SEPTEMBER 21, 1987

Business Insurance®

Reporting weekly for corporate risk, employee benefit and financial executives / $1.75 a copy; $68 a year

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Update

10 work comp insurers seek to withdraw from Maine market

AUGUSTA, Maine—Insurers writing about half of all the workers compensation premiums in Maine are withdrawing or want to withdraw from the state, says Insurance Superintendent Joseph A. Edwards.

About 20% of the market is written by nine insurers or insurer groups whose plans for an orderly withdrawal from the market starting Dec. 31 have or will be approved, Mr. Edwards said.

In addition, Liberty Mutual Insurance

Continued on next page

More syndicates consider leaving N.Y. exchange

By DOUGLAS McLEOD

NEW YORK—Eleven of the New York Insurance Exchange's 45 syndicates are notifying the exchange of their intention to withdraw, exchange sources say.

Under exchange rules, syndicates considering withdrawal in 1988 had to file notice of their intent by Sept. 1.

Some of the notices may be provisional, and the syndicates filing them may ultimately decide to remain on the exchange, exchange observers point out.

However, three syndicate owners confirmed that they will definitely withdraw. Syndicates that last week confirmed filing withdrawal notices are Allianz Syndicate Inc., Fremont Syndicate Inc. and Gamma Re Syndicate Inc.

The 1792 Co., the exchange's largest syndicate in terms of 1986 gross premium volume, and Golden Hill Syndicate Inc. had previously confirmed filing withdrawal notices with the exchange (*BI*, Sept. 14; Aug. 31).

In addition, exchange sources say six other syndicates have filed notices of their intent to withdraw with the exchange. However, officials of these six syndicates either refused to confirm that they had filed intent to withdraw notices or could not be reached for comment.

Joseph Fahys, president of the exchange, refused to comment on whether any notices of intent to withdraw have been filed.

Together, the five syndicates that have confirmed they have filed notices accounted for $56.2 million, or 21%, of the exchange's 1986 gross written premium volume of $267.7 million, with 1792 alone accounting for $26.6 million.

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AEGIS program triggers new suit

By DOUGLAS McLEOD

NEWARK, N.J.—Commonwealth Insurance Co. is suing American Centennial Insurance Co., one of its former managing general agents and more than 40 others to avoid liability on several loss-ridden reinsurance contracts.

The reinsurance agreements that Commonwealth is seeking to cancel from inception all covered business produced by the former MGA, The Underwriters Inc. of Parsippany, N.J.

Principal among these are contracts under which Commonwealth participated on a scandal-plagued reinsurance program covering Associated Electric & Gas Insurance Services Ltd., a Bermuda-domiciled utility industry captive.

Among other things, Commonwealth, a Vancouver, British Columbia-based unit of The Home Group Inc., charges that:

Its own Bermuda-based MGA was bribed to put Commonwealth on the AEGIS program and other risks between 1978 and 1983.

- Several of the defendants diverted AEGIS premiums.
- AEGIS' loss experience was falsified to induce Commonwealth to participate in the program.

The suit, filed Sept. 11 in U.S. District Court in Newark, also names ACIC's former parent company, Beneficial Corp., and several of Beneficial's directors and officers.

Beneficial sold ACIC and other insurance units to a management group in May (*BI*, May 26; April 6).

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Grant Thornton says it's covered for tentative $80 million settlement
Page 3

Photo: Kathryn J. McIntyre

The old city of Monte Carlo overlooks the principality of Monaco's yacht-filled harbor.

Stability reigns

Reinsurers don't foresee rampant competition

By KATHRYN J. McINTYRE and STACY SHAPIRO

MONTE CARLO—Reinsurers are promoting stability in U.S. property/casualty insurance rates next year.

"It is still a tight market," says John Engestrom, senior vp of Skandia America Group in New York. "There is not a free-fall in the cycle."

However, reinsurers acknowledge that conditions in the U.S. primary insurance market are softening—and much more quickly than was expected. Their assessment of how much primary companies are reducing property insurance rates and even shaving casualty insurance rates range from mostly "very little" to occasionally "too much."

U.S. underwriters, and not London underwriters, are cited as most competitive.

Overall, however, there is little concern that the U.S. property/casualty insurance market is about to head into another destructive competitive binge. Generally, reinsurance leaders view the emerging competition as inevitable after improved insurer profits.

"There is no way the insurance or reinsurance market will go on producing high returns without some competition occurring. After two years, people will say that this is a good business and will think about getting into it," says John Lock, general manager of The Mercantile & General Reinsurance Co. P.L.C. in London and chairman of the Reinsurance Offices Assn.

Reinsurers appear confident that competition will not drive rates as low as in the previous competitive market because insurance experts are in control now, not "financial types" (see story, page 72).

Should rates drop below profitable levels, however, reinsurers contend they will not support them and will give up business.

In light of improved profits to date, some reinsurers are giving up tighter terms and conditions they fought for since 1985, including the demand that general liability insurance be written on claims-made policies.

Although the improvement in U.S. underwriting results is beginning to fuel competition among U.S. insurers, it is not enough to attract new European support for U.S. casualty business. Any new reinsurance capacity from Europe for U.S. business generally will be offered only for short-tail property business (see story, page 80).

New capacity is not needed, according to reinsurers, who say catastrophe reinsurance is the only line still needing capacity.

Hoping for rate stability and expecting ceding companies to maintain large retentions, reinsurers expect a smooth renewal season in January, but not much growth.

These are the majority of views of insurers, reinsurers and reinsurance brokers who gathered earlier this month in Monte Carlo for the 31st Rendez-Vous de Septembre, the largest international gathering in the reinsurance business.

Reinsurance company executives and reinsurance brokers from around the world gather in the tiny principality on the Mediterranean Sea early each September to meet clients and associates to discuss the status of current contracts and future business opportunities in particular and market conditions in general.

There is a formal panel discussion one morning during the weeklong meeting, but generally fewer than 200 of the nearly 2,000 registrants at the Rendez-Vous attend. Instead, they meet in groups of two to four—and sometimes more—in hotel lobbies, suites, restaurants and beach cabanas. Their private meetings can be as short as 15 minutes but generally last for a half-hour to an hour.

Most appointments are made in advance, with a few holes left in a schedule to accommodate a new business opportunity.

But, some arrive fully booked, like Jens Juul, manag-

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Update

Comp insurers to leave Maine

Continued from previous page

Co., the largest work comp insurer in Maine with a 32% market share, filed a plan to withdraw from the state this week that was rejected (*BI*, Aug. 24).

Liberty Mutual's plan will be discussed at two Insurance Department hearings this week. However, a state superior court judge has ruled that Liberty Mutual must continue to write coverage for policyholders in the state's assigned risk plan until the policies expire, said a spokesman for the insurer. The court order did not apply to voluntary market policyholders and the insurer has not rescinded cancellation notices for them effective Tuesday, he said.

Mr. Edwards said large insurers whose orderly withdrawals have or will be approved include: Hartford Insurance Group, which writes about 6% of the market; Travelers Corp., with a 5% market share; and Utica Mutual Insurance Co., which also has about a 5% market share.

Other insurers with smaller market shares that plan to withdraw are: United States Fidelity & Guaranty Co.; Covenant Insurance Co. and Covenant Mutual Insurance Co.; Peerless Insurance Co.; Pennsylvania Millers Mutual Insurance Co.; and Graphic Arts Mutual Insurance Co.

Mr. Edwards said he also is reviewing a withdrawal request submitted on Friday by Aetna Casualty & Surety Co., which writes about 7% of the work comp premiums in Maine.

Acceptable withdrawal plans typically include provisions that the insurer will provide coverage until policies expire, will provide a 30-day notice of cancellation and will honor its assigned risk plan obligations through year-end.

Insurers contend that workers compensation insurance in Maine is highly unprofitable because of inadequate rates and substantial losses from employers in the state's assigned risk pool, through which most Maine employers buy their insurance.

Mr. Edwards, who became superintendent June 1, expects that an Insurance Department hearing Monday will help him decide whether work comp rates are too low.

If the 10 major insurers and dozens of smaller insurers that remain in the market pull out of the state, one alternative is to "fix" the system by bringing rates up to meet costs or lowering costs to meet rates, Mr. Edwards said.

Another option is to establish a competitive state fund, Mr. Edwards said. However, Gov. John R. McKernan Jr. opposes that alternative. The governor has not decided whether to call a special session of the Legislature before its scheduled January session to address the situation, the spokesman said.

TPA executives arraigned

CHICAGO—Two corporate officers of defunct third-party administrator Health Insurance Administration Inc. face criminal charges for mail fraud and embezzlement of approximately $1.4 million from nearly 165 employee benefit plans.

Joseph L. Jacobson, 50, and Robert B. Callaghan, 45, were arraigned last week on charges that they embezzled funds from welfare-type plans between January 1982 and April 1986. Mr. Jacobson had been principal stockholder and chairman of Rolling Meadows, Ill.-based HIA and Mr. Callaghan was the company's president and treasurer.

The Labor Department's Pension and Welfare Benefits Administration investigated the firm as part of its examination of companies providing services to welfare plans covered by the Employee Retirement Income Security Act. The U.S. Attorney's office in Chicago will prosecute the case.

The criminal charges allege the pair:

- Embezzled for gambling and other personal purposes approximately $1.4 million from HIA's premium trust and claims accounts, which contained benefit plan funds.
- Used the assets of HIA as collateral for a personal loan to Mr. Jacobson, causing the loan to go into default and then repaying the loan with assets from HIA.
- Mailed false premium trust account statements and audit reports to insurers, underwriters and HIA clients.

If convicted, the men could face up to 75 years in prison, $3.75 million in fines and joint liability for restitution of as much as $1.4 million, according to the U.S. Attorney's office.

Auto workers get pension hike

TORONTO—About 10,000 Chrysler Canada Ltd. workers were expected to approve a six-year contract last weekend that would index pensions to inflation.

Under terms of the contract, which is expected to cost Chrysler $50 million Canadian ($38 million at current exchange rates), pensions for future retirees would include annual adjustments equal to 90% of the Canadian inflation rate. Chrysler's 4,000 current retirees will receive annual increases in their pensions equal to 90% of the Canadian inflation rate but with a maximum annual increase of 6% of pension benefits. By 1992, future retirees' pension benefits are expected to increase to $1,875 Canadian per month ($1,426) from $1,205 Canadian ($916) based on this formula.

The agreement came after a five-day strike by workers during contract negotiations and is expected to set a precedent not only for the auto industry in Canada but also for other industry groups.

Meanwhile, Ford Motor Co. negotiated a tentative contract that includes increases in pensions and improvements in the health care program, according to the United Auto Workers.

Under the tentative agreement, which focuses on job security, workers' pensions will be adjusted "upward each year in order to keep up with anticipated cost of living adjustments for active workers," according to statement from the UAW.

Also "health care and other insurance features were upgraded," said the UAW, which would not release more details.

Ford declined to comment on the changes.

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Broad asbestos coverage affirmed by Illinois court

By STEPHEN TARNOFF

CHICAGO—Liability insurance for asbestos claims is triggered both at the time a victim is exposed to the substance and when a disease is manifested, the Illinois Supreme Court ruled last week.

In upholding a 1986 Illinois appellate court decision that granted broad coverage for asbestos claims, the state high court also affirmed last Monday that coverage for asbestos claims also may be triggered during an interim period between a victim's exposure to the substance and manifestation of a disease.

'It's a wonderful standard, but it's useless. It can't be practically applied,' says Raymark attorney Frank K. Heap.

Whether insurance in force during the interim period would have to respond to asbestos claims has to be determined on a case-by-case basis, the court said.

But, in an important victory for insurers, the court in *Zurich Insurance Co. vs. Raymark Industries Inc.* found that insurers do not have an unlimited duty to defend policyholders under pre- and post-1967 policies after policy limits are exhausted.

The decision is the first asbestos case to be decided since a comprehensive coverage decision by California Superior Court Judge Ira A. Brown Jr. last May found there was a continuing injury from exposure to manifestation (*BI*, June 1).

Many policyholders at that time expected that Judge Brown's ruling would likely have great impact on other asbestos coverage decisions on the trigger of coverage, but the Illinois Supreme Court did not rely on Judge Brown's decision.

Last week, attorneys for Raymark, now called Raytech Corp., said the decision would not have a significant impact on the company and essentially keeps the company in the same position it was in following the similar appellate court decision last year.

"It's like a no-decision," said the company's General Counsel LeGrande L. Young.

But Frank K. Heap, Raymark's attorney in the coverage litigation, said the decision fails to address how to implement certain aspects of the decision, which will cause practical problems for Raymark and its insurers in resolving coverage for asbestos cases.

For example, Mr. Heap questioned how, under the decision, it can be determined on a case-by-case basis whether each insurer that wrote coverage for the company during the interim period must respond to asbestos claims.

"It's a wonderful standard, but it's useless," said Mr. Heap, who is with the Chicago firm of Bell, Boyd & Lloyd. "It can't be practically applied."

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Inquiries not made by *BI*

Unauthorized persons representing themselves as employees of *Business Insurance* have been telephoning companies, asking questions about the salaries and educational backgrounds of certain executives. They also have been soliciting interest in insurance seminars.

Business Insurance has not authorized anyone to ask questions of this type nor solicit interest in insurance-related seminars.

While employees of *Business Insurance* do conduct telephone surveys to complete the various directories that appear in the magazine and the annual *BI Directory of Corporate Buyers*, they do not ask questions concerning executives' salaries and only inquire about educational backgrounds for the Comings & Goings: Buyers column.

Mentor defendants seek Bermuda trial

By ROGER SCOTTON

HAMILTON, Bermuda—All 11 defendants sued by the liquidators of Mentor Insurance Co. Ltd. have petitioned for the suit to be heard by Bermuda's Supreme Court, not by the U.S. District Court in New Orleans, where the suit was originally filed in March 1986.

In what must rank as the most coherent display of unity yet to emerge in the 18-month-old legal battle, the defendants have signed a petition for dismissal on the grounds of "forum non conveniens," a legal doctrine based on a court's power to control the parties and cases before it and prevent its process from becoming an instrument of abuse or injustice.

The defendants include Mentor's parent Ocean Drilling & Exploration Co. of New Orleans; J. Douglas Higley, Mentor's former chairman; several Mentor directors; and Bermuda-based Pinnacle Reinsurance Co. Ltd.

Liquidators Charles W. Kempe Jr. and Michael Arnold have accused the defendants of common law fraud and violations of the Racketeer Influenced and Corrupt Organizations Act and are suing for recovery of about $700 million.

Messrs. Kempe and Arnold allege that seven of the defendants devised a scheme to conceal Mentor's true financial condition by using three excess-of-loss reinsurance contracts arranged with Pinnacle between 1982 and 1984 (*BI*, March 24, 1986).

Pinnacle is appealing a denial of a request for a declaratory judgment that the liquidators of Mentor do not have standing to sue Pinnacle in Louisiana (*BI*, May 11, May 4).

Meanwhile, the defendants, who have consistently denied the allegations, say that the civil case against them represents a transparent

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Inside

✔ Contrary to assertions made by the National Insurance Consumer Organization, property/casualty insurers are not earning 'obscene' profits, this week's editorial points out. **PAGE 8**

✔ Ceding insurers can face various difficulties when trying to collect on letters of credit posted by reinsurers, an attorney observes at a one-day Reinsurance Rendez-Vous in New York, sponsored by Kroll, Tract, Harnett, Pomerantz & Cameron. **PAGE 17**

✔ The liquidators of Cambridge Reinsurance Ltd. now estimate that the Bermuda-based reinsurer is insolvent by almost $64 million—nearly double the amount they originally had estimated. **PAGE 36**

✔ In Perspectives, Sharon Graugnard, president of Preferred Health Management in Arlington, Va., says preferred provider organizations must take the initiative to set up a PPO accreditation system. **PAGE 51**

✔ Employers have strong objections to proposed COBRA regulations, according to the letters they have sent to the Internal Revenue Service. **PAGE 53**

✔ Hospitals are less likely than other types of employers to include medical cost management features in their group health care plans. **PAGE 66**

✔ Peruvian insurers may be allowed to retain up to 70% private ownership under the latest draft of Peru's proposal to nationalize its insurance industry. The bill currently is bogged down in Peru's Senate. **PAGE 85**

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Vol.21, No.38—*Business Insurance* (ISSN 0007-6864) is published weekly at 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 313-446-1611. Copyright 1987 by Crain Communications Inc.

Auditor covered for E.S.M. loss

By MARK A. HOFMANN

COLUMBUS, Ohio—Auditor Grant Thornton says it has enough errors and omissions insurance to cover a tentative $80 million settlement with the liquidator of a creditor of a securities firm for which a former Grant Thornton partner falsified financial statements.

The tentative settlement follows by nearly a year a $70.9 million federal jury judgment, of which Chicago-based Grant Thornton must pay half, in favor of the trustee for the now-defunct E.S.M. Government Securities Inc. (*BI*, Nov. 17, 1986). Grant Thornton also said that award, which currently is being appealed, was covered by its E&O insurance.

The proposed settlement probably will not cause the already tight market for accountants' professional liability insurance to constrict further, with the possible exception of coverage for accountants that audit securities firms, according to several insurers and brokers.

Peter Skomorowsky, a managing director in Grant Thornton's New York office, would neither provide details of the proposed settlement with the liquidator of the E.S.M. creditor, Home State Savings Bank of Cincinnati, nor predict when the settlement would be signed, although he confirmed that the proposal totals approximately $80 million.

Mr. Skomorowsky also declined to comment on Grant Thornton's professional liability insurance beyond stressing that it is adequate to cover the proposed settlement. He also declined to identify underwriters of the coverage.

But sources in the London market say that Grant Thornton's E&O coverage was placed by Lloyd's of London broker Minet International Professional Indemnity Ltd., which places coverage for most top U.S. accounting firms.

London sources estimated that Grant Thornton had no more than $150 million in coverage under a claims-made policy expiring in the spring of 1985 to pay losses stemming from the E.S.M. affair if that policy is the only policy responding to the losses.

The first $20 million of coverage, which London sources say is already exhausted, is led by Lloyd's syndicate 799 underwritten by Robin Jackson and managed by Merrett Underwriting Agency Management Ltd. The first $20 million in coverage probably was placed as either two layers of $10 million or as one layer of $20 million, the sources said.

Mr. Jackson was traveling and unavailable for comment.

About 28% of the first $20 million in coverage is underwritten by H.S. Weavers (Underwriting) Agencies Ltd., the leading U.S. casualty underwriter in London.

Excess layers above $20 million are believed to be led at Lloyd's with syndicate 799 as one of the participants. Affiliates of American International Group Inc. in the United States are also believed to be participating on the excess layers.

An AIG spokesman could not comment on whether AIG units participated in the coverage.

Weavers does not participate on the excess layers, London sources say.

The $80 million tentative settlement would end a 2½ year-old series of lawsuits against Grant Thornton stemming from its work as auditor for Fort Lauderdale, Fla.-based E.S.M. The securities firm was seized by the Securities and Exchange Commission in March 1985 after the SEC charged the firm with fraud. The SEC's action against E.S.M. caused a run on Ohio savings institutions that had invested in the government securities traded by the firm.

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Four more execs quit Willis Faber following merger

By STACY SHAPIRO and CAROLYN ALDRED

LONDON—The exodus of top Stewart Wrightson Holdings P.L.C. officials in the aftermath of the acquisition of the Lloyd's of London broker by rival broker Willis Faber P.L.C. is continuing.

Last week, Willis Faber announced that four additional Stewart Wrightson directors will not join the merged company.

And, there was speculation last week that more people will leave after Willis Faber announced to employees how the merged companies will be structured.

Willis Faber acquired Stewart Wrightson in a deal valued at more than $450 million (*BI*, July 6). The acquisition creates the world's fifth-largest brokerage, based on Willis Faber's and Stewart Wrightson's combined 1986 gross revenues of $391.9 million.

The combined company will retain the Willis Faber name.

The company announced last week that George Boden, deputy chairman of retail broker Stewart Wrightson Ltd., and Tony Keys, Stewart Wrightson's group development director, will not join the merged company, though both have consulting contracts with Willis Faber until the end of 1988.

Both Mr. Boden and Mr. Keys have worked closely with Stewart Wrightson Chairman David Rowland the past few years to strengthen the company.

"I will be pursuing other business interests," said Mr. Keys, who will resign shortly. "The last 11 years at Stewart Wrightson have been super, and David Rowland has been an excellent chairman. . .but there wasn't a good opportunity at Willis Faber on a full-time basis. I wasn't offered a position on the board. I understand the reasons, but I disagreed with them."

Also leaving the merged company are Jeremy Wagener, Stewart Wrightson's group financial director,

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Reinsurers' growth rate slows in first half of 1987

By JUDY GREENWALD

A dramatic drop in net premium growth among U.S. reinsurers during the first half is not an indication of renewed price competition in the reinsurance industry, reinsurance executives assert.

While conceding there have been some instances of rate softening, reinsurers say the slackened premium growth is primarily a reflection of higher retentions by ceding companies taking advantage of their healthy surpluses.

"There's simply less reinsurance premium out there right now" than there was six or 12 months ago, summed up Paul Inderbitzen, executive vp of American Re-Insurance Co. in New York.

According to a survey of 75 reinsurers by the Reinsurance Assn. of America, net written premiums for the six months ending June 30 increased only 8.7% to $6.4 billion from $5.9 billion in the first half of 1986. This compares with a 15% increase in premiums in the first-quarter of this year and a 57.3% increase in the first half of 1986 (see chart).

Similar first-half 1987 premium growth was produced by the 20 largest U.S. reinsurers, based on net written premiums. These 20 reinsurers wrote $5 billion in net premiums during the first half, a 5.9% increase over $4.8 billion in net premiums written by the 20 largest reinsurers during the first half of 1986. Net written premiums among the Top 20 reinsurers grew 13.5% in the first quarter of 1987 and 63.7% in the first half of 1986.

Reinsurers' combined ratios deteriorated slightly on a quarter-to-quarter basis, though the group's aggregate combined ratio improved compared with a year ago.

All reinsurers surveyed posted a 101.5% combined ratio for the first half vs. a 106.3% combined ratio for the comparable period a year ago. However, the reinsurers reported a combined ratio of 100.8% during the first quarter of this year.

The Top 20 reinsurers posted a 100.9% combined ratio for the first half, compared with a 105.5% combined ratio for the first half of 1986. However, the Top 20 reported a combined ratio of 100.6% in this year's first quarter.

Reinsurance executives stated that in light of the industry's vastly improved results in recent quarters, a leveling off in the industry's combined ratio was to be expected.

"I don't think you'll see any real problem with earnings in 1987 and 1988 because of the momentum that's been generated," said Michael Fitt, chairman and chief executive officer of Employers Reinsurance Corp. in Kansas City, Mo.

However, he added if the overall property/casualty insurance market continues to deteriorate at the current pace, "I think '89 will be a difficult year." He added that he hoped that primary insurers that are pursuing market share will reverse that trend.

Reinsurers, though, generally remain pleased with their first-half results.

"Obviously, we're encouraged with the results, and see them as a sign we've got things on the right track," said Donald Cole, president of Constitution State Management

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Asbestos property damage award upheld

By STEPHEN TARNOFF

RICHMOND, Va.—W.R. Grace & Co. contends it is fully covered by insurance for a $6.8 million jury award recently affirmed by a federal appeals court in an asbestos property damage case.

However, at least two insurers are disputing coverage for the award.

In a decision late last month, the 4th U.S. Circuit Court of Appeals turned down an appeal by New York-based Grace to overturn the judgment to the city of Greenville, S.C., which included $2 million in punitive damages.

The city had sued Grace in connection with the installation of the company's asbestos-containing fireproofing product in the Greenville city hall.

The decision is the first by a federal appeals court to uphold an asbestos property damage award against an asbestos producer.

Last week, a spokesman for Grace said, "We believe that insurance will cover any damages," including the punitive damages. But the spokesman said the company had not decided whether it would seek a rehearing in the case.

An attorney for Grace agreed that the company is covered for both the compensatory and punitive damage awards in the Greenville case.

"There's no question in my mind there is coverage," said Grace attorney Jerold Oshinsky, who is with the Washington firm of Anderson Baker Kill & Olick.

Mr. Oshinsky said the punitive damages are covered because South Carolina permits coverage for such awards.

However, an attorney for American General Corp. subsidiary Maryland Casualty Co. of Baltimore, one of Grace's former liability insurers, claims that Grace is not covered for the award under policies written by the insurer.

"W.R. Grace has no coverage for public building ripout cases under the Maryland policies, and the circumstances of the Greenville case certainly underscore that conclusion," said Maryland Casualty attorney Thomas Brunner, who is with the Washington firm of Piper & Marbury.

In addition, an attorney for Aetna Casualty & Surety Co. says the insurer also disputes coverage for the Greenville award.

Grace is currently litigating with its primary and excess liability insurers in three jurisdictions over coverage for asbestos bodily injury and property damage claims.

The company is litigating with its primary insurers since 1950 in New York in a coverage lawsuit brought by primary insurer Maryland Casualty.

Other primary insurers in the litigation include Hartford, Conn.-based Aetna; Continental Casualty Co. of Chicago, a unit of CNA Financial Corp.; Royal Insurance Co., a unit of Royal Group Inc. of Charlotte, N.C.; and General Insurance Co. of America of Seattle, a subsidiary of SAFECO Corp.

In addition, earlier this year, Grace filed a lawsuit in state court in Massachusetts against approximately 70 of its excess insurers seeking coverage for asbestos personal injury and property damage claims.

Grace also is seeking coverage through a third-party action against certain insurers in litigation in Beaumont, Texas, where Grace is a defendant in asbestos property damage litigation.

Last week, an attorney for the city of Greenville said the decision by the 4th Circuit Court was significant because it is the first federal appellate court decision to uphold an asbestos property damage award.

In addition, the federal appellate court is only the second appellate court to address whether recovery for asbestos contamination can be brought as a tort action as opposed to an economic loss, which would have precluded the city of Greenville from filing its tort lawsuit against Grace, said Greenville attorney Ed Westbrook, with the Charleston,

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Satellite launch cheers underwriters

By STACY SHAPIRO

LONDON—Satellite insurance underwriters hope the success of last week's launch of two commercial satellites by European space agency Arianespace will mark the resurgence of the space insurance industry.

Satellite insurers lost confidence in writing coverage for satellites following nearly $1 billion in satellite losses and the shutdown of the world's two launch programs.

The Arianespace commercial satellite launch program was shut down in May 1986 after an Ariane rocket malfunctioned with an $82 million satellite on board.

The Ariane loss followed by four months the Jan. 28, 1986, Challenger shuttle explosion (*BI*, Jan. 26, 1986; June 9, 1986).

However, the launching of the Ariane rocket in French Guyana on Sept. 16 that carried two satellites insured for a total of $140 million will boost underwriters' confidence in the industry, said brokers and underwriters at the International Bar Assn.'s conference on the space industry and insurance last week.

"We have a winning streak of one and we are extraordinarily grateful for that," said James Barrett, president of International Technology Underwriters in Washington, D.C. "This has been a period of a dearth of confidence among underwriters. . . .We need that confidence to return."

Now that the Ariane has been successfully launched, "we can expect a new enthusiasm by manufacturers, owners, users and particularly insurers," said Benito Pagnanelli, space group chairman of Assicurazioni Generali SpA. of Trieste, Italy, Europe's largest satellite underwriter.

"This should give a start to a second and more mature phase of the space commercial activity," he said.

"The Ariane launch was a milestone," said Lee R. Scherer, director of commercial space for General Dynamics Corp.'s space systems division in San Diego.

"Hopefully this success will be the start of a new era in the space industry," said Brian Moore, managing director of Lloyd's of London broker Bowring Space Projects.

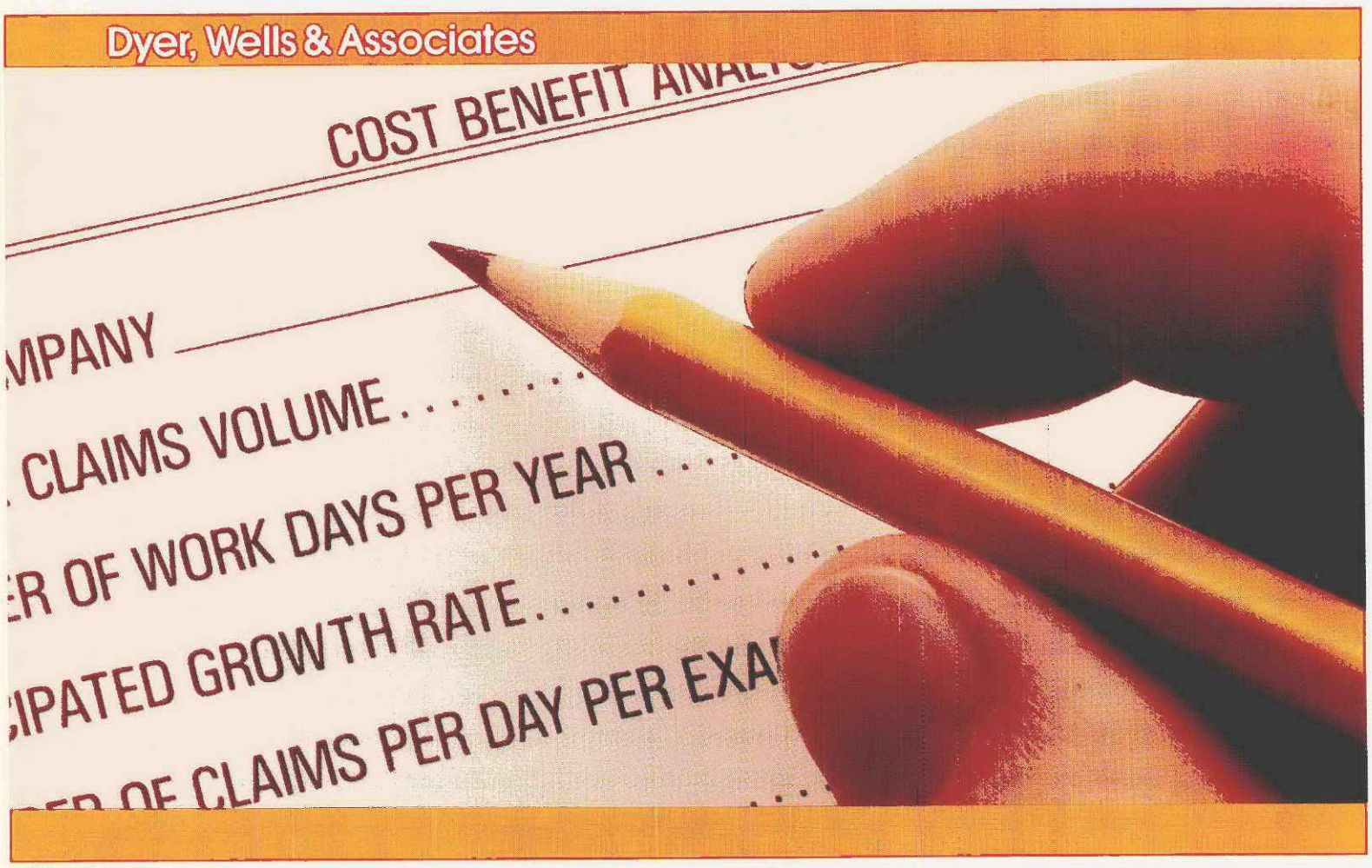
The ECS-4 satellite, owned by the European Space Agency, was insured for a total of $80 million when it was launched last week. While on board the Ariane rocket, $40 million of the coverage was insured by a subsidiary of Arianespace known as S3R, which was established to indemnify satellite owners for the cost of a relaunch.

The satellite had $80 million in coverage written by commercial insurers after deployment. Assicurazioni Generali SpA in Trieste, Italy, was the lead insurer in Europe. The coverage, which runs for 180 days, was placed by Bowring Space Projects and Leslie & Godwin Aviation Ltd. in London and Gradman Holler in Germany.

Aussat A3, owned by AUSSAT Property Co. of Australia, is insured for $60 million by commercial insurers for a one-year period. The coverage, placed by Willis Faber P.L.C. in London and Johnson & Higgins in New York, was led by Lloyd's Ariel syndicate in London. INTEC and Generali also participated on the coverage.

"In real terms, there is no capacity crisis" in the satellite insurance market, said Brian Goodge, a former leading satellite underwriter with Orion Insurance Co. P.L.C. and now consultant with Satellite Insurance Services. "What we have is a crisis of confidence. There is capacity which exists that has not touched the space industry because it is too volatile and unpredictable."

More capacity will be available from the insurance industry when manufacturers have shown more successes in space products, he said. ■



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Glenn Huntley named to *BI's* L.A. bureau

Glenn W. Huntley, 32, has joined the Los Angeles bureau of *Business Insurance* as an associate editor, Associate Publisher and Editor Kathryn J. McIntyre announced.

Before joining *BI*, Mr. Huntley had been a reporter at the Skagit Valley Herald, a daily newspaper in Mount Vernon, Wash., where he covered city and county government affairs among other topics. Prior to that, he was a reporter with the Anacortes American, a newspaper in Anacortes, Wash.

Mr. Huntley

He also has served as managing editor of the Willapa Harbor Herald, a weekly newspaper in Raymond, Wash., and editor of the Raymond Herald, another weekly. In addition, he was a reporter with the Elma Chronicle in Elma, Wash.

Mr. Huntley has won journalism awards from the Society of Professional Journalists/Sigma Delta Chi, the Washington Press Assn. and the Washington Newspaper Publishers Assn.

He received a bachelor of arts degree in journalism in 1978 from The Evergreen State College in Olympia, Wash.

Mr. Huntley will report on a range of risk management and employee benefits topics at *Business Insurance*. He can be reached at 213-651-3710. ■

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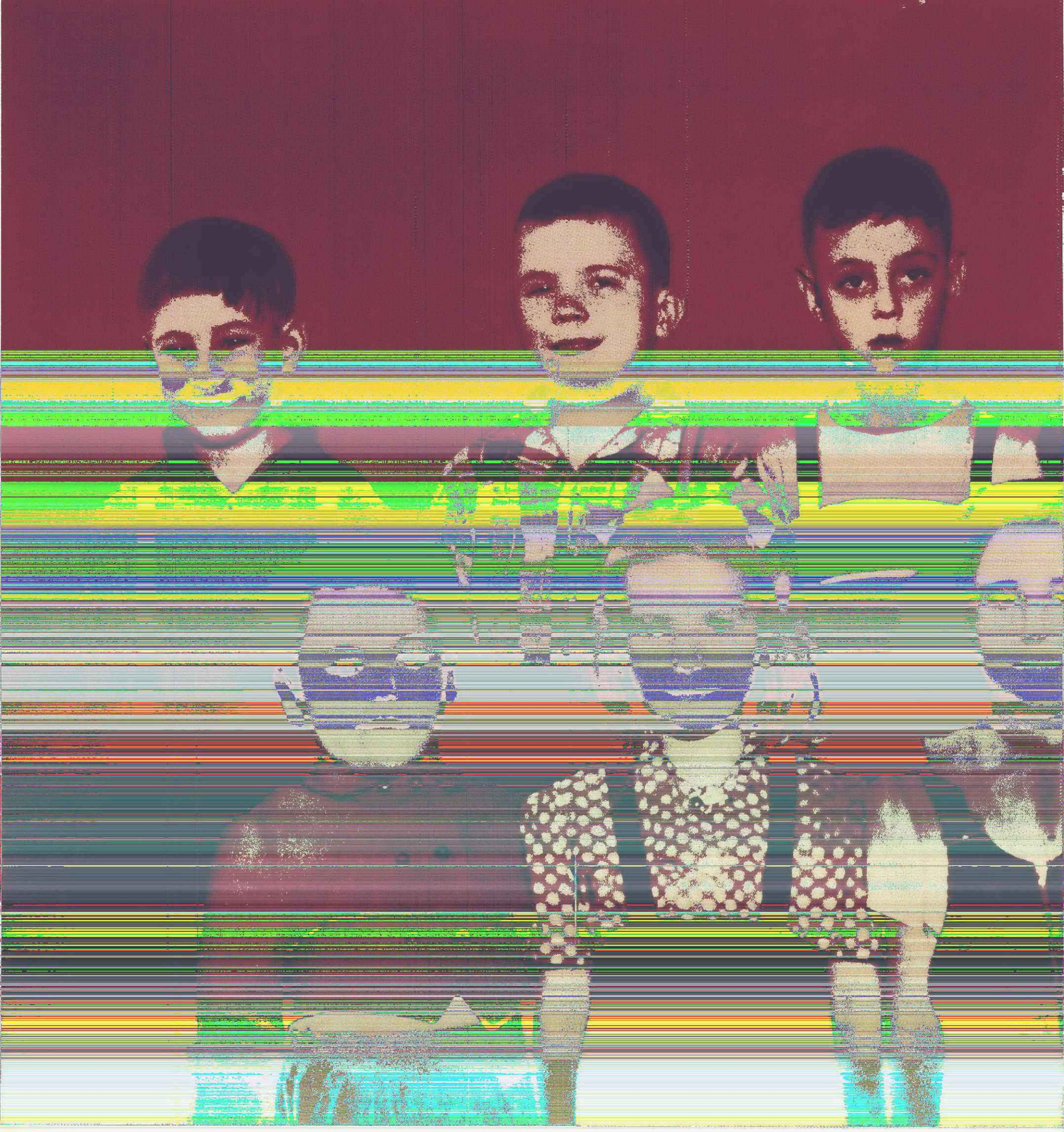

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Opinions

Realistic profits

CONTRARY TO THE the assertions of the National Insurance Consumer Organization, we don't believe that property/casualty insurers are earning "obscene" profits.

As we reported earlier this month, U.S. property/casualty insurers reported net income of $7.5 billion in the first half of 1987, up 29.7% from $5.8 billion during the same period a year ago.

In addition, pretax operating income increased 249.1% to $6.5 billion from $1.9 billion.

NICO President J. Robert Hunter charges that not only are these profits obscene, but that the industry's published results understate its true profitability.

He says if the $1.1 billion paid out in policyholder dividends were not counted as losses and if $5.7 billion in unrealized capital gains were included as income, the property/casualty industry's net profit really was $14.3 billion.

Mr. Hunter's first charge—that the industry's profits are obscene—simply doesn't wash.

Measured against net written premiums of $95.5 billion, the industry's $7.5 billion net profit equals about a 7.9% margin. In our view, and we think also in the view of most fair-minded critics, an 8% profit margin can be described as reasonable.

Mr. Hunter's second charge—that the industry is understating profits by including policyholder dividends as losses and excluding unrealized capital gains from profits—is ridiculous.

If the industry excluded policyholder dividends as losses and included unrealized capital gains as profits, it would violate rules laid down by federal regulatory agencies as well as standards set by the accounting profession.

And, the inclusion of unrealized capital gains—which are no more than paper profits as the market value of assets such as stock increases—as profits could give a terribly misleading picture of the financial well-being of an insurance company.

If these gains were considered in an insurer's profits, a money-losing company could be perceived as a profitable entity. Alternately, a stock market downturn could turn a profitable insurance company into a company whose bottom line would lead many to believe it was headed to insolvency.

We also do not accept the NICO official's argument that the industry's improved profitability proves the tort reform movement is fraudulent.

According to this line of reasoning, tort reform isn't needed because without the enactment of substantial and widespread reforms, the industry still managed to earn higher profits.

Any risk manager can tell Mr. Hunter at what cost the insurance industry was able to recover its profitability. Not only did insurers dramatically increase insurance premiums, but they also stopped writing certain lines of insurance. The unpredictability of the civil justice system will continue to restrict the availability of some lines of insurance, or at least keep the cost high.

Yes, insurers are making money now. And, as a result, competition is returning to the marketplace, decreasing the cost of insurance. Mr. Hunter will not have long to complain about obscene profits, as competitive pricing will soon reduce profits.

Letters

Regulators' real fear is federal control

To the editor: Let's get real about purchasing groups and the intent of the 1986 amendments to the Risk Retention Act of 1981. In the article titled "Purchasing Groups Set Up by Insurers Draw Criticism," (*BI*, Aug. 24) you report the criticism by several insurance commissioners bemoaning the fact that they have lost their regulatory powers. What really frightens them, at least in commercial lines, is that the federal government will attain ultimate control.

Many of us engaged in writing business on a national basis do not fear federal control. It might be better to deal with one gorilla rather than 51 monkeys. The amended act allowing purchasing groups —no matter how formed—allows the flexibility the states don't allow. It fulfills a need to be able to offer a new product in a short period of time.

This gets us back to intent. Michael Mullen of the law firm of Crowell and Moring, who helped draft the act, made the statement to *BI*: "The law was intended to increase the options of both insurers and buyers." These options include only allowing minimal intervention by state insurance commissioners and certainly no control over form and rate. Yet some persist in trying to obtain control. They do this in the guise of "protecting the consumer."

The simple truth remains, with the exception of a very few lines, the examiners in most states have no idea as to how to judge the adequacy or deficiency of commercial insurance rates. Go to any commissioner's office and talk with the examiners. They have hundreds of filings they are trying to handle. Thus, delays, delays and more delays.

And, I don't buy the "protect the consumers from rate gouging," either. Given the freedom of a true free marketplace, rates will adjust. In the meantime, a market continues to exist for certain lines that would not otherwise exist.

While the act isn't perfect and needs to be spruced up, it would be a terrible mistake to amend it to allow state insurance commissioners to get involved in form and/or rate.

Harry L. Baker
President
Professional Insurance Corporation
Seattle

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill., 60611.

Setting the record straight on HIRO

To the editor: In your July 17 issue you printed an article about the formation of Hospital Insurance Reciprocal of Ontario in Toronto.

Contained midarticle is the statement: "HIRO offers a two-year occurrence policy and members must give two years' notice if they intend to leave the reciprocal."

Unfortunately, this information is not correct. HIRO will be writing annual policies of insurance on a claims-made basis for professional liabilities and on an occurrence basis for comprehensive general liability coverages. Each subscriber must undertake a two-year membership period after which time they may give notice of intent, which is an additional two years. Such termination does not affect their continuing liability to the reciprocal for the years they were a subscriber. I trust this will clear up this most important point.

Michael V. McNeill
Attorney/Chief Executive Officer
Hospital Insurance Reciprocal
of Ontario
Don Mills, Ontario

'Victims' misnomer for people with AIDS

To the editor: First, I would like to compliment you for the articles in the Sept. 7 issue dealing with various facets of the AIDS epidemic. Your emphasis on education and awareness rather than panic and ignorance is the most enlightened attitude I have seen in a trade journal to date.

I would, however, like to point out that people with AIDS are not necessarily "patients" nor "victims." As the articles pointed out, there are many "PWAs" who are productive members of the workforce. These people are not in the hospital so they are not really patients and if they are victims, it is of bigotry, fear and ignorance—not AIDS. Using the phrase "people with AIDS" avoids the built-in stigma of the words "victim" and "patient."

Allan Perry
Commercial Underwriting
San Francisco Agencies Inc.
San Francisco

Overfunded plans are employer tax shelters

To the editor: James Whitaker's letter and *most* of your editorial "Collected Thoughts" (*BI*, Aug. 17) are wise and sane. But the *first* "thought" you collect —on Congress and pension plan asset reversions—suggests a surprising naivete about just how pension plans get overfunded in the first place.

For employees, pension plans are simply a way to earn retirement income. But for employers they are (dare I tell tales out of school?) a tax shelter! A company can increase or decrease its annual pension contribution by millions of dollars each year simply by changing its actuarial assumptions. And money "buried" in a pension plan is not taxed.

Since ERISA, U.S. law has been fairly clear that benefit plans exist to serve

Continued on page 10

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ADVERTISING: New York: 212-210-0133; Chicago: 312-649-5276; Los Angeles: 213-651-3710
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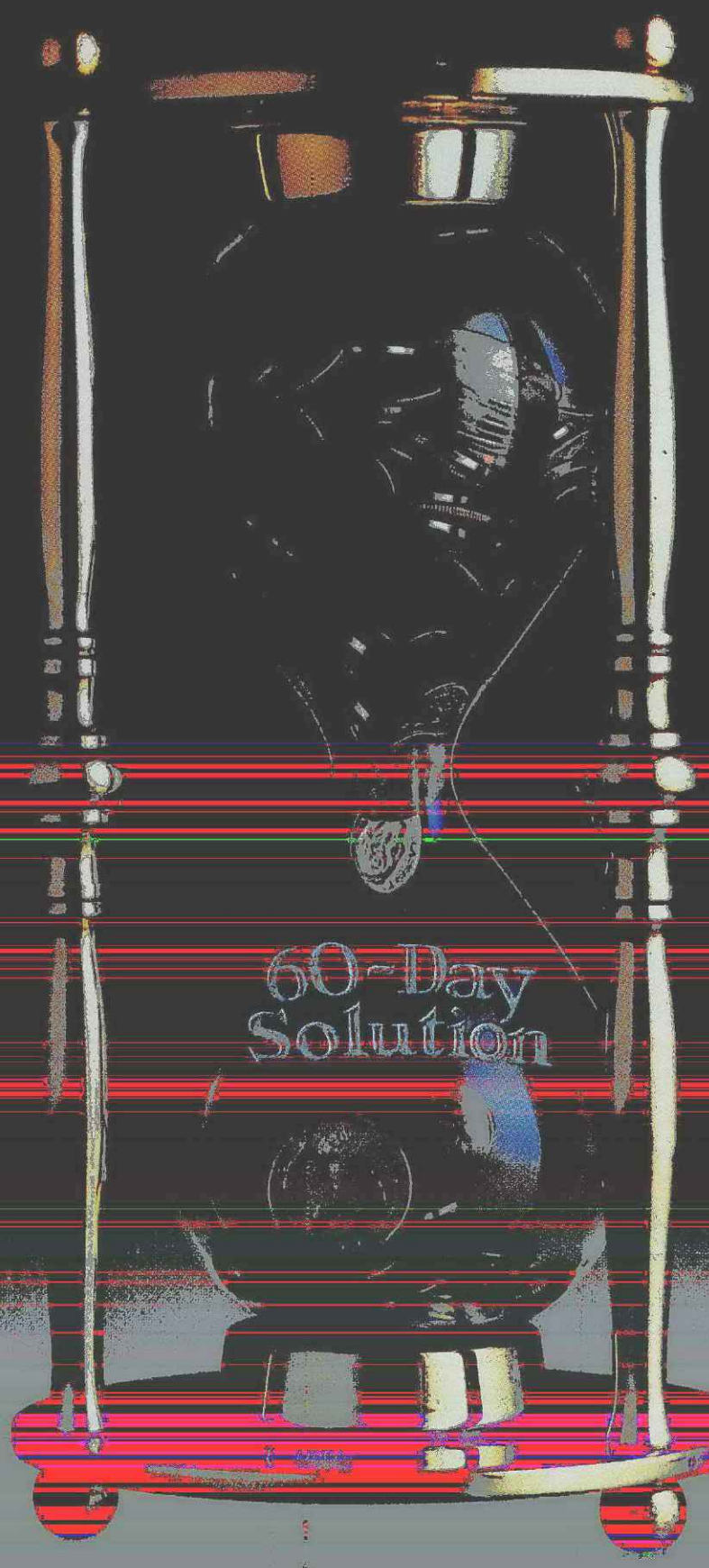

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Letters

Continued from page 8

their beneficiaries: That's the justification for their tax-favored treatment. Insofar as a company uses its pension plan to tax shelter its own income, plan beneficiaries deserve compensation for the service their plan has provided.

So here's a modest proposal for a fairer treatment of excess pension assets. Let companies with overfunded pension plans recover the amount of their excess contributions, recalculated for each year in question based on the less conservative assumptions that would have been reasonable at the time. (It is perhaps only just to allow them to recover interest on these excess contributions, too—at the passbook savings account rate.) Then recognize the *balance* of the excess assets as belonging to the people who own them: the plan's beneficiaries.

'Underfunding and overfunding of pension plans are. . . two sides of the same distorted view of benefits as merely a tax gimmick,' says Mary A. Carroll.

Yes, recalculating past years' contributions is a dreary task, but who among us can expect to generate millions of dollars *without* engaging in a dreary task or two? Don't feel too sorry for them, though; the money they sheltered from a 46% tax rate will come back out at a rate considerably lower.

Underfunding and overfunding of pension plans are *not* distinct phenomena; they are two sides of the same distorted view of benefits as merely a tax gimmick. More than a dozen years after ERISA made it clear that an employee "earns" his benefits every bit as much as he "earns" his wages, all too many companies still treat pension plans as a financial football, to be overfunded or underfunded at the pleasure of management or directors. That attitude is the *real* problem, and it is that attitude that any truly long-range solution must address.

Mary A. Carroll
Chicago

Kennedy plan not so costly

To the editor: Craig Rennpage's Speaking Out article in the Sept. 7 issue of *Business Insurance* is certainly well-timed for the current discussion of Sen. Edward Kennedy's mandatory health care proposal.

While I agree that this proposal needs to be examined closely for its potential impact on current employer health plan costs, I would like to suggest that the "model" that Mr. Rennpage uses in his article to estimate the increase in cost to an employer plan due to the increase in employer contribution to the cost of dependent coverage does not take into account at least one major factor: that the current proposal does *not* require that the employee take the proffered coverage for *dependents* if the employee can show that coverage for such dependents actually exists through a spouse's employer plan.

Actually, it would not necessarily indicate an increase in actual cost to the employer plan of the magnitude that Mr. Rennpage suggests, even if the employer decided to pay 100% of both the employee and dependent costs. This could be so because of the fact that the same new requirements are being made of the spouse's employer, and coordination of benefits savings, the last I read, will still be allowed.

'It is the smaller employer who will be most exposed to a *real* increase,' Mr. Carroll says.

Not only that, but certain spouses, who were primary to the employee's family coverage, will now be primary to their own employer plan because, under the current proposal, an employee may not opt out of coverage, even if covered under a spouse's plan. It might also be argued that most employees with spouses or children who have special needs for medical insurance have probably already opted for the coverage they could buy and, so, the additional lives picked up because of the proposed law are likely, at worst, to be "standard" risks and will therefore add less than the average cost of the current covered persons, at least for larger groups such as the 1,000-life employer in the article.

Obviously, the cost impact to a small employer who is currently paying the minimum for employee coverage and nothing for dependent coverage, and who may be paying low wages to boot, is going to be significant compared with the actual impact to a group such as the one Mr. Rennpage uses as his example. It is the smaller employer who will be most exposed to a *real* increase in covered lives and their associated claims costs against which there will be no COB opportunity.

Of course, if an employer plan is fully insured and the insurance company does not make correct assumptions as to the proper impact of the factors I have discussed above in calculating new rates to be charged the employer, Mr. Rennpage's nightmare example could occur. In such a situation, it might be wise to consider self-funding so that underestimating the impact does not result in a windfall profit to the insurance company!

Hobson D. Carroll
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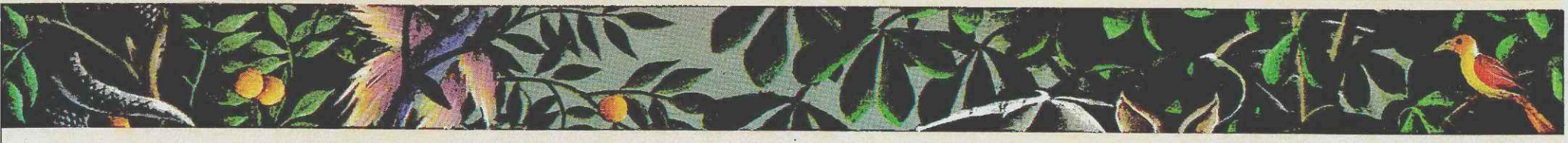

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Monte Carlo forum focuses on risk management

Risk management experts from Europe and North America will meet Oct. 11-14 in Monte Carlo at the fourth international Risk Management Forum sponsored by the Assn. Europeenee des Assures de l'Industrie and the Risk and Insurance Management Society Inc.

More than 500 people are expected to exchange ideas and meet new business associates at the biennial conference, arranged by the Brussels-based AEAI and New York-based RIMS. The conference will be held in the Monte Carlo Convention Centre and adjacent Loews Hotel.

Opening remarks on Oct. 12 will be made by Francois Settembrino, president of AEAI, and director of Tabacofina of Belgium. Mr. Settembrino's speech will be simultaneously translated into English, French and German.

The keynote speaker on Oct. 12 will be Anthony P. Benson, group risk manager for Arthur Guinness Son & Co. Ltd. in London, who will explore how industry is being forced to insure its own exposures to loss and whether risk managers really need bankers rather than insurers. Mr. Benson is past president of the Assn. of Insurance & Risk Managers in Industry & Commerce.

The keynote session will be moderated by conference co-chairman Hugh R. Loader, past president of AIRMIC and group insurance manager of Tetra Pak Insurance Services Ltd. in Britain.

Jeanne E. Ravier of Schlumberger Ltd. in Paris also serves as co-chairwoman of the conference.

Several sessions will be offered twice in two different languages. Sessions will be scheduled to ensure that information is available to delegates who speak only one conference language.

Social events and activities for guests of delegates also are planned. AEAI/RIMS will host a welcome reception on Oct. 11, and the Principality of Monaco will host a reception for delegates and guests on Oct. 13.

A concurrent trade show will feature exhibits by suppliers of risk management products and services.

The following sessions will be offered on Oct. 12:

- "Reinsurance: The Key to Capacity," will explore how effectively risk managers have used reinsurance and whether insurer pooling could supply sufficient capacity without reinsurance. Speakers will include David J. Springbett of PWS International Ltd. and Tom N. Kellogg of General Reinsurance Corp.

P. Richard Hackenburg, executive vp and director of sales at Corroon & Black of Massachusetts and a past president of RIMS, will be moderator.

- "Crisis Management" will be the theme for speakers Oliver Leigh-Wood of Control Risks Ltd. and Martin Langford of Burson-Marsteller.

The session will be moderated by D.I. Ovenden of The Wellcome Foundation Ltd.

- "Contingency Planning" will be offered by various speakers in French, German and English.

The following session are scheduled Tuesday Oct. 13:

- "Is Risk Management Essential to Corporate Survival?" will be explored by Erik B. Rasmussen, chairman and CEO of F.L. Smidth & Co. A.S. of Denmark, Dennis Farthing of RTZ Ltd. in Britain and Mr. Settembrino. The session will be moderated by Arthur P. Bostwick, risk manager of Stone Container Corp.
- "The Liability Crisis: Is it Over?" will be the topic for Alberto Ugona of SFT in Italy, Barry West, head of general insurance for Commercial Union Assurance Co. P.L.C., and Richard J. Holt of Marsh & McLennan Cos. Inc. The moderator will be Enrico Gladulich of Zanussi of Italy.
- "Marketing a Risk" will be presented in English and French by Ken Rolls of Minet Holdings P.L.C. and Tom C. Cannon of Jardine, Emett & Chandler Inc. The moderator will be W. Alex Chrzanowski of Rowntree Mackintosh P.L.C.

The same topic will be discussed in German and English by Wolfram Rohde-Liebenau of Siemens A.G. of West Germany and Erich Winter of Jauch & Hubener of West Germany. Moderator will be by Hauprech von Schenck of Akzo Insurances in West Germany.

- "Risk Financing Methods" will be discussed in French by Philipp Longerstaey of Peat Marwick Main & Co. of Belgium. Moderator will be R. Micalet of E.f Aquitaine.

The same topic will be explored in English and German by Hugh Rosenbaum of the Tillinghast Division of Towers, Perrin, Forster & Crosby Inc. and David Scott of Anistics Ltd. in Britain. Moderator will be Kevin Knight of Australia Post.

- "Minimizing U.S. Liability Exposure" will be examined in German and English by Herman H. Holmann of Ford Co of Europe Inc and F. Graf von Westphalen of von Westphalen in West Germany. Moderator will be Mr. von Schenck.

The session in French and English will be presented by J. Newall of Sedgwick Group P.L.C. and B. Zing of Zurich Insurance Co.

- "Claims-made Liability Policies" will be the topic for Thomas V. Hallet of Frank B. Hall & Co. and Peter Wilson of H.S. Weavers (Underwriting) Agencies Ltd. Jay Waters of Eaton Corp. will moderate.
- "Structuring a Multinational Program" will be offered in French by J.C. Audinot of GAN of France and C. Rocheteau of SGCA of France. Moderator will be J. Auriol of Total Compagnie Francaise des Petroles in France.

For the English/German session, speakers will be V. Blitterswijk of Unilever N.V. in the Netherlands and C. Van Kekan of Nationale-Nederlanden in the Netherlands.

- "Directors & Officers' Liability" will be the topic for B. Linel of CECAR of France and K.C. Sinz of Chubb Group of France.

In addition, the following industry sessions will be offered on Wednesday, Oct. 14:

- Food and drink packaging.
- Oil and energy.
- Transport.
- Chemicals and pharmaceuticals.
- Aviation and aerospace.
- Mining and metallurgy.
- Construction.

Registration for the forum, payable in French francs, is 4,600 francs (about $758) for risk managers and 6,300 francs (about $1,039) for insurers, brokers and other professionals. Registration forms and more information are available from the RIMS Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292. ■

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existing operation. Through the acquisition we are acquiring the expertise of three experienced

Continued on page 16

Federal health care premiums balloon

By JERRY GEISEL

WASHINGTON—The federal government and its employees soon will be hit with sharp increases in group health insurance costs.

Premiums paid by employees covered under the Federal Employees Health Benefit Plan, the nation's largest group health insurance program with more than 9 million participants, will increase an average of 31%. In addition, contributions by the federal government to workers' health care coverage will rise by an average of 32%.

The government pays up to 60% of non-postal employees' health insurance premiums and up to 75% of postal employees' premiums.

Premiums for federal government employees' health insurance are increasing much more than they did at the beginning of this year, when premiums paid by participants climbed an average of 14% and premiums paid by the federal government rose an average of 22%, according to the Office of Personnel Management.

Sharp increases in health care costs and utilization are responsible for the big premium increases, according to OPM, which administers the health care benefit program for federal workers.

In some plans, participants will be facing premium increases exceeding the 31% average hike.

For example, in plans sponsored by Blue Cross/Blue Shield, which covers about 3 million federal employees and dependents, premium increases for participants will range from 40% to more than 60%.

Employees covered by the BC/BS high-option family plan next year will pay monthly premiums of $228.25, up 42.8% from $159.81. The monthly premium for the government will climb 29.8% to $167.88 from $129.33.

The total monthly premium for BC/BS high-option family coverage will increase 37% to $396.13 from $289.14.

Employees enrolled in the BC/BS high-option plan offering individual coverage will pay monthly premiums of $110.16, up 49.6% from $73.65, while the monthly premium paid by the government will rise 32.4% to $77.50 from $58.52.

The total monthly premium for the BC/BS high-option plan offering individual coverage will increase 42% to $187.66 from $132.17.

Employees covered by the standard BC/BS family plan will pay monthly premiums next year of $57.58, up 40% from $41.14, while the federal government will pay monthly premiums of $167.88, up 36% from $123.44.

For individual coverage under the standard BC/BS plan, participants next year will pay monthly premiums of $29.75, a steep 60.9% increase from $18.49, while the federal government will pay monthly premiums of $77.50 up 39.7% from $55.48.

