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update

Risk retention expansion ready for House showdown

WASHINGTON—Legislation to expand the federal Risk Retention Act is headed to a vote in the House of Representatives.

Acting within minutes of each other, the House Commerce, Transporation and Tourism Subcommittee and the full Energy and Commerce Committee last week approved H.R. 5225 on a voice vote after adding several amendments.

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J&J subsidiary denied coverage for Tylenol recall

By DOUGLAS McLEOD

NEWARK, N.J.—McNeilab Inc., a unit of Johnson & Johnson, is expected to appeal a federal judge's ruling that denies coverage under J&J's excess liability insurance program for costs related to the 1982 recall of Extra-Strength Tylenol capsules.

U.S. District Judge Maryanne Trump Barry ruled last week that policies written by Johnson & Johnson's eight excess liability insurers did not include coverage for the estimated $100 million cost of recalling the capsules.

Judge Barry's opinion also noted that evidence clearly showed that neither J&J nor its broker, Johnson & Higgins, ever intended for recall cost coverage to be included under the policies.

J&J—which maintained recall coverage between 1968 and 1970 with Aetna Casualty & Surety Co.—"knew such coverage could be purchased, elected not to purchase it because the cost was prohibitive and now claims that it enjoys recall coverage anyway," Judge Barry's opinion states.

"The question before the court. . .is whether Johnson & Johnson can quite literally 'pass the buck' to its insurers," the opinion says. "To that question, which itself is proof positive of the adage, 'nothing ventured, nothing gained,' the answer must be 'No.'"

Attorneys for the liability insurers expressed satisfaction with the ruling.

Charging that the claims in J&J's lawsuit were "specious," Bruce A. Tritsch, a Rahway, N.J., lawyer representing Northbrook Excess & Surplus Insurance Co., called Judge Barry's analysis of the case "careful and acute."

"We are very pleased with the result and we think if there is an

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Workers comp market in Maine threatened

By CAROL CAIN

AUGUSTA, Maine—The workers compensation market of last resort in Maine is teetering, and a monopolistic state fund could emerge if the state's assigned risk plan topples.

The controversy in Maine, where insurers say workers compensation rates should be at least 200% higher, is one several battles over workers compensation rates being fought across the country.

"Are we at push and shove right now? Probably for the last time," says Maine Insurance Commissioner Theodore J. Briggs, who is holding a special meeting later this week to discuss workers compensation alternatives in the state.

The superintendent believes he has statutory authority to create a mandatory assigned risk plan, in which all insurers writing workers compensation business in Maine would be required to participate. But at least one insurer says it would file a court challenge if it is placed in a mandatory pool.

"Insurers are facing an extremely bleak picture in Maine. . . .It's reaching a boiling point, but no one is quite sure where it's going to go," said Joseph DiGiovanni, New England region vp for the American Insurance Assn. in New York.

And, while the speaker of the state House of Representatives believes the crisis will be resolved, he says Maine would "be better off" if workers compensation insurers pull out of the state and a monopolistic state fund is created.

"I hope they pull out completely. . . .I want a state fund," said

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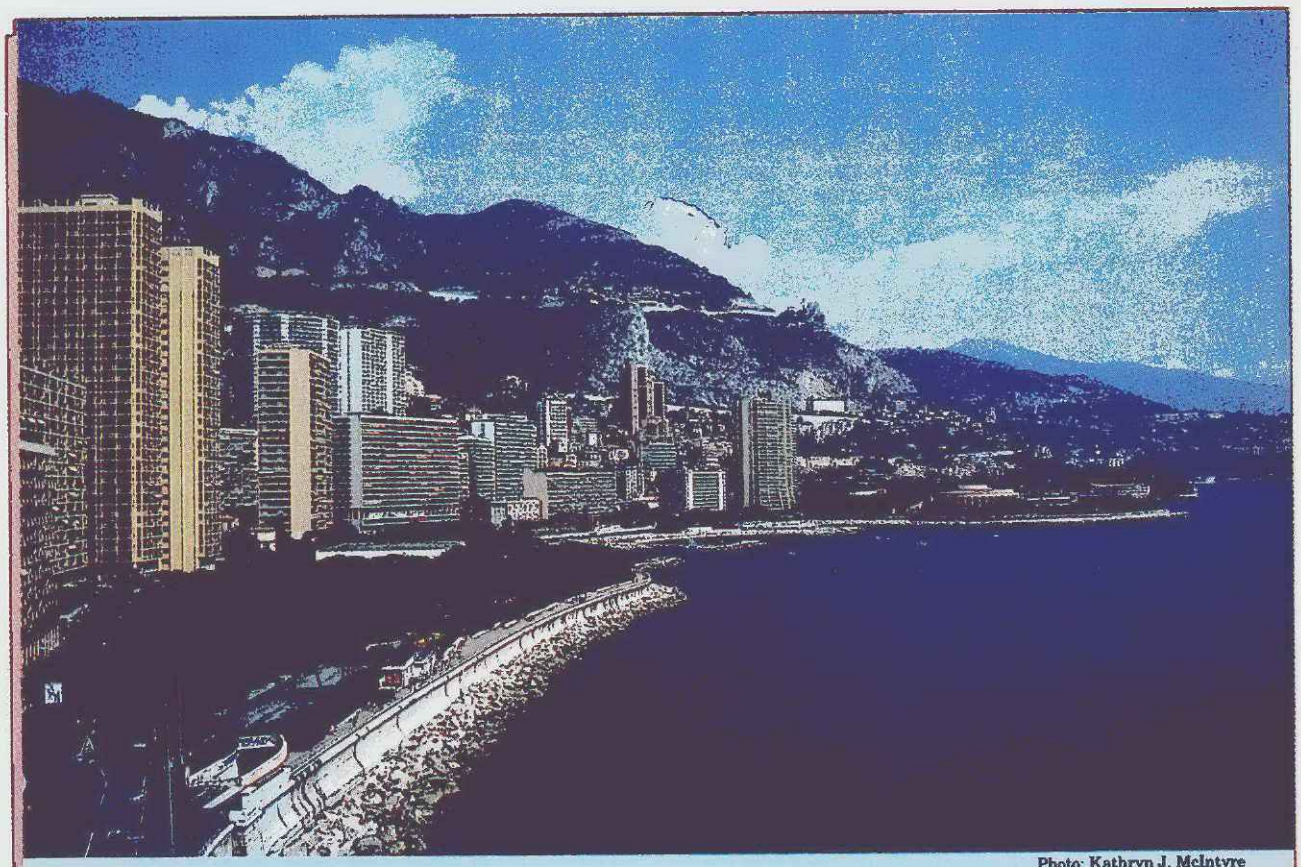


Photo: Kathryn J. McIntyre

Reinsurance leaders gather every September in picturesque Monte Carlo for their annual Rendez-Vous.

Worst may be over

Rate hikes to moderate in 1987: Reinsurers

By KATHRYN J. McINTYRE and STACY SHAPIRO

MONTE CARLO, Monaco—The sellers' market for U.S. commercial liability insurance will prevail for more than another two years, reinsurance market leaders say.

Capacity is not opening up and rates will stay high, perhaps even rising a little more next year, they say. Claims-made policy forms also will be demanded for higher-risk casualty business.

But, commercial insurance buyers have seen the worst of the casualty insurance capacity crunch and big rate hikes.

Limits purchased today probably will be available next year, and rate hikes in 1987 generally will be mild—maybe 10% to 20%—compared with the 100% to 300% rate hikes common for 1986 liability insurance programs.

The rate of property insurance rate increases also is expected to slow, with more reinsurers becoming interested in property risks.

European commercial insurance buyers will find little to complain about in the coming year, with property rates remaining too low to satisfy reinsurers. Only European corporations with U.S. product liability risks will have trouble finding liability insurance and could be forced to accept coverage on a claims-made basis.

Outside North America and Europe, insurance rates generally are expected to remain inadequate in reinsurers' views.

While rating trends may vary around the world, ceding companies worldwide will find retrocessions hard to place. In addition, reinsurers, especially in the London market, are expected to demand more timely payment of premium. Those who fail to comply could see their reinsurance protection canceled.

These are the observations of reinsurance company executives and reinsurance brokers who attended the 30th annual Rendez-Vous de Septembre, held Sept. 8-13 in Monte Carlo.

Although the reinsurance marketplace is only a small portion of the insurance marketplace, reinsurers exert tremendous control over the availability and pricing of insurance. If they provide coverage to insurance companies, capacity opens up and prices fall. If they turn off the spigot, as they did over the last 18 to 24 months, capacity dries up and prices rise.

The highly unstructured Rendez-Vous de Septembre is the largest annual gathering of the world reinsurance market, with executives of reinsurance companies and reinsurance brokers pouring into the tiny principality on the Mediterranean Sea to meet in small groups with colleagues and clients. The first soundings for market conditions in the year ahead are taken here.

Meetings, lasting from 15 minutes to two hours, are held in groups of two to six in hotel lobbies, cafes and beach cabanas—and in hotel suites by those seeking more privacy.

"More of the same" for the worldwide insurance and reinsurance markets in 1987 seemed to be the consensus of those who attended the Rendez-Vous, at which the market is discussed but no business is actually written.

"I think the renewal season will be almost identical to last year," said Jack R. Bagwell, deputy chairman of Lloyd's of London broker S.W. Taylor & Co.

"The hardening market is peaking, but it is not ending," observed Keith D. Gillies, chairman of Lloyd's reinsurance broker Golding Stewart Wrightson Ltd. "It will take three to four years to turn."

"I do not see an area where rates will increase substantially again" during this hard market cycle, observed H. Detlef Luhrsen, a director of Munich Reinsurance Co. in Munich, West Germany. "We have had rate increases the last two years," he said, noting that traditionally in hard markets rates double and triple

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update

Risk retention bill advances

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The House is expected to vote on the bill this week.

Under the amendments added to the House bill:

- Federal courts would have the clear authority to issue an injunction to stop a risk retention group from operating in all states if the court finds that a group is in a hazardous financial condition.
- States still would have the power to specify the form in which employers must comply with financial responsibility requirements.
- The Commerce Department would be required to submit a report to Congress on the effect, if any, that expanding the Risk Retention Act has on easing the liability insurance crisis.

The report also would have to explain the causes of any financial difficulties of risk retention groups and the extent to which the public was protected by abuses involving risk retention groups.

The measure also includes provisions in a bill, S. 2129, passed by the Senate in July that give insurance commissioners more power to regulate risk retention groups outside their states.

Both the House and Senate bills would make it easier for businesses, trade groups and municipalities to purchase all forms of commercial casualty insurance—except workers compensation—on a group basis or to form captive insurance companies called risk retention groups.

The current Risk Retention Act, passed by Congress in 1981, applies to groups established to purchase or self-insure product liability and completed operations coverage.

Meanwhile, the Senate last week began discussing federal product liability reform legislation, S. 2760, approved by the Senate Commerce Committee, but no action was expected.

Senate Majority Leader Robert Dole, R-Kan., brought the bill up last Thursday for consideration, but after a brief debate and opposition from Sen. Ernest F. Hollings, D-S.C., the measure was temporarily shelved.

Sen. Hollings was expected to filibuster against the measure if it was brought up again.

Rescued Palapa satellite sold

WASHINGTON—The satellite communications firm that purchased one of the two wayward communications probes recovered by a space shuttle crew in 1984 apparently bought the probe for about half of what underwriters originally asked.

Sattel Technologies Inc., a 2-year-old firm based in Van Nuys, Calif., purchased the Palapa B2 satellite earlier this month for $18 million, according to published reports. The company bought the satellite from satellite launch insurers that financed its recovery after paying a $79 million claim.

Neither the insurers nor Sattel President George Weischadle would confirm the sale price. However, when asked about the published figure, Mr. Weischadle said, "I won't take issue with that price."

The insurers, International Technology Underwriters Inc. of Bethesda, Md., and Lloyd's of London underwriters led by Stephen Merrett, underwriter for marine syndicate 418, had been seeking between $30 million and $40 million for the satellite (*BI*, Oct. 29, 1984).

"I guess we would always like to get more, but it was a fair return on the cost to get it back," said John Vinter, senior vp with Intec, referring to the $10.5 million the insurers reportedly paid to retrieve the Palapa and the $105 million Westar VI satellites. Both satellites failed to achieve proper orbit after being deployed during a February 1984 shuttle mission.

In addition to the recovery costs, the insurers paid a total of $180 million in claims to the Indonesian government, owner of the Palapa, and Western Union Corp., owner of the Westar satellite.

In a prepared statement, Mr. Merrett said: "I'm delighted to have at last concluded the sale of the satellite." But, reinsurers, rather than syndicate members, will mainly benefit from the sale, Mr. Merrett noted.

"I'm also hopeful that Westar VI will be sold in the near future," Mr. Merrett added. Mr. Weischadle said that Sattel has no plans to acquire the Westar satellite.

Insurers sign consent orders

COLUMBUS, Ohio—Two insurers must begin settlement discussions with 12 municipalities as part of consent orders they signed last week to end an Ohio Department of Insurance investigation into complaints of unwarranted rate hikes.

Department-ordered actuarial studies found that the municipalities had been overcharged between 50% to 600%, according to a department spokesman.

Signing the consent orders were The Home Insurance Co., which was the subject of 12 complaints, including one from a city that previously settled with Home, and American International Group Inc. affiliate National Union Fire Insurance Co. of Pittsburgh, Pa., which was the subject of one complaint (*BI*, Aug. 25).

Although the insurers did not formally admit guilt or liability, they agreed to honor all premium guarantees made to the municipalities and to credit or refund premiums where rating factors had been applied improperly, the department spokesman said.

The insurers also agreed to reimburse the department for the costs of the investigation, which now total $93,000, he said.

The Home said the agreement is an "equitable solution" to "a unique limited situation" and emphasized that the resolution did not include a price rollback. "The main issue was related to certain guarantees issued the municipalities by the company's agent without its knowledge," the insurer said.

National Union officials did not return telephone calls seeking comment.

The department scheduled a hearing Nov. 3 to determine the insurers' compliance with the consent orders.

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Ruling releases two insurers from paying pollution claims

By STEPHEN TARNOFF

BOISE, Idaho—Liability insurers are not required to indemnify policyholders in litigation brought under the federal Superfund Act if their policies were written prior to the law's December 1980 effective date, a federal court judge says.

U.S. District Judge Harold L. Ryan ruled Gulf Resources & Chemical Corp.'s insurers did not have to indemnify it for a natural resource claim, even if pollution that led to damage occurred while the comprehensive general liability policies they wrote for Gulf were in force.

As a result, Continental Re-insurance Co., which insured Gulf from 1972-1978, and Aetna Casualty & Surety Co., which insured Gulf from 1967 to 1972, do not have to indemnify the company in environmental contamination litigation in Idaho, he said.

However, Judge Ryan also ruled on Sept. 2 that Continental Re and Aetna were liable for defending Gulf until the date of his order that determined they owed no indemnity.

And Judge Ryan also ruled that Admiral Insurance Co., which wrote CGL coverage for Gulf in 1982-1983, would have to defend and indemnify Gulf, pending rulings on other arguments raised by Admiral as to why it should not have to provide coverage.

Underlying the coverage dispute is a lawsuit brought by the state of Idaho against Gulf, The Bunker Hill Co. and Pintlar Corp. stemming from pollution allegedly caused by lead and silver mining and smelting activities near Kellogg, Idaho.

Bunker Hill, which merged with Gulf in 1968 and became a Gulf subsidiary, changed its name to Pintlar.

The suit, filed in 1983, sought to recover under the "natural resources" section of the Comprehensive Environmental Response, Compensation and Liability Act, better known as the Superfund Act.

The state sought to recover for damages to the state's natural resources, such as forests, fisheries and wildlife, caused by the pollution. The state also brought a nuisance claim under state law and alleged violations of the state environmental health act.

Last spring, the suit was settled for $4.5 million, with Gulf Resources agreeing to pay $2.9 million, attorneys in the case say.

During the course of the litigation, insurers for Gulf and Pintlar—including Continental Re, Aetna and Admiral—were named as third-party defendants.

Prior to his decision, Judge Ryan had ruled that the state, under its Superfund claim, could only recover damages that occurred after Dec. 11, 1980, the date the Superfund Act went into effect.

He also ruled that the state could recover for damages under its nuisance claim only after Dec. 9, 1979. This was determined by subtracting a four-year statute of limitations from Dec. 9, 1983, when the suit against Gulf was filed.

The question before Judge Ryan was whether insur-

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BI to list reinsurance brokers

Business Insurance will publish its annual directory of reinsurance intermediaries in the Nov. 10 issue, which will include a spotlight report focusing on reinsurance topics.

The directory includes both U.S. and Bermuda-based reinsurance intermediaries and serves as a resource to which subscribers can refer throughout the year.

The directory is printed as an editorial service; there is no charge for intermediaries to be included.

If you have not yet received a questionnaire, you may request one by writing to Marilou Jones, *Business Insurance*, 740 N. Rush St., Chicago, Ill., 60611, or by calling 312-649-5279.

The deadline for returning completed questionnaires to *Business Insurance* is Oct. 6.

Tort reform to appear on ballot in Arizona

By ROBERT A. FINLAYSON

PHOENIX, Ariz.—Arizona voters will get the chance to decide on a measure that would allow the state's lawmakers to limit pain and suffering and punitive damage awards as well as attorneys' contingent fees in third-party litigation.

