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update

Events at Crum & Forster to cost Xerox $160 million

STAMFORD, Conn.—Xerox Corp.'s third-quarter earnings will be reduced by $160 million related to the business of its Crum & Forster insurance subsidiaries.

Industrial Indemnity Financial Corp., a C&F company that writes financial guarantee and contract surety business, is being closed. Current policies will be run off.

In addition, Xerox says it is adding

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Tax reform options

Ways and Means mulls new proposals

By JERRY GEISEL

WASHINGTON—As the House Ways and Means Committee begins to shape the tax reform bill, it will consider a new list of benefit tax options that preserve 401(k) plans but impose onerous rules and taxes in other areas.

The newest options include some taxes and restrictions not recommended by the Reagan administration in its tax reform proposal (*BI*, June 3).

The options paper, prepared by staffs of the influential Joint Committee on Taxation and the Ways and Means Committee, will carry great weight with Ways and Means members who began drafting a tax reform bill in closed sessions last week.

For employers with 401(k) plans, the new options offer hope that the popular salary reduction savings plans will not be eliminated, as proposed by the Reagan administration (*BI*, Sept. 9). The Ways and Means Committee is weighing a proposal that would retain 401(k) plans but limit annual salary deferrals to $5,000 and impose new non-discrimination rules.

And, the new options include new uniform non-discrimination rules for benefit plans that appear less burdensome than a Reagan administration proposal that could have disqualified thousands of employer plans for tax purposes.

But, that is where the improvements over the Reagan administration proposal end.

The options paper proposes slashing the maximum benefit provided to a defined benefit participant to $75,000 from the current $90,000. Similarly, the maximum annual contribution to a defined contribution plan would be slashed to $25,000 per participant, down from the current $30,000 limit. The Reagan administration's tax reform package does not alter the current maximums.

Benefits tax options

	Ways and Means staff	Reagan administration
401(k) plans	Limit annual maximum deferral to $5,000	Eliminate
Defined benefit plans	Cut annual benefit to $75,000 from $90,000	Doesn't address
Defined contribution plans	Cut annual contribution to $25,000 from $30,000	Doesn't address
Health insurance plans	Tax contributions exceeding $120/month for individuals; $300/month for families.	Tax first $10/month for individuals; $25/month for families.
Workers compensation disability benefits	Tax-free if non-disability income is less than $15,000/individuals; $20,000/families	Tax benefits with limited tax credits

Chart: Amy Palmer

"On the retirement side, the proposals are devastating," said Edward J. Davey, vp-technical analysis at Johnson & Higgins in New York.

On the welfare plan side, the paper proposes to tax employees on company health care contributions that exceed $120 a month for individual coverage and $300 a month for family coverage. In contrast, the Reagan administration proposes to include as taxable income the first $10 a month of employer health care contributions toward individual coverage and the first $25 a month toward family coverage.

While the Reagan proposal would affect all employees and was disliked by many Democratic congressmen, the Ways and Means option could be harder to administer.

The Ways and Means options also would include

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ISO may compromise on key provisions in claims-made form

By ROBERT A. FINLAYSON

With state insurance department approval of the proposed commercial general liability policy forms at a standstill, property and casualty insurers are considering key changes in the controversial new claims-made form.

Late last week, the executive committee of the Insurance Services Office met to discuss concerns raised by regulators, insurance buyers and agents and to consider changing the CGL policy forms.

Still targeting Jan. 1, 1986, for implementation of the new policies, ISO is now considering proposals to amend the claims-made form to:

- Change the trigger of coverage to notification of a claim or possible claim by a policyholder to the insurer instead of requiring the notification of a claim by an injured party to the policyholder to trigger coverage.
- Establish a schedule for pricing the extended reporting period endorsement or tail coverage, based on the aggregate policy limits remaining at the time the tail coverage is purchased.
- Generally prevent insurers from advancing the retroactive date, except under a limited number of specified circumstances.

Concerns over the claims-made form is holding up state insurance department approval of both the new claims-made and occurrence forms proposed by ISO.

The ISO executive committee meeting last week comes on the heels of two separate meetings early last week between ISO officials and insurance commissioners from Illinois, New York, Connecticut and Nebraska and with members of the National Assn. of Professional Insurance Agents and the Independent Insurance Agents of America. A meeting with members of the Risk & Insurance Management Society is set for Oct. 21.

Participants in the two meetings held last week say ISO officials appeared willing to make changes in the proposed CGL policy forms.

"We feel a sincere effort was made by the ISO staff in a technically astute manner to respond to concerns voiced by regulators, our association and others," says Patricia Borowski, vp of government and industry affairs for PIA, speaking of PIA's meeting with ISO early last week.

Ms. Borowski notes after ISO made several small concessions to agents

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Transit systems hurdle coverage roadblocks

By MEG FLETCHER

Bus and commuter rail lines nationwide are improvising solutions to the crisis they face in finding affordable insurance for their liability risks.

Commercial insurance rates have zoomed as much as 300% to 1,200% for coverage with drastically lower limits. Sometimes no insurance is available.

As a result, beleaguered public transit operators are appealing to state legislatures to bolster their statutory immunity and to state insurance regulators for protection from midterm policy cancellations.

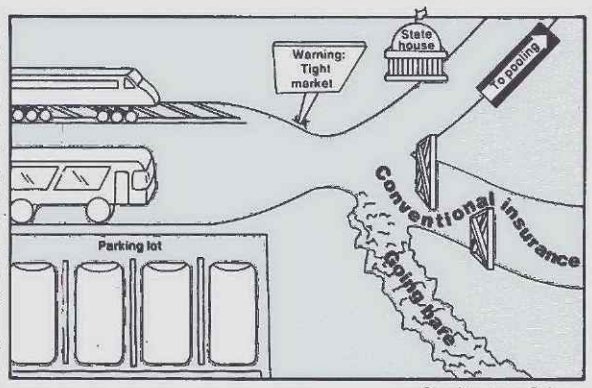
Both public and private transit operators also are employing a wide range of "self-help" solutions, including forming captive insurers, setting up self-insurance pools, arranging the group purchase of excess coverage and raising fares.

However, many transit operations still are being forced to operate with little or no liability insurance, eliminate some service to reduce risk or go out of business entirely.

The insurance crisis "could destroy our industry," said Dennis Long, president of Blue & White Lines Inc. in Altoona, Pa. "It will certainly change it."

"This whole market has been deteriorating," said Bill Boone, director of risk management for the Southeastern Pennsylvania Transportation Authority. The transit district operates 13 commuter rail lines serving 85,000 people daily in the Philadelphia area. It also has bus, subway and trolley operations.

Last year, the district had $148 million in excess coverage for its rail operations. But since Jan. 1, it has not been able to complete its excess program. A few layers of coverage up to $30 million are incomplete while several layers are incomplete between $30 million and $150 million, the maximum coverage sought.



Graphic: Amy Palmer

"There is a substantial lack of available capacity just this year compared with last year," Mr. Boone said.

The railroad insurance market can now supply only about $30 million to $50 million of limits to rail risks, which is about one-third of what it could offer last year, he said.

"Transit districts are really having a crisis getting insurance," said Robert Batchelder, chief counsel for the Washington-based American Public Transit Assn.

Generally, smaller districts are having a worse time securing coverage than larger ones because they deal with less experienced brokers, often have no full-time risk manager and may lack insurance purchasing expertise, said Mr. Boone. "They are in tough straits," he said.

In search of help, some transit districts are:

- Moving toward self-insurance bolstered by their state's governmental immunity laws, which limit their liability.

Denver's Regional Transportation District on Oct. 1 canceled all liability insurance on its 755 buses and is relying on the Colorado state governmental immunity act to cap its exposure. The act limits liability for government entities to $150,000 per person and $400,000 per occurrence, said Steve Grebenstein, Denver's transit district risk manager.

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Xerox adds funds to C&F units

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to the reserves of L.W. Biegler Profit Center, a Chicago-based C&F affiliate that is an underwriting manager for International Surplus Lines Insurance Co. and other Crum & Forster affiliates.

Xerox says the funds are being added in the wake of an actuarial analysis that indicated Biegler's reserves are insufficient to meet estimated future costs of settling claims, both known and unknown.

A Xerox spokesman declined to say how much will be added.

The two developments together will reduce Xerox's third-quarter earnings by $160 million. In the second quarter of 1985, Xerox had earnings of $221 million.

And, Xerox announced it contributed $200 million to C&F to be used to boost the capital and surplus of its insurers. How C&F will allocate the funds to its 33 companies has not been announced.

Court won't dismiss P&G, units

CHICAGO—Cincinnati-based Procter & Gamble Co. will have to litigate in U.S. District Court in Chicago a dispute over insurance coverage for claims arising from use of its Rely tampons, which are alleged to have caused toxic shock syndrome.

U.S. District Court Judge George N. Leighton last week denied motions by P&G and two P&G subsidiaries that they should be dismissed from 1983 litigation brought by Northbrook Excess & Surplus Insurance Co., which insured P&G for $25 million excess of a $1 million per-occurrence and $10 million aggregate self-insured retention when Rely was sold. The suit also names Commercial Union Insurance Co., another P&G excess insurer.

Northbrook argues in its suit that each toxic shock claim constitutes a separate occurrence under its policies and that certain expenses claimed by P&G are not covered (*BI*, April 23, 1984).

While it sought dismissal from the Chicago suit, P&G filed suit in June 1985 in state court in Cincinnati against Northbrook, CU and other former excess insurers, American Employers Insurance Co., Pine Top Insurance Co. and First State Insurance Co. That suit seeks a declaratory judgment that all claims by toxic shock syndrome victims constitute a single occurrence in each policy year for purposes of applying P&G's per-occurrence retention (*BI*, July 1).

P&G manufactured and sold Rely from 1974 until 1980. More than 800 toxic shock lawsuits have been filed against P&G.

Lloyd's broker halts placements

LONDON—Lloyd's of London broker W.G. Hill & Sons (Insurance) Ltd. has voluntarily stopped placing new and renewal business at Lloyd's following disclosures that the broker was involved in the placement of property coverage for Occidental Petroleum Corp. with a non-existent insurance company.

W.G. Hill was one of three London brokers used by Bayly, Martin & Fay International Inc. to place property reinsurance for Occidental's Bermuda captive.

In a lawsuit filed against BMF, Occidental said it was told that the coverage was placed with Phoenix Assurance Co. P.L.C., a unit of Sun Alliance & London Insurance P.L.C. (*BI*, Aug. 26.)

However, the coverage—for which Occidental paid $22.5 million—actually was placed with Phoenix Insurance Co., which officials of BMF and W.G. Hill say they have not been able to locate.

David Carter, chief executive of W.G. Hill's parent, Hill Group Ltd., said the voluntary suspension will continue "until we have resolved the problems with Occidental." He added that W.G. Hill—which issued the cover note on the Occidental placement—also thought that the reinsurance was placed with Phoenix Assurance.

The other two London brokers were Hill Leonard Ltd. and Bijou Insurance Services, neither of which is a Lloyd's broker.

Ruling to come on Mentor panel

HAMILTON, Bermuda—The Bermuda Supreme Court is expected to rule soon on the makeup of a committee of inspection to oversee the liquidation of Mentor Insurance Co. Ltd., the captive subsidiary of Ocean Drilling & Exploration Co. of New Orleans.

Creditors claim they are owed about $178.5 million by Mentor, ordered into liquidation in June by the Bermuda government (*BI*, July 8; June 17). Assets to meet these debts amount to about $148 million, leaving an estimated shortfall of $30.5 million. These unaudited figures are based on records the liquidators say are "incomplete." They say some estimates may be "materially inaccurate."

More than 200 creditors, including banks and reinsurers, met Sept. 20 in Bermuda but couldn't agree on the panel members.

The creditors did agree that Charles Kempe, the Bermuda-based partner of accounting firm Arthur Young & Co. who has been interim liquidator for the past three months, be appointed joint liquidator with Michael Arnold, a partner in the firm's London office.

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Hurricane Gloria damage not as great as feared

By MICHAEL BRADFORD

NEW YORK—Hurricane Gloria, which had been billed as potentially one of the most destructive hurricanes of the century, may feel more like a stiff breeze to many commercial property/casualty insurers.

Insurers last week were still assessing the destruction caused by Gloria, and while precise estimates of insured property losses were not available, insurers and analysts said the final tally would probably not exceed $100 million.

That compares with Hurricane Elena, which the American Insurance Assn. says caused $543.3 million in insured losses when it swept across the Gulf Coast early last month (*BI*, Sept. 9; Sept. 16).

Like Elena, most of the insured damage caused by Hurricane Gloria is thought to be personal lines rather than commercial losses.

Gloria "is not a major factor at all," said James Stradtner, a general partner and insurance industry analyst with Alex. Brown & Sons in Baltimore. "I would be surprised if any insurer had a meaningful loss from Gloria. We were exceptionally lucky."

Herbert Goodfriend, an analyst with Prudential/Bache Securities Inc. in New York, said Gloria "does not appear to be onerous, except in pockets of Long Island. It was far less extensive than the apocalyptic school had predicted."

Gloria first caused flooding and wind damage along the coast of North Carolina before heading up the Atlantic Ocean to rake New Jersey, Long Island and parts of New England.

Although Gloria's winds—which at one time had been clocked at 125 mph—subsided somewhat before they reached land, the storm packed enough punch to

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Photo: AP/Wide World

Much of the damage caused by Gloria consisted of downed trees and power lines.

Women sue 28 officials at Robins

By STEPHEN TARNOFF

ATLANTA—A group of women who claim they were injured by the Dalkon Shield intrauterine device are suing the directors, officers and other employees of A.H. Robins Inc., even though the company has filed for reorganization.

In a 15-page complaint filed Sept. 25 in U.S. District Court in Atlanta, more than 70 plaintiffs accuse Robins' directors and officers of negligently manufacturing the Dalkon Shield, negligently failing to warn users of its dangers and negligently failing to recall the device.

The suit also charges the defendants with fraud, deceit and concealment in withholding vital information from the plaintiffs and public concerning the dangers of the Dalkon Shield.

Although the suit names 28 Robins officers, directors, consultants and employees, it does not name Robins itself.

The plaintiffs seek $20 million in

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M&M official to be new head of NYIE

By DOUGLAS McLEOD

NEW YORK—Joseph Fahys, a managing director of Marsh & McLennan Inc., will succeed Donald Reutershan as president of the New York Insurance Exchange, the exchange announced last week.

Mr. Fahys will leave M&M and join the exchange as executive vp on Nov. 1 and will become president when Mr. Reutershan, 63, retires by March 1, 1986.

Mr. Fahys

Mr. Reutershan, who has been president of the exchange since its formation in 1980, had told the exchange's board of governors that he would retire by March 1987, when he turns 65.

He said his decision to retire by next March was unrelated to the resignations late last month of three top exchange officers (*BI*, Sept. 30).

The three officers resigned over differences with Mr. Reutershan regarding the exchange's organizational structure and processing procedures. The officers were Peter Bickford, vp, general counsel and secretary; Joan Sugar, vp-information services; and Patricia Witt, vp-audit.

Mr. Reutershan and Mr. Bickford refused to comment on specifics of the dispute. Ms. Sugar and Ms. Witt could not be reached.

But, Mr. Reutershan said Mr. Fahys' hiring was the culmination of a long search and not the result of the resignations. "The negotiations with Joe Fahys didn't happen overnight," he said.

The decision to hire Mr. Fahys for the president's post grew out of a search for a vp-operations that began last February, Mr. Reuter-

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Court grants broad cover for DES claims

By STEPHEN TARNOFF

INDIANAPOLIS—The Indiana Supreme Court says the triple-trigger coverage theory should apply to DES-related claims pending against Indianapolis-based Eli Lilly & Co.

The state high court ruled Sept. 12 that, under Indiana law, all of Lilly's insurers from the time a plaintiff's mother ingested the anti-miscarriage drug diethylstilbestrol until a DES-related disease appears are liable for defense and indemnification costs.

"In order to achieve the objectives in Indiana law, of giving effect to the policies' dominant purpose of indemnity, we hold that coverage is triggered at any point between ingestion of DES and the manifestation of a DES-related disease," the court said.

Barring a rehearing before the state high court, Lilly's coverage dispute with its insurers now will return to the District of Columbia Court of Appeals, which had sent the case to the Indiana Supreme Court to decide when coverage should be triggered under Indiana law (*BI*, June 24).

The Court of Appeals referred the case to the state court after the appellate court refused to affirm a ruling by the U.S. District Court for the District of Columbia that the triple-trigger theory applies to the DES claims faced by Lilly (*BI*, April 30, 1984).

Last week, defendant insurers were expected to file a motion for a rehearing with the Indiana Supreme Court.

However, a spokesman for Lilly said the company expects the Court of Appeals to enter a judgment in accord with the state Supreme Court decision.

Lilly filed suit against its insurers in March 1982 in U.S. District Court in Washington, naming more than 60 insurers and Lloyd's of London underwriters that provided excess and umbrella liability insurance to the drug maker from 1947 through 1976 (*BI*, March 22, 1982).

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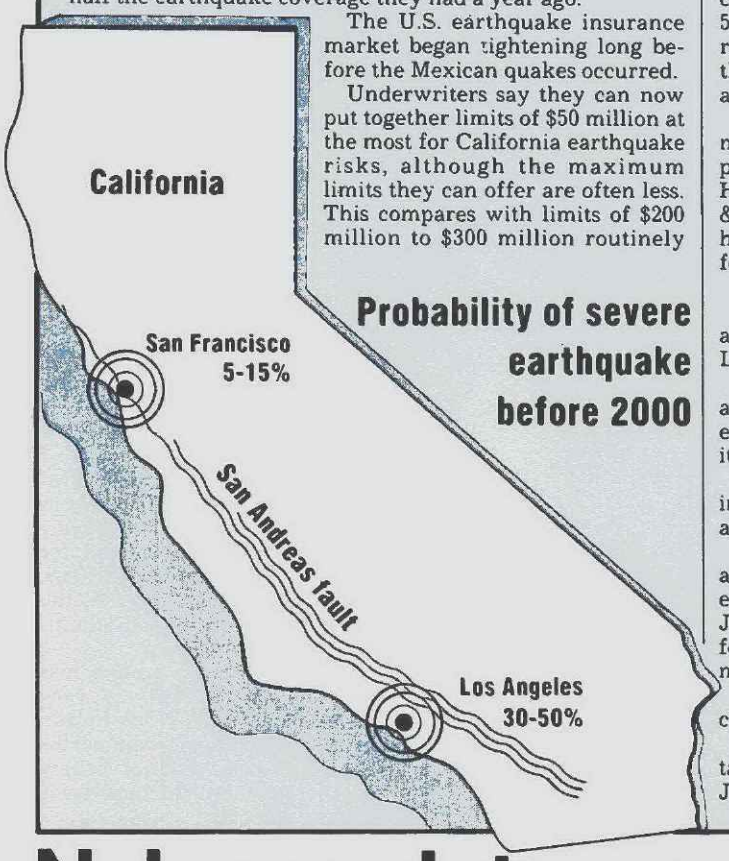
A Shaky Situation

By STEVE TARAVELLA

LOS ANGELES—If an earthquake like the one that devasted Mexico last month rocked the West Coast today, commercial property owners in California have less than half the earthquake coverage they had a year ago.

The U.S. earthquake insurance market began tightening long before the Mexican quakes occurred.

Underwriters say they can now put together limits of $50 million at the most for California earthquake risks, although the maximum limits they can offer are often less. This compares with limits of $200 million to $300 million routinely offered 18 months ago.



And, over the past eight to 12 months, underwriters and brokers estimate, 50% of commercial earthquake capacity has disappeared.

Rates are increasing, too. Coverage that once sold for 5 cents to 10 cents per $100 of insured value now sells for 35 to 50 cents and sometimes $1. In many cases, rates are comparable to Insurance Services Office manual rates, which for the past several years have been about three times as high as the price charged by insurers.

An insurer writing a $5 million layer excess of $5 million might now demand the same premium the policyholder is paying for the entire $5 million primary layer, observes Hermann-Paul Schlander, who underwrites for Anderson & Murison Inc., a Los Angeles wholesaler. Mr. Schlander has written and placed earthquake insurance in California for 35 years.

In addition, deductibles are changing.

"The flat-dollar deductible is out," declares Warren Richardson, marketing executive at Bayly, Martin & Fay Inc. in Los Angeles.

Flat-dollar deductibles, which were common as recently as last December, are being replaced by deductibles that are equal to a percentage of the value of the insured building, its contents and other property on the premises.

Such deductibles, which have commonly been 2% to 5% of insured value, are increasingly rising to 5% to 10%, brokers and underwriters say.

One underwriter recently asked a California risk manager to assume a 40% deductible before it would write coverage for a building that was admittedly a poor risk, recalls James Kelch, senior vp and Los Angeles branch manager for Jardine Insurance Brokers Inc. The risk manager did not purchase the coverage, he adds.

Compounding risk managers' frustrations with these changes is the swiftness with which they are occurring.

For example, about four months ago one California hospital paid $65,000 for $19 million in earthquake coverage, says Jardine's Mr. Kelch. If the hospital sought those limits today, the coverage would cost $85,000 to $100,000, Mr. Kelch estimates.

West Coast risk managers are responding to the reduced capacity and higher prices in a variety of ways:

- Some are still buying earthquake coverage, regardless of price.

If price is of no concern, a company could obtain as much as $70 million in coverage for an exceptional risk on good terrain, reports Alvin Johnson, vp at Fred S. James & Co. Inc. in Irvine, Calif.

- Some are purchasing no coverage.

At a renewal three months ago, one California risk manager tried to replace $18 million in earthquake insurance that he had purchased last year for $22,000 and a 5% deductible. The underwriters would only write $8 million in limits for a $120,000 premium and a 10% deductible.

The risk manager refused those terms and now has no coverage, reports Anderson & Murison's Mr. Schlander.

At least 25 to 30 earthquake policies placed through Anderson & Murison were recently canceled by insurers that lost their reinsurance, Mr. Schlander reports. He does not believe any of these policyholders have been able to find replacement coverage at a reasonable price.

- Some are buying what they can afford but are refusing to purchase costly excess layers.

One Southern California engineering firm, for example, reportedly refused to pay the rate its insurers demanded to renew a $90 million layer excess of $10 million. But, the company did renew the $10 million in primary coverage.

The company would not discuss its coverage.

- Some are opting to insure only those plants or divisions judged to be at most risk.

Managing earthquake risks is important for California companies because of the great probability that a tremor will someday rock the state.

Companies with exposures along the San Andreas Fault in the Los Angeles area have a 30% to 50% chance of experiencing a quake that registers at least 7.6 on the Richter

Continued on next page

N.J. mandate could cause insurers to pull out of market

By MEG FLETCHER

TRENTON, N.J.—New emergency rules in New Jersey requiring insurers to obtain prior insurance department approval before canceling or refusing to renew most property/casualty insurance policies could be a two-edged sword for insurance buyers.

The rules, effective for 60 days from Sept. 17 through Nov. 16, were adopted by New Jersey Insurance Commissioner Hazel Frank Gluck to preserve coverage for policyholders.

"We had an enormous number of complaints" about policy cancellations and midterm rate increases or reductions in coverage, said Ms. Gluck.

The emergency rules were rushed through with the approval of Governor Thomas Kean after Ms. Gluck issued a statement of "imminent peril." The governor's approval precluded the need to satisfy normal waiting periods for new rules.

"These new rules will protect the public by prohibiting detrimental termination practices as well as midterm premium increases and/or reductions in coverage," the new rules state.

For example, 30% of the municipalities and hundreds of other public service districts in New Jersey have lost their liability insurance.

However, the rules may make insurers more reluctant to write new risks in New Jersey and could cause some to leave the state, insurance industry sources warn.

The new rules have had a "totally chilling" effect, reports Robert J. Sullivan, vp of government affairs for Crum & Forster Corp. in Morristown, N.J.

"They went too far and adversely affected the market they were trying to help," he says.

The National Assn. of Professional Surplus Lines Offices Ltd. describes the new rules as potentially "devastating" on the New Jersey insurance market and suggests that insurers may reduce their underwriting in New Jersey or leave the state, according to NAPSLO President Jeremy D. Cooke, who is also president of Major Surplus Inc. with offices in New Jersey and New York.

NAPSLO's board questions the legality of the state Insurance Department applying these rules to surplus lines insurers.

And, NAPSLO contends that the rules do not allow insurers to cancel or not renew their policies even when their own reinsurance is terminated, Mr. Cooke said.

"If an insurer is not able to reduce its limits or modify its terms of coverage to reflect changes and exclusions in its new reinsurance treaties, it will be forced to assume risks and coverage which it did not intend or cannot financially support."

Joe Walsh, president of Great American Surplus Lines Insurance Co. in Cincinnati, reads the rules the same way. He wrote Ms. Gluck that his company may be forced to stop writing insurance in the state after Jan. 1 because its reinsurance will exclude pollution coverage and the company will no longer be able to write or renew pollution policies in the state.

The new rules have had a 'totally chilling' effect, says Crum & Forster's Mr. Sullivan. 'They went too far and adversely affected the market they were trying to help.'

However, Ms. Gluck said that once state officials approve an insurer's general reason for not renewing or canceling a policyholder's coverage—such as lack of reinsurance support—the insurer can terminate coverage without submitting specific risks to the department for individual approval.

But, Ms. Gluck said last week that the rules indeed apply to all admitted and surplus lines insurers writing property and casualty insurance, excluding workers compensation insurance. The rules, which Ms. Gluck said would be clarified by a bulletin she expected to issue late last week, specifically:

- Prohibit midterm premium increases and/or any reduction in the amount of coverage provided under a policy.
- Prohibit insurers from canceling blocks of policies and from not renewing entire lines of insurance, unless Ms. Gluck approves a plan for such actions that minimizes marketplace disruption and provides for alternate coverage at comparable rates and terms.
- Prohibit issuance of a notice of non-renewal or cancellation by an insurer unless the insurer seeks insurance department approval 90 days in advance of the action. The insurer must state the reason upon which the termination is based. The commissioner will review the insurer's submission to determine compliance with applicable statutory or regulatory standards and will advise the insurer, in writing, of approval or disapproval within 30 days.

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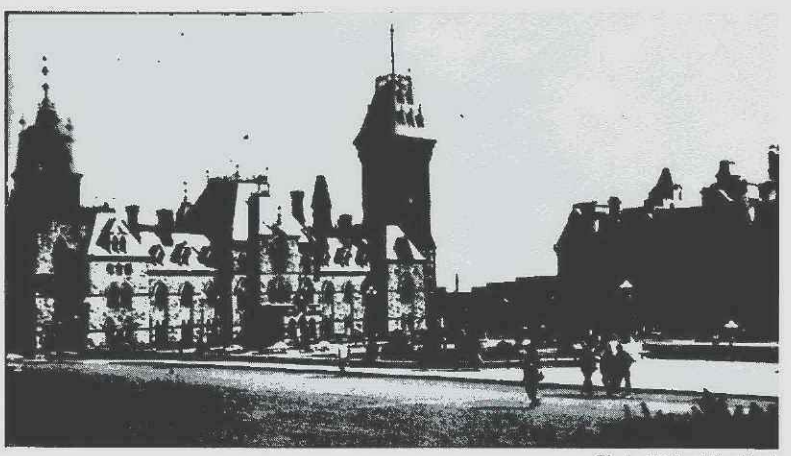

Photo: Michael Bradford

Between conference sessions, attendees at the Canadian meeting of RIMS could visit the Canadian Parliament building in Ottawa.

Canadians feeling D&O coverage crunch

By MICHAEL BRADFORD

OTTAWA, Ontario—Some Canadian companies may find it impossible to purchase directors and officers liability insurance next year, according to an Ottawa-based underwriter.

And, buyers that are able to purchase D&O coverage will pay "devastating" premiums for sharply reduced limits, says Gregg Winterson, senior underwriter at Encon Underwriting Inc. in Ottawa, which manages a Canadian D&O insurance program on behalf of five European underwriters.

Additional coverage of the 1985 Canadian Risk Management Conference, sponsored by the Canadian Capital Region of the Risk & Insurance Management Society, begins on page 14.

Mr. Winterson was a member of a panel addressing the 1985 Canadian Risk Management Conference on the scarcity of D&O coverage in Canada and the United States. The conference, sponsored by the Canadian Capital Region of the Risk & Insurance Management Society, was held last month in Ottawa.

During the past "10 or 12 years, directors and officers liability insurance has gone through a substantial metamorphosis," Mr. Winterson explained.

When buyers first became aware of D&O coverage, "a general attitude developed. . .that only people deemed overcautious, or perhaps paranoid, would consider purchasing this obscure and costly type of insurance."

But, by 1984, directors and officers liability had become "a high-profile consideration in a liability-conscious, or more specifically, a litigation-conscious industry," said Mr. Winterson.

"Buyers had reached a superior level of understanding of the product and were rightfully taking advantage of what was a soft market by insisting upon maximum limits, minimum restrictions and in some cases some

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Quake exposure dropping

LOS ANGELES—Underwriters started reducing their earthquake exposure in 1984, according to statistics from the California Insurance Department.

Underwriters' probable maximum loss (PML) for a quake of 8.25 on the Richter scale, the size of the San Francisco Earthquake of 1906, dropped about 15% for both the Los Angeles and San Francisco areas in January 1984 from a year earlier, the data show.

Insurers' PML today would be much less, according to reports from brokers and insurers who say limits written today are half of what they were last year (see related story).

Richard J. Roth Jr., an assistant insurance commissioner who spearheaded the study, attributes the drop in insurers' maximum PML in January 1984 to lower earthquake insurance limits, fewer policies written, larger deductibles and higher premiums.

The PML is the average probable maximum insured loss that will be experienced by 90% of the structures in a given building class in any of the state's eight earthquake zones.

The PML in the San Francisco area dropped in 1984 to $3.4 billion from $4 billion in 1983. In the Los Angeles area, it dropped last year to $4.7 billion from $5.5 billion in 1983.

PMLs do not consider other claims that must be paid after a quake, including workers compensation; life, accident and health; general liability; theft; or fire.

Quake coverage

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scale by the end of this century, estimates Allan Lindh, a geophysicist with the U.S. Geological Survey in Menlo Park, Calif.

A quake of that magnitude is capable of widespread, heavy damage.

A reminder of this exposure was felt last week, when a tremor that measured 5.0 on the Richter scale jolted portions of Southern California. No injuries or damage were reported.

Those along the fault in the San Francisco area face a 5% to 15% chance of experiencing a quake that registers at least 7.0 on the Richter scale by the end of the century, says Mr. Lindh.

The changing earthquake insurance market conditions have been prompted by a growing reluctance among both direct insurers and reinsurers to assume earthquake business, partly because of the likelihood that a major quake will occur in California, according to experts.

Some underwriters have completely withdrawn from the earthquake insurance market. Others concerned about their earthquake exposures being concentrated in one geographic region have stopped writing the coverage in certain parts of the state, brokers say.

And, some underwriters have stopped writing the coverage temporarily, as part of overall underwriting moratoriums.

Many of the companies that are writing earthquake coverage today only do so on an excess basis. This puts greater pressure on primary insurers, who generally write up to the first $5 million in earthquake coverage.

"Now everybody wants to write excess-of-loss earthquake (coverage), but what good is that if you can't find anyone to take the primary?" asks Mr. Schlander.

Sometimes 12 to 15 insurers are needed just to fill out the first $5 million difference-in-conditions layer before excess insurers will commit to an earthquake exposure, reports Don Sherwood, president of Sherwood Insurance Services Inc., a San Francisco wholesale affiliate of Frank B. Hall & Co. Inc.

And, a few buyers are agreeing to self-insure layers of their coverage that cannot be placed with commercial insurers, he says.

For example, Mr. Sherwood says, a company might buy $5 million in primary coverage from insurers, self-insure the next $2 million layer and then buy excess insurance from an underwriter that will only insure above a $7 million underlying layer.

For instance, First State Insurance Co. currently offers up to $5 million in earthquake capacity, down from $10 million last year. But, to guarantee a safe geographic spread of risk, it frequently only commits $2.5 million, says Peter P. Coghlan, chief property underwriting officer at Cameron & Colby Co. Inc., First State's underwriting manager.

First State writes both primary and excess earthquake coverage.

"Skittish" reinsurers forced Cravens, Dargan & Co. Pacific Coast in January to discontinue a 12-year-old habitational DIC program for dwellings of four families and less, according to Frank Piacente, the company's vp-finance and administration in San Francisco.

The program had a pure loss ratio in the low 20s and was "very profitable," he says. Nonetheless, reinsurers, fearful of their earthquake liabilities, did not renew treaties in January. The business is now being run off.

The program generated about $13 million in gross premium annually.

Meanwhile, to bolster capacity, the Reinsurance Assn. of America and American International Group Inc. are pursuing congressional support for a federal excess reinsurance facility for earthquake losses.

The RAA and AIG have been lobbying Congress since February for their proposal, which would permit direct insurers to purchase limits from the facility of up to 150% of their gross retention and would permit insurers to buy limits up to 300% of their gross retention (*BI*, Feb. 4).

The non-profit, tax-exempt corporation would begin making payments when an underwriter's net loss from an earthquake exceeds 15% of its policyholder surplus or the limits of its catastrophe coverage, whichever is greater.

Participation would be voluntary. If all U.S. earthquake underwriters participate, the corporation could generate an annual premium of about $50 million, its supporters project.

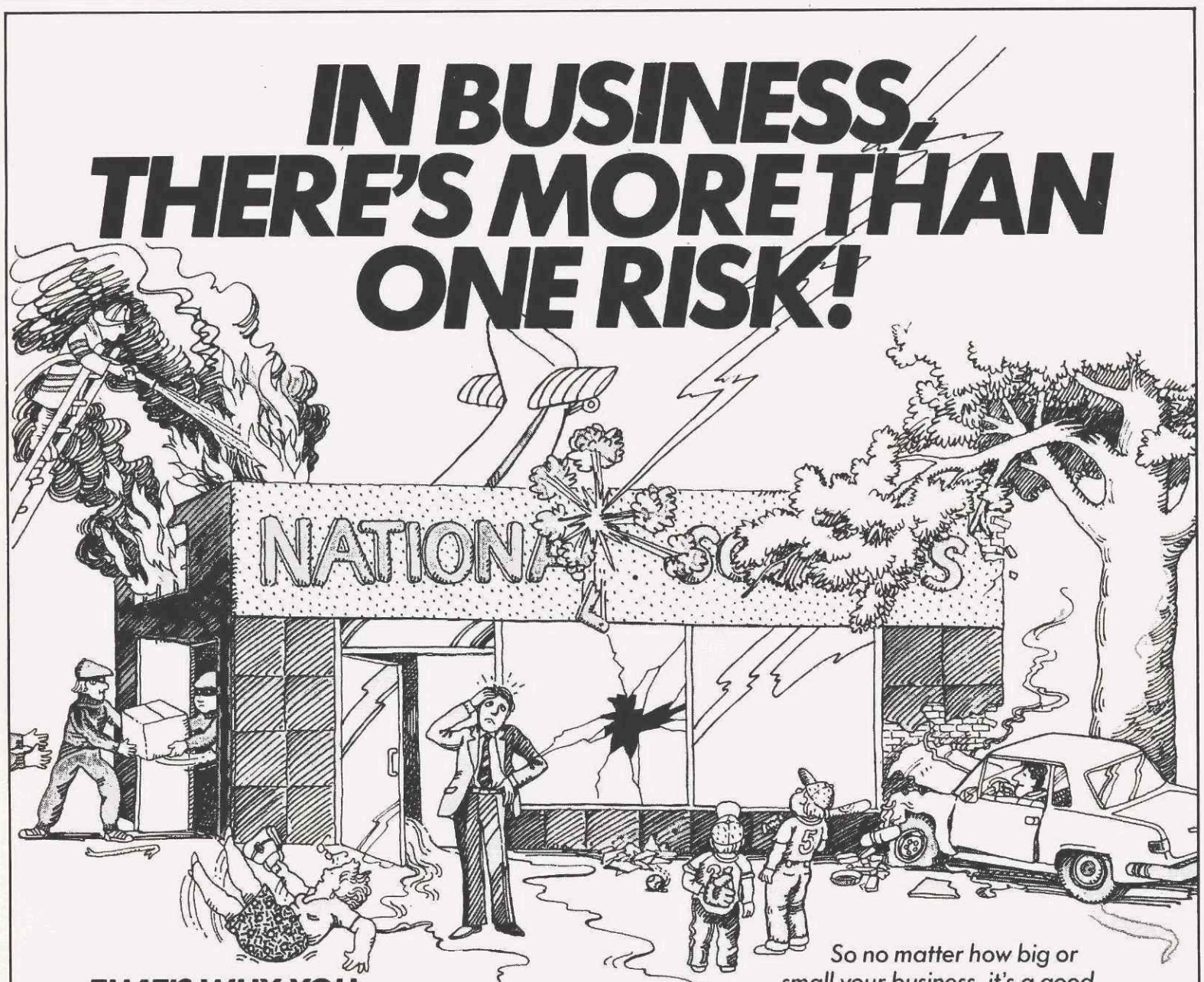
A member of Congress has expressed interest in introducing the legislation, reports RAA Senior Vp James M. Shamberger. Mr. Shamberger declined to identify the congressman.

But, plans to introduce the bill have been put on hold temporarily, pending discussions last week between the RAA and State Farm Insurance Cos. in Bloomington, Ill.

State Farm has been indepedently promoting a similar plan that would establish a federal fund to respond to several types of natural disasters, including earthquakes.

The parties were meeting to discuss consolidating the RAA's reinsurance proposal, which is called the Federal Earthquake Catastrophe Reinsurance Corp., with the State Farm proposal, which is called the Federal Disaster Insurance Fund Corp.

"Two plans up there could just result in chaos and in nobody getting a bill in," explained Mr. Shamberger last week. ■



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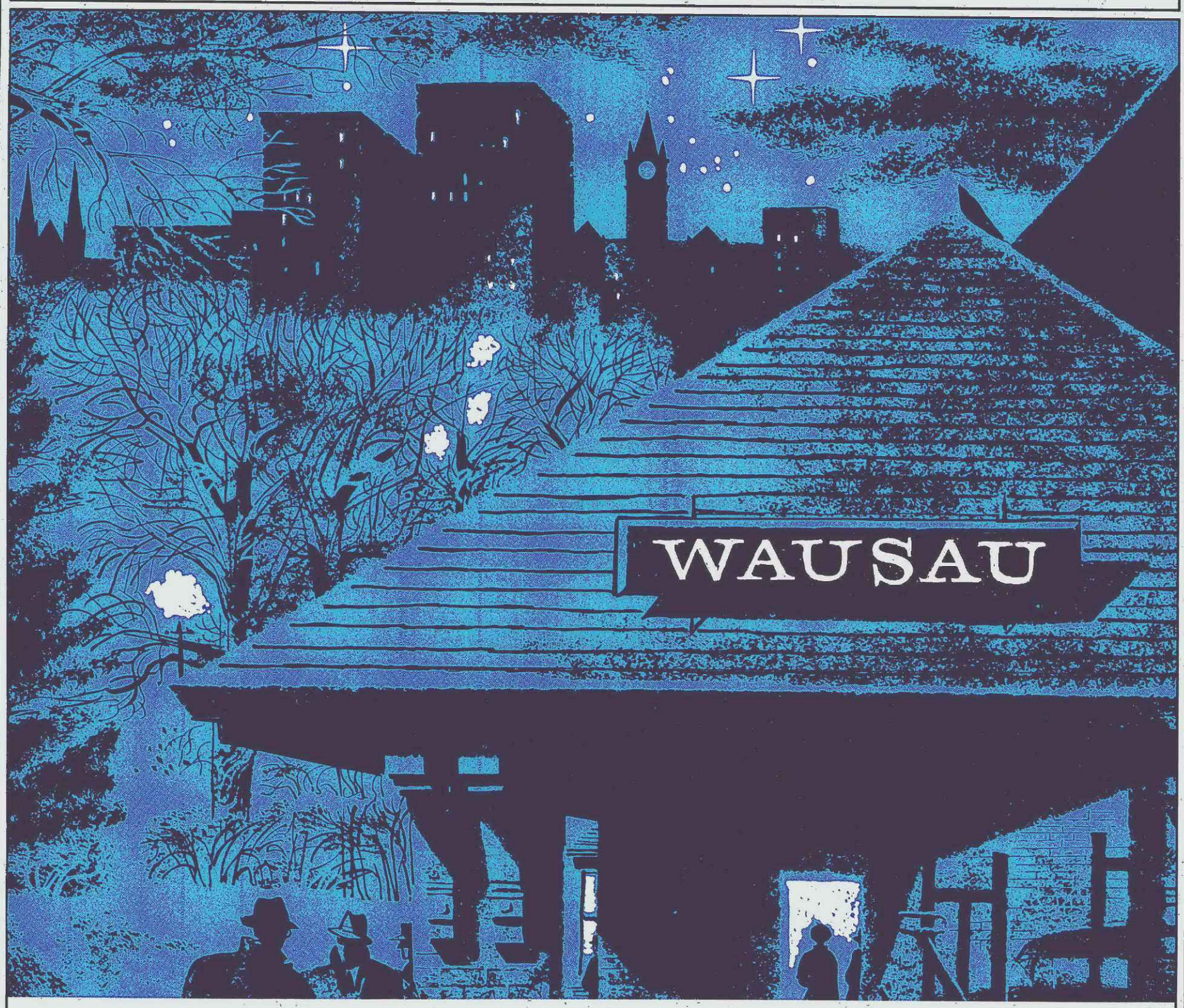

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Robins lawsuit

Continued from page 2

compensatory damages, which could be tripled under the Racketeer Influenced and Corrupt Organizations Act. They also seek $50 million in punitive damages.

However, on the same day the plaintiffs filed their suit, Robins filed a complaint in U.S. District Court in Richmond, Va., that seeks to enjoin various Dalkon Shield-related claims against Robins co-defendants—including the company's directors and officers, as well as hospitals, medical supply houses and other parties.

The company hopes this action will discourage litigation against co-defendants, a Robins spokesman said, adding the action is necessary to protect Robins' assets while it is in reorganization.

Richmond, Va.-based Robins filed for reorganization under Chapter 11 of the Federal Bankruptcy Act in late August, citing the cost of claims filed by Dalkon Shield users (*BI*, Aug. 26).

Under Chapter 11, all litigation against a company is stayed while the company and its creditors attempt to devise a plan to pay the company's debts.

However, Guerry Thornton Jr., the attorney representing the women suing the directors and officers, says his clients are able to press their complaint because the suit was filed against third parties not totally identified with Robins.

