objective standards.

Employers should force rapid agreement in this area because health care providers can't do it on their own, he said.

"The real payoff in terms of better choices will take about three years" from now, Dr. Ellwood predicted. Then employers "will begin to get powerful insights into which providers are producing the best results, which treatments are working and who is having an impact on patients' quality of life."

Speaking from a managed care organization's perspective, Richard A. Maturi, executive director of managed care programs at Blue Cross & Blue Shield Assn. in Chicago, agreed that enabling HMOs and preferred provider organizations to work more effectively will dominate employer discussions of health care in the 1990s.

Whereas the 1980s generally focused on getting employees to se-

lect a particular provider, Mr. Maturi said the 1990s will emphasize getting providers to render the appropriate care.

"Managing a health care cost trend is not going to be driven by whether or not employees are in HMOs or PPOs or what the plan design looks like so much as by how managed care programs actually perform," Mr. Maturi said.

"The yardsticks can be debated, but the message is there is inappropriate medical care going on out there" and employers want to find out why, he said, noting employer now are emphasizing value rather than cost.

Mr. Maturi said that the health care field is heading into an age of increased regulation as employers and managed care organizations attempt to control utilization. However, "the really exciting aspect in terms of applications will be the development of practice guidelines and protocols" distributed to providers to give them guidance, Mr. Maturi said.

Those guidelines could be backed by other decision support systems—for example, a software system that contains not only admission criteria, but that also explains the logic and research behind the criteria. "It can be used as a tool the physician can refer to in making practice decisions," he explained.

However the success of such a program depends on two factors, Mr. Maturi said.

"The first is a strong, redefined locally grounded relationship with physicians" by employers and managed care organizations, like HMOs and PPOs, he said. This relationship "is not just a contract or a business deal in terms of complying with contract terms and pricing," he said.

Secondly, the program will require an understanding by providers, employers and managed care organizations of the local culture and mutual cooperation to introduce these standards into medical practice, he said.

"Employers will continue to look at cost because it won't go away," he commented, but there is increased interest in what value—in terms of money saved, employees' well-being and productivity—employers are deriving from managed care programs. ■

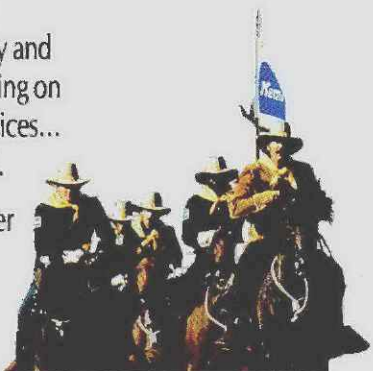
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## Conference spotlights '90s trends

ST. LOUIS—The Council on Employee Benefits' 43rd annual fall conference in St. Louis drew 282 registrants, including employee benefit managers from large U.S. corporations, consultants and insurance company representatives.

The two-day conference featured sessions on health care innovations in the 1990s, long-term care, benefit communications and employee savings plans.

Next year's fall conference will be held Oct. 10-12 in Garden City, N.Y. CEB plans to hold its 1991 fall conference in Chicago.

The Council on Employee Benefits, founded in 1946, is composed of 193 Fortune 500 companies. Its main purpose is to stimulate the development and improve the administration of employee benefit plans among its members. It also provides a medium for the exchange of ideas and information on the design, operation and financing of such plans.

For more information about CEB, contact Roger L. Groh, Corporate Director of Employee Benefits, General Dynamics Corp., 7733 Forsyth Blvd., St. Louis, Mo. 63105.

# Candor eases concern over benefit changes

By CHRISTINE WOOLSEY

ST. LOUIS—Employee benefit managers can use several communication practices to take out the sting when they cut employee benefits or shift more of the cost to employees, an employee benefits consultant says.

Among other things, employers should interview employees about their concerns and balance what employees perceive as bad news about plan changes with different perspectives showing advantages, suggested Dennis S. Roussey, vp in the Cleveland office of the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.

Because benefit changes today most likely entail cutbacks or cost shifting to employees, communicating benefits changes is "not

quite the party it used to be," Mr. Roussey told the 43rd annual Council on Employee Benefits conference in St. Louis earlier this month.

"The message used to be: 'Guess what else I'm bringing you?'" Mr. Roussey noted.

Once employees understood what they were being offered, the rest of the project sold itself, he said.

Now benefit managers have to lower employee expectations—which are higher than ever—and also make sure employees understand benefits, he said.

Higher standards of living and changing demographics are major reasons for employees' high benefit expectations, he said.

"We're all a bit spoiled and we have high expectations just walk-

ing in the door," he said. And working couples and single parents, which comprise a major segment of the workforce, expect plans to be tailored to their unique needs, he said.

Employees also are anxious in

## Council on Employee Benefits

Fall Conference  
St. Louis

today's environment of mergers and acquisitions, divestitures and downsizing, Mr. Roussey continued.

After a company restructures "employees are stunned—they are waiting for the other shoe to drop"

in the form of reduced benefits or cost shifting, he said.

With the rapid pace of business and legislative change, very few employers have time to help employees understand the changes. "It's hardly possible to move through such steps as confrontation, bargaining and acceptance of these changes," he said.

But employers that are making substantial benefit plan changes can promote employee understanding and acceptance in a variety of ways.

First, benefit managers can anticipate objections and concerns by listening to employees informally through supervisors, through suggestions and direct written communications Mr. Roussey suggested.

"A lot of times they are not nec-

essarily totally against the changes. They simply don't understand," he said.

Companies should also consider collecting helpful information about employees through formal surveys, he said.

He recommends benefit managers also identify and address employee concerns.

For example, in a videotape produced by Allied-Signal Corp., a Morristown, N.J.-based manufacturer, a benefits manager confronts employee misgivings about a new managed care network—that they will lose some control over health care choices and may have to use lower quality physicians.

"I don't want to get a bozo for a doctor," says one employee in the tape.

Several others say they are happy with their current doctors.

Allied-Signal's video then explains how network physicians are chosen to alleviate employees' worries.

Employers also should stress the positive aspects of plan changes that employees may dislike, Mr. Roussey said.

For instance, when implementing a second surgical opinion requirement—which employees may find inconvenient—employers should point out that a second opinion may help avoid surgery altogether.

And companies, he said, should stress that increased employee out-of-pocket expenses, generally a sore spot with workers, are almost always lower than the value of the benefit.

In addition, employers should emphasize that benefit plan cutbacks or cost shifts are necessary for the company to remain competitive, he suggested.

Also, an employer can compare its benefit package with those offered by other employers.

The message might be: "We've found a way to offer health care protection to our employees and we've done it without jeopardizing the company's financial future," as was said in a sample video presented during the session.

"People need a clear understanding of why (changes) have to happen," Mr. Roussey said.

He recommends giving employees ample facts and statistics about factors like rising health care costs.

Meetings are the best medium in which to explain benefit changes to employees, he said.

"There's an awful lot of stuff being done on paper," but face-to-face contact is invaluable, Mr. Roussey said.

"It's expensive, it takes a lot of work, but, boy, when you're finished people know what you're talking about."

Whatever medium is used, managers must relay the right message, he said, adding that it is most important to "allow the time to do it right. The agony of going through plan changes can take a long time."

Getting top managers to approve plan changes can take up to two years and many benefit managers may suddenly realize they have only three months left to present a new plan to the workforce.

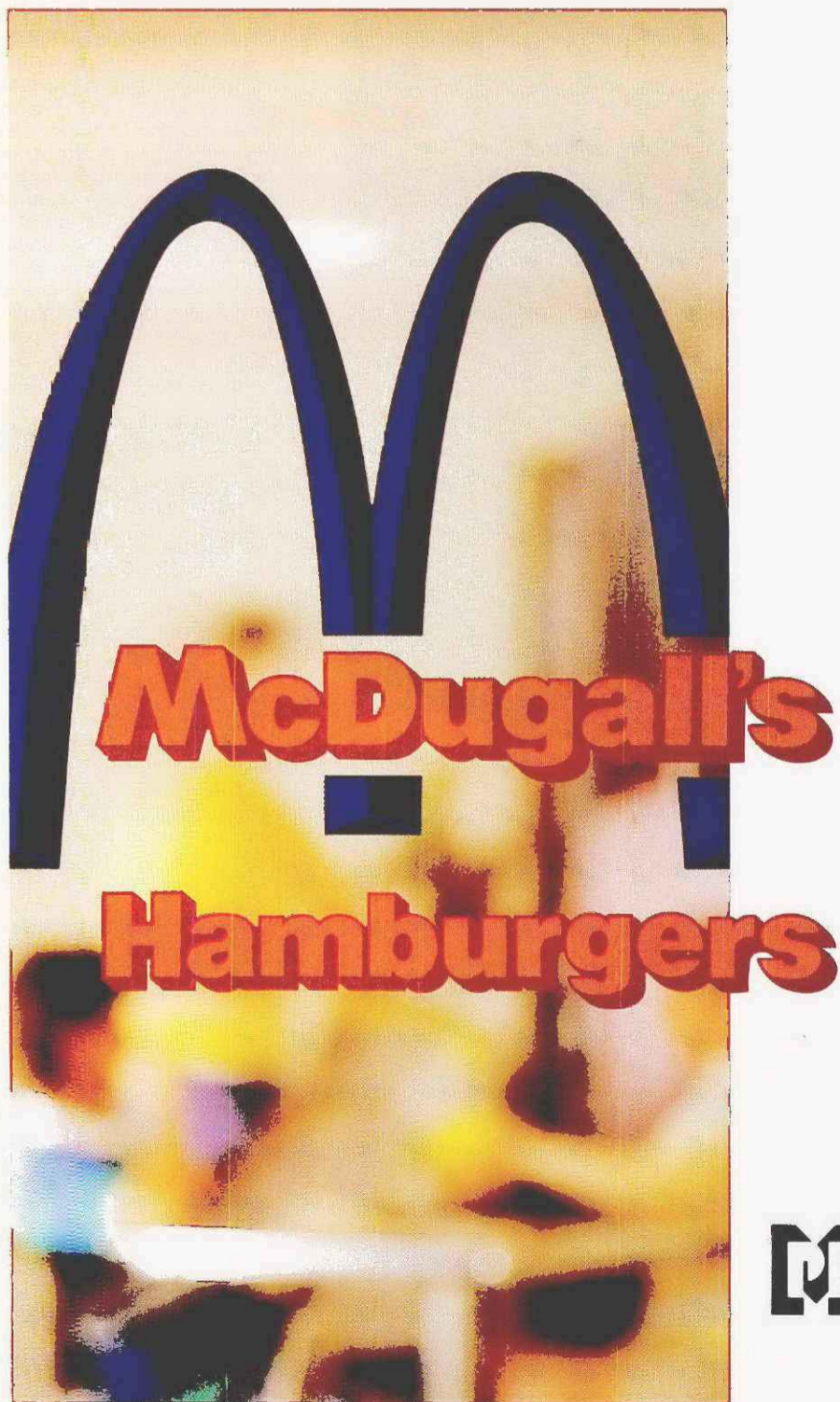
In those three months, employers have to devise a communications strategy, "write it, review it, revise it and print it and make the visuals—the whole nine yards," he said.

Therefore, the earlier that benefits managers start the process, the better, he said.

Mr. Roussey also cautioned benefit managers to avoid making long-term commitments.

"We have to prepare ourselves and our employees for constant change," he said. ■

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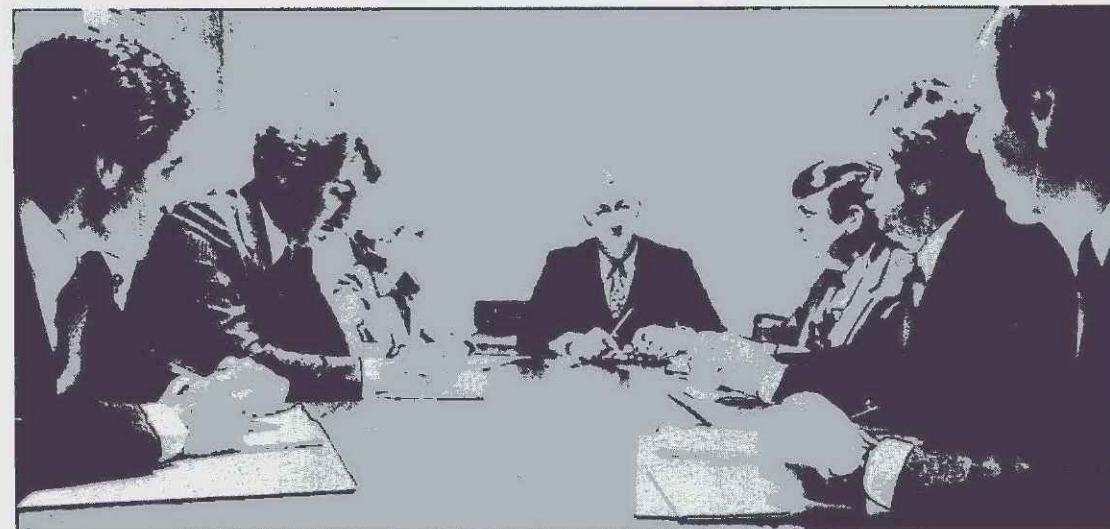
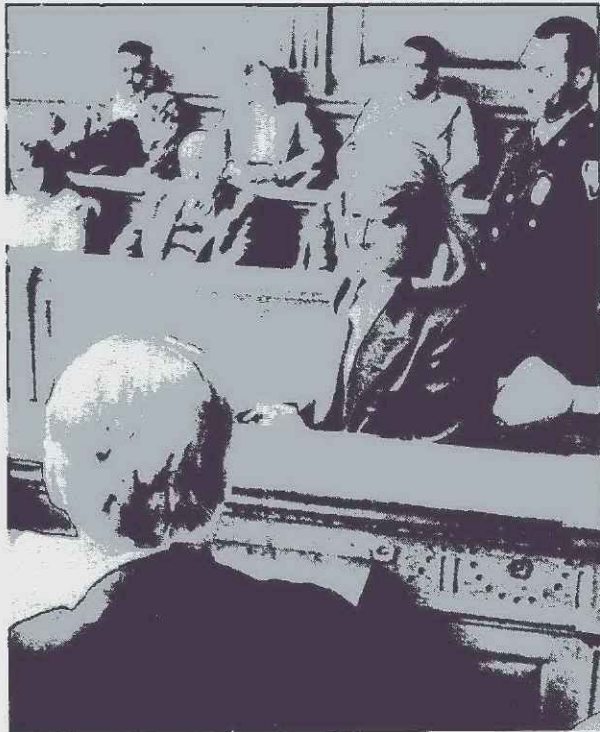


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# Few employers pay cost of LTC cover

By CHRISTINE WOOLSEY

ST. LOUIS—More employers are offering long-term health care plans to workers, but few are willing to pick up any of the tab for the coverage, employee benefits experts say.

"In the last three years there has been a dramatic change in employers' interest in sponsoring (long-term care plans) on an employee-pays-all basis," said JoAnn Mathieu, long-term care director in the employee

benefits division of Aetna Life Insurance Co. in Middletown, Conn.

"Three years ago, we got zero requests for long-term care proposals," she said. But "in the last quarter alone, we sent out 15 proposals."

Employers today are playing "a key role in designing the program that is offered, and they also play a key role in the educational efforts that take place to make sure the employees understand what it is they're being offered," she said.

But despite their interest in sponsoring long-term care programs, employers are not willing to contribute to their cost, Ms. Mathieu said during a session at the 43rd annual Council on Employee Benefits conference held earlier this month in St. Louis.

Employers are hesitant because post-retirement health care expenses—including the cost of long-term care coverage—cannot be pre-funded on a tax-advantageous basis, benefits experts explain (*BI*, March 15, 1987).

In addition, "a lot of the (long-term care) programs were implemented in 1988 and early 1989" and are just catching on, Ms. Mathieu pointed out.

"Long-term care is an emerging benefit," said Richard Gopen, director of benefits at Atlanta-based Centel Corp.

"It has some permanence as a benefit," because "it's based on a real need—the possibility of a large uncertain liability hanging out there

somewhere," he said.

Because many employer-sponsored health care programs were not designed to pay for long-term care, these costs traditionally have been borne by either the families of the individuals receiving the care or by federal programs such as Medicare or Medicaid, Ms. Mathieu explained.