The Arizona Supreme Court upheld a lower-court ruling earlier this month and decided that the measure, Proposition 103, could be placed on the Nov. 4 ballot. In July, trial lawyers in the state had challenged the move to place Proposition 103 on the ballot, contending it posed more than one question.

In Arizona, only one question can be covered in a single ballot initiative.

The trial lawyers had argued that the question of limiting attorneys' contingent fees in third-party lawsuits must be decided separately from the question of capping pain and suffering and punitive damage awards and, therefore, that Proposition 103 should be declared invalid and removed from the ballot.

But Citizens for Fair & Sensible Liability Laws, a coalition of business and professional groups that is backing Proposition 103, argued that both questions are part of the same issue.

The state Supreme Court agreed.

A spokesman for Citizens for Fair & Sensible Liability Laws, explained that Proposition 103 will not impose restrictions on awards in third-party lawsuits; it will only give Arizona lawmakers the authority to impose such restrictions.

Currently, the 75-year-old Arizona Constitution prohibits enactment of any law that would limit a plaintiff's right to recovery in a personal injury lawsuit.

Proposition 103 would "modify the Constitution to allow the Legisla-

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inside

✓ The battle for tort reform won't be over until all the measures enacted pass court muster, points out this week's editorial. Tort reform advocates must be on guard as plaintiffs' attorneys in at least 10 states challenge the constitutionality of tort reform laws that have already been enacted. **PAGE 8**

✓ The cost of medical services provided by health maintenance organizations is less than that provided by the traditional fee-for-service health care delivery systems, according to a study conducted by the Santa Monica, Calif.-based Rand Corp. **PAGE 40**

✓ What should a company do when the claims adjuster says, "No"? Lester L. Lowenstein, director of Coopers & Lybrand's New York-based Insurance Claims Services Group, describes in this week's Perspective section the actions a policyholder can take to contest the opinion of the claims adjuster. **PAGE 47**

✓ The licensing of commercial insurance underwriters, similar to that required of agents and brokers, would make them more responsible and efficient, says James A. Robertson, an author, consultant and former underwriter, in a Speaking Out column. **PAGE 48**

✓ Excerpts from a summary of the tax overhaul legislation now pending in Congress include provisions that are likely to affect employee benefit managers, risk managers and property/casualty insurers. **PAGE 54**

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Tort reform may hurt surplus insurers: Buyer

By MICHAEL BRADFORD

ATLANTA—Surplus lines insurers and wholesalers are supporting tort reform measures even though some of the reforms have the potential to render the non-admitted market useless, a prominent risk manager comments.

"Talking about tort reform is kind of like talking about motherhood. You all support it and you all want it," says P. Richard Hackenburg, staff vp at Allegheny International Inc. in Pittsburgh and immediate past president of the Risk & Insurance Management Society.

But at the same time, "If we all get meaningful tort reform and we come to these wonderful things like predictability of losses and stabilization of claims costs," the need for surplus lines insurance, as well as risk management professionals, could be greatly diminished, Mr. Hackenburg observes.

Appearing as a member of a panel at the annual convention of the National Assn. of Professional Surplus Lines Offices Ltd. that addressed the topic, "The 1986 Marketplace —Is It Buyer Beware?" Mr. Hackenburg reminded wholesalers and surplus lines insurers to be aware of the double-edged consequences of the tort reform issue.

"We're talking about something occurring that could put us all out of business," Mr. Hackenburg said. "The fact is, at the end of the day, you and I and everybody else in this room get paid. . .because we're dealing with problems of this nature. So how much of this tort reform do we really want?

"If my internal budget in my company is $50,000, would I get paid the egregious salary that I'm paid to manage $50,000?" Mr. Hackenburg asked.

"By the same token, if we have tort reform and the business is stable and the primary carriers and the normal market can handle business like it was a piece of cake, what do we need the E&S market for?

"How much do you guys really want tort reform?" Mr. Hackenburg asked his audience.

However, two insurance company executives on the same panel said members of the surplus lines market are strong advocates of tort reform—no matter what the consequences.

Mr. Hackenburg, responding to a question from panel moderator Kenneth Goldstein, president of St. Paul Surplus Lines Insurance Co. of St. Paul, Minn., said he hoped that tort reform measures, which have been enacted in some 34 states already this year, would have an impact on the affordability and availability of coverage for commercial risks.



'We're talking about something occurring that could put us all out of business,' warns Mr. Hackenburg.

But, he added, "Certainly it's too early to tell how effective those particular measures are going to be."

And, despite all the activity behind the tort reform movement, "The fact is that whether tort reform is meaningful or not, (insurers) have to respond to provide a reasonable product and a good risk-transfer mechanism for the public," Mr. Hackenburg stated.

Panel member Stephen R. Smith, president and chief operating officer of Harleysville Insurance Cos. in Harleysville, Pa., said he believes that only around 21 states have enacted tort reform measures that are "meaningful."

In those states, there will be a positive impact on affordability and availability of commercial property/casualty insurance lines, said Mr. Smith.

"The industry currently is rather well-capitalized," said Mr. Smith. "So availability problems shouldn't be driven because of a lack of capital.

"I think the key is senior management of the carriers and their underwriters' perception of the insurance environment in a given state."

Even today, says Mr. Smith, underwriters are willing to commit capital in states where there is a perception of acceptable legislative, regulatory and litigious standards, in states where underwriters can "quantify exposures" and in states where they can predict future loss costs with reasonable accuracy.

"Tort reform is very important," said Mr. Smith. "It will have a very beneficial impact on availability where it's meaningful tort reform. And there are a number of large, important states where the battle is still being fought."

However, Mr. Smith concedes that it is

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Buyers oppose comp rate hike in Louisiana

By CAROL CAIN

BATON ROUGE, La.—Players in Louisiana's workers compensation arena are poised to go to court over a pending rate filing that seeks an average 71.1% increase.

That increase would cost employers an estimated additional $260 million in workers compensation premiums—a severe burden considering Louisiana's lagging economy, according to Clark Cosse, general counsel for the Louisiana Assn. of Business & Industry.

Such a rate increase "would have a catastrophic impact on the already ailing economy of the state," charges Attorney General William J. Guste Jr.

The rate increase request surprised both business and labor. Both made major concessions in 1983 by agreeing to a work comp reform measure that created a wage-loss system of benefit payments, which was supposed to hold the line on rates.

Under such a system, permanent partial disability benefits are replaced by compensation only for proven lost wages after a job-related injury.

The National Council on Compensation Insurance, which made the rate filing July 3 on behalf of its member insurers, argues that the average 31.8% increase that took effect earlier this year wasn't adequate. Neither was an average increase of 17.4% on Sept. 1, 1982, according to the NCCI.

Rates decreased an average 20% in 1983 as part of the new wage-loss law.

A decision on the pending rate filing can come as soon as tomorrow, Sept. 23, when the Louisiana Insurance Rating Commission holds its regular monthly meeting.

The commission deferred action at its July meeting and requested additional data from the NCCI. Action again was deferred by the commission at its August meeting so that an outside actuary could study the data.

"I feel fairly certain that the commission will act (tomorrow)," said Chris Faser, executive officer of the commission.

Although Mr. Faser did not know what action would be taken, he noted: "With the state of the economy in Louisiana, I would hardly think the commission would approve the rate increase."

If the rates are denied, the NCCI will ask for a formal hearing, said Robert E. Maxwell Jr., director of government, consumer and industry affairs for the NCCI. He and others indicate that if the rates are still denied after the formal hearing process is over, the NCCI is planning to go to court over the matter.

On the other side, Attorney General Guste also is itching to go to court. He tried to intervene in August during the commission's informal rate review process but was told by the panel's attorney that such intervention was premature.

Part of the Louisiana controversy centers on the data supplied by the NCCI in its filing for the new increase. The LABI says the filing is based on

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Liability capacity growing: Bailey

By CAROL CAIN

DES MOINES, Iowa—Commercial liability insurance capacity is now increasing, says one insurance company executive.

"There appears to be a light at the end of the tunnel, and it's not a freight train. This is particularly true for Main Street businesses," says William O. Bailey, president of Aetna Life & Casualty Co. in Hartford, Conn.

"I know that most of. . .(the) unavailability (problem) is unaffordability. If you don't want to pay for what is available, you conclude that it is unavailable to you at a reasonable price," Mr. Bailey says.

However, a risk manager disagrees that adequate capacity is available—for a price.

"That isn't the case," counters Richard C. Heydinger, director of risk management for Hallmark Cards Inc. in Kansas City, Kan.

"I think it's been a major problem to all of us, big or small. And I would have to disagree with Mr. Bailey. . .I think all (Risk & Insurance Management Society) members, big or small, have got a lot of situations in where there just has not been availability," Mr. Heydinger said.

"We have been willing to pay for it, even though we think it's overpriced and certainly not the product that it was a few years ago. But it has not been made available to us," he said.

Mr. Heydinger and Mr. Bailey made their remarks during a forum on the commercial liability insurance marketplace—in 1987 and beyond—held at the close of the Midwestern Zone meeting of the National Assn. of Insurance Commissioners, held Sept. 7-10 in Des Moines.

N·A·I·C DesMoines

A six-member panel, in addition to several members of the audience, including a number of state regulators, discussed and debated the recent crisis in the commercial liability insurance market.

They also discussed topics including alternative risk financing mechanisms, reinsurance and tort reform.

Mr. Bailey noted during the discussion that Aetna is now able to provide more coverage in some property/casualty lines.

"I must add two important qualifiers. First, the surplus which many experienced insurance people consider adequate for a responsive insurance marketplace is not yet in place," he said.

"Second, there are some risks my company will not plan to write with any-size capacity," he added. "For example, as long as hazardous waste suits are based on a joint and several liability system with no requirement for cause-in-fact, we won't underwrite gradual pollution exposure or provide protection for owners or operators of hazardous waste sites."

Fireman's Fund Insurance Cos. in Novato, Calif., also will not write pollution exposures, its top executive told the gathering.

"Nobody can cover pollution liability now," said John Byrne, chairman and chief executive officer of Fireman's Fund and another panelist.

And as for other commercial liability lines, Mr. Byrne believes there's a need for another round of price increases of about 15%, plus inflation.

"We took some time getting ourselves into this mess and I think we all know

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N.Y. examining taxicab insurer

By AVRA WING

NEW YORK—About one-quarter of all New York City taxicabs could lose their liability insurance if Yorktown Indemnity Co. is forced to stop operations following a review of its finances by the New York Insurance Department.

Two of three other insurers that underwrite coverage for taxis in New York City said they would be unwilling to pick up Yorktown's book of business, which largely consists of minifleets composed of a handful of cars operated by different shifts of drivers on a rental basis.

The third insurer is considering filing with the Insurance Department for approval of rates to apply to such high-risk business.

The examination of Yorktown, which writes coverage for approximately 3,200 New York cabs, has revealed "serious concerns" about the financial situation of the company, an Insurance Department spokesman said.

The financial concerns are linked to inadequate reserves, a poor premium-to-surplus ratio and lack of sufficient reinsurance, the spokesman indicated.

As of June 30, Yorktown had written $11.8 million in direct premiums and $11.2 million in net premiums this year, according to the Illinois Insurance Department. Policyholders surplus totaled $1.6 million.

Although Yorktown is domiciled in Illinois, its book of business consists solely of New York risks. The Illinois Insurance Department is not conducting a separate examination at this time, the New York department spokesman said, but is "relying" on information gathered in New York.

If the insurer were found to be insolvent, the New York department probably would close it, according to the spokesman, who added that the examination would be concluded "relatively soon."

However, according to Scott Mollen, an attorney for Yorktown, the department raised questions only about the timing of premium payments to the insurer by its underwriting agent, Surface Carriers Agency Transport Ltd.



Photo: AP/Wide World

Many New York City cab drivers would lose their liability coverage if Yorktown is forced to halt operations.

The insurer—purchased last year by S.I.R. Management Corp. of New York from American Commercial Liability Insurance Co. of Grand Rapids, Mich.—began in January to write minifleet coverage.

The company's 1985 annual statement showed no gross or net premiums; earned premiums of $43,145; an underwriting loss of $342,928; investment income of $290,147; a net loss of $303,294; and policyholders surplus of $2.15 million.

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Pollution liability

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ers for Gulf that were on the risk prior to the time in which the damages were recoverable, but at the time the pollutants were released, had to defend and indemnify Gulf for damages manifested after the policy's expiration.

Continental Re argued that release of pollution during 1972 through 1978—the period during which it covered Gulf—that resulted in damages after the policy period, were not covered by the policy.

In his decision, Judge Ryan ruled that only those insurers after December 1979 for the nuisance claim and December 1980 for the Superfund claim were liable.

"The language of the policies is clear and unambiguous," Judge Ryan said. "The property damage for which insurance is provided must occur during the policy period.

"The policy coverage focuses on the time of the occurrence of the damages and not the time of the event which gives rise to the damage," he continued.

But because Continental Re insured Gulf from 1972-1978 and the state could only recover after 1979 for the nuisance claim and 1980 for the Superfund claim, "the Continental policies do not provide coverage for any damages which the plaintiff may recover in this action," the court said. "Continental has no duty to indemnify the defendants in this action."

However, because insurers have a duty to defend until it is determined that they owe no coverage, Judge Ryan ruled that Continental owed Gulf a duty to defend until the date of his ruling.

"The complaint states a claim against the insured during the Continental policy period, and arguable claims and a potential for coverage have existed until the date of this order," the court said.

'Continental has no duty to indemnify the defendants in this action,' Judge Ryan ruled.

"Since a declaration of non-coverage is herein entered by the court, the duty to defend lapses on the date of this order."

Similarly, Aetna—whose policies written for Gulf ran from Nov. 1, 1967, to April 15, 1972—also had no duty to indemnify Gulf because its policies lapsed prior to the time for which damages may be recovered, the court said.

However, Aetna also had a duty to defend until the order was announced because claims contained in the complaint against Gulf related to activities that took place during the time Aetna insured Gulf, the court added.

So far, Gulf's defense costs in the underlying litigation have been funded through an interim agreement with Aetna, Continental and Gulf each paying one-third of the costs. About $400,000 has been expended in defense costs for the underlying litigation.

The court also rejected Admiral Insurance Co.'s contention that it did not owe Gulf coverage because the pollution was "expected or intended" under the policy.

At issue was whether there was an "occurrence" under the policy, which the policy defined as "an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage 'neither expected nor intended' from the standpoint of the insured."

Admiral argued that the "injury" or property damage occurred on a fairly regular basis and thus was "expected." Thus, the insurer claimed there was no occurrence and subsequently no coverage.

The court disagreed, however, ruling that what determined an occurrence was not whether the injury or damage was expected or intended but whether the polluting event was.

"If Admiral is seriously contending that its insurance covers only unexpected injuries, it is likewise arguing that it covers nothing indeed," the court said.

It noted that the language "expected" and "intended" describes the "accident" or the event, and not the resulting harm. If the event or accident is expected or intended, it is by definition not an accident.

"To exclude from coverage damages which are expected to be the result of an accident is to provide no coverage at all," the court added.

In other rulings, Judge Ryan:

- Found that it was premature to address various other arguments by Admiral in which it seeks to deny coverage to Gulf because its policy did not cover "production releases" but only activity involved in the shutdown and sale of the underground mine; did not cover claims arising from "erosion"; and because it did not receive adequate notice from the policyholder.
- Ruled that Gulf could not sue Admiral under the state "trade practices and frauds" statute, but that the company could pursue a claim for punitive damages.
- Dismissed Home Indemnity Co. from the litigation, ruling it had neither a duty to defend nor indemnify the defendants.

Home Indemnity wrote CGL policies for Gulf from July 31, 1963, to March 15, 1968.

- Ruled that Pacific Indemnity Co., which issued three policies between 1972 and 1975 to a joint venture of Bunker Hill and Stauffer Chemical Co. called North Idaho Phosphate Co., insured the individual members of the venture, not just North Idaho.
- Denied motions for summary judgment on the issue of duty to defend and indemnify from Jervois Underwriters and Fidelity & Casualty Co. of New York.

Jervois, a Lloyd's of London underwriter, wrote coverage for Bunker Hill from April 1958 until January 1966, while Fidelity & Casualty wrote coverage for North Idaho Phosphate from Jan. 1., 1975, through Jan. 1, 1981.

Other insurers named in the litigation, although not mentioned in Judge Ryan's decision, include First State Insurance Co., Northwestern National Insurance Co., Northwestern National Casualty Co., The Insurance Co. of the State of Pennsylvania, Pacific Insurance Co. and Insurance Co. of North America.

Last week attorneys in the case differed on its significance.

An attorney for Aetna said the decision was very important.

"It is an extremely significant decision. We are pleased with what Judge Ryan did," said Scott D. Hess, with the Boise firm of Eberle, Berlin, Kading, Turnbow & Gillespie.

"Because Gulf was not legally obligated to pay for anything prior to 1980, there was no compensable property damage during the policy period," he explained.

While Mr. Hess added that the decision was "pro-insurer" and limits coverage available to policyholders, he noted that it applies only to natural resource claims brought under the Superfund Act.

However, a Continental Re attorney said "there was no innovative new legal approach taken."

"From our standpoint, the court read the language of the insurance policy in the plain ordinary meaning as the policy is written," said Mark Lyons, with the Boise firm of Quane, Smith, Howard & Hull.