Mr. Thornton, with the Atlanta firm of Barnett & Alagia, said there is case law to show such actions against directors and officers can be brought, but he said the bankruptcy court has the discretion to allow such a suit.

The suit had been planned before Robins filed for reorganization, he added.

But, the Robins spokesman said, "This action seems to be an effort to circumvent the stay in effect as a result of our filing for Chapter 11."

All complaints against Robins and co-defendants should be heard in the same court at the same time so they can be disposed of in an orderly manner, he added.

Claims against co-defendants are, in effect, claims against Robins, forcing the company to participate in the defense and discovery of the lawsuits and thereby depleting the assets of the company, he added.

The spokesman would not reveal details of Robins' directors and officers liability insurance.

The suit filed by the women in the Atlanta court contends that before and after the time Robins began marketing the Dalkon Shield, some or all of the defendants knew that the device was

The suit 'seems to be an effort to circumvent the stay,' a spokesman for Robins says.

"unreasonably dangerous to the health and reproductive systems of its users."

However, the defendants negligently and consciously "failed to disclose the information to the plaintiffs, other users of the Dalkon Shield or the general public" and failed to issue health warnings and recall letters, the suit says.

This resulted in serious personal injuries to the plaintiffs, the suit adds.

In the count alleging negligent manufacture of the Dalkon Shield, the suit says the defendants "failed to exercise that degree of care which an ordinary prudent director, officer or employee would have exercised to assure that the Dalkon Shield was not unreasonably dangerous to the plaintiffs."

The defendants failed to provide for adequate inspection, testing or development of the device before it was offered for sale, the suit says.

In addition, it charges the defendants knew the Dalkon Shield was potentially a serious health hazard to women users and they negligently failed to remedy defects in the device.

The defendants failed to tell plaintiffs of the device's dangers, failed to provide them with a safe way of using it, failed to place any or sufficient warnings on the product and failed to warn of dangers to the women's reproductive systems, the suit adds.

In the count alleging fraud, deceit and concealment, the complaint claims that the defendants, although they knew of the Dalkon Shield's dangers, "conspired to withhold such information from the plaintiffs, thus denying then the knowledge with which to take necessary safety precautions to avoid injury. . ."

These acts included:

- Frustrating and obstructing the publication of articles on the hazards of the Dalkon Shield.
- Becoming involved in "trade associations that contested findings that the Dalkon Shield and its products were inherently and/or potentially dangerous."
- Committing fraud by delaying and providing inadequate warnings of the health hazards.
- Suppressing and obstructing the dissemination of information to plaintiffs on the health hazards of the Dalkon Shield, "including the intentional unlawful and fraudulent destruction and/or concealment of liability documents and evidence as to the hazards of said IUD."
- Directing and authorizing the use of "perjured and false testimony to conceal defendants' knowledge of defects in the Dalkon Shield and to obstruct the prosecution of legitimate claims and knowledge of dangers in said IUD."

The suit also alleges that the defendants devised "a scheme to defraud the public and members of the medical profession into accepting the Dalkon Shield as an effective and safe intrauterine contraceptive device" while knowing it was not.

In a related matter last week, a federal judge delayed until next month a decision on whether to extend the Dec. 30 deadline for filing Dalkon Shield-related claims against Robins.

Judge Robert R. Merhige said he wanted to explore whether a class should be formed consisting of all current and future Dalkon Shield claimants. Formation of the class would give women who have not yet experienced Dalkon Shield-related injuries a chance to file claims after the ailments appear. ■

Lloyd's suspends 199 for failing test of solvency

LONDON—Lloyd's of London has suspended a record 199 members for failing to meet Lloyd's annual solvency requirements.

The vast majority of the suspended names were members of syndicates formerly managed by PCW Underwriting Agencies Inc., which are facing losses of 130 million pounds ($184.6 million).

Lloyd's has earmarked 56 million pounds ($79.5 million) from its Central Fund to cover claims owed by the suspended members.

About 54.6 million pounds ($77.5 million) will be used to cover PCW losses (*BI*, Aug. 12, Aug. 19).

In addition to the members suspended, 27 PCW members have been given one month to meet the solvency requirement or face suspension, while another 10 PCW members who have indicated they will meet the requirements were given two weeks to raise and transfer funds. ■

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Hurricane losses

Continued from page 2

topple power lines in New Jersey, New York, Connecticut and other parts of New England, leaving millions of homes and businesses without electricity and public utility companies with millions of dollars in repair bills.

The utilities serving these areas were still calculating cleanup and repair costs last week, much of which are not insured.

While utility companies generally purchase property insurance for facilities like substations and generating plants, most utilities do not carry coverage for transmission and distribution lines—the power lines that carry electricity into homes and businesses.

The insurance, known as T&D coverage, has historically been difficult to obtain, brokers and insurers say. When the coverage is written, it usually provides only about $10 million in limits with a deductible of $5 million to $10 million, they say.

'It is unfair to criticize companies like Northeast for not having (T&D) coverage,' said J&H's Mr. Bischoff. 'Utilities should not be expected to have this coverage,' since insurers will not write it for utilities in hurricane- and high wind-prone areas.

In addition, the coverage now can cost as much as 20% of the insured value of the power lines.

Northeast Utilities in Hartford, Conn., which serves 1.3 million customers, is estimating damages to its lines at between $10 million and $20 million.

A spokesman said last week that the company has no self-insured reserve to cover the losses.

The cost of the repairs "will be taken out of our cash-flow," the spokesman said.

Northeast had purchased T&D coverage led by underwriters at Lloyd's of London until July 1, when the underwriters decided not to renew the coverage, the spokesman said. The coverage had limits of $10 million with a $5 million deductible, he said.

Consolidated Edison Co. of New York Inc. estimated damage to its lines at $2 million to $3 million, which would be covered under a self-insurance program, a spokeswoman said.

Con Ed's system suffered minimal damage "because 84% of our load is carried underground. It is not as vulnerable to storm damage," she explained.

United Illuminating Co. in Bridgeport, Conn., did not have damage estimates available but said repair costs would not be as high as Northeast Utilities' estimate of $10 million to $20 million. United serves around 292,000 customers, about 184,000 of which lost power, a spokesman said.

The spokesman said United has always self-insured its transmission and distribution system, "choosing to go that route because storms of this magnitude in this area are rare. This is the most economical way for us to go."

It was too early, he added, to tell if the utility's self-insured reserves would cover the cost of repairs.

Officials at Long Island Lighting Co. could not be reached for comment. The utility, which serves more than 1 million homes and businesses on Long Island, suffered extensive damage to its system.

James Bischoff, a vp with Johnson & Higgins in New York, said, "It is unfair to criticize companies like Northeast for not having coverage. Utilities should not be expected to have this coverage," especially on Long Island since insurers will not write the coverage for utilities in areas where there is a great exposure to hurricanes and high winds, he said.

Very few insurers offer T&D coverage, he added. "It is only offered with a high deductible and pricing is stiff."

J&H has offered the coverage to clients in the past and it is "practically always turned down," he said. "Their loss experiences just don't justify purchasing the coverage."

James McDougald, senior vp with Fred S. James & Co. Inc. in New York, agreed that "it is extremely common for utility companies" not to have T&D coverage.

While some major public utility companies in the Northeast have inquired about the coverage, they have found rates to be exorbitant even with stiff deductibles or retentions, he explained.

"The marketplace has been unwilling to write it," he added. "It has been difficult to get for the past five years" and has become almost totally unavailable this year, he said. "I know of no large carriers that are willing to insure T&D."

While utility companies are adding up repair bills, Atlantic City casinos are tallying gambling and other revenues lost after the casinos shut their doors and evacuated gamblers and hotel guests as a precautionary measure.

Trump Casino Hotel did not have an estimate of the revenue lost during the closure, but a spokeswoman said the casino would have taken in around $1 million for the 24-hour period it was closed.

The casino's business interruption policy would not cover lost gambling revenue because Trump closed voluntarily, she added.

A spokesman for Resorts International Inc. said the lost gambling take and the revenue it would have ordinarily made on hotel registration and restaurant business amounted to around $500,000. He did not know whether the lost funds were insured.

Like property owners, most insurers last week did not have firm figures on the losses caused by Gloria, though some underwriters ventured estimates.

A spokesman at Hartford, Conn.-based Travelers Insurance Co. said its losses are expected to be from $15 million to $20 million, about the same amount caused by Hurricane Elena last month.

Travelers is expecting around 10,000 claims from Gloria, of which about 45% will come from Long Island, the spokesman said. Most of the claims are expected to be personal lines losses.

United States Fidelity & Guaranty Co. in Baltimore said claims will probably total only $2 million to $3 million for both commercial and personal lines.

We have nothing near the market in New England that we have in Mississippi where Elena hit," a spokeswoman pointed out. USF&G had reported approximately $18 million in losses stemming from Hurricane Elena.

Hartford-based Aetna Life & Casualty Co. and susbsidiary American Re-Insurance Co. estimated their losses to be $25 million as a result of Gloria, most of which was personal lines damage.

Industrial Risk Insurers said last week it had received about 100 claims as of last week and expected losses to total between $8 million and $10 million. No single loss was in excess of $1 million, a spokesman said.

A spokeswoman for Continental Casualty Co. in Chicago said the insurer had received around 970 claims late last week that represent about $1.3 million in damages. Most of those losses were from personal lines, she said. ■

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opinions

RIMS proposals make sense

THE INSURANCE Services Office should leap at the compromise proposals offered by the Risk & Insurance Management Society regarding the new commercial general liability claims-made form.

Specifically, ISO should amend its new claims-made form to change the coverage trigger and it should modify its position on including all defense costs within policy limits.

Further, ISO should respond to RIMS' willingness to discuss compromises in the claims-made form and reconsider other important issues.

ISO has already compromised with those representing the interests of insurance buyers. Most recently, ISO retracted two onerous endorsements to the claims-made form that allowed insurers to limit the time frame of the extended reporting period and even their obligation to provide the extended reporting period. But, more compromises are needed.

The coverage trigger is the most important issue.

Risk managers are horrified by the prospect of insurance responding only after a claim has been made against the policyholder.

These risk managers envision being forced to solicit claims from potential claimants in order to be sure that all claims are filed under the policy before the policy is canceled or expires.

They fear that the subsequent policy could exclude coverage for claims related to known losses but that have not yet been filed.

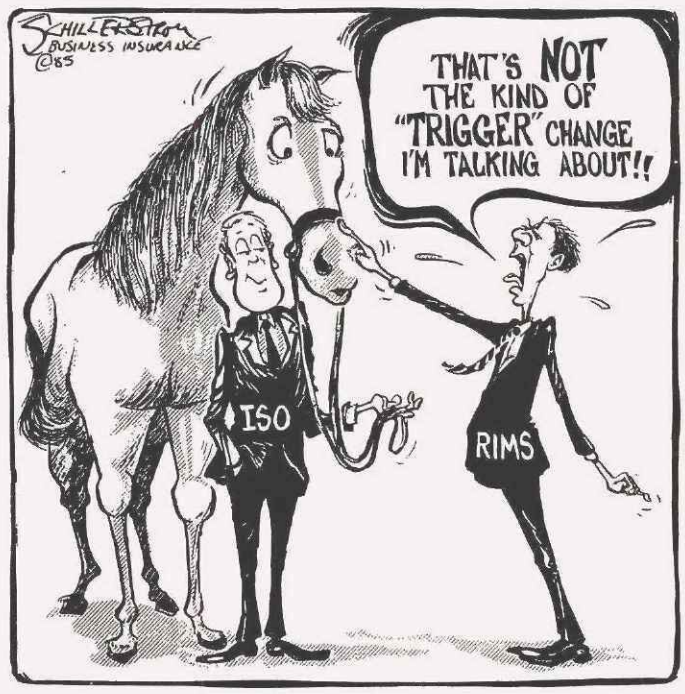
And, risk managers fear that once they report an incident to an insurer, as required by the policy, the insurer will cancel the coverage before claims are actually filed and coverage triggered.

ISO has responded to these concerns by adding the free 60-day mini-tail to claims-made policies, contending that most claims would be filed within that 60-day period, and the option to purchase an unlimited reporting period endorsement for those policyholders that feared additional claims.

But, as RIMS and others correctly point out, amending the policy so that coverage is triggered when the policyholder reports a claim or circumstances that could give rise to a claim is needed to prevent gaps in coverage.

And, RIMS acknowledges that once a policy is triggered by a claim or a report of circumstances that could create claims, that policy would be the only policy to respond to the ensuing losses. This would satisfy the insurers' goal of stopping the stacking of numerous policy limits for related claims.

RIMS' proposal that general liability policies provide a separate limit for defense costs and charge defense costs against the aggregate limit only after the separate defense cost limit is exhausted is also worthy of adoption. The proposal satisfies ISO's stated goals of giving policyholders a stake in how much is spent on defense costs and limiting insurers' liability for defense costs without a drastic reduction in insurance coverage.



RIMS also is identifying other important issues that need to be re-examined, and ISO and RIMS should attack these issues in the spirit of compromise, trying to develop new approaches to:

- How insurers will price the extended reporting period endorsement.
- The exclusion of all coverage for pollution liability.
- Application of the retroactive date.

A positive response to the compromise proposals from RIMS and an open mind on RIMS' concerns would benefit ISO as well as risk managers.

For ISO, satisfying the concerns of RIMS will quell buyer opposition to its new claims-made form. And buyer opposition must be quelled before ISO will be able to persuade regulators in all states to approve the claims-made form for use.

For risk managers, a form that incorporates RIMS' proposals and satisfies major concerns will extend more coverage than the claims-made form as now written.

Granted, even with RIMS' proposals incorporated, the new claims-made form would not be as broad or open-ended as the occurrence form, which RIMS continues to endorse.

But, as RIMS says, a claims-made policy is needed that will satisfy the needs of insurers to better limit their exposures while at the same time satisfying the needs of insurance buyers to purchase a product that they can rely on to pay claims without coverage gaps.

letters

Courts' redefinition of terms causing insurers' woes

To the editor: Far be it from me to argue litigation with a lawyer, much less a lawyer of Eugene R. Anderson's prominence, in defending the point of my Perspective column of July 29th. But Mr. Anderson is not on target when he dismisses the current insurance problems with the courts as a result of "internal insurance industry disputes" (*BI*, Sept. 9).

It is the redefinition of long-understood terms that has caused havoc. And when this results in the elimination of important coverage, it's not just a problem for the insurance industry but for corporate America. The redefinition of the meaning of "aggregate" and "sudden and accidental" exemplifies the judicial inflation I cited. Underwriters would write pollution coverage today if the dictionary definitions of those words still applied. As The Economist has put it: "The biggest disaster for insurers is America's courts."

Robert V. Hatcher Jr.
Chairman and Chief Executive Officer
Johnson & Higgins
New York

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Canada has 10 provinces and two territories

To the editor: Your article "Canadian exchange could open by spring" (*BI*, Sept. 2) was most welcome.

As we are the United States' largest trading partner, we Canadians are sometimes miffed at the lack of attention our economy receives in the U.S. media. Even when we are mentioned, there is usually at least one error that reveals the general lack of knowledge Americans have of Canada.

For example, your writer's article states that, "The proposed exchange must win authorization from all 11 Canadian provinces and territories."

Imagine what a shock it was to your many Canadian readers to find out from an American publication that we have lost one of our territories.

We always thought we had 10 provinces and two territories, but now find we have been shortchanged. Does this mean there are now 51 states?

Shame, shame, eh?

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Frank B. Hall

Continental Illinois offers cost-control program

benefit beat

Chicago-based Continental Illinois Corp. is hoping to control its $11 million health care bill by using a cost-containment program called "Health Wise."

The new program provides incentives for employees to seek cost-effective alternatives to traditional health care.

The Health Wise program, which was designed in-house, took effect Oct. 1 for the 6,000 employees who participate in Continental Illinois' minimum-premium comprehensive medical plan, which is underwritten by Prudential Insurance Co. of America.

An additional 2,500 employees of the bank holding company who are enrolled in one of the five health maintenance organizations offered by Continental Illinois are unaffected by Health Wise.

Although Continental Illinois has previously implemented cost-containment programs, the Health Wise incentives "put some teeth into it," said Dr. Joseph King, director of employee health services for Continental Illinois.

At the core of the program are health consultants—Dr. King and three registered nurses—who are available for employees to call or see in person during working hours.

These consultants oversee virtually every aspect of Health Wise, helping Continental Illinois employees understand and follow the program correctly.

For example, employees can call one of the health consultants every time they receive a recommendation from a doctor to have non-emergency surgery.

The consultant will provide the names of three conveniently located doctors who can give the employee a second opinion, the cost of which is fully reimbursed by the medical plan.

Continental Illinois employees also can receive a second opinion, at company expense, from the physician of their choice.

The company also pays for third or fourth opinions if prior opinions don't provide a consensus, Dr. King said.

However, if an employee fails to obtain a second opinion or if he or she undergoes surgery against the advice of the doctor giving the second opinion, the employee only receives 50% reimbursement for any expenses related to the surgery rather than the usual 80% reimbursement under the plan, Dr. King said.

Previously, the company's second surgical opinion program was a voluntary program, Dr. King explained.

The health consultants also help Continental Illinois employees decide whether a surgical procedure should be conducted on an outpatient basis.

And, as part of the new cost-containment program, 15 routine surgical procedures must be performed on an outpatient basis. Employees are reimbursed for 100% of the cost of these procedures if they are performed on an outpatient basis.

However, if an employee has one of these selected surgeries performed on an inpatient basis, the plan pays none of the hospital room and board expenses or any other expenses that would not have been incurred if the surgery was performed on an outpatient basis, he said.

Previously, outpatient surgery was voluntary and was reimbursed on the same basis as inpatient surgery, Dr. King said.

The cost-containment plan also does not reimburse employees for non-emergency hospital costs associated with Friday or Saturday admissions unless testing or surgery is performed on the day of admission or the following day.

Previously, employees incurred no penalty for weekend admissions, Dr. King said.

The Health Wise program also rewards employees who find errors in excess of $25 in their hospital bills and convince the hospital to correct the error.

The program pays employees a cash bonus equal to half the amount of the error, up to a maximum bonus of $1,000.

In addition, employees can use one of the health consultants to help them find these errors, Dr. King said.

Another cost-savings provision of Health Wise is free medical laboratory services performed by Continental Illinois' certified medical technicians in the Chicago headquarters or at designated laboratories throughout the country.

All employees, except those enrolled in health maintenance organizations, are eligible for free lab work for routine procedures, Dr. King said.

The health consultants also can help employees identify a conveniently located participating laboratory.

Continental Illinois also made another plan design change that took effect on Oct. 1 along with Health Wise. Home health care now is a covered benefit under the comprehensive plan.

Home health care was not previously covered under the plan, Dr. King said.

And, again, the health consultants will help employees arrange home health care services.

Continental Illinois is also planning additional changes to the comprehensive plan design, Dr. King continued.

Beginning Jan. 1, the health plan deductible will increase to $150 per person for individual coverage, with a family maximum of $450, up from $135 per person under the current plan, with a family maximum of $405.

In addition, the out-of-pocket maximum applied to the 20% copayment on expenses exceeding the deductible will increase to $605 from $550 for individual coverage and to $1,815 from $1,650 for family coverage.

Also, concurrent with the start-up of Health Wise came an increase in employees' contributions to the premium for the comprehensive health care plan.

Effective Oct. 1, employees pay $17.76 a month for individual coverage, compared with $16.20 last year.

Employees with family coverage pay $40.84 a month, compared with $37.34 last year.

On Oct. 1, Continental Illinois' contribution to the premium increased to $71.02 per employee for individual coverage, compared with $64.94, and $163.36 per employee for family coverage, compared with $149.36.

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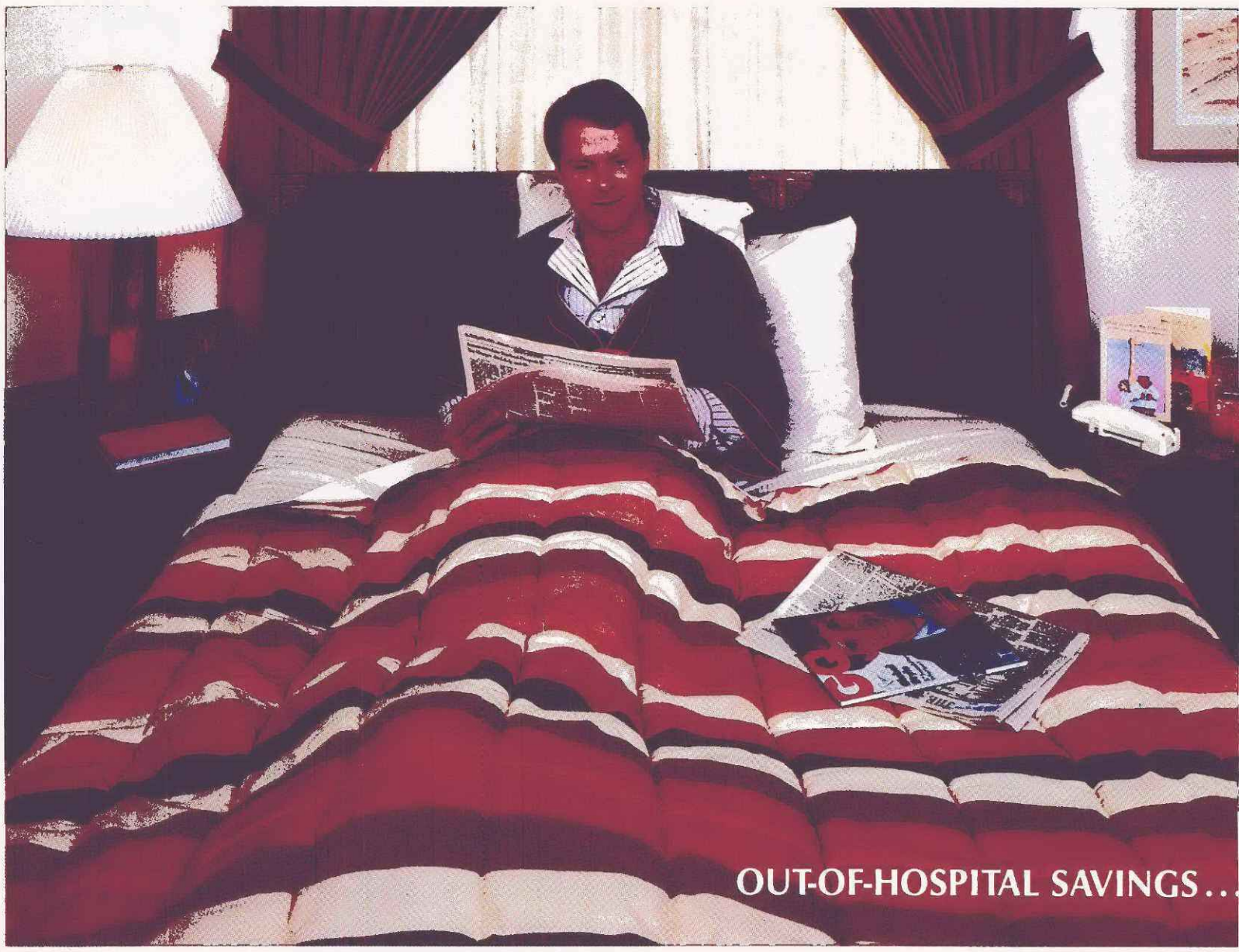

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Continued from previous page

Steelworkers pact

About 200 members of the United Steel Workers Union Local 6772 who work at the Dayton Walther Corp. in Dayton, Ohio, are paying a larger share of their health care benefits under a new three-year contract that took effect Aug. 1.

The new contract calls for higher deductibles on both medical and dental coverge, according to Joseph Ruffolo, group manager of corporate human resources at Dayton Walther.

Previously, USW members had separate non-contributory hospitalization and major medical coverage.

Workers paid major medical deductibles of $50 for individual coverage and $100 for family coverage. In addition, they paid 20% of expenses exceeding the deductible, with no maximum annual out-of-pocket limit.

Hospitalization was covered on a first-dollar basis.

Under the new comprehensive plan, workers pay deductibles on all medical expenses of $150 for individual coverage and $450 for family coverage.

In addition, union members pay 20% of expenses exceeding the deductible, up to an out-of-pocket maximum of $750 for individual coverage and $1,500 for family coverage.

However, employee contributions to the plan premium still are not required, and the maximum lifetime benefit has been increased to $1 million from $250,000 under the old plan.

Under the new contract, health care benefits are underwritten by Blue Cross of Indiana and Blue Shield of Indiana. The old program was underwritten by The Equitable Life Insurance Society of the United States.

The contract also establishes a second-surgical opinion program that covers the cost of second opinions for 15 selected common surgical procedures, including hysterectomies and knee surgeries. However, this program is not mandatory, Mr. Ruffolo said.

The new contract also increases the dental plan's deductibles to $100 for individual coverage and $200 for family coverage, up from $50 per person under the old contract.

However, the plan now reimburses workers 100% for two teeth cleanings and one set of X-rays each year. The plan formerly covered only 80% of these costs after the deductible was paid.

The Equitable still underwrites the dental plan.

Blue Cross refund

Blue Cross of Iowa is refunding $45 million to its subscribers for significantly reducing the number of days spent in the hospital last year.

About 3,000 group subscribers and about 597,000 individual subscribers will share the refund through rate reductions. The reductions will average 13% of annual premium for groups and will be effective upon contract renewal, a spokeswoman said.

Blue Cross attributes the reduction in inpatient hospital days to a utilization review program it began in 1980, in which all Iowa hospitals participate. Under the program, the hospitals conduct their own pre-admission certification and concurrent review of all hospital admissions.

At the time the cost-containment program was implemented, Blue Cross of Iowa was experiencing 878 inpatient hospital days a year per 1,000 participants, compared with a national average of 728 per 1,000, the spokeswoman said. Inpatient hospital days have since dropped 31% to 607 per 1,000 participants, she said.

This is the third time the Blue Cross plan has issued a refund to subscribers because of reduced inpatient hospital days.

The first refund occurred in January 1984, when Blue Cross refunded $24 million to its subscribers, resulting in an average rate decrease of 10% for experience-rated groups, the spokeswoman said.

In September 1984, a refund of $26 million was announced, resulting in a rate reduction of an additional 5% for experience-rated groups.

And, an additional $45 million to $50 million in refunds may be realized by 1987 if the good experience continues, according to the spokeswoman.

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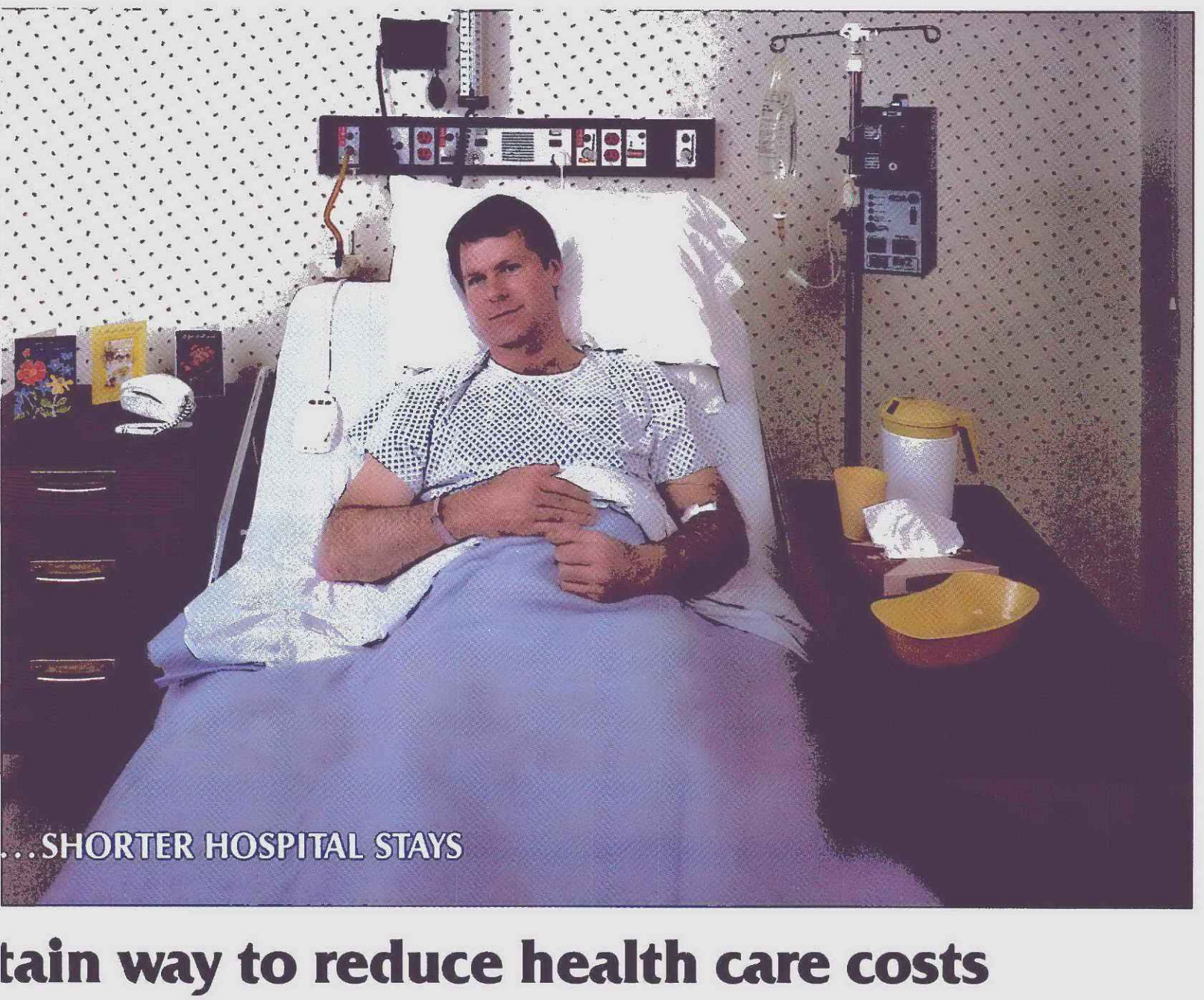

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Little support for benefit tax

BROOKFIELD, Wis.—President Reagan's proposed tax floor on health insurance benefits would be "the beginning of a dangerous precedent to tax all employee benefits in the long term," according to 80% of the respondents to a national survey of benefit professionals.

And, 58% of the respondents agreed with the statement that the administration's health insurance tax proposal "is a totally regressive tax shift which hits hardest low- and middle-income working people."

The responses were included in the second-quarter 1985 National Opinion Panel survey by the International Foundation of Employee Benefit Plans.

Some 107 benefit plan trustees, administrators and other professionals resonded to the National Opinion Survey, a quarterly survey by the IFEBP.

Only 17% of the respondents said that health care cost-containment objectives can be achieved under the administration's tax floor proposal, which would tax employees on the value of their employers' contribution to their health care coverage below a certain amount, called a floor (*BI*, May 6).

In addition, 69% of the respondents said that proposed contribution and distribution restrictions for 401(k) plans would have a substantial negative impact on the growth of the plans, which are the fastest-growing employer-sponsored benefit.

The administration had suggested tightening contribution and distribution rules for the salary-deferred retirement savings plans. However, recently the administration decided to change its position and instead is calling for the total elimination of the plans (*BI*, Sept. 9).

A large majority—85%—of the respondents agreed that "the continuing stream of changes in employee benefit regulation (has) eroded employer enthusiasm to design and maintain attractive employee compensation and benefit packages."

And, 57% of the respondents said it is the responsibility of employers to educate their employees about how pending legislation might affect their benefits.

However, only 35% said that the benefit plans with which they are associated have held employee meetings to discuss or clarify anticipated or established changes in benefit plan design.

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Free copies of the National Opinion Panel survey are available from the Public Relations Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069.

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D&O coverage

Continued from page 3

very imaginative extensions on the policies."

This year, the phrase, "Welcome to my nightmare," best summarizes the condition of the D&O marketplace, he added.

Mr. Winterson

D&O policy terms have changed significantly since 1984, Mr. Winterson remarked. Last year, a three-year policy period was not difficult to arrange, he said, adding that a three-year policy even could be negotiated during the first few months of this year.

However, "as of April or May, three-year policy terms had basically fallen by the wayside. And they are now virtually impossible to put into place."

D&O policy limits have shrunk from the more than $250 million that was available last year to a current marketplace where limits of $65 million "can and should be considered an outstanding achievement," Mr. Winterson noted.

The number of insurers underwriting the coverage likewise has dwindled, he said. "In 1984, a purchaser would not have had any trouble identifying between 12 and 15 insurers, and with a little imagination, may well have found in excess of 20 insurers in North America willing to provide different degrees of D&O coverage."

Today, "a resourceful purchaser might identify 10 sources willing to consider D&O submissions if he or she is prepared to approach the market on a worldwide basis," Mr. Winterson said.

Minimum premiums have also climbed from a low of $200 to $300 for every $1 million of coverage in 1984. This year, facultative reinsurers are demanding such high rates that minimum primary premium levels are being pushed as high as $10,000 per $1 million of coverage, he said.

"Requirements obviously vary with the class of business being underwritten," Mr. Winterson commented, "but with these minimums being imposed, the overall effect is quite devastating."

The outlook for the D&O insurance market in Canada and the United States next year is not promising, said Mr. Winterson. "All indications are that a further tightening can be anticipated.

"Capacity continues to diminish, sources continue to withdraw from the market and premiums are still climbing."

Mr. Winterson said many companies only consider D&O coverage to protect against shareholder suits. But he cited figures from The Wyatt Co.'s annual D&O survey that showed, in 1984, lawsuits from a corporation's customers represented 37.8% of all D&O claims in Canada, while shareholder suits accounted for only 27.8% of claims (*BI*, Jan. 21).

Mr. Hogan

He said suits also were recorded from plaintiffs like employees and former employees, contractors, suppliers, government agencies, prior owners of acquired companies, competitors and creditors.

Other panel members said D&O coverage should not be forgotten once it is purchased.

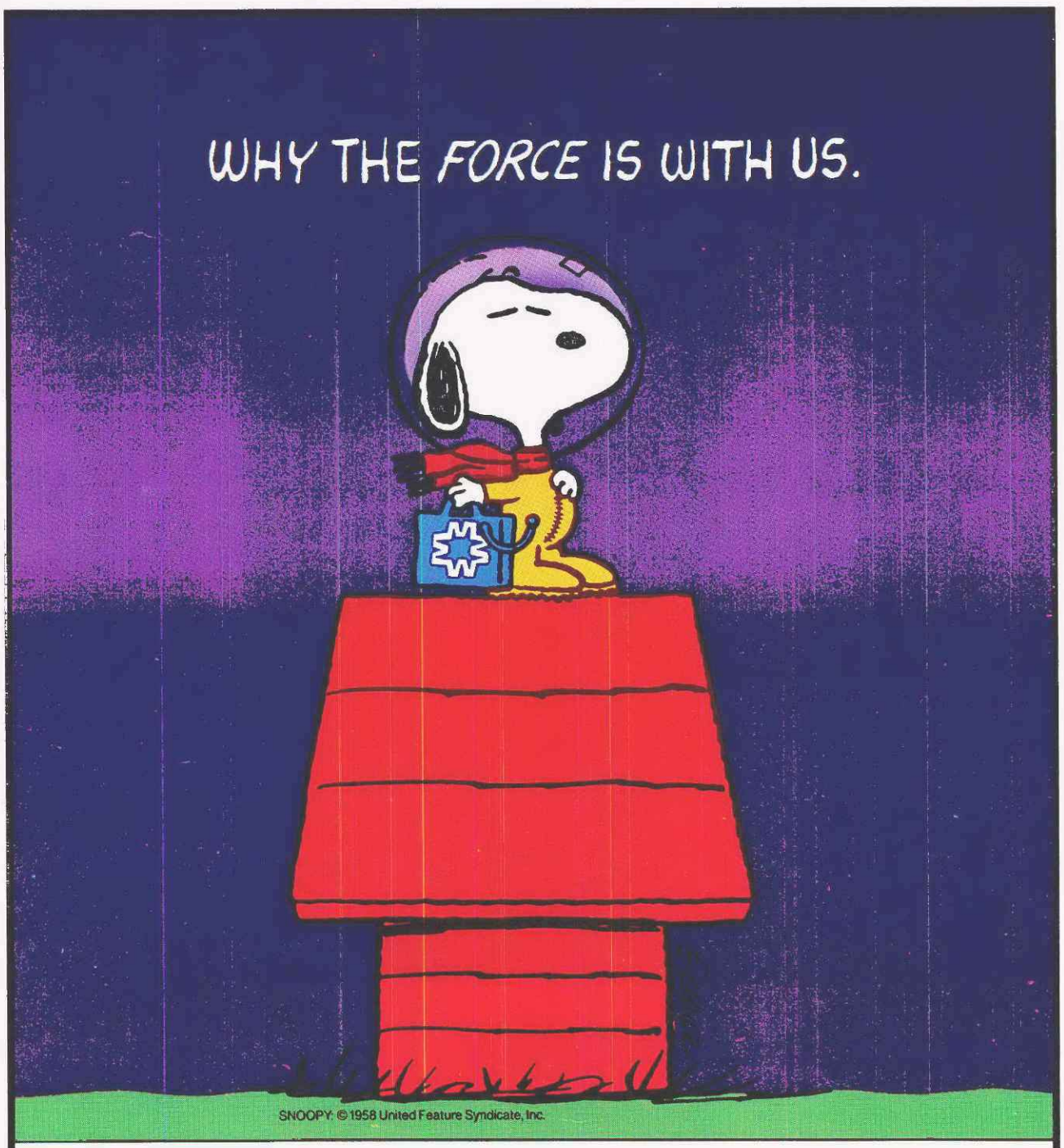
Risk managers at companies that already have D&O coverage in place "should not take directors and officers insurance as another aspect of an entire portfolio with a lot of words in it," said Michael Hogan, vp of Osborn & Lange, a Toronto broker. He said, instead, risk managers should know exactly what is in their policy.

Mr. Spearn

Mr. Hogan also advised risk managers to arrange annual seminars that involve the directors and officers of their corporations in an effort to educate them as to what the insurance is and what it covers.

In addition, risk managers should check corporate bylaws to determine whether the risk manager is considered an officer or director, said John Spearn, a partner in the law firm of Simmers, Harper & Jenkins in Cambridge, Ontario.

"I think you might better. . .check your bylaws and articles to determine whether you would have the exposure. . . ." ■



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Business interruption cover written on varying forms

By MICHAEL BRADFORD

OTTAWA, Ontario—Risk managers must be able to weave through a maze of different business interruption policy forms to be assured they have purchased the appropriate coverage, says a partner with a major accounting and consulting firm.

Ronald G. Jackson, a partner with Coopers & Lybrand in Ottawa, discussed business interruption policy forms and factors related to the coverage at the 1985 Canadian Risk Management Conference in Ottawa.

Mr. Jackson noted several types of business interruption forms, including:

- The gross earnings form, of which there are two versions—a manufacturing version used by heavy manufacturers and a mercantile version used by retail and small manufacturing operations.
- The gross profits form, used by both mercantile and manufacturing operations.

"The big difference between the earnings form and the profits form is the indemnity period," noted panelist Alain Viger, a partner with Coopers & Lybrands' Montreal office.

"Under the gross earnings form, it (the indemnity period) starts when you have an asset that is damaged or destroyed. It will continue until this asset is repaired and is back into function as it was before the loss."

The indemnity period of the gross earnings form usually runs until production returns to pre-loss levels, with no set expiration date, he explained.

Under the gross profits form, said Mr. Viger, "The indemnity period will continue until your sales are back to normal." However, indemnity usually ceases if sales do not return to normal within one year, he added.

Both forms carry a "due diligence and dispatch clause," meaning that the policyholder must act as quickly as possible to restore operation of the business to pre-loss levels, Mr. Viger pointed out.

There are several factors an accountant must focus on when calculating the loss of earnings that would be covered by a business interruption policy, said Mr. Viger.

"Depending on the down time, we'll have to look at production records, sales records, either six months before or after the loss." However, "if the shutdown is for a week, we might go just two months before or after the loss," he said.

Mr. Jackson also added that companies should make sure that all their operations are covered by business interruption insurance.

"A lot of companies have different locations where one plant does one thing, another does something to enhance it. Make sure that you've got global coverage on all plants," he explained.

By having all plants insured, "your policy will cover for that contingent liability of affecting another plant in your operation. So if you've got several plants, make sure you've got global coverage."

Also, risk managers may not immediately recognize extra-expense coverage—which covers excess expenses above normal operating costs incurred by a business owner who continues to operate despite a property loss—as a business interruption policy, said Mr. Jackson.

"We tend to forget this form, although it is common for large companies to have something like extra-expense," he said.

"It is designed for businesses that must continue (operations) in spite of having a loss. In other words, there seems to be a necessity in continuing operations because of the losses that would be incurred if you did not."

Extra-expense coverage sometimes is included as part of a business interruption insurance package, but it can be purchased separately, he said.

Mr. Viger remarked that purchasing extra-expense coverage can protect a company's market share during a lapse in production.

"If you're not producing anymore and have to go outside and purchase your finished product, it might cost you more than what you can sell it for," he noted. "So you're going to be operating at a loss." ■

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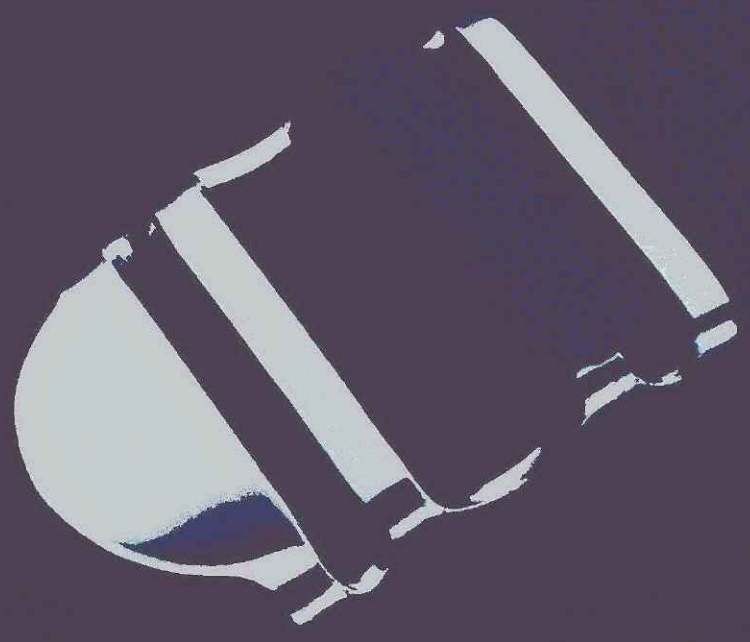

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Prospectus may lure investors to planned Canadian exchange

By MICHAEL BRADFORD

OTTAWA, Ontario—The release this week of a prospectus describing the proposed Canadian Insurance Exchange may ferret out potential investors, according to one of the supporters of the Canadian exchange.