However, because Medicaid usually does not begin paying until the resources of the individual receiving care have been exhausted, and then does not pay for all long-term care services, the need for private long-term care funding has grown, benefits experts say.

"There has been a much greater focus on the need for a systematic program for both insuring and pre-funding long-term care to make it more affordable to a broader population," said Ms. Mathieu.

"The ideal time to fund long-term care is while the person is earning income, just as it is for pensions—not during one's retirement years," she stressed.

American Express Travel-Related Services Co. Inc. was one of the first private employers to sponsor a long-term care program for its employees. The plan, underwritten by a Travelers Corp. unit, was instituted Jan. 1, 1988 (*BI*, Dec. 14, 1987).

The state of Alaska became the first public employer to sponsor a group long-term care plan for its retirees in May 1987 (*BI*, March 16, 1987).

American Express launched its long-term care program because "36% of our employees indicated they have some elder care responsibility,"

## Council on Employee Benefits

Fall Conference  
St. Louis

explained Carol D. Fujita, director of benefits for the New York-based corporation, which employs 90,000 people worldwide.

Because "most medical plans do not provide coverage for long-term care and it is unlikely the government will address" the issue, Ms. Fujita said her company decided to tackle the problem.

The American Express long-term care plan is available to employees, their spouses and to the parents of employees and their spouses. Out of 23,000 eligible employees and retirees, 2,235 employees and one retiree currently are enrolled, Ms. Fujita said.

While Ms. Mathieu admitted that the insurance industry is "in its infancy" with regard to developing long-term care products, she said more and more insurers are offering such coverages.

For example, besides Aetna and Travelers, long-term care plans have been introduced by Blue Cross & Blue Shield of Rochester, N.Y. (*BI*, May 29); Mutual of Omaha Cos. (*BI*, July 10); and CNA Financial Corp. (*BI*, March 6), among others.

In addition, the Blue Cross & Blue Shield Assns. of Michigan and Kentucky are participating in a two-year pilot program believed to be the first employer-paid long-term care plan. The project was launched in April at two Ford Motor Co. plants in Louisville, Ky. (*BI*, March 27).

As long-term care products evolve, there is a "substantial move to more comprehensive coverage," Ms. Mathieu said.

The first generation of products were very narrowly defined, she said. "They provided little or no home care." Typically, a covered individual qualified for nursing home coverage only after a long hospital stay, and home health benefits were available only after an extended nursing home

Continued on page 16

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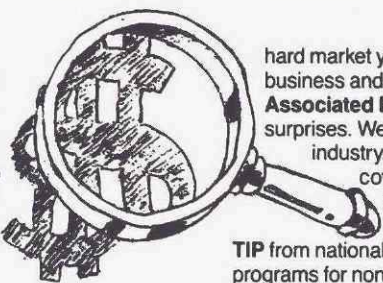
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**Long-term care**

*Continued from page 14*  
stay, she explained.

"They were designed that way because there was no clear indicator on how to measure need (for the benefit), especially in a home environment," Ms. Mathieu said.

However, custodial care is now a central focus of Aetna's long-term care products, she said.

"Our products have moved away from the basis of confinement, and all of them now offer nursing home coverage without prior confinement in a hospital," Ms. Mathieu said.

Coverage is triggered under long-term care policies underwritten by Aetna—and by most other LTC insurers—when it has been determined that a covered individual can no longer perform at least two of the five basic activities of daily living: walking, mobility from one place to another, eating, dressing and using the restroom.

This assessment method, which has "been around in the public sector for years, has been very effective and has been cited as the most efficient and effective way of measuring actual need for long-term care," she said.

Typically, employer-sponsored group long-term care programs are offered to active and retired employees and their spouses, as well as to the parents of employees or retirees and their spouses, according to Ms. Mathieu.

Although employees pick up the entire tab for long-term care programs, they benefit from lower group plan rates.

The programs usually provide fixed daily indemnity benefits, ranging from \$40 to \$120 a day, and employers can establish from one to four benefit levels. The benefits paid are based on the environment in which a covered individual is receiving care—either a nursing facility or at home.

For example, individuals electing nursing home coverage would generally be eligible to receive the full daily benefit, while those choosing some type of home health care may receive 50% of the maximum benefit.

Home care benefits typically cover both custodial services and adult day care, she said.

While many long-term care programs only cover care administered by professionals, "(Aetna's) program folds in an informal support network and will provide the benefit even if a family member is rendering the care," Ms. Mathieu

**Custodial care is now a central focus of Aetna's long-term care products, says Ms. Mathieu.**

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said.

Benefits for most long-term care programs begin after a 90-day waiting period, and they typically are payable for a range of five to 10 years. Maximum benefits vary based on limits set by employers.

Some LTC programs include premium waiver and/or inflation guard features, Ms. Mathieu said.

Under a premium waiver feature, a policyholder who has been receiving benefits for 90 days or longer is not required to make premium payments for as long as he or she is under long-term care, she explained.

The inflation guard is basically an automatic benefit increase provision usually tied to increases in the medical care component of the Consumer Price Index.

Premiums for long-term care coverage are based on the age of the covered individual at the time of enrollment, Ms. Mathieu said. Employees pay their premiums through payroll deductions, while retirees and covered parents are billed directly by insurers.

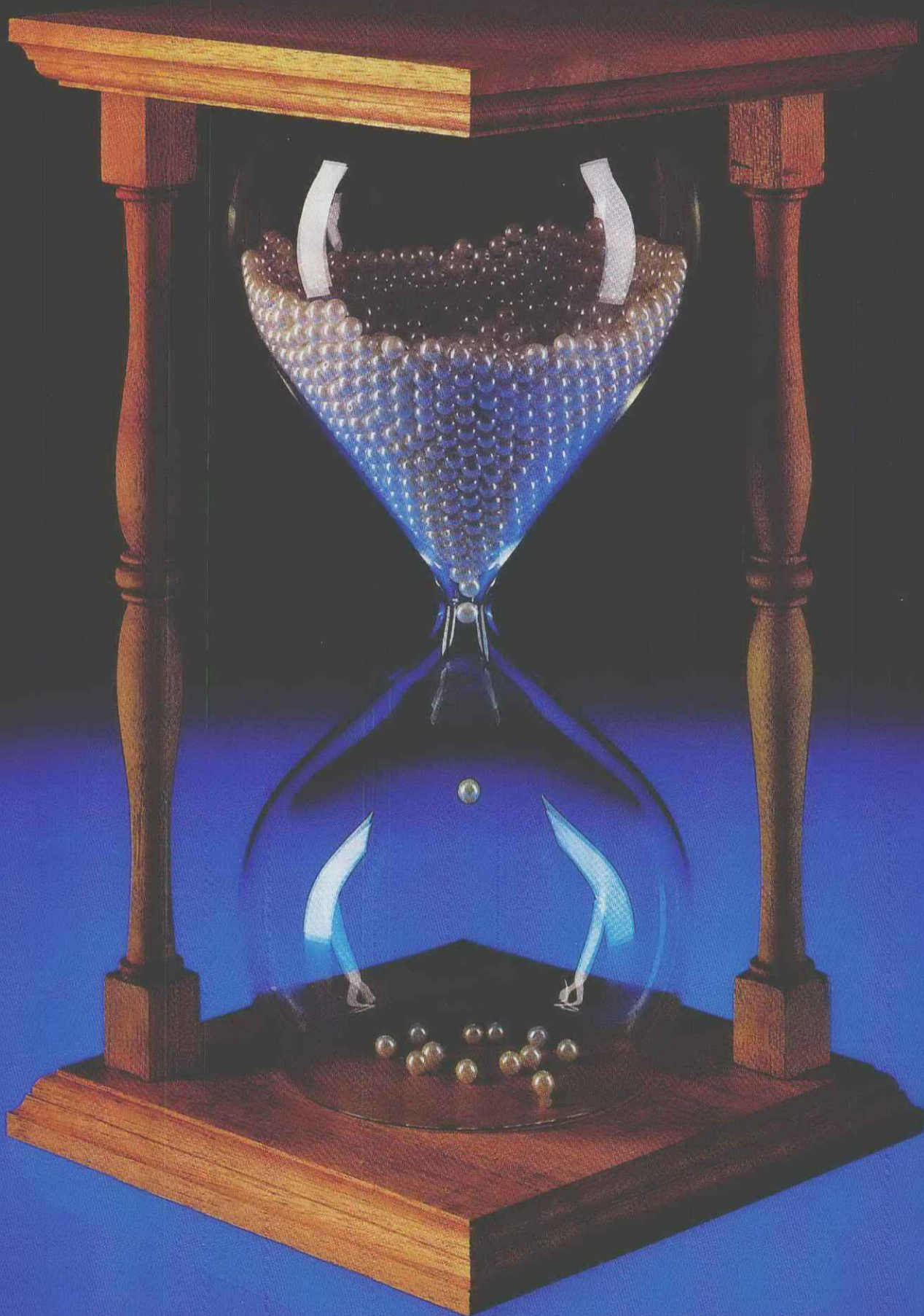
Many long-term plans are portable should an employee change employers.

While the long-term care plans written by Aetna only have attracted an average of 7% to 14% of an employer's workforce, with an average enrollee age of 41, Ms. Mathieu is not disappointed in employee response.

Long-term care programs are still new, she pointed out. "We have a long way to go with regard to the communications/educational effort, and I truly believe those numbers are going to increase.

"There isn't any one-size-fits-all solution, but both the public and the private sectors must continue to work together to define and to implement the most appropriate role for each of them," she said.

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# Berwind seeks to move suit to Bermuda

HAMILTON, Bermuda—Berwind Corp., parent of the insolvent Norad Reinsurance Co. Ltd. of Bermuda, is asking a Pennsylvania Commonwealth Court to dismiss a suit brought against it by Norad's largest creditor, claiming the state court is not a proper forum.

In a brief filed with the court, Philadelphia-based Berwind argues that the suit brought by the rehabilitator of Mutual Fire, Marine & Inland Insurance Co. should be dismissed on the grounds of forum non conveniens and should be refiled in Bermuda courts (*BI*, Oct. 16).

This is the same strategy that currently is being used by defendants named in a suit brought by the liquidators of Bermuda-based Mentor Insurance Ltd., which also is in liquidation.

The liquidators have since filed suit against the defendants, which include Mentor parent Ocean Drilling & Exploration Co., in Bermuda court after a U.S. court dismissed the original suit (*BI*, Oct. 9).

The 5th U.S. Circuit Court of Appeals last summer upheld a decision by a U.S. District Court judge in New Orleans to dismiss the Mentor case on the grounds of forum non conveniens. And, the U.S. Supreme Court recently refused to review the case.

Mutual Fire, Marine—which is in rehabilitation in Pennsylvania—filed suit against Berwind in August, seeking to pierce the corporate veil and hold Berwind responsible for the liabilities of the insolvent reinsurer.

The suit seeks at least \$25 million from Berwind, according to Mutual Fire, Marine attorneys.

However, Berwind's brief counters that by filing suit in Pennsylvania rather than in Bermuda, where Norad is based, Mutual Fire, Marine has attempted to capitalize on the fact that evidence that will demonstrate that Norad existed independently from Berwind is located in Bermuda and, therefore, would be unavailable for Berwind to use in its defense.

The Berwind brief states: "Critical non-party witnesses, including Norad's Bermudian officers and directors, employees of management companies that operated Norad on a day-to-day basis and Norad's auditors who audited the financial statements alleged in the complaint to be fraudulent are subject to subpoena for trial in Bermuda, but not in Pennsylvania.

"Most documentary evidence is also in Bermuda," the brief points out.

By bringing the litigation in Pennsylvania, Mutual Fire, Marine was ignoring the fact that Bermuda had a compelling regulatory and economic interest in the resolution of the conflict, according to the brief.

"It is also probable the Bermuda law will apply to the substantive allegations of the complaint," the brief says.

"The doctrine of forum non conveniens was created to prevent plaintiffs from engaging in precisely this sort of litigation by venue. This is a classic example of a situation where a defendant's ability to present evidence to its defense is severely impaired by the plaintiff's choice of forum," the brief says.

"Justice requires that the case be dismissed in favor of trial in Bermuda."

Berwind in its brief says that it is willing to agree to comparable stipulations made by the defendants in the Mentor case if the litigation is refiled in Bermuda.

The defendants in the Mentor case agreed to waive statute of limitations defenses if the action were

## Bermuda

refiled in Bermuda, the Berwind brief says.

The Mentor defendants also stipulated that any final judgment that was obtained by the plaintiffs in the Bermuda court would be accorded full faith and credit in courts in the United States, the brief points out.

The brief goes on to argue that Mutual Fire, Marine's complaint against Berwind on other grounds, including negligence, breach of

contract and negligent representation should be dismissed. The right to bring an action for these alleged offenses belong to Norad's liquidator, not to Norad's creditors, the brief states.

Norad, which stopped underwriting in 1985, entered liquidation in October 1988.

Norad liquidator Chris Whittle, a partner with accountant Ernst & Young, announced last month that Norad's creditors are expected to

receive a first and final cash payment from the insurer's estate in April 1990.

However, based on current estimates of assets and liabilities, the 50 creditors will receive only about 10 cents on the dollar.

—By Meredith Ebbin

## White-collar crime

Bermuda Attorney General Saul Froomkin will hire a special prosecutor to be responsible for all fraud cases, computer crimes and other white-collar offenses against banks and other companies, in-

cluding insurers.

The prosecutor will be the first specialist of its kind to be appointed by the nation's attorney general.

Business leaders, who saw fraud cases in Bermuda double last year—to 1,142—welcomed the appointment.

The growth of white-collar crime in Bermuda already has led one local insurance company to hire a Lloyd's of London underwriter to price local insurance policies covering employee theft and computer fraud.

—By Roger Scotton

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# National health plan debated

By ADRIENNE C. LOCKE

## Myriad state rules seen as obstacle

WASHINGTON—A national health care policy can succeed only if myriad state and local regulations governing health plans are pre-empted, asserts a lobbyist for a group representing multiemployer health and pension plans.

If the Employee Retirement Income Security Act of 1974 does not pre-empt state benefit laws, employees eventually will end up with unwanted benefits, the lobbyist says.

However, a U.S. representative who supports House legislation re-

quiring employers to offer minimum health care benefits tional says that states should be given some authority to mandate health care coverage that meets the particular needs of its citizens.

The debate over state-mandated health benefits was one of the topics discussed earlier this month at a hearing by the House Labor-Management subcommittee.

A national health care policy, added to state health care requirements, would force many employ-

ers to comply with "crazy-quilt" regulations "imposing unnecessary costs and unwanted benefits" on insured health plans, testified James Ray, working committee member of the National Coordinating Committee for Multiemployer Plans.

"Virtually every state now has enacted mandated benefit laws," said Mr. Ray, who was representing NCCMP Chairman Robert A. Georgine.

"There are literally hundreds of

state and local laws mandating insurance plans to cover specific illnesses or treatment methods, to pay for services by certain types of providers, to cover particular dependents, to use a particular coordination of benefit methods, or to provide continuation coverage and conversion rights," he said.

This situation, he said, developed after a 1985 Supreme Court ruling—in *Metropolitan Life Insurance Co. vs. Commonwealth of Massachusetts*—that said that states may

require group health insurance policies to offer certain benefits (*BI*, June 10, 1985).

As a result, insured health care programs must be tailored to comply with benefit requirements for each state in which employees are covered, Mr. Ray said.

In many cases, plans end up paying for benefits that employees do not want or need, he said.

Coverage becomes more expensive and employers then may be unable to afford other benefits they do want to provide, Mr. Ray explained.

However, Rep. Jim McDermott, D-Wash., testified that "there will probably be some sort of mandated benefits, but the question is how specific they will be."

He agreed that under a national health care program Congress would be responsible for setting standards.

Benefits included in most health care policies, such as hospitalization, could more easily be incorporated into a national health plan, Rep. McDermott said.

National health care legislation should give each state authority to mandate benefits its citizens demand, said Rep. McDermott, a supporter of H.R. 1845, the Basic Health Benefits for All Americans Act, which was introduced by Rep. Henry A. Waxman, D-Calif., in April.

Rep. Waxman's bill is essentially identical to S. 768, introduced by Sen. Edward Kennedy, D-Mass., which would require employers to offer benefits including hospital-

**In many cases, plans must pay for benefits that employees do not want or need, says Mr. Ray.**

and physician services, diagnostic tests, pregnancy and well-baby care and limited mental health care.