Attorneys for Admiral and Gulf declined to comment. ■



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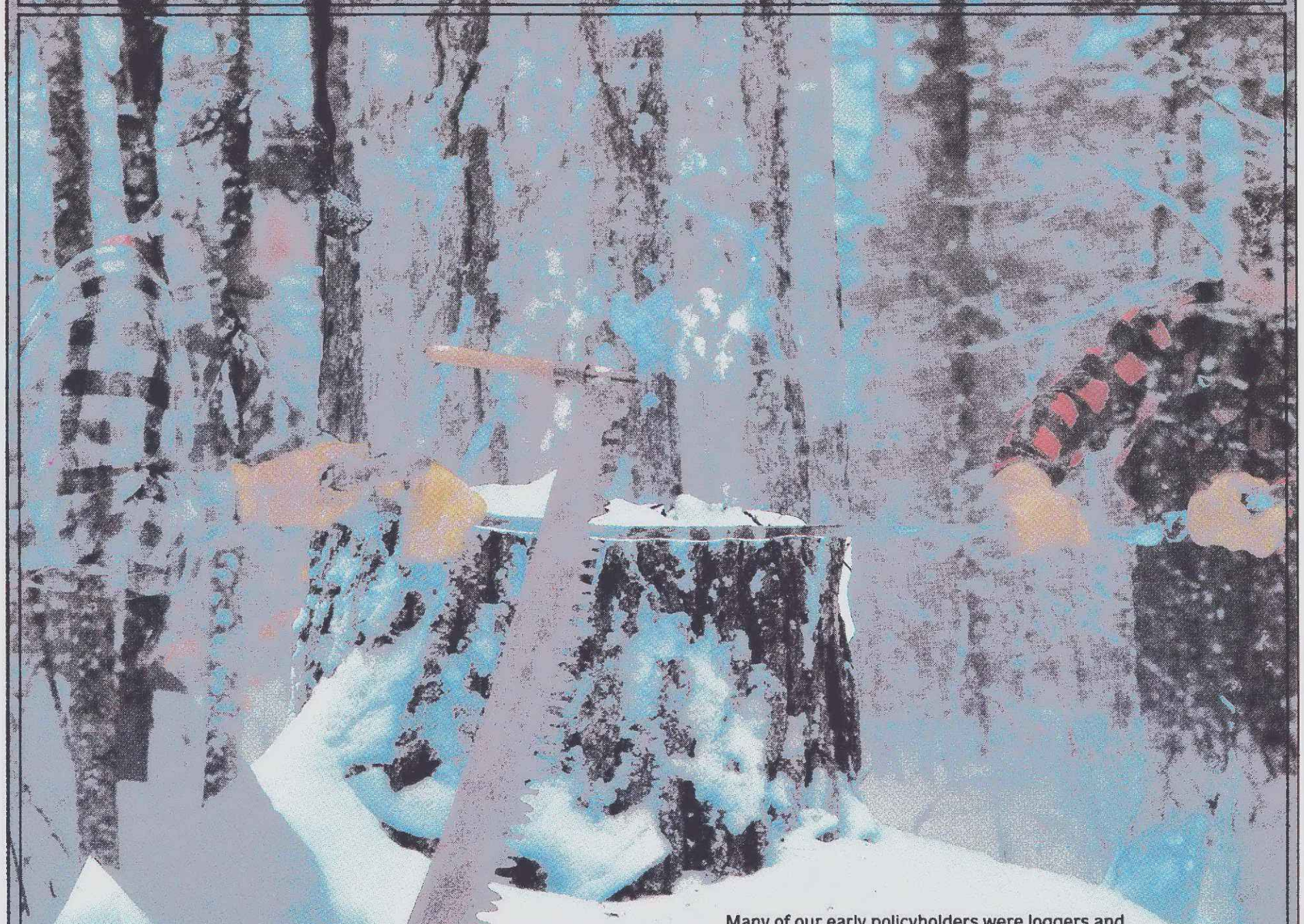
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Maine work comp

Continued from page 1

House Speaker John L. Martin, D-Eagle Lake, adding that if insurers are going to pull out, "the sooner the better."

The state's voluntary assigned risk plan now handles about 80% of the workers compensation policies written in Maine, because insurers—citing inadequate rates—have been withdrawing from Maine's commercial marketplace during the past few years.

These assigned risk policies equal about 50% of the premium volume, according to state officials.

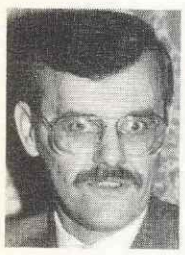
Some 133 insurers that write workers compensation business in Maine participate in the assigned risk plan by paying pool losses in proportion to their share of business in the commercial workers comp market. Insurers were assessed about $7.9 million in this year's first quarter.

With less coverage available on the open market, employers, especially small- and medium-sized employers, have turned to the plan to buy workers compensation ocverage. Larger employers, in most cases, have been able to self-insure their workers compensation risks.

Insurers have been hesitant to completely withdraw from Maine, because many of them service national accounts—employers that have operations in several states, including Maine.

But, the seven insurers that are acting as service carriers for the pool—officially known as the Workers Compensation Insurance Plan—have announced they are unable to take on more business because they don't have the staff in Maine to handle it. The service carriers administer claims and give loss prevention advice to policyholders.

Those seven insurers are Hartford Insurance Group, Travelers Corp., Aetna Casualty & Surety Co., Commercial Union Insurance Co., Maine Bonding & Casualty Co., New Hampshire Insurance Co. and Hanover Insurance Co.



Mr. Briggs

Liberty Mutual Insurance Co., which historically has had the largest share in the Maine workers comp market, and U.S. Fidelity & Guaranty Co. also were servicing carriers, but withdrew last year.

In response to the seven insurers' actions, Mr. Briggs issued an order last month requiring the pool's administrator, the National Council on Compensation Insurance, to assign new business coming to the residual market to all insurers in the state that individually, or as part of a group, had a voluntary share of the states workers comp market that averaged 1% or more from 1983-1985.

The NCCI, however, says that its members do not want their rate-making organization to be part of a mandatory assigned risk pool.

Therefore, the NCCI is withdrawing as the administrator of the plan as of Oct. 1.

That in turn prompted Mr. Briggs to call a meeting for Sept. 26 to discuss alternative mechanisms to service the residual market.

"My job is to provide service to any new risks in the assigned risk plan," he noted.

But, insurers, which want a dramatic increase in Maine workers compensation rates, say they are unsure what they will do if the superintendent forces all 133 or so workers comp underwriters in the state to participate in the assignment of policies for the residual market.

The voluntary assigned risk plan now handles about 80% of the workers compensation policies written in Maine, because insurers—citing inadequate rates—have been withdrawing from Maine's commercial marketplace during the past few years.

"Each member insurer is taking a look at the situation," said the AIA's Mr. DiGiovanni.

"The future just doesn't look very bright," said Joseph P. Hegarty Jr., a senior vp in the Boston office of the Alliance of American Insurers.

Maine workers compensation rates were last increased an average of 25% in March 1981. Legislation enacted last year mandated that rates be decreased at least by an average of 8% on Aug. 1, 1985 (*BI*, March 25, 1985).

According to that law, workers compensation rates are frozen through this year, following the 8% reduction in rates. In 1987 and 1988, rates may be increased, but the increases are limited to 10% each year.

This mandatory decrease in rates prompted even more workers compensation insurers to cut back on the amount of new business they write in Maine (*BI*, July 1, 1985).

Mr. Briggs was planning to announce by the end of last week the results of a series of hearings held earlier this year to determine whether the 8% rate reduction was adequate, or whether rates should be lowered even more. Such a determination was called for in the 1985 legislation.

The superintendent would not release in advance his decision on the rate reduction, though all indications are that the reduction will remain at 8%.

Mr. Briggs also told *Business Insurance* earlier this month that workers compensation rates in Maine are inadequate, but he could not say by how much.

Without either a voluntary marketplace for workers compensation insurance or a residual marketplace, the Legislature probably would create a monopolistic state fund, many work comp observers speculate.

Almost annually, House Speaker Martin has introduced legislation calling for a monopolistic state fund, which would bar insurers from writing workers compensation business in the state.

The legislation would give that task to a specially created, quasi-governmental insurance company.

Six states currently have such monopolistic state funds, while 13 others have competitive state funds that compete with the private market.

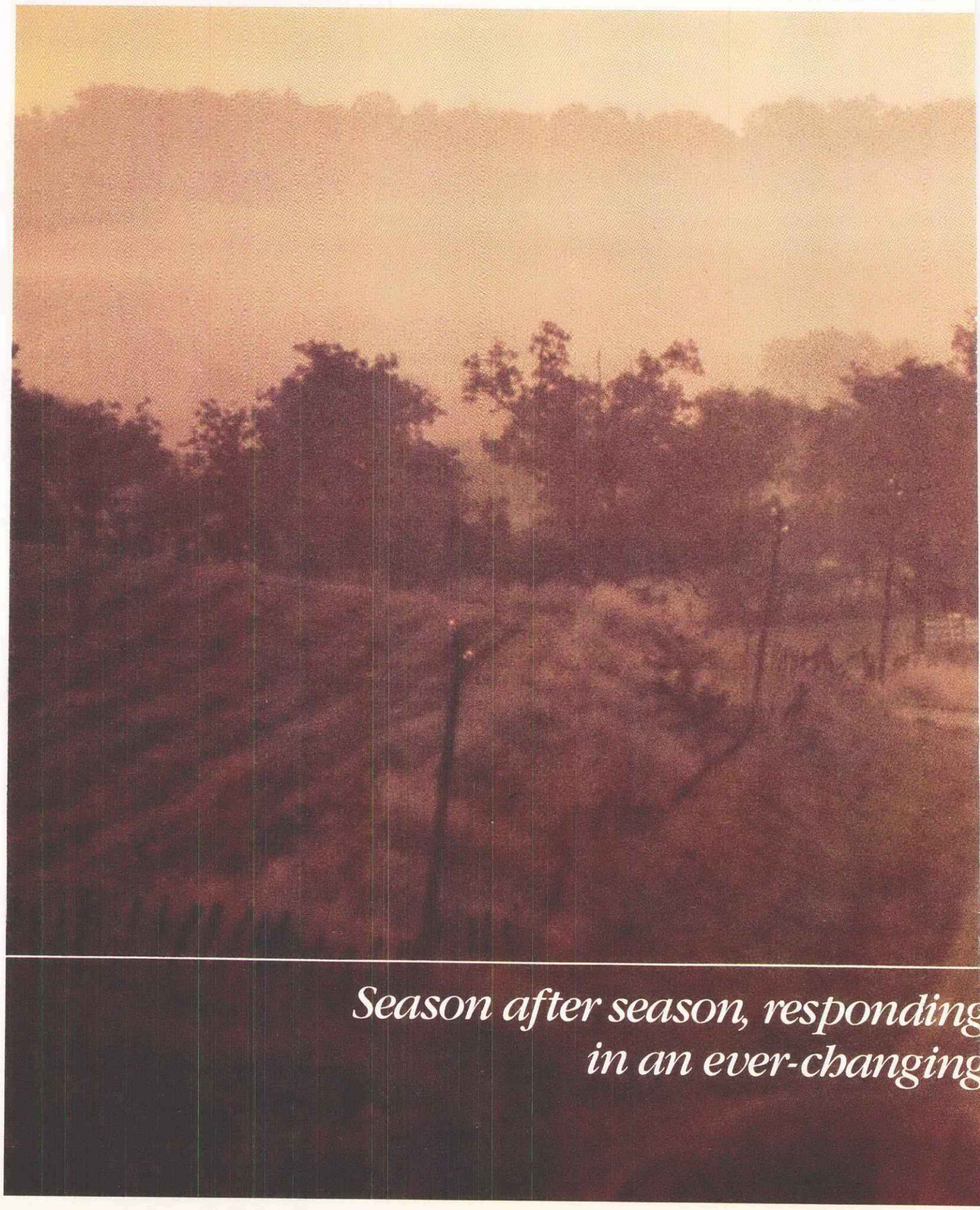
The scenario that is playing out in Maine has implications for the rest of the country, according to Steven D. Millikan, who is vp and director of workers compensation for the Alliance in Schaumburg, Ill.

"We see it in the rating laws. . .perhaps in the benefits structure. What one state does is importable in this day and time," Mr. Millikan said.

When something "unique or punitive" is done in one state, "other states pick up on it," said Mr. Millikan.

"Whatever happens in Maine. . .I think there will be

Continued on next page



Continued from previous page
other ripples in other states with problems," he said.

Rate inadequacy, in particular, appears to be a watched item these days, he said, referring to several other state situations, including a pending 71.1% average rate increase in Louisiana (see story, page 3), and a recent Oklahoma Supreme Court ruling that overturned an average 25.9% work comp rate increase that took effect Nov. 1 and ordered a refund (*BI*, Aug. 4).

Insurers see what is going on in Maine, Louisiana and Oklahoma and in other states, and may make decisions about withdrawing from the market accordingly, predicts Mr. Millikan.

Insurers in Maine say rates need to be increased more than 200%, according to the latest NCCI estimates.

However, employers say it is impossible to determine an accurate rate level, since rate filings in recent years have been denied by Mr. Briggs, who has claimed the NCCI rate applications lack sufficient information.

'In terms of what insurance carriers are entitled to or need in Maine. . .I don't think anyone knows, objectively. Sure, we know what insurers say. . .and we will know when—if—the market becomes competitive,' Mr. Clarkin says.

"No one knows" what rates should be because "a lot of the information needed to establish rates has not been presented," said Stephen Clarkin, director of government relations for the Maine Chamber of Commerce & Industry in Augusta.

"I suspect the trend of placing employers in the assigned risk plan will continue. Sooner or later, all risks in the assigned risk plan will create a problem for employers," he said.

"I don't think we're looking at this yet as a legislative problem," Mr. Clarkin said.

However, he added that several changes are needed in the Maine workers compensation system, "particularly the benefits structure."

"It's nearly impossible to get injured workers back to work," Mr. Clarkin said.

But another part of the problem is the state's "tough" ratemaking laws, he said.

"In terms of what insurance carriers are entitled to or need in Maine. . .I don't think anyone knows, objectively. Sure, we know what insurers say. . .and we will know when—if—the market becomes competitive," Mr. Clarkin said.

And, self-insurers also are affected by the worsening workers compensation insurance market in Maine.

"Whenever you have a bad atmosphere, it really affects all lines" of insurance, explained Roger L. Andrews, manager of insurance and safety for Hannaford Bros. Co. in Scarborough, Maine, as well as chairman of the Maine Council of Self-Insurers.

The current situation gives Maine a bad name, Mr. Andrews said.

"As a council, we're going to work with the Legislature to change the system," he said, adding, however, that it is a slow process.

The National Federation of Independent Business, which represents about 4,600 employers in Maine, most of which have fewer than 12 employees, also will work with the Legislature and the insurance superintendent to improve the situation, said David Clough, the group's director of state governmental relations.

Most of the federation's members buy workers compensation insurance through the assigned risk plan but are unaware of it, since they are issued a policy from an individual insurer, Mr. Clough noted.

Organized labor in Maine also wants to work with the Legislature to improve the state's work comp system, but is less concerned with rates and more concerned with safety, according to Patrick McTeague, an outside attorney for the Maine AFL-CIO.

Better safety and loss-prevention programs are needed, Mr. McTeague said.

The AFL-CIO is drafting legislation it hopes to have introduced next year that would allow manslaughter charges to be filed against corporations and their owners in negligent workplace situations that result in employee deaths or serious injuries, Mr. McTeague said.

Insurers, however, hope the Legislature will give them rate relief exceeding the 10% rate hike allowed in the law enacted last year.

"There is a disbelief, on the part of legislators, labor and business, that rates are woefully inadequate," said Peter Burton, director of government, consumer and industry affairs for the NCCI.

He says the latest indication is that rates are inadequate by 205% in Maine.

"Here's a state that, for whatever reason, allowed for the suppression of rates—at least that is the perception of the insurance industry," Mr. Burton said.

Insurers will withdraw from the marketplace, Mr. Burton predicts. And, in the long run, employers "may be receiving their insurance from a source other than the insurance industry," he said, referring to a state fund.

Insurers say they are not sure what Mr. Briggs will do in light of the NCCI's withdrawal as administrator of the assigned risk pool and the capacity problems of the remaining servicing carriers.

But, it appears that the insurance superintendent must create an assigned risk mechanism.

Representatives from the insurance trade associations, however, say their members are opposed to accepting assignments beyond their capacity, and probably will go to court to fight such a move.

For instance, John W. Purkis, vp and manager of business markets operations for Liberty Mutual Insurance Co. in Boston, said his company will accept new business through a mandatory assigned risk pool, but it also will challenge the action in court.

Liberty Mutual has about 28% of the workers compensation market in Maine and would be assigned residual risks based on that percentage.

However, Mr. Purkis joined officials from the insurance trade associations in saying that the situation was difficult to evaluate at this time.