"The challenge of the document will be to attract non-insurance capital by satisfactory evaluation of (the exchange's) commercial potential," Robert Hilborn, chairman of the government-appointed Insurance Exchange Implementation Committee, told the Canadian Risk Management Conference, held last month in Ottawa under the sponsorship of a Canadian chapter of the Risk & Insurance Management Society.

Investors who may be interested in forming a syndicate on the proposed Canadian exchange will be able to review the prospectus by the end of this week, according to Mr. Hilborn, who also is senior vp at broker Johnson & Higgins Willis Faber Ltd. in Toronto.

"Sources of capital, and whether this capital will be available to form an exchange are the key issues," Mr. Hilborn said.

Mr. Hilborn

And, he added that raising the needed capital "can only be done when the prospectus is out."

The proposed exchange, which is scheduled to open in 1986, is designed as an attempt to shore up shrinking insurance capacity in Canada.

Mr. Hilborn has said that he hopes the marketplace will be operating with 20 syndicates and $100 million in capital by next spring (*BI*, Sept. 2).

While the exchange would have the authority to write all types of risks, it probably would concentrate initially on reinsurance, said Mr. Hilborn.

Mr. Hilborn's committee, which was appointed by the provincial government of Ottawa, will meet with government officials in Ontario next month to present the findings of a study performed by accountant Touche Ross & Co. of Toronto and the Toronto law firm of Fraser & Beatty. The study outlines the proposed exchange's financial and legal structure.

At that time, the committee will also explain how the marketplace is to operate and whether there is sufficient interest on the part of investors.

One of the keys to attracting investors to the exchange, Mr. Hilborn told the gathering, is to convince investors that quality underwriting talent will be managing the syndicates.

"When you go out to talk to potential investors, particularly non-insurance investors, their principal interest is going to be, 'Who is going to be managing my investment?'" he explained.

"We sometimes hear the talent isn't there," Mr. Hilborn added. But, he said, "I don't subscribe to that. I believe that when a market develops, the talent comes there."

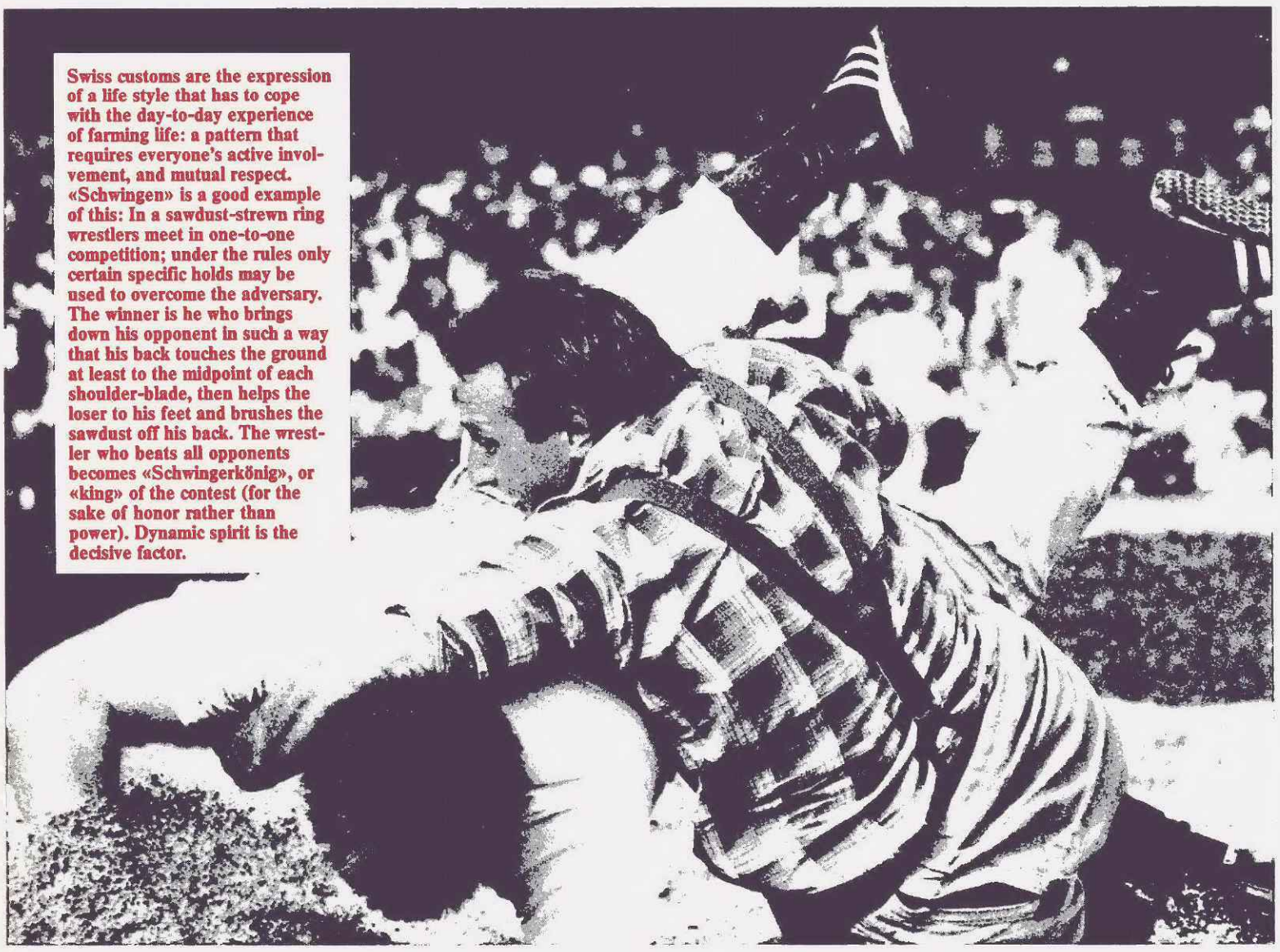
For the exchange to succeed, "we must establish a viable level of participation at the outset," Mr. Hilborn explained.

Sufficient capital must be available to attract brokers to the marketplace, he added.

If government officials are persuaded that a reasonable level of participation in the exchange can be expected, legislation will be drafted that would allow the marketplace to be formed, said Mr. Hilborn.

At that point, the exchange's bylaws, rules and regulations will be developed, membership will be actively solicited and capital will be put in place, according to Mr. Hilborn.

"But, its success will depend on attracting new capital and the effective leadership of the high-profile players in our industry," he said, referring to the New York Insurance Exchange, which benefitted in its early stages from the experience—as well as capital—contributed by large insurance companies. ■



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Tightening of market also affecting Canada

By MICHAEL BRADFORD

OTTAWA, Ontario—The tightening property/casualty insurance market, which has arrived in Canada a little later than in the United States, is likely to change the behavior of some Canadian underwriters, just as it has south of the border, one insurer says.

Mr. Baney

John E. Baney, senior vp of Philadelphia-based CIGNA Corp., said the tightening market has caused insurers like CIGNA to be more careful about the people, as well as the risks, they insure.

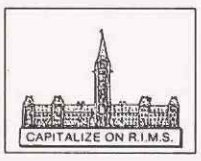
'We're going to be very careful about the security of the people we insure,' Mr. Baney says.

Insurers, he indicated, are looking much more closely at the financial stability and know-how of their potential policyholders.

"We're going to be very careful about the security of the people we insure, the firms we insure and the firms that we reinsure with," Mr. Baney told the Canadian Risk Management Conference, sponsored by the Canadian Capital Region of the Risk & Insurance Management Society.

"My personal experience has been that our largest losses come not so much from insuring bad risks but insuring poor insureds who are weak financially," he said.

In addition, insurers are not as willing to commit surplus to risks that don't offer profit potential, he said. Many are beginning to concentrate more on business "that gives us some hope of making a profit."



And while insurers are exercising caution about the business they accept, Mr. Baney cautioned the risk managers at the conference to use care in choosing an insurer.

"You need to be very, very careful about the financial condition of your primary carriers and reinsurers," he warned.

"I would suggest that you learn about the reserving practices of those companies," said Mr. Baney. "I believe that some are not necessarily reserving adequately. That is a way to show better results for some period of time. But unless the cycle changes quickly for that type of company, you may be...backed by a loser."

Mr. Baney told risk managers to "look at long-term insurance relationships both with your producers and your carriers, because over a long period of time you can develop trusting relationships where carriers are going to be willing to bend and willing to help you with tight covers, as long as you are willing to allow the carrier to make a profit."

A long-term relationship with an insurer may not produce such benefits in a soft market, he said. "But I tell you, in a hard market, you'll be able to get coverage."

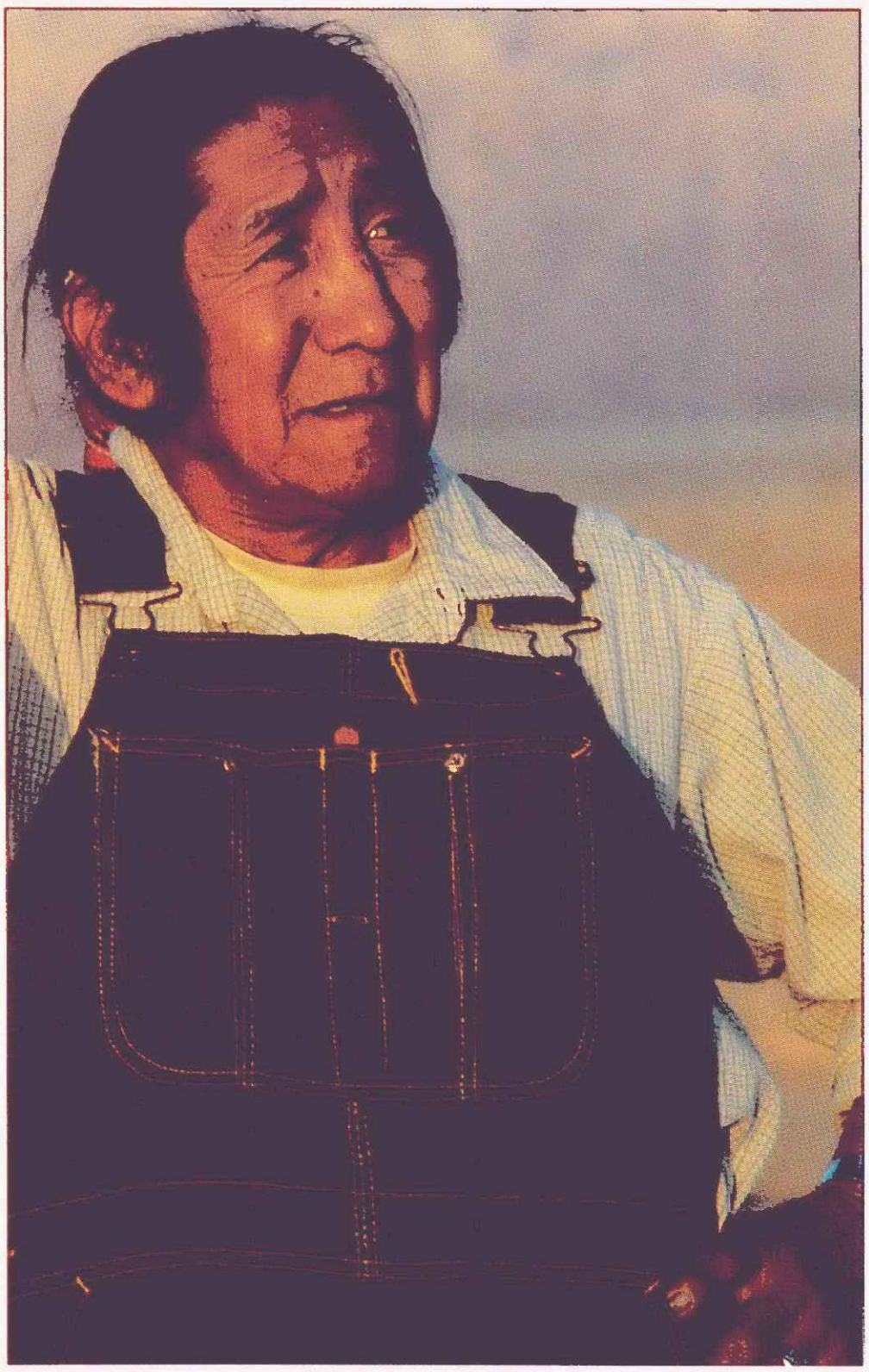
He predicted the U.S. market would be tight for another year, and the Canadian market would remain constricted even longer "simply because you are entering the tight market later."

In a separate session at the conference, Ted Belton, president of the Insurers Advisory Organization, a risk management information and loss-control services group based in Toronto, stressed that "risk managers can no longer sit idly by and just let things happen without trying to influence them."

Mr. Belton, who told risk managers they will have to rely on "survival strategies" during the hardening market, also advised them to build close relationships with their underwriters.

"I don't think it is an overstatement to say that the property/casualty insurance industry is in trouble on a worldwide scale," Mr. Belton remarked. "You need only to

Continued on page 20



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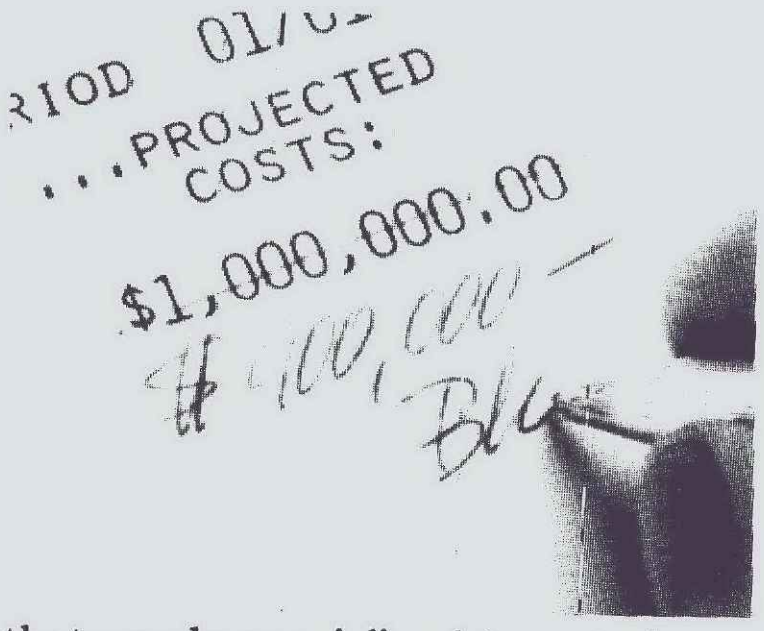

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Canadian market

Continued from page 18

read the headlines every day to realize that."

The property/casualty insurance industry's problems can be traced to four sources, he said:

- Insurer insolvencies.
- The North American civil justice system.
- A shortage of capacity.
- The cyclical nature of the insurance business.

"We have not seen the end of the insolvency problem," said Mr. Belton.

"There are going to be more companies going under. History has shown that an underwriter cannot defy the basic principles of insurance over time and get away with it," he said.

He added, "Risk managers who wish to avoid getting stuck with an insolvent insurer need only remind themselves that there is no free lunch. The lowest price is not always the best."

'The civil justice system in North America is breaking down,' Mr. Belton comments.

Rising claims costs can be linked to the civil justice systems in the United States and Canada, as courts continue to hand out high damage awards, said Mr. Belton.

"The civil justice system in North America is breaking down," he said, pointing out that some observers feel that the system is "totally out of control."

And, the cost of insurance, particularly liability coverages, continues to zoom while insurers' capacity dwindles, he said.

In addition, he pointed out, a problem that "cries out for a solution" is how to balance the supply and demand for insurance and avoid the industry's cyclical patterns of the past.

Richard Hackenburg, president of the New York-based Risk & Insurance Management Society, told risk managers they have to "get back to basics" in the face of a "debilitated world insurance market."

Mr. Hackenburg, staff vp and assistant treasurer of Allegheny International Inc., said risk managers will have to concentrate more on the "controlling and minimization of risk."

In addition, risk managers are going to become a more vital part of their companies, Mr. Hackenburg predicts.

"In recent years, risk managers have acquired financial skills and technical skills of collecting and manipulating financial data by computers.

"These tools will give risk managers a role in the planning processes of their organizations. Their input will be sought for contingency planning, as well as strategic planning," according to Mr. Hackenburg.

That means risk managers will have to broaden their education and their knowledge of "technological advances, legal complexities and cultural nuances," he concluded. ■

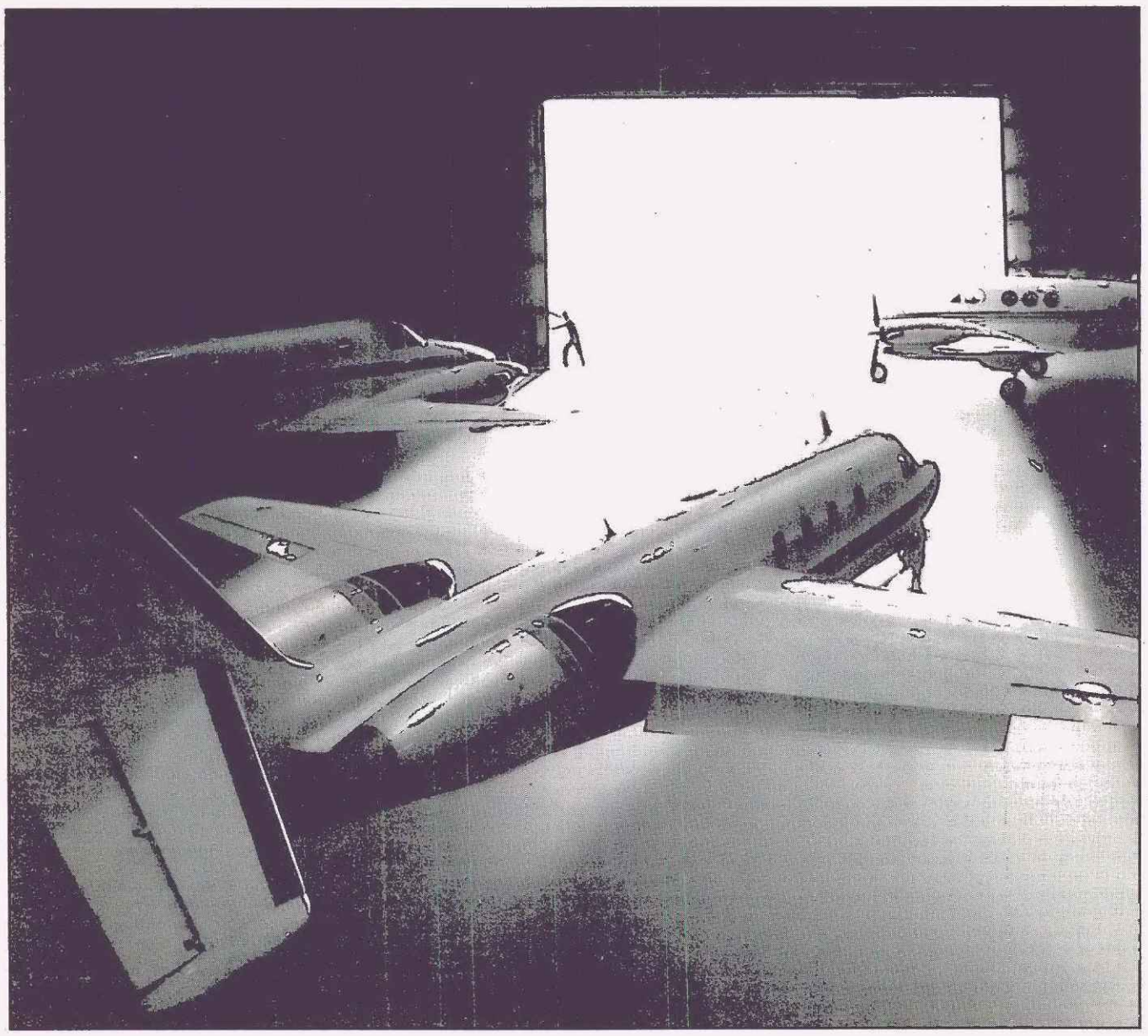
Conference attracts 450

OTTAWA, Ontario—The 1985 Canadian Risk Management Conference, held Sept. 22-25, drew about 450 attendees to the Canadian capital.

The annual meeting is hosted each year by a different Canadian chapter of the Risk & Insurance Management Society, and this year's event was sponsored by the Canadian Capital Region in Ottawa. Registrants from Canadian and U.S. RIMS chapters attended the four-day conference that featured the theme "Capitalize on RIMS."

"I think it is fitting that this conference should be taking place in Ottawa," RIMS President Richard Hackenburg told attendees. "Ottawa, the capital, symbolizes the ties between two nations sharing the world's longest unguarded border," he added.

Risk managers heard about 50 speakers discuss a variety of subjects during the meetings at the Chateau Laurier Hotel. Topics ranged from what to expect when reviewing business interruption claims to a progress report on the proposed Canadian Insurance Exchange.



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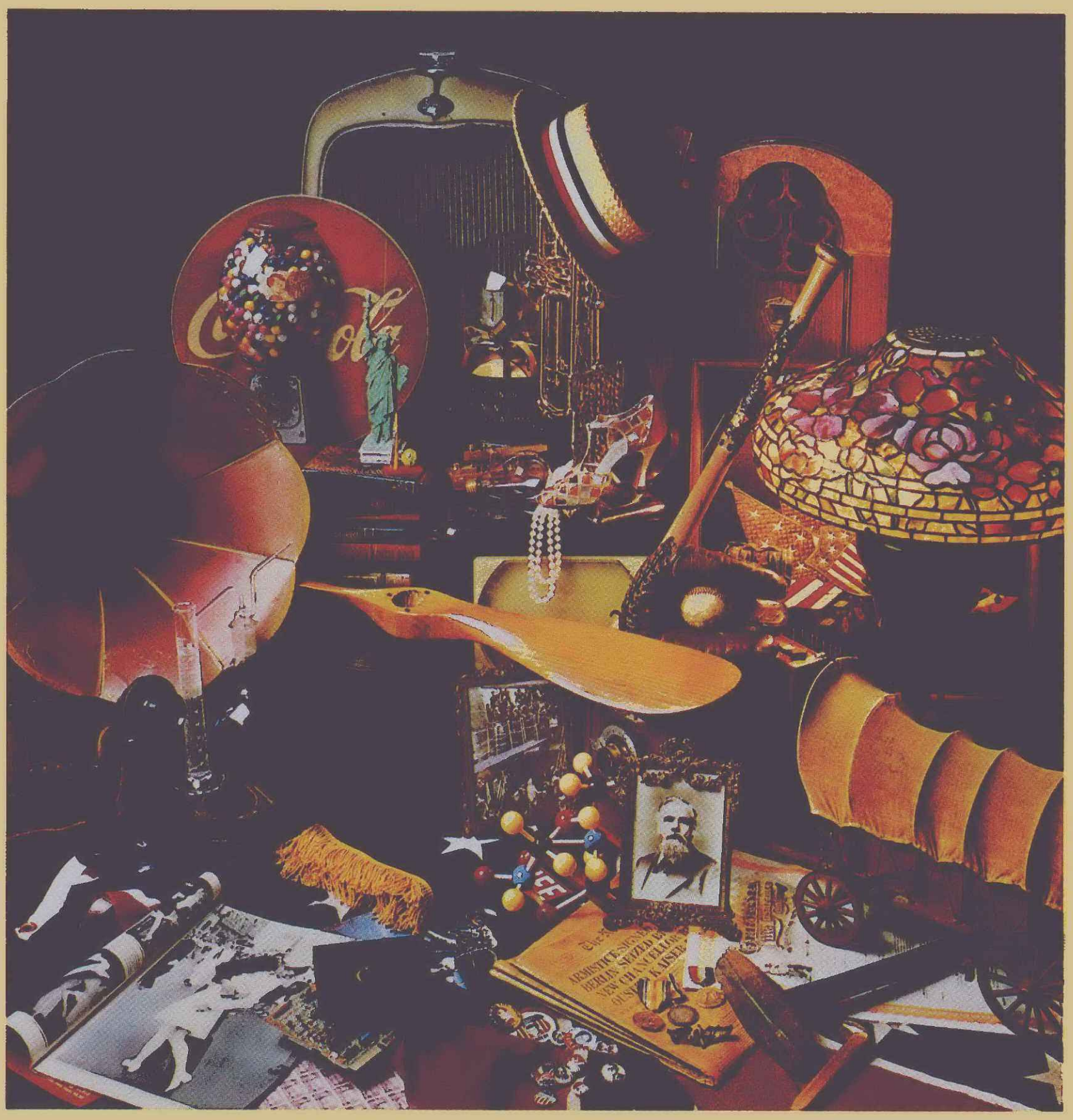

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Cooperation needed to monitor insolvency: Panel

By MICHAEL BRADFORD

OTTAWA, Ontario—Canadian risk managers, brokers, insurance regulators and other members of the insurance industry must work more closely to effectively monitor insurers' solvency, according to a panel of experts.

"I think we all have to recognize that we have a joint problem that we are all going to have to address together," says Paul O'Donoghue, president of Marsh & McLennan Ltd. in Toronto.

Mr. O'Donoghue told a panel discussion at the 1985 Canadian Risk Management Conference, held last month in Ottawa, that a committee composed of insurance industry representatives should be formed to keep a closer watch on the financial condition of insurance companies.

The committee should include "risk managers, brokers, members of the department of insurance and the general insurance industry," he said.

Mr. Donoghue also pointed out that a cooperative effort among members of the Canadian insurance industry could avoid the recurrence of problems like the recent seizure of Northumberland General Insurance Co. in Toronto by Canandian insurance regulators (*BI*, July 15).

Currently, risk managers and insurance brokers only have a vague notion of how financially stable some insurance companies are, said Mr. O'Donoghue, because statistics often are outdated and information gathered from regulators is sketchy.

"If we—or you as risk managers—call up the superintendent of insurance and ask him if he has any doubts about the solvency of an insurance company, he is going to give a well-thought-out and legally correct answer that boils down to: 'Well, they still have their license,'" Mr. O'Donoghue said.

"There are more than 300 licensed property/casualty companies doing business in Canada, and the federal and provincial superintendents of insurance don't have the staffs or ability to be on top of them all at any given point in time," he explained.

In addition, available financial information concerning insurers is not timely enough to give an accurate picture of solvency, Mr. O'Donoghue said.

Brokers have access to the same information as risk managers when trying to assess an insurance company's financial stability, Mr. O'Donoghue said. "And this information tends to be six to 12 months in arrears."

Insurance brokers often arrange interviews with the top executives of insurance companies when there is concern about the underwriter's solvency, Mr. O'Donoghue explained.

"But very often, for a variety of reasons, they are reluctant or very slow in providing information to us on their reinsurance treaties, the state of their reserves. . . .And I think it's a given that analyzing an insurance company's statements is not something you do in a 10-minute period."

Mr. O'Donoghue said that while Canadian insurance superintendents are concerned with the inadequacies of monitoring underwriters and are considering regulatory steps that would lessen the impact of insolvencies, "the most critical issue is the one of timely information."

"By law, federally licensed insurance companies only have to be examined every three years," he said. "Provincially licensed insurance companies get audited every year. Now obviously, that is not suitable. . . ."

The system used to monitor the financial health of insurance companies in the United States is also not as effective as it should be, a panel member from the United States said.

When a U.S. insurer is found to be in financially rough waters and "the deterioration took place over a relatively short period of time, it would probably not be detected in time to be able to do much about it," explained John J. Carey, president and chief executive officer of Allendale Mutual Insurance Co. in Johnston, R.I.

The U.S. regulatory process is not strong partly because budget restrictions keep regulators' staffs thin, he said.

Panelists also said litigation against insurers by policyholders could be reduced through better communications among risk managers, brokers and insurers.

Litigation could be cut if everyone involved knew ahead of time exactly what the policy covers, said Donald I. Brown, president and chief executive officer of Johnson & Higgins Willis Faber Ltd. in Toronto.

Lawsuits filed by policyholders against their insurers will continue, said Mr. Brown, "but I also believe there is a way of avoiding it, albeit simplistic. And that way should be getting back to the basics of the risk manager, broker and insurer getting together. . .to be sure that there is complete understanding on all parts of what is covered, and more importantly on what is not.

"I can't think of any other way of avoiding the litigation process. I guess that's the only way of doing it," Mr. Brown said.

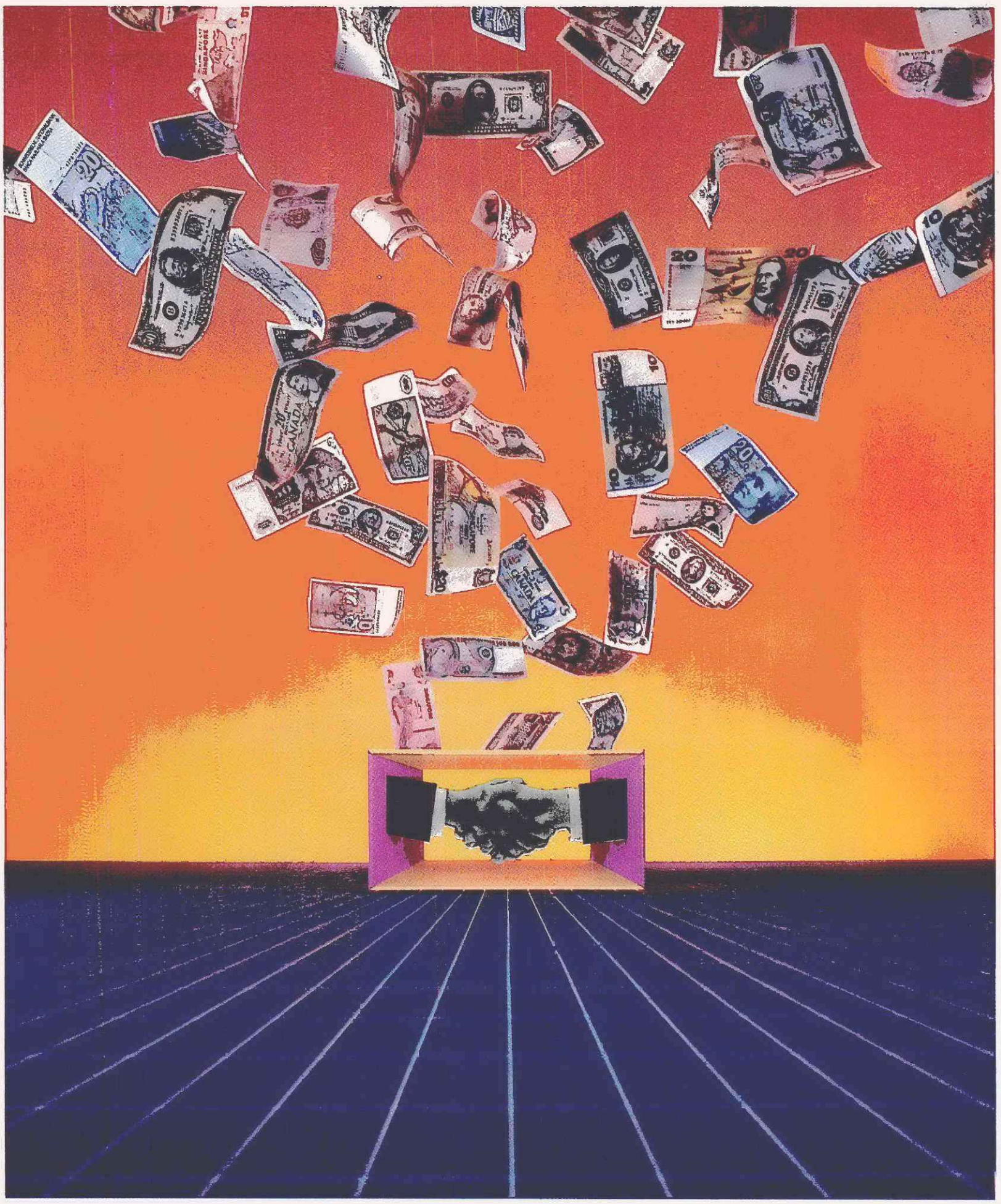
The moderator of the panel, Brian Carmody, risk manager at Atomic Energy of Canada Ltd. in Ottawa, pointed out that when contracts are written by risk managers, brokers and insurers, the contracts are "just words written by ordinary, everyday human beings.

"On the other hand, when the law comes along, the words written by the person off the street are being interpreted by legal counsel. It doesn't seem equitable," he said.

M&M's Mr. O'Donoghue stressed: "We have to work together. I can remember a time when there was a reluctance on the part of some brokers to have clients meet with underwriters. That's going back a long time. Of course that was foolish because the risk manager is the one who understands his risk and can best present it to an underwriter," he said.

Risk managers have to help find solutions to insurance industry problems by "involving government when that's necessary. We've got to have a better monitoring system than the one that is currently in effect. So I think there has to be a closer working relationship in a whole new way between the broker and his clients," Mr. O'Donoghue said.

Also participating on the panel was Cedric G.E. Gyles, chairman and chief executive officer of Reed Stenhouse Ltd. in Toronto. ■



Garro named risk manager at Comcast

comings & goings: buyers

Barbara Garro, 42, has been appointed director of risk management at Comcast Corp., a cable television company in Bala-Cynwyd, Pa. In this newly created position, Ms. Garro will be responsible for the company's property/casualty and liability insurance programs. Ms. Garro will report to Bernard P. Gallagher, the company's vp and treasurer. Before joining Comcast, Ms. Garro served as corporate insurance administrator for Safeguard Scientifics Inc. in King of Prussia, Pa. Ms. Garro has received the Chartered Property & Casualty Underwriter designation and is a member of the Society of Chartered Property & Casualty Underwriters.

* * *

Liz Cronin, 37, has been named manager of health and welfare planning/human resource information systems at Levi Strauss & Co. in San Francisco. In her new position, Ms. Cronin will be responsible for the design and administration of the company's health, life and disability insurance programs, as well as for overseeing computerized employee information systems operations. She will report to Reese Smith, director of employee benefits, and replaces **Donna Tewart**, who has become manager of health and welfare planning for Levi Strauss' Battery Street Enterprises subsidiary. Ms. Cronin, who has worked for Levi Strauss for 12½ years, previously was the company's manager of personnel control systems. She retains her systems duties in her new position. Ms. Cronin received a bachelor's degree in English literature from the University of Illinois-Chicago. In addition, she was a founding member of the Board of Human Resource Professionals, and she is on the board of the group's Bay Area Chapter.

* * *

Brian Jacob, 36, has been appointed program operations manager in the group insurance division of the Bureau of Benefits, which is part of the state of Illinois' Department of Central Management Services in Springfield. In this newly created position, Mr. Jacob has administrative responsibilities with the state's group life and health insurance programs. He will report to Keith Van Geison, manager-group insurance division. Before joining the Department of Central Management Services, Mr. Jacob was a management systems specialist in the Illinois Department of Corrections. He has been employed by the state of Illinois for 13 years. Mr. Jacob has a bachelor of science degree in psychology from Western Illinois University in Macomb.

* * *

James J. Boylan has been appointed director of human resources for Empire Insurance Group in New York. In this newly created position, Mr. Boylan will be responsible for all human resource functions, including administration of all employee benefit programs. He will report to Mort Weinberg, executive vp. Mr. Boylan previously was vp-client services at Human Resources Associates of America in Greenwich, Conn. He has a bachelor of science degree in psychology from Fordham University in the Bronx, N.Y., and a master's degree in business administration from Xavier University in Cincinnati. Mr. Boylan also holds the Accredited Personnel Diplomat designation from the American Society of Personnel Administrators. In addition, he is a member of the American Compensation Assn. and is an adjunct professor at New York University's School of Continuing Education.

* * *

Donald M. Saunders, 46, has been appointed vp and director of human resources for Corroon & Black Corp.'s Benefits and Specialty Sales Group, which is based in Nashville, Tenn. In this newly created position, Mr. Saunders will oversee all human resource functions for the group, including employee benefits and employee wellness programs. Mr. Saunders, who will report to BSSG President Donald R. King, previously was assistant dean and director of student affairs for the Fuqua School of Business at Duke University in Durham, N.C. He received his bachelor of arts degree in history from Westminster College in New Wilmington, Pa., and a master's degree in history from Carnegie-Mellon University in Pittsburgh. Mr. Saunders is a member of the local and national chapters of The American Society of Personnel Administrators.

* * *

Lillian Mullen has been named associate director-risk management at CBS Inc. in New York. Ms. Mullen, 46, will advise the corporation on general insurance matters and will assist with the placement and administration of the general insurance program. She will report to Dennis F. D'Oca, vp-risk management. In her new position, she replaces **Beverly Critz**, who left the company. Before joining CBS, Ms. Mullen was assistant vp at Reed Stenhouse Associates Inc. in New York, and she also had held several administrative and sales positions with INA Life Insurance Co. of New York. Ms. Mullen has a bachelor of arts degree in English from the State University of New York-Albany and a master's degree in English from City College of New York in Manhattan. In addition, she holds the Chartered Life Underwriter and Certified Employee Benefit Specialist designations.

* * *

Guillermo Limon, 37, has been named insurance and risk manager for Houston-based Anderson, Clayton & Co.'s Mexican operations. In his new post, Mr. Limon will be responsible for all risk management duties at the Mexico City operation, with an emphasis on loss prevention inspection. He will report to Rodolfo Rendon, director of government relations, and replaces **Antonio Gutierrez**, who retired from Anderson, Clayton and is now a risk management consultant with Mexico City-based Interproteccion Internacional S.C. Mr. Limon's previous post, that of assistant risk manager, has not yet been filled. Mr. Limon holds a degree in mechanical engineering from Universidad Nacional Autonoma de Mexico.

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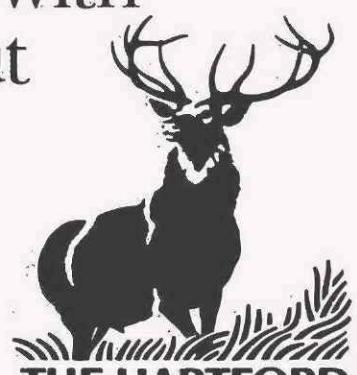

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FASB pension standards to be issued by year-end

CHICAGO—The Financial Accounting Standards Board's final statement on pension accounting will be issued by year-end and will be essentially unchanged from the exposure draft circulated this summer, one board member says.

Under the exposure draft, employers would have to move their unfunded pension liabilities onto their balance sheets (*BI*, Feb. 11.) The move would add millions of dollars in liabilities to many corporate balance sheets.

Arthur R. Wyatt, one of the seven board members of FASB, which sets rules for the accounting profession, mentioned only one possible change, saying, "My guess is that some disclosures will be curtailed or cut back."

And, he said, "I fully expect the standard will be issued by the end of the year.

"The terms of two board members are expiring at the end of the year," Mr. Wyatt said, "and trying to get two new board members up to speed on this topic would be a difficult task."

In a talk to more than 100 members of the Chicago chapter of the Financial Executives Institute, Mr. Wyatt called the proposed pension disclosure standard "the topic that has given FASB the most trouble."

Upon its release of the draft standard earlier this year, FASB had hoped the rule could be adopted by the end of the year.

Since then, the board has listened to more than 60 testimonies at hearings in July and August and received more than 400 letters of comment, Mr. Wyatt said.

While FASB doesn't tally comments in terms of opposition and support, he said, "The comments were almost unanimous that the (proposed) disclosure is too much."

The standard would require, in part, companies to amortize prior service costs sooner. They would have to amortize the costs for the projected service life of employees, instead of the 20 to 30 years now typically used.

In addition, companies would have to place unfunded accrued pension liabilities on their corporate balance sheets.

But Mr. Wyatt said in an interview that companies with overfunded plans won't be allowed to record the pension surplus as an asset on their balance sheets.

While acknowledging the handling appears contradictory, Mr. Wyatt said it was a compromise.

He said the board initially agreed to require projected unfunded liabilities to be recorded on corporate balance sheets, a measure that would have affected most corporations and that generated strong opposition.

"Logically, you ought to recognize the net assets," he said, if FASB is going to require recognition of net accrued liabilities.

"But the board agreed the corporate financial world wasn't ready to book such liability," he added.

In compromising, Mr. Wyatt said the board limited the rule to recording unfunded accrued liabilities and at the same time decided against recording overfunding. The FASB staff has said about 20% of major companies would have to add unfunded accrued liabilities to their balance sheets.

Despite the indication the pension plan overfunding is a real corporate asset—as witnessed by the billions of dollars in pension surplus recaptured—he said FASB views pension plan overfunding as temporary, partially offsetting projected liabilities.

In addition, he said he doubts the FASB will complete work this year on a proposed rule on recording gains on corporate income statements from recapturing surplus by terminating pension plans.

He said the delay would disappoint some corporations.

"I have some people who call me from time to time who are counting on that (recording) gain to make their earning projection," he said.

The proposal would allow companies to book any gain as part of their current-year income.

Currently, FASB requires companies to amortize the gain over a decade or more if they re-establish similar defined benefit plans. Only employers that replace defined benefit plans with defined contribution plans can book the gain immediately.

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New Utah regulator awaits confirmation

SALT LAKE CITY—Harold C. Yancey, a 32-year veteran of the insurance industry, is expected to be approved by the Utah Senate this month as the state's new insurance commissioner.

Mr. Yancey, 59, will succeed Roger C. Day, who is resigning Oct. 15 to become a partner in a new reinsurance brokerage.

Since 1979, Mr. Yancey has been resident manager for Milwaukee, Wis.-based Northwestern National Insurance Co. His managerial duties encompassed three states: Utah, Idaho and Arizona.

Before becoming resident manager at Northwestern, Mr. Yancey was a claims manager for the insurer, a job he also had with American Agencies Inc., the general agency that was purchased by Northwestern in 1975. Mr. Yancey had been with American Agencies since 1953.

Mr. Yancey has an undergraduate degree in business management from Woodbury College in Los Angeles. He also is a member of the Society of Chartered Property & Casualty Underwriters.

Besides working for Northwestern, Mr. Yancey also teaches insurance classes at the University of Utah's School of Continuing Education.

Mr. Yancey will replace Mr. Day, who has held the commissioner's post since 1977.