The subcommittee also heard testimony on whether plaintiffs should be able to recover punitive damages from defendants that violate ERISA regulations.

Allowing these types of awards could encourage "numerous" employers to consider terminating their benefit plans because plan sponsors, as well as insurers, would risk exposure to huge losses, said Duncan B. Blair of Lange, Simpson, Robinson & Somerville in Birmingham, Ala., counsel for Blue Cross & Blue Shield of Alabama.

However, allowing punitive damages would deter insurers that do not now fulfill coverage promises or pay claims on time, said Kathy S. Abascal, an attorney with Manuel Glenn Abascal in Berkeley, Calif.

Insurers now can hide behind the ERISA pre-emption of litigation for breach of contract and fraud involving charges of improperly processing claims, she said.

Designed to ensure workers minimum benefits, ERISA now "instead ensures that the worker will under no circumstances receive more than the bare minimum contract benefits, no matter how much suffering the worker undergoes as a result of being wrongfully refused promised benefits," Ms. Abascal said.

In several cases, she said, policyholders have been harmed financially and emotionally by insurance companies' misconduct involving legitimate claims and had no means to recover any of

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\*Employee Benefit Plan Review, April 1989.



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# Cost concerns spur EBIS/RMIS merger

LAST MONTH, I described the merger of employee benefit and risk management information systems as a necessary next step in software evolution for the risk manager and benefit manager (*BI*, Sept. 25). The reason for the combined system, which I have dubbed ERIS, is a mandate from senior management to contain medical costs arising from health care plans and statutory workers compensation obligations.

This senior management directive, now quite apparent in larger organizations like Fortune 500 companies, will gain momentum as health care expenditures continue to rise. For example, in 1988 the money spent on health care was 11.2% of the U.S. gross national product.

As we all know, one of the fundamental objectives of both a risk management information system and an employee benefit information system is to assist the risk and benefit manager to identify and analyze problem claim areas and formulate proper risk control strategies to effectively deal with them. Those problems may range from a high frequency of workers comp claims, generated by an unsafe plant or lax adherence to safety guidelines by employees; to being charged more for medical services than usual-and-customary fee schedules allow; or to "double-dipping" between group health benefits and workers compensation.

How, then, would one design the ERIS? As with all discussions of information systems, the foundational step is the data base. From there, the basic claims monitoring/adjudication system module would be designed. And lastly, decision support/analytical modules would be designed.

A properly designed data base—containing accurate and comprehensive information—is crucial to the success of an ERIS. Ideally, the data base should contain pertinent employee data (i.e.: age, date of employment, medical history, claims history, job function, etc.).

Secondly, it should have a sub-data base of usual-and-customary medical fees (medical fee schedules) that are integrated with generally accepted medical reimbursement ground rules and guidelines. These have been long used by the health insurance industry and now are increasingly being applied to the workers compensation arena.

Unfortunately, one problem is that there is a lack of consistency among state and federal workers compensation programs on what is meant by a fee schedule. Some are very restrictive in that they only allow a specific dollar amount for a certain medical treatment while others adopt the generally accepted/usual-and-customary fee schedules used by the health insurance industry.

Regardless, the variance in the "fee schedules" is an obstacle that must be overcome by the ERIS vendor. Most RMIS vendors are making strides in this area.

There are two ways to construct the ERIS data base. One is complete integration, which is how California

Interactive Computing Inc. designed its GenView system. Both property/casualty modules and group health care modules draw from a common data base.

The other option is the bridge format. In this option, group health care data and workers comp data are linked by a common element, such as employees' Social Security numbers. Any changes made to an employee's file, be it a workers compensation or employee benefit claim, would automatically update the entire file.

Some of the vendors utilizing this approach are Travelers Corp., Corporate Systems, Risk Sciences Group Inc. and Insurance Software Packages Inc. I am sure that there are more vendors offering a bridge format, and apologize to those unintentionally omitted.

These vendors approach the ERIS design in a similar fashion:

- Travelers' Risk Management Information Services utilizes its existing

EBIS and RMIS to allow the risk manager and benefit manager to easily access and extract data.

If the bridge programs are successful, one would not need to eliminate a system or systems in favor of an all-inclusive ERIS. As we have seen in past columns, scrapping or significantly upgrading systems can be very time consuming and costly.

Another reason for a well-designed link between the two separate data bases resides in the nature of the data being collected by both benefit managers and risk managers.

There are significant differences in the data collected by the two types of data bases, notes Robert T.C. Cone, director of property/casualty development for Consolidated Healthcare Inc. in Richmond, Va.

Insurers, with their focus on regulatory compliance and loss control, traditionally concentrate on gathering

mistakes, identifying duplicate claims is an important cost containment measure that an ERIS can provide.

Misclassification and double dipping can also result when a new episode or injury is related to a compensable pre-existing condition. The health insurer may receive the claim without any knowledge of a pre-existing workers comp claim.

Claims analysis can also be brought to bear on the medical component of either a workers compensation or group health care claim.

This is where the inclusion of an integrated data base—composed of generally accepted/usual-and-customary medical fee allowances—to ascertain the accuracy of the medical treatment is paramount in cost containment.

If medical bills submitted under workers compensation programs are subject to the same degree of scrutiny that health insurers employ in gauging the accuracy and necessity of medical treatment, great amounts of money can be saved. Other cost containment strategies, long a part of the employee benefit manager's arsenal, can be applied in conjunction with an ERIS.

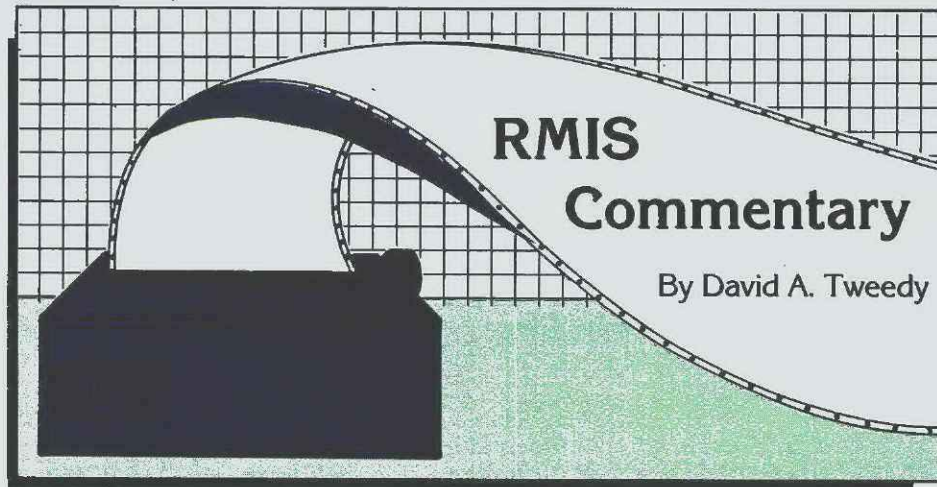
For example, according to Don St. Jacques, director of new products development for Corporate Systems, when medical bills arrive at the claims administrator's office, the adjuster enters the bill into the system. From there, the system evaluates the bill for reasonableness, performs a utilization review, checks medical fee schedules, and submits the bill to a utilization review firm for its input.

Finally, the system would cut the check. Because of the heavy analysis done by the system, there is much less potential for duplicate payment, unnecessary payment either by amount or by frequency, etc.

I know that I have just scratched the surface of this very intriguing issue. I have not even spoken of the decision support modules that an ERIS might employ.

And, though merging the data bases and claim modules of an RMIS and EBIS sounds like "Star Wars" to some, I believe the merger of these two systems is imminent.

Whether it occurs on a fully integrated basis or on the linked data base fashion is almost irrelevant. The fact remains that the ERIS will gain in importance as senior management increasingly emphasizes cost containment.



"Inform" and "Group CARMA" software for policyholders with both group health and workers compensation exposures. Reports are based on the dual data bases and losses are broken out for either exposure in one report.

- Corporate Systems has initiated a joint venture with Republic-RSB Cos. Inc., a hospital bill audit firm. Utilizing each firm's respective strength in the RMIS and EBIS area, the joint venture—called Diagnostic Profiles Inc.—will focus on merging the two disciplines.

- Risk Sciences Group is working with several key clients in the bridge format to combine workers compensation/group health care data for cost containment purposes.

- Insurance Software Packages combines workers compensation modules with group health care management modules, again focusing on merged respective data bases through a common link.

There are distinctive advantages to both the complete integration and bridge approaches.

The completely integrated data base's advantages are a single set of commands and codes for both systems. Learning two different systems is time-consuming, especially when extracting information from either the EBIS or RMIS involves radically different command procedures. Then, obtaining the data may mean deciphering a completely different set of codes within the systems.

Hopefully, the bridge format would allow an easy transition between the

worker training and experience data. For example, on what shift an accident occurred, where it occurred and any other variable that contributed to the accident.

Conversely, the health insurer gathers data on precise diagnostic classifications or precise statement of the medical procedures utilized in an episode of care and so forth.

Whether one pursues a dual EBIS and RMIS approach with a well-linked data base or a completely refurbished and designed ERIS with a common data base, it is imperative that the claims module for monitoring and, in some cases, paying claims be upgraded.

The ERIS claims module must be able to extract relevant data from both group health and workers comp data bases to perform analyses and generate reports. According to Mr. Cone, the primary benefit of a merged system lies in the elimination of improper classification and duplicate payments. The extent of the problem of duplicate claims payments—when an employee files both a workers comp and group health claim for a single injury—varies depending which vendor you ask.

Ken Martino, assistant director of Travelers' Risk Management Information Service, says he does not see many fraudulent duplicate claims. Instead, he says duplicate claims usually are an honest mistake. The injured party sends bills to the wrong provider, genuinely not knowing whether it is a workers comp or group health claim.

Whether they are intentional or honest

*David A. Tweedy is a senior consultant for D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly publication analyzing major risk*



*management information systems and vendors. Mr. Tweedy's column on risk management systems usually appears the third Monday of the month.*

# Contractual transfer of risk

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

This month's material focuses on basic distinctions among the various types of contracts, including insurance policies, through which one party may transfer to another either an exposure to loss before it occurs or the financial burden of a loss after it occurs. The following question and answer are drawn from a recent national examination in ARM 55-Essentials of Risk Control.

**Q:** A contractual transfer for risk control is an agreement under which a transferor shifts to another—the transferee—the loss exposures associated with a designated asset or activity by requiring the transferee to perform certain activities and, in so doing, to assume certain exposures and bear any losses arising out of those exposures.

• Explain how subcontracting the assembly of a product component by a manufacturer is an application of contractual transfer for risk control. As part of your explanation, identify the transferor, the transferee and the exposure(s) transferred.

• Next, describe two circumstances in which subcontracting the assembly of a product component may create new loss exposures for the primary manufacturer of that product.

• And, finally, distinguish between contractual transfer for risk control and exposure avoidance and contractual transfer for risk financing.

## Shifting exposures with basic contracts

### A.R.M. exercises

**A:** • The manufacturer is using contractual transfer for risk control by obligating the subcontractor to deal with all the exposures to loss arising from the assembly activity. The subcontractor thus becomes responsible for all loss prevention, as well as all risk financing, associated with these exposure. The manufacturer is the transferor and the subcontractor is the transferee. As long as the subcontractor fulfills all its duties, the manufacturer faces no exposure to loss from the subcontracted activity.

• By subcontracting the assembly work, the manufacturer relies upon or becomes dependent on the subcontractor to do its part in fulfilling the manufacturer's business obligations to the manufacturer's customers.

However, the manufacturer's right to rely on the subcontractor for the assembly work does not relieve the manufacturer of its obligations to these customers.

Thus, if the subcontractor is not dependable—if it does not complete the assembly work or if its performance is substandard—the manufacturer is exposed to liability to customers that it probably would not face if it had done the assembly work directly.

Furthermore, the subcontractor's operations may be temporarily shut down because of some peril or legal order halting its activities. Consequently, the

manufacturer may find that some risk management aspect of its contract with the subcontractor is unenforceable, thus making its attempted transfer to the subcontractor of no value.

• Contractual transfers for risk control—such as through subcontracting activities, leasing property or entering into surety contracts—obligate the transferee to protect the transferor from loss by performing some act (such as the assembly work in this example) other than paying money to indemnify the transferor for loss.

Contractual transfers for risk control—unlike exposure avoidance, which completely eliminates a possible exposure to loss for all parties concerned—only shifts specified exposure from the transferor to the transferee. Contractual transfer does not eliminate exposures.

Contractual transfers for risk financing—including insurance policies—are agreements under which the transferee agrees to pay money to or on behalf of the transferor once the transferor has suffered a loss. In contrast, contractual transfer for risk control shifts to the transferee an asset or activity, together with associated loss exposures. The transferee agrees to perform some act other than paying for the transferor's losses and, in so agreeing, actually assumes these exposures and becomes responsible for managing them.

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

# Excess insurer not required to drop down

A Missouri appellate court has ruled that an excess insurer had no obligation to pay any loss that was within the policy limits of an insolvent primary insurer.

Billy and Dorothy Coleman were the owners of a shopping center when Prudence Pettus slipped and fell on ice and snow in the center's parking lot. Ms. Pettus and her husband sued the Colemans for \$500,000.

At the time of the injury, the Colemans were covered by a primary insurance policy with a limit of \$500,000 issued by North-West Insurance Co. They also carried an excess policy issued by U.S. Fire Insurance Co. for \$1 million excess of the primary policy limits.

In December 1984, North-West declared bankruptcy and was later declared insolvent. The Colemans had timely filed their claim with North-West. They also notified U.S. Fire of the personal injury action and of North-West's insolvency and requested indemnification.

U.S. Fire declined and then brought this suit seeking a declaration that it had no duty to defend. The trial court ruled for U.S. Fire.

The appellate court concluded that the policy terms were unambiguous and that the insolvency of the primary insurance company did not require the excess insurer to drop down and provide primary coverage.

*U.S. Fire Insurance Co. vs. Coleman*, Missouri Court of Appeals, Aug. 16, 1988 (BI/01/May-\$10).

## Legal briefs

### Street killing not compensable

An employee's death during a meal break as a result of a random street killing did not arise from a "special hazard" connected to employment, the Supreme Court of Minnesota ruled.

The court denied the dependents workers compensation benefits.

On the evening of Aug. 26, 1985, Raymond Gibberd, an employee of Control Data Corp., was shot and killed during the course of an apparent random street assault while walking alone on a public street some distance from his employer's facility. The evidence indicated that he had checked out from his employer's premises for a meal break.

The place of employment was in a so-called "depressed" inner city that was ranked 19th in crime at the time of the shooting, according to national statistics presented in court.

The employer provided a cafeteria on its premises for employees; however, it closed at 3 p.m. The employer had no implied or expressed policy that required employees to leave the employer's premises to eat out.

As an "exempt" employee, Mr. Gibberd had considerable latitude in setting his working hours. Because of demand for computer time, he had been working on a project at night and on weekends.

His dependents filed for benefits. A compensation judge denied benefits

but was overruled by an appellate court.

On appeal to the state Supreme Court, the dependents argued that Mr. Gibberd's death was compensable because the manner in which his death occurred arose from a "special hazard," even though such hazard was physically separate from his employer's premises.

The court concluded that there was no "special hazard" here as the evidence demonstrated that reported incidents of crime were comparable to other areas of the city. Furthermore, the court concluded that Mr. Gibberd was not peculiarly exposed to an external hazard that subjected him to a greater personal risk than one has when pursuing ordinary personal affairs.

*Gibberd by Gibberd vs. Control Data Corp.*, Supreme Court of Minnesota, May 20, 1988 (BI/02/May-\$10)

### Parking lot injury compensable

An employee injured in a far corner of a mall parking lot, where she was required to park, was injured at the "employer's place of employment," thus entitling her to workers compensation benefits, according to the New Jersey Supreme Court.

Marlene Livingstone worked for a branch of Abraham & Strauss Inc. in a shopping mall. She parked in a far corner of the mall's parking lot where

all employees were directed to park. As she proceeded from her car to the employees' entrance, Ms. Livingstone was struck by a car driven by a fellow employee, sustaining injuries for which she sought compensation.

The state compensation department denied benefits. The trial court reversed.

On appeal, the New Jersey Supreme Court noted that the principal issue here was whether compensation was precluded by a bar on coverage for injuries occurring in areas not under the control of the employer. The court concluded that Ms. Livingstone's workday commenced when she arrived in her car at the section of the mall lot adjacent to the employer's premises and, therefore, was in the course of employment when the accident occurred.