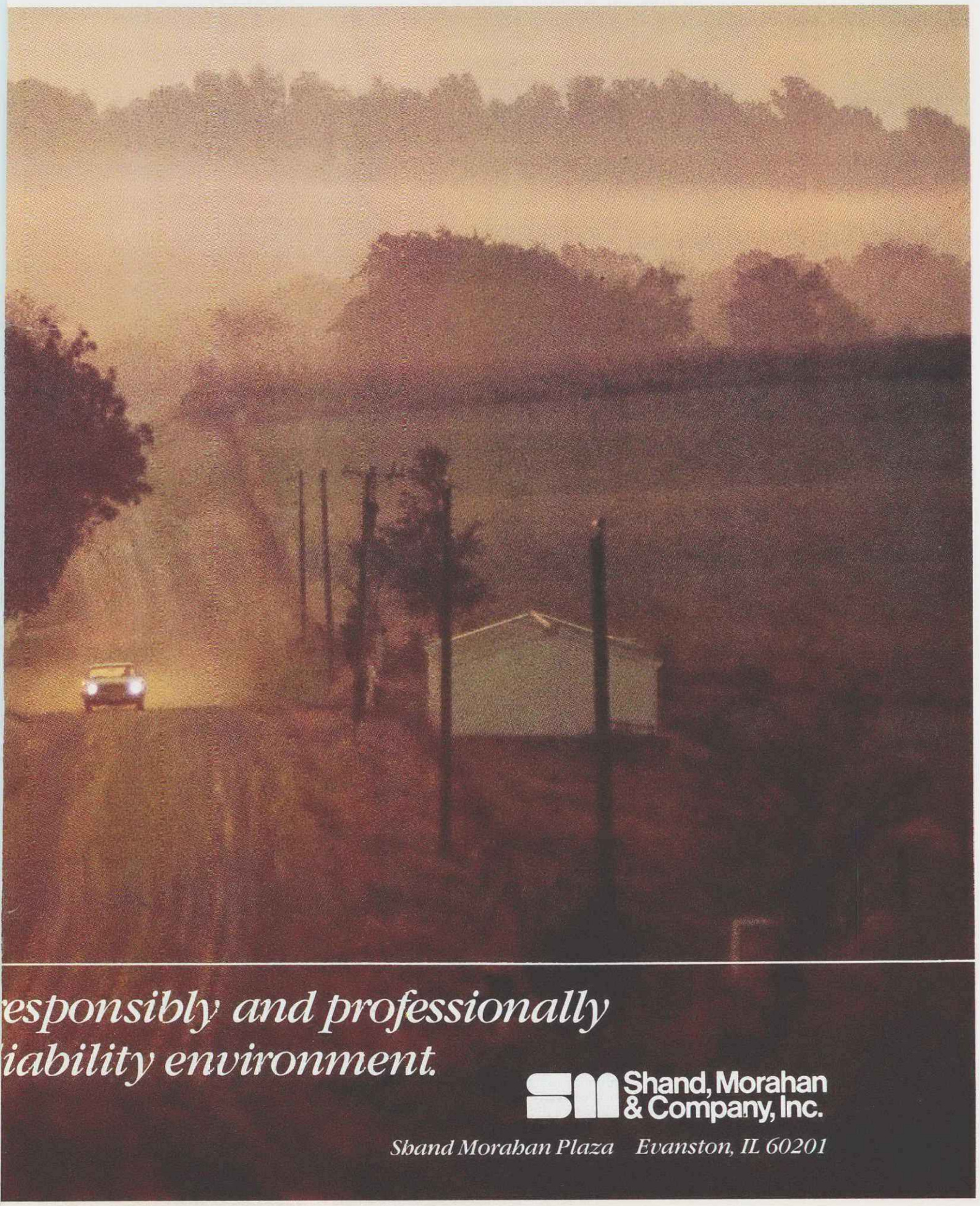
"We are waiting to see what happens," he said.

The Alliance's Mr. Hagerty blames the current situation on legislative action and regulatory response, as well as on employers' insistence on low rates.

Insurers that belong to the Alliance "are just going to wait," Mr. Hegarty said.

"We are not throwing our hands up in abandonment," Mr. Hegarty said.

"But we are saying: 'You (employers) created this, you fix it.'" ■



opinions

New tort reform challenges

THE BATTLE isn't over yet.

As we noted last month, we're encouraged that an unprecedented number of states—some 34 in all—enacted tort reform measures this year.

But enactment of those measures, a vital necessity to ease the liability insurance crisis, is just one stage in the drive to restore balance to the legal system. A sweeping tort reform measure is meaningless if it can't pass court muster.

Now, plaintiffs' attorneys in at least 10 states are going to court to challenge the constitutionality of tort reform actions. And, the challenges won't be limited to those states. The state legislative counsel for the Assn. of Trial Lawyers of America says that challenges eventually could be mounted in any state where tort reform legislation is enacted.

The reasons behind the trial lawyers' challenges are simple: Tort reforms that, among other things, cap damage awards and limit contingent fees will result in less money in the pockets of plaintiffs' attorneys. No one will be able to convince most plaintiffs' attorneys that the benefits of tort reform outweigh the drain on their income.

But risk managers and others, who believe that civil justice reform is necessary to restore balance between the rights of defendants and plaintiffs, can take several steps to counteract the plaintiffs' attorneys efforts.

First, buyers, insurers and others can file briefs in litigation challenging individual state tort reform laws. Insurance industry trade groups for many years have filed briefs in lawsuits against insurers. Now is the time for buyers, brokers and underwriters—all of whom have pledged their wholehearted support for tort reform—to join together to draft persuasive arguments that can be filed with the courts hearing the challenges.

Secondly, those drafting tort reform legislation in states that have not yet enacted such laws—and in those states in which tort reforms have been passed but additional reforms are needed—must make sure the wording of the legislation can withstand any legal challenge.

While we're sure sponsors of tort reform legislation draft their proposal as carefully as possible, sometimes extra care is required.

For example, the wording of Proposition 51, the ballot initiative approved by California voters on June 4 that repeals joint and several liability for non-economic damages, is not clear as to whether the measure applies to cases pending trial when it was approved (*BI*, Aug. 18). Plaintiffs' attorneys are now asking courts to bar application of Proposition 51's provisions to suits filed before June 4.

Proposition 51 drafters say they did not include a clause stating the measure was to apply retroactively because they thought that notion was clear, and because they did not want to give opponents an additional argument to use in their attempts to defeat the initiative. Perhaps, in hindsight, that was a gamble that should have been taken.

The victories that have been achieved in 34 states this year are only a beginning.

If tort reform advocates fail to resist legal challenges and the new laws are overturned, all those hard-earned victories in state legislatures will prove to be hollow.

Tort reform supporters must be on guard to make sure that those new laws, if challenged, are defended in court.

letters

Attacks against claims-made form are unjustified

To the editor: Changes are seldom implemented within an organization or industry without much discussion and, almost inevitably, resistance to any modification of the status quo. Honest debate serves an appropriate and valuable purpose by preventing changes from being implemented without due regard for their consequences and the legitimate interests of those who will be affected by them.

However, no constructive purpose is served when relevant facts are consistently misrepresented by either party to a debate. Such has been the case on recently published attacks against the claims-made commercial general liability policy form.

The claims-made policy is an established, viable and proven product. It has been used successfully for more than 10 years, through hard market and soft, by medical malpractice insurers and for 20 to 25 years in other professional liability lines.

The same conditions which long ago made the claims-made form appropriate and necessary for professional liability coverage now apply equally to commercial general liability risks with latent injury or other long-tail exposures.

And all of the horror stories regarding widespread gaps in coverage, the cost and availability of reporting endorsements, continuity and understandability of the claims-made concept—though they never materialized—also continue to turn up in trade and professional journals.

Yet, it more complicated. But so are the mechanisms of the modern automobile far more complex then the workings of a Model T. Most would agree, however, that despite its complexity, today's auto is far better suited to serve the needs of modern society. The same notion holds foı the increased complexity of medicine, science, farming—and insurance.

Many brokers, agents and customers already are very familiar with the claims-made concept. And for those who are not, the Insurance Services Office and insurers offering claims-made CGL policies are going to great lengths to assure that accurate and understandable information about the new policy form, its applications and the effects of changing from occurrence to claims-made coverage is available to all.

The claims-made form does not solve the problem of increasing claims frequency and severity. It does enable insurers to better cope with it by providing timely and accurate indications of trends in underlying loss costs.

Some early criticisms of the claims-made CGL form were valid and resulted in noteworthy improvements to policy forms. However, those who persist in tearing apart the claims-made concept overlook its proven success and fail to offer a viable alternative that would encourage insurers to offer coverage in a volatile liability environment.

Until critics come forward with something better, insurers, agents and the insurance consuming public will be better served by claims-made than by the absence of any coverage.

Frederick P. Themmes
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General Liability
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St. Paul, Minn.

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Use care in setting up triple-option health plan

To the editor: John D. Moynahan, executive vp of Metropolitan Life Insurance Co., indicates in "Improved Workers Can Help Improve Health Care: Insurer" (*BI*, Aug. 18) that he believes many employers will move toward a triple-option health plan.

These employers will offer to their employees a package consisting of an indemnity plan, a preferred provider organization, and a health maintenance organization. Typically, these three options will be offered through one service entity: a hospital corporation or an insurance company.

I agree with Mr. Moynahan that this is the trend. However, dangers lie ahead.

The current crop of triple option plans are all geared toward encouraging employees to select PPO or HMO alternatives. There is a fine line between encouragement and coercion.

If the indemnity option provides only 70% reimbursement with a $300 deductible, and the PPO option and/or HMO option involve virtually no out of pocket expenses, the average employee really has no choice. He simply will not be able to afford the indemnity option.

In the past, employers simply reimbursed 80% of medical bills—with the employee totally responsible for physician selection. If an employer now coerces an employee into selecting a PPO or HMO provider, that employer must accept liability.

Triple options are a good thing—if they are designed correctly. If not, more and more employers will be defendants in malpractice suits.

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President
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New York sets flex-rating regulations

NEW YORK—New York Insurance Superintendent James P. Corcoran has announced a flex-rating regulation that permits insurers to revise rates from 10% to 30% for more than 20 classes of business without prior approval.

The regulation was promulgated in accordance with tort reform legislation recently signed into law by Gov. Mario M. Cuomo (*BI*, June 30).

According to the department, the regulation also establishes refiling requirements and flex-rating rules and standards, and delineates markets exempt from flex-rating.

Insurers were given the flexibility to adjust rates up or down by 10% for child care liability coverage and directors and officers liability insurance for non-profit entities.

around the states

Lines of business given a plus or minus band of 15% were municipal liability; public school liability; public officials liability; non-profit philanthropic and civic activity liability; recreational liability; other owners, landlords and tenants liability; other manufacturers and contractors liability; liquor law liability; non-livery commercial motor vehicle polices; commercial multi-peril combined effect; business owners policies; and business auto policies.

Twenty percent bands were granted to other directors and officers liability; professional liability; others errors and omissions liability; product liability; completed operations liability and all other liability.

Bands of 30% were approved for high-limit excess liability renewal policies and "A"-rated renewal policies, which refers to any insurance coverage for which rates are individually determined based upon judgment because neither a rate service organization nor the insurer has yet established a manual rate based upon experience.

Lines of business that were exempted by the superintendent from the flex rating regulation include fire and allied lines, ocean marine, inland marine, fidelity, surety, burglary and theft and credit insurance.

The regulation applies to all new policies written in New York on or after Oct. 1, and for all renewal policies written on or after Dec. 1, 1986.

Malpractice warning

SPRINGFIELD, Ill.—The Illinois Insurance Department is warning doctors about buying medical malpractice insurance from Professional Risk Insurers Management Exclusive Co. Ltd.

The department issued an administrative cease-and-desist order earlier this month against PRIME, which is based in Kingstown, British West Indies, because it is not eligible to sell insurance in Illinois.

However, PRIME uses a Chicago post office box and telephone number "which lead prospective insureds to believe that PRIME is located and licensed in Illinois," an Insurance Department spokesman said.

State officials are also warning potential customers to avoid buying coverage from a PRIME affiliate, International Bahamian Insurance Co. Ltd., which writes insurance for podiatrists.

Illinois officials have learned that policyholders in three states—Colorado, Oklahoma and Michigan—have complained that the insurers have refused to pay malpractice judgments, according to Tris Schnepper, the department's supervising insurance deputy.

Typically, according to the department, PRIME supplies an attorney to represent a policyholder defendant. If the doctor loses, PRIME delays paying the judgment until the deadline passes for filing an appeal; PRIME then refuses to pay and cites a nonexistent policy provision requiring the doctor to personally file the appeal, Mr. Schnepper said.

A hearing has been set for Oct. 1 on the department's cease-and-desist order, which applies to PRIME, IBI and other affiliates.

In October 1981, IBI was permanently enjoined from transacting and soliciting insurance business in Illinois because of similar problems.

Illinois Insurance Director John Washburn said PRIME and IBI have completely circumvented the regulatory structure.

"For all practical purposes, the cease and desist order will have little effect on the company's operations, since our only option at this point was to mail it to the post office box," he said.

The department says it has enlisted the help of the U.S. postal authorities to close the post office box.

Dennis Simon, an attorney in Southfield, Mich., for PRIME and IBI, said it is the companies' position that they are not engaged in selling insurance in any of the United States because all policies are requested and executed in St. Vincent, West Indies.

He also denied there were problems in claims payments, and disputed the complaints cited by the department that the policies lack provisions that policyholders must personally post appeal bonds.

Washington rates

OLYMPIA, Wash.—Workers compensation rates in Washington will remain at the current level through the end of 1987, according Gov. Booth Gardner.

"There will be no general industrial insurance rate increase in 1987 as a result of further improvements in the financial status of the Washington State Industrial Insurance Trust Fund," the governor said earlier this month.

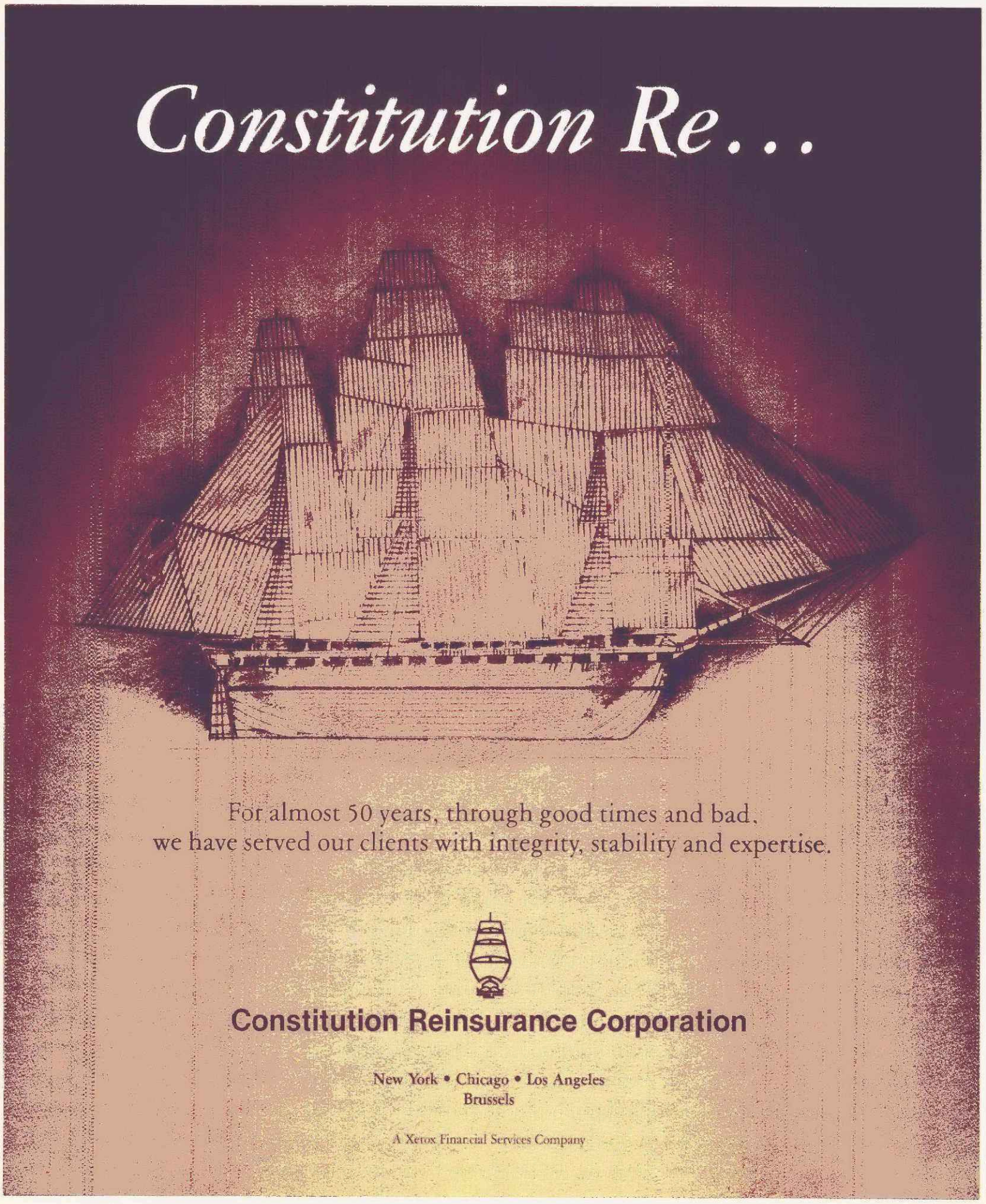
Washington is one of six states that have a monopolistic state fund, which bars commercial insurers from selling workers compensation insurance.

The state fund showed a deficit of $38 million as of June 30. This compares with a $225 million deficit in mid-1985, which resulted in an average 18% rate increase that came on the heels of an average 30% increase in 1984.

The fund is administered through the Department of Labor and Industries, which has been under new management since January 1985. Dick Davis is director of the department.

"Businesses across the state continue to benefit from the sound and aggressive management that Dick Davis has brought to the Depart

Continued on page 14





There seem to be an awful lot of benefit administration and reporting systems out there that have a sort of backwards way of looking at things. Fact is, when you have to make a benefit plan change of one kind or another, you have to go out of your way to "accommodate" the system.