Mr. Day announced his resignation last month, saying he was forming a reinsurance brokerage with Art Dummer, a reinsurance actuary, and Carl Hulbert, an attorney and former Utah insurance commissioner.

The new firm, to be based in Salt Lake City, will be called The Donner Co.

Mr. Day's resignation had been expected because he was appointed by former Gov. Scott M. Matheson, a Democrat, who chose not to seek re-election last year. The new governor—Norman H. Bangerter—is a Republican.

While commissioner, Mr. Day served as president of the National Assn. of Insurance Commissioners in 1983, as well as chairman of several of its committees and task forces. He often is credited with making a significant contribution to the NAIC's solvency surveillance system.

With Mr. Day's resignation, insurance regulators from only four states—Kansas, Louisiana, Mississippi and Florida—will have been in their posts since the 1970s. All four of these regulators are elected rather than appointed.

Of the other 45 state regulators, four were elected or appointed in 1981, 16 in 1983, 11 in 1984, and the remaining 14 in 1985.

Old Dominion sold

TALLAHASSEE, Fla.—The sale of Old Dominion Insurance Co. in Jacksonville, Fla., which was seized in July by the Florida Insurance Department, has been finalized.

The company's president, Larry Haynes, and another investor purchased Old Dominion on Sept. 23 for about $1 million.

Although Old Dominion was solvent, the insurer was taken over by the Florida Insurance Department to preserve its assets in light of a $47 million lawsuit brought by the U.S. Justice Department in which the insurer was named as a defendant.

The primary defendant in that suit is Larry D. Barnette, the former owner of Old Dominion, who was charged with stealing funds from the U.S. government (*BI*, Aug. 5; July 29).

As part of the sale, federal officials agreed to release Old Dominion from the suit.

Proceeds from the sale will be held by the federal government; however, neither Mr. Barnette nor the federal government will have access to the funds until a final decision is reached in the case, according to a spokeswoman for the Florida department.

Mr. Haynes announced in July he was purchasing the insurer with investor J. Edward Houston, president and chief executive officer of J.E. Houston Financial Corp. in Miami and its subsidiary South Florida Savings Bank. However, the sale was not completed until last week because of the involvement of both the state and federal governments and several courts, Mr. Haynes said.

During the time Old Dominion was run by the Florida department, claims were paid but no new business was written.

But, the insurer will resume writing new business now, Mr. Haynes said, adding that the insurer's $1 million in surplus is expected to be doubled through an infusion of capital from its new owners.

Four-year-old Old Dominion wrote more than $10 million in workers compensation, commercial liability and other lines of insurance in Florida in 1984, according to the department.

Missouri regulator

JEFFERSON CITY, Mo.—C. Donald Ainsworth has resigned as Missouri's insurance director at the request of Gov. John Ashcroft.

Mr. Ainsworth, who has been insurance director since February 1981, was appointed by former Gov. Christopher Bond.

When Gov. Ashcroft took office in January, Mr. Ainsworth said he

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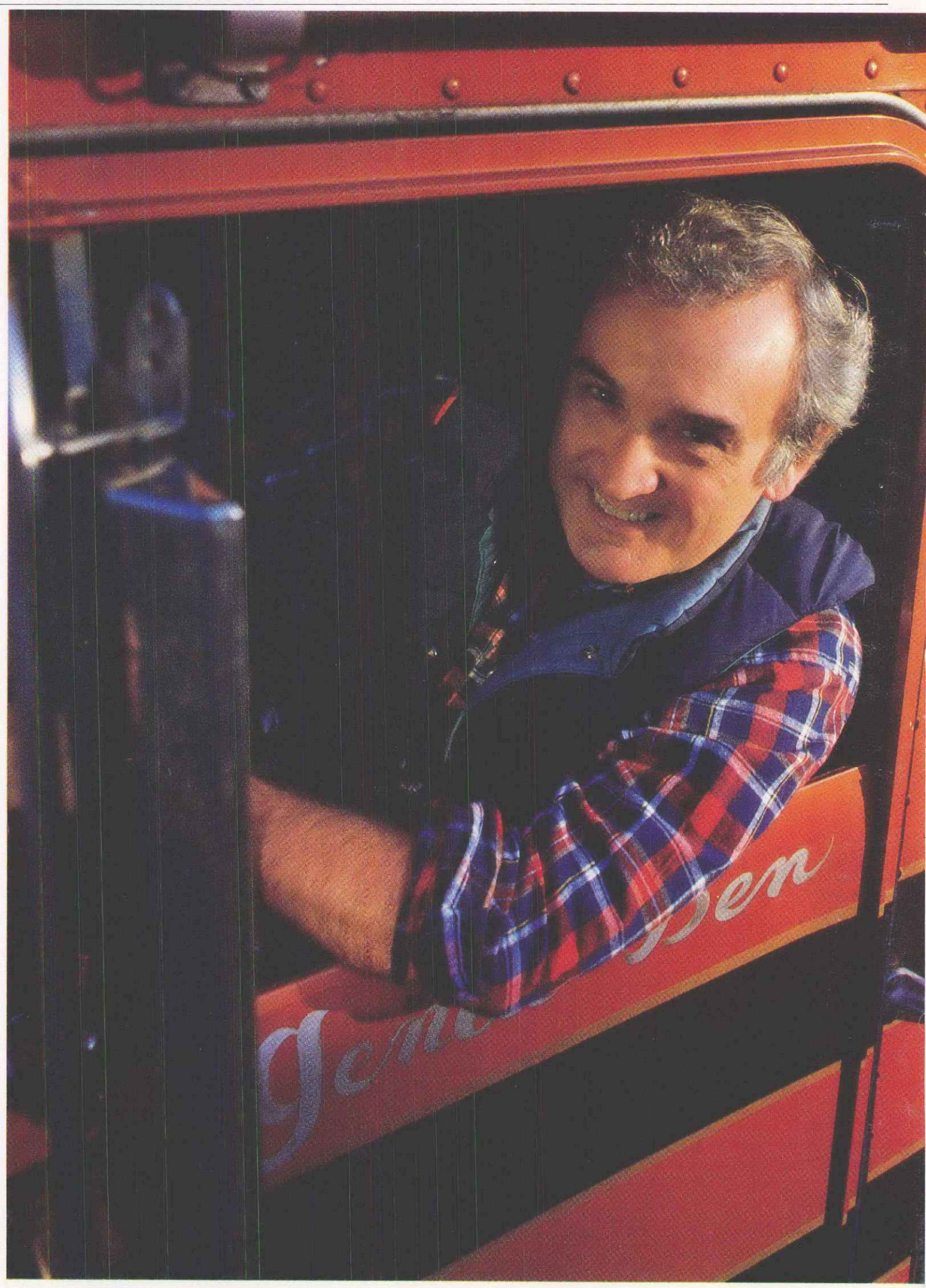

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asked to be reappointed.

However, late last month the governor decided he wanted a new person in the position, said Kenneth McClure, deputy director of administration of the Missouri Department of Economic Development, which oversees the Division of Insurance.

The move is a political one, Mr. McClure said, adding that a search is under way for a new insurance director.

Meanwhile, Deputy Insurance Director Mary C. Hall has been named acting director. Ms. Hall has been with the Insurance Division since 1973 and has been the deputy director since 1981.

Before joining the division Ms. Hall served as a staff member of the Missouri House of Representatives. She also has studied business administration at Southwestern Missouri State University in Springfield.

Mr. Ainsworth was unavailable for comment.

Rehabilitation ordered

NEW YORK—American Fidelity Fire Insurance Co. and American Consumer Insurance Co., two property/casualty insurance units of American Plan Corp., have been placed in rehabilitation in New York.

New York State Supreme Court Justice Kenneth Molloy ordered the two companies into rehabilitation Sept. 6. An appellate court later granted a stay of Justice Molloy's order until Sept. 12, when a request for a further stay was denied.

The New York Insurance Department says the two insurers, based in Woodbury, N.Y., failed to comply with an August 1984 agreement that settled the department's June 1984 move to rehabilitate the two companies.

The 1984 agreement required Plano, Texas-based American Plan to add $2 million in real estate assets to American Fidelity and to repay $6.8 million in loans made by American Consumer to its parent company.

The agreement also required that all transactions between American Plan and the two subsidiaries be approved by the department.

American Fidelity—which primarily writes auto physical damage and liability, group accident and health and commercial multiperil coverages—wrote $8.7 million in net premiums in 1984.

American Consumer—which primarily writes auto physical damage and liability, commercial multiperil and homeowners coverages—recorded net written premiums of $7.7 million.

Work comp hike

HARRISBURG, Pa.—Workers compensation rates in Pennsylvania will increase an average 12.45% during the next 12 months.

The primary reason for the increase is poor loss experience, said Arthur I. Cohen, vp of the Pennsylvania Compensation Rating Bureau, an independent rating bureau in Philadelphia.

Mr. Cohen added that it was claims severity, rather than frequency, that prompted the rating bureau to file for an average 17.15% increase. The state Insurance Department, however, chose to approve a lower increase, a spokeswoman said.

The average 12.45% increase, which was approved by the department last month and is effective Oct. 1, is expected to generate $128 million in additional revenue for workers compensation insurers, she said.

Even with the new increase, workers compensation rates on the average are still lower than they were in 1980, the spokeswoman said.

The last time workers compensation rates were increased in Pennsylvania was Oct. 1, 1984, when an average 1.62% hike took effect.

Average work comp rates were decreased four times between 1981 and 1984.

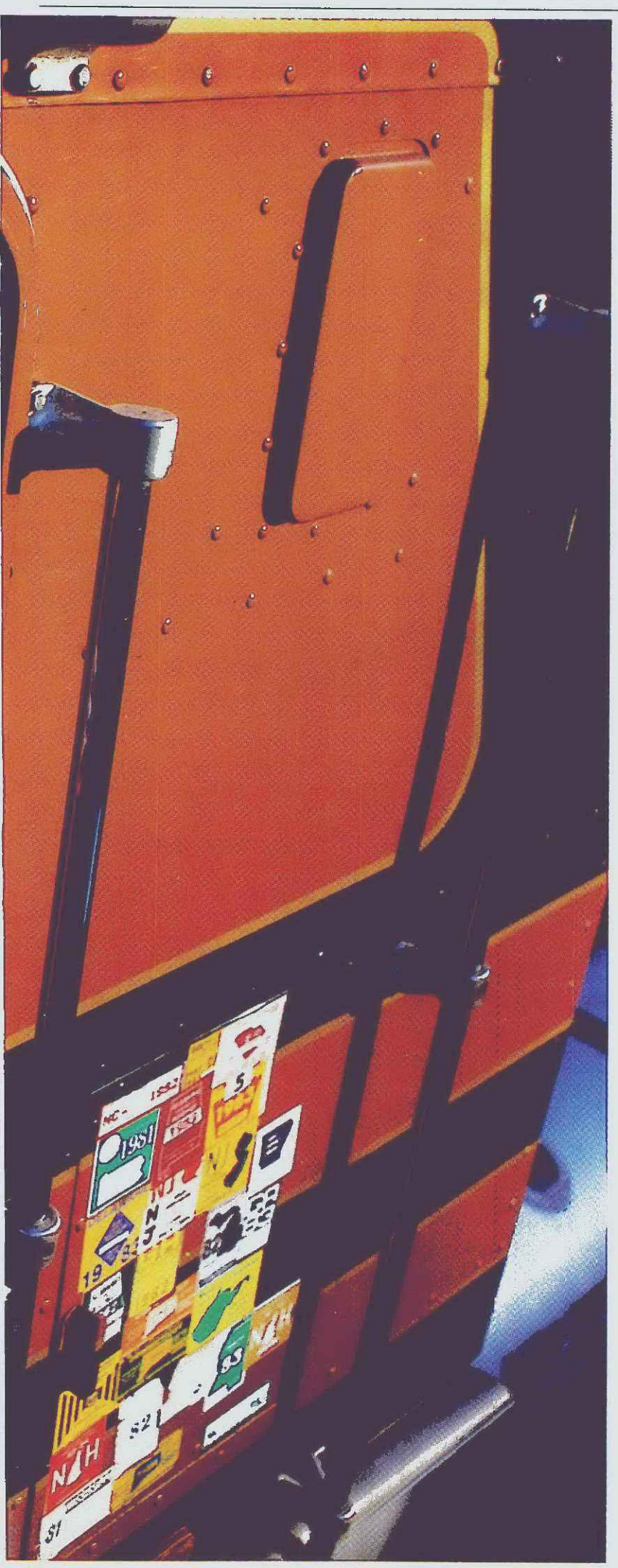
Interim regulator

LANSING, Mich.—Jean K. Carlson is serving as acting commissioner in Michigan. She was appointed to the temporary spot Sept. 16 to replace Nancy A. Baerwaldt, who resigned Sept. 13 to become associate vp for public policy with Mercy Health Services in Farmington Hills, Mich. (*BI*, Sept. 12).

Ms. Carlson has been with the Michigan Insurance Bureau for the past nine years and has been a deputy commissioner for the past seven.

Before that she was a research and fiscal analyst for the state Legislature.

The governor's office is searching for a permanent replacement and hopes to name one soon. ■



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ASK AN ACTUARY

Actuarial methods cause overfunding

Q **Why are so many company's pension plans turning up overfunded these days?**

A Defined benefit pension funds are holding vast assets—assets often substantially in excess of the value of benefits earned-to-date, especially for many pay-related plans.

And, everyone is concerned with the consequences of overfunding. For example, company management is concerned because excess pension assets make them a more-attractive takeover target.

The Internal Revenue Service is concerned because excess assets transferred between pension trusts may buck the Internal Revenue Code requirement that those assets be used for the exclusive benefit of pension plan participants.

The Pension Benefit Guaranty Corp. is concerned because assets recaptured by plan sponsors no longer secure benefits that the PBGC eventually may have to insure.

And, Rep. Ed Roybal, D-Calif., is concerned that "plan termination by employers (will) deprive the American worker of their retirement income security."

(Does that last one sound familiar? If enacted, Rep. Roybal's asset reversion bill no doubt will be the Employee Retirement Income Security Act of 1985.)

Everyone is concerned about the consequences of overfunding. By comparison, little concern has been shown for its causes.

From an actuarial perspective, three causes come to mind.

First, investment return assumptions used for funding pension plans have been substantially below the rates of return available to pension trusts in the past two decades.

To be specific, annual investment returns have been averaging 7% to 11% for an extended period, while actuaries have been funding plans using assumed investment returns averaging 4.5% to 7.5%. Many plans have undoubtedly earned well in excess of their assumed investment rates.

Not only have assets performed better than expected, but liabilities often are lower than plan sponsors realize. Actuaries often use the same investment return rate for funding purposes and for determining the value of benefits earned-to-date. But an actuary now could reasonably calculate the value of benefits earned-to-date using an investment return assumption of 9% per year or more.

This assumption could be justified, since a pension plan can settle its obligation for benefits earned-to-date by purchasing annuities with comparable investment return assumptions.

When a pension plan changes to a substantially higher investment return assumption, the value of benefits earned-to-date is reduced drastically. So, another cause of overfunding results from the high investment returns currently available to settle pension obligations.

A third cause of pension plan overfunding has been the popularity of certain actuarial cost methods for funding pension plans. An actuarial cost method, also called a funding method, is a procedure for allocating the value of pension plan benefits for current plan participants to past, current and future time periods.

For example, many pension plan actuaries use the "entry age normal" method; approximately one-half of the pension plans with at least 1,000 active participants are funded with this method.

In this actuarial cost method, the value of an employee's pension plan benefits is a constant dollar amount or a constant percentage of pay in each time period from the employee's date of first participation under the plan—the entry age—to his or her assumed retirement. This allocation is made *individually* for each employee.

In inflationary times, it can produce a level contribution to the plan, eliminating annual cost increases.

Other popular actuarial cost methods are the "frozen initial liability" method and the "aggregate" method.

In the frozen initial liability method, the unfunded value of pension plan benefits less the "frozen initial liability" is allocated to current and future time periods on a level basis—either a constant dollar amount or a constant percentage of pay—over the current and future periods. This allocation is done for the group as a whole, and not as the sum of individual allocations.

The "frozen initial liability" is the unfunded value of pension plan benefits at some starting point, such as the inception of the plan or the date that the frozen liability cost method is first used. This unfunded value is fixed, or frozen, and is paid for outside of the allocation described above.

In the aggregate cost method, the unfunded value of pension plan benefits is allocated to current and future time periods on a level basis—either a constant dollar amount or a constant percentage of pay—over the current and future periods. This allocation is done for the group as a whole and not individually for each employee.

About one-quarter of pension plans with at least 1,000 participants use one of these methods.

These also are "level cost" methods, meaning an actuarial cost method in which the value of pension plan benefits is allocated so as to produce a constant dollar amount per employee in each time period, or a constant percentage of employees' pay in each time period.

The problem with all of the "level cost" methods is that they generally will move a well-funded pension plan—that is, a plan where assets cover the accrued benefit values with a margin of 10% to 30% or fully cover the accrued benefit values after reflecting future salary increases—into an overfunded position more rapidly than certain other cost methods.

All of the level cost methods usually produce annual contributions substantially in excess of the value of benefits earned in a year.

The causes for overfunded pension plans are going to receive increased attention in the coming months, courtesy of the Financial Accounting Standards Board. Although FASB is indifferent as to whether pension plans are over- or underfunded, its recently published

Continued on next page

Actuaries are *not* for the birds

When an acquaintance asks me what I do for a living and I say I'm an actuary, I generally get one of three responses.

There is the "You mean you're a house for birds?" response. I smile politely and say, "No, an *aviary* is a house for birds. I'm an *actuary*. They're really quite different."

Then there is the "quick topic shift" response. After I speak the word "actuary," there is a momentary pause, and then the topic of conversation immediately changes to a local sports team, a recent news event or the weather. When this happens, I'm never really sure whether my acquaintance does not know what an actuary is and is afraid to ask, or whether he or she thinks I've just said something in very bad taste.

My favorite response runs something like this: "Oh, I know what that is. My sister-in-law in Nebraska is an actuary. She is taking the actuarial exams. Seems like she's been taking them forever. She is employed by an insurance company and works a lot with numbers. Is that what you do?" This response is my favorite because I realize that I have found one of the few people who have heard of actuaries and what they do.

In order to increase those sparse numbers, let me tell you about actuaries and the profession. Actuaries work with financial security plans, such as defined benefit pension plans or insurance plans of all types—life, health, disability, property and casualty. The actuary's primary responsibility is to calculate the liability for benefits promised by the financial security plan and the amount needed to be contributed currently to the plan to fund promised benefits.

When benefits are promised many years into the future, an actuary generally will calculate the current contribution so that all contributions will be the same dollar amount or will increase by a fixed percentage each year. Because an actuary understands the cost and liability implications of various financial security plan provisions, he or she often becomes involved in the design of these plans.

The actuary's cost and liability calculations are based on mathematical models that use probability and statistical theory. Many actuarial calculations today are done through a computer.

Actuaries generally specialize in certain types of financial security plans. For example, I generally work with employee benefit plans. I assist employers that sponsor pension, health and disability plans with the calculation of costs and liabilities for these plans and with designing the plans.

An actuary trains for the profession through a combination of on-the-job experience under the supervision of senior actuaries and through passing examinations offered by the actuarial professional bodies that lead to professional qualification. The most widely accepted standard of qualification in the United States or Canada is fellowship in either the Society of Actuaries or the Casualty Actuarial Society.

To become a fellow in either organization, an individual must pass 10 examinations. The typical individual studies for and completes these examinations in six to 10 years while working in an actuarial position. These examinations emphasize the mathematics used in an actuary's practice and other specialized topics needed to design and value financial security plans.

In closing, I would like to dispel a few stereotypes about what is required to become an actuary.

No, an individual need not be at least as boring as an accountant to become an actuary. And, no, an individual need not sleep with his or her calculator in order to become an actuary—that requirement went out two or three years ago with the advent of personal computers.

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

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

Mr. Miner

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

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

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

perspective

'Maquiladoras' pose special problems

By S. Robert Beane

international issues

AS THE SUN RISES each working day, cars begin their commute south across the U.S. border to Mexico. These commuters are among more than 200,000 employees who work in an industry that is the second-largest foreign-income earner for Mexico after petroleum: the maquiladora industry.

A maquiladora is a company that imports components, processes them and exports them.

Bilateral treaties have been established between the United States and Mexico that permit the maquiladoras to import machinery, equipment and materials from the United States duty-free, or what is more commonly referred to as "in-bond." This procedure was established because these items generally are not be for sale in Mexico and do not compete with Mexican manufacturers but instead would be available solely for export.

When the semi-finished or finished products are sent back to the United States, only the value added to the original materials, primarily the cost of labor, is subject to customs duties.

There is no literal English translation for the word "maquiladora." However, the concept normally is referred to as an in-bond assembly or processing operation.

There are more than 770 maquiladoras representing the electronics, automotive, pharmaceutical, food, toy, coupon-sorting and other industries located primarily in a dozen border cities.

The U.S. corporations and those from other countries that have established maquiladoras are taking advantage of the relatively low labor costs and the proximity to the U.S. market, which reduces transportation costs, to shift labor-intensive processes to these facilities.

And, this shift signifies a growing dependence on maquiladoras. As these companies become an increasingly important component in parent company operations, corporate management is beginning to focus on the need to emphasize plant protection and sound comprehensive risk management programs.

The maquiladoras pose an unusual challenge to risk managers because they involve a combination of U.S. and Mexican insurance requirements. Mexican insurance laws must be followed, but at the same time, U.S. liability concerns must be addressed. There seem to be no insurance regulations that govern maquiladoras.

Thus, the insurance regulations published by the National Banking and Insurance Commission, which apply to all companies located in Mexico, would appear to apply as well to the maquiladoras. Article 3 of this law states that it is illegal to contract insurance with foreign insurance companies on risks in Mexican territory.

But, the U.S. exposures of these border operations usually can be handled under a company's domestic programs.

The following recommendations should help risk managers organize a maquiladora risk management and insurance program in several important areas:

- Fire. Two fire policies can be issued. One should be written in pesos, and this policy should cover the building and replaceable furniture or other contents purchased in Mexico. It should be written with an inflation guard endorsement to make sure the insurable values keep pace with inflation.

The other policy should be in dollars to cover imported machinery, equipment and inventory. This avoids any problems of under-insurance arising from currency devaluations.

- Business interruption and extra expense. The primary concern area in the event of a loss would be continuing expenses and ordinary payroll coverage.

Because of the way the maquiladoras operate, they generally do not generate significant profits in Mexico. These profits almost always are earned in the United States, which creates an interdependency business interruption exposure that should be handled under a U.S. policy.

Extra-expense coverage also should be considered to assist the maquiladora after a major loss.

- Transit. How to insure transit risks is often a difficult decision for risk managers because materials are transferred back and forth across the U.S.-Mexican border.

Having two separate policies, one covering risks in the United States and the other in Mexico, can create problems at the time of a loss because there might be a question of whether the loss occurred in the United States or in Mexico.

Therefore, one policy should be issued covering the entire transit cycle. The policy can be issued in the United States or in Mexico, depending on the terms of sale.

- General liability. Mexico is not as liability-conscious as the United States, because of the different legal and cultural structure that is found in that country.

The maquiladoras' general liability policy would include the normal general liability coverages except for product liability.

Because the maquiladoras generally export their products, the appropriate product liability coverage must be established in the importing country, usually the United States.

Some maquiladoras sell a small percentage of their output in Mexico. In these cases, product liability coverage in Mexico also would be necessary.

Usual liability insurance limits would be between $100,000 and $500,000, depending on the location and assembly process of the maquiladora.

- Money and securities. Because most payrolls are paid in cash, payroll security is an area of concern for risk managers.

Before considering an insurance policy, risk managers should review the maquiladora's security procedures. Armored vehicles can be hired to deliver the payroll, and, for an additional fee, guards will distribute payroll to each employee. With the economic problems Mexico is facing, this is an area that must be reviewed carefully.

- Burglary. With up to three shifts per day, numerous people moving around and production materials or office equipment of varying value, maquiladoras always face the possibility of theft loss. However, with adequate security procedures, the severity of such losses can be minimized.

- Automobile. Protecting against automobile exposures can cause a great deal of concern and frustration. The first step is to identify all of the exposures, such as:

1. U.S. company-owned vehicles traveling across the border.
2. U.S. employee-owned vehicles traveling across the border on personal and/or company business.
3. U.S. leased vehicles traveling across the border.
4. Maquiladora-leased vehicles traveling in Mexico.
5. Maquiladora employee-owned vehicles traveling across the border to the United States.
6. Maquiladora-leased vehicles traveling across the border to the United States.

A company then must decide when to purchase coverage to protect itself, its employees and its vehicles.

The Mexican auto tariff stipulates there must be 10 vehicles to issue a fleet policy. Automobiles and trucks cannot be included in the same policy.

And, maquiladoras need someone to administer the automobile program to keep track of the numerous variables and changes involved. Preferably, this should be someone in the personnel department who is aware of employee turnover.

Indeed, possibly the most important problem facing the maquiladora industry is employee turnover, which may run as high as 10% per month.

High turnover is a result of both over-demand for employees and a reluctance of employers to engage in a wage-war to retain their workers. A wage-war would diminish the main advantage of this industry: low labor costs.

Therefore, maquiladoras must attract and retain employees on the basis of proximity to residential areas, recreational facilities or activities, working conditions and employee benefit plans.

Implementing a comprehensive employee benefits program and communicating that program to employees can be helpful in reducing turnover rates.

The year 1985 began with 734 maquiladora plants. Industry experts predict a 20% increase by the end of 1985.

They also predict that the number of maquiladora employees will increase to 260,000 from the current 200,000.

With Mexico facing $96 billion in foreign debt, 55% annual inflation, currency devaluations and declines in the price of oil, which represents 70% of the country's exports, it is safe to assume that the growth predictions for the maquiladora industry are correct.

Risk managers whose companies currently have maquiladora operations, or those that are planning to establish maquiladoras, should review the various exposures these facilities create and how they should be handled.

As maquiladoras become key production facilities in corporate strategic plans, their combined domestic and international exposures must be carefully assessed so they can be integrated successfully in corporate risk management programs.

S. Robert Beane is vp and manager of the New York International department of Johnson & Higgins. His column on international issues appears the first Monday of every month.

Actuarial methods may cause some pension plan overfunding

Continued from previous page

guidelines for accounting and disclosing for pension plans will highlight some of the causes described above.

The FASB will require companies to charge pension expenses against their earnings and disclose the values of benefits earned-to-date using an investment return assumption that will "settle the obligation."

Investment return assumptions certainly will increase, and some plan sponsors that thought they had a well-funded pension plan soon will be surprised to see that their plan is overfunded.

The FASB also will require companies to have the charge against earnings for pensions expenses calculated using the projected unit credit cost method.

The projected unit credit cost method is an actuarial cost method in which the value of an employee's pension plan benefits is allocated to time periods based on an allocation of his or her projected pension benefit at retirement. The allocation usually is done in proportion to the employee's service with the employer and is made individually for each employee.

The value of the allocated benefit is the cost for the employee over the associated time period.

This method generally produces annual contributions substantially lower than those produced by the more commonly used methods.

This requirement will raise the issue of whether this method is more appropriate than the current method for funding a pension plan, especially for a well-funded plan.

If you have not reviewed the funded status of your pension plan recently and attempted to determine the cause of any overfunding, you might be well-advised to do so now. With all the attention currently being paid to this issue, top management sooner or later will ask the questions that will prompt you to make this review.

To be forewarned is to be forearmed.

Bill would cut 'dual choice' from HMO Act

By JERRY GEISEL

WASHINGTON—Employers no longer would have to offer employees the opportunity to enroll in health maintenance organizations under legislation, S. 1642, introduced by Sen. Malcolm Wallop, R-Wyo.

The measure would wipe out the so-called dual-choice provision of the 1973 Health Maintenance Organization Act. Under that provision, an employer must offer a federally qualified HMO if the company has at least 25 employees in the HMO's service area and the HMO properly approaches the employer.

Sen. Wallop's legislation, if enacted, would take effect Oct. 1, 1987. The measure has the Reagan administration's backing.

The dual-choice provision was made a part of the HMO Act to give the then-fledgling HMO movement a better chance to compete against commercial insurers that dominated the group health market.

Today, however, HMOs have captured between 6% and 7% of the group health insurance market and their annual current growth rate exceeds 20%. So, the removal of dual choice is not likely to have any impact on HMOs, experts say.

Extension of benefits

Legislation that would require employers to extend group health insurance coverage to employees' spouses after a divorce, separation or death may have an even greater impact on employers than initially believed.

It had been thought that measures passed by the House Ways and Means and Senate Finance committees only applied to plans offering hospitalization and medical benefits (*BI*, Sept. 30). But, congressional committee staffers say the measures would apply to all group "health" plans, including dental and vision care plans.

The House measure, H.R. 3128, would require employers to extend group health coverage to spouses for up to five years after the divorce, separation or death of an employee. The spouse could be required to pay the full cost of coverage.

The Senate version of the legislation, which has not yet received a bill number, would require a shorter extension period—only 18 months—but also would require employers to extend coverage to workers who lose their jobs. Spouses and unemployed workers who want to continue coverage could be asked to pay 102% of the employer's cost of coverage.

Medicare costs

Medicare deductibles and coinsurance payments are expected to rise next year, a move that will increase many employers' health care costs.

Under a payment schedule being drafted by the Department of Health and Human Services, the annual deductible for Medicare hospital coverage would rise to $492 from $400 next Jan. 1. This deductible applies for the first 60 days of hospital care.

For hospital stays that last between 61 and 90 days, the daily coinsurance charge would rise to $123 from $100. For any additional days, the coinsurance charge would increase to $246 from $200.

These changes would affect employers that coordinate retiree health care plans with Medicare. These plans are designed so costs not covered by Medicare are picked up by the employer's plan.

As a result, any decrease in the share of retiree health costs paid by Medicare ends up being shifted to plans sponsored by employers.

washington

Group legal plans

Section 120 of the Internal Revenue Code, which allows companies to provide tax-free group legal plans to employees, would be made permanent under legislation, S. 1652, introduced by Sen. John Heinz, R-Pa.

Currently, Section 120 is due to expire on Dec. 31.

"Employer-provided group legal-service plans serve a valuable social purpose by providing working people with access to service they might otherwise not be able to afford," Sen. Heinz said. The senator added that as many as 13 million people may be covered under the plans.

Profit-sharing suit

The trustee of a profit-sharing plan loaned too many of the plan's assets to the company sponsoring the plan, the Labor Department says.

In a suit filed in U.S. District Court in Los Angeles, the Labor Department says Richard Carieri, president of Woodard Laboratories and a trustee of Woodward's profit-sharing plan, improperly loaned plan assets to the company.

Mr. Carieri allegedly violated the Employee Retirement Income Security Act's "prudent man" rule by failing to require prompt and complete payment of a $47,000 loan and by not diversifying the plan's assets yyto minimize the risk of large losses from a single investment, the Labor Department charges.

According to the department, the loan represented more than 90% of the plan's assets.

The department's suit seeks a federal court order to remove Mr. Carieri as the plan's trustee and appoint an independent fiduciary to manage the plan assets. The department also has asked the court to order Mr. Carieri to repay all losses to the plan resulting from his alleged unlawful acts.

As of March 31, 1984, the Woodard profit-sharing plan had 44 participants and $50,310 in assets, the Labor Department said. ■

When it comes to medical opinions, two heads are better than one.

Any way you look at it, getting a second opinion for certain elective surgery makes sense. It either reassures the patient by confirming the need for surgery or avoids the medical risks and costs associated with unnecessary surgery.

Surgical screening is just one of the many benefit options in CURE, the cost containment program from the CNA Insurance Companies. CURE also offers other options such as outpatient surgery, weekend admission limitations and pre-admission review—an enhanced way of reviewing hospital admissions and monitoring care.

With our program's flexibility, you can implement benefits individually or as a package, depending upon your company's requirements. We'll even help document your company's need for cost containment measures by identifying potential problems through our management reports. And to help gain employee understanding and confidence, we offer our communications kit and administrative materials.

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Transit coverage

Continued from page 1

The decision was made after the district's rates went "out of sight," he said. Last year it paid $168,000 for $30 million in liability insurance above a $100,000 self-insured retention. Since July 1, it has been paying an annual premium of $799,000 for $5 million of coverage above a $500,000 self-insured retention, he said.

"I think insurance carriers are pricing themselves out of the market in those areas where governmental entities can rely on solid governmental immunity acts," he said. "I think other states will have to re-examine governmental immunity and limit types of recoveries for tort damages."

Mr. Grebenstein feels "comfortable" with the change. And, the state's position is strengthened further because the Colorado governor recently signed legislation clarifying a part of the governmental immunity act.

'I think insurance carriers are pricing themselves out of the market in those areas where governmental entities can rely on solid govermental immunity acts,' said Denver's Steve Grebenstein.

The Colorado Legislature met in special session last month and passed a bill that clarified that public employees and officials are not personally liable for punitive and exemplary damages unless they are found guilty of "willful or wanton" misconduct or acting beyond the scope of their duties.

In addition, the Legislature clarified the duty of a public entity to defend employees and officials, according to Craig Ellis, acting risk manager for the state.

And, the Legislature also passed legislation authorizing the state to self-insure its liability risks.

In Washington state, which has no governmental immunity law, transit districts are lobbying legislators for passage of such a law, said Jack Tonkovich, finance director of the city of Pullman, Wash.

In addition, lobbying efforts are being made in Pennsylvania to pass a law that would cap transit districts' liability, said Harold Jenkins, president of the Pennsylvania Assn. of Municipal Transit Assns.

"I'd be surprised if every state isn't taking a look at it," said Mr. Batchelder of APTA.

In addition, the American Bus Assn. may discuss a proposal at its conference next month that could provide relief to some bus operators nationwide. The proposal automatically would cap liability awards for bus passengers who purchase certain tickets, in the same way that the Montreal Agreement caps liability awards for plane passengers with international destinations, said Mr. Long of Blue & White Lines.

- Appealing to state insurance regulators to prevent midterm cancellations and seek other relief.

Illinois Insurance Director John E. Washburn has ordered Pacific Employers Insurance Co. in Los Angeles, a CIGNA unit, to stop the midterm cancellation of its insurance coverage for independently owned school buses in Illinois. The company insures more than 1,000 school buses in the state.

The company's cancellation appears to violate the state insurance code, Mr. Washburn said. The Insurance Department has scheduled an Oct. 15 hearing on the matter.

"We must seriously question why CIGNA collected the insurance premium all summer and then chose to cancel its school bus policies just as the school year began," Mr. Washburn said.

"In our estimation, the company arbitrarily terminated its entire school bus liability program without sufficient evidence that risk factors have changed dramatically since the time the company underwrote the risk," he said.

Mr. Washburn said the insurer's action presents a threat of irreparable loss and injury to its policyholders and Illinois residents, and he warned that such action will not quickly be forgotten by the public, legislators or regulators.

Meanwhile, the Wisconsin Municipal Transit Insurance Commission, a pool of transit operations of 16 municipalities in the state, convinced Pacific Employers not to cancel its liability coverage midterm.

Pacific Employers notified the pool in April that it wanted to double the premium or it would cancel the coverage midterm, said Mike Glasheen, secretary/treasurer of the commission and also the transit planner for Racine, Wis.

But, the pool cited a Wisconsin state law that limits an insurer's ability to raise policy rates, he said.

Pacific Employers also wrote comprehensive auto liability and physical damage coverages for 15,000 buses operated by 1,750 public and privately owned bus companies nationwide through a program sponsored by the United Bus Owners of America, according to Thomas Spangenberg, vp at Robert J. McRell Associates in South Plainfield, N.J., which administered the program.

The program stopped writing new and renewal business in August because Pacific Employers withdrew, he said.

A CIGNA spokesman conceded, "We have pulled back dramatically on our involvement with buses and trains."

He said the decision was made because premiums were too low and claims were too frequent. "We've been losing too much money," he said.

And, he said, often a state's assigned risk pool can offer lower rates than CIGNA can.

At least one transit operator has sought insurance coverage for his school buses from his state's assigned risk plan. Chuck Ruane, who operates Goodall's Charter Bus Service Inc. in San Diego, said he got a "good" rate increase—350%—for liability coverage for a fleet of 12 school buses. He declined to reveal the limits or premium.

- Forming captives.

Passenger and freight-handling railroads, facing a 75% decrease in available capacity compared with last year, may be helped if the Railroad Insurance Management Assn. follows through on plans to establish an offshore captive dubbed Railroad Assn. Insurance Ltd. (RAIL).

Individual railroads are scratching this year to find $50 million in coverage, compared with the $200 million they obtained last year.

Plans call for RAIL to write $50 million in liability insurance, in excess of $50 million, for U.S. and Canadian railroad operations, said Jim Edwards, assistant treasurer of the Union Pacific Railroad in New York and president of RIMA.

Proposed coverages include third-party liability and coverage for loss of revenues, Federal Employers' Liability Act coverage and limited pollution coverages. Coverages for bills of lading and foreign rolling stock would be available for an extra premium, Mr. Edwards said.

An informal committee of RIMA has hired International Risk Man-

Continued on page 34

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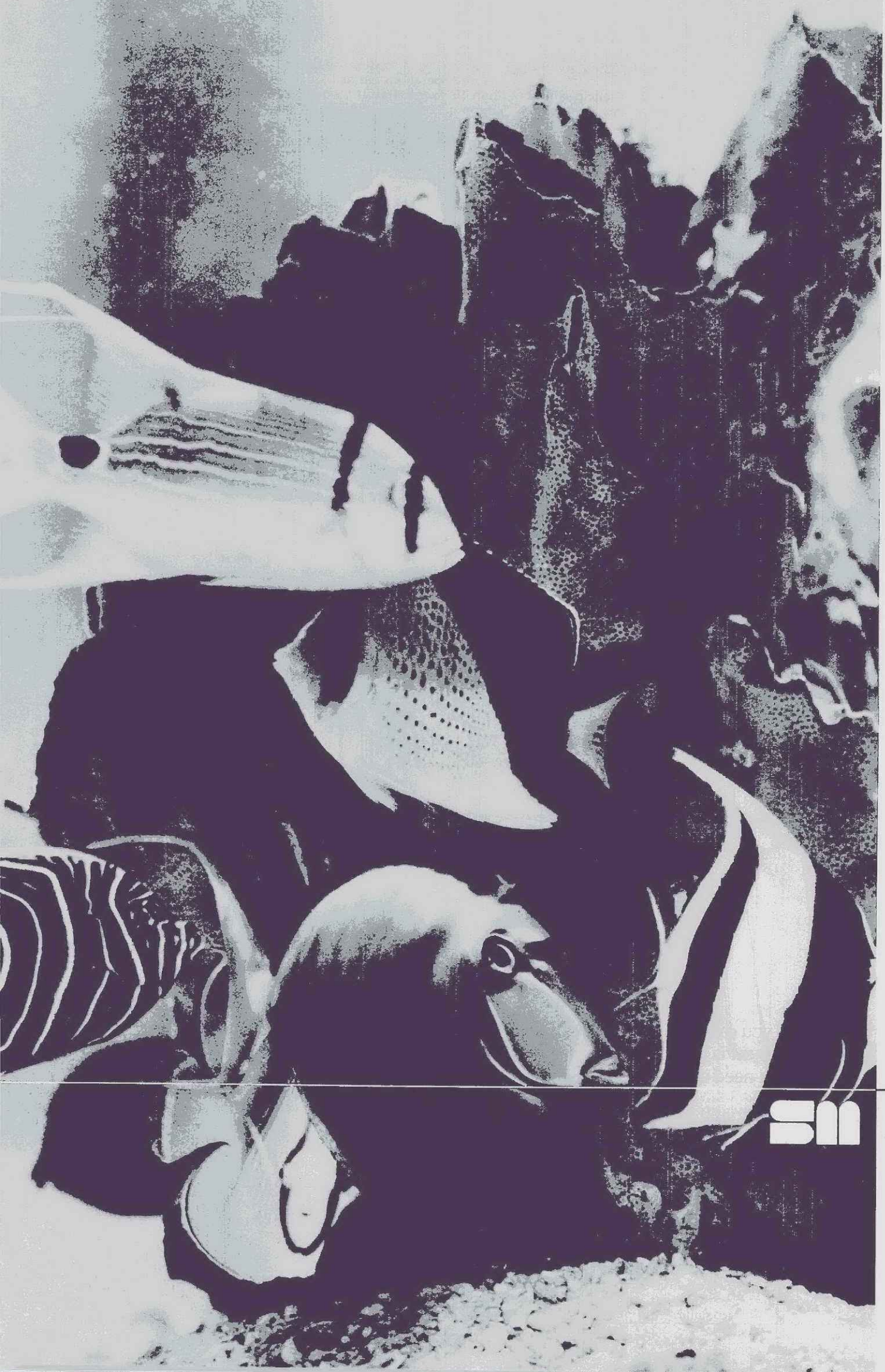

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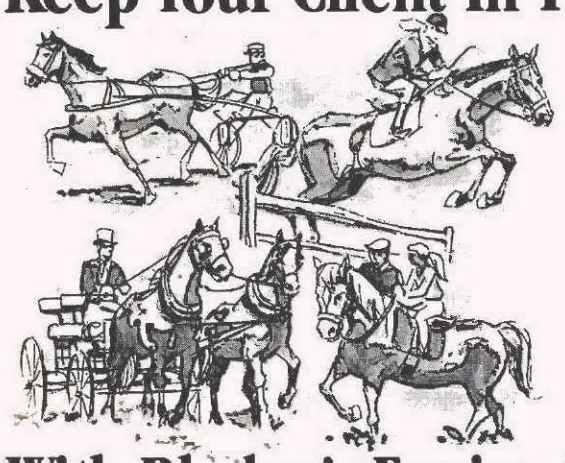

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Agent MGA

Continued from preceding page

and make sure that the operations are running smoothly," Mr. Nicosia said.

Although the MGA has not yet grown to require a separate staff, Mr. Ulrich, the first agent to contract with the MGA, already has placed a few special multiperil contracts through the facility.

Mr. Nicosia

Although Mr. Ulrich said it is too early to anticipate how much business he eventually will place through Tri-State, he is enthusiastic about the service.

"Through the facility we will represent a much larger volume of business and will be able to talk turkey with our carrier," he said. "It will give us much more leverage."

The MGA is particularly valuable to Mr. Ulrich's agency, which had a contract with Crum & Forster Underwriters Group.

Although the Ziegler agency's business written with Crum & Forster was profitable, its total premium volume with the insurer was small, and the agency faced the possibility of cancellation because it could not meet minimum premium volume requirements.