"The fact that Abraham & Strauss neither owned nor maintained, nor had the right exclusively to use this area of the lot does not, in our view, render her injuries non-compensable," the court concluded.

*Livingstone vs. Abraham & Strauss Inc.*, Supreme Court of New Jersey, June 30, 1988 (BI/01/July-\$10).

*These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions 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.*

# Many willing to pay price for LTC cover

## Washington

By ADRIENNE C. LOCKE

WASHINGTON—Almost half of the individuals responding to a recent survey say they are willing to pay \$100 a month to guarantee coverage for long-term care.

Of 1,000 people surveyed, 43% said they were willing and able to pay \$100 a month—either in the form of insurance premiums or new taxes—for long-term care coverage, while 53% would not pay this amount and 4% did not know.

However, of those who said they would not pay \$100 a month for long-term care coverage, 30% were willing to pay \$50 in either premiums or increased taxes to cover the cost of LTC coverage. In addition, 5% of these respondents did not know if they would be willing to pay \$50, while 65% were not willing to pay.

A majority of respondents believe that the government should play a role in making long-term care available to all, according to the survey, "Public Attitudes on Long-Term Care," conducted in July for the Employee Benefit Research Institute in Washington, D.C., by The Gallup Organization Inc. of Lincoln, Neb.

Sixty-four percent say the federal government should help people purchase long-term care coverage, even if it means a tax increase, while 32% opposed federal involvement in long-term care coverage and 5% were not sure.

According to the survey, respondents in lower income groups were less willing to pay extra amounts for long-term care.

For example, 37% of respondents with annual incomes of less than \$20,000 were willing to pay \$100 a month, compared to 47% of those in the \$20,000-\$74,999 range and 56% of those earning \$75,000 or more.

Most respondents expect to pay for their own long-term care, the survey found.

A third would use their personal savings to cover long-term care costs; a quarter would rely on private long-term care insurance; 7% would use medical insurance; 5% would depend on a government program; and 3% would rely on their families to pay, the survey said.

Only 1% said they would rely on either Social Security and Medicare, get a loan, sell their home or any assets, or rely on their pension benefits to pay for care. Another 1% would not be able to pay for any needed long-term care, the survey said.

Two percent had other means to cover long-term care costs and 19% didn't know how they would finance long-term care, according to the report.

Of those who said they would pay for their long-term care costs with private insurance, 64% currently have private insurance, while 25% do not and 11% did not know.

Employers provided long-term coverage to 61% of those who said they had insurance; 27% purchased coverage directly from an insurer; 10% received coverage through an association; 1% received coverage from other sources; and another 1% didn't know the source of their coverage.

Just under half the respondents said they feel that they are as

likely as the average person to need long-term care at some point; 39% said they were less likely than average to need long-term care; 9% believed they were more likely than average to need long-term care and 4% were unsure, the survey said.

Twenty-three percent of respondents said an immediate family member received long-term care

*Continued on next page*

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**Business Insurance**  
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## Washington

Continued from previous page within the last five years, though only 5% of respondents said they themselves had.

Copies of the survey are available for \$275 from Laura Bos or William Custer at EBRI, 2121 K St. N.W., Suite 600, Washington, D.C. 20037; 202-775-6318 or 202-775-6328.

### Aviation liability

A product liability reform bill limiting lawsuits against general aviation manufacturers has been approved by the Senate Commerce Committee.

The bill, S. 640, introduced earlier this year by Sen. Nancy Kassebaum, R-Kan., was passed earlier this month on a voice vote.

The bill applies to aircraft that seat fewer than 21 passengers and would:

- Allow punitive damages only in cases of clear and conscious negligence.

- Restrict aircraft manufacturers' liability for their products to 20 years after an airplane was built or after any replacement parts were used.

- Shield manufacturers from liability if they can show that an accident was avoidable through compliance with a Federal Aviation Administration airworthiness directive, a statement that dictates repairs on aircraft, or with a service bulletin from the manufacturer.

- Limit complaints to two years after an accident.

However, under the bill, manufacturers would remain jointly and severally liable for damages related to their products. The bill would not cap damage awards or attorneys' fees.

A similar bill, H.R. 1307, introduced in the House by Rep. Dan Glickman, D-Kan., cleared the Public Works and Transportation Committee in July (*BI*, Sept. 11, 1989), but has yet to be considered by the Judiciary or Energy and Commerce committees.

### AIDS claims

Payments on AIDS-related health and life insurance claims continued to increase in 1988, but still comprise only a fraction of overall claims reported, a new survey says.

The survey released by the Washington, D.C.-based American Council of Life Insurance and Health Insurance Assn. of America reports payments for individual life insurance claims related to acquired immune deficiency syndrome rose to an estimated \$135.5 million last year, up 3.6% from \$130.8 million in 1987 (*BI*, Feb. 27).

And, AIDS-related group life insurance claims paid by insurers totaled an estimated \$155.5 million in 1988, up 17.4% from \$132.5 million the previous year.

Individual accident and health insurance claims paid by insurers also soared to an estimated \$50.3 million, up 40.1% from \$35.9 million, while group accident and health claims rose to an estimated \$248.6 million in 1988, up 32.2% from \$188 million in 1987, the survey said.

Figures are based on reports of 274 insurers responding to the ACLI-HIAA survey. Researchers extrapolated from these to estimate payments for the entire life and health insurance industry.

Among responding companies, AIDS-related claims were only 1.1% of all individual life insurance claims paid in 1988; 1.6% of all group life insurance claims paid; 0.9% of all individual accident and health insurance claims paid; and 0.8% of all

group accident and health insurance claims paid.

That is slightly higher than in 1987, when the comparable figures were 1.2% for individual life; 1.4% for group life; 0.7% for individual accident and health; and 0.6% for accident and health.

However, the ACLI-HIAA survey notes that 1987 and 1988 figures are not exactly comparable because some companies responding in 1988 did not participate a year earlier.

The rate of increase for AIDS-related claims is slowing down, the survey reports.

For example, the life and health insurance industry as a whole paid an estimated \$589.9 million in AIDS-related claims in 1988, up 21.1% from an estimated \$487.2 million paid in 1987. Between 1986 and 1987 total life and health claims had risen 66.7%, up from \$292.2 million.

The survey also found that the average size of AIDS-related claims paid by insurers has changed for two types of life insurance.

The average size of an AIDS-related 1988 group life insurance claim increased to \$32,400, compared with \$28,700 in 1987, and \$27,300 in 1986.

But the size of individual life insurance claims related to AIDS has steadily decreased to \$19,600 in 1988, from \$23,500 in 1987, and \$30,500 in 1986.

Increased use of AIDS testing in life insurance underwriting could account for the decrease in AIDS-related individual life claims, HIAA and ACLI officials suggest.

The ACLI-HIAA survey cautions, though, that the number of AIDS-related claims paid by insurers may be significantly greater than the survey found because the diagnoses are sometimes misstated.

The survey is based on claims that are known to be AIDS related, but some AIDS claims may not be reported as such, the survey notes.

Death certificates, for example, may list the cause of death from an AIDS-related illness as "occurred due to disease," or—like many New York City death certificates—as "natural" or "external" causes.

Other claims may be misclassified, the survey contends, because the disease may not be recognized as being AIDS-related, a diagnosis or cause of death may not be precisely stated to signal that a claim is AIDS-related or a diagnosis may not have been made at the time of the claim.

And some claims are purposely misstated for insurance purposes, the survey said.

Copies of the 1988 "ACLI/HIAA AIDS-Related Claims Survey" are available from either Judy Finney, Health Insurance Assn. of America, 1025 Connecticut Ave., N.W., Washington, D.C. 20036; 202-223-7786; or Debbie Randolph Chase, American Council of Life Insurance, 1001 Pennsylvania Ave., N.W., Washington, D.C. 20004; 202-624-2414.

### New Labor official

The Labor Department has appointed a new chief of its fiduciary division.

Bette J. Briggs is the new chief of the division of fiduciary interpretation of the Pension and Welfare Benefits Administration.

As head of the division, she will assist the director of the Office of Regulation and Interpretation in developing regulations that affect the operation of employee benefit plans under the Employee Retirement and Income Security Act.

Previously, Ms. Briggs was a senior appellate attorney at the Department of Labor.

She has a bachelor's degree from the University of Wisconsin at Madison, and a doctorate of law degree from the University of Wisconsin Law School. ■

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## Vesting changes

Continued from page 3.

Regardless of the new vesting schedule adopted by employers, the overall cost increases to employers and plans will be no more than 5% in the first year, benefit consultants estimate.

And, for employers with high employee turnover, cost increases will be virtually nil because most employees still would not be fully vested under the accelerated vesting schedules.

"Most employers are kind of ho-hum about all this. It won't raise costs that much because the bulk of their terminations take place before five years," explained Steve Vernon, a consultant with The Wyatt Co. in Sherman Oaks, Calif. "Companies with younger workers who have quick turnover will see no increased costs because most of their people weren't vested anyway," said Fred Rumack, director of tax and legal services with Buck Consultants Inc. of New York.

Generally, the additional cost to employers with defined benefit plans will climb between 0.5% to 2%, consultants estimate.

"Financially, this is a non-issue," said Andy Stratton, a principal in the Atlanta office of A. Foster Higgins & Co. Inc. "It won't cost a company more than a couple of percentage points in their annual contributions."

Hewitt Associates in Lincolnshire, Ill., estimates that for an employer with many defined benefit plan participants already fully vested, employers' costs will increase only by about 0.5%, said Ted Weldon, a consultant.

And, employers with a significant number of employees who leave with between five and 10 years of service would have to increase contributions about 2%, Mr. Weldon said.

Harper L. Garrett, managing director and chief actuary with the Alexander & Alexander Consulting Group in Lyndhurst, N.J., estimates that employers' contributions to defined benefit plans would increase about 0.5% under the faster vesting schedules.

Mr. Weldon also pointed out that employers with fully funded defined benefit pension plans will not be affected by the faster vesting schedule because the employers were not making annual contributions anyway.

However, the costs to defined contribution plans and fully funded defined benefit pension plans probably will increase 1% to 3%—and possibly as much as 5% if many plan participants with five to 10 years of service leave—because of the faster vesting schedule, Mr. Weldon said.

However, consultants and employers agree that confusion over how to integrate pension plan benefits with Social Security will be a more costly and greater administrative headache.

Integration with Social Security permits employers to reduce retirees' pension benefits by a portion of Social Security benefits for which retirees are eligible. Without integration, low-wage earning retirees could conceivably receive more income during retirement through a combination of pension and Social Security benefits than they earned while working (BI, Dec. 5, 1988).

To contain administrative costs, the majority of employers are opting for five-year cliff schedules, under which plan participants are not vested at all until the fifth year, when they become 100% vested, according to benefits consultants.

Consultants and benefit managers agree that five-year cliff vesting is the simplest and least-expensive way administratively to vest employees.

Even though employers may opt

to fully vest plan participants over seven years rather than five years, the cost advantages to the plan or the employer may not outweigh the administrative costs of processing terminations of plan participants who are only partially vested, consultants say.

A five-year graded vesting schedule poses the same administrative headaches as a seven-year program, consultants added.

However, under a five-year cliff vesting schedule, employers would not face such administrative difficulties because plan participants are not gradually vested over the five-year period.

"With everything that has hap-

**'Financially, this is a non-issue. It won't cost a company more than a couple of percentage points in their annual contributions,' says Andy Stratton, a principal in the Atlanta office of A. Foster Higgins & Co.**

pened regarding benefits, you don't want to create more hassles with vesting," observed Warren Field, a principal in the Kansas City, Mo., office of William M. Mercer Meidinger Hansen Inc.

"So the normal choice among our clients is to change over to a five-year cliff vesting schedule without much fanfare," Mr. Field said.

Mr. Garrett of A&A said that among the consulting group's clients, all companies that had 10-year cliff schedules before are converting to five-year cliff schedules now.

And, "some companies that had graded schedules, especially for defined benefit plans, are moving to cliff vesting schedules simply because they are understood to be the easiest to administer," Mr. Garrett pointed out.

For example, Becton Dickinson & Co., a health care products manufacturer in Franklin Lakes, N.J., switched to a five-year cliff schedule for its defined benefit pension plan because cliff vesting is easier to administer, said Thomas Kenney, benefits manager for Becton Dickinson & Co.

As a result, 12,000 plan participants out of a total of 20,000 participants now are fully vested, up from 9,000 participants that had been fully vested.

Becton's plan contributions will increase only 1% under the accelerated vesting schedule, according to Mr. Kenney.

Mr. Kenney also noted that Becton plans to modify its five-year graded vesting schedule for the company's 401(k) defined contribution savings plan.

Under the modified schedule, plan participants will be 50% vested after two years, 75% vested after three years and 100% after four years.

But, in a move to check employee turnover, a plan participant must have five years' service with the company before terminating employment to receive 100% of contributions.

Under the old schedule, plan participants were fully vested after five years, but had to have six years' service with the company before terminating employment to receive full benefits.

The faster vesting schedule will increase plan costs about 1%, Mr. Kenney estimated.

"This is not real dramatic," he said. "We already had fairly liberal vesting to begin with. But we still don't really like to be told what to do."

Meanwhile, graded schedules are still fairly common for defined contribution plans because those plans are designed for portability and today's mobile workforce, observed A&A's Mr. Garrett.

Mr. Rumack of Buck Consultants

concluded.

He also noted that some employers that offered either defined contribution or defined benefit plans with 10-year graded or cliff vesting schedules just scaled down to five-year schedules without much cost impact.

For example, Barnett Banks switched to a five-year cliff vesting schedule for its overfunded defined benefit pension plan.

Under the faster vesting schedule, 3,300 of the overall 18,000 plan participants are fully vested, up from 1,800 fully vested participants under the previous schedule, according to Mr. Garner.

The faster vesting schedule increased the plan's costs 8.5%, according to Mr. Garner.

He explained that the plan costs jumped by a relatively high percentage because of changes in pension accounting required by the Financial Accounting Standards Board's Statement 87.

Potlatch Corp., a San Francisco-based wood products company, dropped its 10-year vesting schedule for its defined benefit pension plan in favor of a five year cliff vesting with no projected contribution increases because the plan is fully funded, according to Sue

Stauduhar, employee benefits manager.

The Potlatch Corp. plan covers about 1,800 salaried employees, she said.

Ms. Stauduhar said the company will not change the five-year graded vesting schedule for its 401(k) savings plan, in which about 1,700 salaried employees participate.

And, Greenwich, Conn.-based Pittston Co., a diverse manufacturing company that specializes in coal mining, changed to a five-year cliff schedule in January from a 10-year cliff for its fully funded defined benefit pension plan, said Frank Lennon, vp-corporate administration.

Pittston, which made no plan contributions last year, will not have to make any contributions again this year, Mr. Lennon said.

Mr. Lennon expects "totally insignificant" plan cost increases.

"No significant costs are predicted due to the change in vesting schedules," he said. "Most of our employees leave in the first three years. The chances are that if they stay for five years they would have stayed for 10 years," he said.

However, the company only calculates benefits at year-end. Therefore, the increase in the number of fully vested participants is not currently available.

He added that the company will not change the five-year graded vesting schedule for its 401(k) plan, in which there are 3,364 participants.

Meanwhile, some employers are holding off informing plan participants about the vesting schedule changes until they are prepared to also explain more complicated

benefit issues, such as the new rules on the integration of pension plans with Social Security, according to benefit experts.

For example, Mr. Kenney of Becton Dickinson said the changes in vesting schedules for the company's defined benefit pension plan and the defined contribution savings plan have not yet been communicated to employees.

Mr. Kenney explained that when the company does formally communicate the changes, it probably will use an internal memo as well as add the changes to the company's interactive touch-activated computerized benefits communications system.

However, Pittston Co. put out a memorandum on the vesting schedule change for the company's pension plan and expects "it to be reinforced at Social Security integration time," Mr. Lennon said.