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around the states

Continued from page 12

ment of Labor and Industries. He and the employees at L&I have literally turned that agency around," the governor said.

With no increase in workers compensation rates for the rest of this year and all of 1987, employers that pay into the fund will go 30 months without a general rate increase, according to Gov. Gardner.

In contrast, workers comp costs are increasing at an average rate of 16% a year nationally, he added.

The lack of work comp rate hikes for 1987 is the result of the agency's efforts to control costs for health care and other benefits, as well as strong anti-fraud efforts, improved claims management and increased investment income, Mr. Davis said (*BI*, Feb. 3).

"We're pleased with the progress we've made on the financial side of the equation, but we know we still have a long way to go," Mr. Davis said.

L&I will make industry- and employer-specific rate adjustments in January, Mr. Davis added.

"Although the average rate will hold steady, we will adjust basic rates for industrial classes and individual employers to reflect changes in the frequency and severity of accidents that have taken place," Mr. Davis said. "Some rates will increase, some will decrease. On average, however, rates will remain the same."

Texas self-insurance

AUSTIN, Texas—Counties in Texas soon will be able to self-insure their general liability risks under a new law passed earlier this month.

Gov. Mark White is expected to sign H.B. 99, which will authorize the creation of a County Government Risk Management Pool, through which the state's 254 counties will be able to self-fund their general liability exposures.

Sam Clonts, executive director of the Texas Assn. of Counties, said his group helped draw attention to the liability insurance crisis the state's counties were experiencing.

Part of the association's involvement was to conduct surveys on the liability crisis and use the results to push for the bill.

"We did surveys on availability, and the attorney general's office did surveys," Mr. Clonts said.

He said the results from the two reports "meshed," revealing that "companies were lumping all government entities together," and refusing to write the coverage.

And, he added, "Losses were not there to justify not writing the business" for Texas counties.

With help from the association, the bill was authored by Rep. John Gavin and Sen. Ray Farabee, both Democrats from Wichita Falls.

Mr. Clonts said the pool probably will provide limits of $300,000 per occurrence and $100,000 per person. Government entities in Texas are immune from awards higher than those amounts under the Texas Tort Claims Act.

In addition to general liability coverage, the pool eventually may provide counties with errors and omissions coverage and liability insurance for automobiles and trucks.

The pool will be created when at least 10 counties agree to contribute funds. The founding counties will appoint a nine-member temporary board of trustees to develop an organizational plan, which will outline premiums, coverage limits and other fees to be charged by the pool. In addition, underwriting guidelines will be structured and procedures for purchasing reinsurance will be established.

The bill calls for the temporary board to complete its organizational plan within 90 days of the board's appointment. A regular board will be established 15 days after the plan is completed.

As a member of the pool, any county will be able to obtain coverage, regardless of its loss history, during the first year.

However, counties may be required to participate in a "risk management appraisal and adhere to the recommendations of such appraisal," the bill states.

If risk management recommendations do not reduce losses to meet the pool's underwriting requirements for the following year, coverage can be denied for subsequent years.

Once a permanent board of trustees is in place, a county government risk management fund will be created. The fund, which will be used to pay claims and administrative costs of the facility, will include premiums, fees and other income due the pool, investments into the fund and interest earned on the pool's investments.

Environmental suit

STOCKTON, Calif.—The San Joaquin County District Attorney's Office is seeking $152 million in civil penalties from Support Terminal Services Inc. for alleged violations of environmental and business laws.

The Dallas-based subsidiary of W.R. Grace & Co. has been charged with, among other things, disposal of gasoline and diesel fuel into an unauthorized lagoon and failure to report some fuel spills.

Fred Johnson, president of Support Terminal Services, did not release the amount of the company's environmental liability coverage, but he noted that parent W.R. Grace has a self-insured retention with excess layers of liability coverage underwritten by several insurers.

He said the coverage would apply to cases of sudden and accidental pollution but, "in general," does not cover instances of gradual pollution. "But there are exceptions on both sides," he said.

Mr. Johnson said some of the charges in the suit "are incorrect," while others "are correct but not necessarily a violation of law. Some are still being investigated."

The district attorney's charges also allege that violation of disposal laws allowed the company to compete unfairly with other storage and transfer firms.

The suit was filed late last month in San Joaquin County Superior Court and addresses alleged violations that occurred during the past three years.

Support Terminal Services stores and transfers gasoline and diesel fuel at the Port of Stockton for several oil companies.

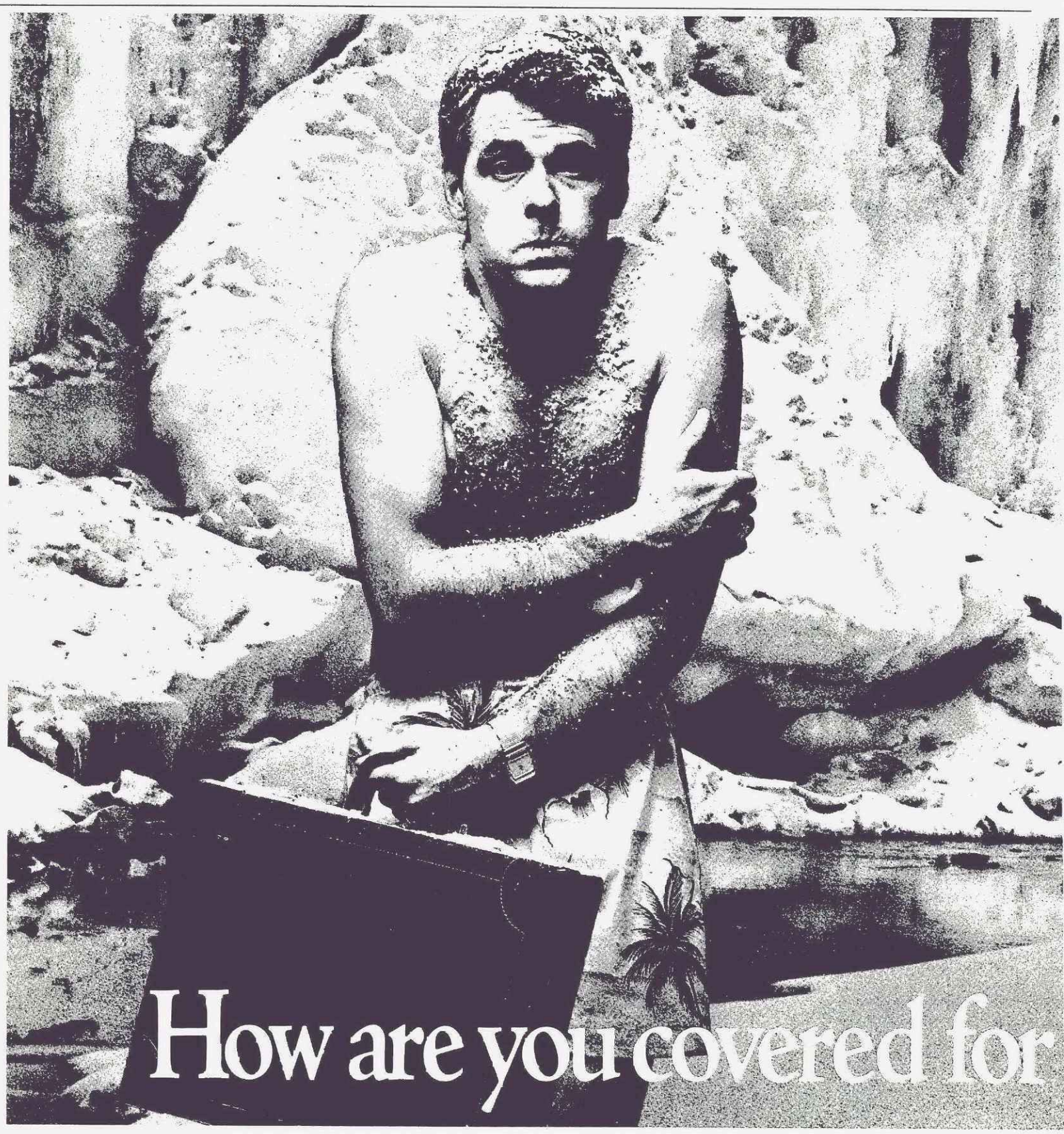
Illinois orders

SPRINGFIELD, Ill.—Illinois Insurance Director John E. Washburn has issued stipulation and consent orders to two commercial liability insurers for violations of state cancellation and non-renewal laws.

Maryland Casualty Co. of Baltimore has been fined $7,500 and asked to correct the infractions, which were identified during market-conduct examinations by the Insurance Department.

Transamerica Insurance Group of Irvine, Calif., has been fined $5,000 and also asked to correct the infractions.

In addition, Transamerica has been ordered to contact all policyholders whose coverage was canceled or not renewed because of the insurer's improper termination of an agency to see if the policies have been replaced to the policyholder's satisfaction. If not, the insurer must reinstate the policies. ■



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Du Pont touts savings of wellness plan

A large chemical company is discovering that a wellness program can save it $2 to $3 in costs related to disability and absenteeism for every dollar it spends to operate the program.

Wilmington, Del.-based E.I. du Pont de Nemours & Co. hired a health educator in 1981 to introduce the program at the company's main plant.

The program has been available to 70,000 employees at more than 75 locations nationwide since 1984, said Bruce W. Karrh, vp of safety, health and environmental programs.

"We were looking for a way to help employees and their families to have healthier lifestyles," he said.

"But, we also wanted to make sure the program was cost-effective and that it was doing something, so we collect and analyze data on how the program is used," he said.

benefit beat

"Now, we have results on how the wellness program has reduced disabilities and absences," he said, though he would not say what the cost of the program is.

"We can't measure what we have saved in health insurance costs because we have changed plans since we've started the wellness program," he said.

But unlike many wellness programs, Du Pont's program involves more than just exercise, Mr. Karrh said.

"The company has given physical exams to employees since 1915. In the wellness program, employees begin with this—a health risk appraisal."

The appraisal examines employees' personal lifestyle factors and their general health condition. After the appraisal, "we tell employees what they need to work on. If the employee agrees, we either enroll them in an appropriate course or provide them with self-help materials," such as smoking cessation products and programs, he said.

"Employee acceptance of the program has been very good," Mr. Karrh added, though he did not provide any figures.

PPO savings

A preferred provider organization and a utilization review program are helping Chicago-based Avondale Industries' Danly Division to contain its health benefits costs.

"We had a Cadillac-type plan before this and our overall costs for all of our salaried and hourly bargaining unit employees were $3.2 million last year," said Eileen Smith, manager of compensation and benefits for the industrial machinery manufacturer.

While she could not estimate the savings under the new plan, "we do anticipate savings," Ms. Smith said.

The company switched from a first-dollar medical plan for its 340 salaried employees to the Blue Cross of Illinois' Participation Provider Option in February, she said. The new plan also includes Blue Cross/Blue Shield's Medical Services Advisory utilization review program.

Under the plan, employees do not contribute to the premium, but they pay a $100 deductible for individual coverage, $200 for coverage of one dependent and $300 for coverage for two or more dependents.

If employees use preferred hospitals, they pay a 15% copayment up to a maximum out-of-pocket expense of $1,150.

If employees do not use a preferred hospital, their copayment is increased to 35% of their total hospital expenses with no cap, Ms. Smith said.

There is a $1 million lifetime maximum on coverage under the plan. The plan also covers organ transplants up to $1 million in a lifetime. And, there is a $50,000 lifetime limit on psychiatric and substance abuse.

But, Ms. Smith says the utilization review program may save the company the most on health care costs.

The program includes preadmission review with length of stay assignment, second surgical opinions, outpatient surgery determination and pre-admission testing.

The service also offers a complete case management program for long-term illnesses. That program includes concurrent review, discharge planning and management of long hospital stays.

The Medical Services Advisory program has helped more than 100 companies to reduce their hospital days per 1,000 employees by more than 1,750, said a spokesman for Blue Cross/Blue Shield of Illinois. The Blues estimate that the program saves an average of $300 for each case reviewed.

Registered nurses work with employees and their physicians from the time the employee telephones the service until the treatment is completed, the Blues spokesman said.

The program suggests alternatives to hospitalization, such as outpatient surgery, but leaves the final decision up to the patient and his or her physician, the spokesman said.

"As an added incentive to use the MSA program, employees who choose not to use the program" pay $500 in addition to any other deductibles and copayments, Ms. Smith said.

"We know that employees are using the program," she said. "And, because of the good feedback from employees who use the advisory program, employees who are not covered under the same plan have tried to call and use the program," she added.

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Continued from page 3

difficult to accurately predict what effect tort reform measures enacted today will have on rates set in the future.

"I perceive that the primary impact of tort reform. . .is that it will tend to stabilize rates and prices over the long term," he said.

A regulatory representative on the panel, Paul A. "Pete" Synott, deputy commissioner of the Virginia Bureau of Insurance in Richmond, said he, too, is a believer in the benefits of tort reform.

"Speaking from one of the states where the battle is still being waged, I believe there will be benefits to meaningful tort reform," said Mr. Synott.

"But I think the industry has to be very careful in projecting credibility on the issue," he added, explaining that tort reform does not mean the cyclical nature of the property/casualty insurance business will come to an end.

Mr. Synott said there is still the danger that underwriters will write to combined ratios of more than 100% when interest rates are high in an attempt to acquire more funds to invest.

On another subject, panel members agreed that regulators are taking more interest in the excess/surplus lines market.

'To the degree that the regulators look after the solvency and financial stability issues of the E&S insurers, we welcome their interest,' says Kenneth Woods of California Union Insurance Co.

The primary reason for increased regulatory interest in the non-admitted market, explained Mr. Synott, is because the marketplace has gotten away from writing only coverages that traditionally have been written by surplus lines insurers.

During the heyday of cash-flow underwriting in the late 1970s and early 1980s, some surplus lines insurers began to ignore the rules that outlined the coverages they could write, according to Mr. Synott.

For example, he noted, some insurers were using presigned affidavits declaring that a risk had been rejected by at least three insurers in the standard market. Only the dates on the forms were blank, said Mr. Synott.

"They started running afoul of the surplus lines regulations on the books," to compete with admitted insurance companies during the competitive market, Mr. Synott explained.

As a result, he said, regulators began taking a close look at surplus lines insurers and started enforcing the rules that governed the non-admitted market.

That scrutiny is not altogether unwelcome, said a surplus lines insurance company executive on the panel.

"To the degree that the regulators look after the solvency and financial stability issues of the E&S insurers, we welcome their interest," explained Kenneth Woods, president and director of California Union Insurance Co. in Los Angeles, a CIGNA Corp. affiliate.



Mr. Woods

However, Mr. Woods added, surplus lines insurance companies do oppose any regulatory actions that would hurt their business.

"To the degree that additional regulations are proposed to impede the way we intend to address the voids left by the standard markets, perhaps we would like to review with the commissioners what their positions are going to be," he remarked.

"I think there may be room in the E&S industry for some additional participation by the regulators," Mr. Woods commented.

"And I think most companies would welcome it. But I think we have to be careful that we are not restricted from doing basically what is our job. That is, addressing the needs left by the standard market." ■

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700 companies belong to NAPSLO

ATLANTA—Members of the National Assn. of Professional Surplus Lines Offices Ltd. headed south this year for their 11th annual convention.

About 1,700 attendees gathered at the Atlanta Hilton Hotel and Towers from Sept. 11-14 for both educational sessions and afterhours socializing.

Members heard speakers discuss topics ranging from 1986 market conditions to the effects of tort reform. The annual income and expense survey gave wholesale brokers and managing general agents an idea of how their companies stack up against each other.

Since its first conference in 1975, NAPSLO has seen its membership grow to 700 from 62. There currently are 446 wholesale broker members, 92 insurance company members and 162 associates.