The total monthly premium for BC/BS standard individual coverage next year will be $107.25 compared with $73.97, up 45%.

But premium increases for other plans will be more moderate.

For example, those with family coverage in the National Assn. of Letter Carriers plan, which is self-insured, will pay monthly premiums of $89.11, up 16.2% from $76.66, while the government will pay monthly premiums of $167.88, up 29.8% from $129.33.

The total monthly premium for family coverage in the letter carriers' plan will increase 24.8% to $256.99 from $205.99.

The monthly premium paid by participants with individual coverage under the letter carriers' plan next year will increase 15.6% to $51.50 from $44.55, premiums paid by the government will rise 32.4% to $77.50 from $58.52.

The total monthly premium for individual coverage in the letter carriers' plan will increase 25.2% to $129 from $103.07.

On the other hand, under the Foreign Service Benefit Plan, which is underwritten by Mutual of Omaha, the monthly premium paid by participants next year for family coverage will rise a steep 52.8% to $157.03 from $102.74, while the monthly government premium will increase 29.8% to $167.88 from $129.33.

The total monthly premium for family coverage in the Foreign Service Benefit Plan next year will be $324.91, up 40% from $232.07.

Monthly premiums for those selecting individual coverage in the Foreign Service plan will increase 52% next year to $56.12 from $36.92, while the monthly government premium will increase 32.4% to $77.50 from $58.52.

The total monthly premium for individual coverage in the Foreign Service plan will increase 40% to $133.62 from $95.44.

However, premiums will be dropping for some employees enrolled in health maintenance organizations that are offered by the federal government.

For example, participants who receive family coverage through the Kaiser Foundation Health Plan of Northern California next year will pay a monthly premium of $50.58, a 14.2% decrease from $58.95. The government's share of the premium, however, will increase 17.3% to $151.74 from $129.33, making the total premium $202.32, up 7.5% from $188.28.

For individual coverage in the Kaiser plan, the monthly premium paid by participants next year will be $21.58, virtually unchanged from this year's premium of $21.56. The government, though, will pay $64.72, a 10.6% increase from $58.52. The total monthly premium will be $86.30, up 7.8% from $80.08.

Similarly, in the Health Insurance Plan of Greater New York, also known as HIP, monthly premiums paid by participants next year for family coverage will drop 18.5% to $53.89 from $66.10, while premiums paid by the government will increase 25..3% to $161.69 from $129.33.

The total monthly premium for family coverage in the HIP plan next year will rise 10.3% to $215.58 from $195.43.

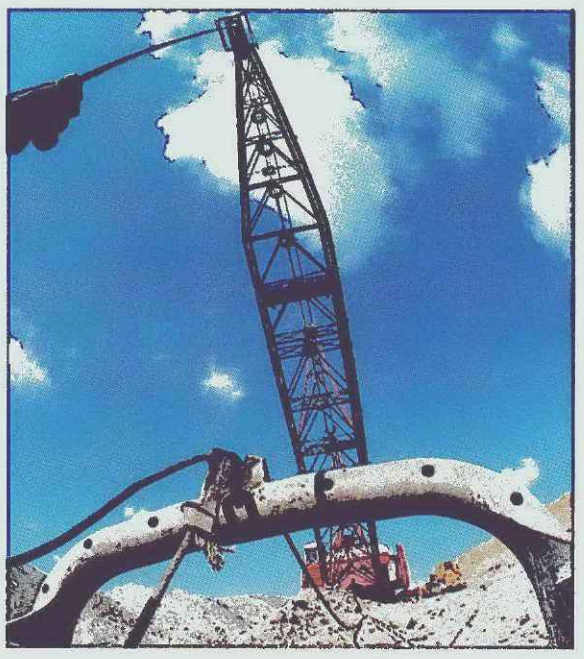
Participants in the HIP plan who select individual coverage will pay monthly premiums of $19.49 up 10.3% from $17.67, while the government's share of the premium will also increase 10.3% to $58.47 from $53.01.

The total monthly premium paid for individual coverage in the HIP plan next year will rise 10.3% to $77.96 from $70.68.

Next year, some 488 different health care plans will be available to federal employees compared with 396 plans this year. Many of the new plans will be HMOs.

Employees will be allowed to change health care plans between Nov. 9 and Dec. 11 during the federal government's annual "open season." ■

Companies,



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Markets

Nobel, Berkley venture to manage risk groups

Hamilton, Bermuda-based reinsurer Nobel Insurance Ltd. has teamed up with Greenwich, Conn.-based reinsurer W.R. Berkley Corp. to launch a risk retention group management company.

The new company, Berkley Nobel Risk Retention Group Managers Inc. of Dallas, is 50% owned by Berkley and 50% owned by Nobel's U.S.A. Group. Management for the new company is being established.

"The two companies bring to bear the resources to do complete risk retention group management," said Jack Zogg, president of Nobel Insurance.

Nobel Insurance brings to the table direct consumer service facilities, while Berkley brings a national network of licensed insurers and expanded reinsurance contacts, said Mr. Zogg.

Nobel Insurance is the "ideal coventurer" agreed William R. Berkley, president of W.R. Berkley Corp.

The Berkley-Nobel management company will offer services relating to each phase of establishing a risk retention group, including:

- Feasibility studies.
- Stock offerings.
- Formation of management.
- On-going customer service.

The first risk retention group to be managed by Berkley-Nobel is under way, having raised $8 million in capital from its more than 700 members. LPG (Liquified Petroleum Gas) Risk Retention Group, which is domiciled in Texas, is expected to begin operations Jan. 1, 1988.

For more information, contact Mr. Zogg at Nobel's U.S.A. group offices at 3010 LBJ Freeway, Suite 320, Dallas, Texas 75234; 214-243-1886.

EIL manager

A new underwriting manager specializing in primary environmental impairment liability coverage has been launched in McLean, Va.

Environmental Insurance Management Inc. expects to write $50 million in direct premiums in its first full year of operation, according to President and Chief Operating Officer John J. Metelski.

The coverage will be written on a claims-made form, and there will be a minimum deductible of $25,000.

Mr. Metelski would not disclose the name of the insurance companies for which EIM will write.

Initially, EIM will concentrate on organizing EIL programs for small to medium-sized manufacturing companies and oil companies. Limits on these programs will be $1 million to $2 million.

According to Mr. Metelski, the company hopes to eventually participate in open market underwriting of policies with limits of $2 million to $4 million.

EIM also will provide claims management services, directing EIL claims to law firms that specialize in pollution liability and to cleanup contractors, Mr. Metelski said.

"Quick response time is very important," Mr. Metelski said, adding that he will market EIM as a company able to respond very quickly to EIL claims.

In addition, EIM will provide pollution claims administration services to captives and risk retention groups.

Prior to establishing EIM, Mr. Metelski was a consultant at Environmental Strategies Corp. in Vienna, Va. Previously, he was a vp at wholesale broker Stewart Smith Mid America Inc. in Chicago.

"I see a clear need for this coverage," Mr. Metelski said. "This liability will not go away.

"To properly protect the financial assets of a corporation, EIL insurance has to be part of the coverage," he said.

For more information contact Mr. Metelski at Environmental Insurance Management Inc., 8260 Greensboro Drive, Suite 600, McLean, Va. 22102; 703-847-6588.

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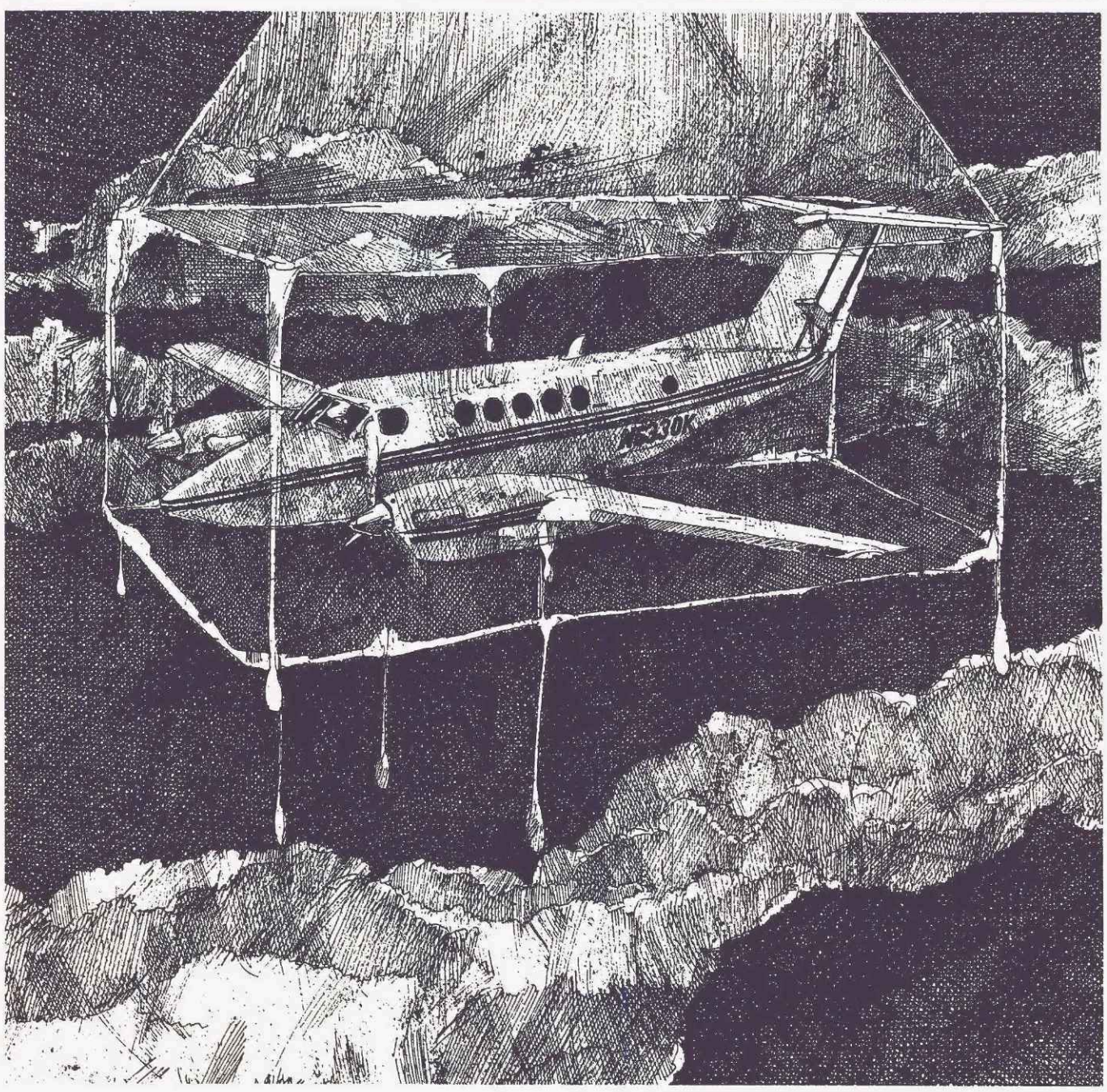

FROZEN ASSETS

Should a mishap put your aircraft on ice, experienced AAU Claims Specialists can fly directly to the scene—in one of our own company planes—ready to put you back in business without delay. Applying expertise they've gained as pilots or mechanics, they'll quickly assess the damage and follow through with the repair facility to make sure quality work (and not necessarily the cheapest) is done. Because of AAU's expedited response, your valuable aircraft asset is not grounded and idle—unproductively frozen—but able to quickly resume its role as a useful business tool. Count on AAU's 50-plus years of experience to keep your assets flying.

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Retain the McCarran-Ferguson Act

In an attempt to address problems which have beset the insurance marketplace, legislation has been introduced to repeal or modify the McCarran-Ferguson Act. Since its enactment in 1945, this Act, which grants states the right to regulate insurance, has been surrounded by myths and misconceptions. These misunderstandings have led some to believe that current insurance problems can be resolved by repeal or reform of the McCarran Act. We disagree. Instead, we believe that repeal or modification would aggravate, not lessen, recent problems. It would result in less competition and higher costs to both insureds and insurers. Fewer insurers would be able to develop or offer needed coverages.

We believe this to be the case for several reasons. First, we feel that there is no evidence to support any connection between the McCarran-Ferguson Act and recent problems of unavailable or unaffordable insurance.

Next, we believe that state regulation has proven effective. It enhances a regulator's awareness of local conditions and allows needed changes to be made with greater flexibility and sensitivity to local concerns.

Furthermore, we suspect that a total repeal of the McCarran Act could result in a dual regulatory system of overlapping, confusing and conflicting authority among state and federal governments.

We also believe it is tort reform and court reform, not repeal or reform of the McCarran Act, which will ultimately address the problems of unavailable and unaffordable insurance. Our industry should accept its share of responsibility for these problems and dedicate itself to exposing the myths and misconceptions concerning the insurance mechanism and its relationship with our court system.

Insurance Agents & Brokers Professional Liability

Insurance professionals can look to Shand Morahan for reliable liability protection for themselves. We have offered a continuous market in Agents and Brokers E&O since 1970. Coverage is written on a claims made basis and is offered to the named insured while acting as an insurance agent, broker, managing general agent, surplus line broker, excess line broker or life insurance agent.

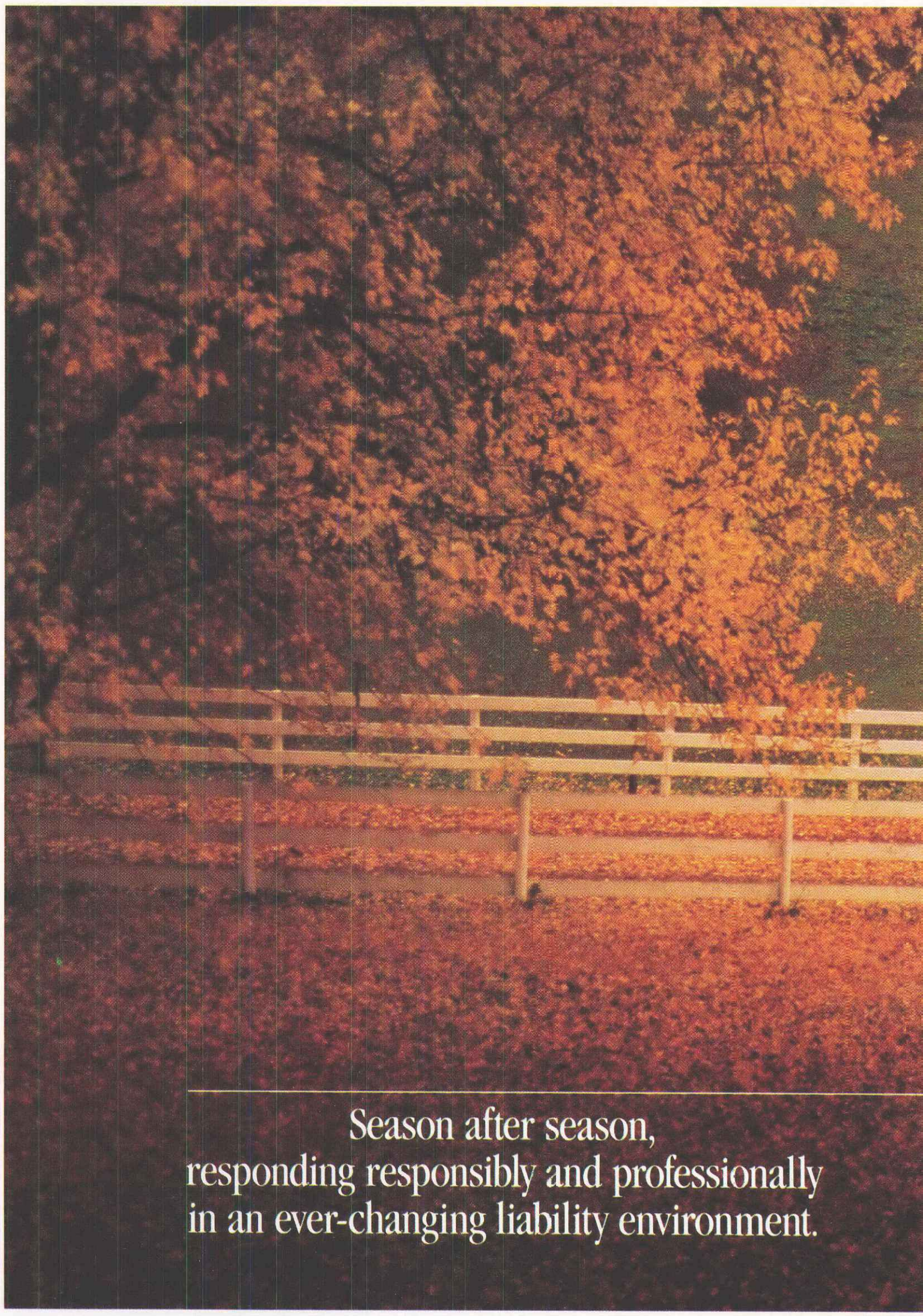
The policy covers acts, errors or omissions in such professional services as notarizing, mutual fund sales, premium financing, insurance consulting, appraising, incidental claims adjusting and public relations activities. Limits of liability up to $3 million are available.

We are particularly interested in medium-sized firms producing $10 million to $100 million annually in premium volume.

Miscellaneous E&O Coverages

Shand Morahan offers a range of E&O coverages for a variety of professions and exposures. These include Franchisor Liability, which covers claims arising from acts, errors or omissions by franchisors and their employees; Electronic Data Processing E&O is available for EDP professionals in firms involved in computer services, programming, systems analysis, software design, training and consulting.

Liability coverage is also available for Manufacturers' Product Engineering/Design E&O exposures of industrial product manufacturers and their employees. Our Specified Professions policy provides E&O protection to a range of professions including management consultants, printers, publishers, public relations firms, property managers, advertisers, claims adjusters and others not covered under our other professional liability policies.

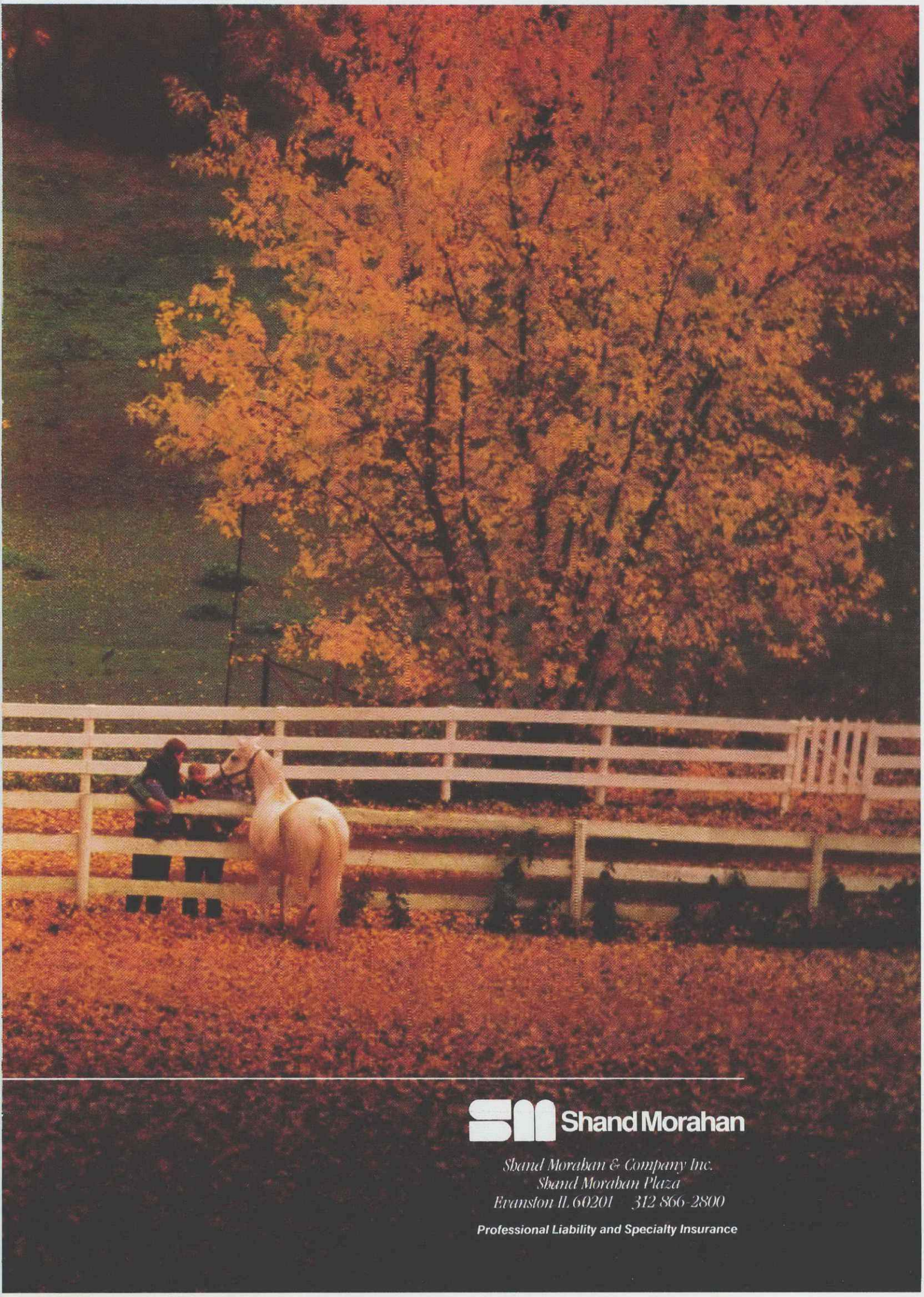


Finally, society's attitudes toward the insurance and tort systems are vital in correcting the problems that exist. A better understanding of the nature and dynamics of these systems and the valuable roles they play in society is equally important in establishing a framework for a lasting solution to our current problems.

Should the McCarran Act be repealed or modified, we envision several potentially adverse consequences: (1) denial or limited access to rating services' resources, (2) market instability, (3) less competition, (4) reduced product development, (5) loss of standardized form and data development, (6) higher costs to consumers, (7) higher actuarial and operational expenses, (8) a more constricted market, (9) restricted entry into the market, (10) withdrawal by some smaller and mid-sized underwriters, (11) territorial retrenchment, and (12) even more expensive and protracted litigation.

For the surplus lines market, where approximately three percent of the property and casualty premiums are written, a dual or federal regulatory structure could result in mandated forms and controlled rates. Both would restrict or eliminate the flexibility necessary for surplus lines insurers to write those risks which standard insurers can not or will not write. In effect, the surplus lines market would find it difficult, if not impossible, to continue to serve its essential and traditional role as a "safety valve" for the standard market.

Shand Morahan, therefore, advocates and supports efforts to prevent the repeal or amendment of the McCarran-Ferguson Act. If you would like additional information on this issue or to obtain a brief guide on writing to your legislators, please let us know. As always, we welcome your comments, thoughts and questions. Simply write to: Joseph J. Prochaska, Jr., Chairman and Chief Executive Officer, Shand Morahan & Company, Inc.



Non-Profit Organization Directors & Officers

Shand Morahan has recently introduced an indemnity insurance policy to protect directors and officers of non-profit organizations. These include hospitals and clinics, retirement homes, mental health centers, professional societies, trade associations, foundations, libraries and museums, country clubs, churches, and cultural or fraternal groups.

Coverage is written on a claims made basis and extends to past, present and future directors and officers. The policy may be broadened to apply to both non-profit and for-profit subsidiary operations, with coverage for prior acts available on an optional basis.

Some non-profit organizations are not eligible under this program. These include governmental entities (other than libraries and museums), utilities, cooperatives, and condominium/homeowner associations.

Association Errors & Omissions Liability

Coverage under this policy is targeted toward non-profit trade associations and professional societies outside of the medical field. The coverage protects not only directors and officers, but the organization as a whole, its employees, and all committee members. This policy may also be broadened to apply to subsidiary operations.

Aside from errors and omissions protection, coverage also extends to personal injury and publishers' liability. The policy is written on a claims made basis, and prior acts coverage is available on an optional.

Shand Morahan is capable of serving the needs of a broad range of non-profit organizations and we welcome your inquiries concerning this growing area of business.

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Markets

Continued from page 22

New West Coast TPA

George Dorsey, former president of San Francisco broker Rathbone, King & Seeley, and five former executives of Industrial Claims Services, a San Francisco-based claims adjuster, have launched a new third-party administrator.

The firm, Dorsey, Nevin & Associates Risk Services Inc., has offices in San Francisco, Los Angeles, Sacramento and Portland.

The company offers claims administration services to both self-insurers and insurers for a variety of lines of insurance.

According to Mr. Dorsey, 80% of the TPA's business will be general liability, 5% will be workers compensation and 15% will be a mixture of fidelity, property and specialty risks.

In addition, the company offers complex litigation claims service, reserve audits, expert witness service, arbitration work, claims surveys and consultations.

Mr. Dorsey predicted that the company would handle the claims of approximately 20 clients in its first year of operation.

There currently are 12 people on the TPA's staff. All five principals of the company are primary stockholders. Mr. Dorsey said employee ownership of the company would result in "consistency of corporate values and employee dedication."

Principals are Paul Anable, former president of Industrial Claims Services; John L. Nevin, former executive vp at Industrial Claims Services; Robert Kearns, former executive vp at Industrial Claims Services; and Robert Knudtson, former Bay area branch manager for the company.

For more information contact Mr. Dorsey at Dorsey, Nevin & Associates, 150 Post St., Suite 400, San Francisco, Calif. 94108; 415-398-8020.

Loss control firm

Keith E. Barenklau, former vp-technical services for Richmond, Va.-based insurer Waite Hill Services Inc., has launched a loss control and safety firm in Richmond.

The new company, Organizational Safety Services, offers a broad range of safety and loss control services to Fortune 500 companies and some governmental agencies. OSS specializes in servicing the paper and pulp industries, electric utilities, major grocery chains and chemical companies. The OSS client roster includes the U.S. Army Corps of Engineers and the U.S. Park Services Bureau.

Mr. Barenklau and a staff of five consultants based around the nation will provide clients in the United States, Japan and Korea with a total loss control program that includes teaching, consulting and implementing loss control measures.

Leroy Abbott, president of Abbott Insurance Associates Inc., an excess/surplus wholesaler in Washington, D.C., owns a small part of the company and acts as the sales arm for association business.

"We provide top-level service in an across-the-board loss control setting," said Mr. Barenklau.

For more information contact Mr. Barenklau at Organizational Safety Services, 11831 Rothbury Drive, Richmond, Va. 23236; 804-794-0691.

TPA expands

Chicago-based third-party administrator Associated Claims Enterprises Inc. has launched a new division to handle hazardous waste claims.

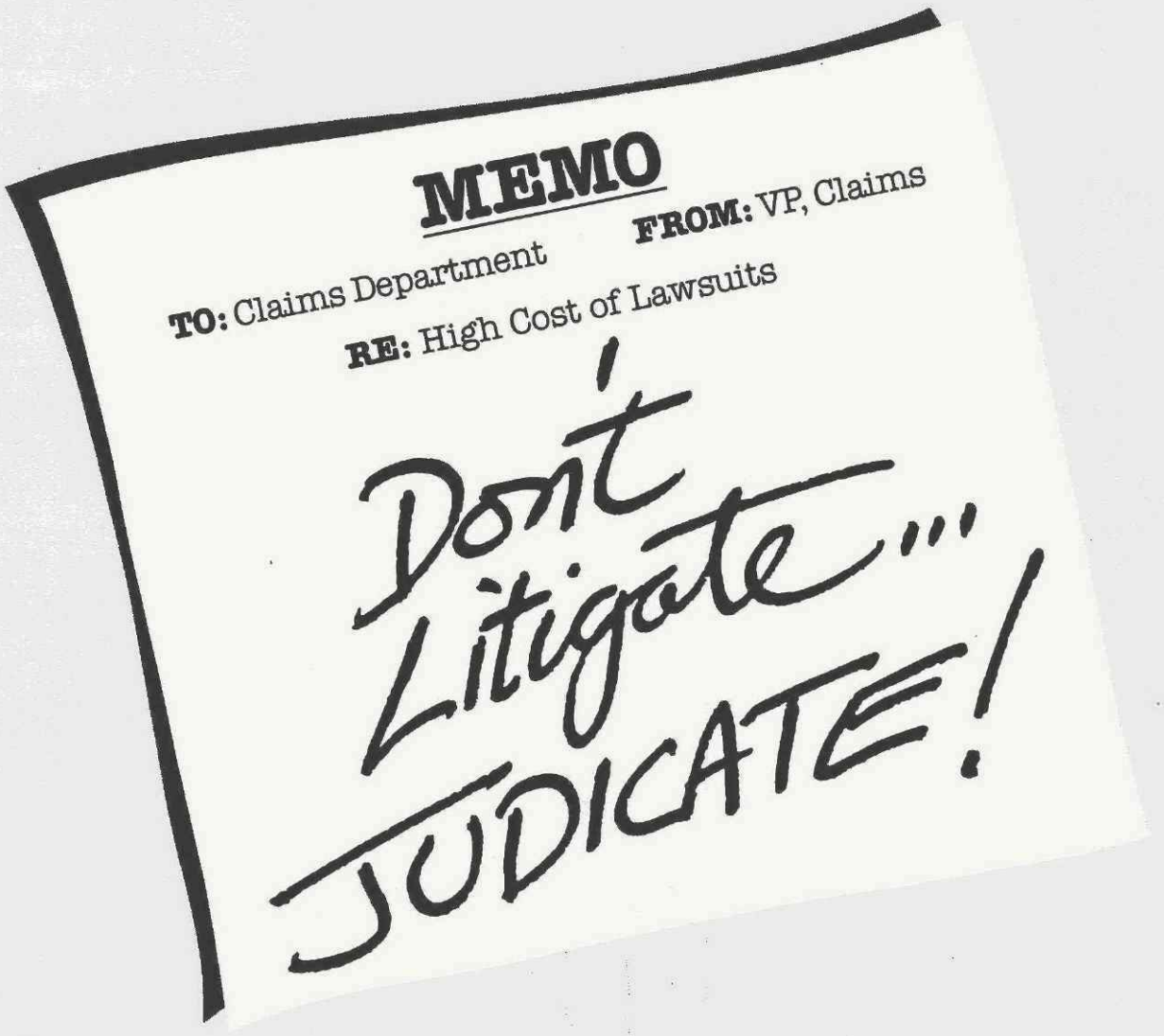
According to President John Hendrickson, the Hazardous Waste Claims Management Division was formed in response to the adverse impact of Superfund legislation, which expands the liability of those deemed responsible for hazardous waste spills.

Associated Claims Enterprises is located at 10 S. LaSalle St., 12th Floor, Chicago, Ill. 60603; 312-263-1620.

CIGNA plan qualified

CIGNA Healthplan of Illinois has received its federal qualification from the U.S. Office of Prepaid Health Care.

In addition, CIGNA has added four northwest Indiana hospitals to its provider network. CIGNA Healthplan now has 30 hospitals and 2,500 physicians in its provider network. ■



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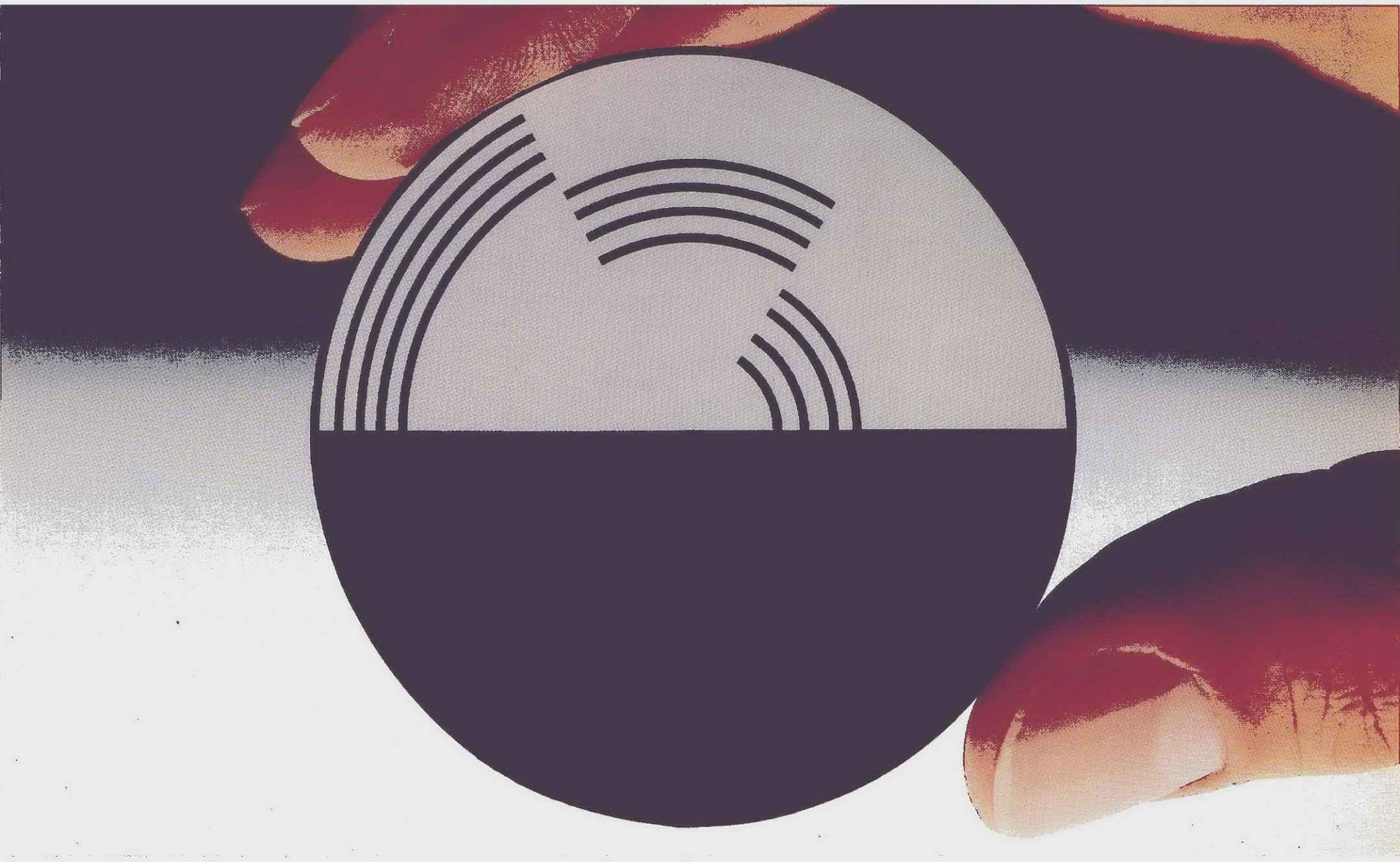

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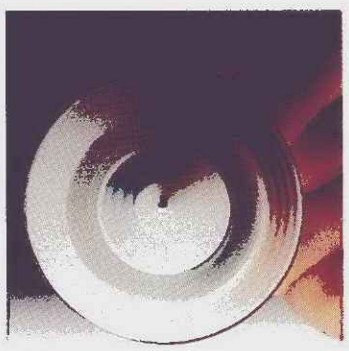

To put it another way, we're on a roll. Now you know us—and what to do with the black and white disk. First, cut it out. Spin it clockwise on a pin, and the outside ring will be red, the middle ring green and the inside ring blue. Spin it counterclockwise, and the color rings will be in reverse.

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Comings & goings: buyers

Risk manager named at Fleming Cos. Inc.

Bart Canon Jr., 33, has been named risk manager at Fleming Cos. Inc. in Oklahoma City. In this newly created position he oversees property/casualty insurance, a risk management information system and claims activity for Fleming, which is a wholesale food distributor with retail affiliates in 33 states.

Mr. Canon

He reports to Roy Vickrey, vp-risk management. Prior to joining Fleming, Mr. Canon was risk manager at InterFirst Corp., a Dallas-based bank holding company acquired by First Republic Bank Corp. Following the merger, he served as insurance products manager. Mr. Canon received a bachelor of business administration degree in finance from Texas A&M University in College Station, Texas. He is a Certified Public Accountant.

* * *

Anthony K. Farina, 48, has been named vp and director of human resources at Financial Guaranty Insurance Co. in New York. In this position he oversees all human resource functions including employee benefits, compensation, management development and training. He replaces **Linda McKeever**, who left the company, and reports to Steven M. Berzin, first vp-corporate development. Prior to joining FGIC, a municipal bond insurer, Mr. Farina was vp of human resources in the international consumer banking division of Chase Manhattan Bank in New York. Prior to that he served with American Express Co. Mr. Farina received a bachelor's degree in English and political science from LaSalle College in Philadelphia and a master of arts degree in international relations from Long Island University. Mr. Farina is a member of the American Compensation Assn. and lectures at the School of Continuing Education at New York University.

* * *

Rita Wilson, 40, promoted to vp of corporate human resource administration at Allstate Insurance Co. in Northbrook, Ill. In this position she oversees administration of corporate employee benefits, compensation and employee relations programs. She reports to Thomas Tewksbury, senior vp of corporate human resources. Previously, Ms. Wilson, who joined Allstate in 1974, served as regional vp for the Chicago metropolitan area. Prior to that she was a regional vp for Allstate in Milwaukee and Houston. She received a bachelor's degree in education from St. Paul's College in Lawrenceville, Va.

* * *

Lee Ann M. Downey, 28, promoted to manager of benefits and compensation at Guaranty National Insurance Co. in Englewood, Colo. In this position she will research and select employee benefits and compensation and oversee the company's payroll function. She reports to Jackie Melton, vp-personnel. Ms. Downey joined Guaranty National, a specialty property/casualty insurer, in 1981 as personnel assistant and was promoted in 1985 to personnel administrator and later to senior personnel administrator, her most recent position. She holds a bachelor's degree in business administration from the University of Southern Colorado in Pueblo. In addition, she is a member of the American Society for Personnel Administration and the Colorado Society of Personnel Administrators.

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Private pension plans grow worldwide

WASHINGTON—Many foreign countries, faced with swelling ranks of retirees, are establishing and expanding private-sector retirement plans to ease the pressure on their draining social security systems, according to a report issued by the Employee Benefit Research Institute.

Many European countries and Japan are implementing both voluntary corporate pensions plans and tax-exempt individual retirement savings plans, according to EBRI, a Washington-based benefits think tank.

EBRI projects that by 2025, the U.S. retirement-age population will be one-third the size of its working-age population. But in other countries, the over-65 population could swell to 40% to 55% of the working populations, which means fewer payroll taxpayers will be supporting more beneficiaries.

"It takes a long time for the seriousness of the funding shortage to sink in," said Haeworth Robertson, managing director in the Washington office of William M. Mercer-Meidinger-Hansen Inc.

"Ten years ago, nobody even considered" the problem, he said. "Even in the U.S., we haven't fully accepted the danger."

In the report, EBRI consultant Lorna Dailey identified two emerging trends: Countries with existing employer-sponsored plans are trying to introduce individual retirement accounts to supplement them and countries that offered only social security-type programs in the past are introducing employer-sponsored plans.

Until recently, individual retirement accounts were available only in the United States and Canada. But in January, the Swiss formally introduced an individual retirement account known as Ordinance 3, which allows employees to contribute a maximum of 8% of their first $35,000 of salary, on a tax-free basis. Interest on the money would not be taxed until assets are withdrawn at retirement.

Self-employed persons not covered by corporate pension plans may contribute up to 40% of their first $35,000 in income.

In Switzerland, there was about $66 billion in private-sector, employer-sponsored pension funds as of July 1, Ms. Dailey said.

In November 1986, the Belgian government introduced "epargne pensions," which encourage retirement savings and investments in the Belgian stock market.

Under the epargne plan, assets accumulate tax-free until the employee reaches 65. At least 30% of assets in the account must be invested in Belgian stocks, and no more than 10% can be invested in foreign stocks, EBRI said.

Individuals may make tax-free contributions of $550 annually to the accounts; government employees and company pension plan participants are limited to $270 annually.

Nearly 1 million workers participate in the program, the Belgian Finance Ministry estimates, with assets totaling more than $450 million.

By early 1988, France expects to offer U.S.-style individual retirement accounts that will have the added feature of government bonuses for deferred withdrawals—5% of the value of the assets if kept until age 63, and 10% if kept until age 65.

Employer-sponsored pension plans in France hold about $14 billion in assets. That amount is small, Ms. Dailey said, because plans are operated on a "pay-as-you-go" system.

The United Kingdom, whose employer plans hold about $285 billion in pension assets, will introduce a personal pension plan in 1988 for workers not enrolled in employer-sponsored plans. The minimum contribution will be 3.8% of salary by the employer and 2% by the employee.

British employees can make additional tax-exempt contributions to personal pension plans depending on age: up to 17.5% of salary if younger than 50; up to 20% if between the ages of 51 to 55; up to 22.5% if between 56 and 60; and up to 27.5% if between 61 and 75.

EBRI also reported that corporate pension funds recently have started in Spain, Portugal and Italy.

The Spanish government in June established the framework for voluntary funded, self-administered corporate pension plans. Now employers in Spain have the power to establish a pension plan and to establish initial benefit and contribution levels.

'It takes a long time for the seriousness of the funding shortage to sink in,' says Mr. Robertson.

In November, the Portuguese government established guidelines for insured, self-administered pension plans that govern financing and investment decisions. However, there are still no formal regulations on eligibility, vesting and benefit levels.

EBRI said the Portuguese government has encouraged the development of funded, corporate pension plans to boost interest in its small but recently successful stock market.

In Italy there are at least 200 corporate pension plans, according to EBRI, even though the Italian government has not formally encouraged their use. While pension-related tax regulations are vague in Italy, premiums for insured pension contracts are considered tax-deductible for employers, and employees can make minimal tax-deductible contributions to corporate pension plans.

In January, the Canadian government established a 25-year plan to improve the financing of its nationwide pension plan, which provides an earnings-related benefit for workers based on payroll taxes to supplement the flat-rate benefit paid to all Canadian residents.

The Canadian government says $57 billion is held by private-sector pension assets.

In Japan, which has $163 billion in private-sector pension assets, employer contributions are fully deductible as business expenses and employees' contributions are fully deductible from taxable income. EBRI also reported that in Japan, where saving for retirement is a tradition, lump-sum payments are often distributed to retirees in lieu of annuities.

EBRI said Japanese employees don't expect to retire at age 55 or 60. The Japanese workers simply accept their retirement benefits and cut down on their working hours.

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SEPT. 28-29. Managed Healthcare: Who's In Control? seminar in Washington, D.C., sponsored by the American Assn. of Preferred Provider Organizations; $450 for American Assn. of Preferred Provider Organizations members; $495 for non-members. American Assn. of Preferred Provider Organizations, 1101 Connecticut Ave. N.W., Suite 700, Washington, D.C. 20036; 202-857-1128.

SEPT. 28-29. The Property & Casualty Insurance Tax Institute conference in New York, sponsored by Executive Enterprises Inc.; $875; $775 for additional registrants from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 within New York.

SEPT. 28-30. Audio-Visual Media for Safety and Health: Developing and Producing Inexpensive Programs course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; $420. University of California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

SEPT. 28-30. Techniques of Loss Control course in Atlanta, sponsored by the Risk & Insurance Management Society Inc.; $540 for RIMS members; $640 for non-members. Fran Jordan, Risk & Insurance Management Society Inc., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 29-30. Recent Developments in Insurance and Reinsurance Disputes in the Property & Casualty Industry conference in New York, sponsored by Executive Enterprises Inc.; $875; $775 for additional registrants from same organization. **Also Oct. 15-16** in San Francisco. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 within New York.

SEPT. 30. Controlling Your Workers Compensation Costs workshop in Springfield, Ill., sponsored by the Illinois State Chamber of Commerce; $90 for ISCC members; $135 for non-members. Illinois State Chamber of Commerce, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

SEPT. 30. Will the Risk Retention Act of 1986 Revolutionize the Way Business Is Done? conference in Philadelphia sponsored by the Insurance Society of Pennsylvania; $125. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

SEPT. 30-OCT. 2. Claims Management course in Chicago, sponsored by the Risk & Insurance Management Society Inc.; $540 for RIMS members; $640 for non-members. Fran Jordan, Risk & Insurance Management Society Inc., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 1. Group Property & Liability Insurance: To Bear or Not To Bear Risk workshop in Irving, Texas, sponsored by the Society of Chartered Property & Casualty Underwriters and the Fort Worth Chapter of the Society of CPCU; $125 for Society members; $155 for all others. Mari Jennings, Professional Services Coordinator, Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

OCT. 1-2. Insurance Market Prospects for 1988—Home and Overseas conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 375 pounds (approximately $615). Caroline Atkinson, Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD; 01-236-2175.

OCT. 1-2. Ergonomics: Building Efficiency and Safety in the Workplace in Los Angeles, sponsored by the Institute of Safety & Systems Management at the University of Southern California; $300. Institute of Safety & Systems Management, University of Southern California, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

OCT. 2. Insurance Market Prospects for 1988 conference in London, sponsored by Insurance & Reinsurance Research Group Ltd.; 325 pounds (approximately $534). Caroline Atkinson, Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD; 01-236-2175.

OCT. 3. Promoting Safety and Health in Today's Economy course in Los Angeles, sponsored by the Institute of Safety & Systems Management at the University of Southern California; $150. Institute of Safety & Systems Management, University of Southern California, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

OCT. 4-7. 1987 Benefit Communication Institute in Williamsburg, Va., sponsored by the International Foundation of Employee Benefit Plans; $525 for IFEBP members; $600 for non-members. Registrations Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

OCT. 5-6. Environmental Risk Management Course: Minimizing and Insuring Against Pollution Liability Exposures conference in Washington, D.C., sponsored by Executive Enterprises Inc.; $875; $775 for additional registrants from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 within New York.

OCT. 5-6. ERISA II: Preparing for Major Pension & Benefit Changes in the 100th Congress conference in Washington, D.C., sponsored by the National Employee Benefits Institute; no charge to single NEBI member representatives; $100 for additional NEBI member representatives; $395 for non-members. National Employee Benefits Institute, 2445 M St. N.W., Suite 400, Washington, D.C. 20037; 800-558-7258.

OCT. 5-6. Health Care Cost Containment workshop in Boston, sponsored by the Health Research Institute; $495. **Also Oct. 26-27** in San Francisco; **Nov. 9-10** in New York; and **Dec. 7-8** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 5-7. Insurer Solvency Assessment conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 506 pounds (approximately $832). Caroline Atkinson, Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD; 01-236-2175.

OCT. 5-7. Employee Benefits: Concepts, Planning and Administration course in Denver, sponsored by the Risk & Insurance Management Society Inc.; $540 for RIMS members; $640 for non-members. Fran Jordan, Risk & Insurance Management Society Inc., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 6. Quality Assurance & Utilization Management: Partners in Managed Care seminar in Monterey, Calif., sponsored by the American Medical Care & Review Assn.'s Medical Issues Section; $250 for AMCRA members; $350 for non-members. American Medical Care & Review Assn., 5410 Grosvenor Lane, Suite 210, Bethesda, Md. 20814; 301-493-9552.

OCT. 6-7. Product Safety and Liability Prevention: The Role of Warnings course in Madison, Wis., sponsored by the College of Engineering at the University of Wisconsin-Madison; $695; $645 less coursebook. Engineering Registration, The Wisconsin Center, 702 Langdon St., Madison, Wis. 53706; 800-262-6243; 800-362-3020 within Wisconsin.

OCT. 6-7. Ergonomics and Job Modification course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; $250. Shari Falkenburg, National Loss Control Service Organization, K-3, Long Grove, Ill. 60049-0075; 800-323-9585; 312-540-2331 within Illinois.

OCT. 6-7. Personnel Law Update 1987 seminar in Boston, sponsored by the Council of Education in Management; $495; $475 each for two or more from the same organization. **Also Oct. 7-8** in Denver; **Oct. 13-14** in Philadelphia; **Oct. 14-15** in Chicago; **Oct. 20-21** in Los Angeles; **Oct. 27-28** in Seattle; **Nov. 4-5** in Detroit, Morristown, N.J., Honolulu; **Nov. 10-11** in San Diego; **Nov. 17-18** in San Jose, Calif., Minneapolis; **Dec. 1-2** in Tampa, Fla.; and **Dec. 8-9** in Phoenix, Ariz. Karen Nelson, Council on Education in Management, 321 Lennon Lane, Walnut Creek, Calif. 94598; 415-934-8333.

OCT. 7. Health Improvement/Wellness workshop in Boston, sponsored by the Health Research Institute; $250. **Also Oct. 28** in San Francisco; **Nov. 11** in New York; and **Dec. 9** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 7. Agency Captives seminar in Austin, Texas, co-sponsored by Rossiter Blumentritt Consultants and Cayman Business Services; $50; $65 at the door. Rossiter Blumentritt Consultants, P.O. Box 12844, Austin, Texas 78711; 512-472-7659.

OCT. 7. Advanced "Post Graduate" Cost Management workshop in Boston, sponsored by the Health Research Institute; $250. **Also Oct. 28** in San Francisco; **Nov. 11** in New York; and **Dec. 9** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 7-8. Fourth Annual Banks and Insurance Conference in New York, sponsored by Executive Enterprises Inc.; $875; $775 for additional registrants from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 within New York.

OCT. 7-9. American Medical Care & Review Assn.'s 16th Annual Conference and House of Delegates in Monterey, Calif.; $575 for AMCRA members; $675 for non-members; $175 for spouses/guests. American Medical Care & Review Assn., 5410 Grosvenor Lane, Suite 210, Bethesda, Md. 20814; 301-493-9552.

OCT. 7-9. Recognition of Accident Potential in the Workplace Due to Human Factors course in Los Angeles, sponsored by the Institute of Safety & Systems Management at the University of Southern California; $435. Institute of Safety & Systems Management, University of Southern California, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

OCT. 7-10. Ninth Annual Meeting of the American Society for Healthcare Risk Management of the American Hospital Assn. in New Orleans; $400 for ASHRM members and Healthcare Risk Management Council of New Orleans members; $340 for additional members from the same organization; $470 for non-members ($70 can apply toward ASHRM membership); $410 for additional non-members from the same organization; $145 for full-time students. American Hospital Assn., P.O. Box 98946, Chicago, Ill. 60693; 312-280-6083.

Continued on next page

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Continued from previous page

OCT. 8. Assessing Vendors (HMOs, PPOs, Utilization Review Firms, etc.) workshop in Boston, sponsored by the Health Research Institute; $250. **Also Oct. 2**[illegible] in San Francisco; **Nov. 12** in New York; and **Dec. 10** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 8. Cost Containment Through Communications and Education workshop in Boston, sponsored by the Health Research Institute; $250. **Also Oct. 29** in San Francisco; **Nov. 12** in New York; and **Dec. 10** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 8. Professional Indemnity-Today and Tomorrow conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 170 pounds (approximately $280) plus VAT. Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD; 01-236-2175.

OCT. 8-9. Labor/Management Cost Containment workshop in Boston, sponsored by the Health Research Institute; $495. **Also Oct. 8-9** in Boston; **Nov. 12-13** in New York; and **Dec. 10-11** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 8-9. Advanced Trial Techniques in Medical Malpractice Cases seminar in San Francisco, sponsored by the Practising Law Institute; $390. Practising Law Institute, Department 8A-105, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, extension 271.

OCT. 9. Offshore Captive Formation seminar in Austin, Texas, co-sponsored by Rossiter Blumentritt Consultants and Cayman Business Services; $50; $65 at the door. Rossiter Blumentritt Consultants, P.O. Box 12844, Austin, Texas 78711; 512-472-7659.

OCT. 9. Current Trends in the Legal Environment of Workers Compensation seminar in New York, sponsored by the National Council on Compensation Insurance; $165 for NCCI members; $205 for non-members. Mary Ellen Robinson, National Council on Compensation Insurance, 1 Penn Plaza, New York, N.Y. 10119; 212-560-1066.

OCT. 11-14. Remembering the Past. . .Anticipating the Future: The Society of Chartered Property & Casualty Underwriters' 43rd Annual Meeting and Seminars in San Antonio, Texas; $325 for Society of CPCU members, $170 for spouses/guests. Society of CPCU, Kahler Hall, Providence Road, CB#9, Malvern, Pa. 19355-0709.

OCT. 11-14. Risk Management Forum: Association Europeean des Assures de l'Industrie and the Risk & Insurance Management Society Inc. International Conference in Monte Carlo; 2,300 French francs (approximately $381) for university members or students; 4,600 French francs (approximately $761) for members of a risk management department; 6,300 French francs (approximately $1,043) for insurers, brokers, adjusters and other professions other than those listed. AEAI/RIMS Monte Carlo Conference, SOCFI, 14 Rue Mandar, 75002 Paris, France.

OCT. 11-16. Fundamentals of Employee Benefits Management conference in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; $900. Registrations Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

OCT. 12-16. Management and Administrative Skills for the Occupational Safety and Health Professional course in Los Angeles, sponsored by the Institute of Safety & Systems Management at the University of Southern California; $735. The Institute of Safety & Systems Management, University of Southern California, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

OCT. 14. Complying With COBRA: The Final Regulations workshop in Chicago, sponsored by the Illinois State Chamber of Commerce; $45 for ISCC members; $70 for non-members. Carol Jensen, Illinois State Chamber of Commerce, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

OCT. 14-15. Constructing, Processing and Marketing Variable Insurance Products conference in New York, sponsored by the Institute for International Research Inc.; $895. Institute for International Research Inc., 310 Madison Ave., Suite 1212, New York, N.Y. 10017; 800-345-8016; 212-883-1770.

OCT. 14-15. Emerging Technology-The Impact on Product Safety, Insurance and Critical Business Decisions conference in Stamford, Conn., co-sponsored by the National Safety Council and the Engineering & Safety Service of the American Insurance Services Group Inc.; $300 for members; $400 for non-members. Edward S. Charkey, American Insurance Services Group Inc., 85 John St., New York, N.Y. 10038; 212-669-0400.

OCT. 14-16. New Age Retirement Planning workshop in New Orleans, sponsored by Retirement Advisors; $495; $395 if registration is made three weeks in advance. **Also Nov. 11-13** in New York. Retirement Advisors, 919 Third Ave., New York, N.Y. 10022; 212-421-2400.

OCT. 14-16. Fundamentals of Property and Casualty Reinsurance Agreements conference in New York, sponsored by Executive Enterprises Inc.; $975; $875 for additional registrants from same organization. **Also Nov. 11-13** in Los Angeles. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 within New York.

OCT. 15. Risk Management and Safety Techniques for Public Agency Recreation Programs and Facilities seminar in Anaheim, Calif., sponsored by Risk Management Seminars; $150 in advance; $175 at the door. **Also Oct. 29** in Pleasanton, Calif.; **Nov. 18** in Sacramento, Calif.; **Nov. 19** in Fresno, Calif. Risk Management Seminars, P.O. Box 1601, Sonoma, Calif. 95476-1601; 415-943-1405.

OCT. 15-17. Annual Conference of the Profit Sharing Council of America in Washington, D.C.; $585 for first member delegates; $525 for additional member delegates; $645 for non-member delegates; $180 for non-delegates. Profit Sharing Council of America, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-3411.

OCT. 17. Humor and the Health Care Professional seminar in Chicago, sponsored by Crane Consultants; $70; $85 after Oct. 7. Crane Consultants, 9040 N. Forestview Road, Skokie, Ill. 60203; 312-674-3320.

Continued on page 34

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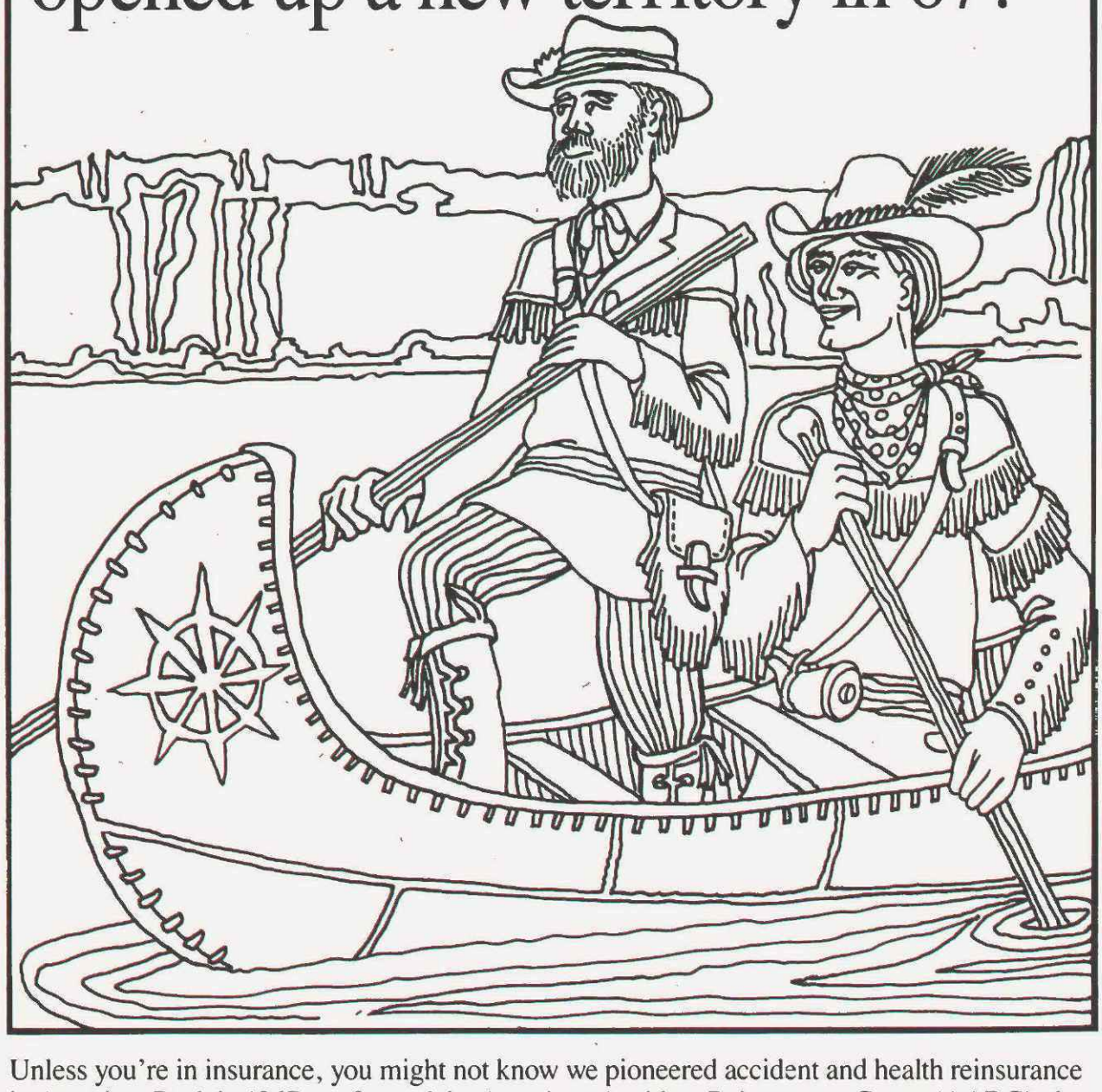

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Datebook

Continued from page 32

OCT. 19-21. Techniques of Finance and Accounting course in Chicago, sponsored by the Risk & Insurance Management Society Inc.; $540 for RIMS members; $640 for non-members. Fran Jordan, Risk & Insurance Management Society Inc., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 19-23. Recognition of Occupational Health Hazards course in Los Angeles, sponsored by the Institute of Safety & Systems Management at the University of Southern California; $735. The Institute of Safety & Systems Management, University of Southern California, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

OCT. 20-22. Cargo Insurance Clauses Workshop in London, sponscred by the Insurance & Reinsurance Research Group Ltd.; 506 pounds (approximately $832). Caroline Atkinson, Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD; 01-236-2175.