Through Tri-State Facilities, Mr. Ulrich will be able to keep his business with Crum & Forster Underwriters Group, and the insurer will benefit by retaining the agency's profitable business.

The MGA is a good idea, "not only to us, but to the insurance companies as well," Mr. Ulrich said.

"We are a team, and to survive we need each other."

It would be "foolish" for insurers to walk away from a good book of business just because the agency did not produce enough premium volume with the company, he pointed out.

Mr. Adams

"The MGA is a step in the right direction," he said.

Richard Adams, vp of Crum & Forster Underwriters Group's New Jersey operations in Morristown, is also enthusiastic about the potential of Tri-State Facilities.

"There is a move toward consolidation of companies and agencies, and we are interested in directing our efforts where they make the most sense," Mr. Adams said.

"We decided that we could no longer write small amounts of business and had to determine how we could best consolidate and still retain our business.

"The arrangement with the PIA will allow agents to pool smaller books of business and consolidate their back-room operations through the MGA. We couldn't afford to continue to do business with those agents on an individual basis," he added.

Both the agent and the insurer agree it is important to maintain good agency/company relationships.

Mr. Adams said that the arrangement allows Crum & Forster to demonstrate that it recognizes the worth of the independent agency system.

"If we didn't take this approach, we wouldn't be able to write (these smaller agencies') business anymore, and we didn't want to turn our backs on our agents," he explained.

"So, we are consolidating that business with agents who qualify for appointment by the MGA," Mr. Adams added. "This helps us preserve our business with them and makes the retention more cost-effective."

Mr. Adams said that, for now, Crum & Forster will write business through the MGA from agencies that already have represented the insurer. He said this will continue "until we get the bugs out of the system and everything is running smoothly."

Mr. Reed

However, he said, as soon as the MGA clears this initial stage and has established a smooth operation, the insurer will consider writing business for other agents who tap Tri-State.

Continued on page 34D

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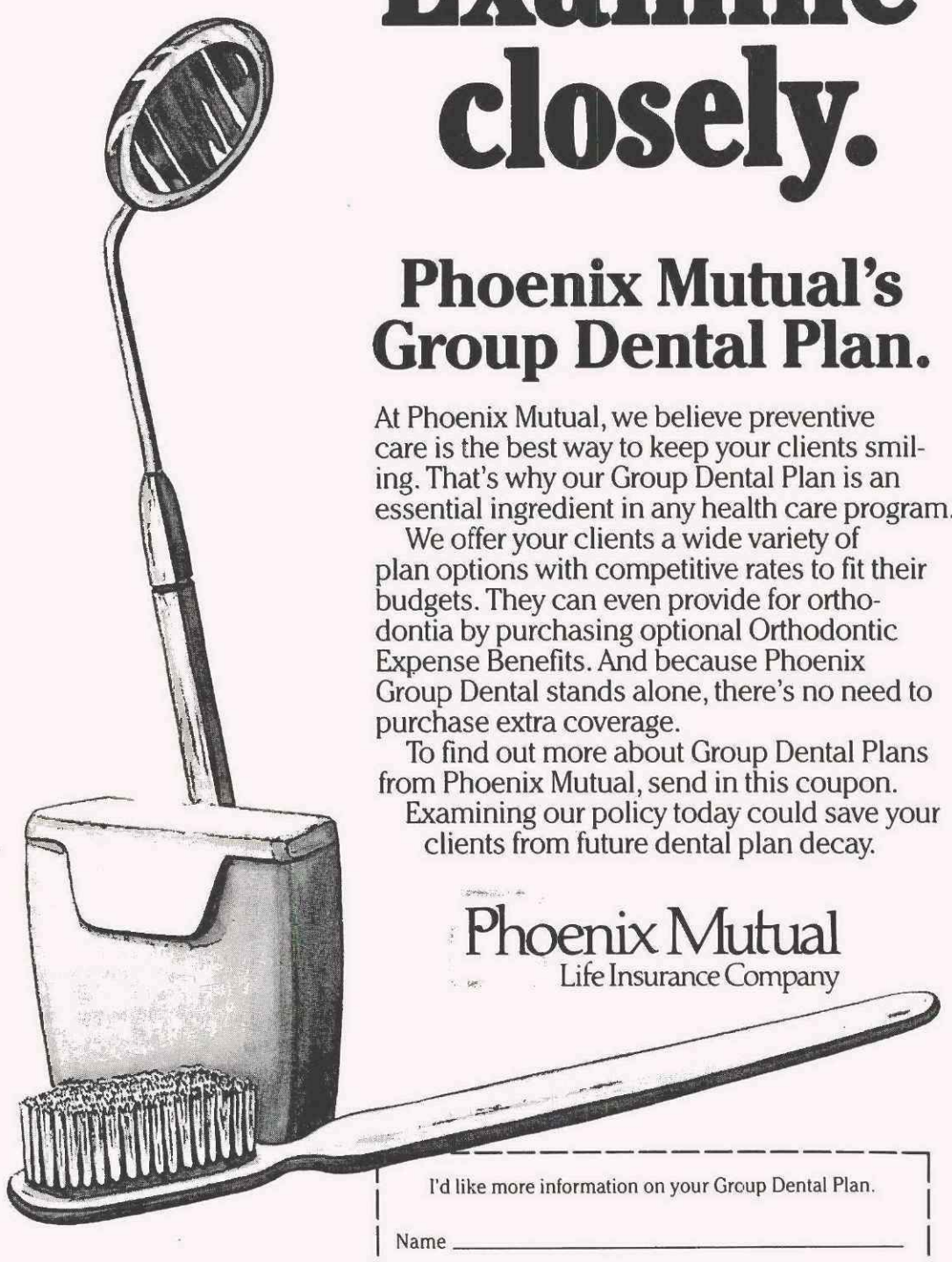

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Agent groups' MGA

Continued from page 34B

Mr. Adams also noted the efforts of the PIA of New York, New Jersey and Connecticut in establishing the facility.

"By its nature, the purpose of an association is to respond to the needs of its constituency," he said.

"Through the MGA, the association will provide a service to its quality agents with less overhead.

"This is an added value to the membership and helps perpetuate the system," Mr. Adams said. "It could also provide new people coming into the system with markets to build equity."

And although the start-up of the facility may be slow, Mr. Ulrich expects that "a few years down the road the facility is going to have some real value to a lot of agents and companies who participate."

The MGA is attracting national interest as well. For instance, the National Assn. of Professional Insurance Agents "will be tracking Tri-State very closely," said Jim Davies, president-elect of the PIA and president of Davies & Associates agency in Murray Hill, N.J.

'Through the facility we will represent a much larger volume of business and will be able to talk turkey with our carrier,' Mr. Ulrich says.

"One of the charges I have for the coming year is to study the feasibility of establishing an MGA" on a national basis, said Mr. Davies.

Several insurers that Mr. Davies has contacted are interested in Tri-State Facilities, he said. And, he added that those insurers are interested in the concept on a national as well as a local basis.

Although the PIA as yet has not taken an official stand on forming MGAs, Mr. Davies said, "I think it is a benefit both to the agency plant and the company plant.

"If a company has a relationship with an agency, and for some reason the growth of the agency is stymied, companies want off that business," Mr. Davies said.

"If the company can somehow consolidate the business of more than one of these agencies, it can retain that business. An MGA gives the agency more viability."

He said an MGA not only can cut an insurer's expenses, but also can offer an agent more flexibility in placing business.

Although Tri-State will be of particular value to smaller agencies that do not produce a great deal of premium volume, larger agencies can benefit, too, Mr. Davies said.

For instance, he said, even though an agency may have a large overall book of business, it may have only a small percentage of that business placed with one particular insurer that offers a product or products that the agency cannot obtain from other insurers.

If that insurer imposes a minimum premium volume requirement on the agency, even a larger agency may find itself faced with the prospect of having its contract terminated, Mr. Davies explained.

In addition, an MGA can be of real benefit to a new agency, he said.

"We're always concerned about how we can generate new blood into the agency system," he added. ■

PIA of Texas delaying plan to form MGA

By LINDA J. COLLINS

AUSTIN, Texas—The Professional Insurance Agents of Texas, which announced its own plans to form a managing general agency last fall, has put that project on the back burner.

Unlike the MGA formed by the PIA of New York, New Jersey and Connecticut, which was designed primarily to provide additional market options to existing agencies, the facility envisioned by the PIA of Texas was to be used in conjunction with a training program specifically for new agents.

"The PIA of New York, New Jersey and Connecticut had to react quickly, because their problem was today," said Steven Hacker, executive vp of the PIA of Texas, referring to associations' goal of finding markets for member agents (see story, page 34A).

The PIA of Texas, however, did not feel such an urgency because its MGA is planned basically as a training program.

In addition, Mr. Hacker said the tightening property/casualty insurance market has resulted in a lack of available reinsurance for the business that would have been written by the Texas MGA.

'There is no question that the MGA would have business. . .it would be swamped,' Mr. Hacker said.

Demand for the MGA would be great in today's market, Mr. Hacker admitted. "There is no question that the MGA would have business; in fact, it would be swamped. . .In this market agents will respond to anything that provides them with a glimmer of hope."

He said that when the PIA of Texas began to consider forming an MGA, it was interested in helping to establish new agents entering the insurance industry.

"Most carriers are demanding that agencies produce a minimum volume of from $100,000 a year upward, so for a new agent the only choice is to buy an existing agency," which in some cases is not economically feasible, he said.

"We planned to create a wholly owned MGA to help these people become qualified agents. It would be accompanied by a training and educational program we already have in place."

He said that, as envisioned, the new agents would place business through the MGA for two to three years, and "at the end of that time, the agents would leave the nest with an established track record, a professional designation and their own book of business."

Although the PIA of Texas has put a hold on its own plans for the time being, Mr. Hacker complimented the PIA of New York, New Jersey and Connecticut for starting its own MGA.

"They ought to be commended for their creativity and innovation," he said. "The industry ought to take note of the fact that there are no rules written to say that agents' associations can't change the distribution system.

"Right now, the mechanism through which insurance products are delivered to the consumer is company-driven, and this is causing a lot of problems for agents," Mr. Hacker explained. ■

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CGL form a radical change, panel says

By LINDA J. COLLINS

HONOLULU—The Insurance Services Office's new commercial general liability claims-made policy represents such a radical change that, "If you fell asleep today and woke up a year from now, you wouldn't recognize this as the insurance business as you know it today," an agent says.

And the CGL claims-made policy, which is scheduled to be implemented Jan. 1, is not the only policy form change facing agents in the coming year, said Alan R. Nelson, vp of the Winona Agency in Winona, Minn.

"All the commercial forms, not only the CGL but also property forms, business interruption, etc., everything is changing on Jan. 1. . . .And every day there is something different," he said, noting that the forms are still undergoing changes.

Mr. Nelson participated in a panel discussion on "The CGL Controversy" held during the Independent Insurance Agents of America's annual convention, held last month in Honolulu.

The so-called stacking of limits, through which courts assign liability for the same claim to more than one insurance policy, prompted ISO to introduce the claims-made policy, said William E. Brady, vp of Crump/Kindler & Laucci Insurance Brokers Inc. in Long Beach, Calif.

Mr. Brady, who also is chairman of the IIAA's Commercial Lines Committee, served as panel moderator.

Mr. Brady explained that the first claims-made policy designed by ISO in 1978 to address the problem of stacked limits was "much removed from the contract we have today." The current version of the claims-made policy, he explained, incorporates many of the changes proposed to ISO by the IIAA's Commercial Lines Committee.

Mr. Brady

Defense stacking of limits has been made possible by court interpretations of when coverage is triggered in long-latent injury claims, Mr. Nelson explained.

The courts have used three basic theories for when coverage is triggered:

- The exposure theory, in which the policy in effect at the time the claimant was exposed to the substance that caused the injury is the policy that covers the claim.
- The manifestation theory, in which the policy in effect when the disease or injury is manifested is the policy that covers the claim.
- The exposure-in-residence theory, better known as the triple-trigger theory, in which the policy in effect when the claimant was exposed and all policies in effect until the disease or injury manifests itself cover the claim.

Mr. Nelson said that the courts in this case consider coverage to be in effect during the entire gestation period.

This stacking of policy limits has created serious problems for insurers, which are finding themselves liable in 1985 for injuries covered under general liability policies they wrote—and priced—decades ago, Mr. Nelson said.

"The stacking of policies was never the intent" of the occurrence form, Mr. Nelson pointed out. "And that's the big reason why we are switching to the claims-made form."

Mr. Nelson also noted that insurance companies that write liability coverage on the current occurrence form "never know when they're done."

Because some injuries may not show up for years after the occurrence that caused them—and that will trigger the occurrence policy—claims can come in years after the policy has expired.

Insurers "can never count their pennies and see how much profit they've made for the year, because it's unknown," Mr. Nelson explained.

The claims-made policy is much easier to interpret, Mr. Nelson said.

"The claims-made policy responds to losses that occur after the retroactive date, if any, in the policy, and for which a written notice of a claim is received from an injured party."

However, the IIAA still sees a problem with the claims-made form that it is working with ISO to correct. The IIAA says there are several ways a policyholder could be left without coverage under the contract.

Mr. Wood

C. Courtney Wood, vp of Marsh & McLennan Inc. in Oklahoma City and a member of the IIAA's Commercial Lines Committee, said that the trigger mechanism in the claims-made policy could be a problem for policyholders because notice of an occurrence

Continued on next page

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New CGL form

Continued from previous page
is not notice of a claim.

But the policyholder, under the terms of the policy, must notify the insurer as soon as the policyholder is aware that an accident or injury has occurred, even though the policy will not respond to the occurrence unless written notice of a claim is filed before the policy expires.

Thus, Mr. Wood pointed out, "once the notice has been turned in, particularly if it has a very severe potential, the insurance company is sitting on notice of a time bomb."

Mr. Wood suggested the following scenario:

The insurer "knows the accident has happened. They know someone's hurt bad and there's a probability that the insured was negligent, yet no claim has been made against the insured in writing and we're nearing the completion of the policy period."

If no claim is filed during the policy period and the policyholder wants to renew the policy, Mr. Wood said, the insurer is likely to say, "Yes, I'll renew the policy, but I want to advance the retroactive date a year."

The retroactive date of the policy usually will be the date of the first claims-made policy. But in this case, if the insurer insists on moving the retroactive date forward, it will mean that any claims that ultimately are filed from that occurrence will not be covered under the renewed policy.

So, if the policyholder wants to maintain coverage for that incident, he or she will be forced to purchase the extended discovery period endorsement, he said.

Under the terms of the claims-made contract, insurers have to offer the extended discovery period, or long-tail, endorsement to their clients, but they can charge up to 200% of the cost of the expiring policy for the endorsement, Mr. Wood explained.

'It is very likely every insurer will put a retroactive date on the first claims-made policy that is the inception date of that policy and will attempt in every way to maintain that retroactive date from that date forward,' says Mr. Savage of ISO.

In short, he quipped, "What's wrong with the trigger mechanism is that the insured can't pull it."

Mr. Nelson pointed out two other situations in which the policyholder virtually would be forced to purchase the long-tail coverage:

- If the insured changes back to an occurrence form from a claims-made policy, since the occurrence policy would cover only situations that occurred while it was in effect, and not situations that occurred while the policyholder was covered by the claims-made policy. And, the claims-made policy without the tail coverage also would not cover those claims, because they would not be filed while the claims-made policy was in force.
- If an insured goes out of business or retires. The insured should purchase the tail in this case because claims may still come in for injuries that occurred during the policy period.

The retroactive date of the new claims-made policy, like the policy's trigger mechanism, was designed to eliminate insurers' problems with losses that have occurred but have not been reported, Mr. Wood said.

"If there were no retroactive date, the new claims-made policy would look off into infinity practically, trying to provide coverage for incidents that have taken place in the past and for which no written claim has ever been made against the insured," he explained.

Still, Mr. Wood reiterated, he is concerned that insurers may advance the retroactive date to avoid liability for claims they know about but that have not been filed.

Richard R. Savage, executive vp of ISO, says he does not expect insurers to move up the retroactive date on a regular basis.

"It is very likely every insurer will put a retroactive date on the first claims-made policy that is the inception date of that policy and will attempt in every way to maintain that retroactive date from that date forward," Mr. Savage told agents.

Mr. Savage

Mr. Savage said that for the first five years the claims-made policies are in force, insurers will reduce the premium they charge to insureds since the form will only cover claims filed since the retroactive date. And he added that if the insurer advances the retroactive date, it will also charge reduced premiums on that account for the next few years.

Although the insurer could collect premiums of up to 200% of the expiring policy's premium by forcing the insured to purchase the extended reporting period endorsement, Mr. Savage said that amount would be offset by the reduced premiums the policyholder would pay during the first years it is insured under a claims-made form.

Mr. Savage added that if an insurer advanced the retroactive date, it would "destroy the relationship" between itself and its client.

In addition, he said that insurers will not want to put themselves into a position where they would have to provide tail coverage to clients, even for a charge of up to 200% of the expiring policy's premium, because then coverage for claims that occurred during that time period would be covered indefinitely until that policy's limits were used up.

And, Mr. Savage said, if a policyholder changed insurers, the new insurer also would have a strong incentive to maintain the retroactive date of the prospect's existing policy in its coverage, he said.

If there is a substantial known loss for which claims have not been made by the time the current policy expires, he said, the new insurer may attach a "laser" endorsement to the policy that will exclude that loss but will permit all other incurred-but-not-reported losses during the policy period.

But, if the new insurer adds that endorsement to the claims-made policy, it also must add another endorsement that gives the policyholder an automatic 60-day mini-tail and the option to purchase full tail coverage for the specific accident or product excluded by the first endorsement.

Also participating in the panel discussion was R.C. Riley, chairman and chief executive officer of Peel & Holland Inc., an agency in Benton, Ky. Mr. Riley, who is chairman of the IIAA's Pollution Task Force, talked about the pollution exclusion under both the claims-made and the occurrence CGL forms.

He also covered this topic at a special breakfast seminar held as part of the convention (*BI*, Sept. 30). ■

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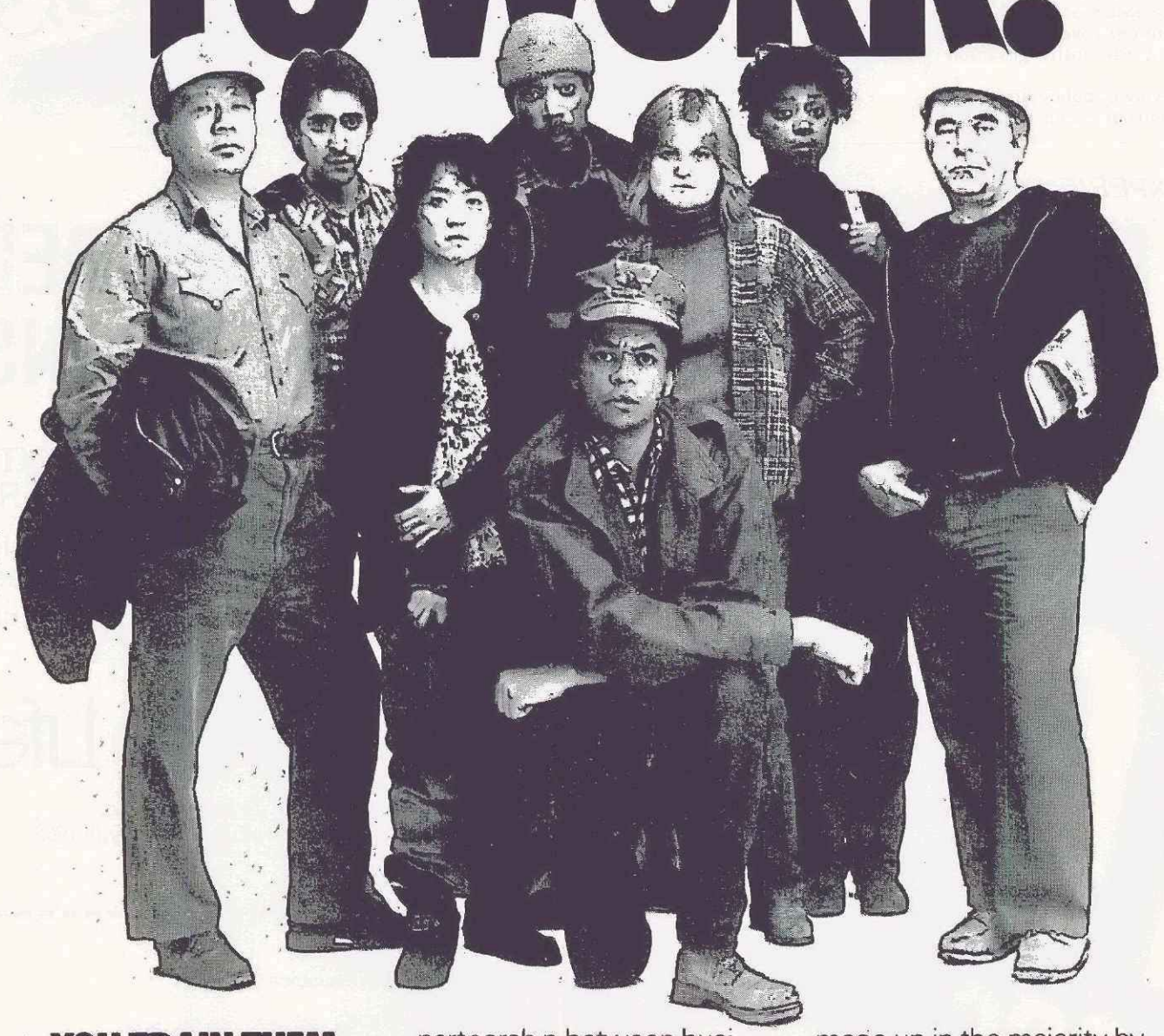

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Agents must be willing to change: Insurer exec

By LINDA J. COLLINS

HONOLULU—Agents must update their operations to keep pace with the changing marketplace, one insurance company executive says.

"All segments of the industry are symbiotic" and current market problems illustrate that the industry "cannot hold onto the technologies of the past and still move ahead," John P. Mascotte, chairman and chief executive officer of New York-based Continental Corp., told agents attending the Independent Insurance Agents of America's annual convention.

In advising agents how to move ahead profitably, Mr. Mascotte recommended that they look carefully at individual staff members to determine whether they balance or accentuate their agencies' strengths.

"Have the individuals on your staff been given a fair and adequate chance to grow?" Mr. Mascotte asked.

Agents must be willing to stimulate the growth of their staff members by supplying educational support and by recognizing initiative, he said.

And, if the agency's employees do not take advantage of such opportunities for growth, he said that perhaps agents should question the employees' role in the agency.

Agents should also determine the lines of business employees enjoy and excel in, so they can focus on and specialize in those lines. In fact, that specialization can reflect favorably on an agent in clients' eyes, Mr. Mascotte said. "You don't have to be equally good at everything. None of us can be."

Another area that agents should examine carefully is their books of business, in order to determine which clients take up too much of the agency's administrative time, lose money for the agency or cannot be adequately served by the agency.

"You do have clients who cost you money. Eliminate those sources of revenue who eat up more in costs than they bring in."

Mr. Mascotte also urged agents to reduce the number of insurers with which they do business.

"Companies may be pompous and bureaucratic, but we are not dumb. If you will negotiate meaningful, long-term relationships with your insurers. . .you will find companies that will make commitments to you."

He stressed, however, that he was not suggesting that agents consider exclusive company representation.

Agents should also automate their agencies, Mr. Mascotte advised. They need to purchase equipment that conforms to agency standards to interface effectively with insurers in the future, he said.

In addition to automating, "Don't be afraid to invent new manual systems for your agencies if it will help you utilize your automation systems more effectively," he urged.

And, agents need to make an all-out effort to increase their sales, Mr. Mascotte added. He pointed out that, over the last several years, the independent agency system's share of the nation's property/casualty premium has been shrinking, but "the top 5% of the agency system is the most rapidly growing segment of the industry."

Overall, the agency system is healthy, Mr. Mascotte said.

"Systems don't fail. Agents fail," he stressed. "Individuals inside the system have not performed the way they should."

In efforts to plan for the future, Mr. Mascotte said agents should keep in mind that:

- The economy is interdependent with the insurance industry.
- The insurance business is becoming increasingly international.
- Industry changes can occur with great speed.
- Insurers can be "awfully stupid," and can make life for themselves and for independent agents "very turbulent."

If agents focus on development of relationships with insurers, staff and clients, and develop new ideas and attitudes toward the industry, they will "reap the benefits of growth, pride, status and profits," Mr. Mascotte concluded. ■

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THE HEALTH PLAN OF AMERICA

Future won't be easy for agents: Panelists

By LINDA J. COLLINS

HONOLULU—Independent agents face a variety of thorny problems in coming years, a panel of industry experts says, including how producers should be compensated and whether agents should reduce the number of insurers with which they do business.

The panel—composed of an agent, a broker, a reinsurance intermediary and an insurer—looked at these and other issues during the Independent Insurance Agents of America's national convention, held Sept. 8-12 in Honolulu.

The panel predicted:

- Agents and brokers will do business with a smaller number of insurers.
- Insurers will start offering alternatives to traditional commission compensation.
- Small independent agents face an uncertain future.

In efforts to cut expenses, as well as develop better relationships with insurers and receive improved support services, agents and brokers will cut back on the number of insurers with which they do business, the panelists said. However, this might not be practical for smaller agencies, some noted.

They cited as an example the contractual agreement between Frank B. Hall & Co. Inc. and Royal Insurance Cos., in which Royal will underwrite all new personal lines business produced by Hall that is not part of the broker s mass-marketing programs.

John F. McCaffrey, chairman and chief executive officer of the Briarcliff Manor, N.Y.-based brokerage, said the arrangement was a logical move for both companies.

Before the deal was struck, Hall's more than $50 million in personal lines business was placed through 74 insurers with claims service "all over the map," he said, adding that the broker felt it was necessary to consolidate the business.

Such a consolidation probably is feasible for major brokers and insurers, but "it won't work for the average agency," said Richard G. Taylor, the new IIAA president and also president of Grant-Hatch & Associates Inc., a Salt Lake City-based agency.

Insurers are more likely to maintain agreements with a large broker like Hall, which has a lot of clout, than with small agencies that cannot provide a large amount of business, Mr. Taylor said.

However, he added that he'd consider going with one market for personal lines if he could find a single insurer that would provide his agency with consistent support.

Once an insurer comes to an agreement with an agency, "it needs to be kept," Mr. Taylor said. "Where I'm having problems is agreements are not being kept."

"Directionally, both companies and agents see the need to gain efficiencies by reducing the number of companies represented," said Edward H. Budd, chairman and chief executive officer of The Travelers Insurance Co. in Hartford, Conn.

He argued that insurers will be willing to respond to agents by maintaining markets if the agents agree to that commitment.

The method by which agents are compensated may change in coming years from the traditional commission method to the zero-based commission, where the agent negotiates the fee needed to service a particular piece of business, panelists noted.

Mr. Budd said that while zero-based commission arrangements are being made between insurers and larger agencies or brokerage houses, such arrangements are not practical for smaller agencies because their accounts are smaller.

And, Mr. Taylor said that while zero-based commissions are appropriate in some situtations, he wouldn't want to see insurers completely stop offering agents a guaranteed commission.

The panel also debated whether current commissions being received by agents are too high.

"Commissions are never too high," said Hall's Mr. McCaffrey.

But, Mr. Budd said insurers should not let premium hikes brought on by the hardening market make them lose sight of their need to remain competitive.

In the long-term, it will be consumers who determine if commissions are too high, he added.

In fact, consumers already are now protesting agent commissions by challenging anti-rebate laws in both Florida and California, observed Mr. Taylor.

Panelists also disagreed about the future of small agencies.

While Travelers' Mr. Budd said that one- or two-person agencies face a short life in today's marketplace, Grant-Hatch's Mr. Taylor maintained that "it depends upon where the agent is located."

Some insurers are committed to rural agents who do not have the volume to run a bigger operation, he said, and the solution for these agents is to plan ahead and look at all their options, such as cluster arrangements.

And, "If agents can make themselves so valuable that the companies can't do without them, they will stay in business," Mr. Taylor added. "I think companies will go with the agency that is profitable."

Mr. Budd told the IIAA conference that, generally, the independent agency system has a lot going for it, but "it has deficiencies and inefficiencies that we're working very hard to correct."

He predicted that today's market problems will bring a thinning out process in the insurance industry.

"Quality companies, agencies and reinsurers will survive and prosper," he said, but others that are not so professional will fail.

"If we step back for a second and look at the property/casualty business, what is happening in our business is really not all that much different than what is happening in other segments of the financial services business," said panelist James J. Meenaghan, president and chief executive officer of John F. Sullivan Co., a reinsurance brokerage in Seattle.

He closed on an optimistic note, saying: "The quality independent agent should start to feel increasingly positive about things.

"The basic underlying health of the business is improving," he stressed, including the strengthening of rates, insurer surpluses and loss reserves. The correction process is well under way."

Moderating the panel was Joseph P. DeCaminada, president of the Society of Chartered Property & Casualty Underwriters and senior vp of The Atlantic Cos. in New York. ■

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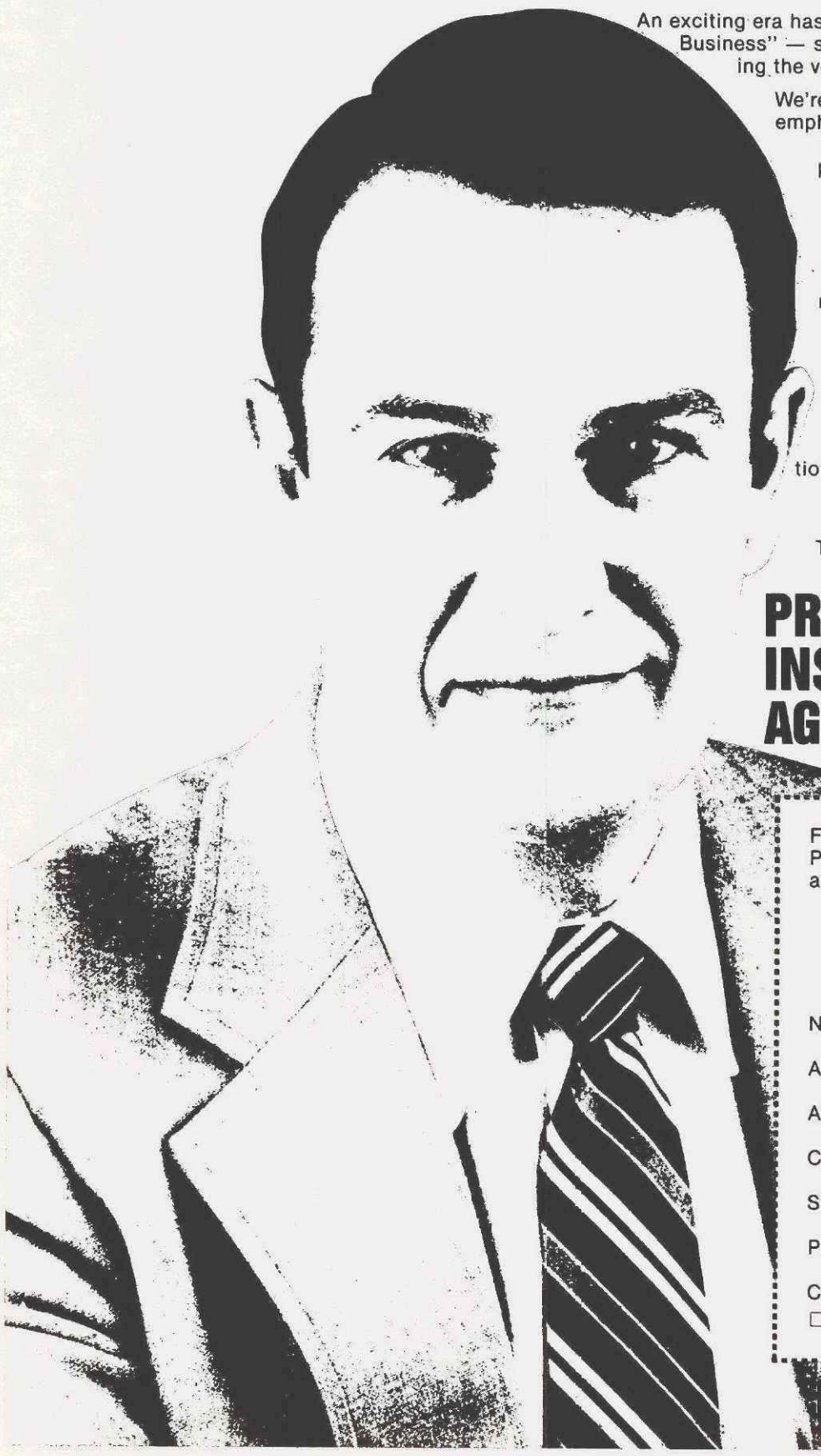

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Agent groups help: England

By LINDA J. COLLINS

HONOLULU—Agents can bring about changes in the industry through membership in an agents' association, says the outgoing head of the Independent Insurance Agents of America.

Frederick J. England Jr., president of Hastings-Tapley Insurance Agency Inc. in Cambridge, Mass., said the IIAA's lobbying efforts on its own and other industry trade associations' behalf help strengthen the insurance industry.

Speaking at the IIAA's national convention last month in Honolulu, he said the association has lent its support in several important areas affecting the insurance industry.

The group is lobbying to amend legislation reauthorizing the federal Superfund Act, to combat bank entry into insurance, and to fight current tax reform proposals.

In addition, the IIAA is supporting adoption of national agency automation standards and the use of the IVANS agency/company/vendor interface network (*A/BT*, Sept. 3, 1984).

The IIAA also has been working with the Insurance Services Office to amend its new commercial general liability policy forms before their scheduled introduction in January, Mr. England said. And, it has held discussions with ISO on plans to include defense coverage within CGL policy limits beginning in July 1986.

Agents have been faced with a year of difficult challenges in a business environment "piled high with frustrations," Mr. England said. He said three areas of concern during 1985, on which the IIAA will keep tabs, include:

- The prospect of far-reaching coverage changes stemming from ISO's new CGL forms and its proposal to include defense costs within policy limits.
- Alarm among reinsurers and others over increasing U.S. exposures due to a "judicial system gone awry."
- A major shift from a competitive to a hardening insurance market accompanied by underwriting restrictions and "significant coverage unavailability."

In summary, Mr. England urged agents to "serve the needs of our industry both with responsibility and responsiveness. . .This is the time to search within ourselves for the best there is and openly to offer it." ■

Photo: Linda J. Collins

Richard Taylor, left, follows Frederick England Jr. as IIAA president.

Insurers, agents need cooperation

By LINDA J. COLLINS

HONOLULU—The "adversarial relationship" between agents and insurers will have to change if the independent agency system is to survive, one insurance company executive warns.

"In isolated cases there has been a positive response, but the vast majority of agents and companies have not moved far enough or fast enough toward the kind of strong partnerships that can substantially enhance their competitiveness," said Edward J. Noha, chairman and chief executive officer of CNA Insurance Cos.

Mr. Noha

Mr. Noha, who spoke to agents attending the annual convention of the Independent Insurance Agents of America, said today's hardening property/casualty insurance market has driven some agencies and companies into an even more adversarial relationship than in the past.

In this type of a market, he added, "agents more than ever require the assurances and the guarantees of a market that only a committed partner can produce.

"The temporary pressures of a tight market must not blind us to the fact that we have to close ranks —as partners—if we are to become more competitive," Mr. Noha stressed.

Agents have presented insurers with a variety of problems, he said, including:

- Dividing an agency's premium volume among too many insurance companies, so that insurers spend more money processing the business than they earn from the agents' books.
- Spending too little time prospecting for new clients and developing their existing books of business.
- Selling products as commodities rather than services, and focusing on the sale rather than customer service.

In turn, insurers have created their own problems by "suicidal rate wars, insufficient reserves and depleted surpluses," Mr. Noha commented.

Cheap reinsurance also helped to "fuel the competitive fires," Mr. Noha said.

Agents and insurers must learn how to work together and cooper-

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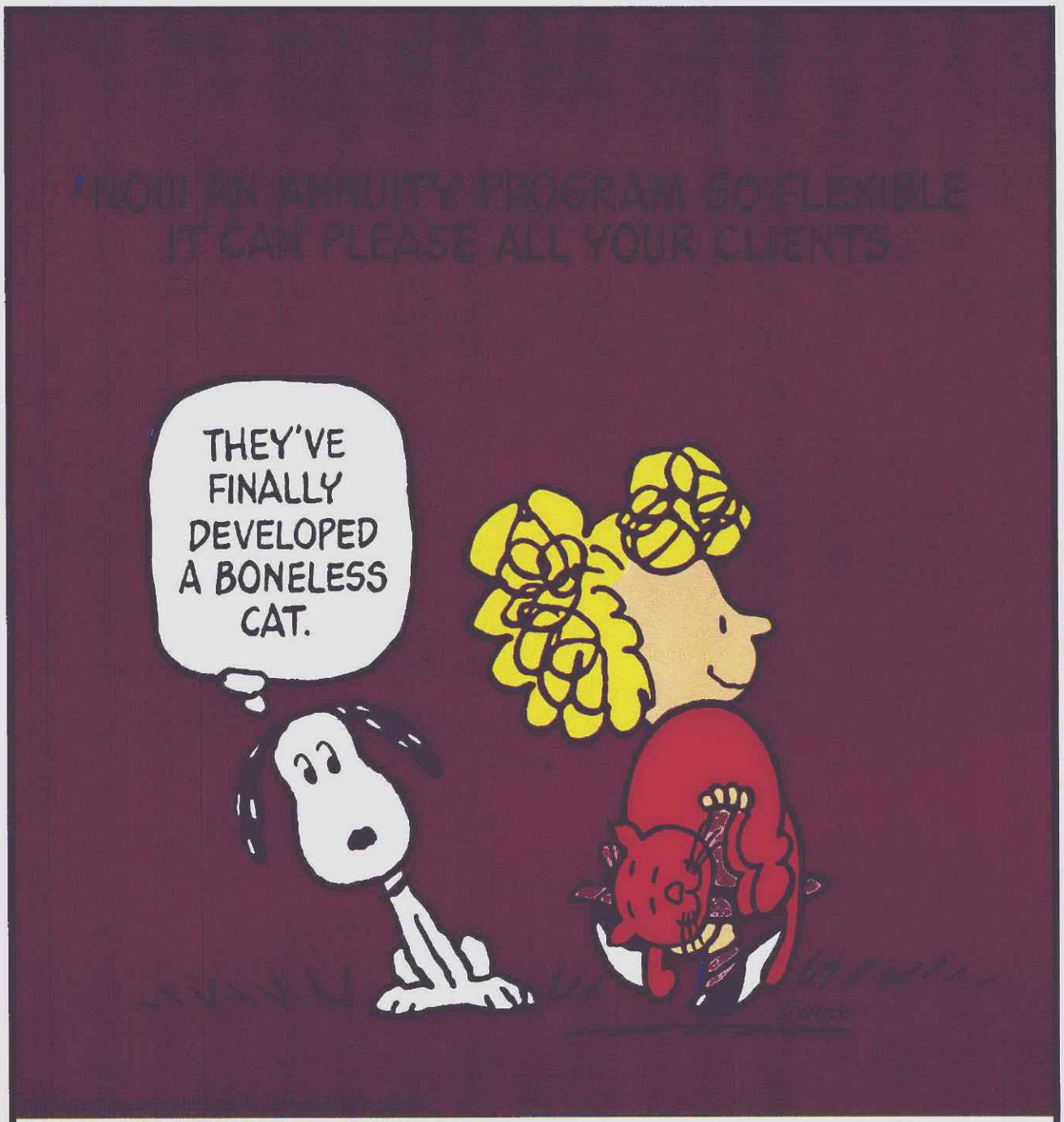

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Noha addresses IIAA

Continued from preceding page

ate in order to win back market share from their competitors in the business, he said.

This will become necessary in the future. Mr. Noha predicts, when the number of independent agencies declines.

"Some companies will consolidate, some will turn to specialty niches and some may go under," Mr. Noha explained.

"And I'd predict that those companies still utilizing independent agents will be reluctant to deal with agencies that offer them only minimal shares of their volume," he added.

Trust must be built between these two industry "partners," Mr. Noha said, stressing that "trust is not built by chronic shopping of business or by low (market) penetration or by invariably submitting mediocre to poor business or by marketing the product as a commodity.

"Trust is not built by companies that are financially floundering or by companies that walk away from commitments made in the past. . .or by companies that carve out a huge block of business that ignores the independent agent," he added.

Mr. Noha said that if agents and insurers teamed up, they could be effective in confronting major industry concerns, including:

'Trust is not built by companies that are financially floundering or by companies that walk away from commitments made in the past,' says CNA's Edward J. Noha.

- A provision in the Reagan administration's tax proposal that would require property/casualty insurers to discount loss reserves. Currently, insurers can deduct reserves for claims to be paid in the future. But, under the Reagan proposal, they would not immediately be able to take full deductions for those reserves.
- The current crisis facing the civil justice system, which "threatens the viability of the entire insurance mechanism.

"The system is sick," he said. "Medicine like the proposed claims-made commercial general liability policy may temporarily mask the symptoms. But, it is not a cure because it does not strike at the causes of the illness." ■

a/bt info

- The Insurance Information Institute has released a revised and expanded edition of "Sharing the Risk." The 192-page book provides a wide range of **information about the property/casualty insurance industry**. The expanded edition includes a revised section on homeowners insurance and new sections on insurance career development, satellite insurance, financial guarantee funds, environmental pollution coverages, occupational diseases and the Insurance Services Office's new comprehensive liability policy. Copies are $4.95 each, or $3 for three or more. They can be ordered from the III, 110 William St., New York, N.Y. 10038.

- The cost of hiring and training an insurance agency producer —and the producer's value to the agency—have prompted agencies and brokerages to consider **career development plans for agency employees**. Such a plan is outlined in a free brochure from the Insurance Institute of America. The brochure, "Career Development Plan for Property/Casualty Production People," was published by the IIA in conjunction with McDonough Caperton Insurance Group in Charleston, W.Va. It outlines McDonough Caperton's performance expectations for employees and lists training and continuing education resources and expense and reward policies. It also includes a chart that lists voluntary and required career development activities for new and developing employees and professional producer/account executives. Order from the IIA, Public Relations Department, 720 Providence Road, Malvern, Pa. 19355-0770; 215-644-2100.