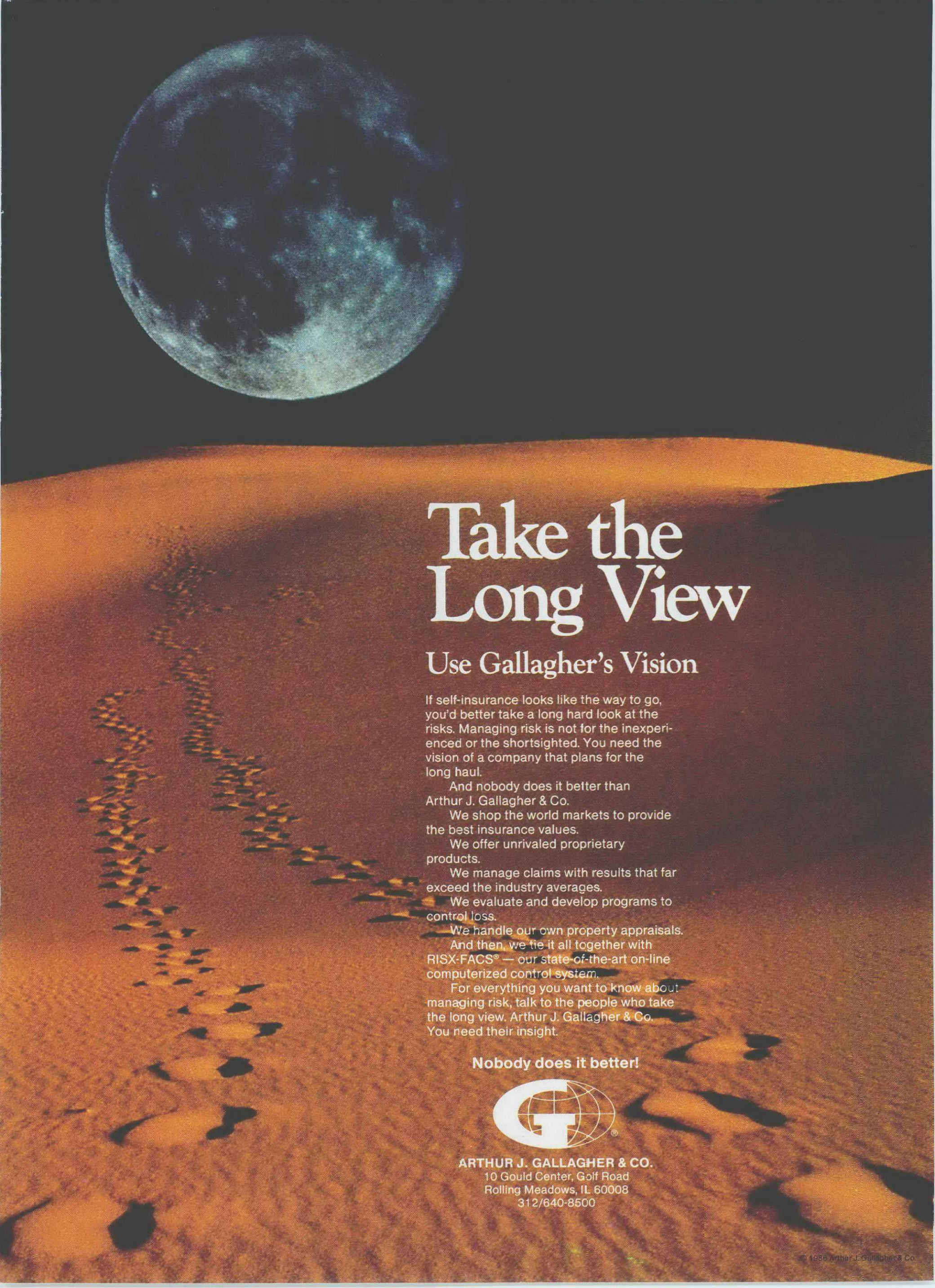
More information is available on NAPSLO from P.O. Box 1507, Roswell, Ga. 30077; 404-998-9075.

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Larger wholesalers profit from tight market

By MICHAEL BRADFORD

ATLANTA—Surplus lines brokers and managing general agents with annual premium volume of more than $15 million appear to be benefiting most from the tight market, according to a survey of members of the National Assn. of Professional Surplus Lines Offices Ltd.

"The larger firms, those with over $15 million in volume, are doing better in almost every single category" measured in the survey, said Russell R. Miller, who conducts the survey annually for NAPSLO.



Mr. Miller

Mr. Miller is chairman of Russell Miller Inc., a San Francisco-based investment banking and consulting firm with clients in the insurance industry.

This year's survey of more than 400 NAPSLO members produced some surprising results, said Mr. Miller, who addressed NAPSLO's annual convention earlier this month in Atlanta.

"The most surprising thing is, that small is not beautiful," said Mr. Miller, meaning he expected the survey to show small firms benefiting more from current tight market conditions.

But, he added, "If you're very small, you seem to do better than if you are midsized. . . .The smallest ones seem to have an ability to move, to duck, to weave, to change their mix" faster than their midsized counterparts.

The survey defines a small company as one with less than $7.5 million in premium volume and a midsized firm as one with premium volume from $7.5 million to $15 million.

Midsized companies are "absolutely under the greatest pressure of any-sized firms in your association," Mr. Miller told NAPSLO conference attendees in Atlanta.

The survey showed that midsized brokers had the lowest average retained commission rate, 6.7% in 1985. Small brokers surveyed retained an average of 9.4% of premium, while large brokers kept 7.3%.

This finding indicates that midsized brokers "either can't negotiate as good of deals with their carriers or they can't be as tough with their producers. I don't know which it is, but it has to be one of those," Mr. Miller said.

But the good news, Mr. Miller points out, is that the medium-sized companies as well as their counterparts, are making money.

In 1985, medium-sized wholesalers recorded average pretax profits per employee of $7,501, up 51% from $4,955 per worker in 1984.

Pretax profits at the large wholesalers surveyed soared 146%, to $19,457 per employee last year, from $7,899 in 1984.

Small companies, on the other hand, saw their pretax profits per employee rise only 16% to $8,537 in 1985 from $7,376 the year before.

The medium-sized firms employed an average of 17.7 employees, while the large companies employed an average of 62.7 workers and the small wholesalers had an average of 10.1 employees in 1985.

Revenue per employee increased the most at the large wholesalers. These companies reported a 31% increase to an average of $80,557 per employee in 1985 from $61,492 in 1984.

Average revenue per employee at midsized wholesalers gained 27% last year to $65,922, compared with $51,796 in 1984, while revenue per employee at small wholesale brokers increased only 8% to $53,882 in 1985 from $49,943 the previous year.

Overall, revenues at the large firms increased 69.1% in 1985, compared with only a 21.1% increase the previous year.

Midsized companies' revenues rose 31.4% in 1985, compared to only a 12% gain in 1984. And revenues at the small wholesalers rose 34.1% last year, up from 15.5% in 1984.

Compensation per worker among the largest wholesalers surveyed rose 17% to an average of $38,698 in 1985, from $32,989 in 1984. Compensation at the midsized wholesalers averaged $39,071 per worker last year, up 40% from $27,887 in 1984, while compensation per employee at the small firms rose 25% to $27,712 last year from $22,134 in 1984.

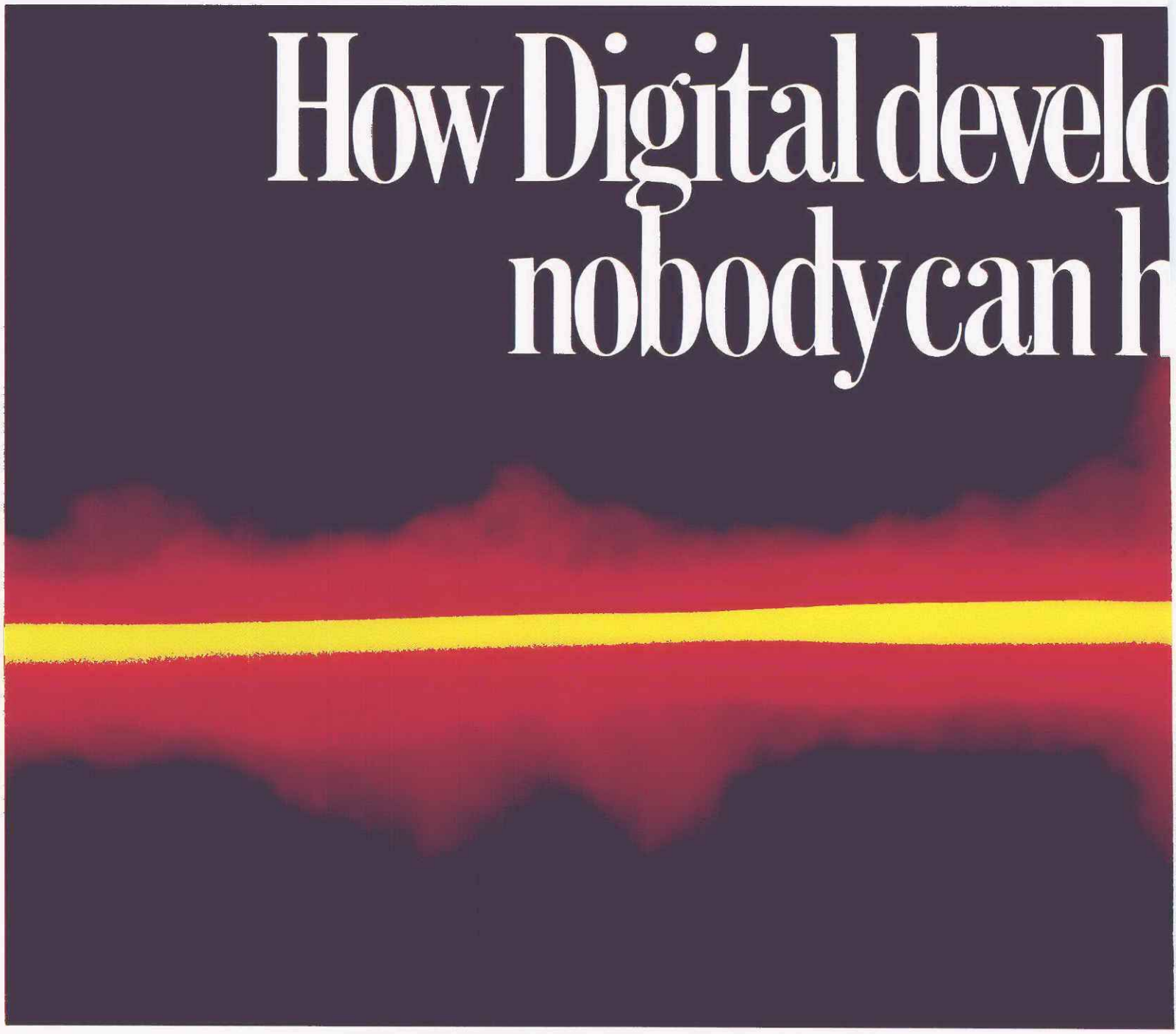
A useful statistic to review "in light of the up-and-coming changes in the tax law," said Mr. Miller, is the one that shows firms do not keep as much working capital as they have in past years.

In growing firms, he points out, "there is always a strain on working capital. And in fact, the better the firm, the faster it's growing, the bigger the strain."

Medium-sized firms "can't seem to retain as much working capital as others," Mr. Miller noted, which means they don't have the "ability to sustain the engine of productivity."

The 21 medium-sized firms that responded to the survey reported an average of 41 days of working capital reserves in 1985, compared with 57 days the year before.

The 43 smaller firms had 55 days of reserves last year, down from 63 in 1984, and the 30 largest respondents averaged 67 days in 1985, compared with 94 days during the previous year. ■



If there's one thing that can make a computer company hot under the collar, it's watching millions of dollars worth of high technology products go up in smoke.

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But in the end, we expect Digital's solution to be quite a breakthrough. For one thing, the new boxes will have low combustibility and will be a lot less expensive to manufacture. And because the packaging materials are expected to be FDA approved, there may be other applications outside the high tech industry.

Now, if you think the only thing Digital will end up with is a very effective way to protect their products from the ravages of a catastrophic fire, think again.

Fortunes improve for NAPSLO 'insurer'

By MICHAEL BRADFORD

ATLANTA—Things are changing for the better at Competitive Casualty Co.

In a flag-waving salute to good old American enterprise, Competitive Casualty's board of directors presented an update of the company's affairs to members of the National Assn. of Professional Surplus Lines Offices Ltd. at the group's conference held earlier this month in Atlanta.

It had been two years since Competitive Casualty's last update, and things have changed quite a bit for the surplus lines insurer since 1984.

While on the Caybusark links, Competitive's board hatched the plan that saved the offshore subsidiary. The chairman and the company's other officials decided to create a syndicate on the Lower Appalachian Insurance Exchange.

"The changing marketplace, which we were preparing for and which we are now exploiting, has presented even more opportunities than even we could hope for," according to the company's chairman.

"Those opportunities only exist, however, for the er. getic, the imaginative and the quick on their feet.

"This is a veritable hog heaven," the chairman said, "and we be the hogs."

The chairman could stress the word imaginative: Competitive Casualty is an imaginary company created by NAPSLO to show trends occurring in the real-life market.

Competitive Casualty is enjoying a banner year for productivity, its board reports. Premiums are soaring, and capital and surplus is at a new high.

"We're rolling in profits," says the chairman.

"We keep tripping over new sources of income. Life is just a bowl of cherries, and we be the plucker."

With all that good news, it's only fitting that the surplus lines insurer should have a couple of setbacks.

To begin with, its offshore insurance subsidiary was not seeing the same kind of stellar financial returns as its parent.

Caybusark Insurance Co., domiciled on the little-known island of Caybusark, is having some problems.

One of the more pressing is the lack of water on the island. Because there is no water on Caybusark, the golf course is sprinkled entirely with rum.

But a more serious setback for the offshore insurer concerned, a premium production lag that is "seriously behind" the parent's projections, says the chairman.

"Budgets were impossible to meet," he said.

But through a series of brilliant moves that outsmarted insurance regulators and awed competitors, Competitive Casualty was able to turn the troubled captive into a healthy company.

While on the Caybusark links, Competitive's board hatched the plan that saved the offshore subsidiary.

"Those sprinklers do wonders for morale," said the company's chairman.

He and the company's other officials decided to create a syndicate on the Lower Appalachian Insurance Exchange.

Skimmer Syndicate was formed to act as a fronting company for Caybusark and to cede 100% of its business to the offshore company.

Competitive Casualty's annual meeting was acted out by its "chairman," Charles McAlear, chairman of McAlear Associates Inc., a wholesale broker in Grand Rapids, Mich.

Thomas S. Bloom, president of McAlear Associates, joined him in the spoof, along with Richard Bouhan, NAPSLO's director of government relations.

But the foolishness surrounding Competitive Casualty did have a purpose, Mr. McAlear explained. The put-on covered the serious subjects of uncollectable reinsurance, insolvency, complicated policy forms, shady business dealings and other real-world manifestations of the current insurance industry.

"We have made it all too easy for companies like Competitive Casualty," Mr. McAlear said.

Real companies, just like the fictitious one, are seeing premiums rise dramatically, sometimes unnecessarily, he explained.

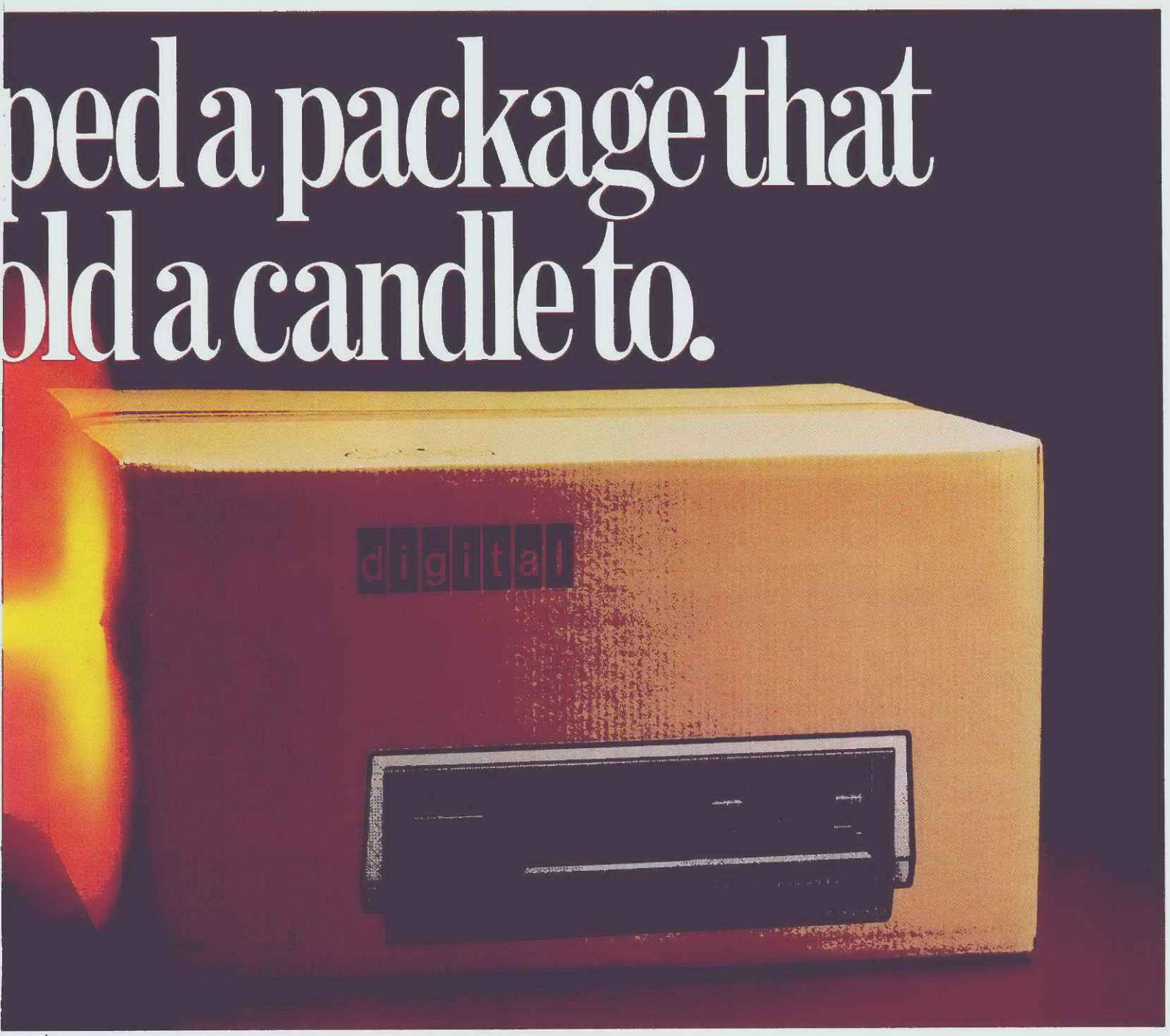
"We've changed forms," he added. "Maybe some of them needed changing, maybe not."

And, there are "no markets for some of the products we are trying to sell," he observed.