OCT. 22. Coping With the Responsibilities of Risk Management workshop in Northbrook, Ill., sponsored by the Chicago, Wisconsin and Northeastern Illinois chapters of the Risk & Insurance Management Society; $80 for RIMS members and prospective members. Art Meyer, Wisconsin Gas Co., 626 E. Wisconsin Ave., Milwaukee, Wis. 53202; 414-291-6520.

OCT. 22-23. Advanced Employee Benefits Workshop in New York, sponsored by the Practising Law Institute; $475; $45 for coursebook only. Practising Law Institute, Dept. 2Z, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

OCT. 22-23. Advanced Employee Benefits workshop in New York, sponsored by the Practising Law Institute; $475; $45 for coursebook only. **Also Nov. 2-3** in New York. Practising Law Institute, Dept. 8A-105, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, ext. 271.

OCT. 22-23. Letters of Credit and Trust Agreements in the Insurance Industry conference in New York, sponsored by Executive Enterprises Inc.; $875; $775 for additional registrants from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 within New York.

OCT. 22-23. Techniques of Self-Insurance: Corporate Survival in a World With Inadequate Commercial Insurance seminar in San Francisco, sponsored by the Practising Law Institute; $425; $45 for coursebook only. **Also Nov. 2-3** in New York. Practising Law Institute, Department 8A-105, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, ext. 271.

OCT. 22-24. 11th Annual Employment Law Seminar in Napa, Calif., sponsored by the Defense Research Institute Inc.; $525 for DRI members; $550 for non-members. Defense Research Institute Inc., 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

OCT. 25-28. 1987 Corporate Health Care Cost Management Conference in Washington, D.C., sponsored by the International Foundation of Employee Benefit Plans; $605 for IFEBP members; $680 for non-members. Registration Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

OCT. 26-27. Insurance Company SEC Accounting and Reporting course in New York, sponsored by Peat Marwick Main & Co.; $725. Peat Marwick Registrar, Executive Education Department, 3 Chestnut Ridge Road, Montvale, N.J. 07645-0435; 800-762-3932.

OCT. 26-27. Fall Conference of the American Assn. of Insurance Services in Charleston, S.C.; $250 for first registrant; $125 for additional registrant from same organization; $100 for spouses. American Assn. of Insurance Services, 1035 S. York Road, Bensenville, Ill., 60106; 312-595-3225.

OCT. 26-27. Year-end SEC Accounting and Financial Reporting for Property/Casualty Insurance Companies conference in New York, sponsored by Executive Enterprises Inc.; $875; $775 for additional registrants from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 within New York.

OCT. 26-28. Government Risk Management Seminars: Basic Fundamentals, Advanced Techniques or School Risk Management in Washington, D.C., sponsored by the Public Risk & Insurance Management Assn.; $350 for PRIMA members; $400 for non-members. PRIMA, 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

OCT. 27. Corporations vs. Directors: The Real Struggle Over D&O Liability conference in New York, sponsored by the Tillinghast Division of Towers, Perrin, Forster & Crosby; $450. **Also Nov. 5** in San Francisco. Conference Director, Tillinghast/TPF&C, 722 Post Road, Darien, Conn. 06820; 203-655-9791.

OCT. 29-31. Asbestos Medicine seminar in Reno, Nev., sponsored by the Defense Research Institute Inc.; $410 for DRI members; $435 for non-members. Defense Research Institute Inc., 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

NOV. 1-4. Insurance Technical Conference in Boston, co-sponsored by the Alliance of American Insurers and the American Assn. of Insurance Services; $275 for Alliance/AAIS members/subscribers; $100 for family members; $325 for non-members. Donna G. Pillstrom, Alliance of American Insurers, 1501 Woodfield Road, Suite 400 W, Schaumburg, Ill. 60173-4980; 312-490-8595.

NOV. 2-6. Developing and Managing a Basic Safety and Health Program course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; $650. Tommy Thomas, NATLSCO, K-3, Long Grove, Ill. 60049; 800-323-9585; 312-540-2400 within Illinois.

NOV. 2-6. Sampling and Evaluating Airborne Asbestos Dust course in Los Angeles, sponsored by the Institute of Safety & Systems Management at the University of Southern California; $725. Institute of Safety & Systems Management, University of Southern California, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

NOV. 4-6. Marine Cargo Insurance and Ocean Cargo Claims seminars in New York, sponsored by the World Trade Institute: one day (Ocean Cargo Claims): $425, $380 for additional registrant; two days (Marine Cargo Insurance): $665, $600 for additional registrant; three days (both seminars): $845, $760 for additional registrant. Registrar, WTI, 1 World Trade Center, 5W, New York, N.Y. 10048; 212-466-4044.

NOV. 5-6. Integrating and Expanding the Role of Employee Health Care conference in San Antonio, Texas, sponsored by the American Hospital Assn.; $395 for AHA members. $495 for non-members. American Hospital Assn., P.O. Box 98946; Chicago, Ill. 60693; 312-280-6083.

NOV. 5-6. Managing Intergovernmental Pools conference in San Antonio, Texas, sponsored by the Public Risk & Insurance Management Assn.; $150 for PRIMA members; $250 for non-members. Public Risk & Insurance Management Assn., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

NOV. 5-6. Recovering Uncollectible Reinsurance conference in New York, sponsored by Executive Enterprises Inc.; $875; $775 for additional registrants from same organization. **Also Dec. 10-11** in Los Angeles. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 within New York.

NOV. 6. Alternate Dispute Resolution and Risk Management: Controlling Conflict and its Costs seminar in New York, sponsored by the Practising Law Institute; $250; $45 for coursebook only. Practising Law Institute, Department 8A-105, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, extension 271.

NOV. 8-11. Legislative Research Commission's Third Biennial Workers Compensation Seminar in Louisville, Ky.; before Oct. 9: $150; after Oct. 9: $190. Charlene Collins, Legislative Research Commission, Fourth Floor, Capitol Building, Frankfort, Ky. 40601; 502-5640-8100.

NOV. 9-10. The Solution to the High Cost Claim—Medical Case Management conference in New York, sponsored by Intracorp; $385; $340 per additional registrant from the same organization. Jackie Mazoway, Intracorp, Chesterbrook Corporate Center, 701 Lee Road, Wayne, Pa. 19087; 800-345-1075.

NOV. 9-10. Medical Malpractice in Cardiac Care seminar, sponsored by Law Journal Seminars-Press; $390; $365 each for two or more registrants from the same organization. Registrar, Law Journal Seminars-Press, 111 Eighth Ave., Suite 900, New York, N.Y. 10011; 800-221-8195; 212-741-8300.

NOV. 9-12. Seventh Annual Construction Insurance Conference and Pre-conference Seminars in New Orleans, sponsored by the International Risk Management Institute Inc., $235 for one pre-conference seminar (Nov. 9): Construction Insurance Primer, Insurance Cost Control, or Risk Financing Alternatives; $495 for conference (Nov. 10-12); $595 for conference and one pre-conference seminar. International Risk Management Institute Inc., 12222 Merit Drive, Suite 1660, Dallas, Texas 75251-2217; 800-527-2580; 214-960-7693 within Texas.

NOV. 9-13. International Reinsurance Practice course in London, sponsored by Insurance & Reinsurance Research Group Ltd.; 675 pounds (approximately $1,110) plus VAT. Joy Bambrough, Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD; 01-236-2175.

NOV. 15-19. National Assn. of Independent Insurers' 42nd Annual Meeting in Maui, Hawaii; $250 for members; $350 for subscribers and guests; $100 for spouses. National Assn. of Independent Insurers, 2600 River Road, Des Plaines, Ill. 60018-3286; 312-297-7800.

NOV. 16-18. Utilization Review Systems workshop in Scottsdale, Ariz., sponsored by the Group Health Assn. of America Inc.; $425 for GHAA members; $500 for non-members. Group Health Assn. of America Inc., 1129 20th St. N.W., Suite 600, Washington, D.C. 20036; 202-778-3275.

NOV. 16-20. Fundamentals of Industrial Hygiene Monitoring course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; $500. John Garis, NATLSCO, K-3, Long Grove, Ill. 60049; 800-323-9585; 312-540-2400 within Illinois.

NOV. 20. Political Risk & Credit Insurance seminar in New York, co-sponsored by The College of Insurance and Cook & Miller; $125. Professional Development Division, The College of Insurance, 1 Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111, extension 303.

NOV. 30-DEC. 1. Behavioral Science as an Approach to Accident Prevention course in Los Angeles, sponsored by the Institute of Safety & Systems Management at the University of Southern California; $375. The Institute of Safety & Systems Management, University of Southern California, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

DEC. 2-3. Legal Aspects of Occupational Safety & Health course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; $385. University of California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

DEC. 2-4. Fundamentals of Insurance course in Atlanta, sponsored by the Risk & Insurance Management Society Inc.; $495 for RIMS members; $595 for non-members; after Oct. 20 add $45. Fran Jordan, Risk & Insurance Management Society Inc., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

DEC. 4-9. 33rd Annual Employee Benefits Conference in San Francisco, sponsored by the International Foundation of Employee Benefit Plans; before Oct. 4: $480 IFEBP members only; after Oct. 4: $525 IFEBP members only. Registration Department, International Foundation of Employee Benefit Plans, 18700 Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

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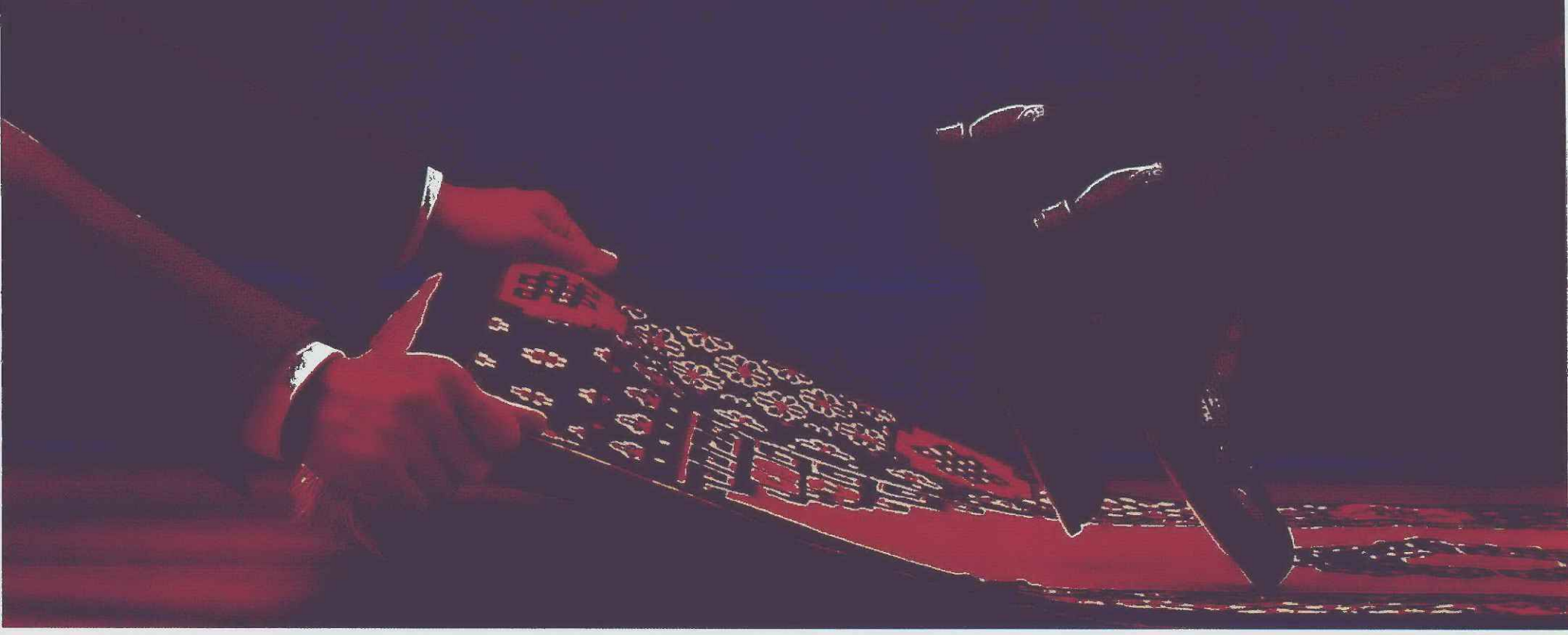

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Losses mounting for Cambridge Re

By ROGER SCOTTON

HAMILTON, Bermuda—The liquidators of Cambridge Reinsurance Ltd. now estimate that the reinsurer is insolvent by almost $64 million—nearly double the amount they originally had estimated.

Meanwhile, two more Bermuda-based insurers announced they are headed for liquidation. Both Fidentia Marine Insurance Co., the insurer allegedly used by former Lloyd's of London underwriters Raymond Brooks and Terence Dooley to channel syndicate premiums offshore, and Southlands Reinsurance, a 14-year-old concern, last week announced their impending liquidation.

And, the liquidator of Mentor Insurance Co. Ltd. says he has found anomalies in Bermuda law that allow policyholders of insolvent insurers to file claims even after insurers go into liquidation.

In an Aug. 17 letter to the creditors of Cambridge Re, the reinsurer's liquidators announced that Cambridge's estimated deficiency stood at $63.6 million as of July 31, $31.2 million more than the previous $32.4 million estimate.

The liquidators explained that unsecured creditors are owed about $80 million, not the $64 million first estimated on May 17, 1985, shortly after Cambridge put itself into liquidation.

Assets also have been restated. They are now estimated at $16.3 million—only about half the original assessment of $31.5 million—after taking into set-offs.

Bermuda-based liquidator David E.W. Lines of Coopers & Lybrand Bermuda and his London-based counterpart, Gerry A. Weiss of Coopers & Lybrand unit Cork Gully, stress that the new liability estimates are nothing more than estimates. The $63.3 million figure includes paid, unpaid and incurred-but-not-reported loss provisions under the broad heading of reinsurance balances due to cedants.

But the good news for Cambridge's 2,000 to 3,000 creditors is

Unsecured creditors are owed about $80 million, not the $64 million first estimated on May 17, 1985.

that an out-of-court settlement has been reached with Orion Royal Bank in London.

The bank, formerly the Royal Bank of Canada (London) Ltd., had been fighting the liquidators over the terms of a $3 million loan it had made in November 1980 to Cambridge's parent, Hamilton Insurance Brokers, which is a unit of Halifax, Nova Scotia-based National Sea Products.

When Cambridge went into runoff in 1984, the bank seized $3 million deposited with it by Cambridge in a managed fund, saying that it was allowed to do this under the terms of the loan. Litigation over the bank's action began in London's High Court late last year (*BI*, Dec. 29, 1986).

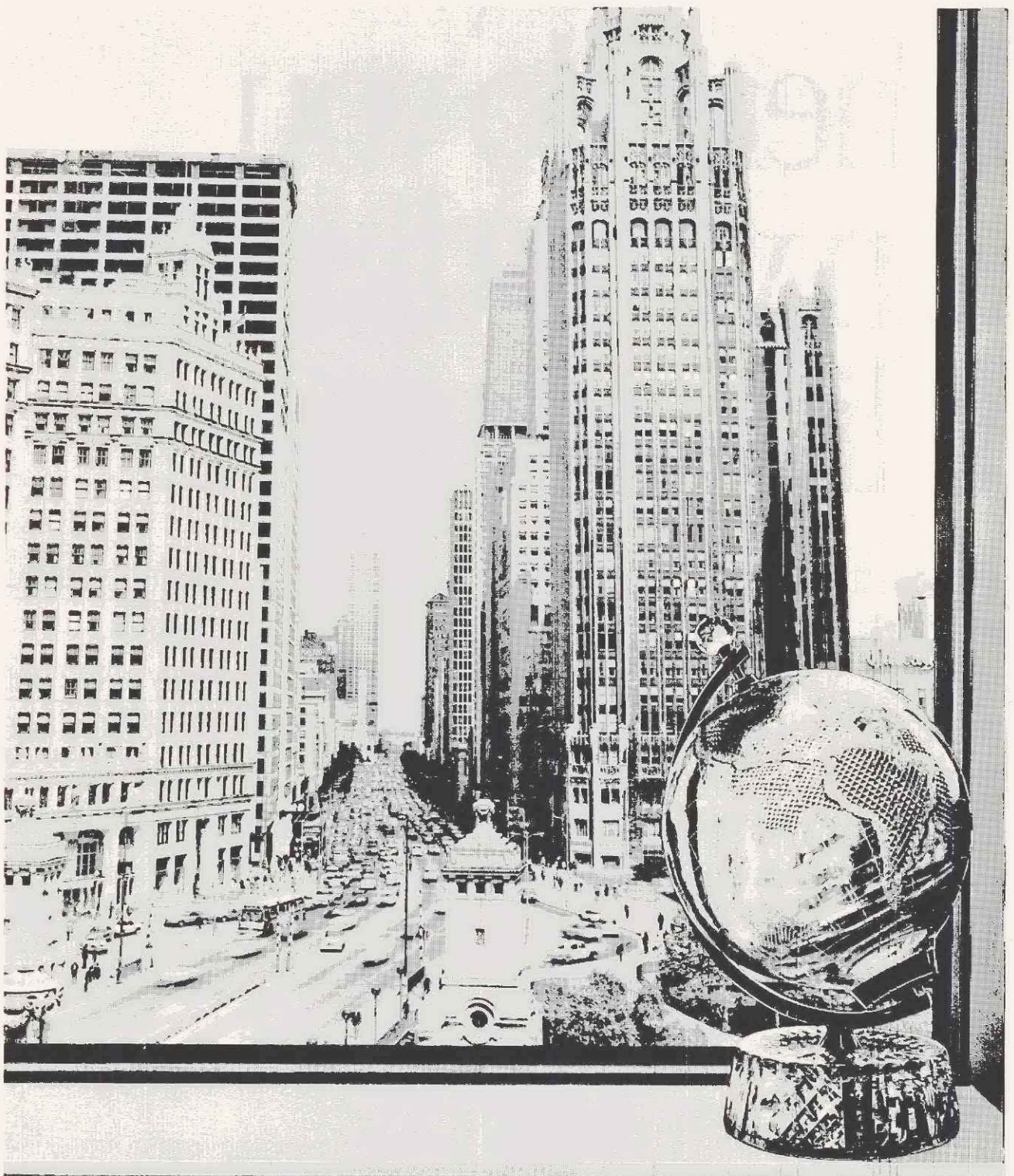
According to the liquidators' latest figures, the settlement has added $2 million to Cambridge's receipts, which have grown to $11.7 million from $9.2 million since the litigation began.

However, cash outflows have risen since the end of last year to $2.3 million—an increase of almost $1 million during the first seven months of the year, most of which went toward joint liquidators' fees and disbursements, legal and computer services and fees to management company Johnson & Higgins.

The new financial numbers have been sent to creditors along with court-ordered information forms and provisional claim calculations, which the liquidators will use to arrive at an actuarial assessment next year of all claims against the reinsurer.

Creditors have until Dec. 31 to object to the accuracy of the calculations. Under a plan approved by Bermuda's Supreme Court, the liquidators will be allowed to assume that creditors who have not provided revised information on their

Continued on page 38



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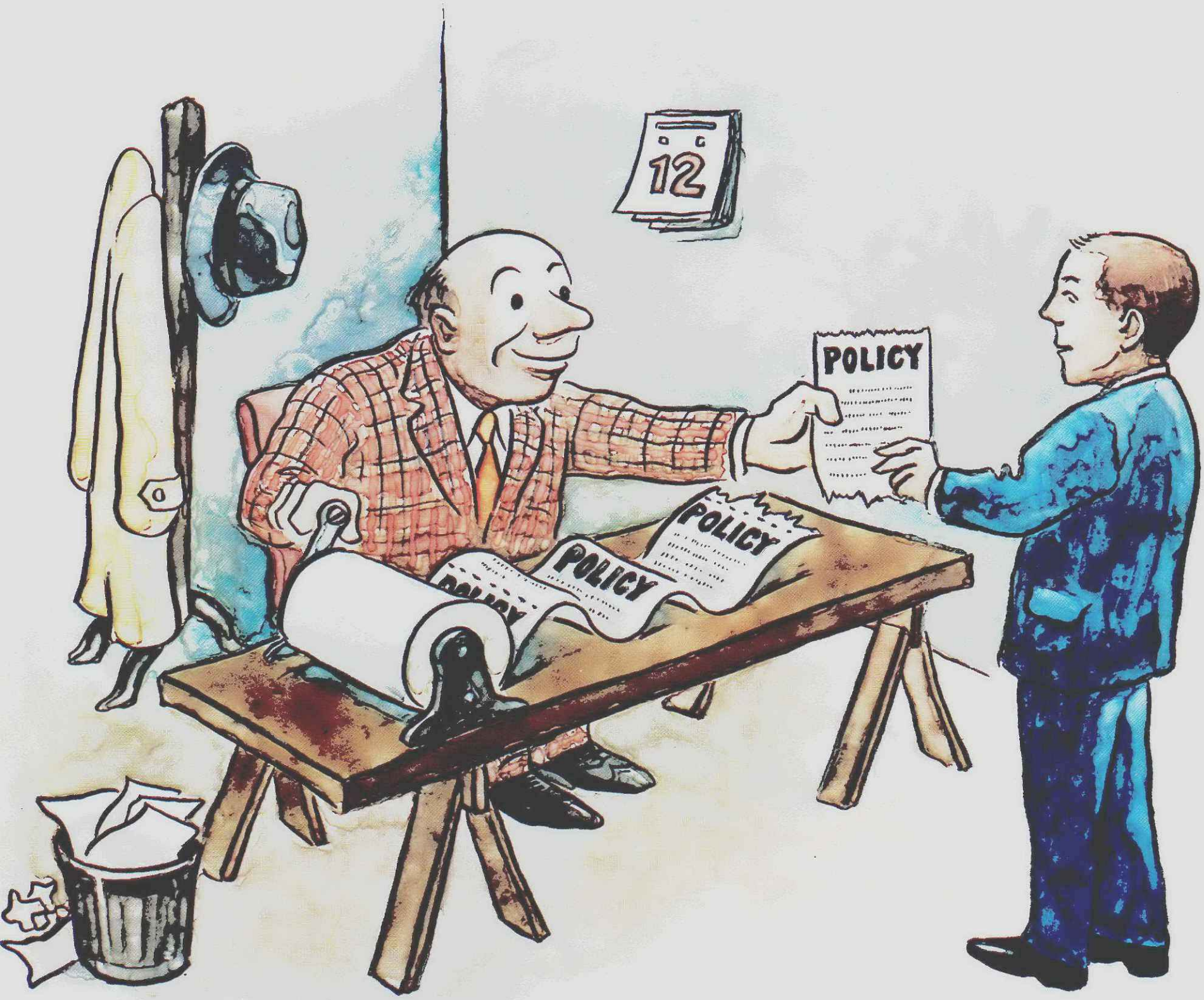

Industry estimates suggest that much of the $50 billion in outstanding reinsurance recoverables may never be paid!

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Cambridge Re

Continued from page 38

claims by the end of the year accept the figures (*BI*, March 16).

After that, Messrs. Lines and Weiss must apply to the court for a final determination of their plan to estimate all contingent liabilities—a move that is intended to shorten the liquidation by approximately 15 years and allow an interim dividend to be paid to shareholders by Jan. 1, 1989.

While Cambridge's liquidation moves along, Fidentia Marine Insurance Co. and Southlands Reinsurance are just beginning their liquidation tribulations.

The 17-year-old Fidentia is the company whose activities sparked a full-scale Lloyd's inquiry in 1983 that resulted in disciplinary proceedings against Messrs. Brooks and Dooley and reprimands for Bermuda-based directors James Pearman and Richard Pearman, both prominent lawyers in Bermuda and members of Lloyd's who refused to appear before the inquiry.

James Pearman says that following an agreement reached last year with representatives of Lloyd's syndicates formerly managed by Brooks & Dooley, Fidentia "is at a stage where it can settle outstanding reinsurance contracts." Under the agreement, Fidentia agreed to wind up its business.

But, Mr. Pearman added, "Fidentia could well remain in liquidation until 1991 because a number of contracts are backed by securities which do not mature until then."

At Southlands Reinsurance, directors have declared the insurance company insolvent and have called a meeting of creditors to have the company placed in liquidation.

According to the company's share register, the majority of Southlands' shares are owned by IPEC Investments Pty. of Adelaide, Australia.

A circular issued by directors last week says that Southlands, which is managed in Bermuda by Westbroke Ltd., stopped all underwriting activity eight years ago because of substantial losses incurred between 1974 and 1979.

"Since then, the only activity of the company has been to run off those insurance contracts existing at 1979 to extinction," says the unsigned circular.

The document makes no mention of the risks reinsured by Southlands, and Westbroke senior executive Alan Brown refused to provide details of the company's business.

"It's a market reinsurance company. That (description) covers it," he said.

A copy of Southlands' balance sheet that was included with the circular shows that for the year ending June 30, 1986, the company had a deficit of approximately $20 million.

The company's assets totaled $587,623, of which $96,534 was due from an affiliate; $490,231 was retained by ceding companies; and $858 was in the form of cash.

But the circular says that underwriters and placing brokers who hold guarantees from a company called Elsea Holding, formerly known as Ipec Holdings, have been advised that the winding up of Southlands will not affect their rights under those guarantees.

Southlands creditors, due to meet on Sept. 25, will be asked to approve the appointment of liquidator Gregory Haycock, a Bermuda-based international partner in the accounting firm of Peat Marwick Main & Co.

Given this activity, Mentor liquidator Charles Kempe's examination of Bermuda law is quite timely.

In his first personal interview since being appointed as one of two Mentor liquidators, Mr. Kempe argues that although Bermuda's legislation has generally been able to withstand the test of a major international insolvency, it could be improved in the area of policy cover termination.

'In Britain and the United States it is cut and dried: Policy cover ceases once liquidation begins. But Bermuda is relying on common law,' and it is still possible to file claims against a policy after liquidation begins, says Charles Kempe.

"There is no statute in Bermuda dealing with the termination of the policy liabilities of an insurer or reinsurer which is in liquidation," says the 50-year-old insolvency practitioner and Bermuda partner in the accounting firm of Arthur Young.

"In Britain and the United States it is cut and dried: Policy cover ceases once liquidation begins. But Bermuda is relying on common law precedents, and it is still possible here to claim against a valid policy after the liquidation has commenced. This does not help with the efficient administration of a winding up."

The alleged anomaly has already cost the Mentor estate an additional $39.2 million since Mentor went into liquidation on June 21, 1985. Initial estimates of the insurer's insolvency were $474.2 million, based on the assumption that no claims would be admitted after that date.

But Mr. Kempe's lawyers have since advised him that under Bermuda law, claims may be established after the liquidation began provided that they are made against the valid contracts issued by Mentor.

Taking into account investment income, Mr. Kempe now estimates that Mentor is insolvent by $505.6 million (*BI*, Aug. 17).

Mr. Kempe—who was handling the liquidation of Ajax Insurance Co. and Dover Insurance Co. before winning the Mentor appointment despite competition from partners in the local office of accountant Coopers & Lybrand—says he will press for Bermuda's 1981 Companies Act to be tightened up to reduce exposure to claims after a liquidation has commenced. ■

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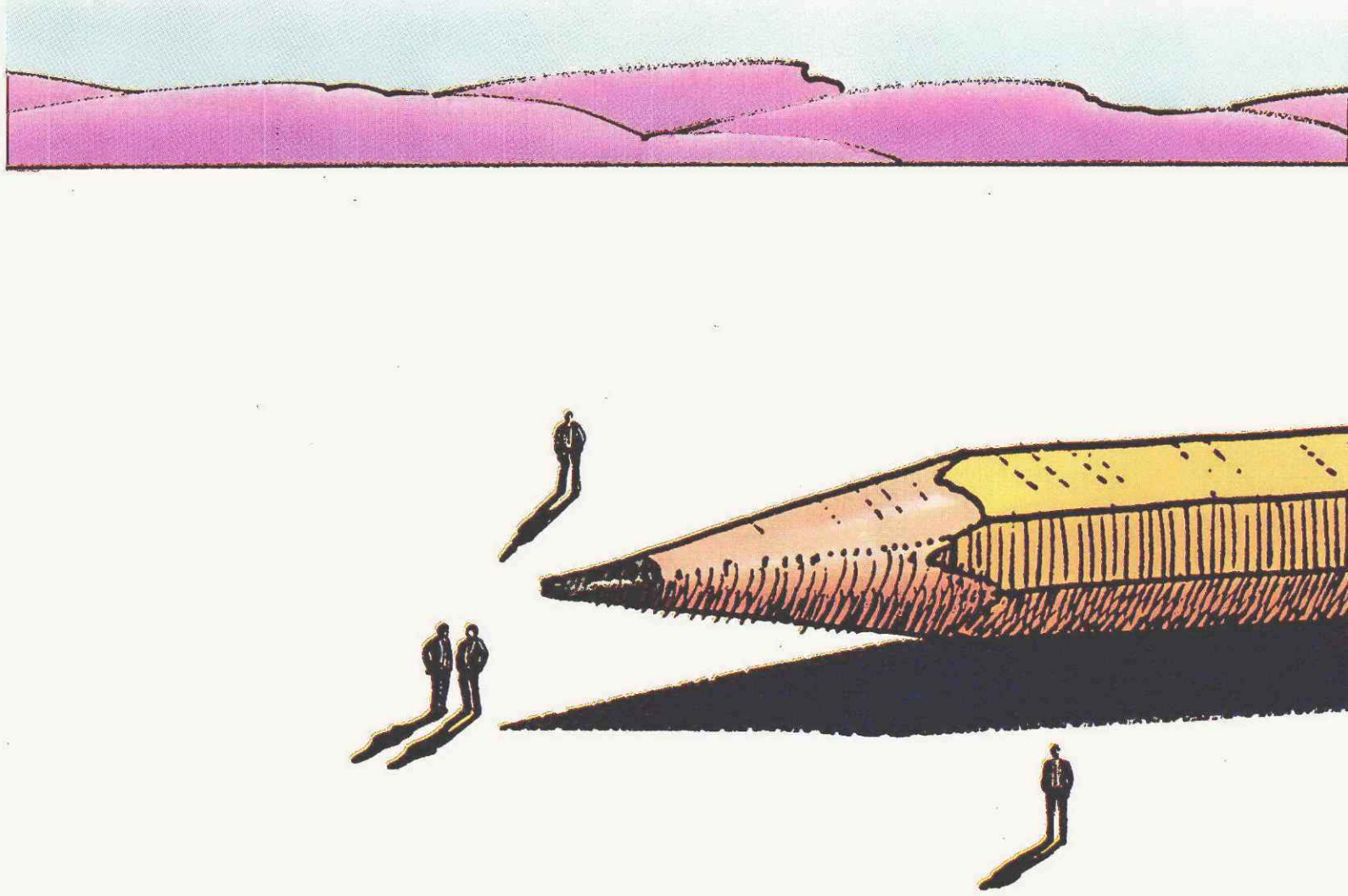

Group auto coverage rewards safe habits

Employees who buckle up and pass up a drink before driving can receive a discount on auto insurance through a new program from NWNL General Insurance Co. of Minneapolis.

The program, called "Safe & Sound," is not just another safe-driving lecture, asserts the Northwestern National Life Insurance Co. subsidiary.

"We will reward you for wearing a belt and not taking one," touts one poster the insurer uses to communicate the program to employees.

Products & services

After attending an hour-long worksite safety presentation and signing a pledge to wear seat belts and drink responsibly before driving, employees are eligible to receive discounts of 15%, up to an annual maximum of $30, on group auto insurance policies from NWNL General.

NWNL General markets its automobile and homeowners insurance policies on a group basis to employers in 12 states: Colorado, Georgia, Illinois, Indiana, Iowa, Kansas, Minnesota, Missouri, North Dakota, Oregon, Texas and Wisconsin. In addition, the insurer has applied for a license in Washington state.

Currently, about 7,000 NWNL General group auto policies are in force through 160 employers nationwide, according to the spokesman.

Employers with at least 100 employees can offer NWNL General group auto coverage to their employees even if other group insurance programs are underwritten by other insurers, according to an NWNL spokesman.

Employees who choose the auto coverage pay for it on a monthly basis through payroll deductions. Premiums vary depending on liability limits, whether the employee opts for collision coverage, and if so, what deductible he or she selects.

Liability limits ranging from $70,000 to $500,000 annual aggregate are available with no deductible. Deductibles available range from $100 to $1,000 for employees who select the optional collision coverage.

Employees insured by one of NWNL General's group auto insurance plans can convert their coverage to individual policies when they change jobs, the spokesman noted. Employees converting to individual policies will be billed directly on a quarterly or biannual basis.

For more information on Safe & Sound, contact Bob Ritchie, Vp-Marketing, at NWNL General Insurance Co., 100 Washington Square, Suite 1725, P.O. Box 1725, Minneapolis, Minn. 55440; 612-342-3423.

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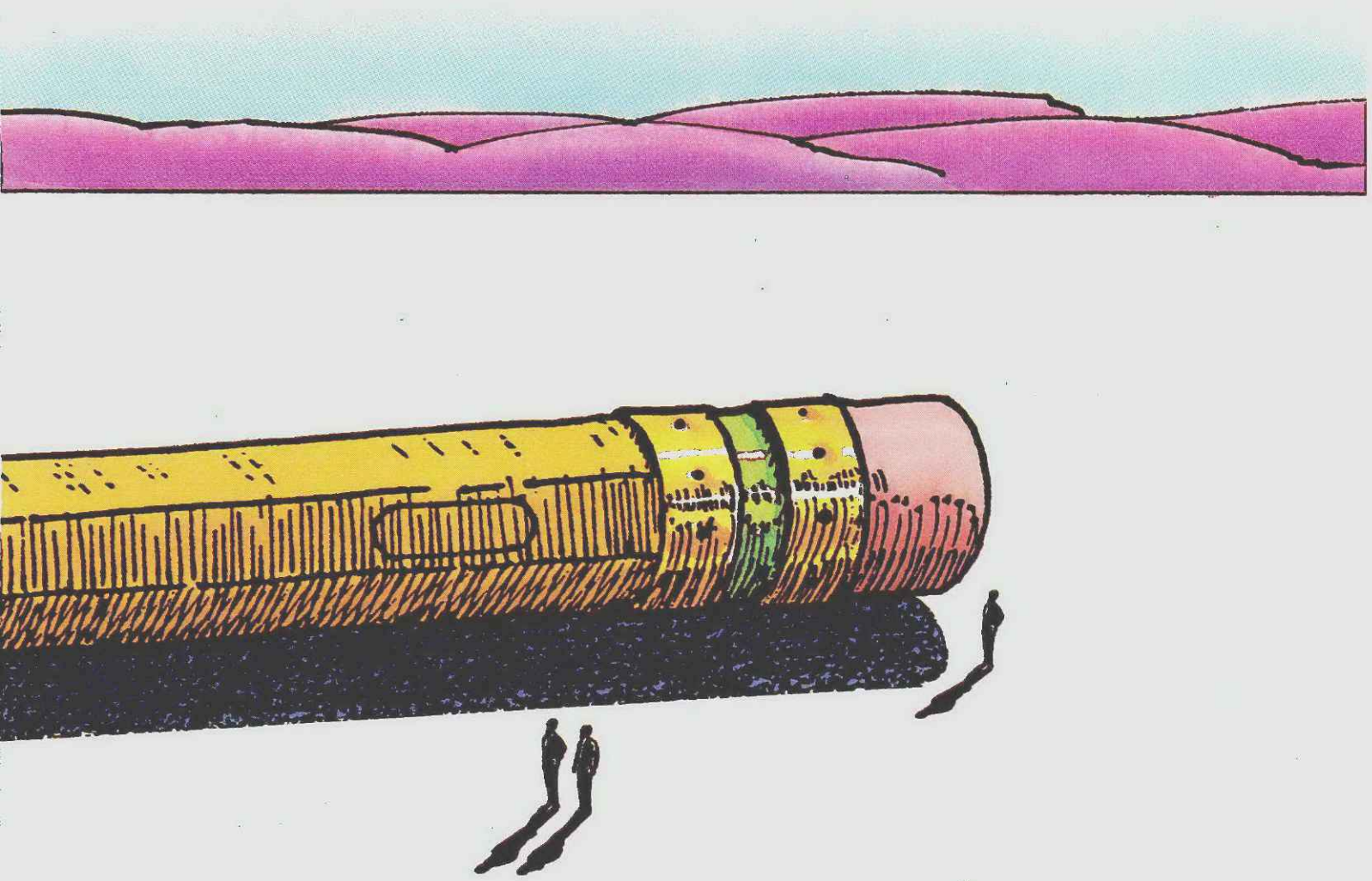

Endoscopic review

Sentinel Review Services Inc., a new medical utilization review system developed by Second Opinion Consultants Inc. of Millwood, N.Y., is designed to reduce employers' and insurers' costs for outpatient endoscopic testing.

Sentinel Review ensures that only those gastro-intestinal endoscopic procedures contributing to a patient's health and well-being are performed, the utilization review firm says.

Three components make up the Sentinel Review program: pre-procedure certification; post-procedure certification; and maintenance of a data base of provider claims experience.

Under the program, patients call a 24-hour toll-free number to submit a request for endoscopic testing, which will be reviewed by a physician panel.

Periodic summary reports of services provided are submitted to the employer, and covered employees are given a pamphlet that clearly describes the advantages to them of this review process.

Procedures covered include: colonoscopy; esophagoscopy, gastroscopy, duodenoscopy; and endoscopic retrograde cholangiopancreatography.

The charges for the utilization review service vary based on the size of the employer, and the fee can be negotiated on either a per-review or a monthly capitated basis.

For more information, contact David J. Finkel, Vp-Marketing, Sentinel Review Services Inc., P.O. Box EE, Millwood, N.Y. 10546; 800-446-4626 in New York state, 800-446-4606 elsewhere.

On-line data

Risk*Talk, an on-line source of information on commercial insurance markets as well as other information, is making its market data more accessible.

Beginning on Sept. 1, separate electronic files on specific types of insurance became available to users.

Previously, most market information was accessed in searchable data bases.

Now, separate electronic files, called icons, exist for such lines of insurance as boiler and machinery, bonds, buffer layers, directors and officers liability, excess property, and wet marine.

Overall, Risk*Talk provides risk managers, agents and brokers, consultants and insurers with market information on 43 categories of commercial insurance.

The two searchable data bases still exist. One, called Risk/Market,

Continued on next page

Products & services

Continued from previous page
contains information on the following coverages offered by insurance companies: auto liability, aviation, general liability, inland marine, product liability, professional liability, property, special events, workers compensation and umbrella.

Seventy of 91 identified insurance company groups have provided information to Risk*Talk.

The other searchable data base, called Wholesaler/MGAs, contains information on 31 lines of commercial insurance offered by MGAs or wholesalers by state, ranging from animal mortality to workers compensation.

So far, this data base includes information on wholesalers primarily in the Southwestern states: Kansas, Oklahoma, Arkansas, Louisiana and Texas.

Information on wholesalers in other parts of the country is being developed.

In addition, Risk*Talk provides subscribers with a weekly digest of insurance news and state regulatory information in 17 different categories. These files include information ranging from requirements for self-insurers to the status of tort reform.

Risk*Talk, which has been in development for 1½ years, has about 30 subscribers.

While initially developed for agents and brokers, Risk*Talk also is being marketed to risk managers, consultants, insurers and MGAs and wholesalers.

"A risk manager can use Risk*Talk to look over the shoulder of his broker—to get another view of the marketplace," commented Don Oden, president of Don Oden Insurance Services Inc., which developed Risk*Talk.

Fees for subscribing to Risk*Talk are: $100 for installation; $100 monthly for Risk/Market information; $100 monthly for only state reference files; $150 monthly for the Risk/Market and state files. The on-line connect time charge is $57 per hour, charged by the minute with no minimum.

For further information, contact Don C. Oden, President, Don Oden Insurance Services Inc., or Stephanie Cesar, Vp-Operations, 8506 E. 61st St., Suite 212, Tulsa, Okla. 74133; 918-254-0544.

Office building cover

Owners of office buildings can purchase comprehensive property and liability protection with limits up to $500,000 from Atlantic Mutual Cos. of New York.

The new program includes special provisions such as building ordinance protection, reimbursement for increased construction costs, garagekeepers insurance and insurance for indoor plants commonly found in modern office building lobbies and atria, a company spokesman explained.

"We believe this plan streamlines the decision-making process for building owners," said John Gubernat, vp of Atlantic Mutual's commercial lines division.

"Instead of having to purchase several insurance policies to protect the variety of office building exposures, we have developed a convenient, single package that includes all of these coverages," he said.

Building ordinance insurance covers costs that result when damage to a building is so severe that the entire building, including undamaged portions, must be torn down and rebuilt to meet current fire and safety regulations, the company spokesman explained.

This provision covers the cost of the demolition and the loss of value on the undamaged portion of the building.

Garagekeepers liability, which is not usually provided by other similar package policies and often must be purchased separately, is automatically included in Atlantic Mutual's office building program with limits of $250,000.

Also included in the program is a provision that provides coverage for damage or destruction of indoor trees and plants up to a limit of $10,000.

Other standard features provided as part of the program include:

- Office contents coverage, up to a limit of $15,000.
- Explicit inclusion of building supplies as part of the building definition.
- General liability for injuries to tenants or the general public.
- Workers compensation and automobile liability/physical damage protection.

Additional coverages can be tacked on to the program for an additional premium:

- Newly acquired building coverage, up to a limit of $500,000 for 90 days.
- Newly acquired personal property coverage, up to a limit of $250,000 for 90 days from the point of purchase.
- Valuable papers and records protection, up to a limit of $10,000.
- Extra expense coverage, up to a limit of $10,000.
- Coverage for personal effects, including that of employees, up to a limit of $5,000.
- Outdoor signs coverage, up to a limit of $5,000.
- Indemnity for fire department service charges, up to a limit of $1,000.

The program is available for a minimum premium of $5,000 with a $250 or higher per-occurrence deductible for the property coverage. No deductibles are applied to the liability portion of the program.

Policyholders can receive a dividend from the insurer based on the experience of the industry group to which they belong, according to William J. Munier, project manager.

For more information, contact a market center manager for Atlantic Mutual Cos.

Placement manual

A new reference manual and update service helps insurance buyers plot their insurance placement strategies.

The Merritt Co.'s "Strategies for Insurance Coverage" informs subscribers of current trends and future forecasts while offering comprehensive information on more than 200 individual coverages, exclusions and limits.

The three-volume manual also includes information on developing hard-to-find non-U.S. insurance company solvency margins, according to the Santa Monica, Calif.-based publisher.

The manual, written by Bernard J. Daenzer, includes agents' reports and actual case histories on a variety of special and often-overlooked insurance coverages, Merritt says.

It also offers key provisions of state insurance laws, including an updated section on state-by-state insurance regulations for non-admitted companies.

Monthly supplements create a growing reference library on the latest approaches to risk management and placement.

"Excess Express," a monthly newsletter written by William R. Feldhaus, covers the latest national and international developments in markets and coverages, changes in the law, legal precedents and unusual risks.

Subscribers to "Strategies for Insurance Coverage" receive the complete three-volume manual along with monthly supplements, the "Excess Express" newsletter, and monthly management briefings.

First-year subscription rates are $277, while annual renewals are $210.

To subscribe or obtain additional information, contact the Merritt Co., Department. 1A713, 1161 Ninth St., P.O. Box 955, Santa Monica, Calif. 90406; 213-450-7234 or 800-638-7697.

Glare filter

OCLI-Optical Coating Laboratory Inc. has introduced an anti-glare filter that fits curved bezel computer monitors.

The optically coated filter removes up to 99% of all reflected glare and reduces the perception of screen flicker while enhancing contrast and character resolution, the Santa Rosa, Calif.-based company says.

OCLI's new Glare/Guard Profile filter—mounted in a light, but sturdy molded plastic frame—comes in various shapes to match the contour of the most popular curved bezel monitors, according to the company.

The Glare/Guard Profile filter currently fits more than a dozen models of cathode ray tubes produced by manufacturers such as Wyse, Wang, Burroughs, Data General, Altos, Televideo and Olivetti.

The two available models are priced at $69.95 and $109.95. Additional models of the Glare/Guard Profile filter are in production.

For more information, write to: OCLI-Optical Coating Laboratory Inc., 2789 Northpoint Parkway, Department 171-1, Santa Rosa, Calif. 95407-7397.

OCLI also offers Glare/Guard filters on a 30-day free trial basis. To order a free trial, call 800-545-OCLI.

Contractors liability

A new general liability policy that covers pollution liability risks for contractors that install, repair or remove chemical and petroleum tanks has been introduced by United Capitol Insurance Co. of Atlanta.

Coverage is written on a claims-made basis and is available through approved United Capitol producers, according to the insurer.

United Capitol offers combined single limits of up to $1 million for general liability coverage, with a separate limit of up to $500,000 for pollution liability.

The minimum premium for the coverage is $75,000 for $500,000 combined single limit and $100,000 for $1 million combined single limit.

For more information, contact Gary S. Resman, Vp, United Capitol Insurance Co., 1400 Lake Hearn Drive, Suite 130, Atlanta, Ga. 30319; 404-843-5599.

Evidence analyzed

The eighth edition of "Evidence in Negligence Cases," published by the Practising Law Institute, provides an understanding of what may and may not be offered in evidence in negligence cases.

The book is written by Charles and Daniel Kramer in a clear, to-the-point style for attorneys to use in the courtroom, its publisher says.

The eighth edition, enlarged by almost 80% since the previous edition, covers the important judicial decisions and legislative developments of the past five years.

The volulme includes chapters on demonstrative evidence, hearsay, pleadings and legal papers, expert testimony, damages recoverable and proof of damages, cross-examination and the use of depositions at trial, among others.

Charles Kramer, a member of the New York law firm of Kramer, Dillof, Tessel, Duffy & Moore, is a frequent lecturer on personal injury litigation and related topics for the Practising Law Institute and other organizations. Co-author Daniel Kramer also is a member of Kramer, Dillof.

The 301-page text, available on 10-day approval, is $60.

For more information, or to receive the Practising Law Institute's 1986 Catalog of Books and Video/Audio Cassettes, contact June E. McDonald, Sales Manager, Practising Law Institute, Department AG, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700. ■

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Info

● "State Legislation 1987: Tort and Insurance Reforms, (Jan. 1, 1987-May 1, 1987)," offers **a state-by-state review of key tort reforms** including joint and several liability, collateral source rule, prejudgment interest and punitive damages reforms. In addition, it reviews key insurance reform actions, such as data reporting requirements and includes charts indicating states that have enacted reforms. The handbook is published by Shand, Morahan & Co. Inc. of Evanston, Ill. Copies are available free by contacting Patricia Reinhardt at Shand Morahan & Co. Inc., Shand Morahan Plaza, Evanston, Ill. 60201; 312-866-0857.

● Recordings of sessions from the **1986 Corporate Benefits Management and Corporate Health Care Cost Management Conferences** are available on cassettes. The conferences, sponsored by the International Foundation of Employee Benefit Plans, included such topics as flexible benefits, tax-qualified pensions and profit-sharing plans, preferred provider organizations, risk management techniques and evaluating alternative delivery systems. Individual cassettes are available to foundation members for $8 each and to non-members for $10 each. Discounts are available for sets of six or more tapes. For a listing of cassettes, contact the Audiovisual Services Department at the International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

● A Hewitt Associates study tracing **changes in employee benefits** is available from the employee benefit consulting firm. Savings and pension plans, health care coverage and group life insurance are included in the topics. The 46-page report, "Salaried Employee Benefits Provided by Major U.S. Employers: A Comparison Study, 1981 through 1986," is available for $25 from Cathy Schmidt, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.

● The problems of aging, disability and rehabilitation were examined at the 11th Mary E. Switzer Memorial Seminar titled **"The Aging Workforce: Implications for Rehabilitation."** The report, composed of five action papers and two special invited papers, includes summaries of recommendations for action in the areas of policy and program development, service delivery, research, training and legislation. Copies of the report are available for $15 from the Switzer Memorial Fund, National Rehabilitation Association, 633 S. Washington St., Alexandria, Va. 22314.

● The Employee Benefit Research Institute reports foreign countries are dealing with the burdens of an aging population by shifting some of the responsibility for retirement income from the public to the private sector. For example, Switzerland has introduced mandatory pension plans, France is considering personal pension plans similar to individual retirement accounts and Britain is encouraging personal pension plans. EBRI's July 1987 issue brief, **"International Trends in Social Security Reform,"** and its August 1987 brief on the corporate and individual retirement plans abroad are available for $10 each from EBRI-ERF Publications, P.O. Box 753, Waldorf, Md. 20601.

● **"AIDS: A Manager's Guide"** is offered by the employment law firm of Schachter, Kristoff, Ross, Sprague & Curiale as a guide for dealing with AIDS in the workplace. The guide provides information on topics including the civil rights of patients with acquired immune deficiency syndrome, the fears of contagion and potential litigation. The booklet is available for $9.95 for a single copy, with discounts for larger orders, from Executive Enterprises Publications Co. Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 212-645-7880, ext. 210.

● The Hartford Steam Boiler Inspection & Insurance Co. offers a catalog of its codes and standards training courses. Seminars and workshops are offered throughout the year in several locations across the country. Topics examined include **pressure vessel design, welding qualifications and boiler operation and maintenance.** For a copy of the "1987 Codes & Standards Training Catalog," write Hartford Steam Boiler Inspection & Insurance Co., 1 State St., Hartford, Conn. 06102; 800-243-0090.

● The International Foundation of Employee Benefit Plans, has published **"The Valuation of Employee Benefits: Theory, Practice and Implications for Tort Actions."** James Lambrinos, associate professor of administration and management at Union College, Schenectady, N.Y., reviewed employee benefits, health care costs and inflation, the value of nonvested pension benefits, computation of Social Security benefits, tax treatment and hypothetical cases and examples. Copies of the report (ISBN 0-89154-321-X) are $5 for members and $9 for nonmembers and may be obtained from the Publications Department of the International Foundation, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

● Employee benefit consultant Kwasha Lipton is offering free reprints of articles. **"Pension Ac-**

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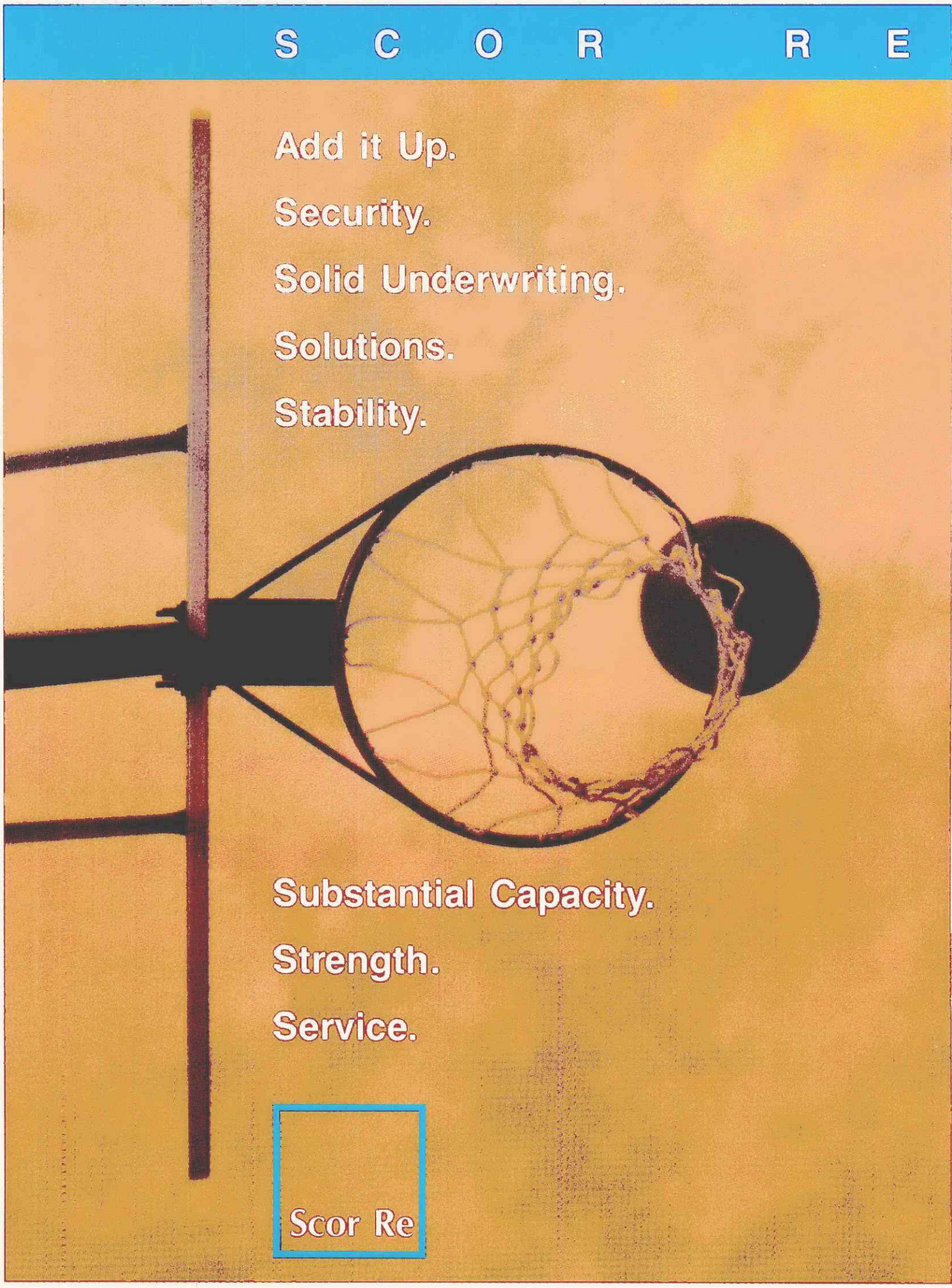

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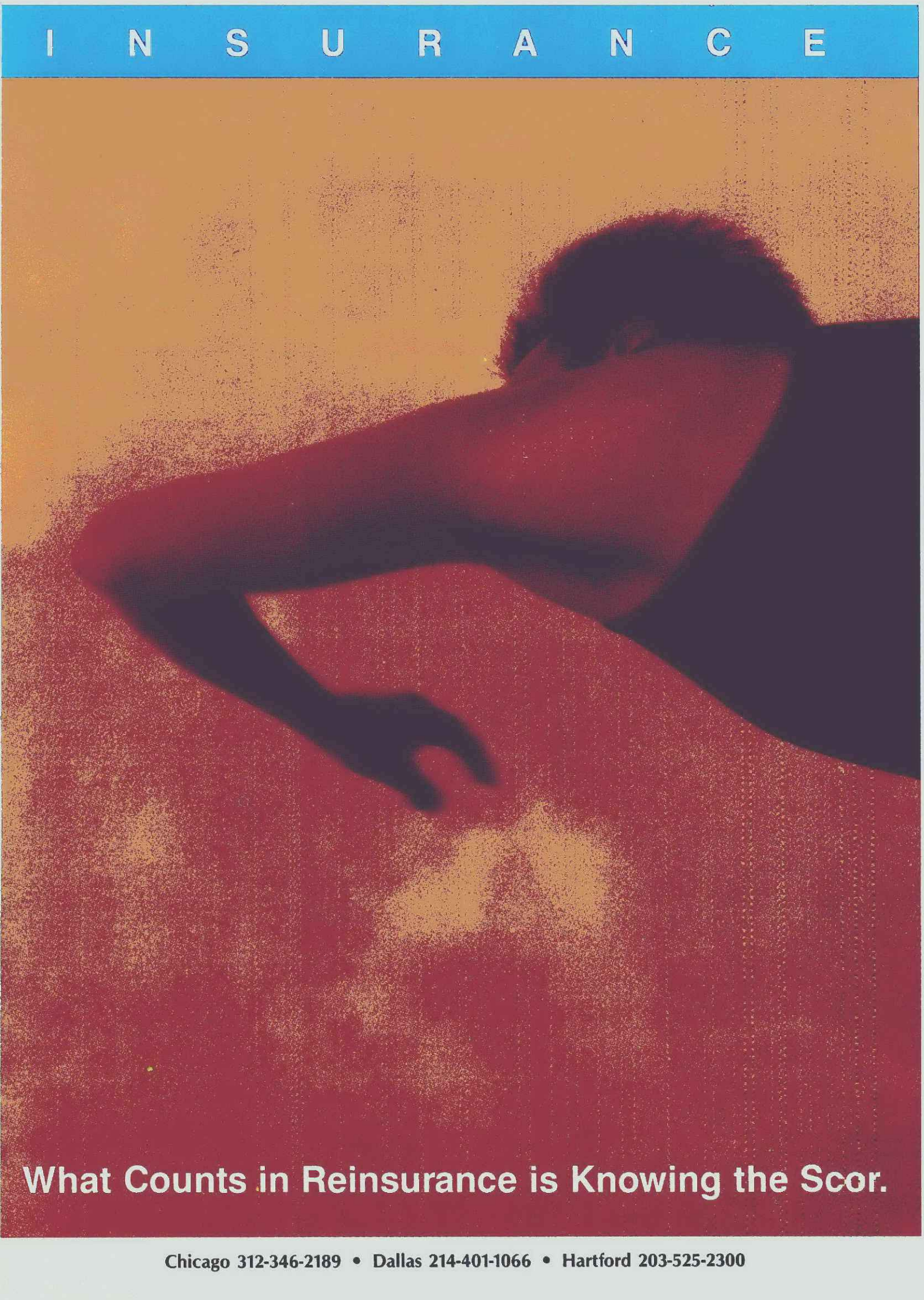
counting: How to Structure Your Year-End Financial Planning" and **"Changes in the PBGC Insurance Program"** are available by writing the Marketing Department, Kwasha Lipton, P.O. Box 1400, Fort Lee, N.J., 07024.

● The fifth edition of **"Avoiding Legal Malpractice Claims,"** published by Duke Nordlinger Stern & Associates Inc., is now available from the St. Petersburg, Fla., risk management firm. The book offers advice on conducting a law firm malpractice exposure audit and addresses the causes of lawyer's professional liability. Topics include an effective time/docket control system for the law office, preventing malpractice claims through successful client relations and avoiding conflicts of interest. Copies of the book are available for $23 each from Duke Nordlinger Stern & Associates Inc., 1336 54th Ave. N.E., St. Petersburg, Fla. 33703-3225.