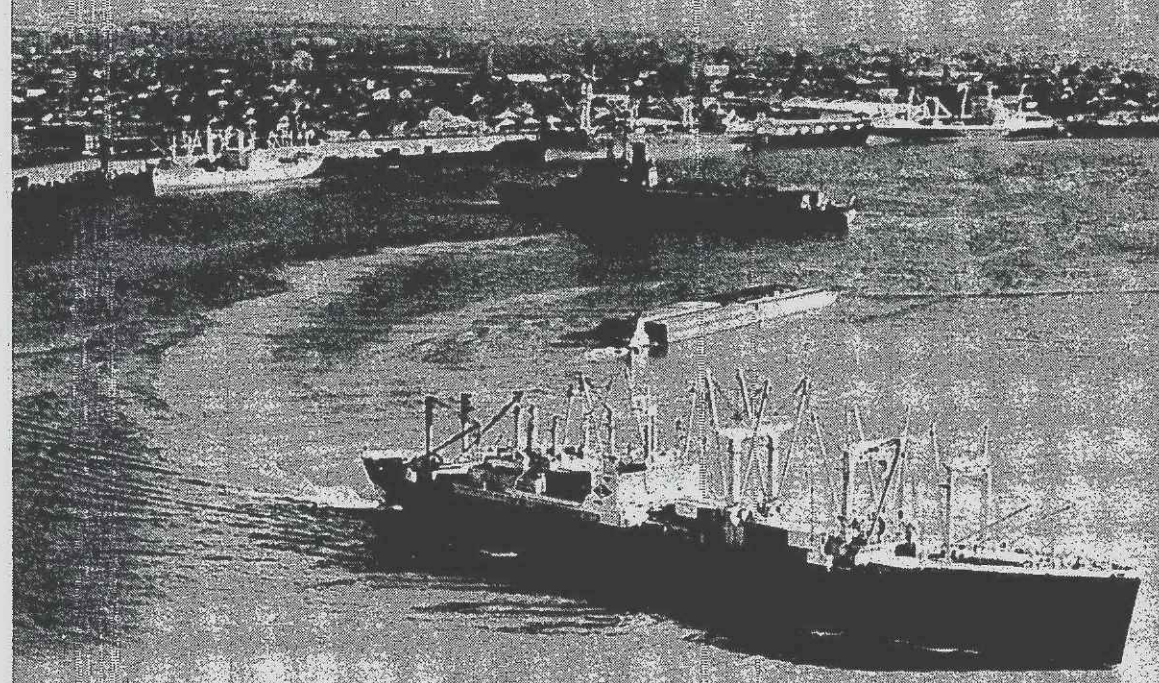
"But we had very positive feedback from our employees. They seem to be pleased knowing they are vested in some sort of pension plan after only five years," he said.

And, Ms. Stauduhar of Potlatch said the change in Potlatch's pension plan's vesting schedule was communicated through an announcement.

She said a memo was distributed to each employee along with information about changes in other benefits.

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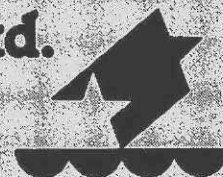
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# Self-administration works: Employer

By MICHAEL SCHACHNER

## TPA 'buffer' called not necessary

SAN DIEGO—Self-insured employers do not need the "buffer" that a third-party administrator provides from employee complaints concerning group health care claims handling, an employer says.

"This buffer concept is pure antiquated nonsense," said Allen Bassuk, vp-risk management for La Quinta Motor Inns in San Antonio, Texas.

"You need an honest relationship with employees," said Mr. Bassuk during a session on the advantages of using a TPA to administer health care claims vs. self-administration at

the ninth annual Self-Insurance Institute Conference, held Oct. 10-13 in San Diego.

"The shrinking labor pool is not going to improve, and benefits are a key to retaining and attracting good employees," said Mr. Bassuk.

However, a third-party administrator told the audience that health care claims administration is too complicated for most employers to handle in-house.

While self-administration is not a panacea for rising health care costs

and rapid employee turnover, it can aid in improving the morale and commitment of employees by creating a team atmosphere, said La Quinta's Mr. Bassuk.

La Quinta, which started administering its employee health care claims a year ago, did not make its decision based on potential cost savings, but rather to foster a more cohesive relationship between employees and management, according to Mr. Bassuk.

"There are cost savings involved"

with self-administration, he said. "But it is not the reason to make the switch because cost savings are not significant when compared with revenues."

Mr. Bassuk said that the costs saved by eliminating TPA fees will more than likely be eaten up by the increased costs of hiring and training additional personnel required to administer claims in-house.

"You will have to pay claims processors and examiners and there may be training costs, too," he explained.

In addition, Mr. Bassuk pointed out that because self-administration is a long-term commitment—as is self-insurance in general—hefty capital investments are required to begin a self-administration program.

"You have to make an initial capital investment in computer hardware and software. The purchasing price can be amortized over time, but you can guarantee that it will have bugs and it takes time to fine-tune your program," he said.

Careful planning is the key ingredient to a successful self-administered program, Mr. Bassuk said.

Since it takes a tremendous amount of paperwork to process just one claim, it is vital that an employer have a free-standing system staffed with competent people, he said.

"TPAs want you to believe that they have all the talent," he said. "That's simply not true. You can find good people who are well-trained. TPAs have the same turnover problem we all do."

Mr. Bassuk also suggests that employers that want to administer health care claims in-house keep the design of their health care plan simple and make sure that claims personnel are involved in determining the design of the plan.

In calculating the cost of a self-administered program, employers must make sure they consider all asso-

ciated expenditures, like hardware and software costs; salaries for the claim processors and examiners, benefit costs; the cost of additional equipment; and consulting costs, including the cost of both legal and data processing advice, said Mr. Bassuk.

But the paramount concern of a self-administered employer—and often the biggest problem for companies that administer health care claims in-house—is employee communications, he said.

"You must bring everyone into the program," Mr. Bassuk said. "Tell them how they can utilize their benefits and let them know that what is saved today can come back to them later in the form of more benefits."

Thomas J. O'Neill, executive vp and chief operating officer with Mass Insurance Consultants & Administrators Inc. in Chicago, a TPA firm, disagreed with Mr. Bassuk's assessment of self-administration.

Administering health care claims in-house is often too complicated to be handled properly by an employer, Mr. O'Neill maintained.

"TPAs used to just process paper and pay claims. Now it's more complex," he said. "CEOs and CFOs are now involved... because it does affect the bottom line. TPAs provide needed specialization."

Employers that self-administer claims too often focus the bulk of their resources on simply processing claims, which Mr. O'Neill termed a mistake. "Only 4% of overall administration costs go here. You need to focus on the remaining 96%."

TPAs, according to Mr. O'Neill, are invaluable for assessing and selecting support services. He said qualified TPAs know who the top reinsurers and utilization review firms are. They can help a client select the proper case management firm, and some TPAs are able to provide UR and case management services themselves, he said.

Companies that use TPAs to administer their self-insured health care plans do not lose control of the program and are free to be involved at the level they choose, Mr. O'Neill insisted.

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**Business Insurance**

# Data needed before self-funding begins

By MICHAEL SCHACHNER

SAN DIEGO—Before a company considers self-insuring its liability exposures, it should have a thorough data base of loss information to project future losses, says a risk management consultant.

"Without this data base, I suggest you defer until you have at least three or four years of solid data," said James V. Davis, chairman and chief executive officer of Corroon & Black Corp.'s Advanced Risk Management Services division in Nashville, Tenn.

Mr. Davis spoke to an audience of risk managers and insurance consultants during a session on self-funding liability exposures at the ninth annual Self-Insurance Institute of America conference, held Oct. 10-13 in San Diego.

For loss forecasting to be specific, it must be based on actual data from the company's loss history, he said. If forecasts are too vague, they will be invalid, he added.

"You must have a feel for how variable your loss estimates are," Mr. Davis said. "You must also know whether your firm can deal with this variability when it occurs. It's an important part of the process.

"You must also calculate what your paid

losses will be because this will affect your cash-flow," he said. "Once you have assembled a data base to estimate your ultimate incurred losses, you can use that to measure different forms of self-insurance."

This data will be useful as risk managers in the 1990s increasingly self-insure all or a portion of their liability risks, Mr. Davis predicted.

Risk managers may wish to establish qualified self-insurance programs for workers compensation and automobile liability coverage, he said.

In addition, companies that do not want to meet all the requirements of qualified self-insurance but still wish to retain a larger portion of their liabilities, may turn to deductible programs for auto liability and general liability insurance coverage, Mr. Davis said.

Under such a program, a company buys an insurance policy with a very high deductible so that the majority of its claims will fall within the deductible, he explained.

In addition, through an agreement in the policies, if the policyholder should become unable to pay claims that fall within its deductible, the insurer will take responsibility for them, according to Mr. Davis.

Once a risk manager decides to pursue a

qualified self-insurance program, he or she must decide on a per-occurrence retention, at what point excess insurance coverage will attach and whether aggregate reinsurance is necessary, Mr. Davis said.

"To establish a cut-off point you should search the data base" to determine where the majority of liability claims fall, he said.

"The basis of self-insurance is to recognize that you don't want to trade dollars with an insurance company," he said, explaining the importance of setting an appropriate attachment point for excess coverage.

Qualified self-insurance, compared with other risk financing options, offers the risk manager three basic benefits, according to Mr. Davis:

- Increased flexibility.

Risk managers can coordinate claims payments and cash flow with a self-insurance program. Risk managers may vary their company's retentions and can change support service companies without changing excess insurers, he said.

- Increased stability.

"I've only seen one firm that has begun qualified self-insurance and has gone off of it," Mr. Davis noted.

Stability is enhanced because self-insurance

permits the company to be less reliant on commercial insurers, and "many of our clients want to wash their hands of the industry after the last hard cycle. Insurance is supposed to be a stabilizing factor and if doesn't do that it's worthless," he said.

Increased stability also comes from tailoring loss control programs to a company's specific needs and from having the ability to handle claims previously paid by an insurance company, he said.

- Greater overall control.

Self-insurers can set their own retention levels, Mr. Davis noted, though excess insurers do influence the size of retention a company selects.

Also, because the risk manager is steering the insurance program, he or she can receive much more direct information about the company's risks, rather than rely on an insurer to provide that information, he said.

Another benefit of self-insurance is that a company pays only its own claims, Mr. Davis noted. Never will it risk paying for another company's losses, either directly or indirectly, he said.

Vicki Gron, vp of Royal Insurance Service Corp., a consulting and claims processing firm in Charlotte, N.C., moderated the session.

## Work comp self-insurance increases employer control

By MICHAEL SCHACHNER

SAN DIEGO—The primary objective of a self-insured workers compensation program is to give an employer complete authority over claims costs and loss control, says a risk financing specialist.

In addition, self-insuring workers comp risks insulates a company from increases in commercial workers compensation rates that typically have exceeded the rate of inflation, according to E. Randall Clouser, senior vp and director of business development with Alexander & Alexander of Missouri in St. Louis.

Mr. Clouser, speaking at a session at the ninth annual Self-Insurance Institute of America conference in San Diego Oct. 10-13, said that a company can find a multitude of reasons to self-insure its workers compensation risks.

By not purchasing primary workers comp insurance, employers can avoid having their workers comp experience inaccurately characterized and being subject to premiums and expense modifications based on improper analyses, Mr. Clouser said.

"In theory, self-insurance allows you to pay only for your losses. There are no insurance charges, commissions or premium taxes," he said.

Finally, a self-insurer can improve cash-flow through deferred claims payment. "An average workers comp claim stretches nine years. Therefore, if you self-insure, the cash is kept within your organization and can be reapplied to the operations."

He said there are several rules of thumb an employer should follow when considering whether to self-insure its workers comp program:

- An employer should be paying annual work comp premiums of at least \$300,000, of which \$100,000 should be generated in one state.

"This allows you enough of an exposure base to spread the risk across enough dollars," he explained.

- An employer should have a strong loss history and an equally strong loss forecast because self-insurance is a long-term commitment and not a quick fix.

Mr. Clouser said that because losses are paid out of current reve-

nues it is important that a self-insurer's assets be at about 140% of its liabilities, or at least 1-to-1.

"This offers the self-insurer the ability to weather downturns. And a net worth equal to 10% of sales and equity of at least 140% of long-term debt will enhance borrowing power," said Mr. Clouser.

- Companies should be able to sustain a single loss of \$100,000 or more per occurrence, he said.

- A local third-party claims administrator should be available because service personnel will be familiar with the types of claims the company faces and will provide better service.

- Risk managers must contract with an excess workers comp insurer that will stay for the long run because although "there are a lot of writers of excess right now, how about when the market eventually turns?"

- A well-defined safety program is vital. "It is critical to define and implement loss control standards. Otherwise, costs won't be managed and the self-insurer will pay for it. Safety programs and incentives do work," he said.

Mr. Clouser said a key element of moving to a self-insured workers compensation program is the full

support of management and management's willingness to provide administrative and financial resources.

If a company considering self-insuring its workers comp risks meets Mr. Clouser's criteria, it should then conduct a feasibility study.

Another panelist, Douglas Hartman, senior manager with Ernst & Whinney in New York, detailed the feasibility study process.

A company should begin its analysis by compiling at least four to six years of back payroll, loss and financial history, he said. In addition, statistical claim reports should be collected for that same period.

To judge whether self-insurance is appropriate, the company should project ultimate losses by using actuarial loss development techniques, Mr. Hartman said.

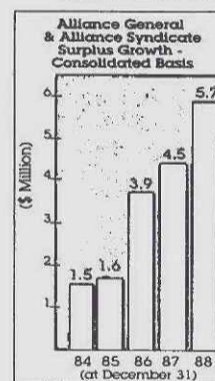
Risk managers should also identify and quantify all of the other costs of a self-insured program, such as TPA fees, surety bond premiums, letters of credit, salaries for additional personnel needed to implement and manage a self-insured program, excess insurance premiums and required state assessments, he said.

Harvey Nolen, president of Total Group Services Inc., a third-party administrator in Grand Rapids, Mich., moderated the session. ■



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**LEGAL SERVICES**  
IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS  
COUNTY DEPARTMENT, CHANCERY DIVISION  
IN THE MATTER OF THE LIQUIDATION OF  
(AMALGAMATED LABOR LIFE INSURANCE COMPANY) NO. 89 CH.3565

**NOTICE**

PLEASE TAKE NOTICE, that on July 5, 1989 an Order of Liquidation with Finding of Insolvency was entered against Amalgamated Labor Life Insurance Company ("Amalgamated") by the Honorable Albert Green, Judge of the Circuit Court of Cook County, Illinois. Zack Stamp, Director of Insurance of the State of Illinois, is the Statutory and court affirmed Liquidator of Amalgamated.

TAKE FURTHER NOTICE that pursuant to the Order of said court, all rights and liabilities of Amalgamated and its creditors, policyholders and all other persons interested in its assets are fixed as of July 5, 1989, unless otherwise provided by such other Order of the Court.

TAKE FURTHER NOTICE that any and all persons, partnerships, corporations, associations, estates, trusts and governmental units having or claiming to have any accounts, debts, claims or demands against Amalgamated or claiming any right, title or interest in or to any funds or property of Amalgamated in the possession of the Liquidator are required to file a Proof of Claim with the Liquidator on or before 4:30 p.m. Chicago Time, July 5, 1990.

TAKE FURTHER NOTICE, that the form of and required content of all proofs of claim are described in the Illinois Revised Statutes, 1987, Chapter 73, Paragraph 821. Proofs of claim, together with supporting documents, if any are to be filed with and may be secured from the Special Deputy Liquidator, Amalgamated Labor Life Insurance Company, In Liquidation, 446 East Ontario Street, Suite 700, Chicago, Illinois 60611. Filing shall occur upon the receipt of Proof of Claim by the Liquidator. The Liquidator reserves the right to require such additional information with respect to any claims as he may deem necessary. The Liquidator further reserves all rights to any and all defenses of Amalgamated concerning such claim. All Proofs of Claim must be duly sworn to before an Officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIMS WITH THE LIQUIDATOR AT HIS ABOVE MENTIONED OFFICE IS JULY 5, 1990 AT 4:30 P.M. CHICAGO TIME. NO PERSON HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST AMALGAMATED LABOR LIFE INSURANCE COMPANY, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE FILED WITH THE LIQUIDATOR ON OR BEFORE JULY 5, 1990 AT 4:30 P.M.