He urged NAPSLO's members to work together to provide quality service for their clients.

"We're working for our clients," Mr. McAlear urged. "More and more, we're not perceiving that.

"We've got an industrywide problem because we're not working together," Mr. McAlear said. "That problem is coming back to haunt us." ■



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ARKWRIGHT BOSTON INSURANCE

Claims-made spurs wholesalers' debate

By MICHAEL BRADFORD

ATLANTA—The claims-made liability insurance policy form is an "unrealistic product" that is being pushed on insurance buyers by some members of the insurance industry, says the president of the National Assn. of Professional Surplus Lines Offices Ltd.

An attempt by the Insurance Services Office "to convert us all to claims-made may well be the biggest sham ever perpetrated by our industry," said Jeremy D. Cooke, NAPSLO president and president of Major Surplus Inc., a New York-based wholesale broker.

The claims-made liability form is especially ill-suited for any program that needs excess layers of coverage, Mr. Cooke said.

"To try and structure, in today's market, an excess program using all the different forms, with the different triggers and discovery periods, is really not professional by either the brokerage industry or the underwriting industry," he said.



Mr. Cooke

Mr. Cooke added that he doesn't believe that buyers or insurers are aware of the "implications" involved in buying coverage on a claims-made basis.

"We must realize in many cases they are only buying 12 months' coverage. To suppose anything else is simply not the truth," Mr. Cooke told the NAPSLO annual convention, held Sept. 11-14 in Atlanta.

If claims-made coverage is not renewed with the same retroactive date and with the same insurer, the buyer has "paid premiums, and coverage has now disappeared," Mr. Cooke remarked. "It is non-existent, and a gap now always will exist."

He also noted that the extended discovery period in the policy doesn't extend the length of coverage, but "it simply extends the period in which claims may be reported—and then, and only then, in most cases for a finite term."

But Richard Foss, president and chief executive officer of LUI Management Inc. in Chicago, which manages syndicates on the Illinois Insurance Exchange, disagreed that continuous coverage is an impossibility under the claims-made form.

"If the same people renew, and the same form is used in the ensuing year, you're going to have that continuity," Mr. Foss remarked.

The claims-made forms offered by insurers in the United States and in the London market are aimed mainly at medium- to large-sized accounts," Mr. Foss explained. Most of those accounts involve "very professional brokers and very professional insurance buyers," he added.

"You can't tell me that the people that have been in the profession so long can't understand the policy."

Mr. Foss said in response to a question from Mr. Cooke that, "in general," he is comfortable with the claims-made form currently being marketed. "I think the product we're selling right now has some weaknesses in it," he admitted. But, he added that brokers are able to look at the "product we're selling" and are able to determine which exposures are covered and which are excluded.

However, Mr. Cooke maintained, "I do not believe our industry can honestly say it is protecting the assets of the insureds when you force them into a claims-made environment. You are protecting the assets of the insured for a 12-month period. That is all the insured knows going in. "It's not until renegotiation of renewals that you are going to discover whether in fact you have a viable product. And it's too late then," he said.

While he concedes there are some lines of coverage that should be written on a claims-made form, Mr. Cook also said: "For heaven's sake, let's have one standard form that is shared by all the carriers so that we know where we stand, we know the discovery periods, we know the retroactive dates. . . ."

He added that, "I really think we've done ourselves a great disservice if we don't wake up to what's going on out there."

Arthur McHugh, senior vp of St. Paul Surplus Lines Insurance Co. in St. Paul, Minn., said, "I agree that a lot of the situations that Jeremy described will occur on 1986 business, and probably on 1985 business."

Members of the insurance industry "should have sat down with each other and tried to come up with a form that was going to address the needs of the industry as well as our own needs. . . .I think that certainly a lot of the claims-made forms being offered today do not offer the coverage that should be offered," Mr. McHugh explained, also noting that reaction from reinsurers and brokers may have frightened developers of claims-made forms into offering a limited discovery period.

"I think that the industry today has the information and the underwriting talent to be able to look at past loss histories and offer a discovery period" that will address claims the insurer can reasonably expect, Mr. McHugh said.

However, "not the asbestos-type claims," he added.

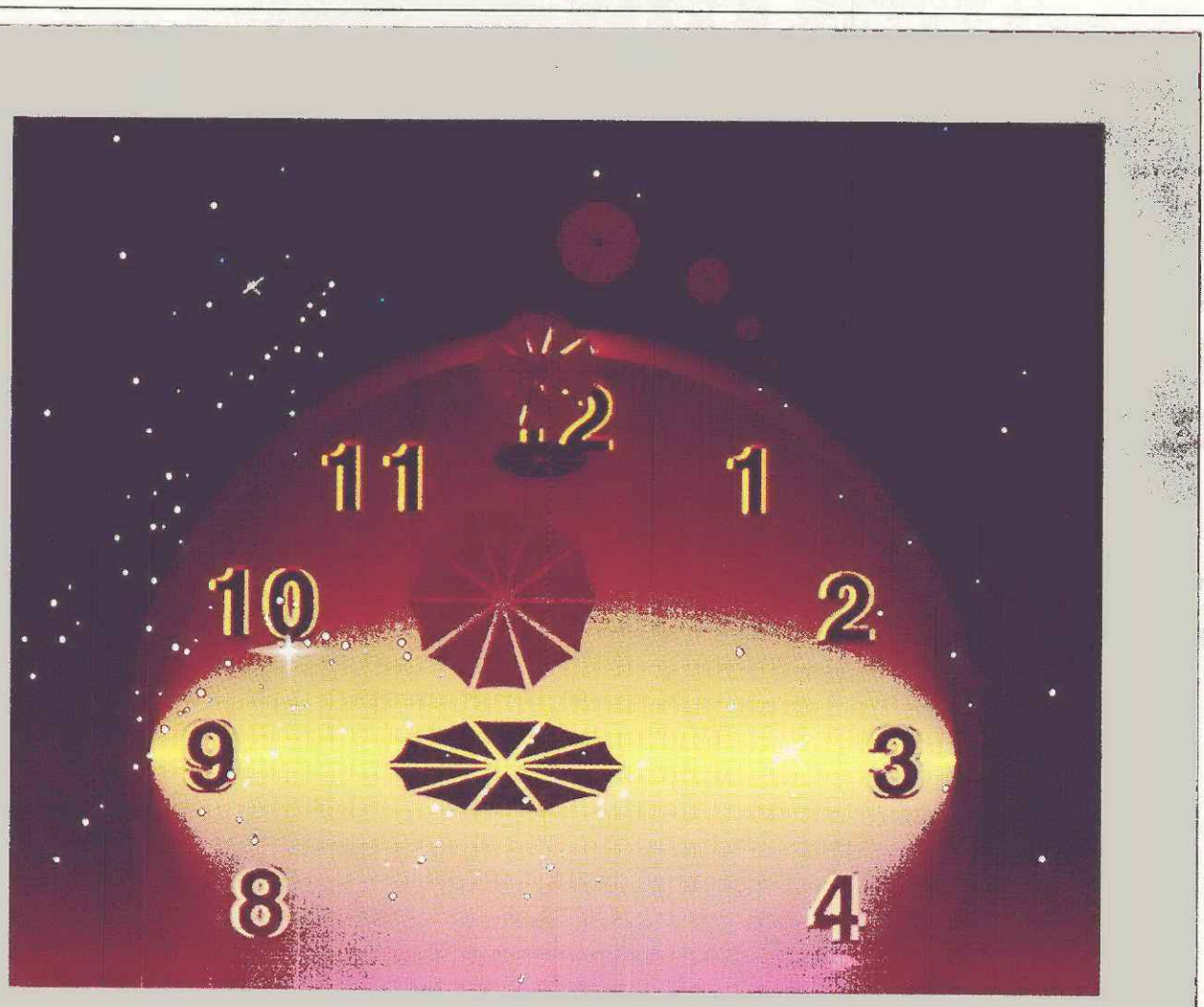
Acknowledging there are problems with the claims-made form, Mr. Foss said that "there has been no real attempt for the companies to sit down and come up with a product."

But, Mr. Foss added, it is not realistic to expect companies not to put in safeguards against the recurrence of situations like the ongoing asbestos injury litigation.

The industry has to develop policy forms that adequately cover long-tail exposures without opening insurers to losses that were never foreseen, he said.

"We've got to sit down and discuss how to handle this," Mr. Foss remarked. "There has to be a format that is acceptable. There have to be underwriters that can sit down and analyze an account and come up with an answer to this. But we've got to talk to each other."

Ronald Gabor, president of Gabor & Co. Inc., a managing general agency in Miami, was the moderator of the session. ■



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Continued from previous page

tion was more prevalent: Treatment in extended care facilities was provided to 67% of plan participants in 1985, up from 62% a year earlier; home health care was covered for 56% of participants in 1985, up from 46% in 1984; and hospice care was covered for 23% in 1985, up from 11%.

Second surgical opinions were reimbursed by plans covering half the participants, which is double the percentage found when the question first was asked three years ago.

And, in half of these cases, incentives were offered for obtaining a second opinion.

Other cost-containment features, first surveyed in the 1985 study, also were found to be widespread. Preadmission testing was offered for almost half the plan participants. Surgery at outpatient clinics was covered for 39%, and 25% of the participants paid lower deductible amounts for certain procedures performed on an outpatient basis.

Ninety-nine percent of the surveyed employees with health insurance in 1985 were required to meet some kind of deductible before coverage commenced. As has been the case since the survey began in 1979, the most common deductible amount was $100, required of 44% of the covered employees in 1985.

However, the percentage of employees that had to meet a deductible of $150 or higher is increasing, to 29% of covered employees in 1985, up from 21% in 1984 and 12% in 1983.

Higher deductible amounts were more common for white-collar workers: 33% of professional and administrative participants and 35% of technical and clerical participants had to meet a deductible of $150 or more, compared with only 23% of production workers.

The vast majority—85%—of employees with major medical coverage had a 20% coinsurance provision in 1985. The coinsurance requirement was 85% for 5% of the employees, 90% for 4% of the employees and some other amount for 5%.

However, for 77% of the employees with major medical coverage, the plan paid 100% of covered expenses that reached a certain level per covered person.

The level of covered expenses required per person before the plan covered all costs was $2,000 for 11% of the participants, $2,001 to $4,000 for 20%, $4,001 to $6,000 for 25%, $6,001 to $8,000 for 8%, $8,001 to $10,000 for 9% and more than $10,000 for 3%.

The survey shows the growth in dental benefits has halted: In 1985, more than 75% of employees had dental coverage, unchanged from 1984.

In 1979, though, only half had dental coverage.

Dental plans most commonly covered a percentage of reasonable and customary charges. All of the dental plans provided at least some coverage for examinations, dental X-rays and fillings. In addition, 99% covered dental surgery, and 98% covered periodontal care, inlays and crowns.

Only 73% provided at least some coverage for orthodontia.

Some 90% of the employees with dental plans had an annual maximum benefit limit for procedures other than orthodontia. The most-common maximum was $1,000, offered to 45% of the employees with dental coverage.

And, 96% of the employees with dental coverage had a lifetime maximum for orthodontia. Again, the most-common maximum was $1,000, offered to 37% of the employees with dental coverage.

The vast majority of employees had coverage for mental health care in 1985, but considerably fewer employees had coverage for mental health care equal to their other medical coverage.

For example, 99% of plan participants had coverage for inpatient mental health care, but only 42% had the same coverage for mental health care as for other inpatient treatment.

Mental health benefits had separate limits on days of hospitalization for 34% of the participants, separate dollar limits for 26%, a separate coinsurance limit of 50% for 3%, no limit on employees' out-of-pocket expenses for 12% and some other limits for 8%.

Similarly, 97% of the participants had coverage for outpatient mental health care in 1985, but only 5% had coverage identical to other medical coverage.

Some 73% of the participants in health care plans had coverage continued for at least one month after retirement.

For 81% of employees whose coverage continued after retirement, there was no change in coverage for retirees under age 65. And, for 73% of employees with retiree coverage, there was no change in coverage for retirees age 65 and over.

For those with retiree coverage, 55% were covered by plans in which the employer paid the entire cost of coverage for retirees under age 65, and 54% were covered by plans in which the employer paid the whole cost of coverage for retirees over age 65.

Only 10% of employees with retiree coverage had plans in which the retiree paid the whole cost of continued coverage.

Employers paid the whole cost of individual coverage for active employees for 61% of the plan participants in 1985, a figure virtually unchanged from 1984.

Also, 42% of participants also could receive fully employer-paid dependent coverage in 1985, which is the first year this percentage has not dropped since this statistic began being gathered in 1980.

Data on amounts of employee contributions for health care were hard to tabulate, the survey said because payroll deductions for health care often are included with deductions for other benefits.

But, in the cases where the amounts were reported, employee premiums averaged $12 per month for individual coverage and $38 per month for family coverage. These amounts are virtually unchanged from 1984.

Some 54% of employees with health care coverage must complete a minimum length of service requirement before being eligible.

The most common periods are one month, required of 16% of participants; two months, required of 8%; three months, required of 19% and six months, required of 7%.

Finally, commercially purchased insurance continues to be the most-common means of providing benefits in 1985, although alternative funding mechanisms are gaining popularity among employers.

Blue Cross/Blue Shield plans or coverage purchased from commercial insurers covered 60% of plan participants with basic hospitalization benefits and 53% with major medical benefits in 1985.

However, at least one-fourth of the plan participants received their coverage under self-insured plans of individual employers or labor-management groups in 1985, which is more than double the percentage of employees covered by self-insured plans in 1980.

And, in 1985, 7% of participants were enrolled in HMOs.

●

Copies of the survey are available for $4.75 each from the Superintendent of Documents. To order request "Employee Benefits in Medium and Large Firms, 1985," Bulletin 2262, Stock Number 029-001-02903-9. Mail order to either Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402, or Bureau of Labor Statistics, Publications Sales Center, P.O. Box 2145, Chicago, Ill. 60690.

The Hartford finished first, fifth and eighth in Group Life.

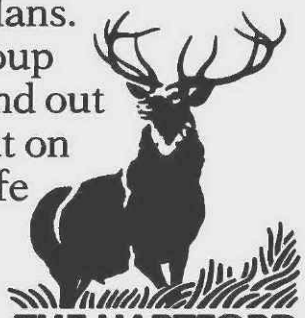
Our Group Life inforce volume rose 24.6% in 1985—the largest percentage increase among the top ten companies.

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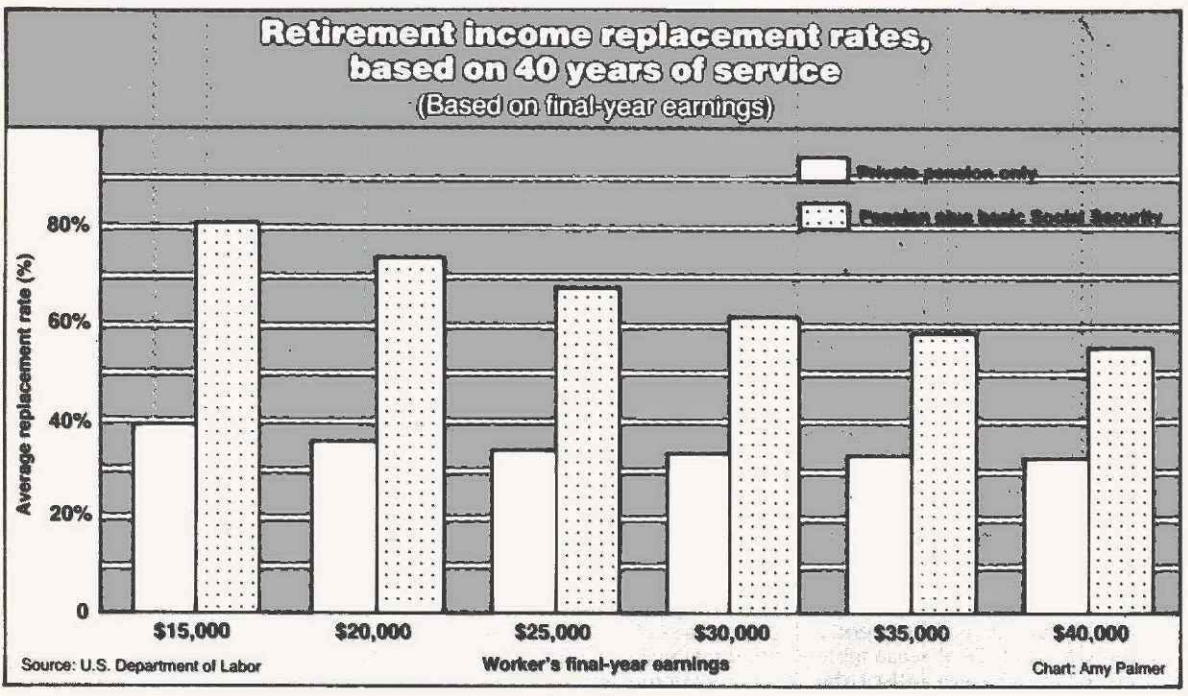
These rankings* make the message clear: more and more brokers and benefit managers are recommending The Hartford for their Group Life plans. Talk to a Hartford Group Representative and find out why. Or you'll miss out on outstanding Group Life plans and services.

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Defined benefit plans cover 80% of workers

By ALISON KITTRELL

WASHINGTON—Employer-sponsored retirement plans cover 91% of employees at medium-sized and large U.S. businesses, according to a Labor Department survey.