● The Defense Research Institute offers a catalog highlighting more than 100 publications of use to risk managers, insurance claims executives and corporate and defense trial counsel. Among the law topics covered in the publications are **asbestos litigation, fidelity and surety, governmental liability and products liability.** "DRI 1987 Publications Catalog" is available free from The Defense Research Institute, Suite 500, 750 N. Lake Shore Drive, Chicago, Ill., 60611.

● **"Analysis of Workers' Compensation Laws,"** a 64-page booklet on statutory provisions of workers comp laws around the United States is available from the U.S. Chamber of Commerce. The booklet covers regulations of all states, territories, federal programs and the Canadian provinces. It also includes changes resulting from more than 165 new laws enacted in 1986. Copies of the booklet Publication No. 6983, are available for $12 from the U.S. Chamber of Commerce, 1615 H St. N.W., Washington D.C. 20062; 301-468-5128.



● The Channing L. Bete Co. Inc. has just published **"About Substance Abuse at Work."** The 16-page illustrated booklet examines commonly abused drugs, their effects on job performance, productivity and safety awareness. It also shows employees where to turn for assistance. For a free sample copy and more information, contact Channing L. Bete Co. Inc., Department PR, 200 State Road, South Deerfield, Mass. 01373.

● **"Liability Risk Retention Act"** is a brochure that explains the Risk Retention Act of 1986. The brochure explains the act in detail, its provisions and how to set up a risk retention group or purchasing group. Also, it provides information for organizations to consider when deciding whether these types of groups are appropriate solutions for their insurance problems. For a free copy of the brochure, contact Jan Lester or Pat Holloway, American Insurance Services, 44 Montgomery St., Suite 1400, San Francisco, Calif. 94104; 800-228-5311; 800-421-9519 within California.

● Abt Associates offers a new brochure on **customer satisfaction programs in the health care industry.** The brochure contains the components of a customer satisfaction program and describes the value of such programs for insurers and third-party administrators, health maintenance organizations, preferred provider organizations, hospitals and employers. For a free copy, contact Morris R. Levene, Program Manager, The Health Group, Abt Associates Inc., 55 Wheeler St., Cambridge, Mass. 02138-1168; 800-624-7100; 617-492-7100.

● **"Legal Malpractice"** is the title of a Jury Verdict Research publication that examines jury reactions to the issues of liability and damages and includes brief summaries of verdicts and settlements in recent cases. Case summaries include the docket numbers, names and locations of plaintiffs' and defense attorneys and expert witnesses, trial dates, claimed injuries, attorneys' offers and demands, as well as plaintiffs' and defendants' contentions. Copies of "Legal Malpractice" may be obtained for $22.50 by contacting Jury Verdict Research Inc., 5325 Naiman Parkway, Suite B, Solon, Ohio 44139-1065.

● **"How to Buy Health Insurance"** is a folder for employers published by the Illinois State Chamber of Commerce. The folder outlines 11 points that benefit managers should keep in mind when making decisions affecting health care benefits. For a free copy contact the Health Care Cost Management Department, Illinois State Chamber of Commerce, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

● Structured Annuity Settlements Inc. is offering a informational package called "Structured Settlements: An Overview" to introduce claims and risk managers to **structured settlements** as a method of settling personal injury, wrongful death and workers compensation cases. To order send $5 to Structured Annuity Settlements Inc., 35 Glenlake Parkway, Suite 480, Atlanta, Ga. 30328.

● Free reprints of "Benefits Basics—Considerations in Self-Insurance" and "Utilization Review and Second Opinion Programs" are available from the International Foundation of Employee Benefit Plans. Both articles, which appeared in The Digest, the IFEBP's monthly newsletter, are aimed at those who are new to the **employee benefits** profession. Each

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Info

Continued from previous page
Article also includes a bibliography. Free copies are available by contracting the IFEBP Publications Department, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

● The American Society of Safety Engineers has published a 72-page "Directory of Safety Related Computer Resources. The book is designed to assist safety professionals in locating products and services related to the use of **computers in safety activities.** The directory includes a comprehensive list of computer software and references by name, subject, description, computer language, system requirements and general costs. Copies of the directory are available for $10 for ASSE members and $15 for non-members by contacting Department F, American Society of Safety Engineers, 1800 E. Oakton St., Des Plaines, Ill. 60018; 312-692-4121.

● "Product Liability Guide for Manufacturers" is a 20-page publication tailored for manufacturers and their employees responsible for handling **product liability** cases, from the initial inquiry to final settlement. The booklet is written by manufacturers and attorneys, based on their actual experiences. The publication provides helpful hints in laymen's language and explains frequently made mistakes that can result in costly settlements. The publication is available for $3 from the Hand Tools Institute, 25 N. Broadway, Tarrytown, N.Y. 10591. Payment must accompany order.

● Florida Insurance Commissioner Bill Gunter's office is offering a free **consumer guide to purchasing commercial insurance.** The booklet explains the coverages available under the umbrella of commercial insurance and has tips to help business owners make good decisions when buying insurance. In addition to examining the basics of commercial insurance, it outlines alternatives to traditional insurance. Copies are available at the Department of Insurance, Bureau of Field Operations, Room 335, Larson Building, Tallahassee, Fla. 32301; 800-342-2762.

● A series of **speeches on tort reforms** advocated by the Alliance of American Insurers is available in booklet form. The speeches include: "Civil Justice Reform: The Future is Now," by Franklin W. Nutter, Alliance president. A seven-point program for industry stabilization is outlined and the need for changes in the civil justice system is emphasized. "In One Era and Out the Other," a speech by Rodger Lawson, Alliance senior vp, discusses the nature of industry cycles. The text stresses the importance of civil justice reform to maintain a healthy financial condition. "Tort Reform—Who Won?," by Dee Ann Bernhard, assistant vp and South Central regional manager, emphasizes the growing importance of national and state coalitions that support tort reforms. "A Special Message to Insurance Communicators," a speech by Mr. Nutter, pinpoints public misconceptions about the insurance industry. The booklets are available by writing the Alliance of American Insurers, Public Affairs Department, 1501 Woodfield Road, Schaumburg, Ill. 60173-4980.

● **"How to Select the Best Child-Care Option for your Employees"** is a new book aimed at helping U.S. and Canadian businesses begin and manage a child-care operation or assist employees in finding existing child-care facilities. The book includes governmental source lists and examples of businesses that have employer-supported child-care programs. It is available for $11.95 plus $1.50 postage and handling from A.N. Weiner, Almar Press, 4105 Marietta Drive, Binghamton, New York, N.Y. 13903; 607-722-0265.

● Exporters and importers may receive a free 41-page guide to shipping arrangements, financial considerations and insurance protection titled **"The Ocean Cargo Handbook"** from the Chubb Group of Insurance Cos.' Ocean Marine Department. Packaging, shipping and contractual arrangements, ocean cargo insurance, financial arrangements and claims are among the topics examined. Buyers' and sellers' responsibilities for providing insurance also are included. Copies of the handbook are available by writing on company letterhead to Chubb Group of Insurance Cos., Ocean Marine Department, 15 Mountain View Road, P.O. Box 1615, Warren, N.J. 07061-1615.

● **"Health Maintenance Organization Selection: A Sourcebook for Employers and Unions"** is available from the New York State Public Sector Coalition on Health Benefits. The publication summarizes the legislative history of HMOs, purported advantages and disadvantages of HMOs and criteria that may be used in selecting a health care delivery system. Copies of the report are available for $5 each. Checks payable to the New York City Public Sector Coalition on Health Benefits may be sent to Donna Gwynne, Employee Benefits Program, 110 Church St., 12th Floor, New York, N.Y. 10007.

● The Insurance Institute of America offers a new claims text, **"Aggressive Good Faith and Successful Claims Handling,"** for use in the first of four courses required for the IIA Associate in Claims (AIC) designation. Copies of the text are available for $17 plus shipping and handling from the IIA, Order Department, 720 Providence Road, Malvern, Pa. 19355-0770. Telephone orders may be charged to VISA or MasterCard accounts by calling 215-644-2100.

●

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Steel firms face huge benefit liabilities

WASHINGTON—Six major steel companies had nearly $12 billion in unfunded pension and group life and health insurance liabilities at the end of 1986, according to a study by PaineWebber Inc.

Of the total, $5.3 billion is unfunded pension liabilities calculated on a Pension Benefit Guaranty Corp. termination basis, while unfunded group health and life insurance benefits for retirees total $6.2 billion.

The study added that by 1991, the total liabilities would exceed $15 billion—$8.6 billion in retiree health benefits and $6.5 billion for unfunded pension liabilities.

The report, "Steel's Retirement Cost Time Bomb," was prepared by Peter F. Marcus and Karlis M. Kirsis of PaineWebber's World Steel Dynamics unit.

But a Merrill Lynch Capital Markets steel analyst was critical of the study, pointing out massive liabilities, particularly for retiree health insurance benefits, exist in all sectors of American industry.

"This study makes it sound as if this is a problem only in the steel industry, but steel accounts for a very small part of the problem," said Charles A. Bradford, a vp at Merrill Lynch Capital Markets, who called the study 'improper analysis."

"The factors that determine the survivability of the steel industry are increased production, steel price stability in the market and things like this," pointed out Jack Sheehan, assistant to the president at the United Steelworkers of America in Pittsburgh.

"Whether or not the pension fund or the insurance program is funded is not one of those things," he said.

Mr. Sheehan also pointed out that health care benefits never have been thought of as funded, and that if a company went under, employees would lose these benefits.

Using PBGC termination valuation methodology, which only includes liabilities accrued to date, the survey authors said Bethlehem Steel Corp. of Bethlehem, Pa., had an unfunded pension liability of $2.5 billion, larger than Dallas-based LTV Corp.'s $2.3 billion liability.

LTV's termination of two plans in 1986 and two in 1987 was the largest claim ever made on the PBGC.

The present value of Bethlehem's group insurance liability is about $1.3 billion, according to the study.

Of the steel companies surveyed, only Pittsburgh-based USX Corp. had a pension fund surplus at year-end 1986—$347.8 million.

Armco Inc. of Morristown, N.J. had an unfunded pension liability of $581 million; National Steel Corp. of Pittsburgh had an unfunded pension liability of $350.6 million; National Intergroup Inc. of Pittsburgh had an unfunded pension liability of $382.7 million; and Inland Steel Industries Inc. of Chicago had an unfunded pension liability of $111.9 million.

For comparison purposes, the study noted that IBM Corp.'s pension plan had a surplus of $7.54 billion at the end of 1986.

For the purposes of the study, the unfunded pension liability was calculated on the PBGC's termination basis, using the agency's assumptions for retirees' age as well as interest rates.

Mr. Bradford of Merrill Lynch believes steel industry pension funds may be better funded than these figures would indicate, because the estimates are based on a very low interest rate—about 7.5%—even though average returns on investment have been in the neighborhood of 15%.

The present value of unfunded group insurance liability for these companies, according to the study, was: USX, $2.32 billion; LTV, $1.57 billion; Bethlehem, $1.29 billion; National Steel, $196 million; Armco, $497 million; and Inland, $284 million.

The study also estimated the value of the PBGC's guarantee for defined benefit pension plans at nearly $8.9 billion for the six major steel companies, which translates to an estimated economic premium of roughly $2,000 to $5,000 per plan participant.

"In effect, PBGC termination insurance converts the pension promise into the equivalent of government-guaranteed debt which, at the expense of other creditors, will delay and reduce the probability of default by highly leveraged firms," the study said.

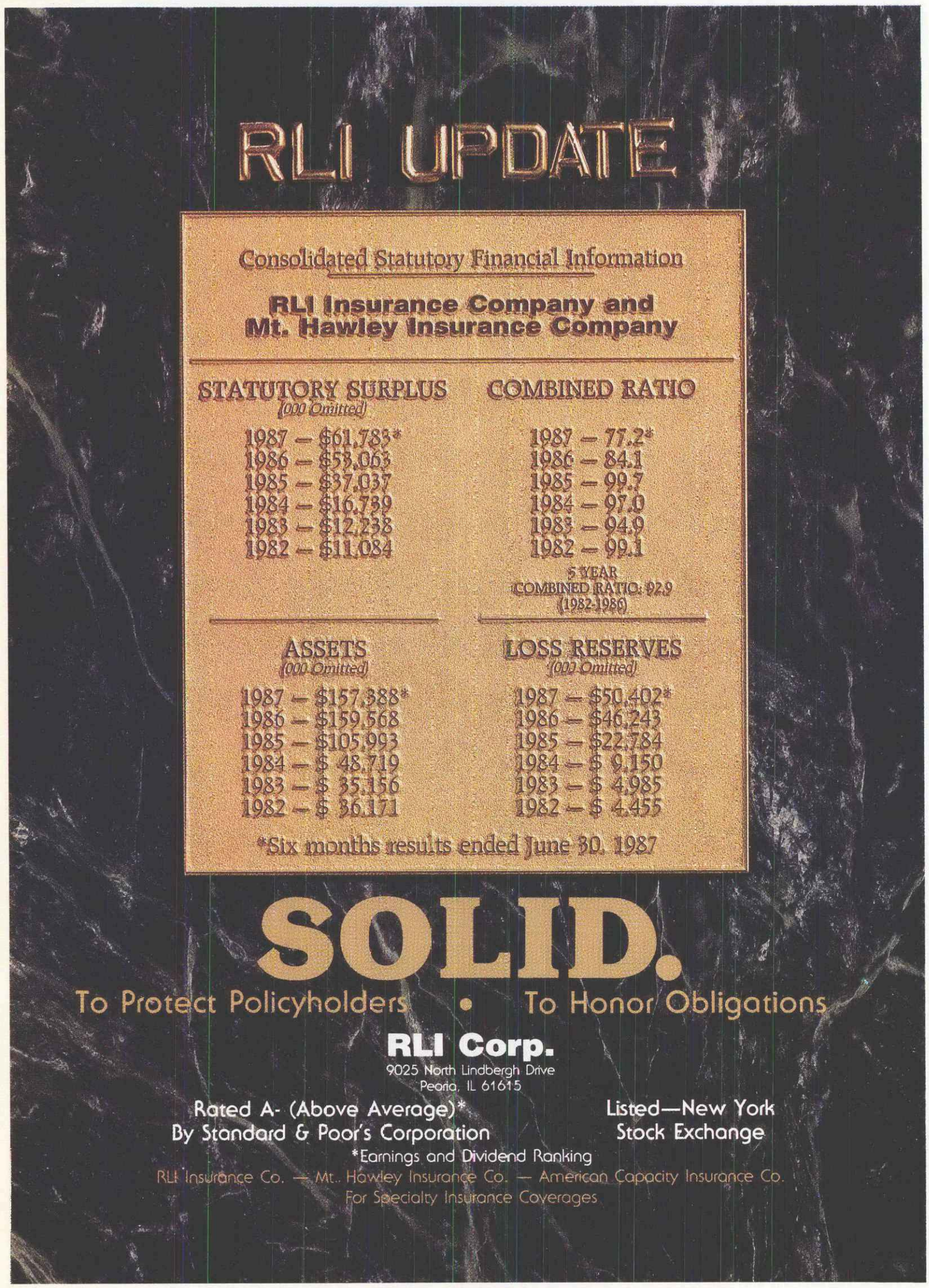
A PBGC official estimated the value of the PBGC guaranteed benefits for the companies, excluding LTV, at $4 billion to $6 billion.

"This guarantee is such a strong incentive that any company that presently has a defined benefit pension plan has seen what happened with Wheeling-Pittsburgh (Steel Corp.), LTV and others and has to contemplate termination as a cheap way to encourage a third party—the federal government—to pay their obligations," he said.

Wheeling-Pittsburgh terminated seven pension plans in 1985, dumping almost $500 million in unfunded liabilities on the PBGC.

The PBGC official added this incentive will become stronger as accounting standards that require public companies to show unfunded pension liabilities on the balance sheet go into effect.

—Crain News Service



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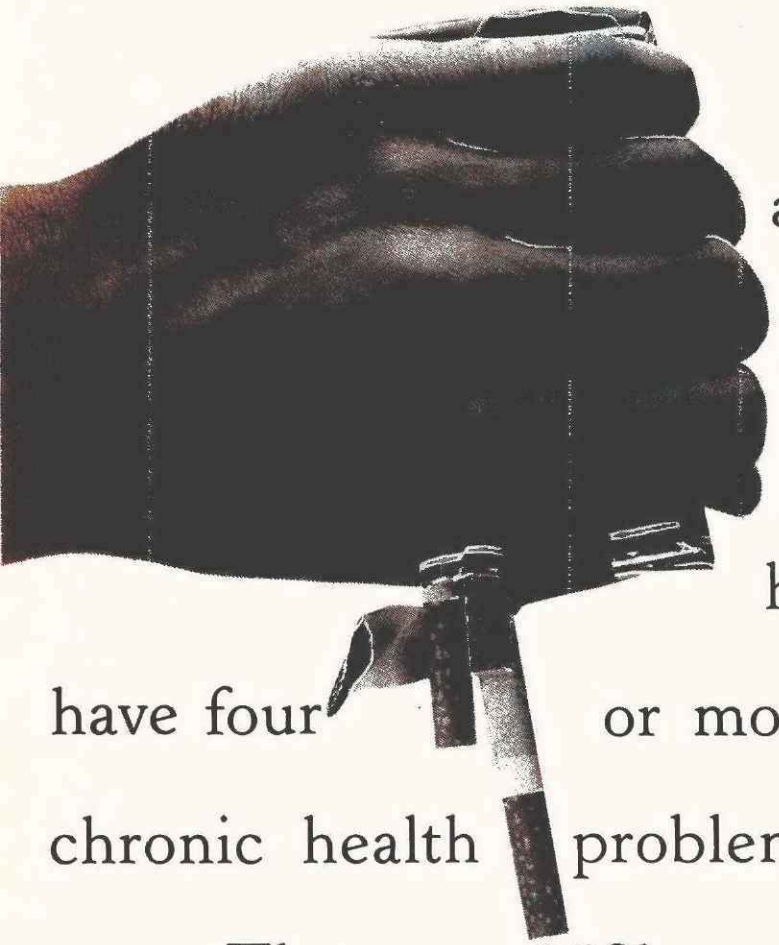

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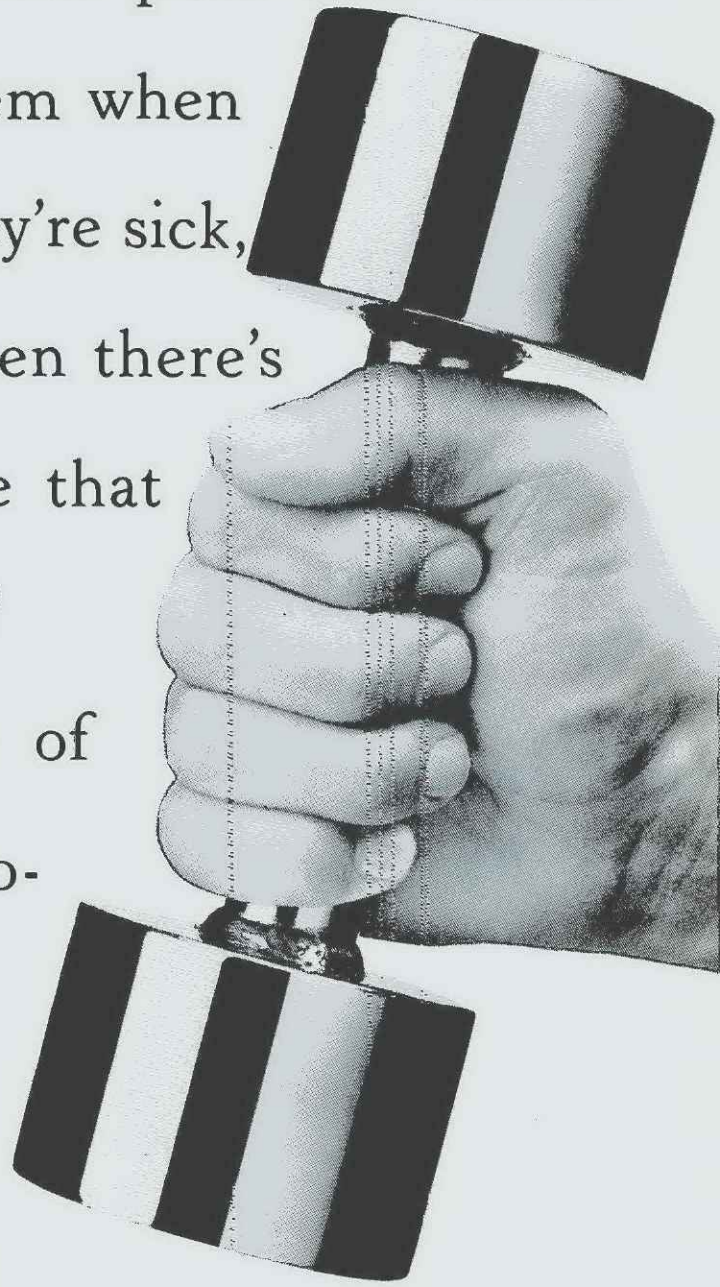

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*Healthcare facts from "Wellness in the Workplace: Implications of Promotion Programs for Planners and Financial Consultants" by John M. O'Donnell, PhD, Nov., '85. © 1987 FHP Inc.

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STANDARDS FOR PPOs

Industry must take lead to set up self-regulatory system

By Sharon Graugnard

THE PAST FIVE YEARS have seen an explosion in the number and variety of preferred provider organizations. Approximately 600 PPOs now operate in 42 states—more than five times the number in existence in January of 1985.

Although PPOs are operational from coast to coast, they differ in design from county to county. In theory, this variety assumes systems are tailored to local market conditions. In practice, this variety can lead to confusion and frustration for purchasers and regulators seeking uniform criteria by which they can assess and evaluate preferred provider programs.

The absence of uniform standards and evaluation protocols have some state regulators worried. Fearing that the diversity in plan structure and sponsorship create the potential for abuses in quality and continuity of care, some favor a more regulatory approach. But, critics contend that regulation will stifle the movement and eliminate the very features that attract purchasers to PPOs.

Is there a need for regulation in the PPO market, or can market forces create a sufficient stick to guide plan design? Should a means of systematically evaluating PPOs be established? If so, who should be responsible for implementing and overseeing such a system—regulators or the industry itself?

Before answering those questions, it is important to take a look at the brief history of PPO development and the response of regulators to this tand the dynamics of their local health care In their first incarnation, PPOs were loosely affiliated groups of providers who agreed to discount their services in exchange for the promise of new patients. Discounted fees and sporadic utilization review formed the basis of many programs organized during the early 1980s.

Although the lure of discounts may have gotten purchasers in the door, it would not be sufficient to keep them there for long. Purchasers soon demanded that performance match claims made during marketing efforts and requested data to verify results. Demands for greater accountability and predictability rearranged industry priorities and subsequent plan design.

Industry credentialing has been favorably received. PPO sponsors are particularly opposed to regulation, yet face confused customers in need of education.

Early PPOs did not place a great deal of emphasis on the "preferred" in the PPO acronym. Little to no formal screening was done to select the preferred providers. Today, competition and legal concerns require that meaningful and uniform criteria be used to designate preferred providers.

Utilization review has been a key feature of PPOs since their inception. Great strides have been made in monitoring the utilization of inpatient services. However, the next and more difficult task facing plan sponsors is the management of outpatient and ambulatory care utilization.

Although PPOs are still offered primarily as options within standard indemnity programs, more of the financing and delivery arrangements are being managed by the PPO entity. Preferred provider arrangements are being replaced by preferred provider organizations.

These new and more complex programs raise new concerns for state regulators.

The first round of state PPO legislation began in 1982 in California. Enabling statutes passed from 1982 to 1984 sought to clear away existing legal and regulatory obstacles that inhibited PPO development.

These first bills were triggered in large part by a bill introduced in Congress in 1983 by Rep. Ron Wyden, D-Ore. The purpose of the Wyden bill was to eliminate barriers preventing health plan payers from negotiating alternative rates of payment with providers or from limiting a patient's choice of a provider based on these negotiated arrangements.

Speaking out

Although the Wyden bill did not pass, it prompted state legislators and regulators to examine existing statutes to determine whether remedies were needed.

The first state legislation mirrored the Wyden bill and had three main outcomes:

- It eased provider selection restrictions posed by freedom of choice and non-discrimination statutes.
- It allowed insurers to enter into selective contracting arrangements with providers.
- It permitted insurance companies to offer incentives or impose penalties to encourage the use of preferred providers.

The impact of the first round of legislation was to clarify the ground rules and types of activities that insurance companies could engage in.

Beginning in 1986 and continuing today, regulators are at a crossroads as they deliberate the need to regulate the PPO industry.

These bills created new market opportunities and new market alliances. Efforts to integrate the health care delivery and financing functions emerged. Joint ventures were established between provider groups and insurers to offer fully insured or stand-alone PPO products.

For regulators, new systems prompted new concerns. Chief among them was the issue of risk assumption.

Restrictions rather than permission were a focus of state PPO legislation passed between 1984 and 1986. Legislation passed during this period focused on operational issues such as:

- Any willing provider provisions.
- Limiting payment differentials to non-participating providers.
- Financial solvency.
- The operation of PPOs as risk-bearing entities.
- Quality of care assurances.

The range of these issues indicate that regulators became more concerned with how PPOs operate rather than whether they can operate at all.

Beginning in 1986 and continuing today, regulators are at a crossroads as they deliberate the need to regulate the PPO industry.

On the one hand, there is an expectation that PPO systems will lead to increased exposure for consumers. On the other hand, these problems have yet to emerge, and some say they will not emerge if market forces are free to operate and guide system development.

Regulators are faced with three alternatives:

- Implement pre-emptive regulations.
- Wait and see whether problems in fact occur.
- Let the market regulate itself.

Having been involved in the PPO market since 1982, I have witnessed a tremendous increase in system depth and sophistication. Of course, some systems and areas are more advanced than others. Yet, there is one thing that all markets have in common: an increase in the influence of purchasers in system planning and design.

Many say it is a buyer's market. This is true only to the extent that health care purchasers are informed. Informed purchasers do not necessarily need reams of unintelligible computer printouts.

Informed purchasers do need a means of objectively assessing programs offered to them. It does mean that employers should understand the health care needs and utilization patterns of their employees. And, it also means that employers should understand the dynamics of their local health care market.

With this information, purchasers can make a significant contribution to the regulation of the PPO industry in the absence of state-imposed regulation.

To meet the information needs of purchasers and satisfy the concerns of regulators, a credentialing system would be a useful means of guiding and regulating PPO development.

If properly structured and applied, a credentialing system conceivably provides the best of regulation and competition.

As a frame of reference for purchasers and regulators, it would serve as an early-warning system to detect potential problems. For PPO sponsors, it would offer minimum program guidelines without stifling innovation and competition of PPOs.

To be effective, a credentialing process should have the following objectives:

- Provide guidelines to ensure accessibility, affordability and accountability.
- Encourage flexibility to adapt to local market conditions.
- Provide meaningful screening of "preferred" providers.
- Assure access to a full range of covered services.
- Assure a proper array of health care providers to render health care services.
- Provide incentives for patients to utilize the preferred providers.
- Offer guidelines for the development of effective utilization review and performance monitoring systems.
- Provide means to measure and monitor consumer satisfaction.
- Ensure management depth and financial solvency.
- Encourage dialogue between purchasers, providers and regulators.

We have already seen some first steps in this area with the development of competitive bidding processes and request for proposals from purchasers.

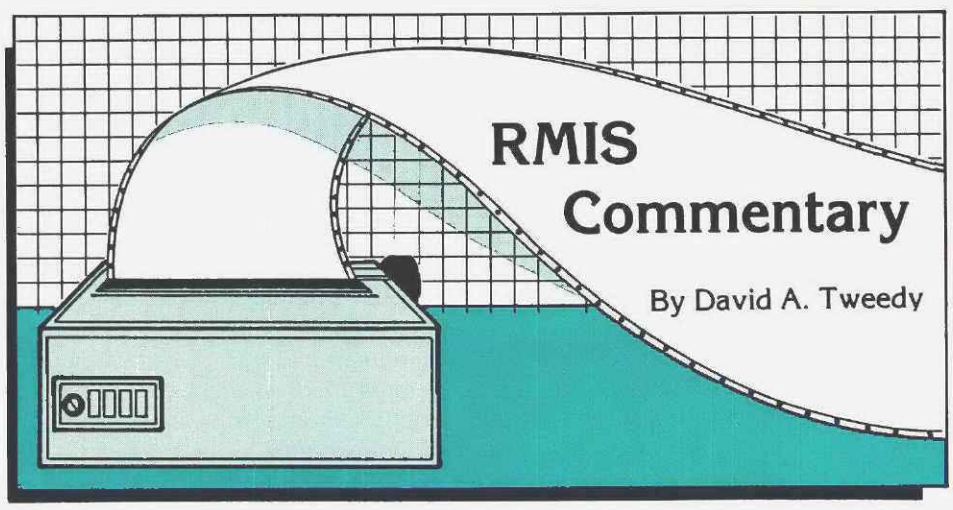
To succeed, a credentialing process would need to offer guidelines rather than mandates. The structure should lend itself to periodic review to determine whether revisions are required based on changing market conditions.

The issue of industry credentialing has been favorably received within the industry. PPO sponsors are particularly opposed to regulation, yet they are faced with confused customers in need of education.

To ease the concerns of purchasers and regulators, it is incumbent upon the PPO industry to take the initiative in this area. It would be a responsible act by an industry that must be particularly responsive to its customers. The alternative may well be the institution of pre-emptive regulations that could bring the PPO movement to a standstill.

Sharon Graugnard is president of Preferred Health Management, an Arlington, Va.-based consulting firm specializing in PPO development, evaluation and assessment. Ms. Graugnard was previously executive director of the American Assn. of Preferred Provider Organizations.

RMIS needs for captives differ



WHAT DIFFERENCES, if any, are involved with risk management information systems designed for risk retention groups and captive insurance companies? That is the major issue of this month's column, and one in which I have seen great interest.

With the increasing frequency of risk retention group, insurance purchasing group and captive formations since the advent of the hard market, there is an increased demand and need for responsive, well-designed risk management information systems.

A RMIS designed for a captive or risk retention group differs from other RMIS in the following ways:

- Quality of information management.

Captives in many ways can be compared with a typical insurance company. However, there is (or should be) one fundamental difference separating such entities from the typical insurance company. Captives and risk retention groups, which were created specifically for the benefit of their members, should provide better information to their membership.

Although there will be some exceptions (i.e., Travelers Corp., CIGNA Corp., Hartford Group and Liberty Mutual Insurance Co., to name a few), insurance company systems are generally geared to provide only standard loss premium information on a quarterly and sometimes monthly basis.

Many times, the data received is old (especially those based on batch systems) and with little of the detail that today's risk management professional requires for solid analysis on claims management, safety, loss forecasting and other activities.

Requests for customized loss runs are either met by indifference, refusal or significant changes. In addition, the data quality is sometimes suspect due to faulty entry (this is an industry-wide problem) (*BI*, Aug. 19, 1985).

I maintain, however, that the RMIS for risk retention groups or captives must be superior to the standard provided by the insurance industry. After all, one of the expected benefits of joining a risk retention group or association captive is better service, such as a well-designed and established risk management information system.

In fact since a captive or risk retention group assumes the existence of many similar types of organizations, the RMIS developed for that entity should provide a uniquely structured array of reports and capabilities, which—if purchased on an individual basis—would be cost-prohibitive. Customization, after all, usually entails many more dollars and much more time.

For example, let us assume that there is a risk retention group with 30 members whose primary activity involves the manufacture of a particular food product. In this example, the product is primarily sold in supermarkets and restaurants. These manufacturers have a high product liability exposure.

The group would like a RMIS to carefully monitor the claims activity, breaking the data down into a variety of specialized product subreports. For example, the members want weekly reports from the system on new incidents, breaking down those complaints into categories such as foreign substance claims, alleged food poisoning complaints, etc. In addition, they want to know the claims' origination (e.g., from supermarkets, restaurants or other wholesale or retail operations).

They also want to know the average shelf-life of the product that resulted in the complaint. They also wanted to know which adjusting firm and adjuster was assigned to the claim, what their response time to the claims was, reserve changes, settlement offers and the like.

In short, this system had to be custom designed to specifically meet the needs of the membership of that risk retention group. That amount of detail is unlikely to occur in the insurance industry since they service such a wide variety of vendors and users.

Does a standard insurance company system provide this degree of specialization? No. Should it? Yes, but it can't in the real world. Should a risk retention group do better? Absolutely.

- More external vendor contact.

The second major difference between a captive/RRG risk management information system and an insurance company data processing system lies in its flexibility of structure.

A comprehensive, well-designed RMIS for captives or risk retention groups should have the capacity to access—and to be accessed by—external vendors such as actuaries, attorneys, claims management administrators, risk management consultants, underwriting managers, etc. In essence, all the major vendors that service the risk retention group should be able to submit and receive information from the RMIS.

Because the system will have to meet the needs and requests of those external vendors, it heightens the necessity for a superbly designed and responsive system. Each of these professionals has his own information needs and type of reports they would want to receive.

For example, the national law firm coordinating legal efforts for the captive or risk retention group probably wants extensive litigation management capability. The actuaries would want data collected in such a fashion that would help them develop loss triangulations, analyze rating adequacy and adjust rating mechanisms.

The underwriter would need to have specific information pertaining to claims, exposure bases and the like. The consultants would need all of these reports, plus a few more that they deem to be important in the process, such as a loss prevention report analysis, claims, sourcing, insureds demographics, costs and investment performance.

The system and vendor would need to be able to respond quickly and cost-efficiently as different requests are made.

- Superior management information.

This represents the need for management reports requested by the board of directors and separate committees of the captive or risk retention group. The loss prevention, underwriting, investment and claims management committees, in addition to the full board, have their own unique information needs, especially in the area of ad hoc ("what if") questions.

For example, what would happen if three of five members left the captive or the risk retention group? What kind of impact on capitalization and premium would that have?

There are scores of other similar questions that the management will need answers to and will be depending upon the RMIS to provide.

The flexibility issue becomes more apparent and necessary if the captive/risk retention group is a "coverage-specific" entity, rather than an "industry-specific" entity. We saw an example of an industry-specific risk retention group above with the food product risk retention group.

A coverage-specific captive provides a specific coverage, such as umbrella liability or pollution liability insurance, for dissimilar members. Because of the non-homogeneity of the participants there would be an even greater demand for customized reports and management information.

The RMIS and its vendors must be able to meet these added demands.

In short, a well-designed system is a necessity, both internally to run the captive and externally to satisfy the information needs of its members.

But have the vendors responded in providing such systems?

A brief review of *Business Insurance*'s RMIS survey (*BI*, July 13), did not reveal any vendor listing a specific product for risk retention groups and captives.

However, I know that there is definite interest on behalf of all of the major RMIS vendors to provide such capabilities. Certainly, several would say that they could customize the system to fit any particular need.

Organizations such as Corporate Systems, Risk Sciences Group, Anistics Inc. and California Interactive Computing Inc., to name a few, have each separately stated that they either are working on such a product or have completed one.

For example, Corporate Systems has developed its version, called "Risk Retention Management Systems" according to Vp and Marketing Director Scott Gilmour.

However, Corporate Systems is finding more interest from insurance purchasing groups rather than RRGs, although he did not divulge the number of inquiries or new clients for this product.

Unfortunately, I do not have the specific information on any of the other vendors either.

The lack of information is not surprising. First, the upsurge in the creation of risk retention groups, captives and purchasing groups is recent. Many of these recently created entities generate low claims volume (i.e., excess liability) and do not require a sophisticated claims-based RMIS.

Secondly, as with risk management information systems in general, prospective purchasers are quick to respond with interest but are slow to buy.

However, as more risk retention groups, captives and purchasing groups are formed, especially those requiring a high claims management emphasis, RMIS will play an ever increasing role in their successful implementation.

Next month I will continue this discussion on captive/risk retention group-oriented RMIS, focusing on the set-up of such a system and how it should meet the needs of prospective (and current) members.

David A. Tweedy is a risk management consultant for D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly publication analyzing major risk management information systems and vendors. Mr. Tweedy's column on risk management information systems appears the third Monday of the month.

Employers' poison pens blast COBRA

Employers want officials in Washington to know how angry business is over proposed regulation to implement the health care continuation provision of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Among other things, the regulations say that a company, including all affiliates, would lose federal tax deductions for health care expenses for a single violation of COBRA (*BI*, June 22).

The proposed regulations, which were written in a question-and-answer format, were published in the June 15 edition of the Federal Register, beginning on page 22716.

The Treasury Department, which drafted the proposed regulations, gave employers and others until August to send their comments regarding the proposal to the Internal Revenue Service.

Comment they did! The IRS received about 4,000 separate letters from employers, both large and small, as well as employee benefit consultants, trade associations, health care coalitions and others interested in the COBRA regulations.

Following are the comments filed by some employers, trade associations and health care coalitions concerning not only the harshness of the proposed COBRA penalties but other items contained in the regulations:

The following comments were submitted by Walter P. Bruen, executive director of compensation at Eli Lilly & Co. in Indianapolis:

It is our understanding that the proposed regulations apply to employer-maintained group health plans on a controlled-group basis. In the case of Eli Lilly & Co., this group would include all employees at operations in the United States. If any one group health plan did not follow the regulations for one former employee for as little as one day, even if inadvertently done and retroactively corrected, the corporation would lose its entire deduction for contributions to all plans of the corporation for that year and, additionally, those individuals within the corporation deemed "highly compensated" would be subject to additional taxable income.

It is our belief that this penalty is unreasonable and goes well beyond the congressional intent in passing this legislation. Eli Lilly & Co. has designed its procedures to comply with the law and to eliminate any possible violation. There would be no intent to deliberately violate the regulations in any of our operations; however, the diversity of our operations and the complexity of the administration of the COBRA provisions make it possible that an administration error could occur with no deliberate attempt to avoid the regulations.

We believe that one violation, standing alone, should not be the subject of such a sever penalty unless intentional misconduct is involved. Retroactive corrections should also be recognized. A minor administrative mistake by one group health plan should not have so significant an impact on the entire corporation.

We would hope you will reconsider the proposed penalty and adopt a more reasonable approach.

* * *

The following comments were submitted to the IRS by Terry A. Guthrie, industrial relations manager at Century Furniture Co. in Hickory, N.C.:

This letter is to voice concern regarding the proposed regulations for implementing the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985. I disagree with the concept of the same penalty for all compliance violations. I recommend penalties be scaled to the level or types of violations and be related to time required to address those violations.

Century Furniture Co. is a medium-sized company that must meet the compliance requirements of COBRA. We have a central corporate office with nine different plant locations. Dealing with the COBRA health care continuation

'It is our belief that this penalty is unreasonable,' says Walter Bruen of Eli Lilly & Co.

provisions becomes more difficult as our company grows. . . . Century is making every effort to meet those provisions, but as our business becomes more complex, I feel that an inadvertent error could prove to be very, very costly. Since we started offering the COBRA continuation provision, we have notified 297 and only 13 have responded.

I recommend you consider writing regulations in which the penalty would relate to the number of compliance violations and/or actual length of time required for properly addressing the violation. In this case, the employer who made an inadvertent error and corrected it would receive a minimum penalty, when compared to the employer who continually failed to comply with the regulations. The penalty could relate the percentage of days not covered in a year to potential deductions for tax purposes. Penalizing the highly compensated will get the attention of management, but the carrier or administrator still are not involved. Many of the compliance errors are made by these organizations.

* * *

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COBRA letters

Continued from previous page

The following comments were submitted by Randolph M. Hale, vp-industrial relations for the National Assn. of Manufacturers in Washington, D.C.:

In addition to the comments below, we request that a public hearing be held to permit public testimony, particularly since Congress did not consider public testimony before enacting COBRA, which brought major changes to privately sponsored employer health plans.

'We request that a public hearing be held . . .particularly since Congress did not consider public testimony before enacting COBRA, which brought major changes to privately sponsored employer health plans,' wrote Randolph M. Hale.

• Penalties for non-compliance:

The penalty for violation of COBRA is loss of the company's tax deduction for the cost of all health-related benefits. Higher-paid employees also must count the value of those benefits as taxable income. The proposed regulations provide that a violation is indeed a violation with no *de minimis* exceptions, and violations, once they take place, cannot be corrected by subsequent action. The administration of COBRA requires a complicated system of notices and billings to separated employees, their spouses and children with whom the employer has never had any other contact.

In practical terms, an employer with multiple locations could lose its tax deduction for health-related benefits through circumstances far beyond its control. For instance, if an employee in City A is separated and the notice to company headquarters in City B is lost in interoffice or U.S. mail, a COBRA notice may not be sent within 14 days, incurring a violation. Since there is no way to correct the violation, the company will lose the tax deduction for the entire year.

Multiemployer plans represent another example of potential violations which could occur through circumstances beyond control of the respective companies involved. For example, in the case of a group health plan maintained by two or more unrelated employers which fails to offer COBRA continuation coverage to a qualified beneficiary, both employers would be disallowed deductions for their group health plans.

Many companies are contractually obligated to contribute to such multiemployer plans. Examples of these include the GPPAW Trust, and hourly employee health and welfare plans (like those maintained by the Teamsters and the Graphics Communications Union). Since companies have no practical control over the day-to-day plan administration within these multiemployer plans, nor over other (even with nominal board representatives) participating employers, the company could be put in a position of non-compliance through no fault or intent of its own.

Subsidiaries are yet another area of concern. Because an employer must comply with the COBRA continuation requirements on a controlled group basis, the actions of one subsidiary will affect the compliance status of other subsidiaries which manage their own plans. Subsidiaries with a large number of locations and few staff to administer COBRA information are also a concern. A bigger concern, however, is how the actions of companies within a holding company may affect one another.

Multiple health care plans, dispersed locations, numerous employees and dependents are characteristics of many such conglomerates, making 100% first-time COBRA compliance unrealistic. For example one company alone could include a complex network of health care arrangements and plan coverage varieties: conventionally insured, self-insured and health maintenance organizations. With hourly, salary and retiree plans, subsidiaries having their own arrangements, and with the nuances introduced by collective bargaining, there could be literally hundreds of "plans" and thousands of people subject to the provisions of COBRA within one company.

Given this size and complexity, occasional inadvertent slip-ups will occur. Most companies can be expected to make "good faith" efforts to comply and to retroactively correct errors when made known. The proposed regulations indicate that only compliance with the *proposed regulations* will constitute good faith compliance, with no mention made of any allowance for correcting prior errors and omissions. Rather, "the tax deduction is denied for any taxable year of the taxpayer during which there are one or more days on which the plan is not in compliance. . ."

NAM recommends: Violations should be attributed to the particular entity committing the violation and penalties assessed on that entity only. Penalizing all subsidiaries, units, participants in the multiemployer plan, etc. can only have the long term effect of reducing benefits and not extending coverage, as COBRA was intended to do. Surely such severe penalties were not envisioned by Congress in legislating COBRA and we urge that the regulation be changed to realistically deal with violations and not discourage employers from providing benefits altogether.

In the long term, companies may be reluctant to join multiemployer plans, since the violation of one company could penalize all. In particular, multiemployer plans are an important vehicle for encouraging health insurance coverage, especially for small businesses and mobile employers who represent a special coverage problem.

• Labor strikes as a qualifying event:

Aside from gross misconduct (addressed below) the circumstances surrounding termination or

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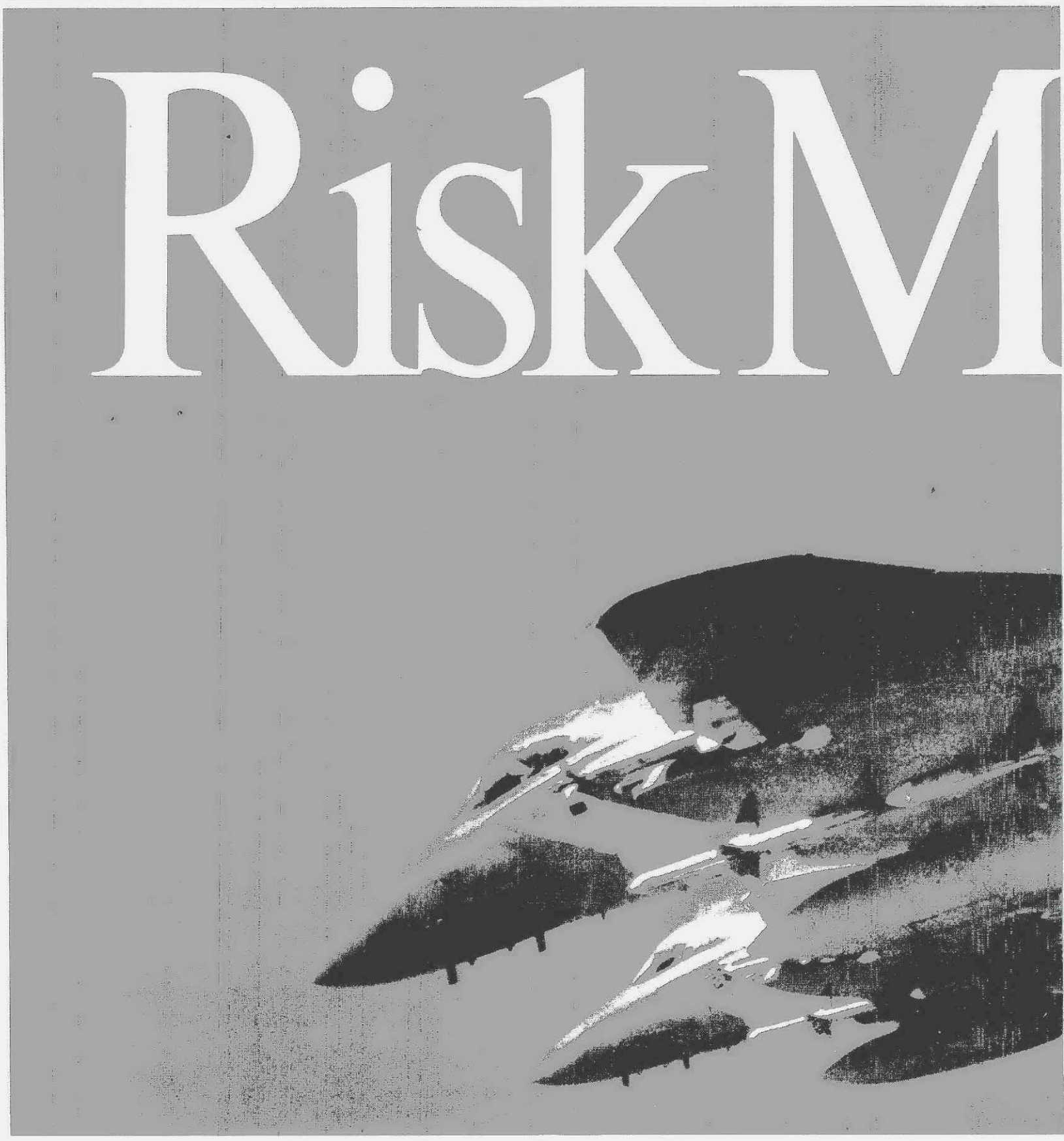
Risk M



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reduction in hours are considered qualifying events for purposes of COBRA continuation. Specifically, the regulations permit voluntary terminations, discharges and strikes or walkouts.

In the case of strikes, the regulations would have the effect of requiring employers to subsidize labor disputes brought against them by the employees.

The cornerstone of federal labor relations policy in the United States has been to encourage free choice by employees as to whether or not they wish to be represented by a union for purposes of collective bargaining. When employees choose to be represented, federal labor policy has encouraged the private resolution of differences by both parties.

While the vast majority of collective bargaining differences are resolved without resort to economic self-help, there are occasions when employees resort to strikes to enforce their demands for improved wages and benefits. A tenet of the United States system of free collective bargaining is that employees have the right to strike to enforce their demands. They must individually and collectively determine whether the cost of engaging in the strike is worth the value of the demanded improvements. Similarly, the employer has the right to accept the cost and consequences of a strike rather than incur the cost of acceding to the union/employee demands.

This proposed regulation would represent an unwarranted interference in the free collective bargaining process. Permitting striking employees to continue health care coverage removes one of the economic consequences of striking. It would encourage more and lengthier strikes. Moreover, most labor contracts contain prohibitions on the right to strike during the contract's term. Even so, some strikes do occur in violation of these no-strike clauses. The proposed regulation would require continuation of health care coverage even in these illegal situations.

Question 19 grants COBRA rights on the premise that strikes constitute a termination of employment. On the contrary, treatment of a strike as a "termination" of employment conflicts with the well-established principle that the relationship existing between employer and employee is not terminated *ipso facto* by a strike. Thus, it would appear that a strike should not be treated as resulting in a "termination of employment" within the context of Section 162(k) of the Internal Revenue Code of 1986.

Q&A 19 should make it clear that continuation coverage does not necessarily have to be made available to all striking employees. For example, assume that upon expiration of a collective bargaining agreement, the employer's obligation to provide benefits under a group health plan expires. Employees who go on strike after expiration of the contract lose their right to coverage under the plan due to the expiration of the collective bargaining agreement, and the employer's obligation to provide benefits under a group health plan. Under such circumstances, a striking employee's loss of coverage is not attributable to the strike, a termination of employment, or a reduction in hours of employment. Instead, the striking employee has lost the right to coverage under the plan maintained by the company solely because the company's obligation to provide that coverage has expired. Q&A 19 should clarify that, under such circumstances, continuation coverage need not be provided.

NAM recommends: Strikes and work stoppages should *not* be included in the definition of a "qualifying event." We urge that the proposed regulations specifically exclude them.

- **Newly added dependents of former employees and dependents:**

These regulations address dependents acquired after the qualifying event. This would significantly expand the potential liability of an employer to individuals with whom the employer has no logical tie.

Under these rules, for example, the original liability for an employee's family unit might be three lives (employee, spouse and child). If the employee divorces and remarries, the divorced spouse remarries and the child marries, the employer liability can increase to three family units and numerous lives, many with no tie to the employer.

That is unreasonable. At most, an employee or spouse who is pregnant at the time of the qualifying event should be able to add the child resulting from the pregnancy. This proposed regulation provides rights to former employees and their dependents that are not granted to active workers.

NAM recommends: We believe this rule is far beyond congressional intent. COBRA rights should be limited to dependents of former employees as of the date of the qualifying event.

- **Separate elections:**

Qualified beneficiaries under the rule would be permitted to make separate elections, a practice that would be extremely difficult to administer.

For example, the spouse of a former employee and dependent children can all make separate elections of coverage under the medical plan or HMOs. The former employee could choose medical only and the rest of the family could choose medical and dental. During HMO open enrollment, each could then choose a different HMO, leading to a complexity of record keeping.

NAM recommends: It would be preferable to have the former employee elect for the family unit, unless waived. If waived, the spouse would make the election, then the dependents. Permission to make separate elections is a privilege not enjoyed by active employees and seems far beyond congressional intent.

- **Definition of gross misconduct:**

The term "gross misconduct" is used in Question 19 to describe the only instance in which a former employee may be disqualified from entitlement to COBRA rights. Given that employers can incur substantial penalties if they do not offer COBRA when it should be offered (even if the failure is in good faith), the term should be defined. Ideally, "gross misconduct" should

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COBRA letters

Continued from previous page

be defined along the lines of assault, theft, sabotage, trafficking in narcotics, gambling, etc., *and* discharges that occur after failure to respond to corrective progressive discipline as well as with normal employee relations practice.

● **Eligibility for other employer plans:**

Question 38 lists conditions under which COBRA coverage may be terminated. Coverage by, rather than eligibility for, another employer plan is such a condition. Experience has already shown that some former employees have elected to retain coverage by their former employer, and in fact, the new employer is remitting payment for that original insurance rather than cover the individual under its own plan.

In this case, it is likely that an individual has joined a company with a contributory plan and minimal coverage, and thus prefers to continue coverage under the old plan rather than the new employer's plan. This is especially true if the new employer lacks dental coverage and the ex-employee wants dental coverage.

It seems unreasonable and outside of congressional intent to allow a "rogue" employer to minimize its cost by paying COBRA premiums to employees' former employers. As a remedy for this situation, we suggest that receipt of payment by the old employer for the ex-employee's health insurance constitute ground for terminating the old coverage and loss of COBRA rights.

● **Small business and COBRA impact on insurance coverage:**

While not within the scope of the current regulations, we urge that company size be reconsidered for COBRA compliance purposes with an exemption for companies with fewer than 100 employees.

Below are summaries of letters from two small companies that are considering dropping health benefits altogether because COBRA compliance has led to exorbitant increases in health insurance premiums for active workers:

● **Watco Manufacturing Co., Kansas City, Mo.:**

Watco Manufacturing Co., with 30 employees, learned on Jan. 13, 1986, that one of its employees had cancer, a problem later diagnosed as terminal. Employment terminated on July 31, 1986, the same day COBRA went into effect. The ex-employee and her husband elected to stay on the plan and paid the premiums according to COBRA. Watco's group insurance carrier sold out to (another insurer) in October 1986.

Meanwhile, Watco attempted to secure more reasonably priced insurance, which had skyrocketed from a monthly premium of $2,500 to approximately $4,900, effective Jan. 1 1987, and to $6,100 effective July 1, 1987. The COBRA continuation was a major factor in this increase.

To date, Watco has been unable to buy insurance elsewhere and the current insurer can be expected to keep increasing the rate. The alternative being considered is cancellation of the insurance program and providing employees with compensation to buy their own insurance.

Prior to COBRA, the affected employee would have had one year of extended benefits and Watco would have been free to negotiate with other companies for a better rate.

The insurance premium is now approximately 50% of the company's net profit aftertax.

● **Acousticom Corp., Elkhart, Ind.**

Acousticom employs approximately 56 people, of which 90% are women. Prior to the new insurance contract year, the insurer notified the company of a 55% increase in insurance rates, leading the company to look for a new carrier. However, all the insurance companies contacted regarding new coverage have refused to pick up COBRA continuees.

Under insurance regulations, carriers are not required to accept continuees as part of the new plan. They state that COBRA continuees are the responsibility of the company they terminate from. The only way they will accept new beneficiaries is if they are actively working.

Acousticom has been advised to continue with its current insurer, but neither management nor employees can absorb the premium increase. Because insurance companies can drop the COBRA continuee at any time, that person becomes the responsibility of the company for all medical expenses if another plan cannot be found to insure that person.

The company is faced with the choice of dropping insurance for *all* employees as a way to avoid COBRA liability. However, this would defeat the purpose of providing medical coverage for active employees. If forced to continue coverage with its current insurer at a much higher premium in order to comply with COBRA, Acousticom is likely to discontinue its group plan.

If the plan is dropped, employees will suffer without medical coverage, a tragedy that COBRA was designed to avoid.

* * *

The following comments were submitted by James A. Brescia, vp of personnel at Harcourt Brace Jovanovich Inc. in Orlando, Fla.:

While I understand the social concerns that led to the passing of the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act, I cannot fathom why the regulations provide such severe and outrageous penalties for an employer who inadvertently makes an error in administering the program.

The penalties for inadvertent failure to extend the group coverage to just one COBRA beneficiary, or if just one subsidiary does not comply with COBRA, seem extremely harsh. It seems that provisions should be made for a sliding scale of penalties for COBRA violations and some distinction should be made between inadvertent violations and willful denial of benefits. At a time when employers are struggling to keep abreast of all the federal and state requirements, the severe penalties that COBRA provides are inappropriate. Even the best-intentioned of employers occasionally makes a mistake.

I would appreciate anything you can do to bring about a more rational approach to COBRA penalties.

* * *

The following comments were submitted by John A. Heenan, director of compensation and benefits for Ramada Inc. in Phoenix, Ariz.:

We would like to provide you with our comments on the proposed COBRA regulations:

● The proposed regulations will increase our benefit and administrative expenses. We have been complying with prior COBRA regulations since September 1986 and have been able to handle the additional workload within our existing staff. The new proposed regulations, we feel, will increase our workload and expense to provide the required support.

● Based upon our group insurance program, the proposed COBRA regulations would provide COBRA beneficiaries with a greater choice of benefits as compared to our active employees. Our program offers medical and dental insurance only on a combined basis; they are not offered separately.

● Additionally, COBRA would allow divorced and widowed spouses (of active or former employees) to add coverage for newly acquired children and spouses. This would expand coverage in our program well beyond the intended scope of our program.

● Another area of concern is where qualified beneficiaries of the same family unit have independent choices on insurance coverage. For active employees, we treat family coverage as one unit and all eligible participants have the same coverage. We feel this provision will add to our workload.

At this point in time, we feel the proposed regulations far exceed the original intent of COBRA, and that significant changes should be made.

* * *

The following comments were submitted by D.J. Crispin, vp of employee benefits, insurance and taxes at The Boeing Co. in Seattle:

Based on our experience with benefit plan administration in general and with COBRA administration in particular, we strongly object to the provisions of the proposed IRS regulations that se-

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verely penalize an employer who is out of compliance one or more days in a year.

In spite of any employer's best efforts to administer the complex requirements of the statute, the chance that a clerical error will occur in the employer's administration of the continuation options is compounded if that employer has a large employee population and multiple plans to administer.

In the language of the proposed regulations, it would seem that making retroactive adjustments on a timely basis to correct inadvertent errors would reflect ". . .good-faith compliance with a reasonable interpretation of the statutory requirements." However, the proposed regulations do not appear to permit such "reasonableness," but rather choose to take the hard-line position that any error, whether or not intentional, is grounds for harsh penalties.

We also question the appropriateness of the recommended penalties. The answers to Questions 3 and 4 clearly point out that an employer loses its tax deduction for the cost of all of its group health plans for a taxable year, and the cost of the coverage for "highly compensated employees" will be included in the gross income of these employees for any taxable year, if the employer is out of compliance one or more days of that year.

By any standard, this level of penalty is unusually severe. In fact, because of the extreme nature of these penalties, it should be recognized that there is little or no incentive for an employer who is out of compliance to correct the error on a timely basis. As a result, the proposed penalties may in certain instances impede rather than ensure compliance with the statute.

The inappropriateness of the penalties is magnified by the provisions of the proposed regulations related to collectively bargained multiemployer plans. To penalize an employer for a COBRA violation when that employer simply contributes a required amount to a trust fund and has no administrative control over the plan, fails to meet any standard of reasonableness. Instead, the provisions place such an employer, who by federal law must comply with the collective bargaining agreement, at the mercy of plan administrators and other employers over whom it has no control.

We would also like to address the approach that the proposed regulations take with regard to dependents who are acquired after a qualifying event (Q&A 17 and 31). As noted in Question 15, the statute defines a qualified beneficiary as an employee or dependent who is covered under the employer's plan on the day before a qualifying event. New family members acquired after the date of the qualifying event do not meet this requirement. Nevertheless, the answer to Question 31 states:

"If the plan covering the qualified beneficiary provides that such new family members of active employees can become covered (either automatically or upon an appropriate election) before the next open enrollment period, then the same right must be extended to the new family members of a qualified beneficiary."