**James W. Schacht, Special Deputy Liquidator, Office of the Special Deputy, 446 East Ontario, Suite 700, Chicago, Illinois 60611, (312) 915-4700.**

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**NOTICES**

**NOTICE INVITING BIDS**  
Sealed bids are invited by the City of Los Angeles, California for furnishing **PROPOSAL FOR INSURER REPRESENTATIVE FOR CITY OF L.A.** in accordance with BID #F5076 and specifications available in Room 850, City Hall East, 200 North Main Street, Los Angeles, CA 90012. Bids to be opened on Nov. 30, 1989 at 11:00 A.M. at above address. Bids are subject to acceptance within three months unless otherwise stipulated by bidder. The provisions of the Los Angeles City Administrative Code, Sections 10.8 and 10.31 will be a part of any contract awarded pursuant to this notice. Date: Oct. 12, 1989 L.D. **RANDALL BACON, General Manager and City Purchasing Agent.**

**Business Insurance Circulation Breakdown\* Commercial Consumers**

<b>Administrative:</b>	
CEO's Presidents and Owners	2,659
Vice-Presidents, General Managers and Other Administrative Personnel	4,006
<b>Financial:</b>	
Chief Financial Officers and Vice-presidents of Finance	2,795
Secretaries, Treasurers, controllers and other Financial Personnel	3,842
<b>Risk/Employer Benefits:</b>	
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
<b>Sub-total</b>	<b>24,021</b>
Associations	554
Government, Unions and Educational Institutions	1,417
<b>Commercial Consumers</b>	<b>25,992</b>
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
<b>TOTAL</b>	<b>50,751</b>

\* Source: Business-Occupational breakdown of qualified circulation, May 29, 1989 issue, as submitted to BPA for June 1989 BPA Publisher's Statement.

## Comp insurers

Continued from page 1  
will continue to service.

Observers say the proposed suspensions are unusual because they stem from market conduct problems, rather than solvency concerns.

Most states do not suspend insurers for breaking non-solvency-related regulations, relying instead on fines, cease-and-desist orders and negative publicity.

However, the suspensions are part of Oregon's new and "more strident" approach to dealing with insurers that do not respond in good faith to regulatory sanctions, Mr. Hennessee said.

Insurance Department Director Theodore Kulongoski last month issued the proposed orders suspending the six AIG insurers' authorization to issue guaranty contracts, which an employer is required to receive from its workers compensation insurer to certify that the employer has purchased workers comp coverage.

The orders, which were stayed by the appeals, were to go into effect Oct. 20.

The orders affect six of the eight AIG insurers writing workers compensation coverage in Oregon: American Home Assurance Co.; Birmingham Fire Insurance Co. of Pennsylvania; Commerce & Industry Insurance Co.; Insurance Co. of the State of Pennsylvania; National Union Fire Insurance Co. of Pittsburgh, Pa.; and New Hampshire Insurance Co.

The six companies currently write workers comp coverage for about 800 Oregon businesses with

more than 33,000 employees, according to Mr. Hennessee.

Two other AIG companies—Granite State Insurance Co. and AIU Insurance Co.—do not face suspension orders because they each had been penalized only twice in the past five years.

Together, the eight AIG units wrote \$14.3 million in workers comp premiums in the state in 1988.

The suspensions were ordered after an audit of departmental records found that the division had levied 181 civil penalties against the eight AIG units since 1984, the department said in a statement.

In 1988 alone, the AIG units received more than 80 of the 678 civil penalties assessed against workers comp insurers and self-insurers in the state, according to departmental figures.

The department has issued fines totaling more than \$104,000 against the eight AIG units since 1984.

Fines against the six units facing the proposed suspension range from \$6,100 against New Hampshire to \$32,200 against National Union, according to departmental records.

"Despite being notified of audit results that showed continuing problems and having paid an unprecedented number of penalties, these insurers have failed to correct their deficiencies," Mr. Hennessee said in a statement. Only one of the fines against the six insurers was contested, according to department records.

"From our perspective, it appears these insurers simply regarded penalties as a cost of doing

business," he said in a statement. "They ignored the fact the penalties are intended to obtain compliance with the Oregon workers compensation laws and regulations," he said.

The fines resulted in part from failures to:

- Make timely payment of benefits to injured workers and their beneficiaries.
- Promptly file, record and

resolution of the issues you have raised prior to the hearing."

Although Mr. Foley declined to discuss the pending case, he emphasized that "the proposed orders do not affect our current policies of workers compensation insurance in any way. We will continue to serve and protect our Oregon policyholders and claimants under the policies we have issued."

The department expects that a

**'Despite being notified of audit results that showed continuing problems and having paid an unprecedented number of penalties, these insurers have failed to correct their deficiencies,' says Matt Hennessee.**

maintain notices of employers' workers compensation coverage with the state.

- Maintain records within Oregon of guaranty contracts, policy cancellations and endorsements.
- Resolve information errors in guaranty contracts.
- Maintain records required by law, including premiums due and collected, employer assessments and employee contributions.

All six AIG companies responded to the department's suspension notices by writing letters requesting hearings on the proposed orders, said Patrick J. Foley, AIG's vp and associate general counsel in New York, in an interview.

In those letters, representatives for the insurers also requested pre-hearing conferences with the department "so that we may discuss a

referee from its hearings division will expedite AIG's appeal by holding a hearing within 120 days rather than the customary 180 days, Mr. Hennessee said.

Pending the outcome of the hearings, the AIG units can write new and renewal policies in Oregon.

If the suspensions are upheld, the insurers would be unable to write workers compensation policies for new policyholders for 18 months. However, the companies could renew existing policies as long as they did not lapse, Mr. Hennessee said in an interview.

In addition, the division planned to audit the performance of the six insurers near the end of the suspension period. Those that failed to meet minimum standards during the period could face permanent revocation of their authority to underwrite workers compensation insurance in the state.

Other state regulators and representatives of insurance trade associations noted that the proposed suspensions of the AIG units for claims payment and record-keeping violations is an unusual and severe penalty, especially because it is being applied to workers compensation insurers.

The suspension of any type of insurer for non-solvency-related reasons is "unusual," said Joseph Edwards, superintendent of the Maine Bureau of Insurance.

"Iowa has never suspended an insurer for other than financial reasons," said Commissioner William Hager of the Iowa Insurance Division. The Iowa division instead relies on fines and cease-and-desist orders, he added.

However, Iowa regulators support "aggressive" regulation to protect insurance buyers, Mr. Hager said. In this case, it appears "that suspension was the next logical step because obviously the lower sanctions did not work," he added.

Suspension is "a very severe penalty," agreed a spokesman for the New York Insurance Department. New York relies primarily on

substantial fines and negative publicity to obtain compliance with its regulations, the spokesman said.

However, the department might consider suspensions if problems with an insurer persist, he added.

"It's a pretty stiff reaction" by the regulators, especially against a company the size of AIG, said an insurance industry observer who asked not to be named.

Suspension of a workers compensation insurer is particularly unusual, observers said, noting that Oregon's unique work comp regulatory system paved the way for the suspensions.

In most states, the agency regulating the state's workers compensation system is separate from the insurance department, which regulates the conduct of insurers, observers point out.

"Most work comp agencies have registering or licensing authority over companies but unclear authority to suspend or fine," explained J.T. Noblin, a Mississippi attorney who is executive director of the International Assn. of Industrial Accident Boards & Commissions. Such authority usually rests with the insurance regulator in a state, he said.

However, a 1987 law put the administration of Oregon's workers compensation system under the Insurance Department's purview, noted Steve Millikan, vp and director of workers compensation for the Alliance of American Insurers.

Oregon also is noteworthy because of its reputation for making heavy "paperwork" demands on insurers, an industry observer pointed out.

However, there has been a trend in several states to emphasize enforcement of timely payment requirements for workers comp claimants, said Eric Oxfeld, counsel to the American Insurance Assn.

Although insurers need time to investigate unusual claims to ensure they are bona fide, routine claims should be paid promptly so injured workers do not have to hire an attorney to obtain benefits, he said.

In addition to examining the AIG units, Oregon is reviewing the records of other companies that write workers compensation coverage to determine whether their actions warrant suspension, Mr. Hennessee pointed out.

"We penalize employers who fail to carry workers' compensation insurance, and workers suspected of abusing our system are under greatly increased scrutiny," he said. "Just as employers and workers are bound by the law, insurers and other vested interests must take note that the workers compensation laws and rules apply to them as well."

"We will take whatever legal steps we have at our disposal to obtain compliance," Mr. Hennessee said.

## Hurricane Jerry

Continued from page 3

The insurer will pay about \$154 million on 50,000 claims from Hurricane Hugo, he said.

Fireman's Fund Insurance Cos. of Novato, Calif., was all but untouched by Jerry, according to a spokesman. "We have one awning loss and that's it," he said last week.

The Texas Catastrophic Property Insurance Assn., a pool of underwriters offering windstorm coverage to businesses in 14 coastal counties, will pay some storm-related claims, said Buddy Rogers, TCPIA's loss manager.

But "it's a little too early to tell" how many, he said. "We're getting conflicting stories. Some say it's catastrophic and others are saying it's light."

The pool's maximum exposure along the coast is about \$4.5 billion, he said.

Galveston businesses suffered mostly broken windows and roof damage, according to Paula Gavin, an assistant to the city manager.

"One small store by the airport was heavily damaged and the west end of the island had quite a few

houses with roof damage and windows out," she said.

A statement released by city officials last week said "the bulk of damage is to hotels, motels, apartments, condominiums, residential roofs, fences, etc."

Damage to the Hotel Galvez on the island was "fairly minimal," with 300 to 500 feet of gutters down and some window and roof damage, said George Van Etten, general manager.

Galveston's Seaside Pointe hotel suffered extensive roof damage, according to a spokeswoman.

Because damage was lighter than first suspected, Galveston did not request federal disaster aid.

The hurricane did "relatively minor" damage to a cooling tower, fans and metal sheeting at Sterling Chemical, a Texas City plant that operated throughout the storm, said Ray Wheeler, the company's Houston-based risk manager.

"Our property coverage does apply, but we have a large deductible and this won't come close to it," he added.

In downtown Texas City businesses had windows blown out and

roofs damaged, but "we came out of it in good shape," said George Stapleton, director of public works and emergency management coordinator.

Texas City saved some time and money because "a few old buildings that were about to fall down, fell down. Now we don't have to tear them down," said Mr. Stapleton.

In Baytown "there were a lot of trees down and cosmetic damage to things like siding and decorative panels. I don't know of any business that was demolished," said a city spokesman.

Although damage from Jerry was relatively light, some insurers were caught shorthanded by the second hurricane to strike the U.S. mainland in less than a month.

"We were running thin on adjusters already," said Bud Trice, assistant vp-catastrophic services with adjuster Crawford & Co. in Atlanta.

"We were able to round up some adjusters, but not the typical force because we still have everybody on the Carolina coast," Mr. Trice commented.

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## Miro investigation

Continued from page 3

million in claims made by the Louisiana company, the official testified.

Mr. Miro also collected \$720,000 in salary and expenses from Anglo-American's parent company in 1988.

The subcommittee's letter to the Justice Department echoes the charges leveled at Mr. Miro during the April hearing.

Regarding his years as a Transit MGA, the letter says: "Mr. Miro engaged in apparent fraudulent underpricing, self-dealing and improper record keeping to write over \$100 million of premiums in only three years. Approximately 70% of this money was kept or controlled by Mr. Miro for his own benefit through his wholly owned Texas agency and his purported offshore reinsurance company."

After an 18-month stay in London following the Transit debacle, Mr. Miro returned to form Anglo-American and several affiliated companies.

"The Anglo-American empire was financed entirely by customer premiums," the letter says. "The capital (and) surplus behind the insurance company was an accounting illusion created through a series of intercompany loans and transactions that substituted worthless promissory notes for cash taken from the company."

"Mr. Miro's real skill appears to be finding complex methods to evade regulation," the letter adds.

After trying without success to locate Mr. Miro to subpoena documents and testimony, the subcommittee asked U.S. immigration officials to notify them when Mr. Miro re-entered the country, according to the letter.

On Aug. 28, Mr. Miro entered the

United States at Lewiston, N.Y., near Niagara Falls, and was found by immigration officials to have committed numerous violations of immigration law, according to the letter.

Mr. Miro first misrepresented himself as a U.S. citizen, according to subcommittee documents. He then told an immigration official that he was a resident alien but that he had lost his green card and that his attorney, Mr. Kroemer, was in the process of applying for a replacement.

However, Mr. Kroemer wrote to the INS two weeks later saying that Mr. Miro had given up his resident alien status and voluntarily turned in his green card in 1983 but that the INS had failed to record this change because of a "bureaucratic snafu."

Mr. Miro had claimed to be a resident alien to the Lewiston inspector because he knew INS computers incorrectly listed him this way and did not want to give information that would conflict with INS records, Mr. Kroemer explained.

A search of Mr. Miro's briefcase at Lewiston also turned up a Mexican passport that Mr. Miro had been using for three years to enter the United States as a visitor, according to the subcommittee documents.

An immigration official photocopied the passport and allowed Mr. Miro to enter the United States as a resident alien.

A subsequent examination of the passport, though, found that Mr. Miro had misrepresented his birthplace as a city in Mexico and that the passport itself may have been a forgery, according to subcommittee documents.

In its letter to the Justice Department, the subcommittee notes that some or all of the actions of

Mr. Miro and his associates may involve violations of mail and wire fraud statutes and other federal laws.

In addition to Mr. Kroemer, the Miro associates named in the letter are Mario J. Mendiola, former Anglo-American treasurer; Sheldon H. Irion, a former Anglo-American president; and David Vaughn, a Baton Rouge, La., attorney who worked for Mr. Miro during the Transit and Anglo-American periods and also briefly served as president of Anglo-American.

Mr. Mendiola and Mr. Irion could not be reached for comment.

**Anglo-American's capital and surplus 'was an accounting illusion created . . . (by) transactions that substituted worthless promissory notes for cash taken from the company,' the House subcommittee alleges.**

Mr. Vaughn said in an interview that he is "furious" about being named in the letter but said he planned to cooperate with a Justice Department investigation.

Mr. Vaughn also denied any role in the Anglo-American failure, saying that he was assured when he joined the company that it was solvent.

"We couldn't afford to even look wrong in this case and (Mr. Miro) understood that," Mr. Vaughn said. "He had one more chance in the insurance business in life and he was going to make sure it was done right. I believed him."

"Carlos was a friend of mine," Mr. Vaughn said. "You don't go to work for someone you don't trust" until he breaks that trust.

Mr. Vaughn added that when he finds out to which Justice Depart-

ment office the investigation is being referred, he will "make a beeline right for their office and give them whatever information they want."

"As a lawyer I don't intend to be found guilty by association," he said.

Mr. Kroemer's statement disputes several specific allegations in the subcommittee's letter, including that Mr. Miro wrote \$100 million in premiums for Transit and kept 70% of this amount.

The statement put Mr. Miro's writings at \$71 million, most of which went to pay claims, bro-

kerage commissions, Transit's fronting fees and reinsurance premiums. Most of the rest of the money was used to pay the operating expenses of Mr. Miro's agency, according to Mr. Kroemer's statement.

The statement did not address the Anglo-American allegations directly, noting that the allegations are the subject of litigation between Mr. Miro and the Louisiana Insurance Department.

Mr. Kroemer had earlier objected to the subcommittee investigation of himself and Mr. Miro in a Sept. 27 letter to Rep. Dingell.

In that letter, Mr. Kroemer accused the subcommittee of "abusive tactics," objecting, among other things, to

• Subpoenas of Mr. Miro's and Mr. Kroemer's American Express

charge records.

• Visits by subcommittee staff members to the Dublin office of Anglo-American International earlier this year, calling the trip a "boondoggle."

"Apart from the fact that there are other federal agencies clearly more competent to undertake whatever prosecutorial activities your subcommittee staff members seemed to have arrogated to themselves, it seems to me that your staff is engaged in both a colossal and expensive waste of time," Mr. Kroemer wrote.

Rep. Dingell replied to Mr. Kroemer in an Oct. 11 letter.

"Mr. Miro's businesses have been cloaked in secrecy and confusion, but they have obviously resulted in huge transfers of money and a lavish lifestyle for the benefit of Mr. Miro. The subcommittee's efforts to document these payments and expenditures has been very revealing as to the ways in which premiums paid for insurance have been used for decidedly non-insurance purposes, while state guaranty funds and policyholders are left to bear the cost," Rep. Dingell wrote.

"Your criticism of the subcommittee staff's trip to Europe as a 'boondoggle' is ironic in view of the extensive domestic and international travel by Mr. Miro and you on chartered jets, the Orient Express and regular airlines, as well as the lavish accommodations enjoyed at the finest hotels, which have been financed by policyholders and the public," the representative continued.