- Members of the National Assn. of Professional Insurance Agents can now obtain **Best's Advanced Rating Reports** on any insurance company at a 50 % discount through the association. Available for $7.50 per company, the reports contain five years of information on the insurer's premiums, operations, profits, leverage, loss reserves and general financial outlook. Reports are available on 1,700 property/casualty and 1,500 life/health insurers. To receive the special discount, PIA members should send a check made out to A.M. Best Co. to PIA-BARR Offer, A.M. Best Co., Ambest Road, Oldwick, N.J. 08858.

- Self-study materials are available from the Insurance Services Office to explain the new claims-made and occurrence forms for **ISO's new commercial general liability policy** as well as the new forms for commercial property, crime, inland marine, and boiler and machinery. The material is designed to acquaint agents, brokers, company underwriters, raters, claims personnel and others with the key aspects of the new forms. Two packets of material are available: One covers the new forms, endorsements and policy-writing rules, and the other covers classifications, rates, rating rules and codes. Packets include workbooks, reference guides and a booklet providing an overview on the CGL changes. Packets are $7.50 each, or $175 for a box of 25. An order blank may be obtained from Michelle Everett, Corporate Communications Department, ISO, 160 Water St., New York, N.Y. 10038.

- A total of 29 essays on **the art of salesmanship** have been compiled in the book "Selling is a Personal Affair," by H. Gordon Bethards. The book is designed to help the experienced salesperson hone selling skills. The 185-page softbound book is available for $9.95 from Century Communications Inc., Department A-28, 5520-G Touhy Ave., Skokie, Ill. 60077.

- **A step-by-step business planning guide for insurance agents and brokers** is available from IIR/ACORD to help producers set short- and long-term business objectives. The guide and workbook, "Formula for Success: An Agent's Guide to Business Planning," helps an agency mathematically diagnose its financial health and evaluate and update its existing business plan. The softbound guide is available for $12 per copy, or $6 each for 50 or more copies, from IIR/ACORD, P.O. Box 253, Kendallville, Ind. 46755, or P.O. Box 120, Tracy, Calif. 95376. ■

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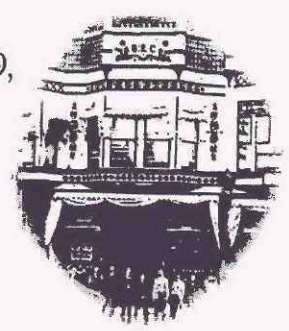

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Independent agents' market share grows slightly

NEW YORK—Insurers that market their products through the independent agency system increased their property/casualty market share for the first time in more than 10 years, according to statistics published in the 1985 Best's Executive Data Service.

In 1984 the market share of these insurers rose slightly to 60.7% from 60.6% in 1983. Much of the increase is attributable to a boost in these insurers' share of the private passenger auto business, which rose to 39.3% of the market from 38.8% in 1983.

Independent agency system companies experienced a loss in homeowners' market share in 1984 to 53.3% from 53.7% in 1983. This represents the smallest loss in homeowners' market share in five years.

However, insurers writing business through independent agents and brokers continue to control more than 80% of the commercial lines market, according to the statistics.

Civil justice reform

WASHINGTON—The National Assn. of Insurance Brokers has adopted civil justice reform as its top-priority public policy issue for 1985-1986.

The association's president, Robert H. Moore, senior vp of Alexander & Alexander Services Inc. in Washington, said, "Our present system of resolving disputes is costly, time-consuming and inconsistent, and the nation as a whole is the loser."

He added that the situation has reached the "crisis stage" and insurers are forced to pass along exorbitant court costs to their clients through rate increases.

He said consumers always have relied on their insurance brokers to help them manage their risks, and it is only appropriate that the NAIB should address the situation head on.

Computer change

NOVATO, Calif.—Fireman's Fund Insurance Cos. has announced that it is replacing its entire personal lines data processing system with a system that is built to IIR/ACORD standards.

Although IIR/ACORD has been working with the insurance industry for years to develop voluntary automation standards, Fireman's Fund is the first major insurer to replace an automation system that is already in place with one that conforms to IIR/ACORD's standards.

Other insurers have simply modified their existing systems to comply with some IIR/ACORD standards.

Fireman's Fund has signed developmental agreements with three agency automation suppliers to modify their systems to provide standard interface capability using IIR/ACORD standards. The insurer is also holding discussions with other automation suppliers to encourage them to join its initiative.

The insurer is designing its Personal Lines Underwriting System (PLUS) to provide faster turnaround time, greater accuracy and lower operating costs for both Fireman's Fund and its agents, the insurer says. The system is still in the developmental stage and will not be operational until sometime in 1987.

The insurer plans to modify its internal procedures and workflow to adapt to the new system.

Automation hot line

WHITE PLAINS, N.Y.—IIR/ACORD, a non-profit association providing services and developing automation standards for the independent agency system, has established a toll-free number for independent agents and brokers who need help with questions about automation.

Information is available on such topics as computer systems, networks, industry standards and technology trends. The toll-free number is 800-431-2720; in New York call 914-682-0800 collect.

Electronic coverage

GREAT NECK, N.Y.—Sterling & Sterling Inc., a brokerage firm in Great Neck, has signed an agreement with Western Union Corp. to provide commercial and personal lines insurance electronically to subscribers of Western Union's EasyLink and Telex services.

More than 1,000 types of insurance are available through Western Union's DIRECT SHOP program, including product liability, ocean marine, credit, travel, life and health coverages. Users simply identify a category of interest. An application form appears on the computer screen requesting all information needed to complete a quotation.

If the user then desires to purchase the coverage, he or she follows simple keyboard instructions and, if the coverage is acceptable, can complete the transaction immediately.

Data banks allow users to check rates for new coverage or compare rates against existing policies.

According to a Sterling & Sterling spokesman, the service will be available 24 hours a day, seven days a week.

Consultants listed

ALEXANDRIA, Va.—A new consulting program sponsored by the National Assn. of Professional Insurance Agents identifies consultants who are recognized authorities in one or more areas of agency operations.

Categories include:

- Mergers and acquisitions.
- Financial planning.
- Office procedures.
- Producer compensation.
- Accounting and audits.
- Estate planning.

PIA members can receive a program kit listing the consultants, their address and phone number, their background, areas of expertise, their fees and the regions of the country in which they are available.

The association's agency consulting committee reviewed the credentials of dozens of consultants to come up with the listing. For more information, write the PIA, 400 N. Washington St., Alexandria, Va. 22314. ■

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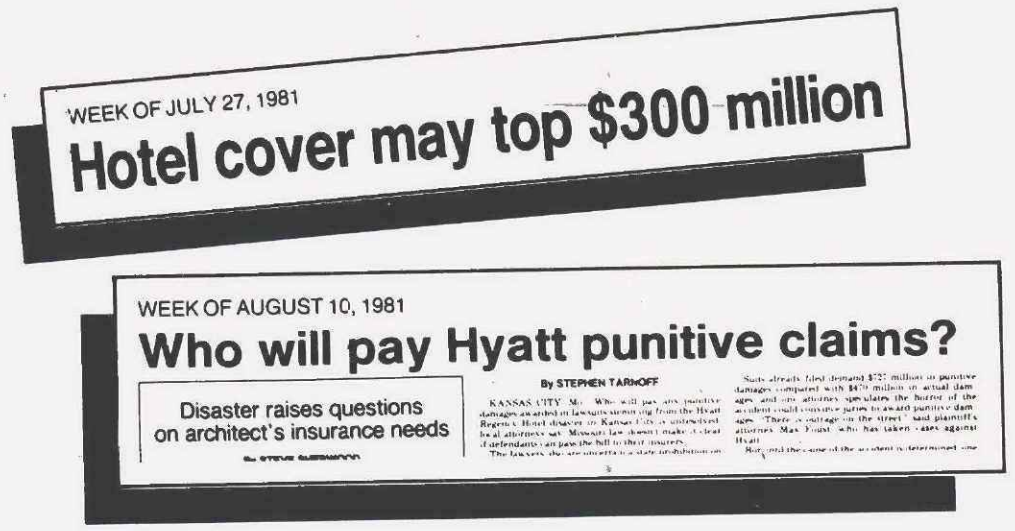

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$1.75 million in primary coverage with a $250,000 retention, said Mr. Jones of the district.

The transit district is still seeking $50 million to $60 million in excess coverage.

Mr. Jones said he feels "a little bit nervous" about operating the district's buses, which travel 35 million miles annually, with so little excess coverage.

The district's experience has been favorable, but the odds are that there may be a catastrophe, he said.

"Some are paying the first-quarter premium and praying for a miracle," said Mr. Jenkins of the Pennsylvania association.

In addition, he says, his own Cambria County Transit Authority has lost one board member and he expects to lose two more because he cannot find public officers liability insurance to cover them.

- Cutting back service.

Mr. Long's Blue and White Lines have parked 24 of its 86 buses and discontinued operations in Maryland, he said. Other cost-cutting measures included reducing some employees' wages. His company operates buses in Pittsburgh and Altoona, Pa.; Orlando, Fla.; and Phoenix, Ariz.

Despite the cutbacks, he will have to find more insurance soon because the Interstate Commerce Commission in November is doubling the minimum required limit of liability insurance to $5 million for interstate bus services with ICC charter rates.

Goodall's Mr. Ruane has cut his 30-bus fleet serving Southern California by at least 10% to 15%, he said.

This year, liability insurance rates for Mr. Ruane's school bus operation increased 350%, while his highway coach coverage was 500% higher.

Mr. Ruane said he will have to increase his business a minimum of 25% to "stay alive."

In addition, two small Florida-based bus services that primarily offered charters have stopped operating.

The dismal prospects some transit districts face has made their operators angry at insurers because they feel their loss experience has not warranted these insurance increases.

APTA's Mr. Batchelder said the operators all feel "very strongly" that there has not been a significant increase in their risk profile.

"We feel the insurance industry is grabbing at replacing their profits that were lost in 1984 in one year, and they are using our industry because we have no choice but to buy insurance," said Mr. Long of Blue and White. "It has been devastating."

But insurers disagree.

A spokeswoman for Lexington Insurance Co. in Boston, a unit of American International Group, Inc. said the experience her company has seen has been "rather poor" through 1984, although 1985 is somewhat better.

"We feel our pricing is appropriate according to underwriting standards," she said. However, she emphasized reinsurance capacity has shrunk while demand for coverage has increased.

In this line, Lexington primarily writes liability coverage for buses and has written $1.7 million in premium volume to date this year, compared with $400,000 last year. However, it has cut in half its maximum limits to $5 million from $10 million last year. It also has increased the required self-insured retentions to $500,000 from $100,000.

Richard Malus, secretary and director of commercial auto and general liability for The Hartford Group in Hartford, Conn., said Hartford's rates are up about 15% to 20% for school and church buses.

"A lot of that is experience rating and responsive to risk experience," he said.

He pointed out that stricter negligence standards apply against vehicles when they are operated for hire rather than for private use.

A spokesman for General Reinsurance Co. in Stamford, Conn., said, "Underwriters are pretty well strapped and (the transit risks') increased visibility doesn't help."

"If you have a loss, it can be a catastrophe," emphasized Richard Kropp, senior vp in underwriting for Shand Morahan & Co. Inc. in Evanston, Ill. ■

'Some are paying the first-quarter premium and praying for a miracle,' said Mr. Jenkins.

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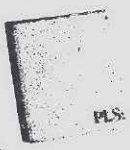

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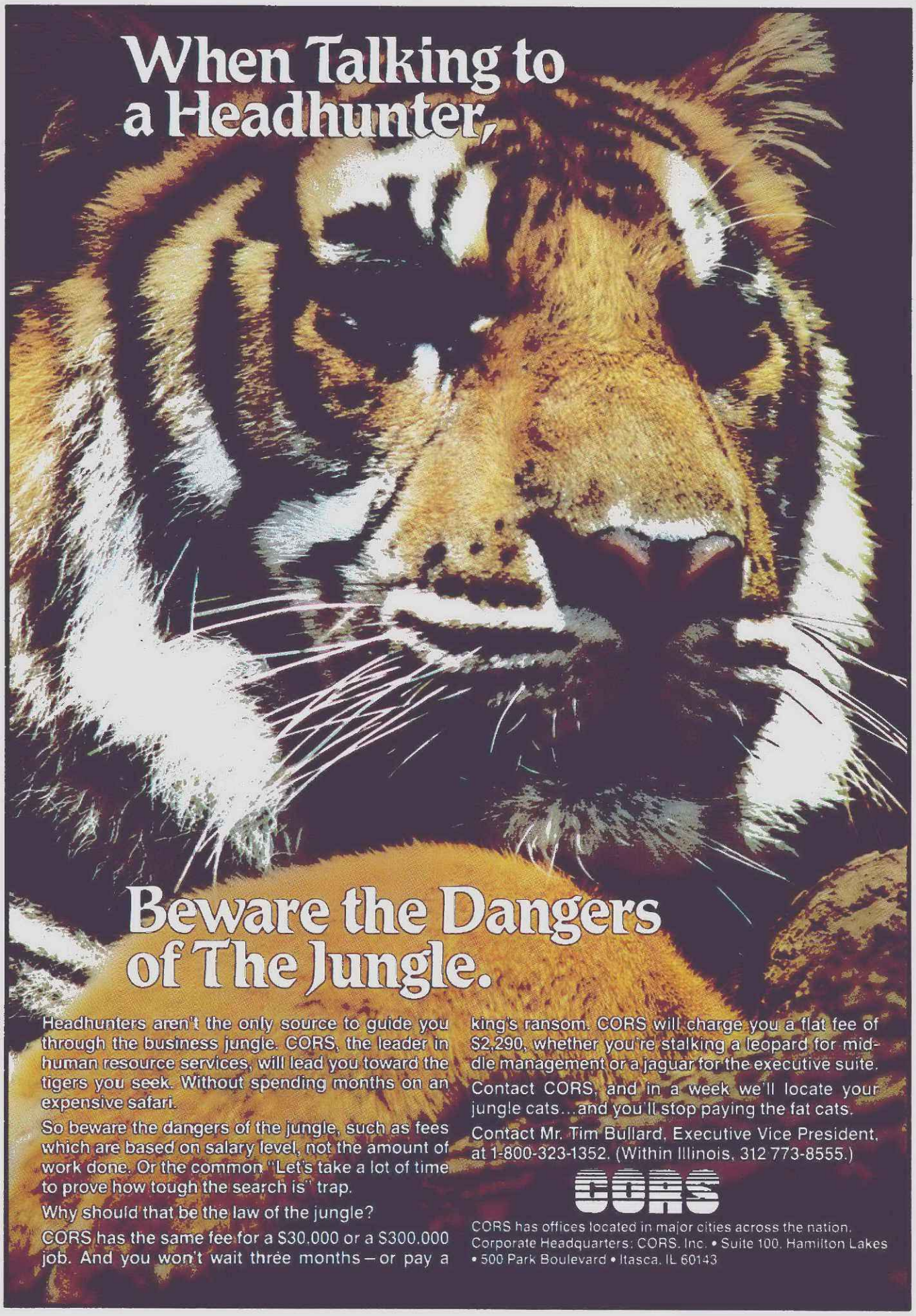

Clark leaves NAIC to manage IIE syndicate

John T. Clark has been named executive vp at Transco Syndicate #1 Ltd., one of the six new syndicates on the Chicago-based Illinois Insurance Exchange.

Mr. Clark, who will manage the syndicate, resigned Oct. 1 as director of financial services at the National Assn. of Insurance Commissioners in Kansas City, Mo.

Prior to joining the NAIC, Mr. Clark was with the Illinois Department of Insurance for 12 years, first as an examiner and then as an assistant deputy director.

Other excess/surplus changes:

James A. Dixon named president and chief operating officer of Floyd West & Co., an excess/surplus lines brokerage in Dallas. Mr. Dixon most recently served as vp-planning with U.S. Insurance Group.

comings & goings: industry

Agents/brokers

Curtis B. Oliver named president and chief executive officer of Frank B. Hall & Co. of Ohio Inc. in Cleveland. Mr. Oliver—who will be responsible for the company's Cleveland, Akron and Columbus profit centers—previously served as vp in charge of production and servicing of corporate insurance clients.

Mr. Oliver

Adrienne Soricelli named vp-claims/loss control at Ulrich Voorhees Warner Associates in Somerset, N.J. Ms. Soricelli, who joined UVW in 1978, previously served as claims manager.

George F. Higgins named senior vp at Johnson & Higgins in New York. Mr. Higgins, who joined the company as a senior adjuster in the New York Property Department in 1958, most recently served as vp.

Douglas Judson named president and chief executive officer of the Los Angeles/Pasadena division of Corroon & Black of California. Mr. Judson joined the division in 1979 and most recently served as senior vp and production manager.

H. Alan Rosenthal joins Cranwill Associates Inc. in New York as vp-structured claims settlements. Mr. Rosenthal previously was regional manager of Merrill Lynch Settlement Services.

Andrew T. Gabor named vp at Hilb, Rogal & Hamilton Co. in Richmond, Va. Mr. Gabor, who joined the company in 1980 and most recently served as assistant vp, will continue as controller.

Donald K. Bingham and **Sally A. Vukov** named vps in the Seattle office of Alexander & Alexander Inc. Mr. Bingham, who joined the company last year, is Northwest aviation and aerospace unit manager. Ms. Vukov, a unit manager specializing in professional liability, has been with A&A for eight years.

Reinsurance

Mark Anthony Zucco named vp at City Syndicate Managers Inc. and Home Re Syndicate Inc., subsidiaries of New York-based The Home Insurance Co. Mr. Zucco, who joined the companies in 1984, most recently served as manager and assistant vp.

Also at The Home, **Robert Wedlinger** named vp and **Abe Altman** named senior vp at The Home Reinsurance Co. Mr. Wedlinger joined Home Re in 1982 to manage its casualty claims operations.

Mr. Altman, who joined the company in 1984, most recently served as vp.

Charles B. Carter named vp and account executive at Cherry Valley, Ill.-based Mutual Reinsurance Bureau.

Gerard A. Dugan named vp at New York-based Skandia America Group. Mr. Dugan, who joined the company in 1979, will manage Skandia Group's claims operations.

Henry A. Walsh Jr. named senior vp at Reliance Reinsurance Management Inc. in Philadelphia, an affiliate of Reliance Insurance Co. of Philadelphia. Mr. Walsh, previously vp at General Reinsurance Corp., assumes responsibility for financial products and specialty programs.

Insurers

Robert D. Blood named vp-group financial services in the group insurance department at The Prudential Insurance Co. in Roseland, N.J.

Mr. Blood, who joined Prudential Insurance Co. in 1956, most recently served as director-group financial analysis in the group insurance department.

Thomas B. Heys Jr. named senior vp and chief operating officer of Provident National Assurance Co. in Chattanooga, Tenn., the group pension subsidiary of Provident Life & Accident Insurance Co. Mr. Heys, who also was named corporate vp of the parent company, joined Provident in 1974 and most recently served as senior vp at Provident National.

Mr. Heys

Kenneth A. Berkov named vp at Boston-based Liberty Mutual Insurance Co. and also becomes Pacific Division manager upon on the retirement of **Bryce McFall**. Mr. Berkov, previously division business sales manager of Liberty Mutual's Middle-Atlantic Division, based in Bala-Cynwyd, Pa., will be replaced in that position by **David Radakovich**, district manager of Liberty Mutual's Washington, D.C.-Maryland District.

Lawrence L. Grant named president of Viking Insurance Co. of Wisconsin in Madison, Wis. He succeeds **Donald W. Anderson**, who retired. Mr. Grant, who joined the company in 1983, most recently served as vp-operations.

Mr. Grant

Ned F. Goetzke named regional vp for the Syracuse, N.Y., region of Wausau Insurance Cos., based in Wausau, Wis. Mr. Goetzke, who joined the company's Milwaukee office in 1966, most recently served as Syracuse regional claim manager. Mr. Goetzke succeeds **Bill Wymore**, recently named se-

Continued on next page

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Mr. Brooks

Mr. Gaudet

Continued from previous page
nior vp at Wausau's corporate headquarters.

Robert D. Brooks named senior vp-claims at Westchester Fire Insurance Co. in Basking Ridge, N.J., a unit of U.S. Insurance Group. Mr. Brooks, who joined USIG's Atlanta branch in 1978, most recently served as USIG regional claims manager in Dallas. USIG is a Crum & Forster unit.

Also at Westchester Fire Insurance, **Douglas A. Gaudet** named vp-business account underwriting and **Thomas C. Schell** named vp-claims. Mr. Gaudet, who joined the company in 1983, most recently served as assistant vp-market development. Mr. Schell previously was assistant vp and general manager of residual market operations for the National Council on Compensation Insurance.

Other suppliers

Richard W. Echtenkamp named vp at Creative Settlements Inc., which is located in Buffalo, N.Y. In his new position with the firm, Mr. Echtenkamp will be responsible for negotiating structured resolutions of litigation involving business dispositions, personal relationships and bodily injury claims. ■

Mr. Echtenkamp

Colorado law allows state to self-insure

DENVER—The state of Colorado now has the authority to self-insure its general liability and automobile exposures.

Gov. Richard D. Lamm signed legislation Sept. 27 that allows the state to self-insure. The Colorado Legislature passed H.B.1001 during a special session last month.

The legislation was needed after Colonial Penn Insurance Co. of Philadelphia, citing a lack of reinsurance, notifed state officials in May that it would not renew the state's general liability and automobile coverages when they expired on Sept. 15 (*BI*, Sept. 23). And, the state received no bids from other insurers by its Sept. 9 deadline.

The bill establishes:

- A division of risk management within the state's Department of Administration. The division will be responsible for conducting a self-insurance program covering all state agencies and for supervising the investigation, adjustment and legal defense of claims against the state and its employees.
- A risk management fund of about $1.8 million to pay general liability and auto claims and associated legal services.

The money for the fund, to be transferred from 23 state agencies, originally was intended to pay for commercial insurance premiums during the the 1985-86 fiscal year.

- A state claims board, under the Department of Administration, to manage the fund and authorize settlements exceeding $100,000.

The maximum amount to be paid from the fund will be the same as the liability limits under the canceled coverage: $150,000 per person and $400,000 per incident. The state previously did not purchase excess insurance and will not do so under the self-insured program.

But, concerns that these limits are too low may prompt the Legislature to consider increasing the limits when it reconvenes in January, said Charles Howe, deputy attorney general.

The bill also defines the responsibility of the state for claims against state employees, he said..

Under the bill, the state is not liable for a judgment against a state employee if the court finds that the employee either acted beyond the scope of his duties or is guilty of "willful or wanton" conduct.

Although the state now can self-insure, the state would consider returning to the commercial market if rates become affordable, said Alan Levine, deputy director of the Department of Administration.

The bill contains a sunset provision and expires June 30, 1986. ■

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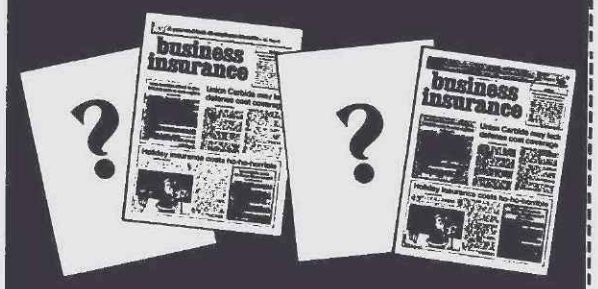

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• The **potential risks of video display terminal use** are covered in a pamphlet available from the Washington state Department of Labor and Industries. The pamphlet, entitled "Workplace Guidelines for VDTs" includes a summary of the findings of a committee of 13 government, health, business and labor officials on topics such as radiation, reproductive risks, vision and physical and mental stress. Free copies of the pamphlet can be obtained by writing to VDT Guidelines, Department of Labor & Industries, AX-31hy, P.O. Box 207, Olympia, Wash. 98504; 206-753-6497.

• A **back injury reduction kit** is now available from Darrell Heppner & Associates Risk Management Services. The kit includes 26-month case studies of three employers using the CompVest, which is a lower-back support vest manufactured by Comp Equipment in St. Paul, Minn. that can be worn on the job. The back injury reduction kit is available for $4.95 from Darrell Heppner & Associates, 154 Sunnyside Drive, San Leandro, Calif. 94577; 415-632-2200.

• "Arbitration Facts 1984-1985 Edition" is a 16-page booklet that details how insurers are turning to **arbitration to resolve claim disputes** rather than relying on costly litigation. The booklet describes how Insurance Arbitration Forums Inc., the nation's largest insurance arbitration organization, helped insurers settle disputes involving more than $335 million in claims in 1984. Insurance Arbitration Forums, a non-profit corporation supported by more than 1,100 insurers, currently administers 12 different arbitration programs. Single copies of the booklet are available free of charge from Insurance Arbitration Forums Inc., 200 White Plains Road, P.O. Box 56, Tarrytown, N.Y. 10591-0066.

• A comparison of medical rate levels of 18 **multiple employer trusts** is included in a brochure now available from Northwest Consulting Inc. Designed for use by actuaries, brokers and others interested in group health insurance, the brochure describes the company's MET rate comparison system. Free copies of the brochure can be obtained from Northwest Consulting Inc., 1756 116th Ave. S.E., Suite 204, Bellevue, Wash. 98004.

• Employees can find out how **good nutrition, regular exercise and controlling stress** can help them feel their best in "About Wellness," a booklet offered by Channing L. Bete Co. Inc. Prices for the booklets range from 69 cents each for 25-49 copies to 15 cents each for 50,000-99,999 copies. To order, contact Channing L. Bete Co. Inc., 200 State Road, South Deerfield, Mass. 01373; 800-628-7733.

• The International Foundation of Employee Benefit Plans is offering a reprint of "Benefits Basics: **Employee Assistance Programs** (EAPs)," an article published in the October issue of the organization's monthly newsletter. The article is aimed at people new to the field of employee benefits and discusses the history, advantages, costs and other issues of EAPs. Free copies are available from the Publications Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

• "Computer Security Issues and Answers" is a new magazine supplement being offered by the Computer Security Institute. The 24-page supplement contains eight articles on **computer information protection** by prominent authors, including FBI Director William H. Webster. For a free copy, send a self-addressed 9- by 12-inch envelope with 73 cents postage to Phyllis St. Martin, Department A5, Computer Security Institute, 43 Boston Post Road, Northborough, Mass. 01532.

• The effects of the increasing number of civil lawsuits on insurance rates and coverages are explained in a booklet offered by the Society of Chartered Property & Casualty Underwriters. "Breaking the Legal Logjam: Alternatives to the Courthouse" presents statistics on the increase in suits and discusses the use of **alternative dispute resolution** to reduce litigation. Single copies are free from the Public Relations Department, Society of CPCU, Kahler Hall, 720 Providence Road, Malvern, Pa. 19355; 215-251-2740.

• The Fisher Associates, an adjusting firm in Torrance, Calif., is offering a manual to analyze problems that result from the issuance of **additional insured endorsements and certificates of insurance**. The manual is available for $20 from Frederick J. Fisher, The Fisher Associates, 3465 Torrance Blvd., Suite N, Torrance, Calif. 90503; 213-540-8803.

• American Network Services Inc. is offering a videocassette training program to prevent **back injuries.** The "Freedom from Back Pain" program includes exercises and posture tips for developing and maintaining a healthy back in an effort to reduce losses resulting from back pain and injury claims. Products offered are "Relaxation Therapy Audiocassette," $12.95 each; a "Freedom from Back Pain Workbook," $4.95 each; and "Personal Concerns Inventory," $9.95 each. For information or to order contact American Network Services Inc., General Offices, P.O. Box 3039, Idyllwild, Calif. 92349; 714-544-1398.

• **General claims, medical malpractice** and **workers compensation** automation as performed by RISKMASTER software products is discussed in notebooks offered by Comtec Inc. "Second Edition: Computer Automation of Manual Functions Within Risk Management" also covers technical issues associated with operating the system software on personal computers. Cost is $4. Copies can be obtained from Comtec Inc., Risk Management Services and Products Department, 24350 Indoplex Circle, Farmington Hills, Mich. 48018; 313-478-8775.

• Rockwood Systems Corp. is offering publications to assist chemical companies in dealing with **environmental impairment liability**. The publications present methods for using water-based foaming agents in preventing the runoff of hazardous materials during fires. Free copies can be ordered from Rockwood Systems Corp., Department JS, 640 E. Main St., Lancaster, Texas 75146; 214-227-3100.

• **"The Effect of 404A Proposed Regulations on Foreign Plans,"** a reprint article available from Kwasha Lipton, discusses this section of the Internal Revenue Code affecting companies whose foreign branches maintain pension plans. Free copies are available by writing Department M, Kwasha Lipton, P.O. Box 1400, Fort Lee, N.J. 07024-1400; 201-592-1300 or 212-279-6800.

• Developing and implementing an effective **risk management information system** is the subject of "Pathways to RMIS: Guidelines for Acquiring, Managing and Using Risk Management Information Systems," a book offered by the Risk & Insurance Management Society. The book covers defining risk management needs, managerial control of RMIS development and acquisition and RMIS applications. Copies of the book cost $24.95 for RIMS members and $29.95 for non-members and are available from Risk Management Society Publishing Inc., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

• An anti-arson brochure is available from American Re-Insurance Co. The publication, "Arson—A Burning Issue," was designed to increase the awareness of the **problems of arson** and offer suggestions to reduce the incidence of the crime. The brochure includes an underwriter's guide and a fire investigation guide. Copies of the brochure can be obtained by contacting Linda Macklin, Director of Communications, American Re-Insurance Co., One Liberty Plaza-91 Liberty St., New York, N.Y. 10006; 212-618-7000.

• **"Employee Assistance Programs**: Their Impact on Health Insurance and Other Company Benefits" is a research report published by the International Foundation of Employee Benefit Plans. Author Joseph A. Madonia, who defines an EAP as "a workplace-centered counseling service provided to employees with behavior and substance abuse problems," summarizes the results of a 1984 study of two groups of Houston firms. The cost is $5 for IFEBP members and $9 for non-members, and copies can be obtained from the Publications Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

• A two-year study of **church property and personal injury losses** is the basis for a guide to the prevention of such losses published by The Atlantic Cos. The booklet suggests precautions church custodians, pastors and trustees can take to reduce the chance of loss due to arson, fire, burglary and storms. For a free copy of "Guarding the House of God," write Howard P. Hoskins, Corporate Communication, The Atlantic Cos., 45 Wall St., New York, N.Y. 10005; 212-943-1800.

• The "1985 Directory of Business Coalitions for Health Action" lists by selected characteristics more than 130 business/health groups formed to implement **health care cost-containment programs**. The book includes summary tables comparing data from 1982, 1983 and 1984, and information on how to contact each of the coalitions. Copies are available for $15 from the Clearinghouse on Business Coalitions for Health Action, Publication #6859, 1615 H St., N.W., Washington, D.C. 20062; 301-4685128.

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Scottsdale offers cover to N.J. day-care centers

Scottsdale Insurance Co., a surplus lines insurer based in Scottsdale, Ariz., is offering liability coverage for day-care centers in New Jersey.

The insurer will write to limits of $1 million, according to a spokeswoman for America's Insurance Center, a Kenilworth, N.J., managing general agent writing the insurance for Scottsdale.

The rates for the coverage are 150% higher than Insurance Services Office recommended rates, she said.

Hazel Frank Gluck, New Jersey's insurance commissioner, said, "The state is very fortunate in that the Scottsdale Insurance Co. is willing to provide this essential coverage and help ease the crisis that was developing here."

She added, "Moreover, the company's policy does not exclude coverage for child abuse incidents, which have been a major factor in making this kind of coverage unavailable."

The MGAs writing the coverage on behalf of Scottsdale are:

- America's Insurance Center, 562 Boulevard, Kenilworth, N.J. 07033; 201-272-6300.
- F.T.P., 457 Central Ave., Jersey City, N.J. 07073; 201-659-0400.
- Executive Excess Ltd. Inc., 126 Wall St., CN 5314, Princeton, N.J. 08540; 800-582-5937.
- Montgomery General Agency, 1415 Route 70 E., Suite 505, Cherry Hill, N.J. 08034; 609-795-6620.

Health claims system

National Risk Management Inc. in San Ramon, Calif., is introducing an automated group health claims management system.

The system can handle medical, dental, vision, prescription and life insurance claims, and is compatible with NRM's workers compensation and accounting systems.

The software system, which can accommodate 99 characteristics per claim, can analyze and project losses. It can compare existing fee schedules, as well as user-designed fee schedules. and can issue claims payments. The system can accommodate small or large employers and public or private companies.

Risk or benefit managers interested in automation but not ready to make that financial commitment can buy, lease or timeshare any of NRM's systems.

In addition to the new group health program, NRM produces work comp and liability programs, including a liability system specifically for public entities.

The stand-alone system costs $29,900 to purchase or $995 per month to lease.

For more information, call National Risk Management at 800-833-2530 in California or 800-NAT-RISK outside California.

Help for hospital risks

Hospitals are facing the challenge of forming effective risk management programs. And, a book from Aspen Systems Corp. can help them meet the challenge.

"Risk Management: A Guide for Health Care Professionals" provides specific guidelines and step-by-step procedures. Author John F. Monagle, president of the National Institute of Hospital Risk Management & Quality Assurance, covers a variety of topics, including:

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- Loss-prevention programs.
- Claims handling.
- Quality assurance.
- Education programs.
- Use of computers in risk management.

The book is available for $29.95 from Aspen Systems Corp., P.O. Box 6018, Gaithersburg, Md. 20877; 800-638-8437, or 301-251-5233 in Maryland. ■

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datebook

OCT. 16-17. Principles of Petroleum Insurance workshop in Denver, sponsored by the Professional Development Institute and Self-Insurance Resource Inc.; $450. Also **Oct. 29-30** in Oklahoma City, **Nov. 6-7** in New Orleans, La., and **Nov. 20-21** in Fort Worth, Texas. Jonathan Jeffrey, Professional Development Institute, P.O. Box 13288, NTSU, Denton, Texas 76203-3238; 817-565-2483.

OCT. 16-17. 1985 Central Regional Meeting of the National Assn. of Independent Insurance Adjusters in Columbus, Ohio; members will be assessed a pro-rata fee; free to company guests and claims representatives. David F. Mehren, NAIIA, 222 W. Adams, #845, Chicago, Ill. 60606; 312-353-0808.

OCT. 16-18. Solvency Assessment course in London, sponsored by Risk Research Group Ltd.; 471.50 pounds ($660). Judith Hobday, Risk Research Group Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD; 01-441-236-2175.

OCT. 16-18. Successful Retirement Planning Programs workshop in Kansas City, Kan., sponsored by Retirement Advisors Inc.; $450. Also **Nov. 6-8** in New York. Registrar, 919 Third Ave., New York, N.Y.; 212-421-2400.

OCT. 17. The Role of the Employee Benefit Manager as a Change Agent conference in Boston, sponsored by The New England Employee Benefits Council; $35 for members; $55 for non-members. The New England Employee Benefits Council, P.O. Box 2594, Boston, Mass. 02208; 617-423-6146.

OCT. 17. RIMS Midwest Regional Conference in Northbrook, Ill., sponsored by the Northeast Illinois Chapter, Risk & Insurance Management Society; $75, attendance limited to members and prospective members. Dorathy Chmielowski, Tribune Co., Suite 2100, 435 N. Michigan Ave., Chicago Ill. 60611.

OCT. 17-18. ABA Institute: Medical Malpractice for Attorneys, Physicians and Risk Managers in Houston, sponsored by the Medicine and Law Committee of the American Bar Assn.'s Tort and Insurance Practice Section, the American Society of Law and Medicine, the State Bar of Texas, the University of Houston Law School, the South Texas College of Law, and the Health Law Institute-University of Texas Health Science Center; $325 for ABA and American Society of Law and Medicine members; $375 for non-members; $50 for law students. American Bar Assn., Division for Professional Education, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

OCT. 17-18. Financial Analysis for Risk Management Decisions seminar in St. Louis, sponsored by The College of Insurance; $750. Registrar, The College of Insurance, 101 Murray St., New York, N.Y. 10007; 212-962-4111, ext. 303.

OCT. 18. The New Insurance Services Office Commercial General Liability Policy workshop in Philadelphia, sponsored by The Insurance Society of Philadelphia Inc.; $90 for members; $105 for non-members; special rates for three or more registrants from same organization. The Insurance Society of Philadelphia Inc., 743 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

OCT. 18-20. California Chapter of the National Assn. of Rehabilitation Professionals in the Private Sector Regional Conference in Palm Springs, Calif.; $165 for members; $175 for non-members. NARPPS, P.O. Box 708, Twin Peaks, Calif. 92391; 714-337-0746.

OCT. 20-25. Fundamentals of Employee Benefits Management course in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; $800. Registrations Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

OCT. 21-23. Second International Seminar on Strategic Planning for Insurance in London, sponsored by The Geneva Assn. and City Financial, a division of Kluwer Publishing Ltd.; 454 pounds ($635.95). Caroline Fletcher, City Financial, 7th Floor, Africa House, 64-78 Kingsway, London. WC2B 6BD; 011-441-831-6909.

OCT. 22. Association Captives: Answer to the Insurance Crisis? conference in Washington, sponsored by the Risk Planning Group division of Tillinghast, Nelson & Warren; $300. Micki Briskin, Risk Planning Group, 722 Post Road, Darien, Conn. 06820-4798; 203-655-9791.

OCT. 22. Controlling Unemployment Insurance Costs Workshop in Springfield, Ill., sponsored by the Illinois State Chamber of Commerce; $90 for members; $135 for non-members. Carol Jensen, ISCC, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

OCT. 22-23. Improving Health Care Management in the Workplace conference in Scarsdale, N.Y., sponsored by The New York Business Group on Health; $345 for members; $395 for non-members. Work in America Institute Inc., 700 White Plains Road, Scarsdale, N.Y. 10583; 914-472-9600.

OCT. 23. Health Improvement/Prevention Workshop in Boston, sponsored by the Health Research Institute; $195. Also **Nov. 6** in New York, **Dec. 11** in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 23. Advanced "Post-Graduate" Cost Containment workshop in Boston, sponsored by the Health Research Institute; $195. Also **Nov. 6** in New York, **Dec. 11** in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 23. Medical Directors workshop in Boston, sponsored by the Health Research Institute; $195. Also **Nov. 6** in New York, **Dec. 11** in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 23. "Worker's Comp: A Review and a Look Ahead" conference in Rolling Meadows, Ill., sponsored by the Illinois Manufacturers' Assn.; $75; $60 for each additional registrant from same company. Holly Hays, Conference Coordinator, Illinois Manufacturers' Assn., 175 W. Jackson Blvd., Suite 1321, Chicago, Ill. 60604; 312-922-6575.

OCT. 23. "Substance Abuse in the Workplace: Intervention—Resolution" teleconference sponsored by Macmillian Healthcare Information Symposiums International in association with The Annenberg Center for Health Sciences and Betty Ford Center at Eisenhower; $225; $195 for two or more registrants from same organization. Viewing at designated hotels in Los Angeles; San Francisco; Denver; Chicago; Bloomington, Minn.; St. Louis; Dallas; Houston; Arlington, Va.; Atlanta; Boston; Detroit; Pennsauken, N.J.; Cherry Hill, N.J.; Saddle Brook, N.J.; Philadelphia; New York; and Cleveland. Macmillian Healthcare Information, P.O. Box 35, Florham Park, N.J. 07932; 213-273-2157.

OCT. 23-25. Techniques of Finance and Accounting course in Minneapolis, sponsored by the Risk & Insurance Management Society's Continuing Education Program; $445 for members; $545 for non-members. Also **Nov. 4-6** in Montreal. Fran Jordan, Administrator-Continuing Education Program, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

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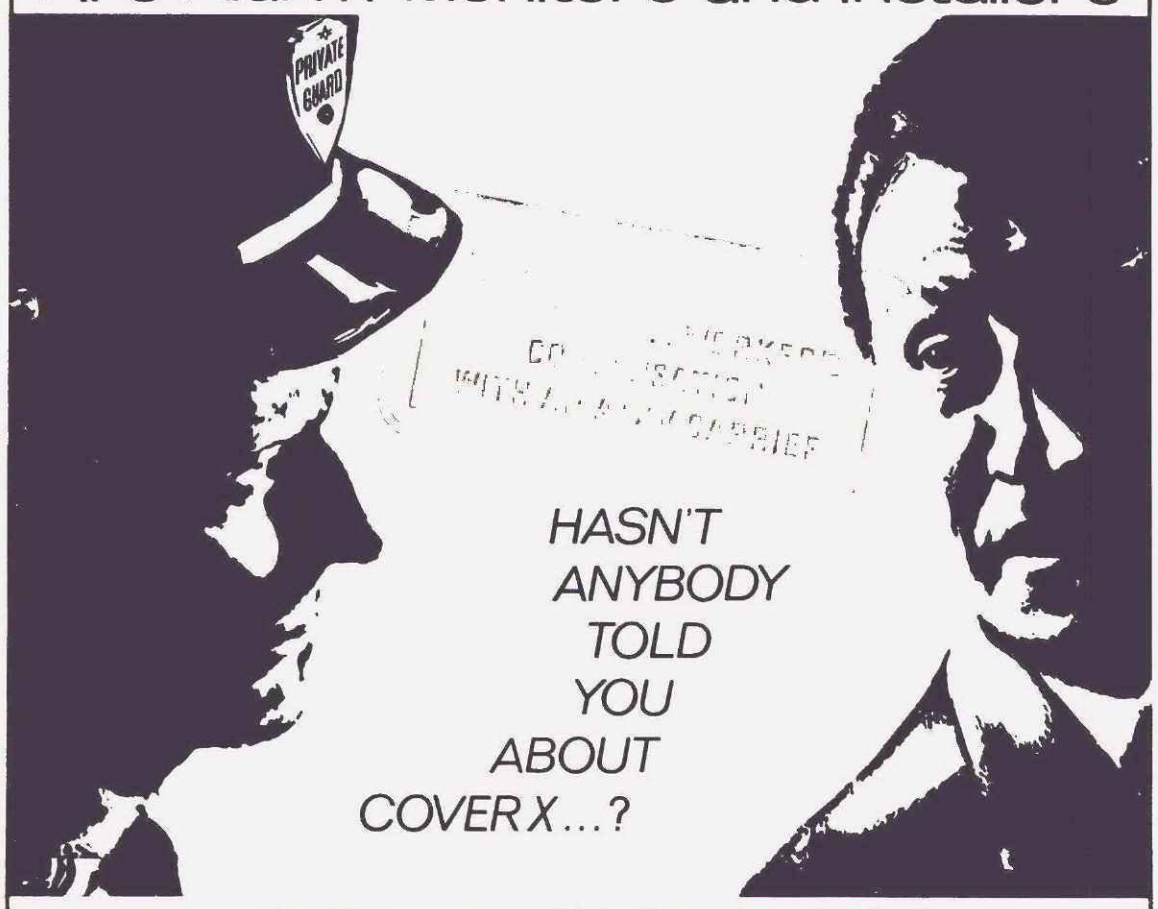

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Continued from previous page

OCT. 23-26. Workers Compensation Issues seminar in Louisville, Ky., sponsored by the Kentucky Legislative Research Commission; $150. Charlene Collins, Legislative Research Commission, State Capitol, Frankfort, Ky. 40601; 502-564-8100.