It is unreasonable to expect an employer to open its group health care plans to individuals who have never had any direct relationship to one of its active employees. In our judgment, the above provision clearly goes beyond the intent of the statute.

In conclusion, we make the following recommendations:

- Apply penalties only to employers who flagrantly violate the continuation coverage requirements or who fail to make good-faith efforts to correct administrative errors in a timely fashion.
- When there is a flagrant violation or a failure to make a timely correction, apply penalties only to the period for which such noncompliance occurs.
- In multiemployer trust situations, apply penalties solely to the ERISA-recognized plan administrator and sponsor.
- Apply the proposed requirements only to dependents who are eligible on the date preceding the qualifying event.

'The proposed penalties may in certain instances impede rather than ensure compliance.'

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COBRA letters

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The following comments were submitted by E. Van Anderson, vp of Grit Publishing Co. in Williamsport, Pa.:

(The) IRS proposed regulations—published in the June 15, 1987, Federal Register to implement COBRA's mandatory continued health care coverage for ex-employees and their families—have merit.

However, the regulations should not make strikers eligible for COBRA benefits. I quote from page 22725 of the IRS proposed regulations: ". . .a strike or a walkout is a termination or reduction of hours that constitutes a qualifying event if the strike or walkout results in a loss of coverage. . . ."

It's one thing if a collective bargaining agreement has guaranteed continued group health care coverage for striking workers—but if there is no such agreement, why should the government saddle the employer with continued health care coverage? Where's the hardship on the striker?

I urge you to eliminate this language from the proposed legislation immediately.

* * *

The following comments were submitted by Arch Payne, director of human resources at FMC Corp.'s Petroleum Equipment Group in Houston:

Proposed regulations published in the Federal Register June 15, 1987, would have the effect of requiring employers to subsidize labor disputes brought against them by their employees.

The cornerstone of federal labor relations policy in the United States has been to encourage free choice by employees as to whether they wish to be represented by a union for purposes of collective bargaining. When employees do choose to be represented, the federal labor policy has been to encourage the private resolution of differences by the parties.

While the vast majority of collective bargaining differences are resolved without resort to economic self-help, there are occasions when employees resort to strike to enforce their demands for improved wages and benefits. A tenet of the United States' system of free collective bargaining is that employees have the right to strike to enforce their demands. They must individually and collectively determine whether the cost of engaging in the strike is worth the value of the demanded improvements. Similarly, the employer has the right to accept the cost and consequences of a strike rather than incur the cost of acceding to the union/employee demands.

The proposed regulations (Q&A 19) would represent an unwarranted interference in the free collective bargaining process. Permitting striking employees to continue health care coverage removes one of the economic consequences of striking. It would encourage more and lengthier strikes. Moreover, most labor contracts contain prohibitions on the right to strike during the contract's term. Even so, some strikes do occur in violation of these no-strike clauses. The proposed regulations would require continuation of health care coverage even in these illegal situations.

Strikes and work stoppages should *not* be included in the definition of a "qualifying event." I urge you to revise the proposed regulations to specifically exclude them.

* * *

The following comments were submitted by Daniel F. Motl, vp and general manager of Badger Foundry Co. in Wonona, Minn.:

Our company pays 100% of all medical insurance for our employees.

During a strike situation our employees are allowed to continue their insurance, but they must pay for it. We feel this is a fair way of handling the situation during a strike.

We are against the IRS interpretation of the COBRA laws whereby the IRS proposes that strikers are entitled to continuation of the group health coverage (at employer cost).

* * *

The following comments were submitted by David J. Stockman, director of corporate benefits for The Stroh Brewery Co. in Detroit:

This letter is to comment on the proposed COBRA continuation of coverage regulations.

General comments are that the regulations are exceedingly complex, far more complex than is warranted by the benefits that will be derived by any citizens of the United States.

Further, the requirements of these regulations go beyond what must have been the general purpose of the COBRA continuation provisions, i.e., protection of former employees and their dependents against financial ruin from catastrophic illnesses. It is hard to imagine that Congress knowingly and intentionally would provide that qualified beneficiaries should be afforded more favorable treatment under a benefit program than active employees themselves are afforded.

The penalties of this law are overly harsh in comparison to any harm that might be done by violation of the rules. Further, the regulations do not provide that corrective action for innocent mistakes should negate penalties. Compliance with all of these regulations by most covered employers is nearly impossible if not impossible, and expectation of compliance is unreasonable. The cost of compliance with these rules far outweighs the benefits derived by former employees and their dependents.

Finally, the rules do not address many complex gray areas and leave employers at the mercy of the Internal Revenue Service as to whether the employer, acting in good faith, will be found to be in violation of the law and, therefore, subject to the horrendous penalties that can be imposed.

I will turn now to more specific comments and questions regarding these regulations:

- Because it actually happened is the only reason that any rational human being would believe that you could put something in these regulations so unfair as to penalize every employer who is party to a jointly trusteed multiemployer trust fund, when one employer member of that fund makes one mistake in regard to one employee. To put such provisions into these regulations undermines their purpose (by causing outrage and demands for repeal of all the regulations) and destroys the credibility of the Internal Revenue Service.
- I believe it must have been Congress' intent that former employees should have the privilege of some coverage to protect them against catastrophic illnesses. Therefore, it seems an unwarranted administrative burden to allow former employees to elect continuation of coverage when they are eligible to elect other catastrophic coverage from the new employer.
- The entire process could be simplified a great deal, and I am sure the basic intent of the law carried out, if employers were allowed to offer exiting employees or other beneficiaries one basic medical benefits plan that would protect those employees from catastrophic illnesses. The additional

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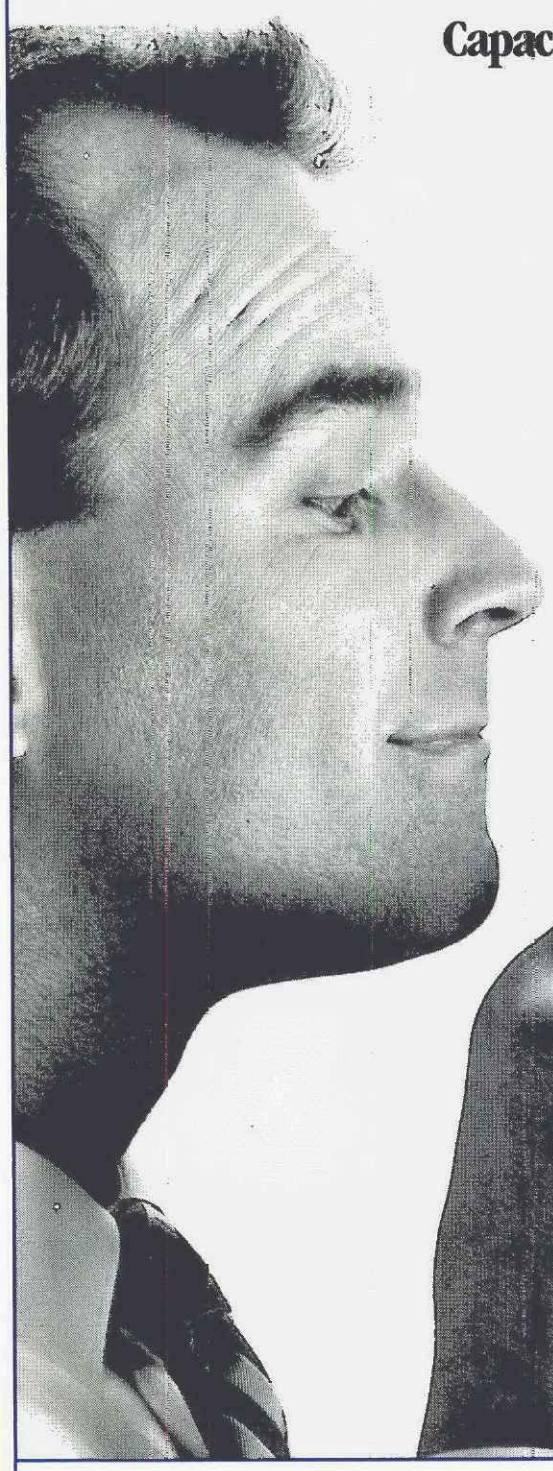

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burdens to the employer from administrative problems and claims expense of offering non-core coverages and all options under flexible benefit programs are unwarranted by the small amount of good done to employees and other beneficiaries. Approximately 5% of eligible former employees have elected coverage. Is all this complexity really necessary? Don't you think the 5% would have been happy with being offered a good basic medical program?

- If a single employer, administering a single employer benefit plan, has designated one employee as the plan administrator of its welfare benefits plans, then does an employee's notification to any employee of the employer about a qualifying event constitute official notification to the employer? Or does this happen only when the officially designated plan administrator has received the notification? Is it correct to interpret that any other employee of the employer so notified has 60 days in which to notify the officially designated plan administrator?

These are the types of technical questions that will cause great time and expense on the part of American business, but which have not been addressed.

- If a plan covers children to age 25, then by offering continuation to children who reach age 25 an employer is actually being forced to offer better provisions than those that were negotiated with its employees' collective bargaining representatives. I doubt that this was really the intent of Congress.
- The regulations state that an employer may offer an alternative to COBRA continuation of coverage. What will be deemed a fair alternative? If an employer offers an exiting employee the alternative of 100% employer-paid coverage for a shorter period of time rather than the 18 months at the employee's expense, what time period is a fair trade-off? Would 30 days be fair? Or 60 or 90?
- The complexity of an employee being able to elect coverage for all beneficiaries, but not reject it, is an overly burdensome technical/administrative provision that is not warranted by the few people who will ever benefit from this provision. You really went overboard on this. Separate elections by the former employee and each of the employee's dependents is excessively complex and offers former employees and their dependents more benefit than is afforded to the active employees.

This provision is certainly not necessary to carry out the intent of the law, i.e., to protect people against catastrophic illnesses. Why do you see fit to add such complexity to the law? And why do you see fit to offer more benefits to former employees than to the active employees who choose to remain employed with the employer?

- Your regulations fail to define adequately when a timely election or payment of premium is made. Is timely payment according to the date the payment was deposited in a postal box, or the date of the postmark, or the date the payment is received by the employer, or, in the case of hand delivery, is it the date the payment was hand delivered to the plan administrator or to any other employee of the employer? Answers to these questions are critical to proper administration of the program.
- Can we reject payment from anyone other than the employee or the other qualified beneficiary? For example, it has already been experienced that a hospital wrote a check for payment of a COBRA continuation premium for a former employee still under the 60-day election period who was admitted to the hospital. Must an employer accept payment from the hospital, or from any person other than the employee or the beneficiary who is to be insured?

'Your regulations saddle employers with expenses for the new spouses of ex-spouses. Does this really make any sense? The employer obligation was primarily to the employee,' says David J. Stockman, Stroh's director of corporate benefits.

- Your regulations saddle employers with expenses for the new spouses of ex-spouses. Does this really make any sense? The law was to provide continuation of protection against expenses for catastrophic care. The employer obligation was primarily to the employee. The employer may or may not have chosen to extend benefits to the employee's spouse. However, any commitment to the spouse is only secondary and by benefit of his or her marriage to the employee. The employer had no direct responsibility to the spouse. Therefore, it is ridiculous that an employer should be forced to offer coverage to the new spouse of the former spouse.

This is another example of exceedingly complex provisions that go beyond the reasonable intent of this law.

- I believe your proposed regulations are still unclear as to when the qualifying event takes place in the situation of an employee who becomes disabled but continues to participate in all benefits plans until recovery, at which time the person may retire or be laid off for lack of work. Is the qualifying event when the employee became disabled and stopped working, or when he/she recovered and then stopped plan participation?

In summary, this whole section of COBRA should be repealed, reconsidered and possibly re-introduced, but only after given reasonable analyses and discussion. The United States of America survived for more than 200 years without COBRA provisions. Once the law was passed it would not have been unreasonable that an adequate amount of time was devoted to developing *reasonable* rules by which that law should be administered. The whole thing should be replaced with simple requirements of offering former employees and dependents conversion to pooled insurance policies that are adequate to protect them against financial ruin due to serious illness.

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COBRA letters

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The following comments were made by Mary F. Mellema, director of personnel at Occidental College in Los Angeles:

After reviewing the proposed regulations, we found that the new requirement that continuation coverage become available to persons other than qualified beneficiaries, i.e., new family members as provided in Q&A 18 and 31, appears to extend, exceed and expand the intent and language of (COBRA), and in our opinion, if continued in the final regulations would amount to legislation by regulation.

Section 162(k) entitled, "Continuation Coverage Requirements of Group Health Plans," specifies that each qualified beneficiary who would lose coverage under a group health plan as a result of a qualifying event is entitled to elect, within the election period, continuation of coverage under the plan. Qualifying events are defined as: death of the covered employee; termination (other than by reason of such employee's gross misconduct) or reduction in hours of the covered employee's employment; divorce or legal separation or the covered employee becoming entitled to Medicare benefits; or a dependent child ceasing to be eligible under the plan.

Key to determining whether an individual may be considered a qualified beneficiary under COBRA is this: Would any one of the above occurrences result in that individual *losing coverage* under the plan? Clearly, at the time of the qualifying event new family members described in Q&A 31 are not covered under the plan. Therefore, instead of continuing coverage for these individuals as qualified beneficiaries, the proposed regulations go beyond the scope and intent of the act itself by requiring an offer of brand new coverage.

It seems highly illogical to assume that lawmakers intended, through the passage of COBRA, to require employers to offer coverage to persons *other than* qualified beneficiaries. This new mandate will undoubtedly result in significant administrative and premium cost increases to employers subject to the act. In particular, plans will become more vulnerable to the effects of adverse selection; that is, the value of benefits provided will exceed the cost of electing such coverage. Adverse selection is openly invited—and clearly and painfully already evident in plan experience in the continuation coverage election by qualified beneficiaries defined in the act. By extending coverage election rights to new family members of those intended beneficiaries, as required in the proposed regulations, the effect of adverse selection would serve to further exacerbate negative plan experience and needlessly escalate the cost of providing health coverage to employees.

It is our position that this subject provision of the proposed regulations is not interpretative but legislative in effect and a public hearing on the proposed rules is hereby requested.

* * *

The following comments were submitted by F.E. Weisensale, president of Liphart Steel Co. Inc. in Richmond, Va.:

We urge you to consider some change to what we understand is intended by the COBRA regulations.

If an employee quits your company to take another job where he is not eligible for coverage for maybe 60 to 90 days, he has 60 days to elect to remain on your policy until he is covered by the new employer.

We do not think this is fair to the employer or the employees he left, because sometimes within the 90 days after he leaves, he may have an accident or illness and after that occurrence elect to pick up the insurance. When he does that, he causes the experience rating of the insurance coverage to increase and as a result would cause the insurance premiums of the employees at his previous employer to be increased. Therefore, they will be paying increased premiums because of a worker who was not even employed by the company when he made his claim.

We do not think this is fair, particularly in cases in which the employees are paying for themselves and/or dependents, rather than the company paying the premium.

* * *

The following comments were submitted by James E. Alexander, director of employee benefits at George A. Hormel & Co. in Austin, Minn.:

Initially, let me state that I am pleased that the (IRS) has finally provided employers some guidance in complying with the new statute. I encourage the Internal Revenue Service to issue the final regulations as expeditiously as possible to facilitate employer compliance with the act.

There are a number of rules proposed that, in my view, impose undue and unreasonable restrictions on employers in the administration of employee health care plans. Specifically, I take strong exception to the following regulations:

- The requirement that continuation coverage under COBRA be extended to dependents of a beneficiary after the beneficiary obtains coverage.

It would seem that the intent of the statute was to provide coverage to dependents of a beneficiary where the latter lost coverage because of death or divorce. This provision would extend coverage to individuals who had no prior connection to an employer and were never covered in the first instance. In fairness, I believe this regulation should be deleted.

- The requirement that COBRA coverage be extended to striking employees.

Again, this was not specifically addressed by the statute. It has long been established that under the National Labor Relations Act, employees have the right to take concerted activity in the context of a labor dispute. It is equally well established that employers should not be placed in a position of financing strike-related activities against itself. I would suggest that unless the collective bargaining agreement between the parties provides for continuation of coverage in the event of a strike, this coverage should not be forced upon an employer who is engaged in an economic struggle with a union. This matter should be left to the collective bargaining process and not usurped by legislative mandate.

- The requirement that an employer with less than 20 employees

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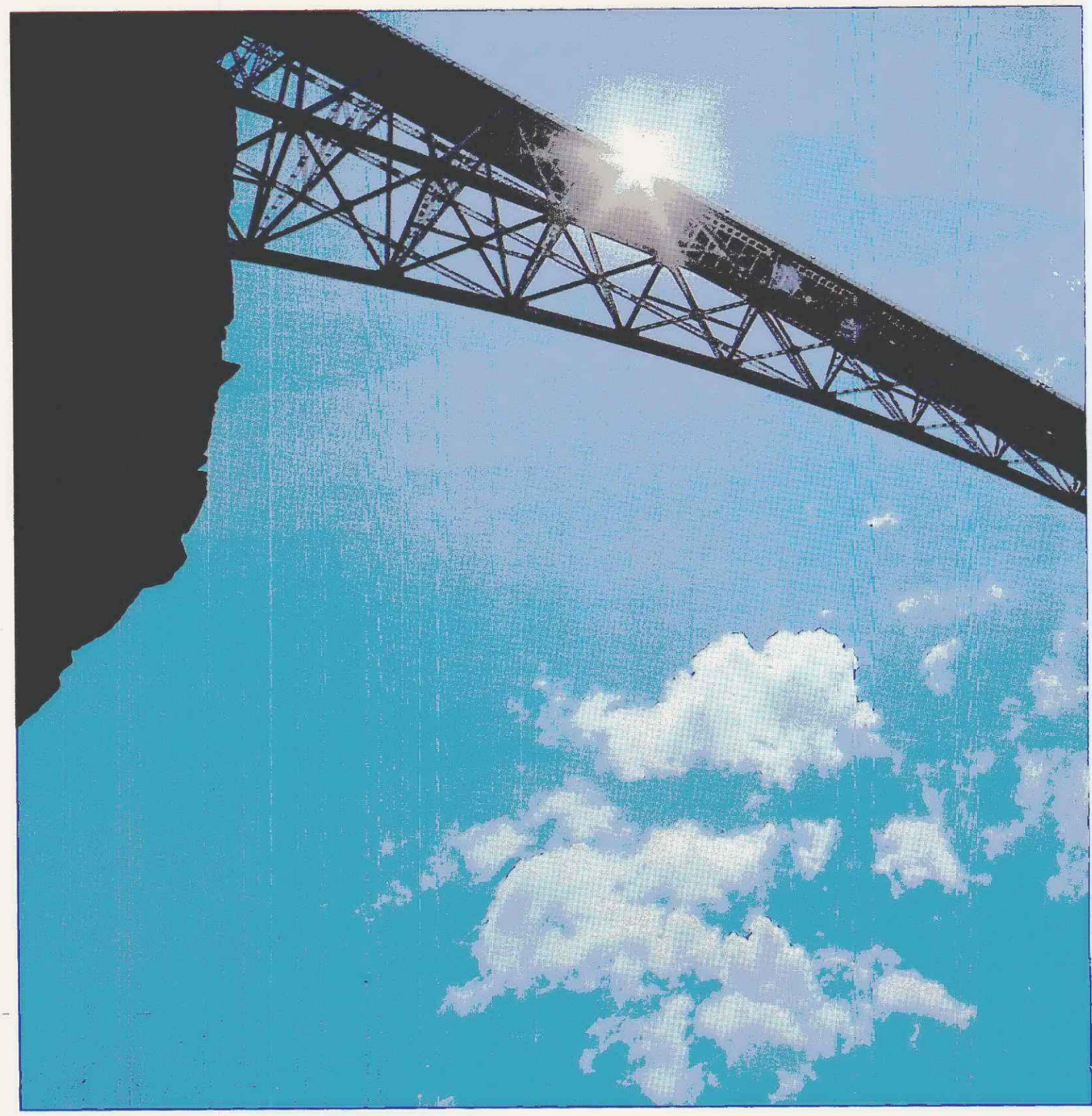

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that is part of larger controlled group comply with COBRA..

Small employers (less than 20 workers) are exempt from the act. The administrative burden on small employers is the same whether that employer is part of a controlled group, or on its own. In some instances, small employers receive additional resource help from the parent corporation. However, in many cases the smaller corporations operate independently and receive little or no administrative help from the parent corporation. For this reason, it is suggested that all small employers be exempt from the act.

- The penalties imposed on noncompliance whether intentional, inadvertent by a parent corporation or a small employer that is a member of a controlled group is the loss of all tax deductions for health care expenses for all members of the controlled group. This penalty is in addition to the income inclusion rule of Section 106(b)(1), which requires all highly compensated employees to add that cost of the health care coverage to their income. This in itself is patently unfair inasmuch as no one in that group could be said to directly benefit from an inadvertent failure to comply with COBRA.

It is submitted that these penalties are far too broad and unreasonably harsh. The goal of any penalty ought to be remedial in nature. Short of that, the penalty, if designed to be punitive, should bear some reasonable relationship to the nature of the violation. The loss of all of the controlled group's tax deductions because of an inadvertent, unintentional error made by a smaller member affiliate is clearly unreasonable. These penalties are especially egregious in light of the fact that the statute itself is relatively new, final regulations have yet to be issued and employers are still struggling to fully absorb its many ambiguities.

'It is suggested that all small employers be exempt from the act,' wrote Mr. Alexander.

It is suggested that the penalties be scaled down to reflect the extent and nature of the violation, whether it was intentional or inadvertent, whether it was committed by a parent corporation or member affiliate and whether any member of the highly compensated group directly benefited from the penalty. At the minimum, the loss deduction penalty should be prorata, i.e. the loss of tax deductions limited to deductions attributable to the member affiliate responsible for the violation, not all tax deductions for the whole group.

Further, it is not clear why all members of the highly compensated group should bear the brunt of an unintentional, inadvertent administrative error. It is respectively submitted that this penalty be deleted in its entirety.

In conclusion, I strongly urge the (IRS) to consider the broad punitive reach of its proposed penalties.

- It is my understanding that the same penalties are applied to employers who participate in collectively bargained multiemployer welfare plans. Particularly disturbing is the fact that the actions of the plan administrator, or even another unrelated employer, will jeopardize the deductions taken by a wholly unrelated company that, through its collective bargaining agreement, is required merely to make contributions to the multiemployer welfare plan. The employer who participates in these plans has no control how each is administered; yet, if an administrator makes a COBRA error, the employer bears responsibility for it.

Again, this is clearly unreasonable. The penalty, if any, ought to be directed to the sponsor of the plan, not the employer whose only nexus to the trust is through the collective bargaining process and the contributions it is required to make.

* * *

The following comments were submitted by Ellen Friedman, manager-benefit planning, at Ameritech Corp. in Chicago:

We believe that the proposed penalty for non-compliance under COBRA is overly harsh. The loss of the tax deduction for health care expenses for an entire year based on even a single, unintentional processing error, is extreme. There is no distinction between an employer who never made provision for COBRA coverage vs. an employer who made an administrative error in good-faith efforts to comply with the law.

Also, expanding the definition of an employer to include all entities under a controlled group can unfairly penalize companies and employees even if their own COBRA administration and compliance has been flawless. Ameritech has 17 subsidiaries that use eight different payroll systems for compliance activities. Grouping together independently sponsored and administered plans for this purpose seems illogical to us. The plans file separately for Form 5500 reporting.

We would also like to emphasize that chances of unintentional administrative error grow with the number of lives covered by a plan. The IRS should retain the authority to adopt reasonable penalties based on the circumstances in the case.

Finally, COBRA has demonstrated the dangers of Congress passing important legislation without the opportunity for public comment. The result is a lack of specificity in the law as it relates to complicated issues of employee benefits where the input of subject matter experts was clearly needed.

* * *

The following comments were submitted by Thomas L. Shade, chief executive officer of Moorman Manufacturing Co. in Quincy, Ill.:

As CEO of a company whose group health plan is one of the finest in private industry, I find the latest regulations issued under COBRA to be an appalling slap in the face.

I am particularly alarmed at the segment of this statute regarding good-faith oversights on the part of employers. As part of the federal bureaucracy, I am sure you are well aware that errors can be made in spite of the best of intentions. Try to imagine the IRS attempting to operate under a system that is so restrictive that they are penalized for oversights lasting no more than

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COBRA letters

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one day! It would be ludicrous to penalize a company millions of dollars in tax deductions for a mere one-day, one-time mistake.

I urge you to reconsider this potentially damaging policy governing good-faith and corrected errors. With further examination, I am sure you will realize that these absurd regulations are not only harmful to employers, but also to the employees and their families you wish to protect.

* * *

The following comments were submitted by John K. Maravich, vp-finance at Southwest Electric Co. in Oklahoma City:

Congress appears to be taking the approach and exhibiting the attitude that American businesses are run by a branch of thieves and cheats, and unless you enact business-destroying penalties and restrictions, they will not comply with the laws and regulations. I also believe that this attitude of Congress is undermining the coordination of efforts needed between business and government to make the United States a world competitor and to revive certain of our local and regional economies.

I disagree with COBRA legislation to begin with, because I feel that it is taking an additional expense and putting it on the business community, which is already struggling to stay alive, much less competitive. I strongly disagree with the penalties associated with COBRA as being:

- Completely disproportionate to the desired results.
- Degrading to the business community as an example of the congressional opinion of business' compliance with laws.
- Representative of the negative attitudes displayed by our congressional leaders toward the required partnership between the legislative branch of our government and the business community on which our economy runs.

Your help in correcting these inappropriate penalties and rules will be greatly appreciated.

* * *

The following comments were submitted by the New York Business Group on Health Inc.'s working group on COBRA regulations, chaired by Linda Franklin, manager of employee benefits at Skadden, Arps, Slate, Meagher & Flom, and Caroline S. Beebe, vp of personnel at Associated Merchandising Corp.:

We have identified the following primary issues that should be considered in amending the regulations:

Administrative issues

- The excessive administrative burdens of COBRA shift the focus from the intent of the law to provide benefits to qualified beneficiaries, to letter-of-the-law compliance with technical regulations. Legislation should not have placed the responsibility on the employer to notify every qualified beneficiary at the time of termination of coverage. The onus of requesting group health continuation coverage should be on the former participant.

Significant administrative costs are incurred with this mailing. Participants could be made aware of COBRA through regular communications.

- Shorten the entire election and premium payment period to 60 days. This is consistent with existing state statutes. Currently, an individual is allowed 60 days following notice to make the election plus another 45 days to make payment. This results in a total period of 105 days, which is excessive.
- Individuals covered under COBRA should not have greater freedom to elect different coverage for family members than (is allowed) for active participants in the plan. During an open enrollment period, all qualified beneficiaries should be required to elect the same option as the "head of the family unit."

Policy issues

- Require a minimum of six months' participation in the group coverage for eligibility for continuation coverage. Typical state statutes permit a service requirement of continuous employment. A similar rule should also apply to the federal statute.
- COBRA protection should be provided for medical coverage only; non-core benefits such as dental, vision, etc., should be excluded.
- COBRA continuation coverage should end when the qualified beneficiary becomes eligible for coverage under a new plan rather than when coverage is elected.
- COBRA provisions should limit coverage to qualified beneficiaries covered under active status and newborns conceived while the qualified beneficiary is active. The legislation does not provide clear guidance on this issue.
- COBRA should provide for pre-emption of state continuation requirements when an individual is covered by both state and federal provisions. Currently, notice rules, coverage periods and costs charged to the employee can all differ.

Financial issues

- The allowable charge of 2% of premium to cover administrative costs is insufficient. Actual reasonable costs should be permitted.
- COBRA rates should change as the company expense for active employees change. If the company receives midyear or multiple rate increases, these should flow through to the qualified beneficiary to the same extent as they do to active participants.

* * *

The follow comments were submitted by Carl M. Lerner of the tax division of Pfizer Corp. in New York:

I am writing to suggest a technical correction for your consideration that involves the scope of the COBRA provisions under section 162(k) of the Internal Revenue Code.

Section 162(k)(7)(B)(iii) exempts from the definition of a qualified beneficiary a non-resident alien, and his spouse and dependent children if they are qualified beneficiaries because of this relationship. However, a U.S. citizen employed by a foreign subsidiary and covered by a foreign medical plan is required to be provided COBRA coverage. This definition is not consistent with the definition in ERISA, which exempts plans maintained outside of the United States for the benefit of individuals who are primarily non-resident aliens (Section 4(b)(4)). The Joint Committee on Taxation's pamphlet on COBRA, released April 25, 1986, indicates that the code and ERISA provisions were to be similar.

Large multinational entities often are not aware of U.S. citizens working for its foreign subsidiaries, especially if the U.S. citizen is hired in the foreign location. To subject the entire controlled group to the loss of a huge deduction in this circumstance is unfair. There is no indication that Congress intended to cover the U.S. citizens who choose to work for a foreign company outside of the United States. We believe that this is extending the health care protection of COBRA too far.

Finally, we have concerns that this provision could make foreign health care plans discriminatory or even illegal under foreign law because they would discriminate in favor of U.S. citizens. If a U.S. subsidiary of a foreign multinational were to require application of the foreign equivalent of COBRA to its foreign nationals in the United States, many of whom probably would be highly paid, the plan could be discriminatory under the U.S. tax law. It is possible a foreign government would treat the application of COBRA to only U.S. citizens and their families in the same way. Because of this, we believe that the application of COBRA to U.S. citizens abroad needs to be more fully considered.

It should not be difficult to correct this problem, with a simple technical correction. We believe that without this change, the law is unfair and serves to hinder the congressional goal of providing good health care to the American public. At the very least, this aspect deserves further study.

* * *

The following comments were submitted by Shirley D. Williams, employee relations/personnel director for the city of Inglewood, Calif.:

I am writing this letter to voice concerns raised by the city of Inglewood administrators after having read the proposed rules governing COBRA. Our concerns revolve around the unnecessary administrative burdens placed on the employer by the proposed rules and the fact that in some instances the rules grant COBRA participants rights that are superior to those of active employees.

A specific example of an unnec-

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essary burden is evidenced in the answer to Question 35. If the qualified beneficiary makes a decision to waive COBRA, why is it necessary to allow him or her to revoke that waiver? It seems that the employer should be able to expect that the initial decision is a final one. Even our newly hired active employees do not have 60 days in which to change their minds regarding health insurance.

We believe that this allowance makes the situation much more confusing for the COBRA administrator since it means that files cannot simply be closed when a waiver is received, but must remain open until the 60-day election period has passed.

Another example is found in Question 37. Active employees and their families are not treated independently (i.e., they are all enrolled in one plan) and, during open enrollment, if the employee switches health plans, the family also is switched. Why, then, should COBRA participants be allowed to make independent decisions concerning their health plans? Does this then mean that separate election forms must be sent to each family member, including dependent children? This makes it conceivable that after an open enrollment period, four members of one COBRA family could be enrolled in four different health plans. This certainly creates a tremendous amount of additional paperwork and definitely makes it more difficult to keep track of all qualified beneficiaries.

We hope that the IRS will take note of the concerns of employers regarding the added burden that COBRA places on benefits personnel and will work toward simplification of COBRA administrative procedures. We should be able to reach a happy medium in the effort to offer health insurance to those who need it without unnecessarily burdening the nation's employers.

* * *

The following comments were submitted by Sheryl L. Sculley, city manager for Kalamazoo, Mich.:

The city of Kalamazoo, Mich., is self-insured with respect to employee health care benefits and is subject to the above-referenced act.

We are deeply concerned about the act's impact on us, and strongly feel that several issues need to be addressed in regulations which will be promulgated pursuant to the act.

First, and most important, self-insurers must be protected against abuses of the system by former covered individuals who pay up to 102% of the applicable "premium" for the duration of an expensive hospital stay, and then cease paying. Such conduct could cause dramatic increases in the cost of providing health care benefits for current employees and their dependents, and may in fact endanger the ability of self-insurers to provide such benefits. Such a result would be directly contrary to the act's purposes.

The same result is true even if the individual would continue to pay the "premium" for all or part of the continuation period. After incurring a hospital bill of $40,000 to $50,000, which is not uncommon, the monthly payment of a $200 premium for 18 or 36 months will never come close to funding the medical cost.

Second, it must be made clear in the regulations that health benefit "continuation" only applies to employees and other covered individuals who are actually receiving such benefits. Health care benefits, for example, may not be "continued" to a probationary employee who has not yet qualified for such benefits.

Third, the scope of health care benefits covered by the act must be limited, in conformance with the act's purpose of continuing basis insurance coverage for persons who would otherwise suddenly lose such benefits. While basic medical and hospitalization benefits are obviously intended to be covered by the act, the act's purposes are not served by requiring the offered continuation of dental and optical coverage. That such benefits are not considered part of a basic health care program is evidenced by the fact that many employers do not even offer these benefits to current employees.

Fourth, because the act's purpose is limited to protecting individuals from unexpected coverage losses, it is not necessary to extend coverage to employees who voluntarily resign.

'It is not necessary to extend coverage to employees who voluntarily resign,' says Ms. Sculley.

Fifth, the term "gross misconduct," as used in the act, must be clearly defined so as to give employers some guidance as to which

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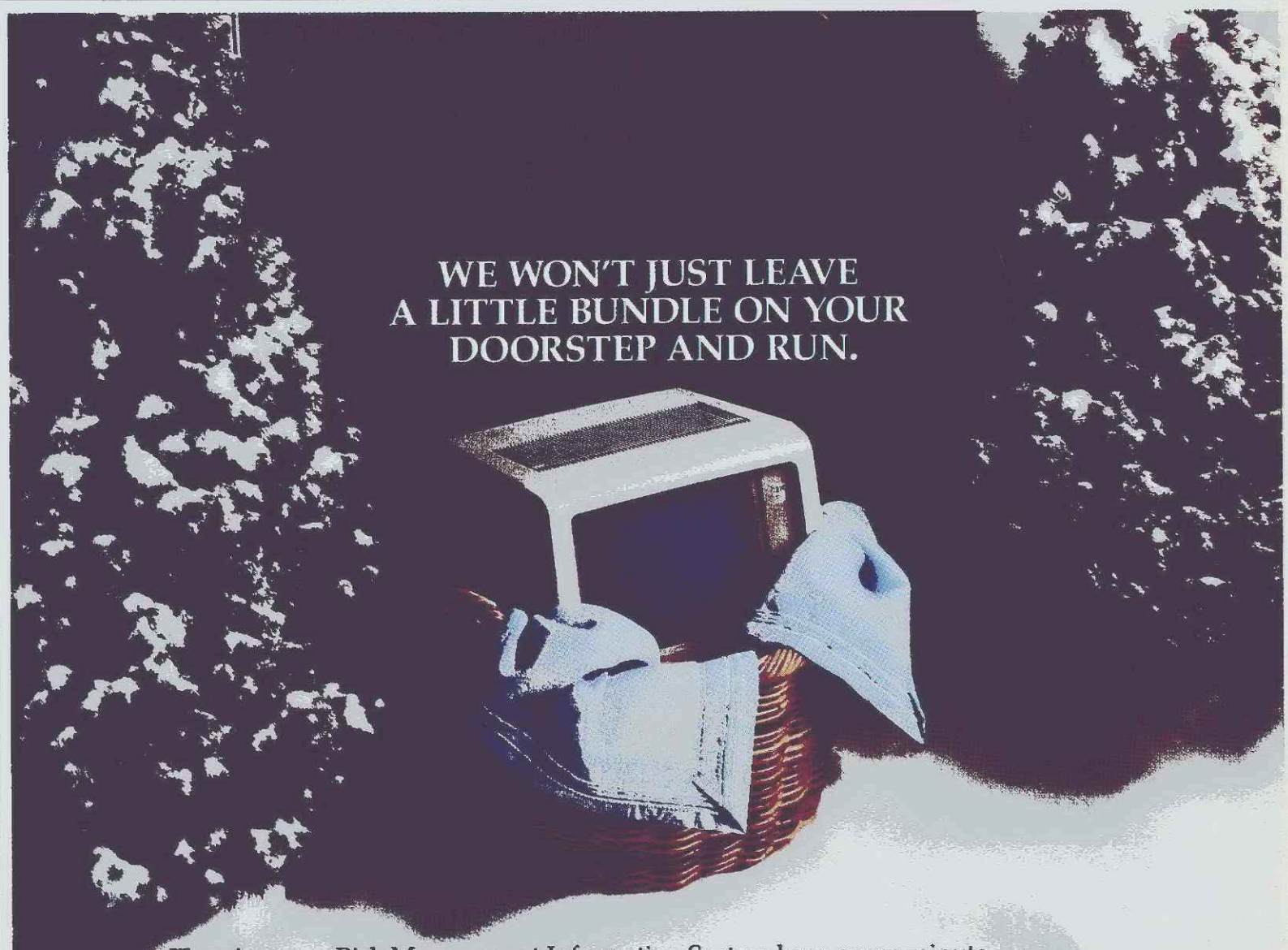

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COBRA letters

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terminated employees must be offered continued benefits.

These issues must be addressed either in the regulations or in amendments to the act. We strongly urge you to take whatever actions you can to effect these changes or interpretations.

Finally, we believe municipal and other public employers should be totally exempt from this law since the funds to provide these benefits come from the taxpayers.

* * *

The following comments were submitted by Robert A. Cafarella, employee benefits manager at Figgie International Corp. in Richmond, Va.:

Although we are a Fortune 500 company, we are made up of many small companies. In addition, we participate in a myriad of multiemployer plans over which we have no control.

It is our intent to fully comply with all of the provisions of COBRA. However, there may be times, through no intentional fault of our own, when oversights occur. After all, we are dealing with people, and ensuring perfect compliance is impossible.

It seems to us that the penalties imposed by COBRA are particularly harsh, especially where oversights are corrected. We hope the Internal Revenue Service will consider changing the current penalties to "penalties of last resort" and develop a more realistic solution to this problem.

* * *

The following comments were submitted by Anthony A. Derezinski, corporate counsel and vp of public affairs for Mercy Health Services in Farmington Hills, Mich.:

Mercy Health Services and its subsidiaries are covered under COBRA's continuation of coverage requirements. We strongly support the intent of COBRA and are pleased to be able to provide continuation of coverage to our former employees.

I believe the Internal Revenue Service has done an admirable job of clarifying for subject employers the myriad of individual circumstances that will arise and the actions that need to be taken to assure compliance with the regulations when a qualifying event occurs that triggers the requirement for compliance with COBRA.

I have the following comments on the proposed regulations:

• **Harshness of the penalties.**

Reaction: The penalties are brutally harsh and need to be modified so that inadvertent clerical and other mistakes will not eliminate an employer's ability to deduct as a business expense the cost of providing health care coverage benefits to its employees. . . . These harsh penalties may cause counterproductive reactions by employers:

- Employers may simply cease providing health care coverage for all of their employees rather than risk losing the ability to deduct the costs of normal health care expenditures for their employees.
- As a variant on this reaction, employers may simply provide the value of the health coverage benefit in incremental wages to avoid the penalty and advise employees to purchase coverage on an individual basis with the added pay. This is an especially strong incentive if high-wage employees may be denied an income exclusion for the actuarial value of health care benefits provided by his or her employer. Employees, however, may find it difficult to find an insurer or HMO to provide him or her with coverage, irrespective of whether he or she is in good health.

Both of the above reactions are reasonable given the potentially harsh sanctions, and both reactions would reduce the availability of health care coverage. It would be highly ironic if COBRA, a law that is intended to widen the availability of health care coverage, actually reduced the availability of health care coverage. This may be the result, however, of such harsh penalties.

Recommendation: We recognize that (COBRA) provides that the elimination of the ability to utilize tax deductions for the cost of the health care benefits provided may be one of the penalties for the failure to provide continuation coverage. However, we believe that the Internal Revenue Service should utilize discretion and provide in its regulations penalties that are consistent with the infraction committed and the law's purpose.

Hence, the regulations should provide a continuum of penalties ranging from reprimands and small fines for minor violations to the loss of the ability to deduct as a business expense the contribution made for these benefits only in instances of willful, repeated and flagrant violations.

In addition, if the violation results in a qualified beneficiary's not having health care coverage for which he or she is eligible, the employer should be required to rectify this omission, including notice to the individual of his or her remedies against the employer. The current draft regulations do not provide this requirement, but should.

• **Good-faith compliance in the absence of promulgated regulations.**

Reaction: Pages 22716-7 provide that covered employers will be considered to be in compliance from Sept. 15, 1987, until the regulations are effective only if they operate in compliance with the terms of these proposed regulations. This means that employers will be held accountable to the IRS for complying with regulation that are not promulgated but which are only proposed.

Recommendation: Employers should be considered to be in compliance from Sept. 15, 1987, to the date that the regulations are promulgated if they operate in good-faith compliance with a reasonable interpretation of the statutory requirements alone and not the as-yet unpromulgated rules. Compliance with the regulations should commence no sooner than their effective date.

• **Incorporation of individual insurance contract as part of a group plan.**

Reaction: Page 22720 provides that certain individual insurance policies come under the aegis of COBRA's continuation of coverage requirements.

It is questionable whether franchise or other individual policies, which are individually underwritten and rated and may be sold through a payroll deduction plan to which the employer makes no contribution, are intended to come under COBRA's ambit despite the regulation's assertion that such plans would not come under COBRA's regulations. The law references group and individual policies.

Recommendation: While there may be desirable public policy reasons to provide continuation coverage for these individual contracts, these contracts are beyond the scope of the law and should not be covered under COBRA's continuation requirements.

• **HMO continuation coverage.**

Reaction: Page 22738 appears to provide that qualified individuals who have elected continuation coverage through an HMO are not

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permitted to switch to an indemnity plan once they move out of the service area unless the employer has employees in the area to which the qualified beneficiaries move and unless an active employee who transfers to that area has the right to elect alternative coverage at the time of the transfer.

This provision will, in effect, deny benefit access to many qualified beneficiaries, since it can be expected that many qualified beneficiaries at or near the date of a qualifying event will move to a new location. It will also be very complex to administer.

Recommendation: Qualified beneficiaries who have elected coverage should be permitted to switch to an indemnity or expense-incurred plan if he or she, or other individual's covered under COBRA's continuation plan, move from an HMO or PPO service area. Unless the provision of the rule is modified, many qualified individuals will, in effect, be totally denied continuation coverage upon the occurrence of a qualifying event since some employers only offer an HMO or some similar managed care system with a closed panel of providers in given geographic areas to its active employees. Hence, the intent of COBRA will be completely subverted if qualified individuals cannot have an expense-incurred or indemnity plan if they move to a location outside the HMO service area or outside the practical range of the managed care panel.

Anthony A. Derezinski, corporate counsel and vp of public affairs for Mercy Health Services in Farmington Hills, Mich., recommends that 'the employer should be required to send the qualified beneficiary a notice by registered mail.'

Obviously, it is recognized that under these circumstances active employees must be treated in a differential manner from qualified beneficiaries.

- **Duration of coverage expansion.**

Reaction: Page 22730 indicates that employers may expand eligibility for coverage beyond the maximum durations required by COBRA. This is a desirable provision, but it needs implementation safeguards.

Recommendations:

- Coverage provided beyond the maximum required time period under the initial aegis of COBRA should be implemented in an equitable manner which does not discriminate against certain beneficiaries. For example, if coverage is voluntarily provided by the employer beyond 36 months, coverage should not be limited to those who are not a significant actuarial risk to the program and potentially costly to the employer. If the coverage beyond 36 months is provided only to those who meet strict underwriting requirements and have excellent health, the employer may make significant profits on the coverage, an undesirable outcome.
- The regulations should also explicitly provide that employers are permitted to extend coverage beyond 36 months so that the ERISA pre-emption holds beyond the 36 months and employers are not found, under state laws, to be in the business of insurance without a certificate of authority.

- **Enrollment of COBRA beneficiary in a conversion health plan.**

Reaction: Page 22731 provides that qualified beneficiaries should be given the right to enroll in a conversion health plan during the 180-day time period that ends on the coverage expiration date if this option is provided to similarly situated active employees. This is a desirable requirement, but it needs refinement to assure that qualified individuals make an informed choice that is in their best interests.

Recommendation: The regulations should provide that an individual must, at the time of a qualifying event, be notified of his or her rights under COBRA and about the conversion plan, including, for each plan, its costs and what changes in cost and benefits may be imposed by the employer and when, its benefit provisions, if there is an employer subsidy and the amount of the subsidy.

In addition, the regulations should provide that the election of the conversion plan shall not preclude the individual from later electing the COBRA plan during the COBRA eligibility period, even if the individual had elected the group conversion plan at the time of the qualifying event.

- **Discontinuation of eligibility for the COBRA plan.**

Reaction: Page 22730 of the regulations provide that COBRA coverage terminates the first date after the date of the election under which the qualified beneficiary has coverage under any other group plan, even if that coverage is less valuable to the qualified beneficiary than COBRA continuation coverage. This requirement may mean, for example, that an individual electing COBRA coverage, and subsequently becoming employed by an employer that provides in its health care coverage plan a pre-existing conditions exclusion, will have serious gaps in his or her health coverage benefits despite the fact that he or she has continuously maintained health care coverage.

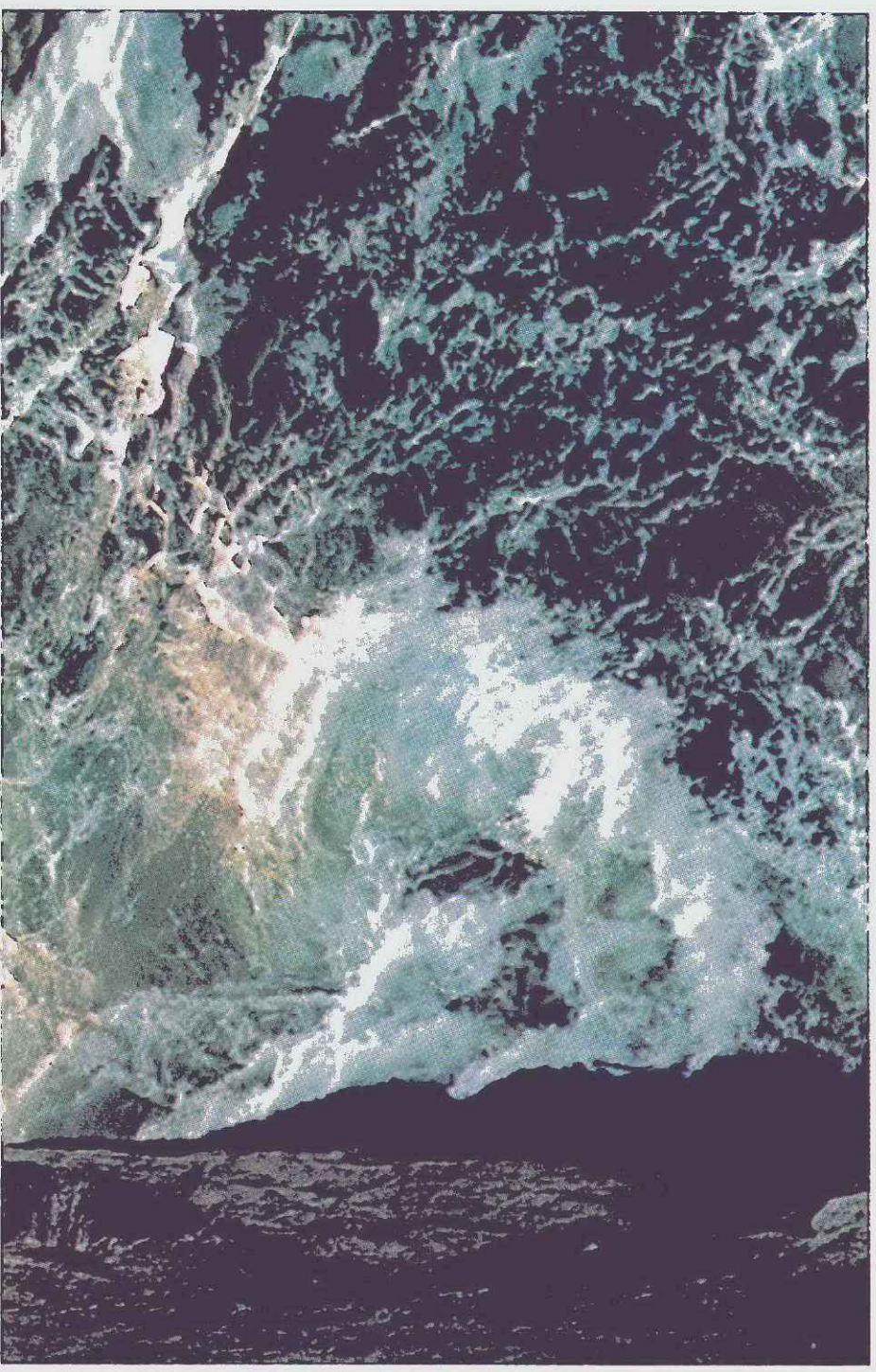
Recommendation: In order to prevent individuals who have continuously maintained health care coverage from having unintended gaps in their coverage, those having coverage under COBRA should be permitted to extend their COBRA coverage through the maximum duration permitted, irrespective of whether or not they become covered under another group health care coverage plan. Coordination-of-benefits rules can then determine the appropriate amount for the COBRA plan and the new group plan to pay.

- **Notice of eligibility under COBRA.**

Reaction: Page 22729 of the regulations provide that notice is deemed to be given to the potential COBRA beneficiary of his or her eligibility the date that the notice is sent to him or her. There is no requirement that the qualified individual must actually have received the notice, and hence, there are instances in which the employer may comply with these regulations without the individual actually having received notice, an undesirable result which undermines the purpose of COBRA.

Recommendation: The employer should be required to send the qualified beneficiary a notice by registered mail. The date of notice should be the date on which the qualified individual receives the notice. If certified mail does not reach the individual, the employer should be required to take all additional reasonable steps to get notice to the qualified individual. Unless all efforts are made, the promise of COBRA will not be realized.

I appreciate this opportunity to comment and trust you will take these comments into consideration when developing the final regulations. ■



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Hospital health plans differ from other firms'

By JAMES M. BURCKE

Hospitals are less likely than other types of employers to include medical cost management features in the group health care plans they offer to salaried employees, a new survey shows.

Presumably, these cost management techniques do not result in as much cost savings to hospitals as other employers, because the techniques reduce hospital utilization, which in turn reduces a hospital's revenue.

In addition, hospitals are much less likely to offer retiree health care and group life insurance benefits than other types of employers, Ill.-based benefit consultant Hewitt Associates.

However, hospitals offer more generous health care benefits than other companies, especially if the employee receives treatment in the hospital in which he or she works, according to the study.

Hewitt, in conjunction with the American Hospital Assn.'s American Society for Healthcare Human Resources Administration, surveyed the benefit programs offered to salaried employees by 96 health care organizations and 812 other companies in various industries to compile the survey.

Only 31% of the hospitals surveyed by Hewitt mandate that salaried employees obtain second surgical opinions before undergoing certain procedures, compared with 50% of companies in general industry.

In addition, none of the hospitals surveyed offered employees increased coverage if they obtained second surgical opinions, while 7% of the other companies included such a provision in the health care plans.

Conversely, 68% of the hospitals offered employees the same level of coverage, whether or not they obtained second surgical opinions, compared with only 43% of the other companies. About 1% of each group surveyed used various other methods of handling second surgical opinions.

Just as hospital health care plans are less likely to encourage second surgical opinions than other companies, the hospital health care plans are less likely to provide incentives for outpatient surgery.

Only 18% of the hospitals responding to the survey said their health plans offer higher coverage for outpatient surgical procedures, compared with 43% of the health plans offered by the other companies surveyed. Sixty-seven percent of the hospital health plans provided the same level of coverage for outpatient surgery and inpatient surgery, compared with only 43% of the companies in other industries.

However, 13% of the hospitals mandated outpatient surgery for certain procedures, compared with just 11% of the other companies surveyed.

About 2% of the hospitals and 3% of the other companies surveyed treat outpatient surgery in some other manner.

Likewise, only 24% of the hospitals reward employees who receive outpatient pre-admission testing. Forty-nine percent of the other companies provided higher coverage to those employees that obtained outpatient pre-admission testing.

Seventy-five percent of the hospitals surveyed—but only 49% of the other companies surveyed—provided the same level of coverage for both those who had obtained pre-admission outpatient testing and those who had not, while 1% of the hospitals and 2% of the other companies had some other provision.

Finally, 51% of the hospital health care plans did not cover hospice care, compared with only 33% of the plans offered by other employers.

Only 5% of the hospitals provided higher reimbursement levels of hospice care compared with hospital care, compared with 7% of the other employers. In addition, 5% of the hospitals—and 11% of the other companies—provided higher coverage levels for hospice care, but capped the amount of hospice benefits an employee could receive.

Thirty-three percent of the hospitals—and 30% of the other employers—provided the same levels of coverage for hospice care as for hospital procedures, while 2% of the hospitals—and 13% of the other employers—provided the same level of benefits for both hospital and hospice care, but capped the amount of hospice benefits an employee could receive.

One percent of the hospitals and 3% of the other employers reimbursed hospice expenses at a reduced rate compared with hospital care, while 3% of each type of employer used some other method to reimburse hospice care.

Hewitt observes: "Because cost management features (like those encouraging outpatient surgery or pre-admission testing) result in little cost savings to a hospital, these features are less common in hospital medical plans than other employer plans."

However, many hospitals offer employees higher levels of health care coverage or reduced deductibles if the employee is treated at the employer's facilities. Forty-three percent offered this type of arrangement, 52% did not and 5% said benefits varied with the health plan option selected by the employee.

If an employee uses his employer's facility for treatment, he or she is likely to receive greater coverage than employees at other types of coverage.

For instance, 59% of the hospitals covered 100% of reasonable and customary charges, assuming that the employer's facility is used. By contrast, only 20% of the non-health care employers surveyed covered 100% of the reasonable and customary charges.

However, hospitals were more likely to require an employee to pay a health plan deductible. Seventy-two percent of the hospital health plans required a front-end deductible, compared with 64% of the other employers surveyed. Only 21% of the hospitals—compared with 30% of the other employers—did not require a deductible, while 7% of the hospitals and 6% of the other employers surveyed said deductible requirements depended on what plan option an employee selected.

Hospitals also were much less likely than other types of employers to offer other types of health care-related benefits.

For instance, only 26% of the hospitals responding to the survey offered medical coverage for retirees past age 65, compared with 85% of the other companies surveyed.

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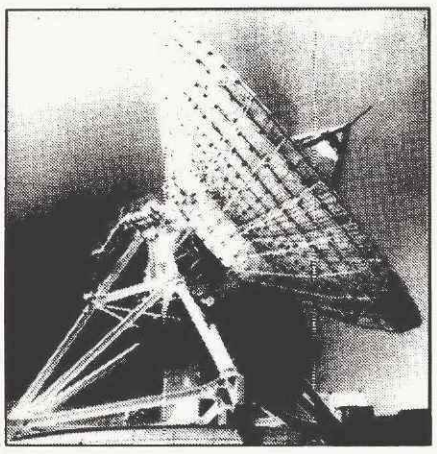

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Hospital plans

Continued from previous page

Also, 82% of the hospitals—compared with 91% of the other employers surveyed—offered some sort of dental care plan, including a flexible spending account, to employees.

And, only 28% of the hospitals—compared with 33% of the other companies surveyed—offered some type of vision care plans, including FSAs, to their employees.

Fourteen percent of the hospitals and 16% of the other employers offered their salaried workers one or more flexible spending accounts, while 14% of the hospitals and 18% of the other employers have instituted flexible benefits programs, the survey showed.

Fifty-two percent of the hospitals offered group life insurance coverage in which the employer pays all costs, compared with only 15% of the other companies surveyed.

Forty-four percent of the hospitals—and 74% of the other employers—offered group life insurance plans in which both the employer and the employee contributes to the cost of coverage, while 4% of the hospitals and 11% of the other employers offered plans in which employees contribute the full premium. However, only 25% of the hospitals offer retiree group life insurance programs, compared with 79% of the other companies surveyed.

Hospital employers are less likely to offer defined benefit pension plans, the survey reports. Only 78% of the hospitals have defined benefit plans, compared with 91% of the other companies that Hewitt surveyed.

Hospitals and other employers generally use the same types of vesting schedules.

Seventy-nine percent of the hospitals—and 80% of the other companies surveyed—offered 100% vesting after 10 years of services, while 2% of each group of employers offered full vesting after five years of service.

Seventeen percent of the hospitals—compared with 12% of the other employers—offered a graded vesting schedule in which an increasing proportion of the accrued benefits of a plan participant becomes vested under various formulas and requirements.

Two percent of the hospitals—and 6% of the employers—used some other type of vesting schedule.

Hospitals and other employers were almost equally likely to offer employees some sort of capital accumulation or defined contribution plan.

Ninety-four percent of the hospitals and 96% of the other employers offered some kind of plan.

Interestingly, 76% of the hospitals surveyed offer employees the chance to purchase tax-sheltered annuities, while none of the other kinds of employers offer this type of benefit.

Sixty-eight percent of the hospitals, however, do not make any type of contribution toward the purchase of these annuities, while 7% provided matching employer contributions and 1% contributed toward the purchase of annuities even if the employee does not contribute.

However, employers in other industries are much more likely to offer employee savings plans than hospitals.

For instance, 68% of the other employers offered 401(k) salary reduction plans in which the employer matches employee contributions.

Only 9% of the hospital respondents offered such a plan. In addition, 8% of the other employers—compared with 6% of the hospitals surveyed—offered a 401(k) plan without employer matching contributions.

Hospital employers are less likely to offer defined benefit pension plans, the survey reports.

Eight percent of each group of respondents offered a savings plan with an employer match but without a 401(k) salary reduction feature.

Also, 19% of the other employers surveyed offered some type of profit-sharing plan, compared with only 1% of the hospitals.

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Copies of the report, "Salaried Employee Benefits, a Comparison Study: Health Care vs. General Industry," are available for $10 from Cathy Schmidt, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.

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Bankers see D&O liability crisis: Survey

By PAUL D. WINSTON

NEW YORK—A directors and officers liability crisis is in the making, according to a recent survey of U.S. bank presidents.

Furthermore, one-third of the bank presidents surveyed by Peat Marwick Main & Co. in its "D&O, Directors' and Officers' Liability: A Crisis in the Making" study said that the problem already has assumed crisis dimensions.

According to the survey of 709 presidents of the nation's largest banks:

- Some 94% view the D&O liability situation as "having some negative effect on corporate governance."
- Some 75% of the respondents blame lawyers and juries that grant high awards for the D&O crisis.
- Eighteen percent of the bankers report that specific changes have been made in lending policies as a result of D&O liability.
- One-third of the respondents report that their banks do not carry liability insurance covering their directors.

"We have heard lately that the D&O problem is no longer a serious issue," said Thomas F. Keaveney, Peat Marwick's national director of banking services. "But the results of this survey indicate otherwise."

Some 91% of the respondents said that there was a D&O liability crisis in the making, 60% said that a problem exists that may grow into a crisis, 33% said the problem has assumed crisis proportions and 6% said that the issue is overblown and there is no crisis.