Regarding the visit to the Dublin reinsurer, Rep. Dingell noted that "other than a brass name plate on the door of an office serving many businesses, (subcommittee staff members) found no personnel or business activity by the reinsurance company." ■

SPECIALTY RISKS



Photo: Mary Durham

Publishing Date:  
November 20, 1989

Ad Closing Date:  
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## Market impact

Continued from page 1

rophe "has got to have an impact" on property catastrophe rates, said Ian Haynes, director of the property division of Lloyd's of London broker C.T. Bowring & Co. Ltd.

"There will not be any rate reductions on American catastrophe reinsurance covers" during this year-end renewal season, said a London-based property/casualty underwriter.

"Considering there have been two large catastrophic events together, we feel there has to be an overall effect on the balance sheets of companies," agreed a spokesman for Munich Reinsurance Co. in West Germany. "So we think it should have some effect on the market."

"It's now a double whammy, and it is, in my opinion, going to have a major impact. I think it may be the thing that starts the change," said Michael W. Cashman, president and managing general partner of reinsurance broker E.W. Blanch Co. Limited Partnership in Minneapolis.

However, Mr. Cashman said that he believes the change will be confined to the property reinsurance market and will not reach the casualty market, which has not softened to the same extent. "The casualty market has remained fairly stable," he observed.

Underwriters with no losses on their programs could be paying up to 25% to 30% more for catastrophe reinsurance, and those with losses will be paying much more, predicted one Lloyd's underwriter.

Policyholders "obviously will have to pay as much or more for insurance or reinsurance," said the London-based underwriter.

"I see a lack of capacity next year and an increase in rating for catastrophe treaties," said Roy B. Oddy, chairman of Dallas-based surplus lines broker Maclean, Oddy & Associates.

The earthquake "plus Hugo, plus \$2.5 billion of loss in the marine market could affect capacity" next year, he said, referring to marine losses like the explosion of the \$1.4 billion Piper Alpha drilling platform.

The earthquake "is likely to be the turning point," agreed a spokesman for London-based reinsurance brokerage E.W. Payne Cos. Ltd.

"At the moment (the earthquake damage) is not big enough to lead to an immediate turn in the direct market, but it will have an immediate impact on the reinsurance market, which will filter through (to the direct market) fairly quickly, leading to increased rates during next year," said Andrew Goodwin, a director and stock analyst with UBS Phillips & Drew of London.

In addition, some primary insurers, like State Farm Mutual Automobile Insurance Co., that are not purchasing catastrophe reinsurance

"may now decide to come back to the market (for reinsurance) and will feel the upward pressure of reinsurance rates," Mr. Goodwin noted.

As a result, he predicts "a turning in U.S. direct rates during 1990."

However, Michael J. Segal, president of Near North Insurance Agency Inc. in Chicago, said he expected to see primary property insurance rates increase within 30 days because of the earthquake and Hugo.

Insurers that do not have an earthquake exposure "will seize the opportunity" to increase prices, Mr. Segal said.

"One would hope that this will be a sufficient jolt to one's appreciation of risk. Although only a substantial loss usually turns the market, there is a good possibility of the market turning (after this), and at least it probably will arrest it," said Jonathan Pryke, chairman of Cuthbert Heath Underwriting Ltd. in London.

"Our opinion is this is just one more brick on the load that will be instrumental in reversing the trends" of softer pricing, said Keith Like, executive vp-commercial lines for Kemper Group's national property/casualty companies in Long Grove, Ill.

"This is enough to turn the market. It isn't the 'Big Loss,' but it is the last in a string of losses during the last three years," said one Lloyd's of London non-marine underwriter.

At least six previous losses—Hurricanes Alicia, Gilbert and Hugo, the Piper Alpha explosion, the October 1987 European windstorm and the U.S. winter weather losses of 1983—are spiraling in the London excess-of-loss reinsurance market, and the addition of the quake will be enough to shrink catastrophe reinsurance capacity considerably, he said.

"We hope we will see better (higher) rates" at year-end renewals, said Peter Hugel, head of the investment department at Swiss Reinsurance Co. in Zurich. "The market might get firm a little bit, but that is the expectation we always have," whether there is a catastrophe or not.

Swiss Re announced last week that the loss from the earthquake to the company will not be more than 100 million Swiss francs (\$61.7 million), which will be paid out of reserves. Claims from a catastrophe like the earthquake have been anticipated, Mr. Hugel added.

Some of the property treaties Swiss Re writes have earthquake exclusions, he said.

However, some observers are pessimistic about the changes that the earthquake and Hugo will cause in the market.

"This won't affect the general rating structure, but it will hit earthquake rating," predicted Geoffrey Kennedy, senior vp of New York-based Fred S. James & Co. Inc.

One U.S. broker said the earth-

quake and Hugo would just be "blips" on the insurance scene and would not have an impact on the market "compared to the billions of dollars of premiums which are written."

"We don't see good prospects for the near term" that the market will turn, said Joseph W. Brown Jr., president of Fireman's Fund Insurance Co. in Novato, Calif.

Glenn Thomas, vp and director of commercial property insurance at Transamerica Insurance Group in Woodland Hills, Calif., said: "I don't see the earthquake having much of an impact on the property market at large." However, earthquake coverage probably will become more expensive, he said.

Edmond F. Rondepierre, senior vp and general counsel for General Reinsurance Corp. in Stamford, Conn. observed that changes in the market are the result of a maze of circumstances rather than a single event.

Decisions by insurers and reinsurers to raise rates are made company by company and are seen clearly as a change in the market only in retrospect, he explained.

Regarding the impact of the recent disasters, he noted that "you don't know how many companies will react and which ones will react," making a prediction about the market's course difficult.

One immediate effect of the earthquake—coming on the heels of Hurricane Hugo—has been to send many insurers and reinsurers scrambling to line up reinstatements of their catastrophe reinsurance and retrocessional coverages, reinsurance brokers and others report.

Many brokers were standing in long lines at Lloyd's last week trying to buy extremely expensive reinsurance reinstatements for their clients that otherwise would be left without reinsurance until year-end renewals.

Reinsurance contracts commonly offer ceding companies coverage for one event, with one free reinstatement for a second event, brokers report. An additional premium is usually due for more than one reinstatement.

Because Hurricane Hugo was treated as two events under the 72-hour clause contained in many catastrophe reinsurance contracts, U.S. ceding insurers have already sought a second reinstatement and the quake may send them back to reinsurers for a third (BI, Oct. 9).

"The companies are under a great deal of pressure to do those quickly," said James P. Snedeker, senior vp with G&R Intermediaries Inc. in New York. "It's very clear that a lot of people are scrambling to get covers in place."

The reinstatements are not coming cheaply, he noted. In some cases, a reinstatement—good for another nine weeks on a program that renews Jan. 1—is costing as much as a full-

## Tremor revives interest in earthquake facility

NEW YORK—Several corporations called Marsh & McLennan Cos. Inc. after the California earthquake to discuss dusting off Quake Holdings Ltd., a proposed policyholder-owned earthquake insurance facility shelved in 1988.

Quake, a Cayman Islands holding company for a proposed Barbados-based captive, Earthquake Loss Fund Insurance Co. Ltd., was to provide limits of \$75 million excess of \$25 million.

Although 45 Fortune 500 companies initially expressed interest, Quake was mothballed last year when earthquake coverage became available as commercial property markets softened (BI, June 20, 1988).

Several companies last week asked M&M if the California earthquake would likely lead to a contraction of commercial earthquake capacity that would once again make Quake Holdings viable, said William Schneider, a Marsh & McLennan Worldwide managing director.

After an advisory board with representatives of about 12 corporations decided in May that the Quake idea was worth pursuing, M&M began studying what coverages the facility should offer and how the coverage should work, Mr. Schneider said.

The California quake forced cancellation of a follow-up meeting, he said. No new date has been set.

Meanwhile, M&M is re-evaluating its study of the facility's potential coverages in light of last week's disaster, Mr. Schneider said.

—By Douglas McLeod

year of coverage, he said.

"Some companies are so desperate for coverage they are paying a premium to get that coverage in place," he observed, adding that this is more prevalent in the London excess-of-loss reinsurance market—known as the LMX market—than in the U.S. reinsurance market.

London sources agree that U.K. underwriters offering reinstatements for nine weeks of coverage are charging premiums equal to between 75% and 100% of the 12-month premium.

"We are thinking of buying another reinstatement cover, but the rates are unbelievable," said one London non-marine underwriter. "The market is prepared to write another reinstatement but only until the year-end for 75% of the premium of a 12-month policy."

Reinsurers also are using various mechanisms to adjust pricing on reinstatements, including profit commissions and no-claims bonuses to ceding insurers, Mr. Snedeker said.

Under another mechanism, the cost of a second or third reinstatement is figured by charging the ceding company a base premium plus an added premium calculated by applying a rate to the limits used up in the underlying reinsurance layer, he said.

With this mechanism, the cost of the reinsurance coverage rises as the reinsurer's exposure to loss increases, he explained.

One Lloyd's underwriter who is writing these reinstatements faced a line of 30 to 40 brokers the day after the earthquake.

"The market is extremely jittery at the moment," said the E.W. Payne spokesman. Because of Hurricane Hugo last month, "some reinstatements may not be in place. We are trying to corral capacity which is not usually involved to get the coverage for the last 10 weeks of the year. A lot of reinsurance programs have blown."

"Lloyd's (excess-of-loss reinsurance) syndicates already are under some pressure," said Mr. Goodwin of UBS Phillips & Drew. "Some more Lloyd's syndicates are going to blow through their reinsurance protection and have to make cash calls on names. There will be quite a tightening for the XL renewals in January."

The LMX market is "in an absolute turmoil," reported one London-based claims manager. Brokers already have been busy in the last few weeks trying to get reinstatements for insurers following Hugo and now are out in the market in droves again "facing a very grave shortage" of catastrophe coverage.

The LMX market "is in an extremely sick state" and excess-of-loss reinsurance "prices are going to be sky-high," he predicted.

Retrocessional capacity "seems to

be getting more and more limited, and it's becoming very much a supply-and-demand issue whereby the price is increasing because the supply is decreasing," Mr. Snedeker said.

At the same time capacity is becoming limited, the combined impact of the earthquake and the hurricane is likely to cause ceding insurers to seek more reinsurance, reinsurers and brokers say.

"Now it has been clearly illustrated that you can have three bad ones in a 60-day period, so I think people will be looking for higher catastrophe limits," observed Michael G. Fitt, president and chief executive officer of Employers Reinsurance Corp. of Overland Park, Kan.

"Whether it will be affordable remains to be seen," Mr. Fitt added.

Ceding insurers generally set a minimum acceptable limit for their catastrophe covers, and whether they buy additional limits depends in part on how much they can afford and their perception of the likelihood that the added limits will be needed, he explained.

"The perception of what can happen has been greatly enlarged by this 60-day period," Mr. Fitt said.

Blanch's Mr. Cashman agreed that the combined effect of the earthquake and hurricane losses will prompt insurers to try to limit their exposures in the future.

He noted that ceding companies may do this by buying additional catastrophe reinsurance, reducing retentions or buying various types of stop-loss reinsurance coverage to limit their exposure to an aggregation of occurrence retentions.

Mr. Cashman added that heavier use of reinsurance by ceding companies coupled with reinsurance losses generated by the two disasters may result in a tightening reinsurance market.

While Hurricane Hugo by itself probably would not have had such an impact on the reinsurance marketplace, the earthquake may have tipped the scales toward a tightened market, he suggested.

For companies that have been hit hard by the earthquake and the hurricane, Mr. Snedeker said he would propose renewal reinsurance contracts that include "some form of amortization of the loss over a reasonable period of time so that the hit is spread out."

Such an amortization of losses could take place over a period of six years or more, Mr. Snedeker said.

This story is based on reports by Carolyn Aldred and Stacy Shapiro in London; Douglas McLeod and Judy Greenwald in New York; and Mark A. Hofmann in Chicago. It was written by Managing Editor James M. Burcke.

## Personal injury suits likely

Government entities and construction and engineering firms likely will be sued for deaths and injuries caused by the collapse of highways and bridges during last week's California earthquake, attorneys predict.

A 1963 state law abrogated blanket immunity from liability for the state and municipalities, said Mary Belgrade, an attorney with the Alliance of American Insurers in Schaumburg, Ill.

However, some immunities may protect defendants in quake-related suits.

California law does not allow a plaintiff to recover non-economic damages from a government entity, she said, though punitive damages for wrongful death can be awarded.

"There is no doubt in my mind that there are a lot of people... whose minds have been working on who they can sue," said David A. Bakst, an attorney with Morrison, Mahoney & Miller in Boston.

Mr. Bakst predicted "plenty of lawsuits and few wins."

State law "may or may not" provide immunity to government agencies in suits alleging design flaws in collapsed bridges and freeways, said Ignazio J. Ruvolo, an attorney with the San Francisco firm

Bronson, Bronson & McKinnon. "It depends on the facts and how things shake out in discovery," he said.

He explained that if a design was approved by a government body and a court determines the agency acted reasonably in approving the design, the agency would be protected from suits charging the design contributed to the accident.

Private companies that worked on designing a bridge or freeway that fell during the quake could be protected from lawsuits as well, Mr. Ruvolo noted.

A contractor is generally protected if it followed a government-approved building plan, he said.

"If the design is not obviously unsafe, the contractor will not be held liable for building it in accordance with the specifications, even if building it that way causes an accident," he noted.

California law may also protect engineers involved in the design of a bridge or freeway that was damaged, said Mr. Ruvolo.

"If, at the time the design was made, he was doing work consistent with what any firm would do, he would not be liable," Mr. Ruvolo explained.

—By Michael Bradford and Laura Mazzuca

## Quake losses

Continued from page 1

However, the amount of insured damage throughout the Bay Area will not even approach the amount of overall losses because relatively few property owners purchase earthquake insurance. Observers estimate that no more than 20% of California homeowners purchase the coverage, while the percentage of businesses with the coverage is roughly the same or smaller.

The high cost of earthquake coverage, combined with mandatory deductibles ranging from 5% to 10% of policy limits, prompts many businesses to self-insure their earthquake exposures, said Bernard H. Mizel, president and chief executive officer of broker American Business Insurance Inc. in San Francisco.

Statewide, "I would be very sur-

prised if over 5%" of commercial policyholders purchase earthquake insurance, said Scott Hauge, president of Cal Insurance & Associates in San Francisco.

Charles L. Ruoff, senior vp and director of strategic planning for Fred S. James & Co. Inc. in New York, said that although he could not be specific, total damage from the earthquake will be less than damages from Hurricane Hugo, and that insured earthquake losses definitely will be even lower.

"The major difference between Hugo and the earthquake is that windstorm is a basic peril covered under property policies and earthquake is not. Normally, 75% of total damage in a hurricane is insured, compared with 25% of total damage being insured in an earthquake," Mr. Ruoff said.

Jon Ingenthron, risk manager for

the city of Oakland, said that only a few city-owned buildings are covered for earthquake damage.

"Because quake and flood insurance is prohibitively expensive, we only purchased (the coverage) for properties funded through bond issues," he explained. "It appears that only four structures are insured for quake damage and, unfortunately, the deductibles are 5% of value."

Three of the structures that are covered "are in good shape," Mr. Ingenthron added, "pending analysis by a structural engineer."

But, "we lost a City Hall annex building," he said. The 76-year-old structure valued at around \$12 million was heavily damaged by the quake. "It was very brittle and sustained the most damage," he said. "It's still being evaluated."

The other facilities insured for earthquake damage are the \$60 million main City Hall building, the \$30 million Henry J. Kaiser Convention Center and the \$40 million Scotland Memorial Convention Center.

Mr. Ingenthron said the aggregate value of municipal buildings in Oakland is about \$550 million. While damage to most of the facilities does not appear to be major, "it feels like no structure is undamaged."

Mr. Ingenthron said the four buildings with earthquake coverage were not insured to their full value, although he could not provide specific policy limits. The coverage is spread among several insurers including Utica Mutual Insurance Co.; RLI Insurance Co.; Allianz Insurance Group; and Associated International Insurance Co.

Although the commercial damage in the Bay Area is likely to be huge, businesses appear to have fared much better than residences.