OCT. 24. Health Care Cost Management—An Organizational Approach seminar in New York, sponsored by The New York Business Group on Health; free. The New York Business Group on Health, 622 Third Ave., 34th Floor, New York, N.Y. 10017; 212-808-0550.

OCT. 24-25. Intergovernmental Pool Directors and Trustees seminar in San Francisco, sponsored by the Public Risk & Insurance Management Assn.; $150. PRIMA Pooling Seminar, 1120 G St. N.W., Suite 707, Washington, D.C. 20005; 202-737-7556.

OCT. 24-25. Self-Funding Your Employee Benefits meeting in San Francisco, sponsored by American Management Assns.; $620 for members; $715 for non-members. Registrar, AMA, P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

OCT. 24-25. Labor/Management workshop in Boston, sponsored by the Health Research Institute; $195. Also **Nov. 7-8** in New York, **Dec. 12-13** in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 24-25. Aviation Insurance Briefing 1985 conference in London, sponsored by Risk Research Group Ltd.; 276 pounds ($386). Judith Hobday, Risk Research Group Ltd., Bridge House, 181 Queen Victoria St., London, EC4V 4DD; 011-441-236-2175.

OCT. 24-26. 38th Annual Profit Sharing Conference in New Orleans, sponsored by the Profit Sharing Council of America; $515 for members; $545 for non-members; $190 for non-delegates. Profit Sharing Council of America, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-3411.

OCT. 28. "Risk Management of PCBs in Electrical Systems" course in Seattle, sponsored by Electro-Test Inc.; $95. Also **Oct. 29** in Portland, Ore.; **Nov. 1** in Sacramento, Calif.; **Nov. 4** in San Francisco; **Nov. 6** in Las Vegas, Nev.; **Nov. 18** in Salt Lake City; **Nov. 20** in Denver; **Nov. 22** in Albuquerque, N.M.; **Dec. 4** in San Diego; **Dec. 5** in Newport Beach, Calif.; **Dec. 6** in Los Angeles; **Dec. 10** in Phoenix, Ariz. Electro-Test Learning Center, P.O. Box 159, 3470 Fostoria Way, San Ramon, Calif. 94583; 415-866-8566.

OCT. 28. Commercial General Liability program in New Orleans, sponsored by the International Risk Management Institute Inc.; $235. Conference Coordinator, International Risk Management Institute Inc., 10300 N. Central Expressway, Building III, Suite 208, Dallas, Texas 75231; 214-363-9656.

OCT. 28-29. PPOs & HMOs: Caveat Emptor conference in Chicago, sponsored by Business Week and Washington Health Letters; $650. Business Week Executive Programs, PPOs/HMOs, 1221 Avenue of the Americas, 33rd Floor New York, N.Y. 10020; 212-512-3583.

OCT. 28-29. Conference on Political Risk in New York, sponsored by Frost & Sullivan Inc.; $595; $345 for additional registrants from same organization. Victor Hertz, Manager, Political Risk Services, Frost & Sullivan Inc., 106 Fulton St., New York, N.Y. 10025; 212-233-1080.

OCT. 28-30. An Introduction to Insurance Marketing course in London, sponsored by Risk Research Group Ltd.; 431.25 pounds ($603.75). Judith Hobday, Risk Research Group Ltd., Bridge House, 181 Queen Victoria St., London, EC4V 4DD; 01-441-236-2175.

OCT. 28-30. "Keys to Profit"—Seventh Annual Meeting of the Premium Audit Advisory Service of American Insurance Services Group Inc. in New Orleans; $150 for employees of subscribing companies; $250 for others. William F. Hauswirth, CPCU, Manager-Premium Audit Advisory Service, 85 John St., New York, N.Y. 10038; 212-669-0528.

OCT. 28-31. Fifth Annual Construction Insurance conference in New Orleans, sponsored by the International Risk Management Institute Inc.; $585. Conference Coordinator, International Risk Management Institute Inc., 10300 N. Central Expressway, Building 3, Suite 208, Dallas, Texas 75231; 214-363-9656.

OCT. 28-31. National Safety Council Congress and Exposition conference in New Orleans, sponsored by the National Safety Council; $125 for members; $175 for non-members. Registrar, NSC, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800.

OCT. 28-NOV. 1. Developing and Managing a Basic Safety and Health Program course in Long Grove, Ill., sponsored by the National Loss Control Service Corp.; $650. Tommy Thomas, NATLSCO, Route 22 and Kemper Drive, Long Grove, Ill. 60049; 312-540-2400, 800-323-9585.

OCT. 29. Basic Benefits program in Boston, sponsored by the New England Employee Benefits Council; $175 for members; $215 for non-members. Benefits Seminar Coordinator, New England Employee Benefits Council, P.O. Box 2594; Boston, Mass. 02208; 617-732-5788.

OCT. 29-30. Excess and Reinsurance: The Myth—The Realities conference in Stamford, Conn., sponsored by the Risk Planning Group of Tillinghast, Nelson & Warren Inc.; $600; $550 for additional registrants from same company. Micki Briskin, Risk Planning Group, Tillinghast, Nelson & Warren Inc., 722 Post Road, Darien, Conn. 06820-4798; 203-655-9791.

OCT. 30. Chicago Area HMO Shoot-Out seminar in Chicago, sponsored by the Assn. of Certified Employee Benefit Specialists; $35 before Oct. 25; $45 thereafter. Tom Gaffigan, ACEBS, P.O. Box 600, Chicago, Ill. 60690; 312-732-3988.

OCT. 31. and NOV. 6. The New Commercial Property and Liability Coverage and Rating Workshop two-day series in Rolling Meadows, Ill., sponsored by the Society of Chartered Property & Casualty Underwriters and the Insurance School of Chicago; $125 for one day only; $200 for two-day program. Insurance School of Chicago, 330 S. Wells St., Suite 202, Chicago, Ill. 60606; 312-427-2520.

OCT. 31. Philly "I" Day conference in Philadelphia, sponsored by the Philadelphia Chapter of the Society of Chartered Property & Casualty Underwriters, Independent Insurance Agents & Brokers Assn. of Philadelphia and Suburbs, Delaware Valley Chapter of The Risk & Insurance Management Society and the Insurance Society of Philadelphia; $35. Peter Raymond, Aetna Life & Casualty, 1 Logan Square, Philadelphia, Pa. 19103; 215-854-7350.

OCT. 31-NOV. 1. New Approaches to Solving the Insurance Industry Capacity Shortage conference in New York, sponsored by Executive Enterprises Inc.; $750; $650 for each additional registrant from the same organization. Executive Enterprises Inc., Session #5AINS19/E5347, 33 W. 60th St., New York, N.Y. 10023-7988; 212-489-2680.

NOV. 1. Current Trends in the Legal Environment of Workers Compensation seminar in New York, sponsored by the National Council on Compensation Insurance; $110 for members; $145 for non-members. Michelle Lajzer, NCCI Public Affairs Department, One Penn Plaza, New York, N.Y. 10119; 212-560-1026.

NOV. 4. Controlling Workers Compensation Costs Seminar in Chicago, sponsored by the Illinois State Chamber of Commerce; $90 for members; $135 for non-members. Also **Nov. 12** in Springfield, Ill. Carol Jensen, ISCC, 20 N. Wacker Dr., Chicago, Ill. 60606; 312-372-7373.

NOV. 4-5. The 1985 London Insurance Conference in London, sponsored by Oyez International Business Communications Ltd.; 375 pounds ($525). Mavis Gold, Oyez International Business Communications Ltd., Bath House (3rd Floor), 56 Holborn Viaduct, London EC1A 2EX; 01-441-235-4080.

NOV. 4-6. Twelfth Annual Computer Security Conference in Rosemont, Ill., sponsored by the Computer Security Institute; $645 for members until Oct. 18, $680 after Oct. 18; $695 for non-members until Oct. 18, $730 after Oct. 18.; $665 for additional non-members until Oct. 18, $700 after Oct. 18. Computer Security Institute, 43 Boston Post Road, Northborough, Mass. 01532; 617-845-5050.

NOV. 4-6. Advanced Risk Management Techniques seminar in Washington, sponsored by the Public Risk & Insurance Management Assn.; $350 for members; $400 for non-members. Dean Phelus, PRIMA, 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

NOV. 4-8. Advanced Reinsurance Practice course in London, sponsored by Risk Research Group Ltd.; 718.75 pounds ($1,006.25). Judith Hobday, Risk Research Group Ltd., Bridge House, 181 Queen Victoria St., London, EC4V 4DD; 01-441-236-275.

NOV. 5-7. Basic Safety Management seminar in Boston, sponsored by the International Safety Academy; $445; $415 for three or more registrants from the same organization. Also **Dec. 2-4** in Houston. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147, 215-241-5800 in Pennsylvania.

NOV. 7-8. Chemicals in the Environment: Responsibility and Liability program in Washington, sponsored by The Environment and Safety Services Division, The Bureau of National Affairs and The Washington College of Law-American University; $300 for BNA subscribers; $325 for non-subscribers. Chemicals in the Environment Conference Registrar, BNA Conferences, The Bureau of National Affairs Inc., 2550 M St., N.W., Suite 699, Washington, D.C. 20037; 800-424-9890 or in Washington, 202-452-4420.

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Florida firms control medical costs: Survey

MIAMI—Florida employers are taking a variety of steps to control health care costs, according to a recent survey by the South Florida Health Action Coalition Inc.

Among the cost-containment initiatives reported in the survey of 120 employers throughout Florida were:

- Increased deductibles and employee premium contributions.
- An increase in the number of companies requiring second opinions for some surgical procedures.
- An increase in the number of companies offering their employees the option of enrolling in a preferred provider organization.

However, the survey found a slight decrease in enrollment in health maintenance organizations. The employers surveyed reported that only 10% of their employees were enrolled in an HMO in 1984, down from 13% in 1983.

HMO enrollment among public employees actually increased slightly to 16.8% in 1984 from 16% in 1983, according to the survey. But, enrollment of private-sector employees fell to 5% in 1984 from 8% in 1983.

This is in contrast to the survey's findings about PPO enrollment. In 1984, 59% of the responding companies said they either offered or were considering a PPO option for their employees' health care coverage. This is a dramatic increase over 1983, when only 14.7% of the companies said they either offered or were considering a PPO option.

The survey also found a definite move away from fully insured health care programs. In 1984, 30% of the employers reported their plans were fully insured, down from 47% in 1983.

In contrast, 44% of the employers in 1984 said their plan was self-funded, and an additional 18% said it was a minimum-premium plan. In 1983, only 36% said their plan was self-funded, and only 15% had a minimum-premium arrangement.

The survey also found a marked increase in several cost-containment changes to the design of health care plans, including:

- Second opinion programs. Some 43.6% of the employers in the 1984 survey reported their plans included a mandatory second opinion program for selected surgeries, and an additional 23.5% said such a program was under consideration at their company.

In 1983, only 15% said they had a mandatory second opinion program, and 30% said such a program was under consideration.

In addition, 43.6% of the employers responding to the 1984 survey said their plans included an optional second opinion program for selected surgeries. In 1983, 44% of the plans included an optional program.

- Pre-admission testing. In 1984, 80.6% of the employers said their plans require pre-admission testing, and an additional 10% said such testing was under consideration. In 1983, only 48% said their plans require pre-admission testing, and only 6% were considering it.
- Utilization reviews. Some 55% of the employers in the 1984 survey said their plans included utilization review, and an additional 21% were considering including it. In 1983, only 44% said their plans included utilization review, and only 17% were considering it.

And, the survey also found an increase in the amount of cost-shifting to employees, including:

- Increased employee premiums. In 1984, 23% of the employers said they had increased the employees' share of their health plan premium, and an additional 18% were considering a hike. In 1983, only 16% had increased the employees' share of the premium, although 31% were considering doing so.
- Increase in deductibles. In 1984, 29% of the employers reported raising their health care plan deductible, and 21% were considering an increase. In 1983, only 20% hiked deductibles, although 34% considered it.

For instance, in 1984, 36% of the employers said their plan had a deductible of $100, down from 56% in 1983. But, 31.2% reported a deductible of $200 in 1984, up from 21% in 1983.

The same percentage of plans—95%—required employees to pay a deductible in 1984 as in 1983.

- Increasing coinsurance. In 1984, 13% of the employers reported that they had increased the coinsurance employees were required to pay under their health care plan, and 12% said they were considering an increase. In 1983, about half as many—7%—increased the coinsurance requirements, although 24% considered it.

In addition, the survey noted the employers are increasingly offering diagnostic screening and wellness programs.

For example, 33.6% of the employers offered a screening program for high blood pressure in 1984, compared with 29% in 1983. Sixteen percent had a screening program for diabetes in 1984, up from 12% in 1983. And, 14.5% offered screening for blood cholesterol in 1984, up from 9% in 1983.

Twenty-seven percent of the employers reported they offered a stress management program in 1984, up from 17% in 1983. And, 33.6% offered classes in cardiopulmonary resuscitation in 1984, up from 31% in 1983.

Some 23.5% offered a fitness or exercise program in 1984, up from 15% in 1983. Counseling for alcohol or drug abuse was offered by 18.5% of the employers in 1984, up from 12% in 1983.

And, programs to help employees stop smoking were offered by 21% of the employers in 1984, up from 11% in 1983.

Finally, the survey questioned employers about the role the state should take in enacting medical malpractice reform to control health care costs.

The state Legislature is scheduled to take up medical malpractice reform in its next session, and 46.2% of the employers that responded to the South Florida Health Action Coalition's survey said that this reform should be given the highest priority on the legislative agenda.

Specifically, 59.6% of the respondents favored a limit on attorneys' fees in malpractice cases, 46.2% favored a cap on awards for pain and suffering and 46.2% favored increased authority for the state in licensing and disciplining physicians and other health care providers.

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Copies of the study, "Survey of Employer Health Care Benefit Plans and Cost Containment Initiatives in Florida—Analysis of Results for 1984 Data," are available free from the South Florida Health Action Coalition Inc., Suite 330, 7925 N.W. 12th St., Miami, Fla. 33126; 305-592-4936.

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Five insurers form national PPO network

Five group health insurance companies are forming a partnership to establish a network of preferred provider organizations across the nation.

Although group health insurers have been actively setting up preferred provider organizations for several years, the formation of Boston-based Private Healthcare Systems Ltd. marks the first time insurers have joined forces to establish PPOs, says James D. Motz, vp-group insurance for Great-West Life Assurance Co. in Englewood, Colo., PHS' founding partner.

PHS, which plans to establish PPOs in about 40 cities within three years, hopes to have its first PPO operational in the Chicago area by early next year, Mr. Motz said.

Other cities in which PHS initially will establish PPOs include Atlanta, Dallas, Houston, San Francisco and Tampa, Fla., Mr. Motz said.

markets

The other partners in the venture are Chicago-based CNA Insurance Cos.; Crown Life Insurance Co. of Alexandria, Va.; MONY Financial Services, a unit of The Mutual Life Insurance Co. of New York; and Time Insurance Co. and Western Life Insurance Co., both units of New York-based AMEV Holdings Inc.

The partners have a combined annual group health premium volume of $2.5 billion and cover about 3 million lives under group health insurance contracts, Mr. Motz noted.

Each of the five partners contributed $2 million in capital to form the partnership, Mr. Motz said, adding that the current partners hope as many as five additional insurers will join PHS, which would increase total capitalization to $20 million.

In addition to the five insurer partners, a sixth participant in PHS is the Health Data Institute, a Boston-based health care claims analysis firm that will help PHS select the health care providers that will make up the PPOs and provide utilization review services.

Although the preferred provider organizations will be established by PHS, the PPOs will be marketed to employers through each of the health insurers that are members of the partnership, Mr. Motz said, adding that plan design will vary from insurer to insurer.

"Each carrier packages, promotes and prices the network," explained William J. O'Keefe, vp-group operations with CNA.

The five insurers decided to band together so they could "form arrangements like the giant health insurers have," Mr. Motz explained. "This allows us to have enough market share and clout to get preferential treatment from providers."

Initially, PHS will sign contracts with hospitals in each area to form the PPO, Mr. Motz said, adding that it will subsequently sign contracts with individual physicians, most of whom will be staff members of the participating hospitals.

PHS will select hospitals "according to the capacity of the hospital to deliver quality care" as well as their cost efficiency, Mr. Motz said, adding that PHS hopes to sign contracts with about 25% of the hospitals in a given area.

By using the Health Data Institute to screen potential preferred providers, "PHS will have the ability to identify quality providers, using state-of-the-art techniques to assess quality of hospitals and their cost-efficiency," he said.

Besides the quality of the hospitals making up the PPOs, a key element of the PHS network will be a utilization review system developed jointly by PHS and HDI, Mr. Motz explained.

"We have the best reviews in the business," he boasted.

For example, the attending physicians who are part of a PHS PPO will have all non-emergency hospital admissions and outpatient surgery pre-approved by PHS.

Registered nurses who are PHS employees will type information about the patient into a computer, which then will prompt the nurse to ask additional questions about the patient's condition and the type of care the physician is recommending.

The computer program is designed to help the nurse tailor his or her questions to each specific case to ensure that only necessary treatment is authorized, Mr. Motz explained.

"We are able to ask the right questions to reach appropriate conclusions for each patient in a timely and efficient manner," said Dr. Paul H. Gertman, chairman of HDI.

If the treatment recommended by the physician does not meet the criteria stored in the computer, the case is referred to a review physician, who is a practicing physican who contracts with HDI.

If the treatment is not approved by the review physician, another physician is called to examine the patient and render a second opinion.

Mr. Motz said limiting second opinions to only those cases in which there are differences between the attending and review physicans saves employers money.

Among the reviews provided by the PHS utilization review program include:

- Length of stay.
- Appropriateness of care.
- Whether treatment should be provided on an inpatient or outpatient basis.
- Whether discharge occurs on the planned date.

Although Mr. Motz said the amount an employer will save by participating in a PHS PPO depends on the design of the employer's plan, he said the review procedures should cut health costs by 6% to 10%.

Although the first PPOs established by PHS will not be operational until next year, Mr. Motz said the utilization review program is already operational and employers can purchase the program on an unbundled basis from PHS. ■

'Blue Book' lists HMOs nationwide

A total of 470 health maintenance organizations nationwide are listed in "Blue Book: A Digest of HMOs," published by the National Assn. of Employers on Health Care Alternatives.

For each HMO, the book includes name, address and phone number; the president or chief operating officer; the marketing director; the medical director; the type of HMO; the date it began operating; whether it is federally qualified; whether it is non-profit or for-profit; and enrollment.

The book is available for $49.50 from NAEHCA, 1134 Chamber of Commerce Building, 15 S. Fifth St., Minneapolis, Minn. 55402. ■

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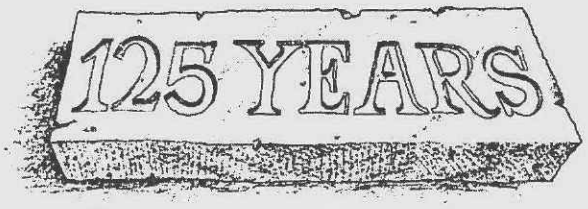

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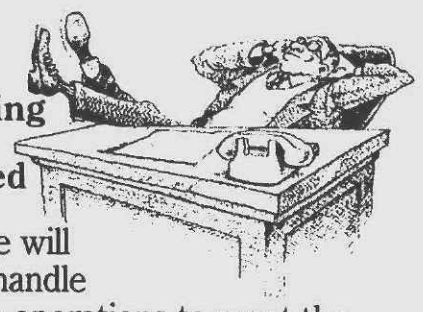

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NCCI to fight comp rate reduction in Maine

By CAROL CAIN

AUGUSTA, Maine—The National Council on Compensation Insurance expects again to challenge the constitutionality of a new law that requires a minimum 8% reduction in Maine workers compensation rates.

But for now the NCCI, an independent New York-based rating and research organization, will follow a temporary order issued Aug. 27 by Insurance Superintendent Theodore T. Briggs to file lower rates.

The NCCI complied with the order last week by filing for an average 8% decrease in workers comp rates, shortly after a Kennebec County Superior Court judge denied its petition for a temporary injunction on Mr. Briggs' order.

However, in its lawsuit, the NCCI also charged that the state's new work comp law, which took effect July 1, is unconstitutional and confiscatory, noting that rates are grossly inadequate and have been for several years.

That portion of the lawsuit is still pending, since hearings on the rate decrease have not yet been held and a permanent rate order has not yet been issued.

A series of hearings is expected to begin in a few weeks and will last several months.

Mr. Briggs issued his temporary order in August to comply with provisions in the new state workers compensation reform law. According to those provisions, workers comp rates were to be reduced this year by "at least" 8% and then frozen for the next 18 months. After that, rates could be increased as much as 10% annually for two years (*BI*, July 29, July 1).

The 8% decrease is retroactive to Aug. 1 and applies to new, renewal and outstanding business, said Peter Burton, director of government, consumer and industry affairs for the NCCI's New England region. He explained that the decrease will apply to the unexpired portion of workers compensation policies that expire after Aug. 1.

When he issued the temporary order, Mr. Briggs said he saw no reason to wait until the end of the hearing process, which takes several months, to decrease rates by the minimum 8% required in the new law.

At the end of the hearing process, rates may be decreased even more, Mr. Briggs said. It is at that time that the NCCI "probably will pursue" the issue in court again, said Mr. Burton.

Lower rates ordinarily would be welcomed by employers, but many of them have been forced to buy coverage from the state's assigned risk pool because insurers have reduced the amount of business they write in Maine, said Stephen Clarkin, director of government relations for the Maine Chamber of Commerce & Industry in Augusta.

Mr. Briggs had announced in July that he would hold a fact-finding hearing to determine what impact the insurer cutbacks would have on the market and what licensing action, if any, could be taken against the insurers.

However, Kennebec County Superior Court Judge Donald G. Alexander last month questioned whether the Maine Bureau of Insurance has such authority, and Mr. Briggs has canceled plans to hold the hearing.

Maine's workers comp insurers suffered a $105.2 million underwriting loss in 1984, said Robert Hilton, a senior vp with the NCCI.

And, the state's assigned risk pool, known as the National Reinsurance Pool, has seen its volume rise as insurers have reduced the amount of business they write.

The pool reported about $32 million in gross premium in 1984, but expects that figure to jump to between $40 million and $45 million at the end of this year, which probably would make the pool the largest writer of workers compensation in the state, overtaking Boston-based Liberty Mutual Insurance Co., which wrote $36 million in gross premium last year, Mr. Burton said.

In June, Liberty Mutual placed a moratorium on soliciting new work comp business in Maine and said it would apply stricter underwriting guidelines to existing policies.

The NCCI predicts that by year-end more than two-thirds of the estimated 22,000 employers that purchase workers compensation coverage will buy their insurance from the assigned risk pool.

The NCCI's actuarial data shows that rates need to be increased significantly above the current level simply to maintain the Maine workers compensation system, Mr. Hilton said, noting that insurers are paying out $2 of benefits and expenses for every $1 of premium collected.

Workers compensation insurers in Maine have not been granted a rate increase since 1981, despite general inflation and spiraling medical costs, he added.

"No other business in the country would be expected to deliver goods for less than it costs to produce them, but that's exactly what Maine politicians are demanding of the insurance industry. Employers wouldn't sell goods for half-price and labor certainly wouldn't work for half of a fair wage. Why should insurers?" Mr. Hilton asked.

"Maine has a Cadillac system of workers compensation. It's extremely generous. But even though Maine is paying high rates, those rates don't come close to covering the cost of delivering that system," he added.

Maine has the third-highest workers compensation benefit level in the country, Mr. Hilton noted. ■

DES ruling

Continued from page 2

Indemnity Insurance Co. of North America, now a CIGNA Corp. unit, provided first-layer excess coverage to Lilly from the early 1940s through the early 1950s. It was followed by various Lloyd's underwriters and other companies in the 1950s and 1960s and by The Home Insurance Co. in the 1970s.

The coverage was brokered by Marsh & McLennan Inc.

The major issue in the insurance litigation is when DES-related "injury" occurs under the approximately 242 manuscript policies written for Lilly by its insurers.

Insurers in the litigation took differing positions. Some said injury occurs when the mother ingested DES, others argued it occurred at the manifestation of a DES-related disease in the daughter many years later, while some underwriters took no position.

Lilly, however, argued that all policies from the time of ingestion through manifestation should apply.

In referring the case to the Indiana Supreme Court, the District of Columbia Court of Appeals asked the state high court to decide several issues including:

- Whether extrinsic evidence should be considered in determining the trigger of coverage.
- If extrinsic evidence should not be considered, what theory of coverage should apply?

On the first issue, the insurers contended that under Indiana law extrinsic evidence should be considered.

Insurers argued that such evidence is relevant for determining the parties' intent in adopting the policies, their conduct in applying the policies, Lilly's sophistication as a bargaining partner and the medical nature of DES-related illnesses.

However, the state Supreme Court disagreed. It noted that, under Indiana law, if an insurance policy is ambiguous, it must be interpretec most favorably for the insured.

In the Lilly case, the court said, there were at least two possible time periods when triggers of coverage could occur: exposure and manifestation.

Thus, the language is ambiguous or susceptible to more than one meaning, it ruled.

The court also noted that ambiguous policy language should be interpreted to further the policy's purpose of indemnifying the insured.

"This objective of promoting coverage leads to us to the conclusion that consideration of the extrinsic evidence is unnecessary to interpretation of the policies," the court said.

"We therefore hold that under Indiana insurance law the insurers' proffered evidence would not be considered."

The court subsequently ruled that the triple-trigger theory applied to the Lilly DES claims.

"This holding comports with the rule of interpretation that the courts should strive to give effect to the reasonable expectatons of the insured," the court said.

"We therefore adopt the multiple trigger interpretation of the 'injury/occurrence' language in Lilly's policies."

A spokeswoman for Lilly said, "The decision will result in substantial insurance coverage for product liability claims filed against the company arising from its sales of DES."

Lilly's insurers have declined to reimburse the company for costs incurred in its DES litigation since 1972, she said.

In addition, the spokeswoman noted the company has "adequate insurance coverage" for its product liability exposures, but she would not disclose details of the company's coverage.

An attorney for Lilly said because the triple-trigger theory had been applied by both the federal District Court and the Indiana high court, the District of Columbia Court of Appeals probably would follow.

Theodore R. Boehm, with the Indianapolis firm of Baker & Daniels, added it was not likely that the U.S. Supreme Court would take the case if the insurers petition the high court for review.

"We're very pleased," said Mr. Boehm of the decision. "We think it is correct."

However, an attorney for The Home said that it was "not a foregone conclusion that the Court of Appeals will enter judgment" based upon the Indiana Supreme Court decision.

Sheila Birnbaum, with the New York-based firm of Skadden, Arps, Slate, Meagher & Flom, also said insurers may also raise other issues before the Court of Appeals.

She characterized the decision as "not unique at all."

Other attorneys for insurers declined to comment on the impact of the decision.

Lilly manufactured and sold DES between 1947 and 1967. It and other drug manufacturers have been subject to numerous personal injury suits brought by daughters of women who ingested the drug during pregnancy.

About 350 cases are currently pending.

DES has been linked to vaginal and cervical cancer and other diseaes in the daughters of the women who took the drug during their pregnancy. ■

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ISO has altered forms several times already

Since first introducing its new commercial general liability policy forms in March 1984, the Insurance Services Office has issued a string of amendments to those forms.

ISO has filed four major amendments in the past 16 months, along with several minor revisions.

The most far-reaching changes were made in December 1984 when ISO amended the new CGL policy forms to:

- Exclude all pollution coverage from both the claims-made and occurrence policy forms.
- Provide a retroactive date provision to the claims-made policy form.

Any incidents occurring before the retroactive date would be excluded from current coverage even if claims were filed during the policy period.

- Allow insurers to charge up to 200% of the original premium if the policyholder wanted to purchase extended reporting period, or tail, coverage.

These proposals triggered efforts by the risk management and agent/broker community to block approval of the new policy forms by state insurance departments.

To date, only 26 states and the District of Columbia have approved the new forms and several of those states are reconsidering their position.

In response to the criticism from buyers and brokers, ISO again amended its new forms in February.

First, it extended to 60 days from 30 days the time period in which a policyholder may purchase extended reporting period or tail coverage under a claims-made policy.

In addition, ISO said it would include free of charge a 60-day mini-tail of coverage to accommodate buyers' fears that insurers would immediately cancel coverage if the policyholder reported an incident that would trigger claims.

Athough these changes were welcomed by buyers and agents, most said the proposed claims-made form still was not acceptable to them.

Again moving to mollify buyers' and agents' concerns, ISO announced in September that it would withdraw several endorsements that would have allowed insurers to limit tail coverage under the CGL claims-made policy.

Those endorsements would have allowed insurers to:

- Limit the length of tail coverage on an individual policy, so long as that time limit were specified at policy inception.
- Endorse the policy so that the insurer would not be obligated to provide tail coverage if the policyholder canceled or did not renew the policy.

CGL changes

Continued from page 1

and buyers in February, ISO officials seemed unwilling to accept other key changes in the proposed claims-made contract sought by agents and buyers.

This position changed in August after it became clear that ISO officials were unsuccessful in rallying support for the claims-made CGL form at a July 25 meeting of 27 state insurance commissioners in Chicago, according to sources.

In fact, risk managers, agents and brokers were able to use the meeting to convince insurance commissioners that they should scrutinize the policies filed by ISO, the sources add.

Ms. Borowski says PIA "realizes that part of this increased receptiveness by ISO is because the approval process at the state level has not gone as they had hoped," adding that ISO is "not on schedule with state approval" of the policy forms

Other participants in the current round of negotiations with ISO put it more bluntly.

"When push came to shove with the regulators, they came to us and asked what the problem was," says C. Courtney Wood, a vp with Marsh & McLennan Inc. in Oklahoma City and a member of IIAA's commercial lines committee.

"My feeling at the moment is that there is really a good chance that ISO can be persuaded to modify the filing and that once that is done, states would approve it," says Frank R. Tierney, assistant vp for risk management with Consolidated Natural Gas Service Co. in Pittsburgh and chairman of the products and services committee of RIMS.

"I would think that because RIMS has been so vocal in its opposition to the claims-made policy it has probably slowed down the approval process at the regulatory level," maintains Mr. Tierney. "ISO has made no progress in obtaining additional approval at the state level and without a substantial number of additional states, they're going to have an impossibly difficult situation come Jan. 1."

Agents and buyers agree this renewed willingness on the part of ISO and some of its member companies to compromise on several key issues appears to be an 11th-hour attempt by the insurer group to push state approval of the forms back on track. No state has approved the form during the last four months.

To date, only 26 states and the District of Columbia have approved the new CGL policy forms, and several of those states are reconsidering their decision to approve the new insurance contracts. Maryland, which approved the forms in early June, was the last state to do so.

Insurance commissioners "recognize the need for changes in the (CGL) forms," says Bruce W. Foudree, insurance commissioner for the state of Iowa and president of the National Assn. of Insurance Commissioners. He says that commissioners are not looking to disapprove the CGL policy forms, but rather they are "focusing on how to make this thing work."

The commissioner says he is confident that an agreement can be reached with ISO that will "iron out these bugs so the forms will work with the least amount of confusion and gaps in coverage."

At the heart of the concerns raised by regulators, risk managers and agent/broker groups is the trigger mechanism proposed by ISO in the new claims-made CGL policy.

Under the existing occurrence CGL form, it is merely the occurrence of an incident or accident—which subsequently could result in a claim for damages—that triggers coverage under the policy. It does not matter when the claim actually is filed with the insurer; only the time and date of the incident or accident are signficant.

But, under the new claims-made policy, only the filing of a claim by an injured party triggers coverage. Although the policyholder is required by the policy to notify the insurer of any incident that may result in a claim, that notification does not trigger coverage.

Buyers and agents fear this will give underwriters the opportunity to cancel the policy or exclude coverage for incidents reported by policyholders.

And, although the policyholder must be given the option to purchase extended reporting period, or tail coverage, if the underwriter cancels the policy, that coverage can cost up to 200% of the original premium, regardless of how much of the aggregate limit of the policy is still available.

Buyers and agents have suggested instead that coverage under the claims-made policy be triggered when the policyholder notifies the insurer of a specific incident that probably will result in a claim.

"The problem with the claims-made trigger is that the insured can't pull it," complains Mr. Wood of M&M.

Insurers designed the claims-made trigger to prevent stacking of policy limits in cases of long-latent illness when the time at which the illness occurred is difficult to pinpoint, Mr. Wood notes.

The courts generally have held that in the case of long-latent illnesses, such as asbestosis, all policies in effect from the time of exposure to the harmful substance through the manifestation of the illness, including the latency period, are triggered.

Continued on next page

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CGL changes

Continued from previous page

Insurers complain that this interpretation of the occurrence policy makes it impossible for them to calculate their exposure.

Mr. Wood says the compromise suggested by IIAA and RIMS would address the "legitimate" concerns of insurers over the stacking of policy limits while ensuring that policyholders have coverage for most accident situations.

Mr. Tierney says insurers are using the proposed claims-made trigger to establish "an iron clad assurance that their obligations are extinguished with the expiration of the claims-made policy." However, he says, "a viable risk transfer mechanism requires some continuation of that obligation" beyond the expiration of the policy.

If insurers agree to allow policyholders to trigger coverage by the reporting of an incident that is specific as to time and date, Mr. Tierney explains, they may have to pay claims after a policy expires "but they have the opportunity to reflect that in future charges," he says.

For most groups involved in the negotiations with ISO, the adoption of this new trigger is essential before they will support the new claims-made CGL policy.

"If there is a known incident, coverage should be triggered," says William E. Brady of Kindler & Laucci Insurance Brokers in Long Beach, Calif., and chairman of IIAA's commercial lines committee. Mr. Brady says IIAA will not support the claims-made CGL policy unless the trigger is changed.

The cost of the extended reporting period or tail coverage is the second-biggest concern of buyers and agents.

Under the claims-made CGL policy proposed by ISO, insurers would be able to charge up to 200% of the original policy premium for tail coverage. Risk managers and agents fear that this maximum charge will become the standard throughout the industry. This, they say, is particularly troublesome because of the aggregate policy limit in the new CGL policies. For an insured that has used up most of the aggregate limit of a policy, tail coverage may not prove economical at 200% of the original policy premium.

Furthermore, buyers and agents explain, an insurer writing a new policy or renewing an old one may, using a so-called laser endorsement, exclude coverage for a known incident that can be expected to result in future claims. If the aggregate limits are exhausted or the policyholder cannot afford the 200% charge for tail coverage, there would be no coverage for claims stemming from the incident.

Buyers and agents say they would like to see ISO change the proposed claims-made CGL policy to allow for a reinstatement of aggregate limits for tail coverage, but those involved in the negotiations with ISO say insurers appear unlikely to accept this suggestion.

"ISO sees this as an economic issue," explains PIA's Ms. Borowski. "And they said they are not prepared to negotiate economic issues."

However, ISO was responsive to a proposal that a matrix be developed that would base the cost of the tail coverage on the aggregate limits remaining in the policy at the time the tail is purchased, Ms. Borowski says.

While buyers and agents admit this would not address the concern that low or exhausted aggregate limits would leave the policyholder with inadequate tail coverage, it does bring the price of the tail endorsement more in line with the coverage it will provide, they say.

Much concern also has been raised over the retroactive date provision in the new claims-made CGL form. Coverage for incidents that occur before the retroactive date is excluded under the new claims-made form, even if claims are filed during the policy period.

As long as the retroactive date is the date of the inception of the first claims-made policy, the policyholder would not have gaps in coverage. But, if a subsequent claims-made policy insurer advances the retroactive date, the policyholder would be left without coverage for incidents that occurred after the expiration of the former occurrence policy and before the inception of the new claims-made form.

ISO insists that in most cases the insurer will set the retroactive date as the first day of the first claims-made policy, but buyers and agents fear insurers will continue to advance that date with every renewal, forcing the policyholder to buy tail coverage each time at 200% of the policy premium.

PIA and IIAA have suggested that ISO develop a manual rule that would limit the circumstances under which an insurer would be allowed to advance the retroactive date.

Both buyers and agents also generally oppose ISO's plan to include defense costs within policy limits beginning July 1, 1986. However, participants in the current negotiations with ISO appear to be less hopeful that a compromise can be reached on this issue.

IIAA's Mr. Brady says the agent group agrees with insurers that some cap on defense costs is needed, but says ISO's solution is "not satisfactory."

Several groups have suggested that a sublimit for defense costs be established based on a percentage of the total aggregate limit of the policy. When that sublimit is exhausted, then defense costs would be charged against the aggregate indemnity limit.

But sources close to the negotiations with ISO say it is unclear whether insurers will be willing to accept this compromise.

Insurers also are not expected to reinstate coverage for sudden and accidental pollution exposures, as requested by several groups. ■

Big award upheld against Andersen

NEW YORK—A U.S. District Court judge has upheld a $17 million injury award—that will increase to $22 million because of interest payments—against Big Eight accounting firm Arthur Andersen & Co..

The award came in connection with losses Manufacturers Hanover Trust Co. suffered after the collapse of Drysdale Government Securities Inc.

On Sept. 12, Judge Richard Owen denied Chicago-based Andersen's motions for a new trial, for judgment in favor of Andersen and for a reduction in the size of the award.

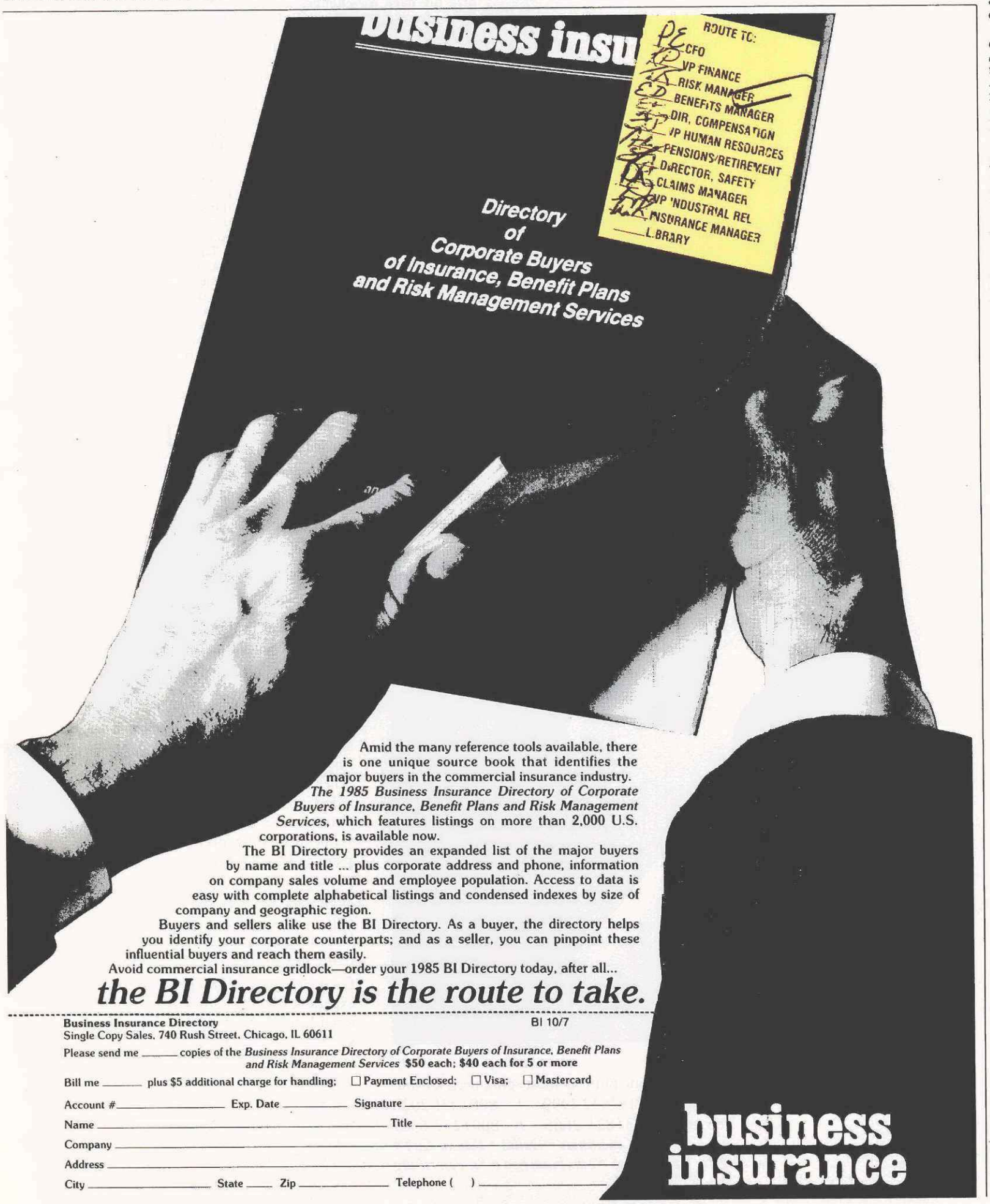
Andersen filed the motions after the March 21 award. The jury found that Andersen violated three sections of federal securities laws and that the accountant was guilty of common-law fraud and negligence (*BI*, April 1).

The suit arose out of the 1982 collapse of Drysdale Government Securities Inc., a unit of Drysdale Securities Corp. that was involved in the sale and purchase of government securities known as repurchase agreements.

Andersen was the auditor of Drysdale.

A Lloyd's of London syndicate managed by Merrett Syndicates P.L.C. with Robin A. Jackson as underwriter is the lead underwriter on Andersen's primary professional indemnity insurance coverage.

An attorney for Andersen said the company would appeal. He declined to comment on the type or amount of the accounting company's insurance. ■



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business insurance

N.J. mandate

Continued from page 3

However, this provision does not apply to any notice of cancellation issued for non-payment of premium or "moral hazard," which is an increased possibility that the policyholder may destroy the property for his personal gain.

In all cases of non-renewal, the insurer must give the policyholder valid notice at least 30 days and not more than 45 days before policy expiration.