A majority of bankers also said the D&O crisis is having a damaging effect on the "quality of corporate governance." Some 73% of the bankers said either the situation is having some negative effect or that the situation is having some negative effect and definitely getting worse. And, 21% said a considerable or great deal of damage has already been done to the quality of governance.

When asked how much of an effect the D&O problem has had on their own banks, the majority—about 60%—indicated there was at least a measurable impact. Forty-two percent said some effect could be felt, 15% indicated a considerable effect and 5% a great deal of effect.

Some 75% of the bankers attribute the problem to lawyers and juries granting excessive awards, 55% blame heavy publicity concerning large settlements, 40% blame the insurance industry, 33% blame inadequate legislation, 28% blame the joint and several liability concept and 25% blame judges.

Given the scenario that the current situation continues unabated, more than half of the respondents said the banking industry's ability to attract and retain qualified board members would be hampered. Only 13% said the D&O liability crisis would have little or no effect on the banking industry, while 12% offered no response.

Some 80% of the bankers said no changes had been made in their bank's lending policies as a result of D&O liability issues.

Among the bankers that did make changes, one-third reported overall controls had been tightened, and about 15% replied that lending polices were being updated or that more detailed lending documentation was being required.

While the majority of institutions represented—94%—carry bankers blanket bond coverage, only two-thirds have D&O liability coverage.

Therefore, it is not surprising that about two-thirds of the respondents indicated they would consider buying personal D&O coverage, if it were available, as a supplement to any coverage they might already have.

Of the 33% of bank directors who do not have D&O liability coverage, about two-thirds indicated they had the coverage in the past five years. Of this group, one-fourth said they could no longer get coverage at any price, 61% found it unreasonably priced and 13% had been turned down for the coverage they sought.

About 30% of the bankers reported premiums for D&O liability coverage had risen in excess of 300% at last renewal. Only 7% experienced no change or a slight decrease in cost. Some 60% predicted that premiums would continue to increase during the next five years, while 20% predicted that rates would either decline or remain the same.

Asked about changes in deductibles at last renewal, 27% reported no change, 13% experienced increases greater than 300% and 35% had experienced increases up to 300%. Forty-six percent expect to see the trend of increasing deductibles continue, while about 20% believe deductibles will remain the same at their next renewal.

Bankers also saw rising premiums and deductibles for bankers blanket bond coverage.

Some 70% indicated premiums for bonds had risen at last renewal, while 11% reported no change. In addition, 42% reported rising deductibles and 37% experienced no increase.

Peat Marwick asked for respondents' opinions on six legislative proposals that have been suggested to limit directors' and officers' liability:

- A cap on the financial liability of board members. About 70% were in favor of this proposal, while 24% were opposed.
- A cap on attorneys' contingency fees. Eighty percent strongly favored this proposal, 13% were somewhat for it and 3% were somewhat against it.
- Limits on punitive damages. About three-quarters of the respondents strongly favored this proposal, with 18% somewhat in favor and 3% somewhat or strongly opposed.
- Elimination of joint and several liability. Almost 60% strongly favored this proposal, with 26% somewhat in favor of it.
- Recovery of legal fees. About 90% of the bankers said they favored permitting "a defendant to sue a plaintiff for the cost of his or her defense in lawsuits where the defendant prevails."
- "Poison pill" proposal. Only 26% expressed strong approval of holding directors liable if they adopt "poison pill" arrangements without prior shareholder approval.

The majority—38%—somewhat approved of holding directors in this situation liable, 14% were somewhat opposed and 5% were strongly against.

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A free copy of the survey, "Directors & Officers' Liability: A Crisis in the Making," can be obtained by contacting any local Peat Marwick Main & Co. office.

American business has one word for the way we handle claims:

Rendez-Vous

Continued from page 1

ing director of GTE Reinsurance Co. Ltd. in Bermuda, who had 65 appointments scheduled.

Observing the lobby of the Hotel de Paris, a favorite of the European reinsurers, or the open bar of the Loews Hotel, a favorite of the Americans, between 9 a.m. and 5 p.m. is like watching adults play musical chairs as reinsurance men —and only a sprinkling of women —shift tables for the next meeting. The lobbies quiet down between noon and about 2:30 p.m., when everyone attends luncheons, and after 5 p.m., when people prepare for the round of evening cocktail and dinner parties that are hosted by reinsurers and reinsurance brokers.

The highly unstructured meeting provides the first soundings for property/casualty insurance and reinsurance market conditions in the year ahead.

'It's a quiet time. A lot of people are at the beach and the casinos,' observes Ward Gordon, chairman of Intere Intermediaries Inc. in New York. 'There is some business going on. It's pro rata exchanges between European companies.'

And, generally, the predictions are accurate.

For example, reinsurance leaders warned in 1984 that their losses were so large they would have to pull capacity from the 1985 renewals, creating a capacity crunch that would send rates spiraling throughout the commercial insurance marketplace in 1985.

They were right. By the next Rendez-Vous in 1985, the worst crunch in the history of commercial insurance business was in full force.

In September 1986, reinsurance leaders said the worst was over and that commercial insurance buyers had seen the worst of the casualty capacity crunch and big rate hikes.

That, too, proved true in 1987.

Although the reinsurance marketplace is only a small portion of the insurance market in terms of premiums, reinsurers' willingness or refusal to accept risks from ceding companies exerts tremendous control over the price and availability of commercial insurance. If they reduce the supply of reinsurance, as they did two and three years ago, rates climb and availability shrinks.

But now, conditions in the reinsurance market are relatively stable, with some competition creeping back. This year people were smiling contently about their profitable results and market conditions.

There also appeared to be less excitement in the lobbies, and people were more relaxed.

Mr. Dwane

"There seems to be less to say," commented James E. Dwane, president of Prudential Reinsurance Co. in Newark, N.J. "Last year, people were talking more about renewals and speculating. This year, there is nothing critical to say. It is the calm after the storm."

"It's a quiet time. A lot of people are at the beach and the casinos," observed Ward Gordon, chairman of Intere Intermediaries Inc. in New York. "There is some business going on. It's pro rata exchanges between European companies. They are checking terms going forward."

"It's more quiet than in the past because again there is a market in the United States," said Wallace Winter, president of Intere. "People were scurrying in past years because they needed a place to put business."

Mr. Winter

"People are not looking for business," observed Mr. Engestrom of Skandia America.

"Everybody is hoping for a quiet life at the moment," said Mr. Lock. "It seems to be a year that everyone would be happy if the status quo continues."

Mr. Lock

Whether it was stability in the market or the sunny skies, the hotel lobbies did not appear to be as crowded as in years past. The official attendance was released at just under 2,000 people, the same as the last two years.

Assessments of the degree of competition in U.S. property/casualty market varied, although most agreed 1987 rates have been prized as good for the seller of coverage.

"Competition is a non-issue on the casualty side," declared Paul F. Butler, president of St. Paul Reinsurance Management Corp. in New York. "There is some erosion of property rates," he admitted.

Mr. Butler predicts that casualty insurance rates paid by U.S. commercial insurance buyers will be "static," while property rates will be down 10% to 15%.

St. Paul Re, which writes about 90% of its $385 million in gross premiums in the United States, is looking to develop more international business. Mr. Butler's experience includes 22 years with American International Underwriters, president of AFIA Worldwide Insurance and president of Frank B. Hall Overseas and Frank B. Hall Reinsurance before joining St. Paul Re in November 1986.

The primarily treaty reinsurer, catering to the broker market, would like to develop more business in the Far East, Southeast Asia, Latin America and some areas of southern Europe, Mr. Butler said.

"We have no volume target," Mr. Butler stressed.

Mr. Dwane of Prudential Re was reluctant to generalize about U.S. market conditions, explaining he sees variations from region to region, line by line, and by distribution system.

Pressed, he summarized that in the United States and Canada "it's getting more competitive in shorter-tail property lines. The more hazardous the property, the less competitive. In lighter casualty, it's starting. The most stable is the high-hazard casualty.

"It's happening a little quicker than the industry needs and it's a little unfortunate," he added.

"We hope most excess property would try to renew as is," Mr. Dwane said. "Casualty treaty capacity will increase a little bit, but rates are holding, with terms broadened."

Maybe some commercial accounts will get rate relief "on liability policies, but there will be no difference for tough risks like pharmaceutical companies, or directors and officers liability insurance."

However, Prudential Re does not expect to reach its original projected growth of 15% to 17% this year because property rates are down. Almost 70% of its premiums

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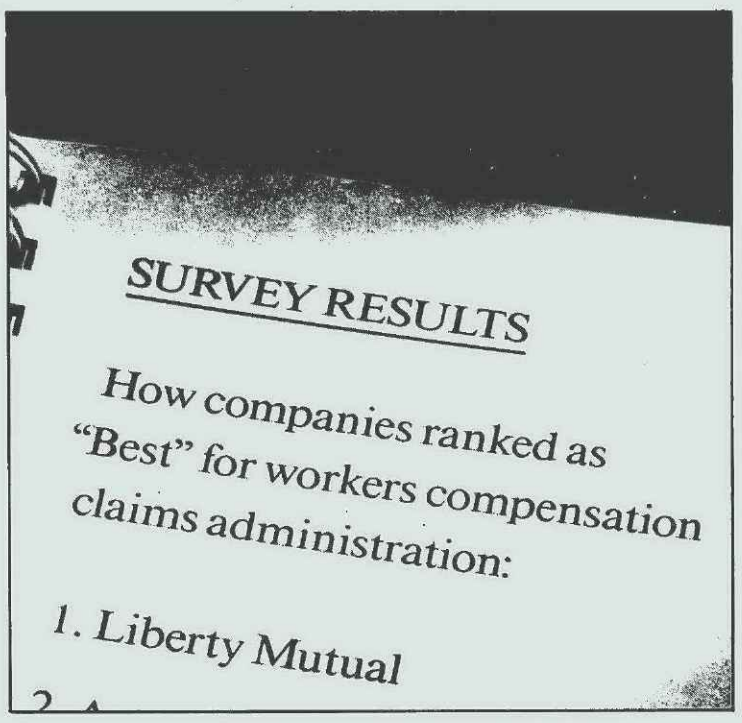

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Rendez-Vous

Continued from previous page

is related to property risks, including marine and aviation risks.

Mr. Dwane sees sunset clauses—which limit occurrence-based coverage to a certain number of years—being liberalized, and loss ratio or aggregate loss caps being lifted.

"Renewals will be down a little, but not as much as some have projected," predicted Mr. Gordon of Intere.

"On the primary side, there is a fair amount of competition," said Mr. Winter of Intere.

"Rates for corporate buyers could be off 20%, bringing them to where they should have been in the first place," said Mr. Gordon.

"Everyone wants to know what is happening with property," said Mr. Engestrom of Skandia America. "Some say rates are going nowhere and some say they are going down the drain."

"There must be pressure on property rates because there were very few catastrophes. But the current rating is right. You have to fund for the bad years," Mr. Engestrom said.

"Casualty has plateaued, but it's not down," he added.

Ceding companies are trimming rates, but behind them are reinsurers writing aggressively, said Raanan Ben-Zur, chairman of Lloyd's of London broker PWS Group.

"London is not prepared to be as competitive. The United States is still flexible and they get the business," he said.

"Most rate reductions we have seen are correct—are technically justifiable," said Francois Chavel, executive vp of Scor Reinsurance Co. in New York.

Mr. Rhulen

Not everyone agrees. To illustrate the competition in the property insurance market, Walter A. Rhulen, president of Rhulen Agency Inc. in Monticello, N.Y., reported that the premium recently charged to insure a $70 million building in Manhattan owned by the Rhulens was $12,000.

"You can't survive a wastepaper basket fire with $12,000," said Mr. Rhulen.

'Renewals will be down a little, but not as much as some have projected,' says Mr. Gordon.

Sphere Drake Insurance P.L.C. will not follow U.S. property insurance rates down, said Ian Dean, chairman, chief executive and general manager.

Sphere Drake will stop writing U.S. property reinsurance before entering stiff competition, he said. Already, Sphere Drake has lost property business because the rates were too low.

U.S. primary insurers, too, are reducing casualty rates, said Joseph J. Prochaska Jr., chairman and chief executive officer of Shand, Morahan & Co. in Evanston, Ill., which manages surplus lines insurer Evanston Insurance Co. "You see very few rate increases."

Mr. Prochaska

For example, some product liability insurance policies are being renewed at premiums 20% to 30% less than last year, he said. And, Shand has lost some directors and officers liability insurance business to competitors that were quoting lower premiums.

Reinsurers are not supporting this rate cutting, which Mr. Prochaska said is being done by insurers writing on a net-line basis.

Reinsurers are more carefully monitoring their ceding companies' rating than in the last cycle, with many using sophisticated computer programs to track rating.

Skandia America, for example, has computerized systems to price excess-of-loss reinsurance on an exposure and an experience basis. And, it prices facultative reinsurance "from the ground up," says Mr. Engestrom.

A system for not only pricing but also underwriting pro-rata contracts is in the works at Skandia America, Mr. Engestrom added.

"Few reinsurers monitored ceding companies last time around," said Mr. Butler of St. Paul Re.

St. Paul carefully monitors its ceding companies' rates and "if we don't like it, we walk away," Mr. Butler said. St. Paul has not written some facultative property accounts because the price was too low.

Overall, current pricing is "adequate to support ongoing business," according to Mr. Butler and most other reinsurance executives. "Whether pricing is adequate to pick up past losses is a question in our minds," he added.

If primary pricing gets too low for reinsurers' tastes, they will simply raise the cost of excess-of-loss reinsurance, predicts Richard E. Cole, president of treaty broker Cole, Booth, Potter Inc. in Old Bridge, N.J. Reinsurers told him that they should not give rate reductions in January. But, he expects there may be some for catastrophe reinsurance because of the dramatic increases at the last few renewals.

Capacity also is no longer a problem, reinsurers say. "I don't believe there was ever a shortage of capacity for the vast majority of property risks," commented Mr. Dwane of Prudential Re. "If you wanted to pay the price, it was there."

Acknowledging that "some casualty capacity was not available at any price" in the last few years, Mr. Dwane said, "Right now, there is more of a balance. But, there is more demand for higher limits than there is supply."

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Recently, there may only have been $10 million in limits available for high-hazard casualty risks when $25 million was sought, Mr. Dwane said. Now, when $50 million is sought, there may be $25 million available, and "at a price," he said.

"If you mix all the lines together, there is basically equilibrium" in supply and demand, Mr. Dwane said.

"There are no capacity problems, except umbrella, but that's a matter of price," said Mr. Cole of Cole, Booth, Potter.

There are "few vacuums" in capacity, Mr. Butler said, adding that there may be some capacity shortages in the catastrophe covers.

With rates expected to hold steady and adequate if not slightly more capacity in the market, reinsurance renewals are expected to go smoothly in January.

Mr. Butler expects renewals in January to be "less onerous than 1/1/87, which was less onerous than 1/1/86."

"We will get things done earlier, which will allow ceding companies to deal on a more timely basis with clients."

Mr. Butler advised risk managers against moving their accounts for price in the upcoming renewals. "If I were a risk manager, I might want to get quotes to keep my carrier honest, but if my carrier is impeccable financially, I'm not sure I would move."

'If you mix all the lines together, there is equilibrium' in supply and demand, says James Dwane.

Mr. Butler said he is concerned about the financial impact on insurance companies of asbestos and toxic tort losses yet to emerge and the problems of collecting reinsurance.

Reinsurance contracts will be "renewed calmly in January," Mr. Chavel of Scor Re predicts. All business will be placed, and everyone expects at improved terms, he said.

As evidence of current stability in the marketplace, treaties are not moving between reinsurers based on price, Mr. Butler said.

However, Mr. Cole said, "It's competitive in that our clients are looking at other bids. Clients are getting a lot of visits from our competitors."

Few reinsurers expect primary companies to buy more reinsurance for 1988.

"They still like the rates and they know more about the business," said Mr. Butler of St. Paul Re.

While new business production is ahead of last year, Skandia America is writing less business this year than it expected because many ceding companies kept much more business net, Mr. Engestrom said. "The ceding companies like the price" they are getting for their products, he explained.

"If retentions come down, it won't be much smaller than $5 million," Mr. Gordon of Intere predicted.

Mr. Cole reports that some of his regional insurance company clients are considering even larger retentions in 1988.

"Companies may buy more on top if rates come down, but not on the bottom. They feel they've saved money," he said.

However, Mr. Dwane of Prudential Re suggested, "There will be some decreases in nets because some are too uncomfortable even for larger companies."

A ceding company with a $7 million to $10 million net retention might want to buy reinsurance to decrease the retention to $5 million or even $2 million, he said. "It would be a question of rates," he added.

While the prevailing mood at the 31st Rendez-Vous de Septembre was satisfaction and contentment with the state of the insurance and reinsurance business, not everyone agreed.

"I am very pessimistic because everyone is optimistic," said Shlomo Jannai, general manager of Israel Reinsurance Co. Ltd. in Tel-Aviv. Ceding companies are "flush with money" and so are "spreading it around," he observed.

Whether the majority opinion on market conditions among reinsurance experts gathered at the 31st Rendez-Vous de Septembre proves correct next year, those attending accomplished major goals. In the words of Mr. Gordon from Intere: "A lot of people here want to see clients, be seen and have a more visible profile." ■

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Cutthroat competition won't return: Experts

By KATHRYN McINTYRE and STACY SHAPIRO

MONTE CARLO, Monaco—The commercial insurance market will never become as competitive as it was in the early 1980s, reinsurance leaders agree.

But there is little consensus on how long this current turn toward competition will last.

"Competition will not be as cutthroat," said Paul F. Butler, president of St. Paul Reinsurance Management Corp. in New York. "People learned too much. Insurance people are back in control of their industry."

"In the late '70s, early '80s, insurance people lost control of the industry to financial people," Mr. Butler said. Even if interest rates were to soar to 20% again, financial people will not regain control, he predicted.

"Hopefully companies are being run by insurance professionals who will realize if they need to lose business," said James E. Dwane, president of Prudential Reinsurance Co. in Newark, N.J.

"I can't imagine the cycle going as deep as before," agreed Richard E. Cole, president of treaty broker Cole, Booth, Potter Inc. in Old Bridge, N.J. Interest rates are too low and, during the last downturn, insurance companies used up their cushions, such as excess assets in pension funds and the value of their buildings, which some sold.

"Rates will go down, but the market will not crash," predicted Pierre D. Croizat, president of Scor Reinsurance Co. in New York. Losses emerging from prior years' underwriting, problems collecting on reinsurance, low interest rates and little new capital from outside the industry will keep the market tighter, he said.

But, Mr. Croizat acknowledged that "many people have new money and pressure from shareholders to show more income."

"The market will never be as soft as it was. It will be more stable," said Joseph A. Zaffarese, managing director of Pearson & Georgi International Inc., a Hoboken, N.J., reinsurance broker. Mr. Zaffarese joined the firm in May after leaving Frank B. Hall's reinsurance unit in New York in February.

"Companies lost too much money in the past. They have tighter controls on underwriting and pricing and have larger actuarial staffs and claims staffs," he said.

While there is more capacity in the market today, "it is not the same capacity as it was in the early 1980s," said Isao Kuzuhara, associate director/general manager of the reinsurance department in international operations at The Dai-Tokyo Fire & Marine Insurance Co. Ltd. in Tokyo. "There is more professionalism in the remaining capacity. It is good capacity."

" '88 will be the year of the underwriter," predicted John Engestrom, senior vp of Skandia America Group in New York. "From now on, underwriting discipline counts."

Skandia America, for example, wrote only $106 million in net premiums in the first six months of 1987 against capital and surplus of $302 million. "We will be under $300 million, but we are not concerned," Mr. Engestrom said. "We want quality first, volume second," he said.

Skandia writes about two-thirds of its business on a treaty basis and one-third on a facultative basis. Slightly more than one-third of its business is casualty, about one-third is property/mutiline and the other one-third includes surety, financial guarantees, marine and aviation. Skandia America specializes in small to medium-sized ceding companies.

'The market will never be as soft as it was. It will be more stable,' says Joseph A. Zaffarese. 'Companies lost too much money in the past. They have tighter controls on underwriting and pricing and have larger actuarial staffs and claims staffs.'

Mr. Engestrom admits, however, that he has some "concern over what the established players will do with their increased surplus," referring to both primary and reinsurance companies. "There is no question the big stock companies want more business."

Just entering a softer market, few reinsurance leaders want to try to predict when it will end, but a few will.

"The soft market will end at the end of 1988," predicted Walter A. Rhulen, president of Rhulen Agency in Monticello, N.Y. "It will be a very rapid cycle," he said. "It is already as soft now as it was at the height of the soft market.

However, his brother Peter Rhulen, president of Rhulen Intermediaries Inc., predicts the soft market will continue into the first six months of 1989.

"The up cycle was very short this time," observed Raanan Ben-Zur, chairman of Lloyd's of London broker PWS Group. "If the downside is short, it will be very dramatic.

"It only takes the stock market to fall for companies to go out of business," he suggested. "If it suddenly goes down 25%, companies will have to revalue their stocks and reserves."

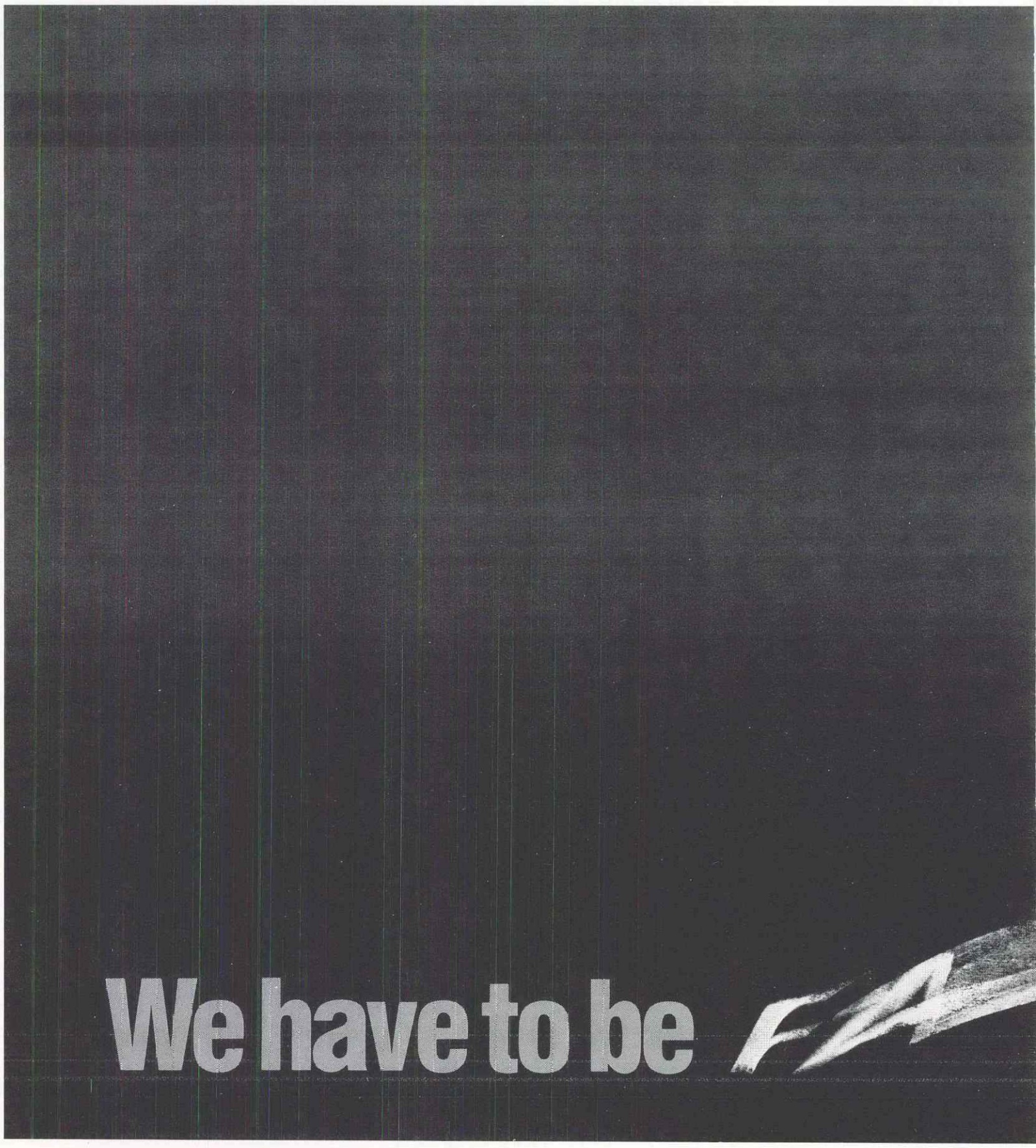
A single insured disaster, however, will not change the market, Mr. Ben-Zur suggests. "The world reinsurance market has perfected itself. There is much more of a premium base to work from."

"The hard market won't happen again this decade," predicted Theodor Dielmann, executive vp of Hannover Re in Hannover, West Germany.

"The market is going down and there is nothing that is going to stop it."

Acknowledging that "it is a pessimistic view," Mr. Dielmann said that Hannover Re will not follow the market down. "We are no longer expanding in a major fashion. We will retrench" if rates go down, he said.

The market is not as healthy as it thinks it is, said one London broker who declined to be identified. "If the wind blows and things burn, then results won't be as good." If the normal amount of fire losses had occurred, "the market would not have softened so quickly," said the broker, who added that in 33 years he has not seen the market become competitive so quickly. ■



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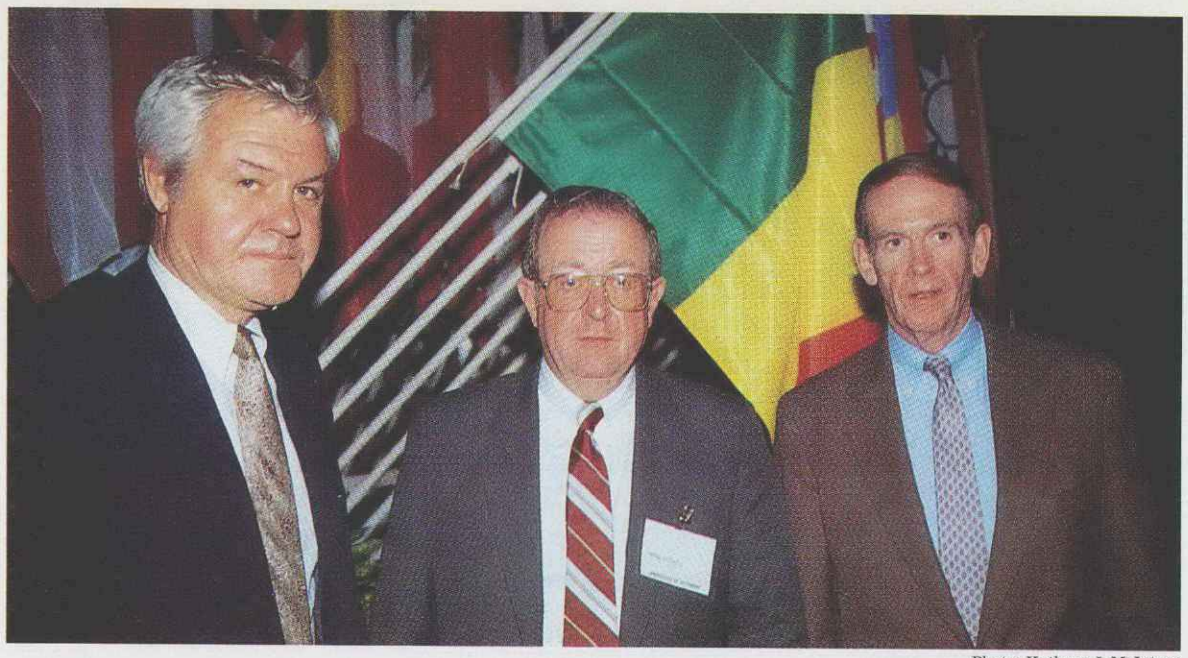

Photo: Kathryn J. McIntyre

The Rendez-Vous panel included St. Paul's Mr. Butler, Gillette's Mr. Mather and CIGNA's Mr. Baney.

Alternatives won't replace commercial insurers: Panel

By KATHRYN J. McINTYRE

MONTE CARLO, Monaco—Alternative risk funding mechanisms developed during the recent liability insurance crisis will not replace the commercial insurance business, according to a risk manager, an insurance brokerage executive and a reinsurance company president.

If commercial insurers provide a good product at an appropriate price, "The bulk of risk managers are going to return to the financing arrangements they have found most acceptable over time," according to William L. Mather, administrator of risk management at The Gillette Co. in Boston.

"It seems that the growth or decline of alternatives must vary inversely with the rise and fall in the traditional market," Mr. Mather said.

"Insurance in all its traditional and alternative forms continues to be the most significant way to manage risk," contends Frank J. Tasco, chairman of Marsh & McLennan Cos. Inc. in New York.

"There is no alternative to insurance—unless extreme good fortune or insolvency qualify as alternatives," says Paul F. Butler, president of St. Paul Reinsurance Management Corp. in New York.

Mr. Tasco

The three risk management and commercial insurance leaders participated Sept. 8 in a panel discussion on "Alternatives to Insurance" during the 31st annual Rendez-Vous de Septembre.

Mr. Mather, the immediate past president of the Risk & Insurance Management Society Inc., the largest organization of North American risk managers, observed that "risk management programs have always and will continue to utilize alternatives to insurance. Deductibles, self-insured retentions, paid-loss retros and captives are all alternatives to insurance and one or more of these alternatives have long been present in practically every risk management program."

Recently, however, the "scope and intensity" of the use of these alternatives increased due to "the withdrawal by traditional underwriters and the extremes to which risk managers have been forced to replace at least some of the lost coverages."

During the tight market, commercial insurers "withdrew from underwriting in selected areas totally, restricted coverage which was written and imposed astronomical premium increases," Mr. Mather recalled.

"The widespread scope of these changes and the degree to which they impacted many long-term relationships between underwriters and insureds with favorable loss ratios created a climate which drove many risk managers to alternatives to insurance.

"The withdrawal of financing by traditional insurers created a vacuum. Into this vacuum poured the cash and resources of hundreds of enterprises, guided by brokers, lawyers and investment bankers."

Conning & Co. of Hartford, Conn., an analyst and investment firm, has predicted that the alternative risk financing market will grow by $35 billion to 34% of the $215 billion in total commercial risk financing funds in 1990 from 28% of $135 billion in 1986.

However, there is a wide spectrum of companies using alternative risk financing mechanisms, Mr. Mather said. "On one end we would find the view that such alternatives are a short-term solution to a momentary aberration in the traditional marketplace. As such, this group anticipates returning to the traditional insurance markets when conditions improve. At the other extreme are individuals who view their use of alternatives as a long-run shift in their risk financing arrangements. The latter group does not visualize returning to the traditional market. Between the two extremes are the bulk of these participants."

This "very large group will be influenced by the current and anticipated action of the traditional

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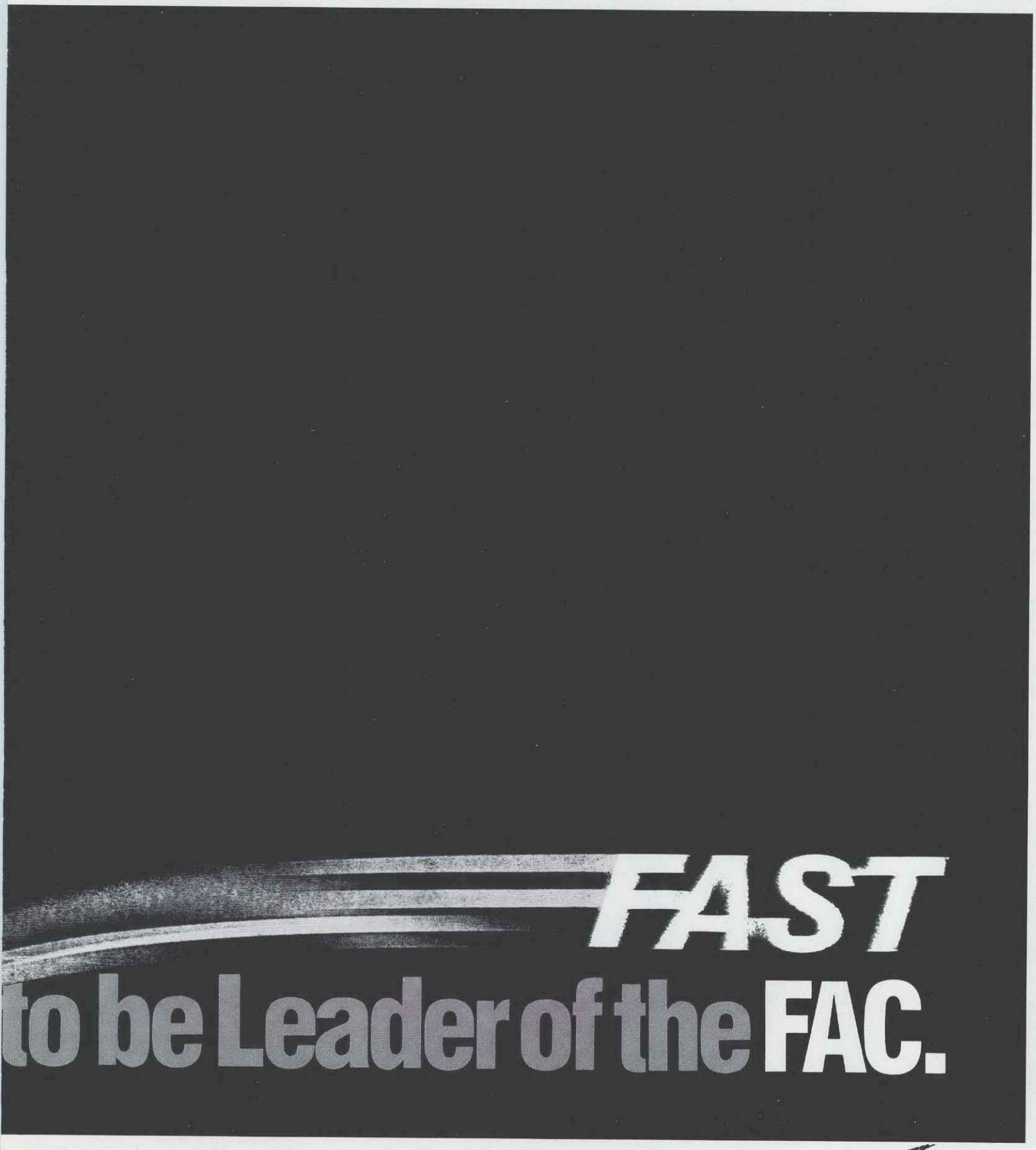

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Risk financing

Continued from previous page

market," Mr. Mather said. "The traditional insurers must demonstrate that they can provide services not available from the alternative markets."

"There were very few risk managers who got up one morning and said, 'the insurance market is in such bad shape I am going to eagerly run out and start my own insurance company.' There are some risk managers and insurance managers who are still very frustrated and extremely angry at the performance of the insurance marketplace. And those people have worked particularly hard and will be the last people to leave the alternative financing schemes.

"The average risk manager," he said, "is going to be influenced by what the traditional insurers do. If they reverse their position, as we've seen some signs, not only from a price standpoint but from a quality of coverage standpoint and availability of coverage standpoint, I think that the majority of risk managers not now utilizing the traditional market will come back to the traditional market."

The traditional market "is a more comfortable environment," Mr. Mather explained privately after the panel discussion. "There's a lot of work in these alternatives and the average risk manager has enough to do looking after what he is supposed to look after as opposed to outside activities."

However, "some risk managers, having tasted success with an alternative scheme, are going to stay with them."

Mr. Mather warned traditional insurers against competing "only on price," or "we may find ourselves back at the bottom of the next market disaster."

Mr. Tasco of M&M agreed that insurers should not compete only on price, suggesting that to do so turns insurance into a commodity.

"The added value in insurance is often an intangible—good services and reliability consistently provided over time. For consumers, that means quality claims settlement, improved loss control and other services," he said.

However, "when the price and terms of coverage fluctuate drastically from year to year, the product fails to accomplish its intended purpose: to substitute a known cost for an unknown cost and stability for instability."

Mr. Tasco said recent price and availability problems involved only excess liability lines, while "there was only a moderate change in the marine, aviation and HPR (highly protected risk) property markets. These specialized markets serve as evidence that commercial insurers can underwrite catastrophic risks effectively on a more stable, long-term basis."

Mr. Tasco advised insurers to update policies to better define the risk being covered and to make sound underwriting a priority.

In addressing alternative risk funding mechanisms, Mr. Tasco excluded the M&M-organized policyholder-owned insurance companies A.C.E. Insurance Co. Ltd. and X.L. Insurance Co. Ltd.

"These are examples of broker-initiated facilities and are innovative, workable responses to clients' needs," Mr. Tasco said. They also use the traditional distribution system—brokers—and complement the existing insurance market.

"What will keep these facilities successful in the long run will be their ability to fit into the mainstream of our business and become part of the traditional market."

"Because of their special lines focus on excess liability, I am convinced they will get the pricing right," he added.

But while "there is an appropriate place for the policyholder-owned insurance companies, the new risk retention groups authorized by the Risk Retention Act of 1986 probably will not have a long-term impact on either the market or the industry—not unless they are properly funded and organized and run professionally."

This means they need "sufficient capital, spread of risk and knowledgeable underwriting," he said.

Mr. Tasco also suggested that while Risk Retention Act proponents argued it would "calm the violent swings of the insurance cycle by substituting capacity from policyholders rather than from commercial insurers, there are equally persuasive arguments that this will not blunt the cycle."

Instead, Mr. Tasco suggested, "through innovative and well-planned efforts by corporations, brokers, insurers and reinsurers, together there is a good chance the next decade could witness the taming of the liability insurance cycle and the continued growth and importance of our industry."

Mr. Butler of St. Paul Reinsurance Management contended that "when we talk about alternatives we really are talking about ways to manage predictable risks so that they do not threaten financial solvency. . . . At some point, insurance or reinsurance is needed."

Using a simple example to illustrate his point, Mr. Butler cited a car owner who accepts a $500 deductible on collision insurance as what he can afford to lose at one time.

But, 20 car owners each with a $10,000 car can agree to pool their resources and not buy any collision insurance. If any one driver has a collision loss, each agrees to pay up to $500. "But what happens if there are two total losses?" Mr. Butler asked. "This group needs to purchase some type of insurance that will place a stop-loss of $10,000 over a given period of time.

"This is an extremely simplistic situation, but it does illustrate much the same situation that faces any pooling mechanism: The losses must be stemmed at a particular point or the pool will be in financial jeopardy."

"Modern corporate risk management programs primarily consist of three layers of risk," he explained.

"The first layer involves statistically predictable costs," which for many years had been covered by the traditional market, he said. Rising claims frequency and severity driving up premiums and administrative expenses in this layer, "makes handling the risk internally attractive to some companies. This first layer is the most easily self-insured."

The second layer of risk as described by Mr. Butler involves "risks that are predictable over the long-term but are not predictable in the short-term."

And, this is the layer "where the risk manager really must do his job," Mr. Butler said.

"The risk manager needs to determine the average expected cost of risk financing," he explained. And, "the risk manager must determine his company's risk tolerance level in order to determine how much of this layer, if any, should be self-insured."

How much should be self-insured "to a great extent will depend on the type of business involved," Mr. Butler explained. "If the business is highly leveraged (has high fixed costs from debt and large-scale operations), then its ability to self-insure in this second layer is limited because it is extremely sensitive to fluctuations in revenue."

The third layer of risk "involves catastrophic losses of an unpredictable nature or size. For this layer, insurance is imperative," Mr. Butler said.

The panel was moderated by John E. Baney, president of the international and broker division of CIGNA Corp.'s property and casualty group in Philadelphia. ■

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Alternatives don't solve deep problems: Reinsurer

By KATHRYN J. McINTYRE

MONTE CARLO, Monaco—Alternative risk financing mechanisms do not solve the problems underlying the liability insurance crisis, warns a reinsurance company executive.

"And that is particularly true of pools," advises Paul F. Butler, president of St. Paul Reinsurance Management Corp.

The underlying problem is the prevailing theory that all victims should be made whole, Mr. Butler said in a speech at the Rendez-Vous de Septembre.

"It certainly is an attractive theory. Unfortunately, it has been extended judicially to provide for victims compensation by insurance companies without regard to fault or fairness," and the compensation includes payment for non-economic and economic loss, he said.

Now, Mr. Butler predicted, "risk retention groups will replace the insurance industry as a new pool of money for those looking for more 'deep pockets.' "

As proof, Mr. Butler cited the doctor-owned medical malpractice insurers that "first began with low premiums, high hopes and enough capital to entice the judiciary. Today, they are seeking some of the highest rate increases in the country. Loss prevention and control are just not enough in today's environment."

However, self-insurance may prove to be a blessing in disguise, Mr. Butler said. "Self-insurance does not provide the same ability for the judiciary to seek redress from those with deep pockets. In many cases, the choice will be to overcompensate the victim and jeopardize the business enterprise or to compensate the victim only for economic losses when this is justified by correct findings of fault," he explained.

"This is not to say that lawsuits will end because self-insurance has increased," he said. "It will force many more cases into arbitration since the large amounts of money that induce both victim and lawyer to pursue the case in the courts just will not be available."

Mr. Butler expanded on his remarks regarding the judicial system in response to questions from the audience on tort reform in the United States.

He suggested that if the Supreme Court becomes a more conservative court in the future, as is expected, and that stance filters down through the judiciary, "tort reform may not be as necessary as it had been perceived to be."

Other insurance experts on the panel offered different insights on the issue of tort reform.

William L. Mather, administrator of risk management at The Gillette Co. in Boston, observed that "an unfortunate circumstance was the attempt to link the problems of the insurance industry with tort reform."

"The percentage of tort reform affected is still relatively minor, and yet the insurance industry is recovering. It is particularly difficult to press tort reform from the industry because the evil that was supposedly causing the problems has not been done away with, yet the industry is recovering. So now, it lends credence to the arguments. . . that this was a red herring.

"Those people who truly believe in tort reform, and most risk managers do, have to redouble their efforts, because we've lost ground in the last year," Mr. Mather advised.

Frank J. Tasco, chairman of Marsh & McLennan Cos. Inc. of New York, commented: "I've always wondered what we wanted out of tort reform. We are in the insurance business and trying to insure risk. If we legislate too heavily, we might throw the baby out with the bath water."

Mr. Tasco said he does not view tort reform as having a positive or negative influence on the expansion of the insurance market. "What will expand the marketplace is carriers will raise the level of their underwriting, centralize it, put it in the hands of senior people, tighten up wording and keep their fingers crossed. It's the best you can do."

John E. Baney, president of the International and Broker Division of the property and casualty group of CIGNA Corp. and moderator of the panel, suggested that "the problem is more deeply rooted" than the tort reforms of limiting punitive damages or contingency fees will solve.

He cited the broad interpretation of insurance contracts by the courts and the "propensity of the U.S. citizen to sue at the drop of a hat."

"Irrespective of large awards, we have frequency of awards and significant litigation costs."

Responding to Mr. Tasco's suggestion that insurers tighten policy wording. Mr. Baney asked: "How tight can you make underwriting and still sell it?" ■

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ROA seeks London market standards

By STACY SHAPIRO

MONTE CARLO, Monaco—The Reinsurance Offices Assn. wants to upgrade standards in the London market, says Chairman John Lock.

As a result, the ROA—which represents 320 member reinsurers, including 105 London companies—has established a working party to improve standards in the reinsurance market for policy wordings, claims administration and premium payments.

Together with other London-based associations of brokers and underwriters, the ROA hopes to upgrade the standards in London to "create a solid base from which the market can work," said Mr. Lock at the Rendez-Vous de Septembre.

"In the past, most of the practices in London were understandings rather than written rules. Now we are setting down standards for brokers and underwriters. . . .This should avoid all too many situations that are unresolved on whether information is correct, premiums are paid or unpaid," explained Mr. Lock, who also is general manager of The Mercantile & General Reinsurance Co. P.L.C. in London.

"We are not talking about price cartels but about creating a solid base on which the market can work," he said.

'In the past, most of the practices in London were understandings rather than written rules. Now we are setting down standards for brokers and underwriters,' says ROA Chairman John Lock.

Already this year, virtually the entire London non-marine insurance and reinsurance market, including syndicates at Lloyd's of London and ROA member companies, introduced new internal systems to speed up the payment of claims and premiums (*BI*, Dec. 8, 1986). These terms of trade, which were on trial for six months, are currently being reviewed (*BI*, Aug. 31).

Now the ROA is examining the relationship between ceding companies and their reinsurers or retrocessionaires, explained Mr. Lock. The ROA currently is examining the obligations of ceding companies, reinsurers and reinsurance brokers and hopes to have a "provisional" report written early next year, he said.

If action needs to be taken, the ROA will then consult with the other London market associations, like Lloyd's and the British Insurance Brokers' Assn. Also, the ROA strongly believes that more work should be done to standardize policy wordings throughout the London market, said Mr. Lock.

Working parties and committees currently are examining policy wordings with the hope of "producing recommended wordings for all reinsurance contracts," said Mr. Lock.

At the moment, the ROA is working on refining the definition of an "event" in property reinsurance contracts, he said. Standardized wordings could then be accepted or rejected by reinsurers and ceding companies, he said.

"It must make sense to get a degree of standardization" in London, said Mr. Lock. "There is a mutual recognition that the problems of the soft market were not just pricing but inadequate (market) mechanisms. The ROA, Lloyd's and brokers separately have seen these weaknesses are there and have come to the same conclusion."

Although the London market may now compete for business on rates, terms and conditions, the market "will move together" to improve its underlying practices to avoid the problems created by the soft market, Mr. Lock said. ■

Reinsurers seek quality risk pools

MONTE CARLO, Monaco —Reinsurers have a key concern in supporting pooling mechanisms for funding risks: the desertion of good risks from the pool, according to Paul F. Butler, president of St. Paul Reinsurance Management Corp. in New York.

Before a reinsurer will provide catastrophe reinsurance to a risk financing pool, the group must show that it has "instituted underwriting, claims and loss control engineering. . . .We really want to see a group that charges realistic premium rates that are designed to produce a profit," Mr. Butler said during a panel discussion earlier this month at the 31st Rendez-Vous de Septembre.

In addition, reinsurers want to see "strong capitalization. This means an upfront commitment from the members. Assessments are fine on paper, but rarely work out as well in practice."

The reinsurer also wants to be sure that the "capital will remain with the group."

Because the primary impetus for forming risk sharing pools was the lack of commercial insurance capacity, "as capacity returns to the traditional market, there could be a temptation, particularly among the members of the group which have had relatively clean loss pictures, to shop for cheaper insurance rates," Mr. Butler said.

"There should be some type of provision that prevents members from withdrawing capital," he advised.

"Quality management" also is important to reinsurers, as exhibited by marketing support to pursue additional members and a written business plan, Mr. Butler added.

"This support could come from within the group or from the outside. In fact, administrative support very well might come from traditional insurance companies since they already have developed much of the expertise needed."

—By Kathryn J. McIntyre

WILL YOUR REINSURER STEP FORWARD WHEN THERE'S A LOSS?

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GENERAL REINSURANCE CORPORATION, STAMFORD, CONNECTICUT. OFFICES IN ATLANTA, CHICAGO, COLUMBUS, DALLAS,

New broker acquisition wave hits London

By STACY SHAPIRO

The sale to Abaco Investments P.L.C. will give Morgan, Read & Coleman Ltd. 'a platform on which to expand,' says MRC Chairman Roger Morgan. 'You need a public company to be effective.'

MONTE CARLO, Monaco—A new wave of brokerage acquisitions is surging through the London market.

Specifically, just before the Rendez-Vous de Septembre, Abaco Investments P.L.C., a holding company, announced that it was buying Lloyd's of London reinsurance broker Morgan, Read & Coleman Ltd. for 20 million pounds ($32.9 million), according to MRC Chairman Roger Morgan.

Abaco will pay 13.6 million pounds ($22.4 million) in cash, plus Abaco stock, of which Mr. Morgan and his family will receive 6.4 million pounds ($10.5 million) for his 2,744 shares of MRC.

And, Abaco will buy additional MRC stock options in 1988 and 1989 for an additional 6.4 million pounds ($10.5 million), said Mr. Morgan.

Abaco, whose shareholders include British & Commonwealth Holdings P.L.C. and Standard Chartered Bank P.L.C., has been on the acquisition trail recently, having bought several loss adjusters and two other Lloyd's brokers since the end of 1986.

In August this year, Abaco completed its purchase of Lloyd's brokerage group Cayzer Steel Bowater Holdings Ltd. and last October bought Lloyd's broker Burgoyne Alford Ltd.

Both these brokers handle primary insurance and MRC has been bought "to be the specialist reinsurance broker," said Mr. Morgan.

All three brokers are expected to act separately, although they all have the same parent company, he said. "It doesn't work to have all the companies under one board."

MRC was formed in August 1976 by Mr. Morgan, Tony Read and Derek Coleman, who were former directors of Sterling Offices, an established reinsurance brokerage purchased by Alexander Howden Group P.L.C. in 1974.

Each partner owned one-third of the company, which became a Lloyd's broker in 1977, until Mr. Read left and sold his shares back to the company. Mr. Coleman retired last year and also sold his shares back to the company.

Today, MRC employs 69 people and produced 4.2 million pounds ($6.1 million at Nov. 30, 1986, exchange rates) in brokerage revenue and investment income for the year ended Nov. 30, 1986. Total pretax profits last year exceeded 1.5 million pounds ($2.2 million), said Mr. Morgan.

The brokerage almost exclusively handles excess-of-loss reinsurance, including London market excess-of-loss reinsurance, and is strong in Japan and the Far East, said Mr. Morgan. MRC also has interests in reinsurance brokers in France and the Caribbean.

The sale to Abaco will give MRC "a platform on which to expand," said Mr. Morgan. Trading in Abaco stock will give MRC executives more incentive to continue with the company and will attract more experts to the company.

"You need a public company to be effective," he said.

Among the people that MRC already has attracted is Andrew Leslie, former chairman of the North American division of Lloyd's broker Leslie & Godwin Ltd., who joined the company a year ago.

Meanwhile, former chief executive of Lloyd's broker C.E. Heath P.L.C. Peter Methley and Benchmark P.L.C. bought Lloyd's broker H.J. Symons & Co. Ltd. in July from Symons' single shareholder, Russell Hitchings, for an undisclosed sum.

Symons is now held by Peter Methley Holdings Ltd., which incorporates the H.J. Symons Group of Companies. Mr. Methley, who owns 60% of the company, is chairman and chief executive.

Symons, which was founded in 1878, consists of a Lloyd's brokerage that devotes 65% of its business to reinsurance and a Lloyd's members' agency. With a total of 95 people in London and Nottingham, the company's group aftertax profits last year totaled 630,000 pounds ($934,290 at year-end 1986 exchange rates) on brokerage revenue of about 2.5 million pounds ($3.7 million), said Mr. Methley.

The company's business predominantly is derived from Europe, with clients also in the Far East and Australia, he said. The company also has small accounts in United States and Canada.

Mr. Methley hopes to strengthen the company by adding about 20 people next year and expanding in areas the company is not strong in, such as the United States. He hopes the company will be able to trade on the London Stock Exchange in the next five to seven years.

Mr. Methley resigned as chief executive of Heath in October of last year following the merger of Heath with Fielding Insurance Holdings Ltd. and the appointment of Richard Fielding as Heath's chief executive. "I left Heath because the Fielding deal came along and it was clear the Mr. Fielding would have to be made chief executive. I thought, well, that's my job—arrivederci."

As Heath's chief executive, Mr. Methley said he was in favor of Heath completing its deal with Fielding and then considering a merger with Lloyd's broker PWS Holdings P.L.C.

After Mr. Methley left, however, PWS launched an unsuccessful reverse takeover bid for Heath (*BI*, June 22).

"Had I remained chief executive, I would have done the Fielding deal and three months later done the PWS deal," said Mr. Methley. "If you had brought the two in together it would have made a lot of sense."

After working for other companies for 30 years, Mr. Methley thought it was time to own his own Lloyd's broker and looked through 40 candidates before choosing Symons, which was "profitable. . . clean. . . with no horrendous problems or need for capital." ■

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Changes surprise veteran attendees of Rendez-Vous

By STACY SHAPIRO

MONTE CARLO, Monaco—Surprises greeted attendees of the 31st Rendez-Vous de Septembre in Monte Carlo.

Modern art adorned the principality, including recognizable colorful sculptures by Alexander Calder in the small gardens in front of the old Casino and the Hotel de Paris. Their placement and identifying signs looked temporary.

More curious to Rendez-Vous veterans were the larger-than-life and very permanent looking brass sculptures of a man and a woman set next to the old Casino. Most spectators, trying to interpret a round, bronze object at the feet of the female sculpture, deemed the newest couple in Monte Carlo to be Adam and Eve.

The pair could not be overlooked by those attending the traditional Monday evening reception outside the Casino hosted by the principality.

And all week long, tourists posed next to the sculptures for photographs.

While not complaining, people who were asked for their opinions agreed the modern art clashed with the old world charm of most of the surrounding architecture.

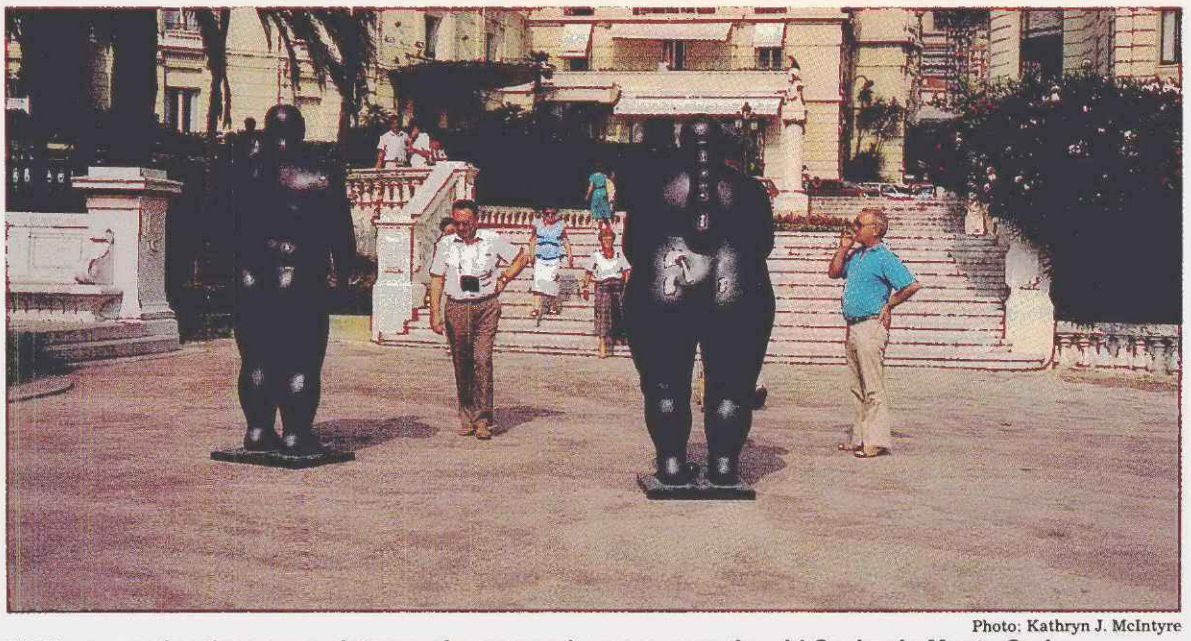

Photo: Kathryn J. McIntyre

Visitors examine the new sculptures of a man and woman near the old Casino in Monte Carlo.

Also startling to Rendez-Vous registrants was the demolition of the old Cafe de Paris, where hundreds met during past Rendez-Vous to discuss business over coffee.

The Cafe de Paris is being rebuilt to accommodate more people, but construction is expected to last two years.

A temporary Cafe de Paris was set up further up a hill from the old cafe, but few people knew about it and the noise from construction was sometimes deafening for those who ventured there.

Not only was the Cafe de Paris missing, but the elegant gardens that stretched for two blocks in front of the old Casino also were torn up by six cranes digging a giant hole where flowers usually blossomed.

The reason: to build a 1,000-space underground parking lot, which Monte Carlo desperately needs. Work should be finished by 1990, and the flower beds are to be restored.

Also new this year: People who are not residents of the European Community need a visa to enter France. Since most people travel to Monte Carlo via Nice, France, the nearest airport, French visas were a must.

But, unfortunately, some people did not remember the visa requirement, which was instituted after the Rendez-Vous last year.

The French explained that the visa requirement would thwart the entry of terrorists into their country.

A London broker who is an Australian citizen flew to Nice, was refused entry and had to fly to Rome to obtain a visa. He arrived in Monte Carlo toward the end of the meeting.

For the Rendez-Vous, however, the visa requirement delayed the arrival of some attendees.

For example, a London broker who is an Australian citizen flew to Nice, was refused entry, and had to fly to Rome to obtain a visa. He arrived in Monte Carlo toward the end of the meeting.

The composition of the attendees at the meeting also seemed different this year. Although the official attendance was released as just under 2,000—the same as during the last two years—there seemed to be fewer people.

But, there seemed to be more spouses, which one reinsurer said is a sign of prosperity in the reinsurance business.

Americans also seemed to be fewer in number, while Londoners seemed to be more prevalent. But, one London broker said he had never seen so many American brokers.

While there were surprises and changes at the 31st Rendez-Vous, many traditions remained.

Lloyd's of London broker PWS Group hosted its Sunday evening reception in the foyer of the Loews Hotel, an event that has become the unofficial opening of the Rendez-Vous.

Other entertainment lived up to the Rendez-Vous tradition of gracious hospitality and good food.

For example, the French agency and brokerage group MEPA Group Holding S.A. this year hosted a brunch for hundreds around the pool at the Sea Club.

Ten Bermuda-based reinsurance companies, three reinsurance brokers and three banks hosted their fifth annual reception—this year an afternoon gathering at the Le-Maona Restaurant in the Monte Carlo Sporting Club.

All but a few of the representative hosts sported Bermuda shorts for the afternoon.

The reinsurance company hosts were: Aneco Reinsurance Underwriting Ltd., Belvedere Insurance Co. Ltd., Forum Reinsurance Co. Ltd., G.T.E. Reinsurance Co. Ltd., Hudson Reinsurance Co. Ltd., Independence Insurance Co. Ltd., National Underwriters (Reinsurance) Ltd., Paumanock Insurance Co. Ltd., Pinnacle Reinsurance Co. Ltd. and Victory International Ltd.

The three reinsurance broker hosts were: Amberco Brokers Ltd., H&H Reinsurance Brokers Ltd. and Intere (Bermuda) Ltd.

The three bank hosts were the Bank of Bermuda Ltd., the Bank of N.T. Butterfield & Son Ltd. and Bermuda Commercial Bank Ltd.

Smaller parties were hosted by reinsurers and reinsurance brokers throughout the week in hotel gardens and restaurants.

And, Lloyd's broker Kinimonth Lambert Ltd. invited its guests aboard the M.Y. Moonmaiden II, which was docked in the harbor below the Hotel de Paris.