In San Francisco, damage to city-owned buildings was "relatively minor," said Keith Grand, risk manager for the city of San Francisco. "We've had some plaster off the wall and cracks," he noted.

"By and large, we're self-insured for property risks in general, whether or not the peril is an earthquake," said Mr. Grand. He was unable to say how much money is available to pay for damages, pointing out that the city does not have a separate budget to cover uninsured property damage.

Mr. Grand estimated city property is valued at around \$4 billion.

The state of California also is facing loss of revenue from tolls from the damaged San Francisco-Oakland Bay Bridge and will have to foot repair bills for the bridge.

While \$76 million in "use and occupancy" insurance will cover some of the lost toll revenues, there is no coverage to repair damage to the bridge caused by the earthquake, said Ralph Maurer, risk manager for the state of California. Media reports have said the bridge may be out of

## Insurers again write new quake policies

At least two California insurers last week quickly lifted the traditional moratorium on writing new earthquake insurance policies following a quake.

The customary moratorium, which has lasted up to 30 days, is viewed as a prudent measure by insurers because of the likelihood of aftershocks, said James Snyder, president of the Personal Insurance Federation of California, an association of personal lines insurers.

"The idea is you don't insure a burning building," Mr. Snyder said.

For example, virtually all insurers imposed such a moratorium following the 1987 quake centered in Whittier, Calif., he said.

However, Allstate Insurance Co. and Fireman's Fund Insurance Co. said late last week that they had resumed writing new personal and commercial earthquake business after imposing a brief moratorium following Tuesday's catastrophe.

Although Allstate has resumed writing new earthquake coverage, it will not write new coverage in 17 counties surrounding the epicenter of last week's quake until agents inspect the property to be insured, said Susan Francesconi, territorial underwriting manager for Allstate in San Jose.

Likewise, a spokesman for Novato, Calif.-based Fireman's Fund said that new earthquake coverage written statewide by the company won't be binding until the premises are inspected.

Other insurers said they may follow suit and drop the moratorium.

For instance, Farmers Insurance Co. last week imposed the typical 30-day moratorium in 20 counties affected by the quake, but "it could change. It's not a magic number," said a spokesman. "It could be altered once we go in and reassess the situation."

State Farm Mutual Automobile Insurance Co. has imposed a 30-day moratorium within 100 miles of the quake's epicenter, said a company spokesman.

Mr. Snyder noted that insurers may be lifting the moratorium because of competition among insurers and in response to "insurer bashing" in California, as represented by Proposition 103.

It shows that "insurers are grappling with how to regain trust and confidence," Mr. Snyder said.

—By Louise Kertesz

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## Cleanup coverage ruling

Continued from page 2

rather a "coercive demand letter" compelling the policyholder to clean up the site.

The letter is "sufficiently adversarial to constitute a suit under New York law and within the meaning of the policy," the court ruled.

Furthermore, the court said it is in the public's, the policyholder's and the insurer's best interests to treat these types of demand letters as lawsuits because the earlier the cleanup process begins, the less expensive it will be.

The court also struck down Travelers' argument that the insurer had no duty to defend Avondale against the Louisiana agency's order.

"Travelers can be excused from its duty to defend only if it can be determined as a matter of law that there is no possible basis in law or fact upon which the insurer might be held to indemnify Avondale."

The court went on to say that there is not enough evidence to

"clearly negate" the possibility of coverage. "Travelers, therefore, has a duty to defend the private actions," the court ruled.

Travelers attorney Mary Kay Vyskocil of Simpson, Thacher & Bartlett in New York said the insurer will attempt to appeal the case to the U.S. Supreme Court on procedural rather than substantive grounds.

If the insurer is successful in proving the procedural posture of the case was improper, both the 2nd U.S. Circuit's ruling and an underlying district court's ruling would be voided.

However, Supreme Court review is highly unlikely, Ms. Vyskocil conceded.

Meanwhile, attorneys say the 2nd Circuit's decision will be enormously influential on litigation nationwide over coverage for government-mandated pollution cleanups.

"The 2nd Circuit has always been thought of as a junior Supreme Court," said Mr. Fryer,

pay for freeway repairs.

Possibly the most costly freeway damage occurred on Interstate 880 in Oakland, where a mile-long section of the upper level of the double-deck freeway fell onto the lower deck. The death toll from the freeway collapse originally was estimated at more than 200, but officials said late last week that the number of fatalities could be much lower.

Businesses and homes sustained heavy damage nearer the epicenter of the quake.

Robert Palmer, personnel director for the city of Santa Cruz, said early estimates put total damages in that city at around \$350 million. He said 201 residences and 72 businesses had been damaged by the quake, including much of the downtown Pacific Garden Mall.

Around 30% of the commercial structures damaged will have to be torn down, he said.

Robert Shepherd, finance director for the city of Santa Cruz, said lost property taxes and sales taxes from

Continued on next page

Avondale's attorney.

Attorneys note that the ruling will weaken insurers' claim that the only two federal circuit courts to have ruled on coverage for government-mandated pollution cleanup have favored insurers.

"It blunts the suggestion that carriers have been making that the federal appellate courts favor their point of view," said policyholder attorney Robert Saylor of Covington & Burling in Washington, D.C.

Furthermore, "the overwhelming number of state courts and federal district courts favor the policyholder," Mr. Saylor said.

Pointing out that many property/casualty insurers are based in Connecticut and New York and that the 2nd Circuit includes those states as well as Vermont, Mr. Saylor noted that the decision was handed down from a federal appellate court in the "backyard of the insurance community."

"When their own federal court speaks, it would seem to speak louder," he observed.

Continued from previous page  
 businesses that are destroyed will be "horrendous" and could amount to \$2 million to \$3 million. There is no insurance coverage to make up those revenues, he said.

Damage in Santa Cruz will amount to "hundreds of millions," he said. "The downtown area is devastated. All those buildings were built before the earthquake codes." He said it is unlikely that commercial property owners in Santa Cruz have earthquake coverage.

However, city property held up well, Mr. Shepherd pointed out. "Damage was not that heavy. We had a lot of equipment broken and broken water mains, that kind of thing. What's above ground was not that bad."

Mr. Shepherd said he believes the city's property insurance excludes damage from earthquakes, although he had not examined the policy late last week.

Vince Pisani, general manager of the CSAC Excess Insurance Authority, a Sacramento-based underwriting pool that offers "substantial limits" of earthquake coverage to counties in the state, said he did not expect damage to facilities in Santa Cruz County to be significant.

Damage also was heavy in the downtown area of Los Gatos, north of Santa Cruz. Around 100 homes and commercial buildings were left uninhabitable by the quake, said Marilyn Rasmussen, executive assistant to the town clerk.

Retail shops, boutiques and restaurants in Los Gatos were housed in old buildings that crumbled during the quake, Ms. Rasmussen said. No damage estimates were available there.

However, in the Silicon Valley, a community of computer makers and other high-tech businesses, damage was relatively light.

Mark St. John, director of risk management at Intel Corp. in Santa Clara, said: "If you just drove around Silicon Valley, you would see no signs of the earthquake. If you go next door into Los Gatos, suddenly you see the signs."

Mr. St. John said Intel was "very, very fortunate. All our damage was cosmetic. . . I would say the impact of the earthquake was negligible."

He said Intel's losses shouldn't come close to \$1 million, unless yet-to-be discovered damages are found.

Intel carries \$110 million of earthquake coverage written by CIGNA Corp.; an American International Group Inc. unit; The Home Insurance Co.; and Royal Insurance Group, according to Mr. St. John.

Intel's deductible on the coverage is 5% of the value of a damaged building or \$5 million, whichever is less, Mr. St. John explained. In no case is the deductible less than \$250,000.

Other cities and businesses in the Bay Area also escaped serious damage.

Doug Byrd, risk manager for the city of Mon-

tere, said the quake left power outages and "an occasional broken window."

Damage at San Francisco-based Chevron Corp.'s scattered properties around the Bay Area was largely cosmetic, reported Dave Barksdale, manager of corporate programs-Insurance Division.

"I have heard of no damage of a catastrophic nature" to Chevron properties, he said.

A spokesman for Pacific Gas & Electric Co. said the San Francisco-based utility had no dollar estimate of damage to the utility's facilities.

However, he reported substantial damage to distribution systems in the Marina district of San Francisco—the site of a spectacular fire after the earthquake—and a few other areas.

In addition, PG&E's Moss Landing power plant in Monterey County was being inspected for damage, which could be substantial, he said, adding that the switchyard at the plant needed extensive repair.

The spokesman said PG&E purchased insurance to cover the damage, but could not elaborate.

Many risk managers, especially those whose companies suffered serious damages, could not be reached because their facilities were closed or telephone lines were severed.

Risk managers at businesses and municipalities that believe they weathered the earthquake reasonably well noted that undiscovered damage could lead to future problems.

"The insidious thing about assessing earthquake damage is the invisible or yet-to-be discovered damage that can only be found through tedious structural inspections," said Mr. Ingenthron, Oakland's risk manager.

And, he stressed, there is a danger that such inspections will not be thorough.

"One serious risk that must be managed is the risk of the instant expert in quake analysis," Mr. Ingenthron remarked. "Those are the people who take a look and make an analysis based on their own personal experience."

Hugh Strawn, director of catastrophe services for the insurance industry-supported Property Loss Research Bureau in Schaumburg, Ill., said that as the quake area becomes more accessible, insurers and public offices will face the problem of "standing rubble"—buildings that appear whole but that have suffered extensive structural damage. Public officials may raze the buildings before adjusters can assess the damage, he said.

"Damage to buildings will be more severe than it appears externally," said Herbert Tiedemann, a consultant engineer with Swiss Reinsurance Co. of Zurich, Switzerland.

Jeffrey Pettegrew, risk manager of the Contra Costa County Municipal Risk Management Insurance Authority, said that although Contra

Costa "escaped the wrath of the earthquake," his counterparts with municipalities in the Bay Area face the thorny problem of keeping building occupants out of structures until the facilities are declared safe.

"One of the major issues you will see unfolding involves public safety vs. the demand by people to get back into their buildings," said Mr. Pettegrew.

Few insurers last week could give any estimate of their losses.

Fireman's Fund estimated Wednesday that the quake will cost the insurer no more than \$50 million after taxes and reinsurance recoveries.

Fireman's Fund expects 2,000 to 5,000 claims from the quake, Mr. Byrne said. About 22% of the company's homeowners policyholders in the Bay Area buy earthquake insurance, he said.

"We expect to pay out between \$150 million and \$200 million on a direct primary basis," he said.

While many insurers said they did not expect major losses because they did not write a great amount of earthquake coverage in the Bay Area, some insurers have considerable earthquake exposures.

For example, Bloomington, Ill.-based State Farm Mutual Automobile Insurance Co. has written about 116,000 earthquake policies in the Bay Area, said a company spokesman.

Factory Mutual Engineering Assn. in Norwood, Mass., which provides technical services for insurer members of the Factory Mutual System, had 85 calls from policyholders reporting losses by last Thursday morning, said Tom Hollowell, vp and adjustment division manager.

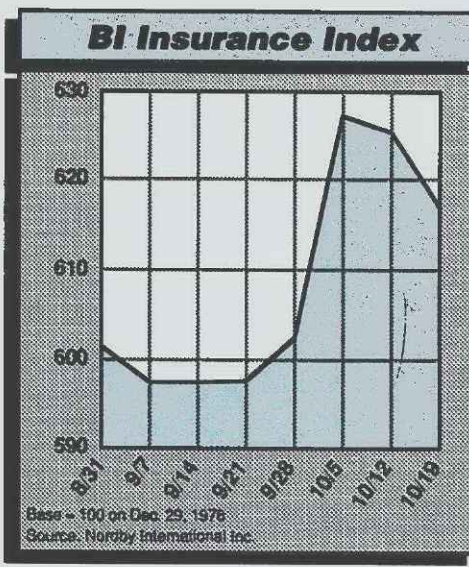
None of the calls reported total losses, he said, adding that most reports concerned cracked walls and broken glass.

Last week's disaster could attract attention to the Earthquake Project, an insurance industry-supported proposal to establish a federal program that would provide both primary earthquake coverage and excess-of-loss earthquake reinsurance (BI, Oct. 12, 1987).

Franklin W. Nutter, president of the Alliance of American Insurers and chairman of the Earthquake Project, pointed out that, historically, Congress has not often acted until a noteworthy disaster to put an insurance program in place, citing the federal crime insurance program that sprang from the urban unrest of the mid-1960s as an example.

"Hopefully, the consciousness of Congress will be raised by this earthquake," he said.

This story is based on reports by Michael Bradford and Louise Kertesz in Los Angeles; Mark A. Hofmann and Laura Mazzuca in Chicago; and Michael Schachner in New York. It was written by Managing Editor James M. Burcke.



Pushed down by the Oct. 13 stock market slump, insurance industry stocks declined during the five-day period ending Oct. 19, despite large gains following the California earthquake. The Business Insurance Index fell 8.0 points to 617.5 from 625.5 on Oct. 12. Advancing issues were led by Phoenix Re Corp., up 19.5%; Trenwick Group Inc., up 13.01%; and Arthur J. Gallagher & Co., up 12.97%. Decliners followed HMO America Inc., down 19.1%; Pacificare Health Systems, down 11.7%; and Selective Insurance Group, down 8.0%. The BI Index lost 1.3% last week; the Dow Jones 30 Industrials fell 2.6%; the New York Stock Exchange Composite dropped 2.4; and the Standard & Poor's 500 lost 2.3%.

**British Issues**

Oct. 19 Companies	Price	P/E	Div. %	Yield %	High-Low
Comml Union	442	18.4	29.3	6.6	442-435
Genl Accident	1013	10.0	68.0	6.7	1013-991
Royal Royal Exch	222	14.1	15.7	7.1	222-212
Royal	465	14.2	34.0	7.3	465-438
Sun Alliance	289	8.5	17.0	5.9	290-287

Brokers	Price	P/E	Div. %	Yield %	High-Low
Bradstock	195	13.4	10.0	5.1	195-175
CE Heath	473	13.5	34.5	7.3	476-455
Hogg Robinson	145	10.1	9.7	6.6	145-129
Lloyd Thompson	227	15.1	9.3	4.1	227-210
PWS Holdings	43	10.8	2.7	6.2	43-38
Sedgwick Grp	265	18.7	16.7	6.3	265-241
Steel Brl Jones	231	14.4	15.3	6.6	231-215
Willis Faber	244	17.2	15.3	6.3	245-222

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

# BI Industry Stock Report

OCT. 19, 1989

10/13/89 THROUGH 10/19/89

BROKERS												CONGLOMERATES & HOLDING COMPANIES												INSURERS/REINSURERS												HEALTH MAINTENANCE ORGANIZATIONS																																																																																																																																				
Company	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Company	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Company	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Company	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value																																																																																																																									
Alexander & Alexander	NYS	32.38	-0.77	39.25	33.25	22.63	1140	1.00	3.09	18	2.90	11.16	Lawrence Insurance Group	ASE	7.38	-4.84	-7.81	10.75	6.63	2	0.28	3.80	17	3.19	2.31	FHP International	OTC	49.00	-1.01	317.02	51.13	10.88	898	0.00	0.00	24	3.54	13.84	HMO America Inc.	OTC	6.88	-19.12	632.94	10.63	0.81	563	0.00	0.00	-15	1.12	6.14	Pacificare Health Sys.	OTC	26.50	-11.67	112.00	30.38	5.63	378	0.00	0.00	32	6.35	4.17	Safeguard Health Enter.	OTC	11.38	-1.09	111.63	12.50	4.50	122	0.00	0.00	18	2.99	3.80	Sierra Health Services	ASE	7.25	1.75	346.15	8.25	1.25	331	0.00	0.00	-7	1.59	4.56	United Healthcare Corp.	OTC	11.00	-6.38	158.82	12.63	3.88	1116	0.00	0.00	-5	0.31	35.48	United Medical Corp.	ASE	6.75	-1.82	25.58	7.25	4.13	21	0.00	0.00	24	4.11	1.64	U.S. Healthcare	OTC	14.38	0.88	155.56	14.88	5.25	1240	0.23	1.60	46	2.87	5.01	Western Health Plans	ASE	NA	NA	NA	1.25	0.13	-	0.00	NA	0	0.82	NA	HMOs	AVERAGE	-4.3	206.6							0.2	13		ALL COMPANIES	AVERAGE	-0.2	49							2.5	10	

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