• Prohibit changes in policy terms and conditions. The renewal terms must be "at least as favorable to the insured as the expiring policy at the same limits and terms, subject to changes approved by the commissioner."

Many insurers feared this provision prohibited rate increases at renewal, but Ms. Gluck said insurers would be able to raise rates at renewal without her approval.

However, insurers will need insurance department approval to reduce limits provided under the expiring policy.

A policyholder can contest the cancellation or non-renewal of an insurance policy by filing a written complaint with the Department of Insurance. And, insurers violating the emergency rules face penalties and an order to immediately reinstate canceled or non-renewed policies without a lapse in coverage.

A group of about 30 industry representatives and their attorneys met Sept. 30 with Ms. Gluck and proposed an alternative plan to replace the rules, said Mr. Sullivan of Crum & Forster, who is coordinating the group.

The plan, which has been endorsed in principal by 16 insurers in the state, calls for the establishment of a Market Assistance Plan coupled with new regulations concerning midterm and block cancellations, he said.

The so-called MAP could assist in finding coverage for day-care operations, liquor law and governmental liability coverages, he said. It would include committees of admitted and surplus lines representatives as well as a group that could advise about risk-sharing mechanisms, he said.

Mr. Sullivan also contends that insurers should be free to cancel or not renew insurance policies for a variety of reasons including adverse loss experience, substantial changes in applicable reinsurance and agency terminations.

Ms. Gluck, however, is not enthused about the success of MAP programs elsewhere.

"In order to take a step back, we need some guarantees," she said.

While acknowledging that the Sept. 30 meeting with insurers was "very good," Ms. Gluck commented that if she had obtained a similar response from industry representatives at a meeting she held a few months ago, the emergency rules would not have been issued.

"If everybody can stay cool, we may very well come up with an agreement," she said.

The group was to meet with Ms. Gluck again late last week to discuss the proposal and related matters.

While there are fears insurers will leave New Jersey, spokesmen for several insurers writing in New Jersey said last week that they would still consider writing new business in New Jersey but are monitoring the situation carefully. These insurers include members of CNA Financial Corp., Kemper Group and Fireman's Fund Insurance Cos. ■

NYIE president

Continued from page 2

shan said. The exchange board decided in February to create the post of vp-operations, which is similar to the position of chief operating officer.

However, Mr. Reutershan said that since his scheduled retirement date was approaching, he later told John Bretherick—president of Continental Corp., an exchange board member and head of the search committee—that he should look for a replacement for Mr. Reutershan instead.

With Mr. Fahys joining as executive vp, the exchange no longer is looking for a vp-operations, a spokeswoman said.

Mr. Reutershan said that he and Mr. Fahys will discuss permanent replacements for the three resigned officers. Interim replacements were named last month.

"Anyone of significance that is hired is going to be hired with his approval, because he's the one who has to live with them," Mr. Reutershan said.

Mr. Fahys currently heads M&M's Management Services Group and is responsible for the brokerage firm's captive insurance company management operations. ■

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update

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Absolutely Brilliant and Futuristic High-Tech Thinkers often ignore (or are unaware of) the old standbys of good loss prevention practices as they apply to the protection of property and profit. During the past few years, Industrial Risk Insurers has found a great amount of intellect and energy devoted to the acceleration of technological growth, but a lack of knowledge and control over the ordinary dangers of combustible contents, combustible construction, and special hazards. Let's examine a few examples in the semiconductor industry:

Research Laboratory. April 1983. Northeastern U.S.A. Cause: immersion heater in polypropylene tank. Sprinkler protection: none. Damage: immediate booth destroyed; entire cleanroom contaminated. Estimated loss: $1.7 million. IRI Comment: this kind of loss is becoming as common as an old shoe. With immersion heaters and plastic tanks, it's not a question of whether a loss will happen, but **when.** The double trouble of this loss was the combination of the immersion heater in the plastic tank and a cleanroom which lacked sprinkler protection, yet was loaded with combustibles.

Fabrication and Testing Area. April 1981. West Coast U.S.A. Cause: silane gas released to fiberglass reinforced plastic duct; ignition followed. Sprinkler protection: complete above and below ceiling, but lacking within the duct. Damage: exhaust ductwork destroyed; damage to computer system, other equipment and stock. Estimated loss: $1.6 million. IRI Comment: after the loss, it was determined that the nitrogen purge system was inadvertently shut off, permitting undiluted silane to contact air and ignite spontaneously. A critical omission in this incident was lack of sprinklers in the plastic duct, although a case could be made for using noncombustible duct in the first place.

Wafer Fabrication Section. February 1985. Western Europe. Cause: immersion heater in a plastic wet bench (sound familiar?). Sprinkler protection: complete, except for spaces above noncombustible, suspended ceilings. Damage: wet bench and exhaust hood damaged beyond repair; corrosive fumes caused serious damage to highly sensitive electronic and optical equipment. Estimated loss: $5.4 million. IRI Comment: another classic case of **when,** which completely interrupted production for two weeks and partially interrupted it for 14 weeks more.

There Have Been Many Losses in the Semiconductor Industry, and there are still many more potential situations which are of great concern. Because of this, IRI studied the subject and established protection guidelines in an attempt to control losses in this industry. The results of this work are available in two forms: the 2nd Quarter 1982 issue of **The Sentinel,** our external house organ, which features a "Focus on Semiconductor Manufacturing"; and procedure manual section, P.11.1., titled "Guiding Principles for the Protection of Semiconductor Facilities". A complimentary copy of each is available from Mrs. P.A. Sasso, IRI, 85 Woodland Street, Hartford, Connecticut 06102 or call (203) 525-2601.

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Financial:

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Secretaries, treasurers, controllers and other financial personnel ...6,886

Risk/employee benefits:

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

Sub-total 22,087

Associations 804
Government, unions and educational systems 1,030

Commercial Consumers

Sub-total 23,921

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Insurance companies 6,089
Financial institutions 536
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* Source: Business/Occupational breakdown of qualified circulation, May 6, 1985 issue, as submitted to BPA for June 1985. BPA Publisher's Statement.

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A Request for Proposal ("RFP") is now being prepared. Marsh & McLennan, Inc., 1221 6th Avenue, New York, New York, ("MMI") has been retained by Special Master Kenneth R. Feinberg to assist in preparation of the RFP and in evaluation of the claims administration proposals. (MMI and its affiliates will not bid on any contract.) An Advisory Group of five Vietnam veterans has been appointed to advise the Court regarding implementation of the Payment Program.

The RFP will be distributed on or about October 15, 1985. Firms wishing to receive the RFP should send a short letter expressing their interest, summarizing their qualifications and experience, and indicating whether they may be interested in providing claims administration services, investment management services, or both. Letters should be received by the undersigned no later than October 15, 1985.

Kenneth R. Feinberg
Special Master
"Agent Orange" Product Liability Litigation
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1575 Eye Street, N.W.
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Dated: September 18, 1985
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Benefit tax options

Continued from page 1

as taxable income to employees all employer contributions to dependent child care, educational assistance, group legal plans, van pooling and the cost of the first $50,000 of group term life insurance. The administration recommends that all these programs—except for van pooling—retain their tax-free status.

The Ways and Means Committee also will study new options dealing with the taxation of workers compensation benefits and the taxation of the property/casualty insurance industry (see stories, page 50).

The 354-page options paper will become the Ways and Means blueprint for designing a tax reform bill, experts say, pointing out that the proposals were drawn up at the request of Ways and Means Committee Chairman Daniel Rostenkowski and have been labeled "The Rostenkowski Plan."

"Clearly, the options paper has the imprimatur of Mr. Rostenkowski," said J&H's Mr. Davey.

"The staff options will become the basic working document that Ways and Means members will be dealing with" as they draft a bill, said Stuart J. Brahs, executive director of the Assn. of Private Pension and Welfare Plans in Washington.

"Unless a committee member raises objections, staff options could be accepted," Mr. Brahs predicts, noting the great weight staff recommendations have on committee members unfamiliar with benefit issues.

The options paper also shows that the desire to restrict employee benefit plans to gain revenues or stop alleged tax abuses is not limited to a few Treasury Department officials, but is shared by others.

"Mr. Rostenkowski is revenue-driven," said Henry von Wodtke, a benefit consultant with Buck Consultants Inc. in New York. "Benefits are where he thinks revenues can be gained."

For example, taxing employees on term life insurance would raise $9.8 billion in revenues over the next five years, while lowering maximum pension benefits and contributions would increase revenues by $2 billion, according to a Joint Committee analysis.

"This is a revenue-driven document," observed Mr. Brahs of the APPWP.

However, there already is some congressional opposition to the Ways and Means proposals. More than 200 congressmen have signed a resolution proposed by Rep. Augustus Hawkins, D-Calif., opposing new employee benefit taxes.

While congressional resolutions have no legislative teeth or force of law, the benefit community hopes that the resolution will signal Ways and Means Committee members that the House is opposed to benefit taxes, said James Klein, manager of pensions and employee benefits at the U.S. Chamber of Commerce in Washington.

In addition, when the Ways and Means Committee starts work this or next week on the employee benefit provisions in the tax bill, Rep. Beryl Anthony, D-Ark., will propose that annual 401(K) salary deferrals be reduced to no less than $15,000 a year and that the current non-discrimination rules continue, said Mr. Brahs.

The options paper, in contrast, proposes lowering to $5,000 from the current $30,000 the maximum annual employee salary deferral that can be made to a 401(k) plan. In addition, employee contributions to an Individual Retirement Account would be offset dollar for dollar by 401(k) deferrals. Under current law, 401(k) deferrals have no effect on an employee's ability to contribute to an IRA.

The options paper also proposes a new, more restrictive non-discrimination test.

Under the new test, plan discrimination would be tested by comparing deferrals made by highly compensated employees with deferrals made by lower-paid employees.

Highly compensated employees would include:

- Employees who own 5% or more of a company.
- The 10 employees who own the largest percent of a company and whose income exceeds $30,000.
- Employees earning more than $50,000.
- The top 10% of employees based on salary, excluding employees earning less than $20,000 and employees earning less than $35,000 who are not among the top 5% in compensation.
- Family members of the 10 highest-paid employees.

This lengthy definition of highly compensated employees sharply contrasts with current non-discrimination tests that simply compare deferrals made by a company's highest-paid one-third of employees to deferrals made by the lower-paid two-thirds.

Aside from making the discrimination test more complex, the options paper makes the actual deferral percentage test more strict.

Under the proposal, the average deferral percentage (ADP) by the group of highly compensated employees could not exceed 125% of the ADP of the lower-paid. For example, if the ADP for the lower-paid was 4%, then the highly compensated employees could defer an average of 5%.

By contrast, under current rules, the average deferral by the higher-paid one-third cannot exceed the greater of:

- 150% of the ADP of the lower-paid two-thirds.
- 250% of the average deferral among the lower-paid two-thirds, as long as the difference between the average deferrals of the two groups does not exceed 3%.

The options paper also proposes that employer matching contributions be considered in the discrimination tests and creates separate tests for contributions that are not immediately vested.

Under current law, employer contributions can be included in the discrimination tests at the discretion of the sponsor. Otherwise, such contributions only have to meet very general non-discrimination guidelines.

The proposal says that employer contributions that are immediately 100% vested, subject to withdrawal restrictions and do not exceed 100% of an employee's contribution would be added to the ADP of the lower-paid before the deferral discrimination tests were carried out.

For example, if the lower-paid defer an average of 4% and the employer contributes 50 cents for every $1 of salary deferred—or 2% of the employee's salary—the ADP for the lower-paid would be 6%. That ADP would be multiplied by 125% to determine the ADP permitted for the highly compensated.

'Mr. Rostenkowski is revenue-driven,' said Mr. von Wodtke. 'Benefits are where he thinks revenues can be gained.'

Because of ambiguous language in the options paper, it wasn't immediately clear last week how the proposal would affect employer matching contributions that are not immediately 100% vested or do not meet the withdrawal restrictions.

Apparently, though, the average matching contributions for highly paid employees couldn't exceed 110% of the average employer matching contribution for lower-paid workers.

The best that can be said about the 401(k) proposals is that "at least they don't abolish the plans," said Buck's Mr. von Wodtke. Several weeks ago the administration, which originally had proposed limiting annual 401(k) contributions to $8,000 and more complex non-discrimination rules, reversed itself and proposed eliminating the plans to make its tax reform package revenue-neutral.

The Ways and Means options also are more favorable in the area of uniform non-discrimination rules affecting benefit plans.

The options paper proposes an alternative to the Reagan administration's rigid mechanical test on benefit plans to ensure that a company's benefit plans do not discriminate against lower-paid employees.

Under the option, a benefit plan covering 100 employees in a company with different lines of business would be considered non-discriminatory as long as 90% of the plan's participants were eligible to participate and no more than 25% of the participants were highly compensated.

By contrast, the Reagan proposal called for much more rigid rules that could have disqualified thousands of plans (*BI*, Aug. 19).

Under the Reagan administration's uniform non-discrimination test, the percentage of highly compensated employees covered by a benefit plan would be computed. That percentage would be compared with the percentage of other non-union employees covered by the plan.

In order for the plan to receive favorable tax qualification, the percentage of highly compensated employees could not exceed 125% of the percentage of other employees covered by the plan.

For example, if 95% of a company's highly compensated employees were covered under a corporate pension plan, then at least 76% of its non-union employees would have to be covered under the plan.

If the pension plan flunked this 125% test, it would lose its tax-favored status and participants would be taxed on the value of their benefits.

Firms with different units and separate benefit plans for each unit would be most likely to flunk the 125% test. For example, a company would fail the test if its highly paid employees were concentrated in one unit and covered under that unit's benefit plan.

That could happen, since a major corporation may have many different units, each with its own benefit plan with very different levels of compensation.

To prevent workers from being taxed on the value of their benefits, a company would have to offer a uniform benefit plan to all employees in different corporate units.

The new option appears to be a major improvement and less burdensome, said Thomas Ucko, manager of technical analysis at Frank B. Hall Consulting Co. in Briarcliff Manor, N.Y.

But, one benefit manager said the new proposal needs much more study. For example, it is not clear what would qualify as a "different line" of business.

Meanwhile, many in the benefit community oppose the options paper proposals limiting maximum pension benefits and contributions.

If Congress accepts the proposal to slash to $75,000 from $90,000 the maximum annual pension benefit that can be provided through a defined benefit plan and to lower to $25,000 from $30,000 the maximum annual per-employee contribution that can be made to a defined contribution plan, it will be the third time since 1982 that legislators have tampered with these limits.

First, as part of the 1982 Tax Equity and Fiscal Responsibility Act, Congress rolled back the maximum defined benefit limit to $90,000 from about $137,000, while the defined contribution plan maximum was cut to $30,000 from $45,000. These limits were frozen until 1986.

Then, the 1984 Deficit Reduction Act barred any increases in these limits until 1988. The latest proposal not only would lower the maximum limits, but freeze those limits until 1991.

Experts say the limits will force companies to provide promised benefits that exceed these limits through excess plans. Excess plans, unlike qualified plans, are not advance funded. Contributions and tax deductions are taken only at the time benefits actually are paid, which means the benefits are less secure.

"Employees don't have the same security as they do under qualified plans. If a company goes broke, the employees are left with paper promises," said David Blecher, a consultant and attorney for Hewitt Associates in Lincolnshire, Ill.

In addition, under the Ways and Means options, employees generally would pay a special 15% tax on pre-retirement pension and savings plans distributions before age 59½. The tax could be avoided if the distribution were rolled over into an IRA and not withdrawn until an individual reached age 59½.

The new options also would impose a 15% excise tax on reversions employers collect when they terminate overfunded pension plans. The administration had earlier proposed a 10% tax. ■

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Insurers say planned taxes would add to market woes

By JERRY GEISEL

WASHINGTON—Congressional staff proposals to impose new taxes on property/casualty insurers would fuel major rate hikes and further shrink capacity in an already tight commercial insurance market, insurance lobbyists say.

The proposals, which would force the industry to pay an additional $5.5 billion in federal taxes during the next five years, also could threaten the solvency of insurance companies and make corporations reluctant to purchase and pump dollars into insurer affiliates, the experts say.

"Any increase in taxes on the industry means less capacity," warns Andre Maisonpierre, president of the Reinsurance Assn. of America in Washington.

"The proposals are bad news for the buyer and for the seller," says Steve Broadie, an attorney and tax specialist for the Alliance of American Insurers in Washington.

The proposals, drafted by Joint Committee on Taxation and House Ways and Means Committee staffers, are intended to replace an earlier loss reserve discounting plan drafted by the Treasury Department and backed by the Reagan administration.

Under the new proposals:

- Insurers no longer would be allowed to take immediate tax deductions for loss reserves set up to cover claims paid in the future. As is now the case with self-funded employers, a deduction could only be taken at the time a claim is actually paid. This proposal would go into effect in 1989.
- Insurers would be taxed on some income that is now tax-free, like interest on municipal bonds.

Effective on tax-exempt income received after Dec. 31, an insurer would be required to reduce its loss reserve deductions by 15% of its tax-exempt income.

For example, if an insurer set up a $200 million loss reserve and earned $100 million in tax-exempt income, the company could deduct only $185 million of those reserves from its federal taxes.

Presumably the proposal would sunset in 1989, when insurers no longer could take tax deductions for loss reserves.

- Companies filing consolidated tax returns could only partially offset profits with losses incurred by their property/casualty units. Only 35% of an insurer's losses could be deducted to determine the consolidated taxable income of a parent.

This proposal would go into effect in January, but it would expire at the end of 1988.

- Limits would be placed on the amount of net operating losses that property/casualty insurers could carry-over from a past tax year and apply against current income. The carry-over would be limited to 35% of net operating losses or 35% of a company's taxable income, whichever is less.

This would be effective in January and expire at the end of 1988.

- Insurers would be taxed on a portion of unearned premium income. Some 20% of the annual increase—if any—in an unearned premium reserve would be included as taxable income. The proposal would take effect in January.

Also, the options paper revives a proposal to increase to 4% from 1% the federal excise tax on casualty reinsurance premiums paid to foreign insurers. The proposal, slated for January implementation, is supposed to raise $210 million over the next five years. It isn't clear why the proposal refers to only casualty reinsurance premiums.

Last year, the Senate approved a higher excise tax on property and casualty reinsurance premiums, but a congressional conference committee stripped the provision from what became the Deficit Reduction Act of 1984 (*BI*, April 23, July 2, 1984). The committee was convinced by insurance lobbyists that the increased excise tax would violate tax treaties with foreign trading partners and disrupt international reinsurance agreements.

The only solace insurers can take from the property/casualty tax provisions is, that they are so overwhelming and would cause such damage to the economic stability of the industry, that Congress never would approve them all.

"The proposals are so awful that they will be easier to defeat," said the RAA's Mr. Maisonpierre.

Indeed, Mr. Maisonpierre and other insurer lobbyists believe that by unveiling all the options the committees' staffs are trying to "club" the industry to join ranks and support a tax-raising proposal.

"That's a pretty shabby approach," said Leslie Cheek, vp-federal affairs in the Washington office of Crum & Forster.

Property/casualty trade associations, in fact, have endorsed a proposal that—like the committees' proposal—would partially tax unearned premium. Currently, such income is not taxed until it is earned.

Forcing insurers to adopt the cash method of accounting and taking tax deductions only at the time a claim is paid would cause the most damage to the industry and to policyholders, lobbyists say.

The Alliance's Mr. Broadie, for example, warns that if Congress adopts the proposal, rates could increase 15% to 30%. "The effect would be devastating," he says.

Currently, insurers immediately tax deduct loss reserves established to pay claims in the future. These reserves are supposed to be established at the ultimate cost of the claim to be paid in the future, not at an amount recognizing investment income to be earned.

But, Mr. Maisonpierre is concerned that many insurers already are close to operating on a cash method of accounting and that reserves already are inadequate. If insurers could not take immediate tax deductions for loss reserves, they would lose a financial incentive to establish adequate reserves and the financial stability of the industry would be damaged.

Companies that file consolidated tax returns would be reluctant to invest in and purchase insurers if they were unable to offset property/casualty losses against profits earned by other corporate units, Mr. Maisonpierre says.

"We have a lot of insurers that are alive because parents have put money into them," Mr. Maisonpierre says. Corporations would be reluctant to make such capital infusions if the tax advantages of owning an insurer were weakened.

But not all insurers agree. Some say the ability of companies with insurer units to use underwriting losses to offset other profits gives such subsidiary insurers a competitive advantage over insurers that do not file consolidated returns.

"The consolidated tax return proposal is the first step in creating a more level playing field for all companies," observed Walter D. Vinyard Jr., an attorney with Zuckert, Scoutt, Rasenberger & Johnson in Washington. ■

Tax on comp benefits eased in new proposal

By CAROL CAIN

WASHINGTON—A loosely-knit, broad-based coalition that opposes a tax on workers compensation disability benefits is buoyed by the latest tax reform proposals under study by the House Ways and Means Committee.

The new package of proposals calls for the taxation of workers compensation and black lung indemnity benefits, but at effectively half the rate proposed by the administration.

"It's significant good news. But our full mission is yet to be completed," said Robert E. Vagley, a partner in the Washington law firm of Preston, Thorgrimson, Ellis & Holman, which represents the coalition of business, labor, insurance and other interests that opposes any taxation of workers compensation benefits.

Under the newest proposal, only a portion of workers compensation disability benefits received by an injured worker would be taxed if the worker's adjusted gross income is greater than a specified amount. (Medical, vocational rehabilitation and burial benefits would not be taxed.)

Specifically, if a couple's adjusted gross income exceeds $20,000 a year, excluding workers compensation or black lung benefits, the amount taxed would be either half of their adjusted gross income above $20,000 or the actual amount of benefits, whichever is less.

For instance, if a couple filing a joint return reports $25,000 in adjusted gross income, and one of them also received $10,000 in workers compensation benefits, then only $2,500 of those benefits would be added to their adjusted gross income and taxed. ($25,000 is $5,000 greater than the $20,000 salary cutoff, and half of $5,000 is $2,500.)

The same formula would apply to single taxpayers, but the cutoff is $15,000 in adjusted gross income.

However, if a married couple files separate returns, any workers compensation benefits paid to either would be taxed.

The Reagan administration's tax reform proposal released in May calls for all workers compensation and black lung indemnity benefits to be taxed. However, in certain instances based on adjusted gross income, injured workers would be eligible for a 15% tax credit.

The amount on which the tax credit would be based is the difference between the workers compensation disability benefits and half of the worker's gross income exceeding $14,000 for married couples and $11,000 for single taxpayers—*including* workers compensation and black lung benefits.

For instance, using the same married couple and figures in the previous example: If a couple earns $25,000 in income and one receives $10,000 in workers compensation benefits, they would be ineligible for a tax credit. ($25,000 plus $10,000 in benefits is $35,000, which is $21,000 more than the $14,000 cutoff mark. Half of this $21,000 is $10,500, which is greater than the $10,000 received in benefits; therefore, all of the benefits are taxable.)

However, if the couple earned $13,000 in income and one of them received $7,000 in workers compensation benefits, $4,000 of those benefits would be eligible for the 15% tax credit. ($13,000 in income plus $7,000 in benefits is $20,000, which is $6,000 more than the $14,000 cutoff for married couples. Half of this $6,000 is $3,000, which is $4,000 less than the $7,000 received in workers compensation benefits. Therefore, a tax credit would be applied to this $4,000.)

Both proposals to tax workers compensation benefits would be effective Jan. 1, 1987.

The latest proposal would raise an estimated $3.4 billion in revenue from taxes over a five-year period, while the Reagan administration's proposal would raise an estimated $6.2 billion over the same period, Mr. Vagley said, using information compiled by the Joint Committee on Taxation.

This reduction in taxation is important because many believe that individual state legislatures would increase workers compensation benefit levels to offset any tax.

According to the National Council on Compensation Insurance, indemnity benefits would need to be increased 23% under the Reagan administration's proposal to restore current benefit levels. The increase in benefits needed under the newest proposal before the House Ways and Means Committee has not been calculated yet, but it would be less.

The Reagan administration assumes that states will increase their benefit levels to offset taxation of workers compensation disability benefits, says NCCI President Kevin M. Ryan.

Workers compensation disability benefits generally provide two-thirds of the workers' average weekly wage, reflecting the tax-exempt status of benefits.

To increase the benefit amount, however, would take time. As Mr. Ryan pointed out in testimony in July before the House Ways and Means Committee:

"The process of amending workers compensation laws is slow, difficult and costly, and there is no guarantee that all 50 states will raise their benefit levels to fully offset the effects of taxation.

"To the extent that benefit levels are increased, employers will bear the costs of taxation; to the extent that they are not, these costs will be borne by injured workers. Moreover, the tax proposal ignores that any such benefit increases are likely to disrupt the business and insurance climates in all states."

Principally, the coalition fighting taxation of workers compensation benefits argues that tort awards are not taxed and workers compensation benefits—which are a substitute for tort awards under the workers compensation no-fault system—should not be either.

The U.S. Chamber of Commerce and the National Assn. of Manufacturers also are part of the coalition fighting the taxation of work comp proposals. Labor interests are represented on the coalition by the AFL-CIO and the United Mine Workers of America. Insurance interests are represented by the Alliance of American Insurers, the National Assn. of Independent Insurers and the American Insurance Assn., six individual insurers and the National Assn. of Casualty & Surety Agents.

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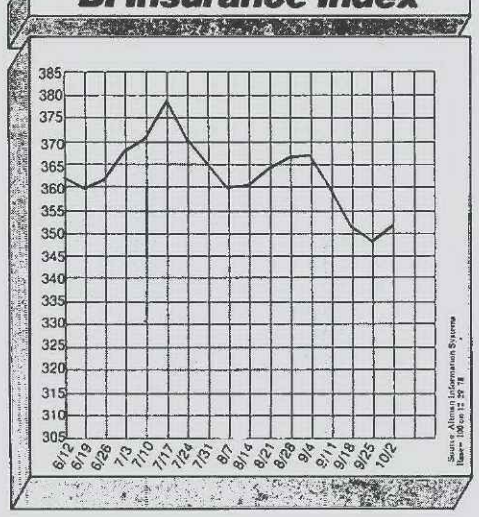

The *Business Insurance* stock index began an upward climb during the most recent trading period, putting an end to its three-week-long plunge. The *Business Insurance* index closed at 352.2 points for period ending Oct. 2, up 4.2 points from 348.0 points on Sept. 25. In all, a total of 28 stocks posted gains, 17 stocks declined and 12 stocks were unchanged. The biggest gains for the period were posted by Tokio Marine & Fire Insurance Ltd., up 18.4%; USF&G Corp., up 9.3%; Old Republic International Corp., up 8.5%; SRI Corp., up 7.4%; American Indemnity Financial Corp., up 6.1%; and Continental Corp., up 5.9%. The biggest losses were posted by Nobel Insurance Ltd., down 12.9%; Torchmark Corp., down 5.0%; Kansas City Life Insurance Co., down 4.1%; Durham Corp., down 3.2%; W.R. Berkley Corp., down 2.4%; and Frank B. Hall & Co. Inc., down 2.2%. The *Business Insurance* index rose 1.2% for the period. The New York Stock Exchange composite rose 1.7%; the Standard & Poor's 500 index rose 1.9%; and the Dow Jones 30 Industrials rose 1.6%.

British Issues

1 Oct Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	222	N/M	16.9	7.6	226—	222
Genl Accident	603	25.1	31.4	5.2	612—	595
Gdn Royal Exch	662	57.6	38.6	5.8	673—	660
Royal	655	81.9	35.0	5.3	660—	642
Sun Alliance	450	N/M	23.6	5.2	455—	445
Brokers						
CE Heath	633	8.2	37.5	5.9	633—	628
Hogg Robinson	271	11.3	14.3	5.3	271—	267
JH Minet	215	11.3	11.0	5.1	215—	210
Sedg Grp	345	13.8	17.8	5.2	345—	343
Stew Wrightson	665	12.8	32.8	4.9	687—	665
Willis Faber	695	17.8	23.6	3.4	705—	695

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Reserve deficiencies still major problem for insurers

By MYRON M. PICOULT

Special to Business Insurance

OUR POSTURE TOWARD the property/casualty insurance industry's reserve position has been noted several times in past columns: Simply put, the industry remains on the short end of the stick, notwithstanding efforts to address the reserve deficiencies that have developed over the past few years.

At times, the need to restore reserves to a realistic level of adequacy has become a catalyst behind efforts to reverse pricing downdrafts.

Mr. Picoult

Inaccurate reserve assumptions become the ultimate bane of securities analysts' long-term earnings projections. Furthermore, more often than not, they result in bad business decisions by the management of property/casualty insurers.

Pricing based on incorrect reserve levels can be either too high or too low and result in underwriters remaining in specific markets too long or withdrawing from markets prematurely.

When insurance gurus and company managements talk about reserves, the latter almost always in a positive vein, the general nomenclature revolves around aggregate reserve levels, incurred-but-not-reported losses and workout trends. Nary is a word said about loss adjustment expense reserves.

Perhaps this is the case because it is clearly the smaller portion of the total reserve figure. However, we think it deserves much more attention, both inside and outside the insurance industry, because of what we perceive to be significant shortcomings in aggregate loss adjustment expense reserve levels.

To begin with, some definitions are in order.

Loss adjustment expenses are the sums that insurers pay to settle claims other than the loss payments themselves.

Loss adjustment expense reserves normally are divided into two segments: allocated and unallocated. Allocated loss adjustment expenses are the expenses that can be assigned to specific claims. These costs include lawyers' fees, adjusters' fees and police or motor vehicle report costs.

Unallocated loss adjustment expenses are those costs that cannot be assigned to a specific claim. They may include miscellaneous expenses incurred at an insurer's branch or home office relating to loss trends on a particular line.

Our sense is that management pays too little attention to the loss adjustment expense figures. We have heard of instances where loss adjustment costs have exceeded reserves by 50% or more.

In order to come up with some consensus figures, we conducted a survey of 15 key commercial and personal lines underwriters, some of which are shown on the accompanying table. The data is a mix of statutory data and data compiled according to generally accepted accounting principles. The differences between the statutory and GAAP reserves include salvage and subrogation. Statutory accounting prohibits insurers from carrying salvage and subrogation recoverables as an asset or as a reduction in loss reserves.

Hence, to convert GAAP reserves to statutory figures, salvage and subrogation recoverables must be added to the data.

To conduct the study, we culled data for year-end 1983 and 1984 and for the first six months of 1985. We found the following:

- Data from A.M. Best Co.'s 1985 aggregates and averages study put loss adjustment reserves as a percent of total reserve for publicly held property/casualty insurers at 12.7% at year-end 1983 and 12.8% at year-end 1984. (First-half 1985 data is not available.)
- In most instances loss adjustment expense reserves—as a percentage of total reserve—were somewhat higher as of June 30, 1985, compared with year-end 1983 and 1984 levels. However, the numbers for CIGNA Corp., Aetna Life & Casualty Co. and two personal lines insurers were somewhat to slightly lower after the first half of 1985.

Commercial insurers led the firms whose percentage of loss adjustment expense reserves increased as of June 30, 1985.

- We found that the percentage of reserves set aside for loss adjustment expenses was generally higher for the personal lines insurers than for the commercial underwriters. This seems to reflect the greater incidence of individual claims seen by the personal lines insurers.

However, it also raises questions about the adequacy of loss adjustment expense reserves for commercial property/casualty underwriters. While the number of cases conceivably could be lower, the nature of commercial claims would imply that litigation and support/discovery costs per case would be much greater than for personal lines claims. Insurers must respond to even spurious suits or face a bad-faith situation.

We do not purport this review to be a totally incisive study. But it does raise questions about loss adjustment priorities that insurers' managements should address.

Although loss reserving may be a metaphysical art, we almost sense that many insurers have hired Inspector Clousseau to develop their loss adjustment expense reserves.

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts.

Analysis of selected insurers' loss reserves
(In thousands of dollars)

Company	Period ending	Loss & loss adjustment expense reserves	Loss reserves as % of total	Loss adjustment expense reserves as % of total
Aetna Life & Casualty	6/85	$6,097,000	88.0%	12.0%
(Statutory)	12/84	5,915,000	87.0	13.0
	12/83	5,593,000	86.6	13.4
American International	6/85	3,319,000	92.5	7.5
Group	12/84	3,132,000	92.7	7.3
(GAAP)	12/83	2,799,000	92.6	7.4
Chubb	6/85	1,417,736	81.7	18.3
(GAAP)	12/84	1,306,930	82.4	17.6
	12/83	1,112,844	82.3	17.7
CIGNA	6/85	5,963,500	88.3	11.7
(GAAP)	6/85	5,715,200	87.4	12.6
	6/85	4,935,300	86.5	13.5
Continental	6/85	2,990,137	87.1	12.9
(Statutory)	12/84	2,859,434	87.2	12.8
	12/83	2,851,995	87.3	12.7
Home Group	6/85	2,598,000	84.4	15.6
(GAAP)	12/84	2,475,000	86.7	13.3
	12/83	2,394,000	87.6	12.4
Kemper	6/85	759,036	85.9	14.1
(Statutory)	12/84	751,514	86.8	13.2
	12/83	809,472	86.1	13.9
Ohio Casualty	6/85	744,839	81.1	18.9
(Statutory)	12/84	698,616	81.1	18.9
	12/83	625,094	81.4	18.6
St. Paul Cos.	6/85	3,085,000	80.9	19.1
(Statutory)	12/84	2,917,500	81.2	18.8
	12/83	2,413,000	81.7	18.3
Travelers	6/85	4,857,800	84.7	15.3
(GAAP)	12/84	4,671,300	84.9	15.1
	12/83	4,324,700	85.8	14.2
USF&G	6/85	2,781,173	83.2	16.8
(Statutory)	12/84	2,603,313	83.1	16.9
	12/83	2,330,817	83.6	16.4

Chart: Amy Palmer

Frank B. Hall

Frank B. Hall & Co. Inc. has sold to Reliance Insurance Co. newly issued Hall 12% exchangeable preferred stock and warrants to purchase 2.7 million shares of Hall common stock. The preferred stock is exchangeable at Hall's option into 13% Junior Subordinated Notes due 1997. The preferred stock must be fully redeemed by 1997 and, at Hall's option, may be redeemed at any time after Sept. 15, 1990.

The warrants are exercisable for six years at an exercise price of $27.375 per share.

Hall says the $50 million in proceeds from the sale will be used to repay the $25 million Hall borrowed from Reliance in August and to reduce other debt. Reliance currently owns 20.5% of Hall's common stock. ■

BI Industry Stock Report

October 2, 1985 9/26/85 thru 10/2/85

		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Brokers									
Alexander & Alexander Svcs	NYSE	28.00	-0.4	0.0	1.00	3.6	28.00	27.75	269.1
Baldwin & Lyons Inc	OTC	60.00	0.0	9.9	0.80	1.3	60.00	60.00	0.0
Corroon & Black Corp	NYSE	45.50	-0.5	0.0	1.00	2.2	46.00	45.50	64.4
Crump E H Cos Inc	OTC	28.88	1.3	18.6	0.50	1.7	28.88	28.13	180.5
Eaett & Chandler Cos Inc	OTC	13.50	-0.9	34.6	0.00	0.0	14.00	13.50	9.1
Gallagher Arthur J & Co	OTC	34.50	-1.4	19.3	0.28	0.8	34.63	34.38	81.7
Hall Frank B & Co Inc	NYSE	27.25	-2.2	0.0	1.00	3.7	27.63	27.25	126.9
Marsh & Mclennan Cos Inc	NYSE	68.50	1.5	17.5	2.68	3.9	68.50	67.00	379.8
Poe & Assoc Inc	OTC	8.00	0.0	0.0	0.80	10.0	8.00	8.00	1.2
Reed Stenhouse Cos Ltd	OTC	21.88	0.0	28.4	0.00	0.0	0.00	0.00	0.0
AGENTS/BROKERS	AVERAGE			36.3		2.4			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	41.50	0.3	14.4	1.36	3.3	42.50	41.50	2,628.0
Anderson Clayton(Ranger/PanAm)	NYSE	43.38	5.8	31.9	1.32	3.0	43.88	41.50	80.6
Armco Inc	NYSE	8.75	-4.1	0.0	0.00	0.0	9.00	8.75	336.8
Berkley W R Corp	OTC	20.00	-2.4	58.8	0.32	1.6	20.25	20.00	193.6
CIGNA Corp	NYSE	54.13	2.9	76.2	2.60	4.8	54.63	53.00	660.9
City Investing Co. (Home Ins.)	NYSE	7.25	0.0	1.1	0.00	0.0	7.25	7.25	0.0
CNA Finl Corp (CNA)	NYSE	50.50	1.8	17.5	0.00	0.0	50.88	49.00	136.4
General Re Corp	NYSE	82.88	4.2	131.5	1.56	1.9	82.88	80.25	379.8
ITT (Hartford Group)	NYSE	34.25	5.8	9.9	1.00	2.9	34.25	34.00	4,211.2
Sears Roebuck & Co. (Allstate)	NYSE	32.75	-0.4	8.8	1.76	5.4	33.13	32.75	2,286.2
Teledyne Inc (Argonaut)	NYSE	237.25	1.7	5.1	0.00	0.0	237.25	231.00*	185.2
Transamerica Corp (Occidental & Fred S. James)	NYSE	27.88	2.3	14.4	1.68	6.0	27.88	26.88	523.0
CONGLOMERATES/HOLDING COS.	AVERAGE			9.7		1.8			
Insurers									
Aetna Life & Cas Co	NYSE	45.00	1.7	18.5	2.64	5.9	45.13	43.63	2,023.3
American General Corp	NYSE	29.25	4.0	9.1	1.00	3.4	29.75	28.50	1,460.5
Amern Heritage Life Invt Co	NYSE	33.88	0.0	9.9	1.20	3.5	34.25	33.88	2.9
American Indty Finl Corp	OTC	17.50	6.1	0.0	1.12	6.4	17.50	16.50	10.9
American Intl Group Inc	NYSE	85.50	1.3	22.9	0.44	0.5	85.50	83.88	688.8
Aneco Reins Ltd	OTC	1.25	0.0	0.0	0.00	0.0	1.25	1.25	4.3
Avemco Corp	NYSE	30.25	0.0	13.3	0.60	2.0	30.25	30.25	10.5
Business Mens Assurn Co Amer	OTC	26.50	2.9	7.7	1.04	3.9	26.50	25.50	68.2
Chubb Corp	NYSE	68.75	-0.2	16.8	2.34	3.4	69.63	67.50	289.4
Combined Intl Corp	NYSE	43.75	3.6	8.3	2.16	4.9	43.75	41.50	215.8
Continental Corp	NYSE	40.50	5.9	19.9	2.60	6.4	40.50	38.88	728.8
Crown Life Ins Co	OTC	225.00	-2.2	13.6	0.00	0.0	230.00	225.00	0.1
Durham Corp	OTC	38.25	-3.2	7.1	1.28	3.3	38.25	37.75	40.9
Farmers Group Inc	OTC	59.00	1.7	10.1	1.76	3.0	59.00	57.38	675.1
Fremont Gen Corp	OTC	23.63	-1.6	0.0	0.48	2.0	23.63	23.13	233.9
Great West Life Assurn Co	OTC	430.00	0.0	11.1	1.60	0.4	430.00	430.00	0.0
Hanover Ins Co	OTC	43.75	3.6	59.9	0.56	1.3	44.00	41.50	85.3
Hartford Steam Boiler Insptn	OTC	50.50	0.0	15.9	2.00	4.0	50.50	49.50	12.3
Kans City Life Ins	OTC	23.50	-4.1	9.3	0.87	3.7	24.25	23.50*	7.1
Kemper Corp	OTC	53.50	2.4	15.4	1.80	3.4	53.50	52.63	72.0
Liberty Corp S C	NYSE	29.13	-1.3	12.8	0.72	2.5	29.88	29.13	11.0
Lincoln Natl Corp Ind	NYSE	42.13	2.1	10.1	1.84	4.6	42.25	40.50	93.3
Mission Ins Group Inc	NYSE	4.13	3.1	0.0	0.00	0.0	4.25	4.13	139.7
Monumental Corp	OTC	29.63	-0.8	10.9	1.40	4.7	29.63	29.13	7.8
Nobel Ins Ltd	OTC	10.13	-12.9	13.3	0.25	2.5	11.50	10.13	25.3
Northwestern Natl Life Ins	OTC	21.25	4.9	5.5	0.80	3.8	21.25	20.63	967.9
Ohio Cas Corp	OTC	57.25	2.7	21.4	2.80	4.9	57.25	55.50	373.7
Old Rep Intl Corp	OTC	30.25	8.5	8.1	0.74	2.4	30.25	28.25	110.7
Orion Cap Corp	NYSE	24.50	0.0	0.0	0.76	3.1	25.00	24.25	28.5
Protective Corp	OTC	18.00	-1.4	6.6	0.66	3.7	18.25	17.75*	75.8
Provident Life & Acc Ins Co	OTC	23.50	-2.1	6.4	0.76	3.2	23.75	23.25	455.8
St Paul Cos Inc	OTC	68.50	0.7	0.0	3.00	4.4	68.50	67.13	199.0
SAFECO Corp	OTC	38.75	4.4	12.6	1.60	4.1	38.75	36.88	229.5
Sri Corp	OTC	18.25	7.4	53.7	0.80	4.4	18.25	17.00	56.9
Seibels Bruce Group Inc	OTC	18.50	5.0	0.0	0.80	4.3	18.75	17.25	91.9
Statesman Group Inc	OTC	4.25	0.0	0.0	0.15	3.5	4.50	4.25	17.1
Tokio Marine & Fire Ins Co	OTC	230.50	18.4	43.4	1.05	0.5	230.50*	214.00	17.4
Torchmark Corp	NYSE	19.00	-5.0	7.9	0.60	3.2	19.63	19.00	889.1
Travelers Corp	NYSE	41.75	4.0	10.1	2.04	4.9	41.88	40.88	1,433.4
United Fire & Cas Co	OTC	24.50	0.0	21.3	1.20	4.9	24.50	24.50	0.0
United States Fid & Gty Co	NYSE	33.88	9.3	141.1	2.20	6.5	33.88	31.25	829.6
Uslife Corp	NYSE	35.25	0.4	7.9	1.04	3.0	35.25	35.13	188.2
Washington Natl Corp	NYSE	23.75	0.5	6.9	1.08	4.5	23.75	23.25	35.9
Zenith Natl Ins Corp	OTC	19.25	-0.6	0.0	0.68	3.5	19.75	19.25	56.6
INSURANCE COMPANIES	AVERAGE			17.6		2.3			

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