As if to reflect the upbeat mood of the Rendez-Vous this year, the weather was especially sunny and clear for those who could slip to the pool or the beach for a little swimming and sunning. ■

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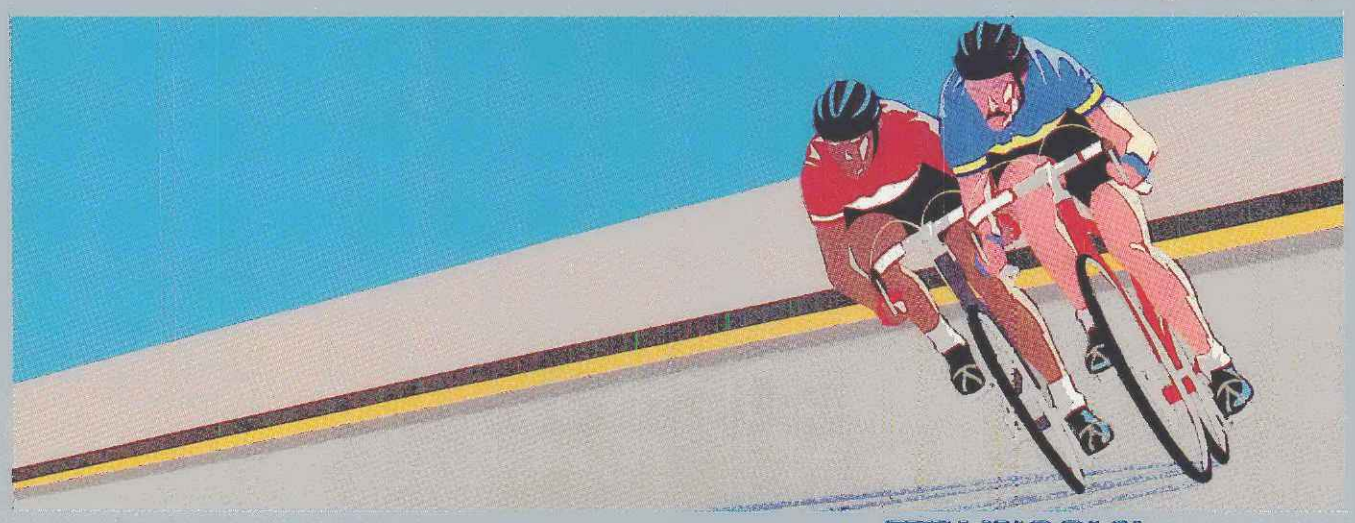

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Market stability reigns outside U.S.: Reinsurers

By STACY SHAPIRO

MONTE CARLO, Monaco—While the U.S. property/casualty insurance business suffers extreme cycles of competition and capacity crunches, other world markets are much more stable, according to reinsurers.

"If you look at the whole world, there aren't really great variations in rates, as you see in the States," observed John Lock, general manager of The Mercantile & General Reinsurance Co. P.L.C. in London, during the 31st Rendez-Vous de Septembre.

"Many European treaties over the last 10 years have seen their terms vary only marginally," Mr. Lock said. "The Third World, too. The only varying areas are U.S. casualty and some catastrophe covers."

The main reinsurance renewal season has passed in some nations and competition did not produce the dramatic swings that were experienced in the United States, observers say.

For example, when Japan went through its renewal season in April, there was some pressure on rates, depending on the amount of coverage sought, said Ronald Iles, chairman of Alexander Howden Reinsurance Brokers Ltd. in London.

But the Ministry of Finance in Japan must approve new rates, so the rating system is stable, Mr. Iles said.

The Australian renewal season in July exhibited "a lot of competition and we saw some rate reductions," said Mr. Iles.

In preparation for the upcoming January renewal season in other countries, Mr. Iles met with representative of Ingosstrakh, the Soviet state-owned company that places all outward Soviet reinsurance, and clients from Bulgaria, Yugoslavia, Hungary and Poland.

While expecting property insurance rates to become more competitive, Mr. Iles predicted casualty rates will hold steady "because there is less capacity."

"Outside the United States, the market is softening," because of more capacity in all classes of business, reported Raanan Ben-Zur, chairman of Lloyd's of London broker PWS Group in London. "It doesn't mean that there are rate cuts, but there is more capacity."

However, he added that "capacity is not growing as much as in the rate cutting of 1983 and 1984, although there will be more than in 1986 and 1987. The only area with problems is casualty."

For example, PWS renewed in July reinsurance on a $1.5 billion property risk for a non-U.S. ceding company. The risk had been a problem to place for three years, but "this year, the renewal acted like butter. The account found more capacity than was needed with new reinsurance companies in Europe coming on board on a quota-share basis," Mr. Ben-Zur reported.

U.S. reinsurance brokers attending the Rendez-Vous also are interested in placing reinsurance for Europeans.

"We're trying to convince European buyers that there is still an American market for international business," said Ward Gordon, chairman of Intere Intermediaries Inc. in New York. Several major U.S. property/casualty companies are willing to write more international reinsurance, he said.

International business generates about 10% to 15% of Intere's business.

The European market is so attractive that E.W. Payne Cos. Ltd. is planning to expand its brokering operations there. Currently, the Sedgwick Group P.L.C. unit brokers reinsurance in London, the United States, Canada and Australia.

Jean-Francois Gelot recently joined Payne as director of the Overseas Group to develop offices in continental Europe for placing reinsurance in the domestic market.

Mr. Gelot was most recently an independent consultant and prior to that managing director of the Arthur J. Gallagher & Co. office in Bermuda.

A succession of small brokerage acquisitions is planned, Mr. Gelot said, with the first probably in Paris. ■

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Sale cheers Sphere Drake chief

By STACY SHAPIRO

MONTE CARLO, Monaco—Anyone who knows Ian Dean, chairman of Sphere Drake Insurance Group P.L.C., could spot his broad smile as he sauntered through the hotels, parties and restaurants during the 31st Rendez-Vous de Septembre.

Mr. Dean and a group of investors had just announced they were buying Sphere Drake from Alexander & Alexander Services Inc. after two years of serious negotiations and five years of anguish.

About 25% of the company will be owned by each of four groups: Mr. Dean and Sphere Drake directors; Dai-Tokyo Fire & Marine Insurance Co. Ltd. of Japan; Centre Investors, an investment affiliate of Lazard Freres & Co.; and Electra Investment Trust P L.C., a British investment trust (*BI,* Sept. 7).

Under the terms of the sale, A&A has agreed to finance 26 million pounds ($42.8 million) of the estimated 34 million pounds ($55.9 million) value of Sphere Drake and guarantee the loss reserves and reinsurance recoverables arising from 1986 and prior years.

Manufacturer's Hanover Trust is providing additional financing to the investor group, which is being advised by John C. Head III of John Head & Partners, who is credited with organizing the deal.

Under the terms of the agreement, the investors only had to come up with 8 million pounds ($13.2 million) to buy Sphere Drake, confirmed Mr. Dean.

The investors have as long as 10 years to pay the 26 million pounds ($42.8 million) back to A&A, said Isao Kuzuhara, associate director and general manager of the reinsurance department of the international operation of Dai-Tokyo.

The repayment of the money, however, is dependent on the future profits of Sphere Drake and any outstanding liabilities for which A&A is responsible under the terms of the sale.

A jovial Mr. Dean said at the Rendez-Vous, "The reception here has been fabulous. It is a joy to us because the struggle of five years is over. (Sphere Drake) could have been a problem for the marketplace if it had gone into runoff."

The negotiations are expected to be finalized this month and the sale will take effect Jan. 1.

A&A acquired Sphere Drake as part of its 1982 Alexander Howden Group P.L.C. acquisition and soon discovered that Sphere Drake was in the middle of the troubles at Howden.

Five ex-Howden directors were accused by A&A of allegedly using corporate assets to set up one or more companies in Panama to accept retroceded reinsurance from Howden reinsurance companies, including Sphere Drake (*BI,* June 27, 1983). Following the discovery of these problems, A&A was forced to bolster the reserves and increase the underwriting capital of Sphere Drake.

Recently, five men—including ex-Howden Chairman Kenneth V. Grob—have been criminally charged in connection with the transfer of "millions of pounds" from Howden and its subsidiaries prior to 1982 (*BI,* Sept. 14; July 20).

Mr. Dean arrived at Sphere Drake in January 1982, just "before the balloon went up." The company was technically bankrupt by the end of 1982, said Mr. Dean, who said he would have left Sphere Drake then if another opportunity had come along.

Now, in retrospect, "I wouldn't have missed the experience," he said.

With the help of A&A, Mr. Dean and the staff of Sphere Drake have turned the company around to become a well-respected insurer in the London market, observers attending the Rendez-Vous said.

Sphere Drake, which is authorized to write all classes of general insurance business by the British Department of Trade and Industry, increased its authorized share capital to 50 million pounds ($77.3 million) last year through a capital reorganization plan that was approved by the High Court in London.

At the end of 1986, the company showed pretax profits of just under 2.4 million pounds ($3.5 million at applicable exchange rates), up from an overall loss of 8.7 million pounds ($12.6 million) in 1985.

A&A first tried to sell Sphere Drake in 1985 and approached Dai-Tokyo, whose U.K. affiliate, Dai-Tokyo U.K. Ltd., has been managed by Sphere Drake Underwriting Management Ltd. since 1973.

"They asked me to buy Sphere Drake, but because of the past contingencies, no one knew what the future tab would be," said Mr. Kuzuhara.

Then, in March of this year, Dai-Tokyo was told that there was another potential buyer for Sphere Drake and became interested. "We are confident that Sphere Drake will make lots of money," said Mr. Kuzuhara. "Ian Dean and his team are a good underwriting team and everybody is happy in that way."

"A&A offered to finance the venture and we hemmed and hawed for about one-thousandth of a second and said yes," said Mr. Dean.

Mr. Dean said he is delighted with the group of investors who are purchasing Sphere Drake. "It is a shareholding group that understands insurance," he said.

The morale of the company, which employs 430 people, is very high, he added, and "the London market is pleased." ■

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Claims-made form now a 'dead issue'

By KATHRYN J. McINTYRE and STACY SHAPIRO

MONTE CARLO, Monaco—It's back to basics for using claims-made policy forms to underwrite liability risks, according to reinsurers.

Claims-made forms are appropriate for professional liability risks, directors and officers liability insurance and very hazardous liability risks, most reinsurance company executives say.

Just two years ago, reinsurers were almost unanimous that claims-made forms were needed to successfully underwrite most types of liability insurance in the United States.

Under a claims-made form, the insurer is liable only for claims made within the policy period, or reported within an extended reporting period.

Under the more prevalent occurrence form, the insurer is liable for all claims related to an occurrence during the policy period, regardless of when the claim is filed. Claims-made was intended to give insurers a clearer idea sooner of their liabilities and to allow them to more accurately price liability insurance.

"Claims-made is a dead issue," according to Francois Chavel, executive vp of Scor Reinsurance Co. in New York. Scor, which writes casualty reinsuranee for a mixture of large and smaller ceding companies, stayed with occurrence forms in recent years when others were promoting claims-made policies.

'Claims-made is a dead issue,' says Francois Chavel of Scor Reinsurance Co. in New York.

"Claims-made is a bust," said James E. Dwane, president of Prudential Reinsurance Co. in Newark, N.J.

"We always had dual facilities for occurrence and claims-made," Mr. Dwane noted. During the January 1987 renewals it became apparent that claims-made was not going to sell for run-of-the-mill general liability risks, he said.

Claims-made policy forms should be reserved for classes that generate long-tail exposures, such as errors and omissions, directors and officers liability and other professional liability coverages, Mr. Dwane said.

"Claims-made is dead for general lines, but not for certain lines," said Paul F. Butler, president of St. Paul Reinsurance Management Corp. About 15 to 20 hazardous industries must be written on a claims-made form under St. Paul's treaty requirements for ceding companies, he said.

Claims-made was "an overreaction," according to Ian Dean, chairman, chief executive and general manager of Sphere Drake Insurance P.L.C. in London. "Inevitably the market will go back to being a losses-occurring market," he said.

But, while Mr. Dean sees the demise of claims-made forms, he predicts the survival of certain reinsurance policy provisions that limit the liability of reinsurers, such as limited reinstatements and sunset clauses. While he expects these to be liberalized, he does not expect them to be eliminated.

Others disagreed, saying sunset clauses and limited reinstatement are being lifted.

Claims-made was no more welcome to corporate buyers in Europe than the United States. The London market tried to force the claims-made form on coverage for exports to the United States. European ceding companies balked and developed their own occurrence market in Europe.

"The claims-made form has not succeeded in Europe, and the occurrence form is being more and more used," said Ron Iles, chairman of Lloyd's of London broker Alexander Howden Reinsurance Brokers Ltd., a unit of Alexander & Alexander Services Inc. in New York. ■

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Rendez-Vous highlights new business ventures

By STACY SHAPIRO

MONTE CARLO, Monaco—The 31st Rendez-Vous de Septembre proved to be a good platform for reinsurers to announce new companies and arrangements that may provide additional capacity for U.S. and non-U.S. ceding companies next year.

For example, English & American Insurance Group P.L.C. announced that it is setting up a new underwriting agency to write property excess-of-loss treaty reinsurance business.

Northgate Underwriters Ltd. will underwrite for two British Department of Trade and Industry-licensed insurance companies. The insurers, which will put up 7.5 million pounds ($12.3 million) in capital each, are:

- Polygon Insurance Co. (U.K.) Ltd., a wholly owned subsidiary of aviation underwriter Polygon Insurance Co. Ltd. of Guernsey, which will have 70% participation on Northgate's slip. Polygon's major shareholders are KLM Royal Dutch Airlines, Scandinavian Airlines System and Swissair. Polygon has been a quota-share reinsurer of English & American for non-marine, marine and aviation business since 1986.
- Crombie Insurance Co. (U.K.) Ltd., which will write 30% of the Northgate slip, is a subsidiary of major Canadian property and financial services group Empire Co. Crombie. Crombie has been a quota-share reinsurer of English & American since January 1985 for non-marine, marine and aviation business.

In addition, English & American will write 15% of the qucta-share reinsurance of Polygon U.K.'s participation in Northgate. Other reinsurers will include Meadows Indemnity Co. Ltd., a captive owned by Gould Inc. of Rolling Meadows, Ill., confirmed Tony Taylor, managing director of English & American.

Northgate is part of the overall development plan of Polygon and Crombie in the London market, which has been considered for several years.

"Northgate starting now has nothing to do with market conditions, but with a business plan," said Mr. Taylor.

Also at the Rendez-Vous, *Business Insurance* learned that London-based Scor (U.K.) Reinsurance Co. Ltd. plans to set up an underwriting agency in London next year to write bankers blanket bond and building guarantee coverages on behalf of several companies.

Scor Underwriting Management Co. Ltd. will write Scor U.K.'s prominent blanket bankers bond business, said Scor U.K. Managing Director Jean-Bernard Fay.

In addition, Scor Underwriting Management hopes to find other European or Far Eastern companies for which to write, along with Scor U.K., to build up about 15 million pounds ($24.7 million) in capacity per risk in the next three to four years, said Mr. Fay.

Also at the Rendez-Vous:

- Two West German reinsurers announced a co-reinsurance agreement under which they will share a percentage of the reinsurance treaties they write beginning at year-end renewals.

The supervisory and executive boards of Eisen und Stahl Ruckversicherungs A.G. and Hannover Ruckversicherungs A.G. also are empowered to act for each other (*BI*, Sept. 7).

- Dr. Michael D. O'Leary attended his first Rendez-Vous to tell reinsurers and brokers about two companies he heads that write with American medical malpractice coverages. In April this year, the Paradigm Insurance Co. started writing onshore in Frankfort, Ind., the business of its predecessor, Medi-Trust Reinsurance Co. Ltd., which had been based in the Turks & Caicos Islands since July 1985, he said.

Paradigm, which writes medical malpractice coverage for emergency room physicians, will write at least $18 million in premiums this year.

In August, Paradigm also set up in Barbados Tri-Star Reinsurance Ltd., which is managed in Bermuda, with $1.2 million in paid-up capital. ■

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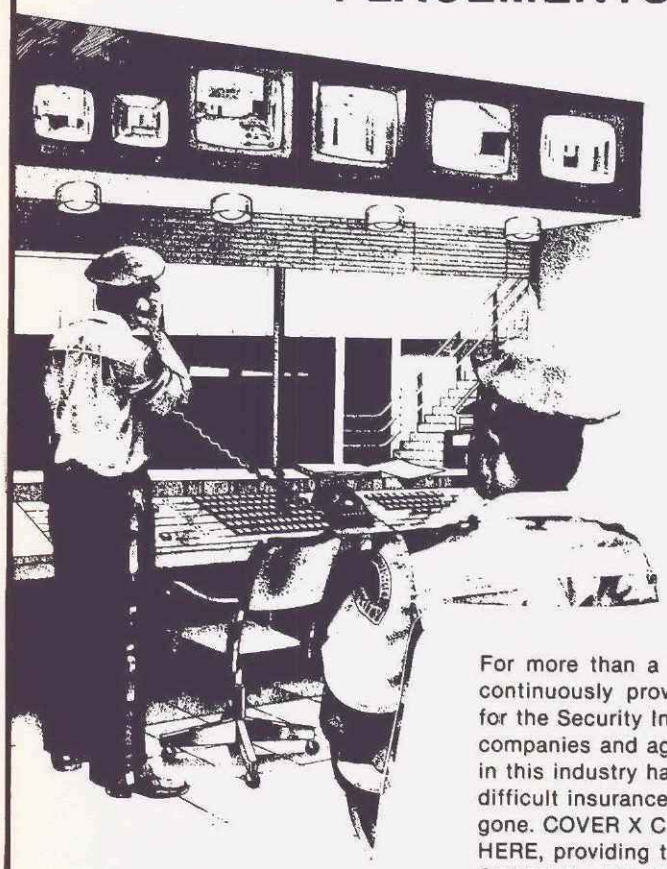

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OFFICES NATIONWIDE

Peru waters down nationalization proposal

By MARIA KIELMAS

LIMA, Peru—Peruvian insurers and domestic regional banks may be allowed to keep up to 70% private ownership under the latest draft of Peru's proposal to nationalize its insurance and banking industries.

The bill currently is being debated in the country's Senate, the upper house of the Peruvian Congress.

In July, President Alan Garcia had proposed that all Peruvian insurers be nationalized (*BI*, Aug. 17).

Insurance observers in Lima suggest that one reason the government relaxed its stance could be its difficulty in finding qualified staff to run newly nationalized insurance companies.

An insurance executive, who asked to remain anonymous, said, "They (the government) have enough trouble trying to find people to run the banks, let alone the insurance companies."

The nationalization bill was passed by the lower house of Congress, the Chamber of Deputies, and was expected to have passed the Senate earlier this month but has been bogged down in debate by such questions as which specific companies should be nationalized.

And, while the executive and legislative branches of Peru's government generally support the nationalization proposal, the judiciary is opposed.

Protests against the nationalization bill have also played a considerable part, as opposition to the bill has raised numerous stumbling blocks previously not considered by the government, sources say.

Over the last month, Peru has witnessed the most highly organized right-wing campaign against the government since the left-wing military government of Gen. Juan Velasco Alvarado from 1968 to 1975. That regime introduced sweeping land reforms and nationalized oil, mining, fishing and banking industries, which were returned to private enterprise by subsequent governments.

The protest movement, called Libertad, or Freedom, is led by Peru's most famous novelist, Mario Vargas Llosa. The campaign has succeeded in reviving the right-wing opposition, which was crushed by the ruling Allianza Popular Revolutionara Americana (APRA) in the 1985 elections.

In response to Libertad, President Garcia said that nationalization was not a move against freedom, but against control of finance in Peru by four powerful family groups in the country.

In an effort to restrict family shareholdings in the financial sector, the new nationalization bill stipulates that the maximum any individual may hold as a shareholder in insurance companies be between 1% and 2%, depending on the company's size.

The definition of an "individual" shareholder in the new bill includes parents, spouses, siblings and children.

Said one insurance company executive, "Not even a second cousin can be a shareholder."

In addition, trading of insurance and banking stocks was suspended on the Lima Stock Exchange by Peru's securities regulatory agency, CONASEV, shortly after the nationalization bill was first proposed July 28. However, a source in Lima said that limited, unofficial trading of the stocks is taking place.

According to President Garcia's Independence Day speech on July 28, state takeover was necessary because the financial sector was discriminatory in its investments and ignored Peru's developmental needs.

Both the financial sector and the government seem to agree that the Constitution demands fair cash payments before any properties are nationalized. But there is no agreement on the amount of payment.

The Banking Superintendency, which regulates the banking and insurance industries, stipulates very conservative accounting procedures, and assets of financial institutions are listed at purchase value, not market value.

Market sources in Peru suggest, however, that the true market value of insurers could be three or four times higher than the amount under consideration by the government.

Assets of the whole financial sector could be as high as $1 billion, observers say. Peru's total foreign debt totals $14.3 billion.

'We are all relieved to be keeping our jobs,' a Peruvian insurance executive says of the latest draft of the bill.

During the debate over the proposed nationalization law in the Chamber of Deputies, members suggested that the value of the insurance sector simply be taken as the difference between book assets and liabilities, thus paying no regard to the sector's substantial properties, including real estate, shares in industrial companies, shares in other insurance companies and shares in banks.

The government is still relying on support from the main opposition party, the United Left Alliance (IU), to push the nationalization bill through the Senate. The IU initially made this support conditional, calling for some form of amnesty for political prisoners.

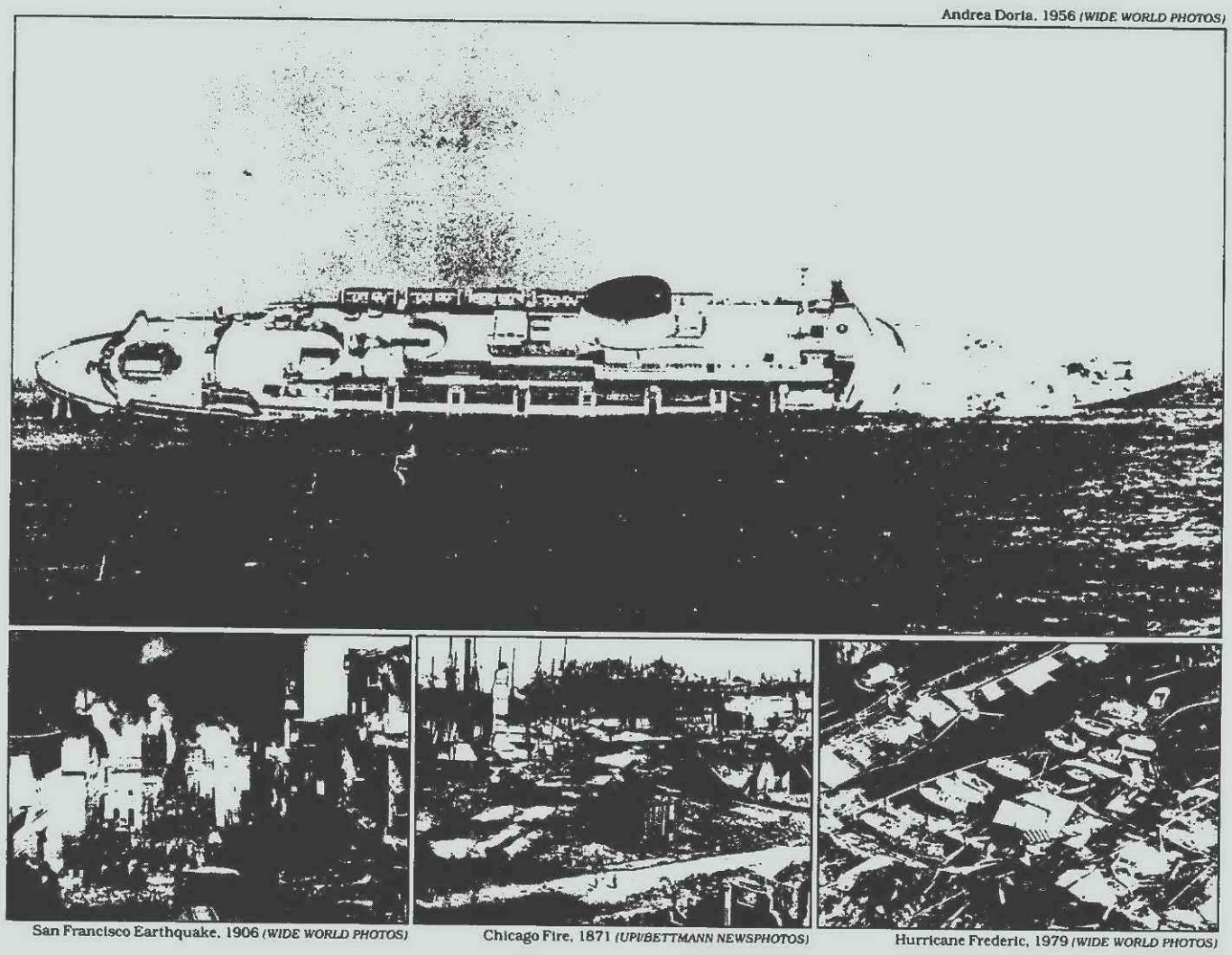
However, the offer was withdrawn following the recent assassination of a top government official, Rodrigo Franco, who headed the state food and agriculture agency, Enti, and was speculated to be the next head of Peru's Cultural Bank.

The ruling APRA party was split on the issue of nationalization, and political commentators in Lima say that the government does not wish to compromise any further with the left wing.

Another reason for easing the state takeover of insurers could be "they want to keep a door open" to the business community, *Business Insurance* was told.

South America's Interamerican Council of Commerce & Production and the Interamerican Federation of Insurance Companies have publicly asked President Garcia to reconsider his nationalization measures, which they said would only continue underdevelopment in Latin America.

An insurance executive who had been speaking to *Business Insurance* from the start of the nationalization debate, and who was trying to accustom himself to losing his job, said: "We are all relieved to be keeping our jobs. Over the last month we have lost a lot of weight and a lot of sleep." ■



Andrea Doria, 1956 (WIDE WORLD PHOTOS)

San Francisco Earthquake, 1906 (WIDE WORLD PHOTOS)

Chicago Fire, 1871 (UPI/BETTMANN NEWSPHOTOS)

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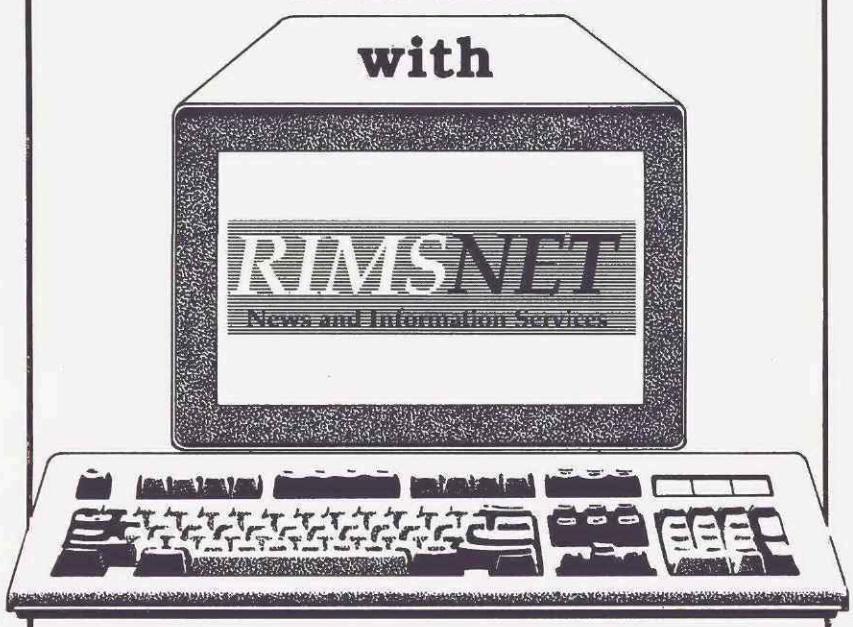

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Comings & goings: industry

Orr succeeds Hampton as CEO at UNUM Corp.

James F. Orr III, president of UNUM Corp. in Portland, Maine, has been named to the additional post of chief executive officer.

Mr. Orr succeeds **Colin C. Hampton**, who will serve as chairman of the board until he retires on Feb. 1.

UNUM has not yet named a successor to Mr. Hampton as chairman.

In other insurer changes:

D. Richard McFerson was promoted to executive vp-property/casualty insurance operations at Nationwide Insurance Co. in Columbus, Ohio. Previously, Mr. McFerson was senior vp-finance at Nationwide.

Eugene J. Ciarkowski promoted to vp-subsidiary operations and secretary at The Mutual Benefit Life Insurance Co. in Newark, N.J. Prior to his promotion, Mr. Ciarkowski was second vp, counsel and secretary. He also is vp and secretary of MBL Holding Corp., a wholly owned subsidiary of Mutual Benefit Life.

Darrell J. Baird joined Pacific Compensation Insurance Co. as vp and Northern California regional manager. Most recently, Mr. Baird was Northern California divisional manager for Argonaut Insurance Co. of Menlo Park, Calif.

James S. Mason named vp/general manager of St. Paul Fire & Marine Insurance Co.'s Cleveland service center. Previously, Mr. Mason was vp-general manager of the Des Moines service center. **Franklin R. Westpfahl Jr.** succeeds Mr. Mason as vp-general manager of the Des Moines service center.

Donald J. Dalebroux appointed vp and manager of the Pacific southwest region of Wausau Insurance Cos. in Los Angeles. Mr. Dalebroux succeeds **James Mainardi** who was promoted to senior vp-field operations. Mr. Dalebroux has served as regional claims manager of the Pacific Northwest region since 1972.

Also at Wausau, **David W. Stevens**, who has served as vp of the New Jersey region since 1983, has been appointed to serve as vp for both the New Jersey and New York regions. In New York, he succeeds **Hugh McGraw**, who died in July.

C. Lee Gabbert appointed vp-claims of Continental Insurance Co.'s agency group in Piscataway, N.J. Previously, Mr. Gabbert was senior vp-claims at UAC's home office in Piscataway.

Daniel A. Farrar joined Industrial Indemnity Co. in San Francisco as vp-workers compensation claims/rehabilitation. Before joining Industrial Indemnity, Mr. Farrar was corporate secretary and Western zone claims manager for The Home Insurance Co. in the company's Houston and New York offices.

Agents/brokers

P. Richard Hackenburg joined Corroon & Black of Massachusetts in Boston as executive vp and director of sales. Mr. Hackenburg is responsible for the direction and management of the production department. Previously, Mr. Hackenburg was staff vp and assistant treasurer at Allegheny International Inc. in Pittsburgh. Mr. Hackenburg is a past president of the Risk & Insurance Management Society Inc.

Mr. Hackenburg

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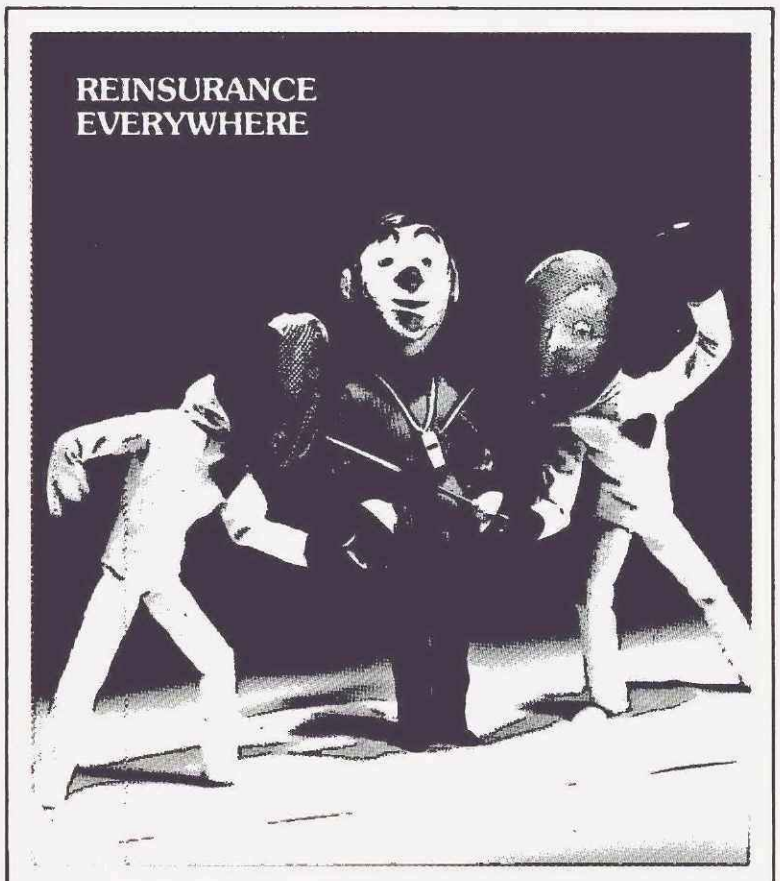

The Intermediary

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Also at Corroon & Black of Massachusetts in Boston, **Joseph Tarbell** named executive vp and director of servicing. Previously, Mr. Tarbell was a vp at Marsh & McLennan Inc. in Boston.

In addition, **Gary Stitham** named executive vp and director of marketing for Corroon & Black of Massachusetts Inc. in Boston. Previously, Mr. Stitham was a senior vp.

Peter Durkalski promoted to president of International Special Risk Services Inc., a division of Arthur J. Gallagher & Co. in Rolling Meadows, Ill. Previously Mr. Durkalski was vp of ISRS.

At Jardine Emett & Chandler Inc. in San Francisco, **Jeffrey Morgan** and **Sylvia Pearson** promoted to vps from assistant vps and **Brian Downie** joined as vp from Lincoln National Life Corp. in Fort Wayne, Ind. In the Los Angeles office, **Linda Walker** promoted to vp from assistant vp.

Steven R. Fuhrken promoted to vp at the Lockton Insurance Agency in Prairie Village, Kan. Mr. Fuhrken is an account executive involved in the marketing and servicing of commercial accounts in Lockton's commercial lines department. Also at Lockton, **John P. Mundy** promoted to vp.

Carol Capossela joined New York-based The Kornreich Organization as vp in the financial institutions division. Previously, Mr. Capossela was a risk manager at Reliance Group Holdings Inc. in New York.

Chas. J. Brannen appointed vp of structured settlement services in the New York office of Marsh & McLennan Inc. Previously, Mr. Brannen was West Coast manager in the Palo Alto, Calif., office of Benefit Designs Inc., a Cincinnati-based broker.

Theodore J. Fuller elected executive vp of the Pennsylvania Corp., a Philadelphia-based subsidiary of Johnson & Higgins. Previously, Mr. Fuller was senior vp and manager of the Costa Mesa, Calif., branch office of Johnson & Higgins.

In Johnson & Higgins' New York office, **Frank N. Laudani, Robert G. Kleckner Jr., Richard P. Lasko,** and **Alec A. Pandaleon** were elected vps.

Tom Tapin joined Frank B. Hall & Co. of Missouri Inc. in St. Louis as vp and assistant manager in the risk management unit. Previously, Mr. Tapin was underwriting manager for the national accounts department of Novato, Calif.-based Fireman's Fund Insurance Cos.

Reinsurance

James R. Horein elected senior vp from vp at the Lincoln National Life Insurance Co. in Fort Wayne, Ind. Mr. Horein is the director of special risks reinsurance in the company's reinsurance division. Mr. Horein also was elected a senior vp of Lincoln National Health & Casualty Insurance Co.

Peter A. Gentile named senior vp of Atrium Corp. in New York, a wholly owned subsidiary of North American Reinsurance Corp. He will be responsible for developing and marketing financially oriented property/casualty and life insurance products. In addition, Mr. Gentile was named vp for North American Re. Mr. Gentile was formerly a partner in Peat Marwick Main & Co. in New York.

Mr. Gentile

James W. O'Brien joined Nelson Hurst & Bailey, New York-based reinsurance intermediaries, as senior vp. Mr. O'Brien will be responsible for production of property and casualty reinsurance business.

At F&G Re Inc. in Morristown, N.J., the reinsurance unit of USF&G Corp., **Timothy J. Olson** and **Peter A. Dodge** promoted to vps from assistant vps.

W. Brant Chandler joined the Dallas office of Sullivan Payne Co. as vp-treaty producer. Previously, Mr. Chandler was vp in the Dallas office of Hileman, Justice & Co.

Excess/surplus

David E. Stahl joined Associated Risk Managers of Ohio Inc., a program-oriented wholesale brokerage in Worthington, Ohio, as executive vp. Previously Mr. Stahl was a broker at Montgomery & Collins in Columbus, Ohio.

Arthur J. Forenza Jr. promoted to executive vp of Glanvill Special Risk Insurance Brokers Inc., an affiliate of Jardine Emett & Chandler Inc. Mr. Forenza heads the San Francisco office of Glanvill, a New York-based wholesale brokerage. Previously, Mr. Forenza was a vp.

HMOs/PPOs

Dr. Jeffrey R. Weiner named executive vp of the health management division of U.S. Bioscience, a subsidiary of U.S. Healthcare Inc. in Blue Bell, Pa. Previously, Dr. Weiner was vp-medical delivery for U.S. Healthcare.

Michael J. Barone named vp-professional relations for INSURx Inc., a Cleveland-based pharmaceutical preferred provider network. Prior to joining INSURx, Mr. Barone was director of the prescription drug program for Blue Cross and Blue Shield of Ohio.

Other suppliers

At Buck Consultants Inc. in New York, **Thomas Boustead, Jeffrey T. Edwards, Pamela A. Jeffery** and **Kenneth P. Sengel** promoted to associate benefit consultants.

James C. Kiefer joined the Denver office of Buck Consultants as a consulting actuary. Mr. Kiefer comes to Buck from Powers, Carpenter & Hall where he was senior vp and manager of the welfare consulting division.

Arnold I. Turkheimer joined the Pittsburgh office of Buck Consultants as a communications consultant. Mr. Turkheimer comes to Buck from William M. Mercer-Meidinger-Hansen Inc. where he served as senior communications consultant.

At Dallas consultant Green & Associates Inc., **Kenneth Baker** elected president, **James R. Vice** elected vp and **Elaine K. Allen** elected vp. Ms. Allen will continue to serve as corporate secretary. **Robert L. Greene** who organized the firm in 1974 will serve as chairman of the board.

Derick Shoff appointed executive benefit consultant at the Johnson Cos. in Newton, Pa. Mr. Shoff is responsible for marketing executive benefit programs. Prior to joining Johnson, Mr. Shoff was a senior marketing representative for Trilog, a Philadelphia-based defined contribution plan consultant.

Minh D. Vu joined The Wyatt Co. in Chicago as a consultant in claims administration and audits. Prior to joining Wyatt, Mr. Vu spent six years with the Kemper Group in various underwriting and claims capacities.

Robert F. Rollins joined POMCO as director of sales and marketing in the White Plains, N.Y., office. Mr. Rollins is responsible for new client development and services. Previously, Mr. Rollins was assistant vp and director of commercial lines sales for Utica National Insurance Group in Utica, N.Y.

Ross Underdahl promoted to senior group representative at National Benefit Resources Group Services Inc. in Minneapolis. ■

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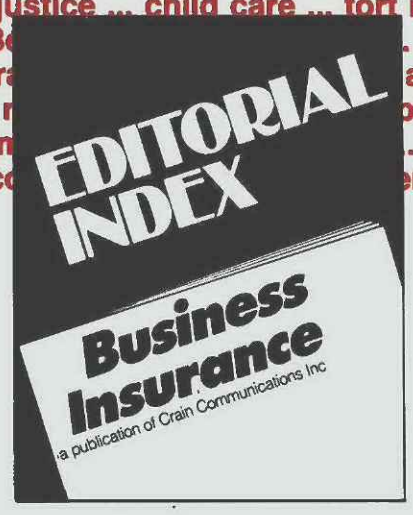

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Mentor suit

Continued from page 2

exercise in international forum shopping.

In a 43-page court memorandum, they argue that the fact that Bermuda law does not allow the treble damages available under the U.S. RICO statute does not make the island an inadequate forum for the suit.

The defendants claim that the liquidators have ignored Bermuda's strong ties to the dispute and its regulatory and economic interests in the resolution of the case. And, the defendants maintain that the liquidators are seeking to avoid the testimony of Bermuda-based non-party witnesses, who cannot be subpoenaed by any American court.

The defendants say that if their petition is successful they will agree to:

- Submit to the jurisdiction of the Bermuda court.
- Waive statute of limitations provisions, provided the action is begun in Bermuda within a year.
- A stay of any and all related legal proceedings in the United States.

Once in the Bermuda court, the defendants say they will call as witnesses Bermuda Finance Minister Clarence James, Registrar of Companies Verbena Daniels, Mentor's auditors Peat Marwick Main & Co. of Bermuda, former Mentor President John Boden, former Mentor Controller Angus Hyslop and many others parties in the dispute and vital to the defense.

In addition, they say that key documents—Mentor's business records and Peat Marwick's audit papers—are also in Bermuda under the control of the island's Supreme Court or the non-party witnesses.

The memorandum, which supports the petition and is signed by all of the defendants, says that one of the central issues in the case is whether, as the liquidators allege, Peat Marwick's Bermuda office was deceived into improperly accounting for the reinsurance contracts written by Pinnacle and giving balance sheet relief resulting in Mentor's loss reserves being understated so as to induce policyholders and ceding companies to place business with the ODECO subsidiary.

The liquidators allege that secret side letters existed between Pinnacle and Mentor, which effectively changed the contracts from risk-bearing instruments to mere deposit arrangements. Deposit arrangements do not qualify for balance sheet relief.

'Plaintiffs will have to prove their allegations that Peat Marwick Bermuda was deceived as to when Mentor could expect payments under the Pinnacle agreements,' the memorandum says.

"The principal non-party witnesses on the issue of liability will be the partners and staff of Peat Marwick Bermuda," says the memorandum. "Their understanding of the Mentor/Pinnacle agreements and the proper accounting treatment to be given to those agreements will be a central matter in the case.

"More importantly, plaintiffs will have to prove their allegations that Peat Marwick Bermuda was deceived as to when Mentor could expect payments under the Pinnacle agreements. The liquidators are apparently determined to cling to this allegation even though Peat Bermuda reviewed letters of credit which clearly documented that no payment would be made for 10 years," the memorandum says.

"Plaintiffs may wish to escape Peat Bermuda's testimony, but as a matter of fairness this case should be tried in Bermuda so that the defendants will have the opportunity to compel testimony from the Bermudian auditors."

The document goes on to say that evidence the defendants will be able to produce before a Bermuda jury will prove fatal to the liquidators' case. This evidence, they say, will be obtained from the staff of Mr. Kempe's own accounting practice, which the defendants allege has treated a Pinnacle-type contract entered into by Walton Insurance Co. Ltd. of Bermuda in exactly the same way as the Mentor agreements were treated.

Accordingly, Walton staff will be called to the witness stand, as will the officers and employees of Belvedere Insurance Ltd. and Tate & Lyle Reinsurance Ltd., both Bermuda-based underwriters.

Ms. Daniels and Mr. James will be called on to testify on the economic and regulatory context in which certain decisions were made in Mentor's winding-up proceedings. They also will be questioned about relationships between captives and their parents—evidence the defendants say is only available in Bermuda and will prove critical to issues involving piercing the corporate veil.

The memorandum argues that Bermuda's interests would be best served by having the case tried in a Bermudian court. Louisiana, by comparison, has little or no interest in the case, the defendants claim. They maintain that a jury trial will take "many months" and will place an onerous burden on Louisiana jurors.

Already, the case has generated thousands of pages of briefs and exhibits and seven volumes of the court record, the memorandum says. And, the document quotes a 5th U.S. Circuit Court of Appeals criticism of the Eastern District of Louisiana, which was admonished last year for accepting disputes between British insurers that should have been heard in the United Kingdom.

The defendants also argue that Bermuda has "a special interest in insurance accounting practices concerning reinsurance." They say that reinsurance agreements of the type at issue in the Mentor case are common to the Bermuda market and are marketed by reinsurers as tools used to strengthen the balance sheets of insurers in Bermuda, the United Kingdom and the United States.

"The proper method for reflecting such agreements in financial statements is a matter of utmost concern to Bermuda and its insurance industry," says the memorandum.

Arguing that Bermuda law applies in this case, the memorandum also points out that the New Orleans court will not be as familiar with the governing law and related regulatory principles as a Bermudian court would be. In addition, affidavits of British lawyers suggest the court will face difficult "first impression issues under that foreign law which would far better be left to the Bermudian courts to resolve," the memorandum says.

The memorandum was submitted on behalf of defendants Clovis H. Steib, Ronald W. Herman, Odie F. Vaughan, Herman S. Kelly, William L. Colson (deceased), J. Douglas Higley, Pinnacle, ODECO, Mentor Holding Corp., Hugh J. Kelly and James L. Kilpatrick. ■

Social Security program is biased: Study

DALLAS—The Social Security system is causing a massive shift of funds to whites from blacks and is unfairly taxing all American workers, who are paying more into the system than they will receive at retirement, according to two separate studies by the National Center for Policy Analysis.

Both studies indicate workers would do better if they were able to invest their retirement savings privately.

The studies were prepared by Peter Ferrara, a Washington attorney and leading critic of the Social Security system, and John Goodman, president of the NCPA, a Dallas-based public policy research organization.

The NCPA said black workers receive "far less" in benefits primarily because they have a shorter life span. As an example, the study said a white male entering the labor market today can expect to receive 74% more in Social Security retirement benefits and 47% more in Medicare benefits than a black male earning the same wage.

The study is based on 'common but incorrect actuarial assumptions that everyone lives to their expectations of life and then drops dead. They have said previously that blacks live to age 64 and then die,' says Robert Myers.

"Among children born today, only 58% of black males and only 75% of black females are expected to reach the age of 65."

According to the NCPA, a single black male, earning the median income, can expect to receive $27,743 in total benefits, measured in 1986 prices. A white male with identical wages can expect $40,610 in benefits—about 50% more.

"The effects of the welfare state are devastating for blacks in terms of the loss of Social Security benefits. In fact, the treatment of the two races by Social Security is so different, the very constitutionality of the system may be questioned."

However, Robert Myers, former chief actuary and deputy commissioner for the Social Security Administration, labeled this assertion "rubbish," and said race is "not always easily determinable" from Social Security rolls.

Mr. Myers said although he has not yet seen the study of black workers by the NCPA, "their work previously was faulty" and based on "common but incorrect actuarial assumptions that everyone lives to their expectations of life and then drops dead. They have said previously that blacks live to age 64 and then die. The assumption is an average which means half live longer and do draw extended benefits."

He said such studies also ignore survivor benefit payments.

Some organizations representing blacks have considered similar findings in the past, but after further study, agreed Social Security does indeed "help the lower-paid worker," he said.

Neither the National Assn. for the Advancement of Colored People nor the National Urban League offices in New York had any comment on the NCPA report.

In other findings, the NCPA said single workers earning the median income can expect to pay as much as $57,669 more in FICA taxes than they would receive in Social Security benefits.

A working couple, both earning average incomes, can expect to "lose" $82,814, while a professional couple, both of whose members earn high incomes, would pay in about $200,000 more than they would receive in benefits.

All the examples are based on persons 20 years old in 1986.

"In order to pay the benefits that have been promised to today's young people, as much as 38% of workers' incomes will have to be collected in payroll taxes during the next century," said Mr. Goodman. He said the prediction is based on projections by the Social Security Administration.

He also pointed out there will be a dwindling supply of workers to support Social Security beneficiaries in the next century.

In 1950, there were 48 million workers and only 3 million retirees, a ratio of 16-to-1; by 1979, the ratio of workers to beneficiaries was 3-to-1; and sometime in the next century the ratio will drop to 2-to-1 or lower.

Although Social Security is "a bonanza" for current retirees, the expected rate of return promised to workers at most age levels today "is abysmal when compared to the alternatives offered by the private capital market," the study said.

Mr. Myers said the study contains only time-worn criticisms.

"The problem with all these studies is that they view Social Security as a system where everyone gets back exactly what he puts in and they assume people can and would go out and invest that money at 6% real interest, which I don't think is possible over any extended period of time," he said.

Mr. Myers said the real interest earned by pension plans in general has been 2% to 3% for a 20- to 30-year period.

He said such studies often include Medicare costs and label the whole package a Social Security problem "and act as though it is all retirement benefits."

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Grace appeal

Continued from page 3

S.C., office of Blatt & Fales.

At issue in the Greenville case was a fireproofing product Grace manufactured called Monokote. Grace sold the product to the city and it was used in the construction of the Greenville city hall in the early 1970s.

Until May 1971, all of the Monokote that Grace sold contained asbestos. However, at that time, in response to concerns and publicity about health risks resulting from asbestos exposure, Grace began manufacturing a new type of Monokote without asbestos.

Asbestos-containing Monokote was applied to the steel beams of the new city hall constructed in Greenville beginning in November 1971, even though the asbestos-free Monokote had been on the market for approximately six months, according to the court.

In 1985, Greenville sued Grace seeking compensatory and punitive damages.

In February 1986, a U.S. District Court jury in Greenville awarded the city $6.4 million in compensatory damages, saying the company was negligent and breached an implied warranty. The jury also awarded the city $2 million in punitive damages (*BI*, Feb. 17, 1986).

The compensatory award was subsequently reduced to $4.8 million by the district court. After the judge in the case refused to grant a new trial, the company appealed to the 4th Circuit.

In a decision written by Judge Sam J. Ervin III, the three-judge panel of the appeals court—applying South Carolina law—first rejected Grace's contention that Greenville should not be able to recover for negligence because the city had suffered only an economic loss and there was no physical injury to persons or property.

Grace argued that Greenville's only recourse for damages from installation of the asbestos-containing product in a contract action is for breach of warranty.

However, the appeals court ruled that the installation of Monokote constituted contamination of the city hall with asbestos fibers, which endangered the lives and health of the building's occupants and that this enabled the city to bring a tort action against Grace.

"We think that the South Carolina courts would be willing to extend tort liability to the manufacturer whose product threatens a substantial and unreasonable risk of harm by releasing toxic substances into the environment, thereby causing damage to the property owner who has installed the harmful product in his building," the appellate court said.

"In this case, Greenville cannot be precluded from asserting a claim for negligence on the part of Grace simply because none of the occupants of the Greenville city hall has yet developed an asbestos-related disease.

"We think that a plaintiff such as Greenville should not be required to wait until asbestos-related diseases manifest themselves before maintaining an action for negligence against a manufacturer whose product threatens a substantial and unreasonable risk of harm. . . ." the court said.

Under South Carolina law, to establish a defendant is liable for a defectively designed product due to negligence or breach of warranty, a plaintiff must prove the product, as designed, was in a defective condition, was unreasonably dangerous to the user when it left the defendant's control and caused the plaintiff's injuries, the court said.

An additional requirement in negligence cases is that the plaintiff must prove the manufacturer breached its duty to exercise reasonable care to adopt a safe design. Taking into consideration evidence that the asbestos in Monokote was not particularly useful or desirable, that the fiber in Monokote had been identified as a potential health hazard and that the asbestos released into the city hall by Monokote posed a serious health risk for building occupants, there was sufficient evidence to find that the Monokote was unreasonably dangerous and defective, the court said.

There also was sufficient evidence to find that Grace knew of the risks associated with the asbestos-containing Monokote when it sold the products to Greenville, the court said.

The court also rejected Grace's claims that the $4.8 million compensatory award and the $2 million punitive award to the city were unsupported by the evidence.

The court said that the compensatory award—including $3.8 million to cover the cost of removing the Monokote from the city hall during a planned 12-year program and $975,000 to cover the projected cost of maintaining the Monokote in a safe condition before it is removed from the building—was proper.

The court said that the $2 million punitive damage award against Grace was reasonable given evidence that:

- Grace knew of the health risks associated with asbestos exposure when it sold Monokote to Greenville.
- Grace knew Monokote often failed to bond properly, thus creating a danger that asbestos fibers would be released into the Greenville city hall.
- Grace already had developed and had begun selling an asbestos-free form of Monokote in response to concerns and publicity about the health risks associated with exposure to asbestos.

"From this evidence, the jury reasonably could have concluded that Grace had acted willfully, wantonly or recklessly in selling the asbestos-containing Monokote to Greenville in conscious disregard of known risks associated with the presence of asbestos in the product," the court said. ■

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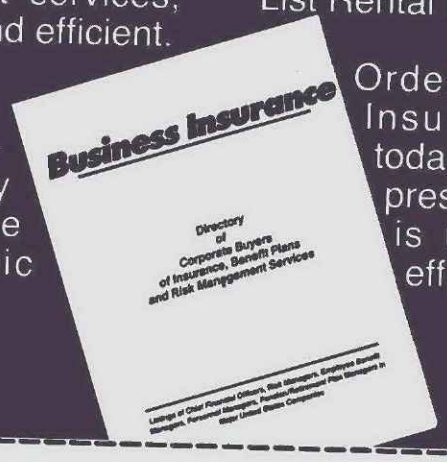

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Commonwealth suit

Continued from page 1

Commonwealth charges that Beneficial and the directors and officers learned of the alleged bribery, premium diversions and fraudulent loss runs in an investigation of the AEGIS program and that they deliberately concealed this information from Commonwealth.

James H. Gilliam Jr., general counsel for Beneficial, denied the charges in an interview.

"There is simply no merit to the allegations that Beneficial directors and officers conspired to do these things," he said.

"It is ridiculous for Commonwealth to assert that any such conspiracy even occurred," he added.

Separately, the U.S. Postal Service confirmed last week that it is investigating the AEGIS reinsurance program jointly with the office of the U.S. attorney for the Southern District of New York.

"It is in the investigative stage. We have been looking at the whole situation for a period of months," said Postal Inspector Robert Mignogna, who would not comment further on the nature or targets of the investigation.

ACIC itself sued The Underwriters and several other parties in U.S. District Court in Newark in 1984, charging that the MGA conspired to divert AEGIS premiums and to bind ACIC on portions of the AEGIS program without the insurer's knowledge (*BI*, Oct. 29, 1984). That lawsuit is still pending.

In addition, Commonwealth sued Beneficial and its directors and officers in July, charging that it was defrauded on reinsurance contracts covering business produced by another former ACIC managing general agent, Barrett Treaty Corp. of Huntington, N.Y. (*BI*, Aug. 3).

Beneficial has filed motions to dismiss the Commonwealth complaint or to stay the proceedings pending an arbitration of the dispute between Commonwealth and ACIC.

Commonwealth, meanwhile, has asked a judge in U.S. District Court in Manhattan—where it filed the July complaint against ACIC—to transfer the action to the New Jersey court.

To complicate matters even further, Commonwealth last Wednesday filed an identical complaint in U.S. District Court in Newark.

U.S. District Judge Charles S. Haight Jr. in New York last week was considering Beneficial's motion to stay and Commonwealth's motion to transfer.

Separately, Judge Haight gave ACIC 20 days to choose a new arbitrator in the Barrett dispute. ACIC had asked the court to enjoin arbitration proceedings after Commonwealth appointed an arbitrator on ACIC's behalf, claiming that ACIC had defaulted in its choice of an arbitrator.

Judge Haight voided Commonwealth's choice of an arbitrator on ACIC's behalf, but also concluded that ACIC's original choice was invalid.

Commonwealth has not paid ACIC claims on business produced by Barrett Treaty or The Underwriters since 1984. However, ACIC has not demanded arbitration on The Underwriters' book.

Commonwealth's latest complaint involving the AEGIS program names 43 defendants. In addition to ACIC itself, defendants include:

- The Underwriters; its owner, John A. Kraeutler; and two related companies owned by Mr. Kraeutler, John A. Kraeutler Inc. and J.A.C.K. Holding Co. Inc.
- Joseph F. Ambriano, who acted as a broker on the AEGIS account and who the suit says controlled New York-based Interamerica Reinsurance Corp. and Reinsurance Corp. of Panama, S.A., which reinsured ACIC on the AEGIS business.
- Richard Greene, treasurer of The Underwriters.
- R. Donald Quackenbush, former chairman of ACIC.
- Joseph L. Kelley and J.L. Kelley Inc. of Franklin Lakes, N.J., which acted as a reinsurance intermediary for ACIC.
- Beneficial and 32 of its directors and officers.

The Underwriters became one of ACIC's managing general agents in August 1977, the complaint notes.

In early 1977, a predecessor of AEGIS, General Assurance Services Ltd., had hired Guy Carpenter & Co. Inc. to place its reinsurance, the suit notes.

GAS Ltd. had suffered "extensive losses" since its formation in 1975, however, and Carpenter informed the captive later in 1977 that it was unable to find reinsurers willing to accept the risk.

In early 1978, GAS was reorganized, changing its name to AEGIS. However, AEGIS continued to have difficulty finding reinsurers, and Mr. Ambriano and Mr. Kraeutler, aware of the problems, "moved in to exploit that situation to their personal advantage," the complaint charges.

The complaint alleges that ACIC, The Underwriters and Messrs. Ambriano, Kraeutler and Quackenbush conspired to gain control over the "enormous stream" of premiums generated by AEGIS "in order covertly to divert millions of dollars in premium income to their personal use."

With the advice of Messrs. Ambriano, Kraeutler and Quackenbush—and aided by employees of Ebasco Risk Management Consultants Inc., the captive's manager—AEGIS structured an insurance program under which it offered utilities a $10 million liability limit, the suit says.

'There is simply no merit to the allegations that Beneficial directors and officers conspired to do these things,' says James H. Gilliam Jr., general counsel for Beneficial.

AEGIS retained the first $1 million per occurrence, reinsuring the remainder in layers of $1.5 million excess of $1 million; $2.5 million excess of $2.5 million; and $5 million excess of $5 million.

ACIC reinsured the entire $1.5 million excess of $1 million layer and also acted as a retrocessionaire of a Swiss Reinsurance Corp. unit on the two upper layers.

Two Ebasco employees were "corrupted. . .with various financial benefits to ensure their cooperation" in diverting AEGIS premiums to bank accounts controlled by Mr. Ambriano and Mr. Kraeutler, the suit charges.

One of the employees, Paul Wilson, was found dead of a cocaine overdose in a New York apartment in June 1983, according to the complaint.

In order to induce Commonwealth and other reinsurers to accept retrocessions from ACIC on the AEGIS program, Mr. Ambriano and Mr. Kraeutler had a summary of the captive's loss experience from December 1976 to May 1978 prepared, the suit says.

This loss run showed only one loss exceeding $1 million, where in fact more than 10 such losses had been reported to AEGIS, Commonwealth charges.

In May or June of 1978, Mr. Ambriano and Mr. Kraeutler met with Commonwealth's Bermuda representative "and offered him large amounts of money as a bribe to place Commonwealth behind Centennial as a reinsurer on the AEGIS program," the suit alleges.

Commonwealth's Bermuda MGA was Fordingbridge International Ltd., later known as Fordingbridge International Underwriters Ltd. Although the Commonwealth complaint does not name the Fordingbridge employee who accepted the alleged bribes, ACIC's suit against The Underwriters named Fordingbridge's president, Nicholas Jones, as a participant in the alleged scheme.

The bribe was to be paid from AEGIS premiums diverted by Mr. Ambriano, Mr. Kraeutler and others, and disguised as brokerage commissions ostensibly paid for the placement of AEGIS reinsurance with ACIC, according to the complaint.

Neither Mr. Ambriano nor Fordingbridge actually performed any brokerage function, though, and AEGIS itself did not believe any commissions were being paid on the ACIC placement, the suit says.

Between 1978 and 1983, more than $4 million was paid to Commonwealth's agent, some of which the agent kept and some of which was passed to Mr. Ambriano, Mr. Kraeutler, Mr. Greene—The Underwriters' treasurer—and others, Commonwealth alleges.

As a result of the alleged bribes, the complaint charges, the Bermuda MGA bound Commonwealth to a $100,000 participation on the $1.5 million excess of $1 million layer, and to a 10% participation on an ACIC property/casualty quota-share treaty.

Although the quota-share treaty did not specifically cover AEGIS-related risks, ACIC planned to cede its own retention on the $1.5 million excess of $1 million layer into the treaty, "thereby shifting virtually all of its risk to its reinsurers," the complaint says.

Among those participating in the alleged concealment of AEGIS losses were Messrs. Ambriano, Kraeutler, Greene, Quackenbush, Wilson and Kelley, ACIC and J.L. Kelley, its reinsurance intermediary, the suit says.

As early as 1978, the complaint says, some of ACIC's reinsurers other than Commonwealth were aware that AEGIS claims exceeding $1 million were being concealed.

When representatives of one of these reinsurers, Colonial Assurance Co. of Elkins Park, Pa., asked Mr. Ambriano for an explanation of the unreported claims, Mr. Ambriano denied their existence, the suit says.

The complaint does not identify the Colonial representatives, though Louis Mazzella—who owned Colonial through two holding companies—has identified himself as the source of this information.

Colonial was declared insolvent by Pennsylvania regulators in 1984, and Mr. Mazzella is currently facing federal charges that he defrauded ACIC of $2.4 million in AEGIS reinsurance premiums.

At some point prior to 1980, Mr. Mazzella—after being "stonewalled" by Mr. Ambriano and Mr. Kraeutler—informed Donald K. Smith, an ACIC senior vp, that AEGIS claims reported to reinsurers in the $5 million excess of $5 million layer had not been reported to lower-level reinsurers, the suit says. Mr. Smith said he would look into the matter, but ACIC never apprised its reinsurers of the situation, according to the complaint.

Mr. Mazzella subsequently advised Ronald C. Ade, then ACIC vice chairman, of the suspected fraud. Mr. Ade—who was already concerned about inadequate claims handling procedures at ACIC—met with Mr. Kraeutler in November 1981 to discuss the AEGIS program, the suit says.

After this meeting, Mr. Kraeutler called Mr. Mazzella "in an effort to suppress Colonial's questioning," according to the suit. "Kraeutler told Colonial that its efforts were fruitless because Ade would shortly be fired. Quackenbush fired Ade in November 1981 before he could complete his investigation," and ACIC continued to conceal AEGIS losses from its reinsurers, the suit charges.

Beneficial and its directors and officers started their own investigation of the AEGIS program not later than 1981, and the official in charge of the investigation reported directly to Finn M.W. Caspersen, Beneficial's chairman, the suit says.

Beneficial later fired Mr. Quackenbush and other ACIC officers.

ACIC terminated its MGA agreement with The Underwriters as of June 1, 1983, and canceled its then-existing reinsurance contracts on the AEGIS program effective Dec. 31, 1983.

Commonwealth's participation on the reinsurance program also ceased as of Dec. 31, 1983, the suit says.

Commonwealth in 1984 asked ACIC to allow its auditor, Coopers & Lybrand, to audit records on the AEGIS program, but ACIC refused and has continued to refuse Commonwealth access to records, the suit claims.

The complaint charges all the defendants except Beneficial and its directors and officers with violations of the federal Racketeer Influenced and Corrupt Organizations Act.

Commonwealth's suit also charges all defendants except Beneficial and its directors and officers with fraud, intentionally inducing Fordingbridge to violate its duties and commercial bribery under New York and New Jersey statutes.

Beneficial—accused of knowing of the alleged conspiracy and failing to notify Commonwealth—is charged separately with fraud, negligence and breach of fiduciary duty.

If Commonwealth fails in its attempt to have the reinsurance agreements canceled from inception, the suit asks that the defendants be ordered to indemnify it for losses paid under the contracts.

Messrs. Kraeutler, Quackenbush, Kelley and Jones and officials of ACIC could not be reached for comment on this story, though Mr. Kraeutler has previously denied similar allegations leveled in ACIC's complaint against The Underwriters.

Mr. Ambriano also denied that allegations in an interview last week.

"Why would I bribe a man to write a $100,000 line part of $1.5 million? It's ridiculous," Mr. Ambriano said.

Mr. Ambriano added that AEGIS loss runs had been prepared by Ebasco and a New York law firm, and were not his responsibility.

"The Commonwealth must be desperate to get out of the business that Mr. Jones wrote for them," Mr. Ambriano observed. "They are just looking for somebody else to blame, and I guess I'm one of the guys they're trying to blame."

In an affidavit filed in ACIC's suit, Fordingbridge's Mr. Jones also offered an explanation of the commissions that ACIC and Commonwealth have described as diversions of premium.

In the July 1985 affidavit, Mr. Jones said that Mr. Kraeutler planned to move a Cayman Islands-based insurer he owned to Bermuda and to increase the insurer's capital and surplus.

In order to capitalize Island Reinsurance Co., Mr. Kraeutler asked Mr. Jones to retain in Bermuda a portion of the commission otherwise payable to The Underwriters. To accomplish this, the affidavit says, Mr. Kraeutler proposed increasing Fordingbridge's commission to 12% from 10% and reducing The Underwriters' commission to 5% from 7%.

Mr. Jones agreed to this after being assured that the plan would not violate U.S. tax laws, and paid the retained funds to Mr. Kraeutler in cash on a few occasions before insisting that he open a Bermuda bank account, according to the affidavit.

Mr. Jones said that he believed that all commission payments had been reported to ACIC and that ACIC had sanctioned Mr. Kraeutler's Island Re plan. ■

Canadian RIMS chapter elects officers

CALGARY, Alberta—The Southern Alberta Chapter of the Risk & Insurance Management Society has elected new officers for the 1987-1988 term.

Elected president was Michelle Waldner, insurance representative of Shell Canada Ltd. in Calgary. Last year, Ms. Waldner was vp-program director of the Southern Alberta RIMS chapter.

Other new appointments include:

- **Don Johnson, coordinator of risk management of Home Oil Co. Ltd. in Calgary, named vp and education director. Mr. Johnson previously was secretary of the chapter.**
- **Zain Bond, manager-administration of Morgan Hydrocarbons Inc. in Calgary, named secretary.**
- **Shirley Shigematsu, supervisor of administrative services at Panarctic Oils Ltd. in Calgary, named treasurer. Ms. Shigematsu held the same post last year.**
- **Linda Barron, insurance risk analyst at Canterra Energy Ltd. in Calgary, named house director.**
- **John Buysschaert, manager-corporate insurance at Trizec Corp. Ltd. in Calgary, named legislation director. Mr. Buysschaert had been president of the chapter.**
- **Juliane Charrett, coordinator-insurance and property taxes at BP Resources Canada Ltd. in Calgary, named membership director. Ms. Charrett held the same post last year.**
- **Pat West, risk analyst at Trizec Corp. Ltd. in Calgary, named social director. Ms. West held the same post last year.**
- **George Simpson, risk manager-Western division of The Co-operators Group in Calgary, named program director and national chapter representative. Mr. Simpson held the post of chapter representative last year.**

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Asbestos cover

Continued from page 2

Mr. Heap said it was likely that Raymark would seek a rehearing by the state Supreme Court.

But an attorney for policyholders applauded the court's decision on the trigger of coverage.

"It is a very favorable decision," said Eugene R. Anderson, with the New York firm of Anderson, Russell, Kill & Olick. "It is another one of a string of victories where the policyholder got virtually what it asked for."

Attorneys for insurers also praised the decision because of the finding that insurers have no duty to defend new or pending asbestos cases after a policyholder's coverage limits are exhausted.

"The court made crystal clear that in pre-1967 and post-1967 (policies) when the aggregate is exhausted, insurance companies no longer have to defend these cases," said Peter John, with the Chicago firm of Phelan, Pope & John, which represents Zurich.

In addition, Mr. John said that even though the court did not adopt Zurich's position on the trigger of coverage—a variation of the exposure theory—it was significant that the court's decision was based on the contract language rather than on insurance law principles that grant broad coverage to policyholders.

Another attorney for insurers, who asked not to be identified, said that Raymark suffers significantly by the court's decision on the duty to defend issue because while excess insurers will have to pay Raymark's defense costs, those insurers will reduce the amount of coverage available to Raymark by those costs.

"It gives Raymark a victory on the coverage part but a horrendous defeat on the duty to defend part," said an attorney for insurers close to the litigation, who added: "On balance, Raymark loses more on that issue than it gained on the trigger issues."

Raymark, which currently faces approximately 26,000 asbestos lawsuits, has about $130 million of liability coverage remaining. Recently, it settled about 20,000 cases for approximately $56 million—about $2,800 per case. But it is currently offering settlements of only about $542 per case on average, said Mr. Young, the company's general counsel.

Raymark's primary liability insurers beginning in 1941 were Employers' Liability Assurance Corp., the predecessor of Commercial Union Insurance Co., from 1941-1945 and 1947-1950; Globe Indemnity Co., 1950-1951; Federal Insurance Co., and its predecessor, United States Guarantee Co., 1951-1967; CU, 1967-1969; and Zurich Insurance Co., from 1969-1982.

'It gives Raymark a victory on the coverage part but a horrendous defeat on the duty to defend part,' says an attorney representing insurers. 'On balance, Raymark loses more on that issue than it gained on the trigger issues.'

In 1978, Zurich filed a declaratory judgment action against Raymark, Federal and CU asking the court to construe various coverage and defense issues concerning asbestos claims filed against Raymark. Northbrook and Globe subsequently entered the litigation.

In 1982, Raymark filed a counterclaim for a declaratory judgment against Zurich, CU, Federal and Globe, seeking a ruling on coverage and defense obligations.

Among the major issues in the case were when "bodily injury, sickness and disease" occur under the liability policies, thereby triggering coverage.

Zurich and Northbrook argued for variations of the exposure theory—that bodily injury occurs when a person inhales and retains asbestos fibers in the lungs.

However, Zurich further argued that there should be a pro-rata allocation of indemnity and defense costs of each claim among the triggered policies.

Federal argued that an insurer must provide coverage only if the claimant's disease is manifested during the policy period.

CU argued each case must be examined individually and that the insurance in force at the time when asbestos claimants allege they suffered injuries must respond.

Raymark sought triple-trigger coverage: The company argued there is continuing bodily injury from exposure through the time a claimant files an action alleging an asbestos-related disease, and thus any insurer on the risk during that time must respond.

In 1983, Cook County Circuit Court Judge James C. Murray ruled that coverage for Raymark was triggered both during the period when a victim inhales asbestos and when the disease is manifested in a victim—often many years later (*BI*, Oct. 10, 1983).

Raymark and various insurers subsequently appealed parts of the lower court's decision, while insurers also appealed a later ruling by Judge Murray that said under pre-1967 primary policies the duty to defend Raymark continued beyond exhaustion of policy limits.

Last year, an Illinois appellate court affirmed Judge Murray's decision on the triggers of coverage being exposure and manifestation, and potentially during the interim period as well (*BI*, June 2, 1986).

However, the appellate court overturned Judge Murray's ruling that insurers had a duty to defend policyholders after they had exhausted the limits of liability under their policies.

Zurich, Raymark and Northbrook appealed the decision to the state Supreme Court.

The high court first affirmed the ruling that coverage is triggered at exposure, manifestation and possibly during the latency period.

"The evidence in the record amply supports the circuit court's finding that 'bodily injury' occurs when asbestos fibers are inhaled and retained in the lung," the court said. "We therefore conclude that an insurer whose policy was in force at the time a claimant was exposed to asbestos must provide coverage for the claim."

In addition, the court said that given the ordinary meaning of the term "disease," the evidence supports the conclusion that disease occurs, and therefore triggers coverage, when it is manifested—when a disease is reasonably capable of being diagnosed.

And, the court agreed with the circuit and appellate courts that between exposure and before manifestation, asbestos victims could be classified as having a "sickness" but whether that sickness triggers coverage must be determined on a case-by-case basis.

The court specifically rejected Raymark's contention that the triple-trigger theory should be adopted for every case.

"Both the circuit court and the appellate court properly rejected Raymark's contention that those who ultimately manifest an asbestos-related disease necessarily sustained 'bodily injury' between the time when they were no longer exposed to asbestos and the time when their disease manifested itself," the court said.

But the court accepted Raymark's contention that each insurer whose policy is triggered is jointly and severally liable for total indemnity and defense costs of a claim without proration.

The court also affirmed the appellate court opinion that the insurers writing pre-and post-1967 policies had no duty to defend Raymark for new or pending cases after policy limits were exhausted.

"We conclude that pursuant to the plain and unambiguous terms of the policies issued before September 26, 1967. . .the insurers' duty to defend suits against Raymark is subject to the liability limits of those policies and is further limited to the defense of claims with respect to which insurance is afforded by the policies.

"Once the applicable indemnity limits of a policy are exhausted by the payment of judgments or settlements, no insurance is afforded by that policy.

"We therefore hold that when an insurer has properly exhausted its policy limits by the payment of judgments and/or settlements, it is no longer obligated to defend any actions against Raymark, whether such actions are pending at the time of exhaustion or commenced thereafter," the court ruled.

While the state Supreme Court decision settles the issue on the trigger of coverage and the duty to defend, there are still numerous issues pending before lower courts.

"This case is far from being over," Mr. Young pointed out.

For example, Raymark is seeking reimbursement of more than $20 million of defense and indemnification costs from insurers for amounts it spent prior to court-ordered funding of those costs by insurers.

Also to be decided is if certain excess insurers that wrote coverage above the layer written by insolvent insurer Transit Casualty Co., which is in liquidation in Missouri, must begin providing coverage.

Zurich also is looking to recover a portion of $17 million in defense costs from Federal and CU that Zurich has paid. ■

Willis Faber resignations

Continued from page 3

and John Sicely, group secretary.

The departure of the four Stewart Wrightson directors followed by one week the resignation of Alan Colls, chairman of Stewart Wrightson Ltd., who earlier this month turned down an invitation to join the board of the merged companies and relinquished his executive responsibilities with Stewart Wrightson (*BI*, Sept. 14).

His departure rocked the London market, whose members had expected that he would stay with the merged company (see story, page 81).

Stewart Wrightson's specialist aviation reinsurance brokerage subsidiary, Nicholson Stewart Wrightson, also will not be part of the merged companies.

Three directors who own 49% of Nicholson Stewart Wrightson, including Managing Director Martin Nicholson, have decided to exercise their option to acquire the remaining 51% stake held by Stewart Wrightson Holdings.

Willis Faber's handling of Nicholson Stewart Wrightson was one of the reasons behind Mr. Colls' resignation. He had helped establish the subsidiary and served as its chairman in addition to his other duties at Stewart Wrightson.

"I was not happy with the way the merger was being handled in the areas in which I was directly involved. I cannot join a board unless I know I can give 150%," Mr. Colls said.

"I was ultra-enthusiastic about the merger. I felt that if handled properly the combined company would be unbeatable in the world."

However, Mr. Colls said, "although Stewart Wrightson has had three mergers in its recent history, Willis Faber has had none and has had no experience of creating a combined group."

Mr. Colls hopes his action will help the company "make the right decisions" in the future.

"I hope this will pull the board together. There are still many areas where decisions have to be made, and I very much hope they will get them right," he said.

Mr. Colls said he would not join Nicholson Stewart Wrightson, where his role "was mainly non-executive." Although he has no definite plans for the future, "it's pretty safe to say I'll still be in the (insurance) business," he said.

Mr. Nicholson and fellow Nicholson Stewart Wrightson Directors B. Stewart-Brown and Richard Holt are buying the remaining 51% of the company for 3.5 million pounds ($5.8 million), Mr. Nicholson confirmed.

Nicholson Stewart Wrightson employs just under 50 people, all of whom will remain with the company, said Mr. Nicholson. The company reported aftertax profits in 1986 of 1.9 million pounds ($2.8 million), he said.

The directors decided not to sell their 49% stake to Willis Faber primarily because Willis Faber's "value of our company differed from the value we. . .gave to it," said Mr. Nicholson.

Observers also pointed out that Willis Faber and Nicholson Stewart Wrightson have vastly different management styles.

Mr. Rowland, who is now a deputy chairman of Willis Faber, said he was saddened by the departures.

"Each person on the board of Stewart Wrightson believed that it was the right thing to do for shareholders" he said, referring to the decision to sell the company.

Meanwhile, Willis Faber last week told employees at both companies that:

- Stewart Wrightson North America Development Ltd., which is responsible for handling North American retail business in London, will remain a separate company under the Willis Faber holding company.

The unit's chairman will be Simon Harrup, who was chairman of the North American division of Stewart Wrightson and is a member of the new Willis Faber board. Nigel Chamberlain, who joined Stewart Wrightson after resigning as chairman of C.E. Heath P.L.C.'s North American division, will be managing director.

- General reinsurance brokerage subsidiary Golding Stewart Wrightson Ltd. will be absorbed into Willis Faber's reinsurance division.
- Stewart Wrightson North America Holdings Ltd., which includes U.S. surplus lines brokerage Stewart Smith Holdings Inc., will be part of a new division called Willis Faber International. Viscount Chelmsford, a Willis Faber director and chairman of Willis Faber International Ltd., will be chairman of the division. Pat Osborn, chairman of Stewart Wrightson North America, and H.V. White-Smith, deputy chairman of Willis Faber International, will be deputy chairmen.
- Roger Elliott, who will be joint Willis Faber deputy chairman with Mr. Rowland after Dick Bowes retires at the end of the year, will be chairman of Willis Faber's powerful aviation division. John Palmer-Brown, chairman of Stewart Wrightson Aviation Ltd., and Martin Hedley, deputy chairman of Willis Faber's aviation division, will be deputy chairmen. ■

Grant Thornton

Continued from page 3

Home State Savings—E.S.M.'s largest creditor—failed shortly thereafter, having sustained losses of about $147 million on investments with E.S.M.

In addition, about 70 other Ohio savings institutions closed temporarily. Several municipalities that had invested with E.S.M. also suffered losses.

Overall, E.S.M.'s creditors suffered roughly $315 million in losses.

Shortly after E.S.M. was shut down, a court-appointed receiver for E.S.M. sued Grant Thornton, then known as Alexander Grant & Co., and one of its partners for $300 million in compensatory and unspecified punitive damages. The suit charged the accounting firm with "gross negligence" in conducting audits and preparing reports for E.S.M. and a related company.

A former Grant Thornton managing partner for South Florida pleaded guilty to fraud charges in 1985 that he received $200,000 from E.S.M. officials for certifying false financial statements about the securities firm.

The official admitted that he knew as early as 1979 that some of the information he certified as correct was false.

Ohio authorities also sued Grant Thornton in an attempt to recover the money it had to pay depositors after Home State failed. In addition, the municipalities involved in the affair sued the auditor to recover their losses.

In all, about 20 suits were filed.

Several insurers and brokers last week said the proposed settlement probably will not have a great impact on the already tight market for accountants' professional liability insurance, though insurers may become even more leery of accountants involved in work for securities firms monitored by the Securities and Exchange Commission.

Whether the proposed settlement will set a legal precedent for accountants' liability is particularly critical to the stability of the market, according to Richard Cowan, vp with Fred S. James of California in San Francisco.

"A case that does not set precedent might not have a great long-term impact on the market," Mr. Cowan said.

"I don't anticipate it having much of a fallout," said John Dodsworth, president of CAL Accountants Mutual Insurance Co. in Palo Alto, Calif., and the director of finance and administration for the California Certified Public Accountants Society.

He said he would be "very surprised" if the settlement has any major financial repercussion on the accountants professional liability insurance market as a whole."

"By the time you slice up the settlement among all the insurers, the piece that any one end-of-the-line reinsurer ends up with is very small."

He added, however, that the sheer size of the proposed settlement might make some insurers "leery of accounts involving the larger accounting firms."

Mr. Cowan agreed. He said a settlement the size of the tentative proposal "will probably have some reverberations in the market, especially for large accounting firms."

Jim Knupp, assistant vp at Chicago-based Crum & Forster Management Corp. (Ill.), would not speculate on the effect of the settlement on the market as a whole.

He did say, however, "I would not anticipate the Grant Thornton case would have a significant impact on our approach to the marketplace."

CFMC (Ill.), an underwriting management subsidiary of Crum & Forster Inc., underwrites the professional liability insurance program sponsored by the American Institute of Certified Public Accountants in New York.

"The only impact will be on the London view and the reinsurance view of Big Eight accounting firms," said Michael Silchuck, vp of Herbert H. Landy Insurance Agency Inc. of Needham, Mass.

The Landy agency administers a professional liability program sponsored by National Society of Public Accountants of Alexandria, Va. The program is written by Chicago-based Transportation Insurance Co., a subsidiary of Continental Casualty Co., a CNA Financial Corp. unit.

Mr. Silchuck says that his firm handles insurance for only small firms with five or fewer accountants. "We stay away from people with heavy auditing," he says. "We don't write firms that do SEC work."

Because of the nature of the market the Landy agency serves, the tentative Grant Thornton settlement "wouldn't have any direct impact" on its program, Mr. Silchuck said.

However, Nicholas Gassman, assistant marketing director for Professional Liability Underwriting Managers Inc. of Minneapolis, a Corroon & Black Corp. subsidiary, thinks the settlement could have a considerable impact on underwriters.

"I don't know if it's going to affect rates, but I do think it will affect underwriting. Any company that takes an $80-million hit is going to look at writing that sort of risk again with a raised eyebrow," he said.

Mr. Gassman predicted that although the settlement will not affect PLUM, insurers "are going to scrutinize underwriting more." He said he thinks accountants who do a moderate amount of work for firms monitored by the SEC may find coverage harder to obtain.

Mr. Gassman said small firms generally stay away from SEC work and firms that draw a large portion of their accounts through SEC work generally will have the expertise to avoid trouble.

"Experience counts," Mr. Gassman said. "It's the guy with 10% or 15% of his accounts in SEC work who might burn you. He might be the flamethrower."

"It does open people's eyes," he added. Insurers "are going to say 'Hey, accountants can take a big hit like any other professionals.' "

PLUM writes accountants' professional liability coverage with limits of up to $50 million.

Mr. Silchuck of Landy Insurance Agency also observed that even before the Grant Thornton tentative settlement, the accountants professional liability insurance market "is a very limited market. There were upwards of 10 companies competing for the business in the early 1980s, now there are only a handful competing on a national or even regional or state-by-state basis."

Mr. Cowan of James also noted that "the market is still tight, but there appears to be a stabilizing market for small to medium-sized firms." ■

ISO to withdraw Ohio rate filing

COLUMBUS, Ohio—The Insurance Services Office will withdraw its product liability rate hike request in Ohio following the state Insurance Department's objection that the rates were excessive and not substantiated.

The rates, submitted by ISO on March 1, called for a 30.6% combined increase in product liability rates. ISO had requested no increase in the base rate on bodily injury and a 40% increase in the property damage base rate.

However, the Insurance Department's actuarial firm, the Tillinghast Division of Towers, Perrin, Forster & Crosby Inc. of Darien, Conn., found ISO's combined rate increase to be excessive and lacking in sufficient substantiating data, said Peg Ising, assistant director of the department.

Tillinghast estimated an 11.9% decrease in the bodily injury base rate and an 8.8% increase in the property damage base rate would be more appropriate.

George Fabe, director of the Insurance Department, instructed ISO to withdraw the filing by Sept. 1 or face an administrative hearing. ISO agreed and submitted a filing that, in effect, rolled rates back to 1986 base rates.

The state has given ISO 60 days to inform its member insurers of the rate change, Ms. Ising said.

Around the states

ISO acts as a rating bureau for approximately 280 member companies licensed in Ohio.

—By Laura Mazzuca

'Excess profits' cited

COLUMBIA, S.C.—Rate cuts or changes in annual filings could be ahead for nine commercial insurers cited by the South Carolina Department of Insurance for "excess profits."

Chief Insurance Commissioner John G. Richard's office investigated the companies after actuaries reviewed the insurers' 1985 and 1986 annual statements, which prompted the department to request information for the three years preceding those reports.

The records showed that 35 major property/casualty insurers may have earned "excess profits" during the "insurance crisis" of 1985 and 1986, according to the department. Other companies are expected to be named by the Insurance Department.

While the deadline for insurers to request hearings was last week, a department official said several companies were likely to be granted extensions.

"We'll listen to what the companies have to say. We don't know if any rates will be cut," said Joe Barnett, special assistant to the commissioner. Mr. Richards will "have to make up his own mind about ordering reductions," Mr. Barnett said.

The Insurance Department cited the following companies for "excess profits" in the following lines:

- Commercial multiperil lines: Hartford Accident & Indemnity Co. and Hartford Fire Insurance Co., both units of Hartford Insurance Group; Liberty Mutual Insurance Co.; and North River Insurance Co. and Westchester Fire Insurance Co., both units of Crum & Forster Inc.
- "Other" liability lines: Great American Insurance Co., a unit of American Financial Corp.; International Insurance Co., another Crum & Forster unit; National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc.; and St. Paul Fire & Marine Insurance Co., a unit of The St. Paul Cos. Inc.
- Medical malpractice insurance: St. Paul Fire & Marine.

The state's Department of Consumer Affairs' advocacy division is

Continued on next page

Update

Federal judge affirms offsets

CHICAGO—A federal judge has reaffirmed a decision that reinsurers can offset moneys they owe an insolvent insurer with what the insurer owes them if both debts arise prior to liquidation.

U.S. District Court Judge Brian Barnett Duff earlier this month rejected motions by the liquidator of Chicago-based Reserve Insurance Co. to reconsider a 1985 decision by another federal judge (*BI*, Nov. 11, 1985). That decision, by U.S. District Court Judge Paul E. Plunkett, held that 26 reinsurance companies that wrote reinsurance for Reserve could offset the debts they owed Reserve with money Reserve owed the reinsurers.

Reserve was declared insolvent and ordered liquidated in May 1979. The liquidator contended that the reinsurers owed Reserve approximately $2.8 million.

Philip O'Connor, former Illinois Director of Insurance acting as liquidator for Reserve, sued Reserve's reinsurers and three other entities that managed or had the right to manage the reinsurance contracts to recover reinsurance proceeds and unearned premiums.

"We're very pleased with the outcome and that our position has been vindicated by a second federal judge," said David Spector, an attorney with the Chicago firm of Mayer, Brown & Platt who represents a group of the reinsurers in the case.

John N. Gavin, an attorney for the liquidator with the Chicago firm of Hopkins & Sutter, said there is a "strong inclination" the liquidator will appeal the decision to the 7th U.S. Circuit Court of Appeals. The decision gives preference to reinsurers of insolvent companies at the expense of policyholders, Mr. Gavin said.

Bhopal claims settlement urged

BHOPAL, India—Bhopal District Court Judge M.W. Deo last week urged attorneys for Union Carbide Corp. and the Indian government to reach a settlement over the December 1984 toxic gas leak in Bhopal, India, before the next hearing in the case on Oct. 30, a Union Carbide spokesman said.

Danbury, Conn.-based Union Carbide said in a statement that both sides are "earnestly seeking a compromise that they hope will lead to a just and reasonable settlement of the Bhopal case."

Bruce Finzen, a Minneapolis-based attorney who is representing the Indian government, said if the two sides cannot agree on an overall settlement, agreement on a settlement solely for interim relief for the gas leak victims is possible. More than 2,000 people were killed in the accident, and thousands more were injured.

The government, which has rejected a $350 million settlement offer by Union Carbide, has sought $3.12 billion in compensation.

M&M adopts poison pill plan

NEW YORK—The board of directors of Marsh & McLennan Cos. Inc. last week adopted a "poison pill" plan to protect shareholders in the event of an attempted takeover.

M&M Chairman Frank J. Tasco said in a statement the plan is intended to protect the interests of M&M shareholders and assure their "fair and equal treatment" if there is a takeover attempt but that it was not developed in response to any specific effort to acquire control of the firm.

Under the plan, in the event of a takeover attempt or if at least 20% of the company is acquired, shareholders would be able to buy a new series of preferred stock. If 20% of M&M is acquired, the stockholders also would be able to buy the acquiring company's common stock at a 50% discount.

M&M stock traded at $64.38 a share on Sept. 17, down slightly from $64.75 a week earlier.

Insurers sue River Plate Re

HAMILTON, Bermuda—Several insurers are suing River Plate Reinsurance Co. Ltd. of Argentina in Bermuda's Supreme Court to recover more than $200,000 in claims.

Orion Insurance P.L.C. is seeking $89,000; Berisford Mocatta & Co., $40,000; and John Francis LeMay and Colin William Speckly, representatives of Lloyd's of London syndicates 122 and 546, are jointly seeking about $80,000.

And last week River Plate's Bermuda underwriting manager, Bott & Associates, said it ceased writing for the reinsurer about six months ago and is running off its business. Bott predicted in March that it would write between $2 million and $3 million in property/casualty business on behalf of River Plate.

However, "none of the legal actions against River Plate in Bermuda concern business written by Bott & Associates," stressed President Michael Bott. He also said that no dispute exists between the underwriting manager and River Plate.

Briefly noted

One of Lloyd's of London's leading aviation underwriters, **Eddie Simms of the Ariel syndicate,** resigned last week for "personal reasons." Methuen (Lloyd's Underwriting Agents) Ltd. is expected to announce a successor soon. . . .Four unauthorized insurers are expected to ask Iowa Insurance Commissioner William Hager to overturn an Insurance Division hearing officer's rejection of their argument that Iowa regulators lack jurisdiction to regulate **purchasing groups** under the 1986 amendments to the federal Risk Retention Act (*BI*, Sept. 14). . . .**The Independent Insurance Agents of America Inc.** has filed suit in the 2nd U.S. Circuit Court of Appeals to reverse a Federal Reserve Board decision allowing an Indiana bank holding company to sell insurance through two state-chartered subsidiaries. The IIAA charges the activity violates a congressional ban on banks' insurance activities. . . .The **Pension Benefit Guaranty Corp.** is considering returning four LTV Corp. pension plans taken over by the agency last year and early this year to the company because LTV has granted supplemental benefits to participants of the plans.

NYIE syndicates

Continued from page 1

Apart from 1792, Allianz ranked as the New York exchange's ninth-largest syndicate on the basis of 1986 gross written premium volume.

For the first quarter of 1987, the five syndicates produced $10.9 million, or 18.2%, of the exchange's gross premium volume of $59.8 million, with 1792 accounting for $8.3 million.

The five syndicates reported total policyholders surplus of $32.1 million as of March 31. This represents 12.2% of the exchange's total surplus of $243.2 million at the end of the first quarter.

Even if all 11 syndicates that have reportedly filed notices with exchange ultimately withdraw, the impact on the exchange may not be significant, some exchange participants say.

"In my opinion, it's not going to make a significant difference because, other than 1792, none of these were significant providers of capacity at the New York Insurance Exchange," said Roy G. Nelson Jr., president of Johnson & Higgins Willis Faber (USA) Inc., one of the largest exchange underwriting managers.

Mr. Nelson also said that he hopes that some of those filing notices will be convinced to remain on the exchange.

Of the exchange's 45 syndicates, an estimated 17 would be actively writing business if the 11 syndicates withdraw. Several of the syndicates filing withdrawal notices have been inactive for varying periods, including Fremont, Gamma Re and Golden Hill.

Separately, a New York Insurance Department spokesman confirmed that the exchange has asked the department to petition for court-ordered liquidation of three of the exchange's eight insolvent syndicates: KCC New York Syndicate Corp., Pine Top Syndicate Inc. and U.S. Risk Inc.

The board of governors has declared eight syndicates insolvent since last summer. One of the syndicates—The Heartland Group Inc.—has already been ordered liquidated by a New York court, while liquidation petitions are pending against three others: Burt Syndicate Inc., First New York Syndicate Corp. and Realex Group N.V.

A fourth insolvent syndicate, Candon Syndicate N.V., has obtained an injunction against liquidation proceedings.

The exchange announced earlier this month that it would draw down $25 million of its security fund deposits to cover the expected unpaid obligations of the insolvent syndicates (*BI*, Sept. 7).

An actuarial review of six of the eight insolvent syndicates concluded that unpaid obligations could add up to at least three times the amount available in the security fund to cover the liabilities, exchange sources have said. The security fund totaled $39.1 million at the end of 1986.

Discussing the withdrawals, Mr. Nelson and other exchange participants noted that exchange syndicates—each of which lost its $500,000 security fund deposit in the drawdown—cannot be hurt further by staying on the exchange and would continue to have a voice in charting the exchange's direction if they remain.

The exchange's most active syndicates—those that have written most of their business in the last two years—have been profitable and should continue to do well, Mr. Nelson said.

He conceded, however, that withdrawals will increase the cost of doing business on the exchange for syndicates that remain, since exchange expenses must be spread over a smaller number of underwriting members.

A major headache in this area, he noted, is the exchange's building in lower Manhattan, acquired in 1984, on which the exchange carries a $20 million mortgage at a 13% interest rate. As the exchange grapples with ways to reduce expenses, one possibility it might consider is a sale-leaseback of the building, Mr. Nelson noted.

Under exchange rules, syndicates considering withdrawal next year must file a notice of intent by Sept. 1 and must cease writing new and renewal business by Oct. 1.

The syndicates also must submit withdrawal petitions that include detailed plans for the satisfaction of the syndicates' obligations. Under the rules, syndicates may either arrange to reinsure all of their liabilities with reinsurers acceptable to the exchange, or establish a trust account from which claims can be paid.

Such trust accounts must name the exchange as trustee and must be maintained for a minimum of three years. After three years, the exchange board may approve the release of funds from the trust account to the underwriting member to the extent they exceed 150% of actuarially certified loss reserves. Otherwise, funds and other assets in the accounts may be released only with exchange approval to cover syndicates' losses and expenses and to pay exchange assessments.

Allianz Syndicate, owned by Allianz of America Inc., filed a withdrawal notice but is still deciding whether to follow through with the withdrawal, according to Assistant Vp Thomas Kilcher.

Mr. Kilcher said that, for a variety of reasons, Allianz has not made the kind of underwriting profit on exchange reinsurance business that it had expected.

Fremont Syndicate, which wrote gross premiums of $8.4 million last year but stopped writing business March 1, will definitely withdraw, according to David McIntyre, chairman of the syndicate's parent, Fremont Indemnity Co.

The syndicate's management company also writes business for Fremont Indemnity off the exchange, he noted.

"Since they both do the same thing, we felt it was in our best interests to do it in one spot," Mr. McIntyre explained.

Gamma Re Syndicate also stopped underwriting in January, and new and renewal business has since been written by its parent, Gamma Reinsurance Co., according to Treasurer Thomas C. Pucci.

The parent company has its own accounting and data processing systems and decided that it would be more efficient to write business off the exchange rather than continue working with the exchange's parallel computer systems, he explained.

Although Gamma Re submitted a withdrawal notice, the parent company is continuing efforts to find a buyer for the syndicate, Mr. Pucci said. As part of such a sale, the syndicate would cede all of its liabilities to the parent company, which also may indemnify the buyer for a possible future assessment by the exchange to rebuild its depleted security fund. ■

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Around the states

Continued from previous page

intervening in the case on behalf of consumers.

"We want an independent evaluation of 'excess profits,' and we've retained a property/casualty actuary to review the filings," said Raymon Lark, head of the advocacy division. "We hope we can get agreement on what 'excess profits' are and then decide how new rates should be applied."

—By Karen Huelsman

EIL coverage hearing

LOS ANGELES—The California Department of Insurance will investigate possible alternatives to a reported lack of environmental impairment liability insurance during a series of public hearings next month.

The hearings, were recommended by the state's Task Force on Toxics, Waste and Technology, which found that coverage for potential hazardous waste problems was not readily available from private insurers.

The task force concluded that the lack of coverage impeded cleanup of existing hazardous waste sites and prevented effective hazardous waste management.

The hearings will explore several topics including:

- Availability of liability insurance through private insurers providing coverage for personal injury, property damage and attendant risks of environmental impairment through sudden and gradual pollution.

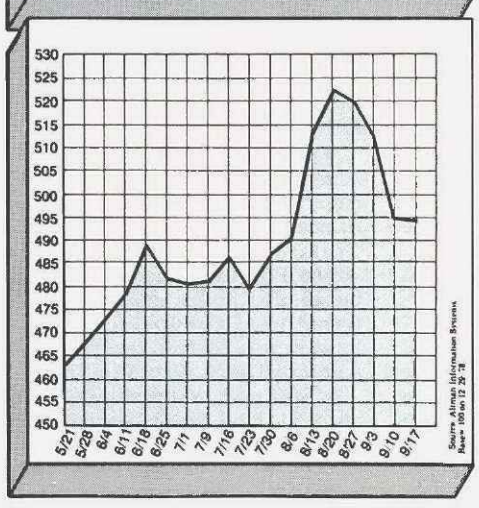
The department has expressed interest in hearing the views of those who generate and transport hazardous waste; owners and operators of treatment, storage and disposal facilities; and remedial cleanup contractors.

- Factors contributing to a lack of coverage.
- Alternatives to traditional markets. The Insurance Department seeks comment on the availability and viability of captives and risk retention groups.
- Viability of state intervention through mandatory pooling arrangements, an assigned risk pool, a state insurance fund or other regulatory measures.

The hearings will be held in Sacramento at the Lincoln Plaza Auditorium, 400 P St., on Oct. 26-27 and in Los Angeles at the State Office Building, 107 S. Broadway, Room 1138, on Oct. 29-30. Persons can participate in the hearings by advising the insurance commissioner in writing by Sept. 30. For information contact Jerry Whitfield, Special Deputy Insurance Commissioner, 100 Van Ness Ave., San Francisco, Calif. 94102; 415-557-3908.

—By Glenn Huntley

BI Insurance Index



Industry stocks saw a slight drop this week as the *BI* fell one half a point to 494.3 on Sept. 17 from 494.8 on Sept. 10, a 0.1% decline. Leading gainers were: American Indemnity Financial Corp., up 5.8%; and AVEMCO Corp., up 5.2%. Decliners were led by: Poe & Associates Inc., down 11.1%; and Washington National Corp., down 4.9%. The Dow Jones 30 Industrials were down 1.9%; the S&P 500 fell 0.7%; and the NYSE Composite fell 0.6%.

British Issues

Sept. 16 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	389	14.4	17.8	4.6	389—366
Genl Accident	1093	11.2	38.3	3.5	1093—1037
Gdn Royal Exch	1033	12.9	46.5	4.5	1033—1006
Royal	567	9.6	21.2	3.7	567—539
Sun Alliance	1120	12.3	32.2	2.9	1120—1075
Brokers					
CE Heath	510	15.2	34.5	6.7	513—510
Hogg Robinson	213	11.8	9.6	4.5	220—210
JH Minet	417	14.6	12.9	3.1	428—405
Sedg Grp	290	16.8	16.4	5.7	297—285
Willis Faber	360	14.1	14.8	4.1	375—358

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Largest U.S. reinsurers' first-half 1987 results

(All amounts in thousands of dollars) (Ranked by net reinsurance premium written)

Reinsurers	Policyholders' surplus (reinsurers only)	Net reinsurance premiums written 1987	Net reinsurance premiums written 1986	Net reinsurance premiums earned	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1987	Combined ratio 1986
General Re	$2,183,661	$1,158,731	$1,214,235	$1,188,238	$896,799	75.5%	$289,307	25.0%	100.5%	104.9%
Employers Re	763,042	597,780	556,852	620,371	487,316	78.6	121,942	20.4	99.0	104.7
American Re	470,415	495,605	454,547	519,620	398,242	76.6	109,861	22.2	98.8	97.2
Munich Re	420,656	343,403	301,602	352,154	241,556	68.6	104,633	30.5	99.1	101.2
North American/Swiss Re	582,266	327,425	367,533	315,562	214,322	67.9	118,953	36.3	104.2	110.7
Prudential Re	389,737	338,093	288,292	328,190	241,912	73.7	92,053	27.2	100.9	106.8
USF&G	N/A	211,993	78,302	201,764	142,787	70.8	59,557	28.1	98.9	101.9
Kemper Re	281,572	174,733	197,042	188,355	154,636	82.1	31,840	18.2	100.3	107.1
National Re	161,142	162,267	163,925	168,910	143,871	85.2	27,630	17.0	102.2	107.4
Transatlantic Re	130,044	152,848	130,970	141,180	114,399	81.0	36,592	23.9	104.9	111.1
CIGNA Re	178,175	137,522	134,030	132,432	98,748	74.6	38,475	28.0	102.6	103.9
Continental Re	118,302	137,464	130,615	135,259	102,079	75.5	40,371	29.4	104.9	107.1
Constitution State Mgt.	N/A	129,320	103,625	123,978	97,112	78.3	29,896	23.1	101.4	109.2
Constitution Re	149,117	110,473	93,937	112,124	82,685	73.7	28,108	25.4	99.1	102.5
Skandia America Group	301,773	105,855	90,115	106,871	71,376	66.8	40,530	38.3	105.1	114.4
Buffalo Re	166,744	100,772	88,737	92,261	99,591	107.9	18,138	18.0	125.9	110.6
St. Paul Re	N/A	100,721	115,445	103,955	78,799	75.8	24,926	24.7	100.5	99.1
PMA Re	52,258	92,691	65,539	55,897	47,641	85.2	14,060	15.2	100.4	101.2
US Int'l Re	102,081	86,250	89,383	89,256	67,760	75.9	22,598	26.2	102.1	97.5
New York Ins. Ex.	N/A	82,635	101,303	90,940	77,669	85.4	28,224	34.2	119.6	139.4
Totals for top 20	**6,450,985**	**5,046,581**	**4,766,029**	**5,067,317**	**3,859,300**	**75.4**	**1,277,694**	**25.5**	**100.9**	**105.5**
Total for all companies	**8,468,157**	**6,382,062**	**5,870,698**	**6,360,568**	**4,805,758**	**75.6**	**1,656,049**	**25.9**	**101.5**	**106.3**

*Top 20 totals do not include Putnam Re

Source: Reinsurance Assn. of America

Reinsurers' results

Continued from page 3

Co., a Travelers Corp. unit in Hartford, Conn. Constitution State posted a 101.4% combined ratio in the first half, compared with a 109.2% ratio for the comparable period a year ago.

Mr. Cole also said that he did not think rate cutting was primarily responsible for the sharp decrease in reinsurers' net premium growth.

"I think there's just less business being written," said Mr. Cole, adding that reinsurers are making a profit based on a smaller dollar volume.

The decline in growth is not an indication prices are going down and therefore a reason for "gloom and doom," he said. "I don't think the industry has gotten to the point of making those mistakes yet."

"I think it reflects stability of pricing, both in the primary business and at the reinsurance level," commented N. David Thompson, president and chief executive officer of North American Reinsurance Co./Swiss Reinsurance Co. in New York. "I don't think it reflects significant price cutting."

Mr. Thompson noted his own company reported a 10.9% decline in its net written premiums to $327.4 million largely because of an increase in the amount of business retroceded to its parent company, Swiss Reinsurance Co. in Zurich.

Other executives pointed out that while there is price cutting at the primary level, reinsurers are not following that lead.

"I have no reason to believe the reinsurance industry is supporting the current price cutting (by primary companies)," said Employers Re's Mr. Fitt.

"Hopefully, reinsurers will remain sane and not cut the rates," commented Bard E. Bunaes, chairman and chief executive officer of Constitution Reinsurance Corp.

He added there are "some very obvious signs" of primary companies cutting rates. "We just hope the reinsurance industry will remain more careful than the primary industry and hold the line so we don't have the same mess."

The reinsurance industry, he pointed out, still has a lot of problems to clear up, including unrecoverable retrocessions.

The decreased growth "would indicate to us there is obviously not as big an increase in facultative prices as a year ago," said Nigel Harley, chairman of Continental Reinsurance Corp. in New York.

Referring to reinsurers' combined ratios, Mr. Harley said results "probably have gotten as good as it's going to get," saying that much more of an improvement would come as a big surprise.

"I think it's difficult to draw any conclusions" about underwriting results "on a quarter-to-quarter basis," said Paul F. Butler, president of St. Paul Reinsurance Management Corp. "We don't see any noticeable increase in loss activity."

However, Mr. Butler did note that a slowdown in premium growth does have an effect on combined ratios.

John W. Smithsen, president and chief operating officer of PMA Reinsurance Corp. in Philadelphia, which specializes in working-layer casualty business for standard lines of insurance, said he anticipates a "reasonable" market at least through the January renewals because of the limited number of casualty reinsurers writing business.

The adequacy of reinsurers' loss reserves has improved, although it remains a cause of concern, reinsurance executives say.

"I think a lot of strengthening has gone on over the last 24 months," said American Re's Mr. Inderbitzen. However, "I think probably for a lot of people there still needs to be a continuing strengthening of reserves."

Reserve levels and premium-to-surplus ratios are much stronger now than they were three years ago, said Constitution State's Mr. Cole.

Most reinsurers feel they have brought their reserves up to where they should be, said Employer Re's Mr. Fitt. As to the question of their adequacy, however, "I think that's a moving target. I don't think it's something you can say 'yes' to today and be right tomorrow."

Mr. Butler said he expects that in the "not-too-distant future" reinsurers will begin to boost their reserves in anticipation of toxic waste losses.

Reinsurers said they were happy with their own companies' first-half results.

Despite the decline in growth in net premiums, American Re expects to maintain pricing and underwriting standards at a proper level, said Mr. Inderbitzen.

"We're pleased with our results," said Mr. Bunaes of Constitution Re, which posted a 99.1% combined ratio in the first half of 1987, an improvement over a 102.5% combined ratio for the comparable period a year ago. He pointed out, however, that Constitution Re's improved results were at least partly attributable to the absence of natural catastrophes. ■

BI Industry Stock Report

SEPT. 17, 1987 9/11/87 THRU 9/17/87

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	26.00	4.0	-1.9	32.00	22.38	504	1.00	3.8	23.0	2.98	8.72
Baldwin & Lyons Inc.	OTC	18.00	0.0	-18.2	27.00	17.25	0	0.20	1.1	7.2	16.40	1.10
Corroon & Black Corp.	NYSE	31.00	1.6	-5.0	37.25	26.63	106	0.84	2.7	14.4	6.31	4.91
Gallagher Arthur J & Co.	OTC	21.25	2.4	-19.0	31.00	19.00	16	0.40	1.9	16.0	4.81	4.42
Hall Frank B. & Co	NYSE	10.00	-1.3	-31.0	19.00	8.75	179	0.00	0.0	16.0	0.00	N/A
Marsh & McLennan Cos. Inc.	NYSE	64.38	-0.6	6.0	72.00	56.00	544	2.40	3.7	16.7	5.14	12.53
Poe & Assoc Inc.	OTC	10.00	-11.1	-16.7	13.25	10.00	0	0.00	0.0	16.7	0.00	N/A
BROKERS	AVERAGE		-0.7	-12.3					1.9	15.4		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	26.00	3.0	-1.0	37.00	24.25	155	0.28	1.1	7.3	13.72	1.90
Berkshire Hathaway Inc.	OTC	3900.00	3.4	38.3	3992.00	2510.00	129	0.00	0.0	26.8	62.53	4.05
CIGNA Corp.	NYSE	62.88	-0.2	14.3	69.50	55.00	754	2.80	4.5	8.1	42.01	1.50
CNA Fin'l Corp.	NYSE	56.00	-3.4	4.2	64.38	47.25	191	0.00	0.0	11.4	42.71	1.31
General Re Corp.	NYSE	56.50	0.7	1.8	68.88	47.63	1339	1.00	1.8	15.2	23.47	2.41
ITT (Hartford Group)	NYSE	60.25	-3.0	12.9	66.38	50.00	2079	1.00	1.7	13.3	44.08	1.37
Sears Roebuck & Co. (Allstate)	NYSE	52.25	-0.5	31.4	59.50	39.88	2612	2.00	3.8	12.7	32.94	1.59
Transamerica Corp.	NYSE	42.75	-0.6	31.0	51.38	31.50	982	1.76	4.1	8.7	26.94	1.59
CONGLOMERATES	AVERAGE		-0.1	16.6					2.1	12.9		
INSURERS												
Aetna Life & Cas Co.	NYSE	59.13	-1.9	4.4	68.13	55.75	1874	2.76	4.7	8.3	44.75	1.32
American General Corp.	NYSE	37.88	-1.0	2.7	44.75	34.88	1192	1.25	3.3	10.1	27.13	1.40
Amer Heritage Life Invt	NYSE	29.50	0.4	14.9	34.00	25.75	2	0.96	3.3	14.5	20.37	1.45
Amer Indty Fin'l Corp.	OTC	13.75	5.8	-23.6	19.00	12.75	209	0.56	4.1	14.5	20.40	0.67
American Int'l Group Inc.	NYSE	79.00	2.9	29.2	83.75	60.00	1017	0.30	0.4	15.7	29.02	2.72
Aneco Reins Ltd.	OTC	3.25	0.0	52.6	4.38	2.13	32	0.00	0.0	15.7	1.93	1.68
AON Corp.	NYSE	27.63	-1.3	4.7	29.88	23.25	207	1.20	4.3	9.6	15.23	1.81
Argonaut Group	OTC	45.25	4.6	115.5	52.13	21.00	198	0.00	0.0	13.9	14.60	3.10
AVEMCO Corp.	NYSE	22.88	5.2	-12.8	25.25	13.25	36	0.28	1.2	14.4	6.94	3.30
Business Mens Assurn Co.	OTC	43.63	2.3	68.6	48.25	25.25	240	1.10	2.5	14.4	22.15	1.97
Chubb Corp.	NYSE	63.13	0.2	6.5	73.50	53.75	417	1.88	3.0	8.9	39.52	1.60
Continental Corp.	NYSE	45.00	2.3	0.6	54.88	40.38	1007	2.60	5.8	8.9	41.62	1.08
Durham Corp.	OTC	29.25	0.0	5.7	34.00	27.38	6	0.92	3.1	19.1	26.15	1.12
Farmers Group Inc.	OTC	44.25	0.0	14.2	51.00	38.75	830	1.20	2.7	13.4	19.95	2.22
Fireman's Fund Corp.	NYSE	35.75	1.8	1.8	42.75	33.50	376	0.40	1.1	13.4	23.55	1.52
Fremont Gen Corp.	OTC	15.75	-3.8	-2.4	20.50	14.75	172	0.60	3.8	13.4	16.75	0.94
Home Group Inc.	NYSE	17.88	-2.0	-14.9	24.88	17.50	333	0.20	1.1	3.9	16.30	1.10
Hanover Ins Co.	OTC	35.25	1.4	11.0	37.25	29.50	38	0.36	1.0	8.0	20.91	1.69
Hartford Steam Boiler	OTC	29.75	0.0	26.2	36.63	23.50	153	1.00	3.4	12.3	10.17	2.93
Kansas City Life	OTC	29.75	0.0	15.5	31.00	25.75	0	0.00	0.0	12.3	0.00	N/A
Kemper Corp.	OTC	31.50	-2.3	26.0	38.75	25.00	433	0.60	1.9	10.0	23.48	1.34
Liberty Corp S.C.	NYSE	46.75	-2.1	27.2	50.75	36.50	27	0.80	1.7	18.1	19.96	2.34
Lincoln Nat'l Corp.	NYSE	51.38	-4.0	10.8	60.50	44.38	664	16	4.2	10.3	44.85	1.15
NAC Re Corp.	OTC	24.75	0.0	-5.7	32.25	22.50	24	0.00	0.0	31.7	18.12	1.37
Nobel Ins Ltd.	OTC	13.00	-3.7	-20.0	18.50	10.75	210	0.00	0.0	31.7	0.00	N/A
Northwestern Nat'l Life	OTC	27.75	-1.8	-10.5	32.38	24.00	76	0.96	3.5	7.8	33.26	0.83
Ohio Cas Corp.	OTC	43.00	1.8	11.3	49.25	38.50	373	1.68	3.9	10.5	26.80	1.60
Old Rep Int'l Corp.	OTC	29.25	1.7	6.8	33.63	23.63	159	0.74	2.5	9.8	19.80	1.48
Orion Cap Corp.	NYSE	21.38	-2.8	-21.2	31.00	20.00	29	0.76	3.6	9.8	9.39	2.28
Protective Corp.	OTC	16.25	2.3	-9.7	21.25	12.38	78	0.70	4.3	14.0	16.51	0.98
Provident Life & Acc Ins Co.	OTC	23.75	0.0	-3.6	28.75	19.13	0	0.84	3.5	18.6	27.00	0.88
St. Paul Cos. Inc.	OTC	50.75	0.2	26.1	55.00	40.25	693	1.76	3.5	9.4	29.89	1.70
SAFECO Corp.	OTC	32.25	-0.4	20.6	34.50	24.38	913	0.96	3.0	11.2	19.68	1.64
SCOR US Corp.	OTC	14.50	0.0	26.1	16.25	11.00	156	0.00	0.0	13.3	8.08	1.79
Seibels Bruce Group Inc.	OTC	15.00	1.7	1.7	19.00	14.25	85	0.80	5.3	9.9	11.88	1.26
Selective Ins Group Inc.	OTC	25.00	-1.0	14.9	27.50	21.00	28	1.08	4.3	7.9	16.02	1.56
Statesman Group Inc.	OTC	6.25	-3.0	31.6	7.06	3.88	142	0.05	0.8	7.9	5.19	1.20
Tokio Marine & Fire Ins	OTC	70.75	0.7	26.6	103.38	63.88	13	0.19	0.3	60.0	0.00	N/A
Torchmark Corp.	NYSE	30.50	-1.6	17.3	36.75	23.75	427	1.20	3.9	10.9	13.01	2.34
Travelers Corp.	NYSE	44.00	-0.3	-1.4	52.63	41.50	1590	2.28	5.2	9.1	45.03	0.98
Trenwick Group Inc.	OTC	14.50	3.6	-12.1	19.13	11.50	68	0.00	0.0	17.9	13.83	1.05
United Fire & Cas Co.	OTC	31.25	0.0	-5.3	33.00	26.50	13	0.96	3.1	9.2	18.32	1.71
United States Fid & Gty	NYSE	41.63	1.2	4.7	48.75	37.00	5118	2.48	6.0	8.9	20.19	2.06
UNUM Corp.	NYSE	24.38	-2.5	-9.3	31.38	20.38	280	0.40	1.6	8.9	26.81	0.91
USLIFE Corp.	NYSE	39.38	0.6	-9.5	47.63	34.75	152	1.12	2.8	10.1	43.09	0.91
Washington Nat'l Corp.	NYSE	33.63	-4.9	5.1	37.88	23.25	50	1.08	3.2	19.7	43.09	0.78
Zenith Nat'l Ins Corp.	NYSE	21.75	-0.6	-17.9	24.00	21.13	45	0.80	3.7	19.7	11.19	1.94
INSURERS	AVERAGE		-0.0	9.6					2.7	13.5		
ALL COMPANIES	AVERAGE		-0.1	8.0					2.5	13.7		

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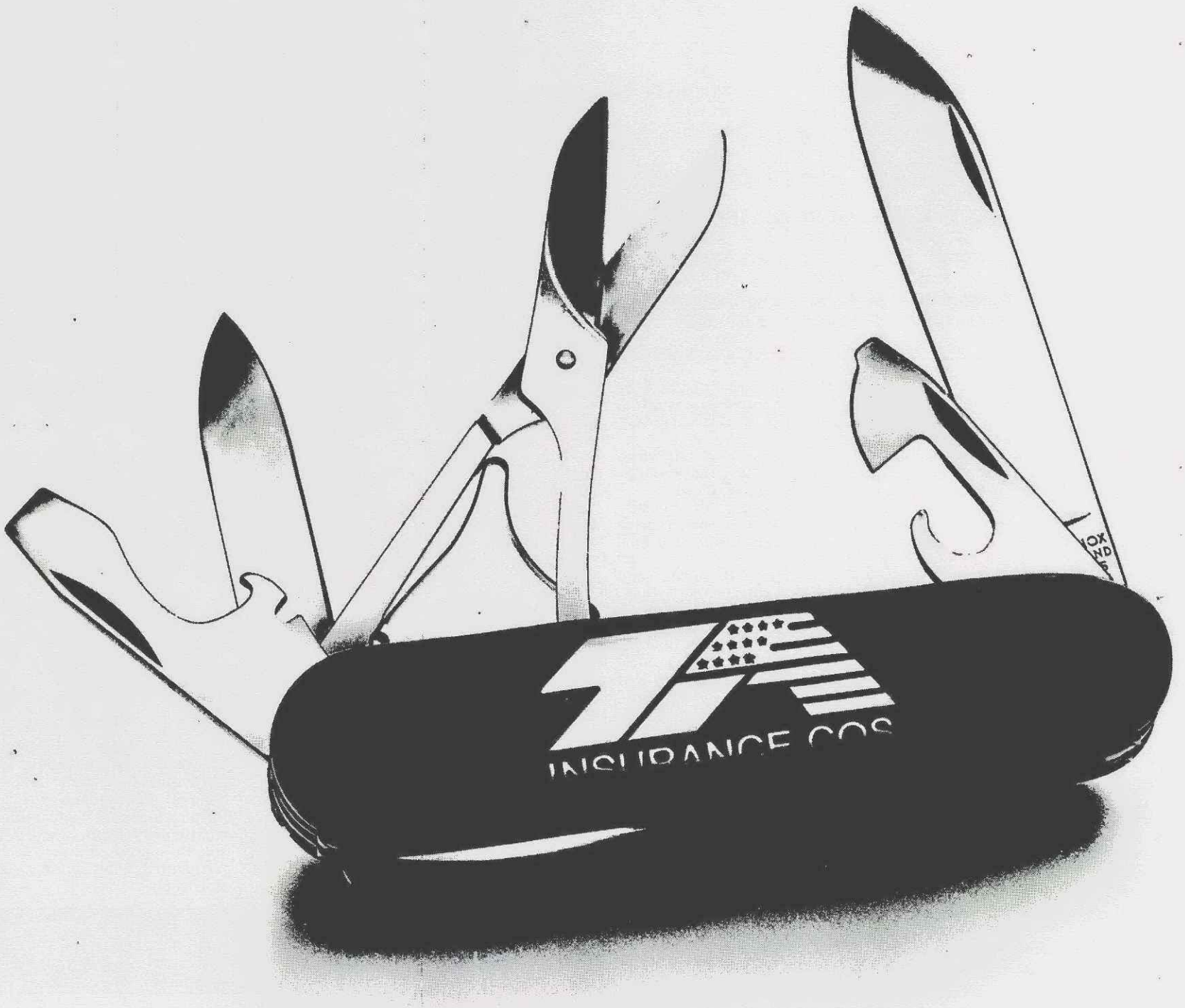

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