The most-common type of retirement plan is the defined benefit pension plan, offered in 1985 to 80% of the employees surveyed in "Employee Benefits in Medium and Large Firms, 1985."

The employer paid the full cost of the defined benefit pension plan for 90% of the participants in 1985, down from 95% in 1980.

In addition, the study found that 41% of the employees were covered by defined contribution retirement plans, which the study defines as plans that do not allow withdrawal of employer contributions before retirement except in the case of death, termination of service or hardship.

But, a total of 53% of the employees were covered by one or more defined contribution plans, including those plans with less-stringent withdrawal rules. And, the survey authors point out, many such plans with less-stringent regulations also are used by employees to save for retirement.

In its seventh annual study of firms with at least 100 to 250 employees, the Labor Department's Bureau of Labor Statistics collected data on almost 4 million employees at 1,325 businesses nationwide, except in Alaska and Hawaii.

In the area of retirement income, the survey's findings include:

- For 70% of the employees covered by defined benefit plans, their pension was tied to their earnings. And, for 82% of those employees, the basis for figuring the benefit was their earnings during the final years of their employment.
- Some 61% of all defined benefit plan participants were covered by plans in which the benefit formula was integrated with Social Security.
- Some 69% of employees with defined benefit pension plans vested after 10 years of service at any age.
- Most employees covered under private pension plans were not required to work to age 65 before retirement.

However, many plans allowing early retirement did include length-of-service requirements for collecting pension benefits, and most plans provided reduced pension benefits to those who retired before the age specified by the plan.

- Employees who retired after the normal retirement age rarely received a pension benefit before retirement, and postponed retirement rarely was fully reflected in increased pension benefits.
- Virtually all employees that were covered by defined benefit pension plans had plans that provided for survivor benefits in case the employee died before retirement.
- Some 41% of the employees in defined benefit pension plans had increase the benefit paid to current retirees at least once between 1980 and 1984. However, the vast majority of those increases were discretionary increases rather than automatic adjustments for inflation.
- Some 27% of all employees participated in savings and thrift plans, making them the most popular of the defined contribution plans studied.
- Twenty-six percent of the employees surveyed had access to a 401(k) plan, and the availability of 401(k) plans was higher for white-collar than for blue-collar workers.
- One-fourth of all employees surveyed participated in an employee stock ownership plan in 1985. ESOPs, which are fully funded by the employer, provide employees with stock in their company.
- Eighteen percent of all employees had profit-sharing plans in 1985.

For 70% of the employees in defined benefit pension plans, their final benefit was tied to their earnings. And, for 81% of those employees, the benefit was tied to

Continued on page 26



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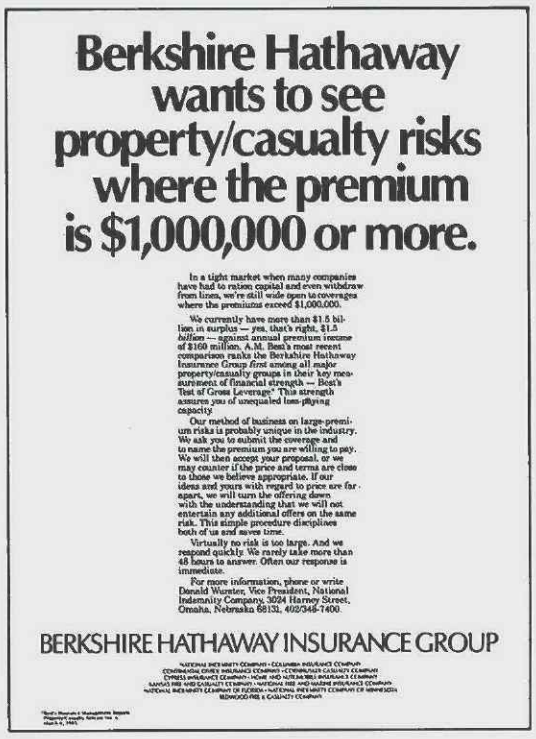
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Most employers offer health cover: Study

By ALISON KITTRELL

WASHINGTON—Health insurance continues to be one of the most common benefits at medium-sized and large U.S. companies, according to a recent report by the U.S. Labor Department's Bureau of Labor Statistics.

However, the nature of that coverage is changing gradually to include broader tyoes of coverage, higher deductibles and more cost-containment features.

In its seventh-annual study of companies with at least 100 to 250 employees, the Bureau of Labor Statistics collected data on almost 4 million employees at 1,325 businesses nationwide, with the exception of Alaska and Hawaii (see story, page 24).

Among the findings of "Employee Benefits in Medium and Large Firms, 1985" are:

- Some 96% of employees at medium and large firms have health insurance. And, as in past years, virtually all workers are covered for major medical costs.
- Coverages for less-traditional medical expenses, such as vision care and drug abuse treatment, are less prevalent but are becoming more commonplace.
- Cost-containment provisions also are on the increase.
- Most plans have deductibles, and the most-common deductible amount remains $100, as it has since the survey was begun in 1979. However, the percentage of employees paying a $100 deductible is decreasing, and the percentage paying a deductible of $150 or more is on the rise.
- Most plans include a coinsurance provision, in which the covered employee pays 20% of expenses after the deductible is met. However, for more than 75% of plan participants, there is an out-of-pocket limit on employees' expenses.
- More than three-fourths of plan participants had dental coverage in 1985, about the same as in 1984.
- Ninety-nine percent of employees with health care coverage had coverage for inpatient mental health treatment, and 98% had coverage for outpatient mental health treatment. However, mental health coverages were provided at the same level as other health coverages for only 42% of the employees with inpatient coverage and for only 5% of those with outpatient coverage.
- Most of the plans extended coverage for retirees.
- Employers paid the full cost of employee health insurance for 61% of the covered workers; the employer paid the full cost of dependent coverage for 42% of plan participants.
- More than half—54%—of plan participants were required to complete minimum service requirements, which usually were one, two or three months.
- Although insured health plans covered 60% of the plan participants surveyed, the incidence of self-insured plans and health maintenance organizations is growing.

The survey shows that 96% of employees at medium and large U.S. companies have health care coverage, and that virtually all of those are covered for major categories of medical care, including hospital room and board, miscellaneous hospitalization services, outpatient care such as emergency room visits and rehabilitative therapy, X-rays and laboratory work.

In addition, the incidence of coverage for less-traditional care is on the rise. For example, the percentage of plan participants covered for alcoholism treatment in 1985 grew to 68% from 61% in 1984. Coverage for drug abuse treatment grew to 61% of participants in 1985 from 52% in 1984.

Vision care was offered to 35% of health insurance participants in 1985, up from 30% in 1984 and only 18% in 1979. And, hearing care was available to 17% in 1985, up from 14% in 1984 and 10% in 1983.

Cost-containment features are being integrated more often into medical coverage, the study showed.

For example, coverage for less-costly alternatives to hospitaliza-

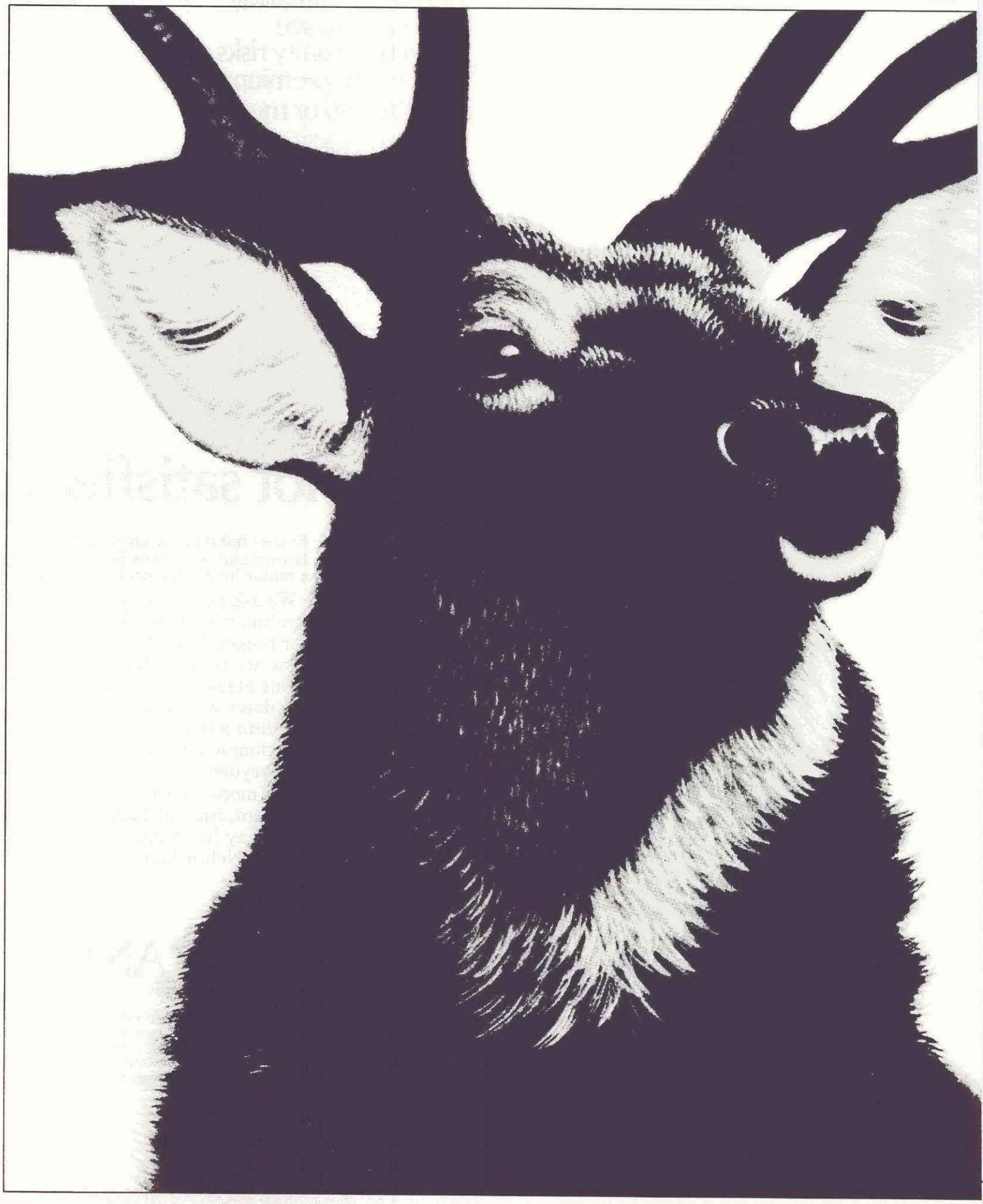
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Participation in employee benefit programs
(By percent of employees at medium and large U.S. firms)

Benefit program	All employees	Professional and administrative employees	Technical and clerical employees	Production employees
Health insurance	96%	97%	96%	96%
Employee coverage wholly employer-financed	61	56	51	69
Dependent coverage wholly employer-financed	42	36	33	50
Long-term disability insurance	48	64	61	32
Wholly employer-financed	38	49	48	27
Life insurance	96	97	96	96
Wholly employer-financed	86	85	85	87
Retirement plan	91	93	93	89
Defined benefit	80	81	82	78
Defined contribution	41	49	49	32

Source: U.S. Department of Labor

Chart: Amy Palmer



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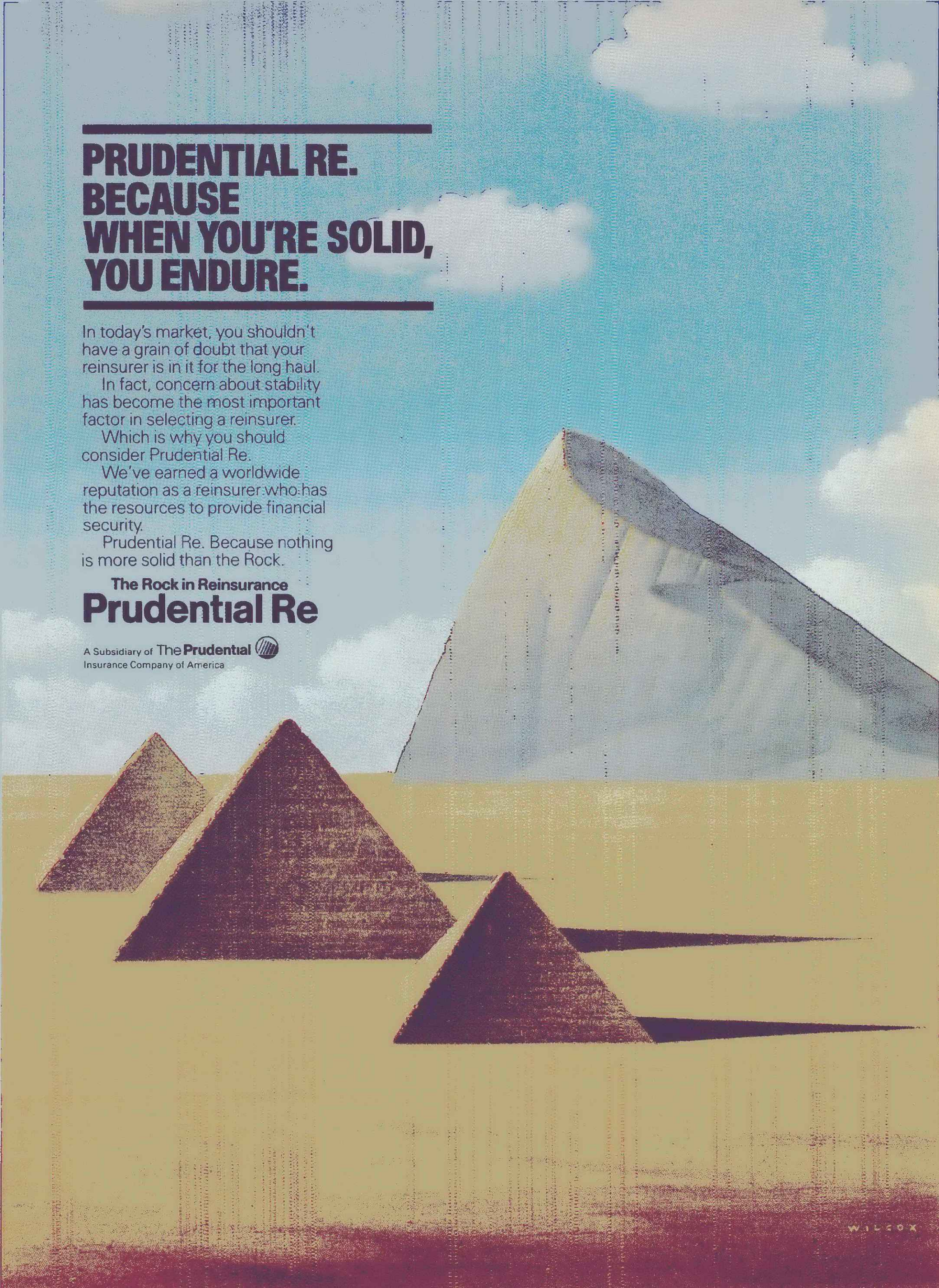
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Retirement plans

Continued from page 24

earnings at the end of their career, rather than throughout their career. Such terminal earnings plans usually yield a higher retirement benefit, because most people earn more at the end of their careers than at the beginning.

For 84% of the employees with terminal earnings-based plans, an average of five years of earnings was used to figure the benefit. And, for 83% of these employees, the benefit was based on the earnings during the employee's highest-paid consecutive five years, usually during the last 10 years.

Twelve percent of the employees in terminal-based defined benefit plans had a final benefit based on three years of earnings.

In addition, 29% of employees in defined benefit pension plans had plans that paid benefits based on a set dollar amount per year of service.

For 66% of those employees, the benefit was a flat monthly amount companywide per year of service. For 8%, the amount varied according to years of service.

And, for 26%, the amount varied according to the individual employee's earnings.

Blue-collar workers were more likely than white-collar workers to have pension benefits based on a flat dollar amount: 52% of the production workers had pensions calculated on a dollar-amount formula, compared with only 5% of professional and administrative employees and 13% of technical and clerical workers.

The percentage of an employee's income that was replaced by pension benefits was higher among lower-paid workers, and that disparity was even more evident when Social Security income was figured into the total retirement income.

For example, among defined benefit pension plan participants who retired after 40 years of service, private pension plans replaced 39.8% of pre-retirement income for those employees who had final annual earnings of $15,000, 34% of pre-retirement income for those employees with final annual earnings of $30,000, and 33.6% of pre-retirement income for those with final annual earnings of $40,000.

When the private pension plan was combined with the employee's Social Security benefit, excluding any Social Security for spouses or dependents, the combined benefit replaced 81.4% of pre-retirement income for employees who retired after 40 years of service with final annual earnings of $15,000.

But, among employees who retired after 40 years of service, the combined benefit replaced only 62% of pre-retirement income for those with final annual earnings of $30,000, and 55.1% of pre-retirement income for those with final annual earnings of $40,000.

Some 69% of the participants in defined benefit pension plans had 10-year cliff vesting, or fully vested after 10 years of service at any age. In cliff vesting, a plan participant is not vested in any of the pension plan until he or she is fully vested.

In addition, 7% had cliff vesting after 10 years of service after age 18, 10% had cliff vesting after 10 years of service after age 19 or later, and 2% had some other kind of cliff vesting.

Thirteen percent of the defined benefit plan participants had a graduated vesting schedule, giving them the right to increasing shares of their accrued pension benefits until full vesting is reached.

For 23% of those with graduated vesting schedules, full vesting occurred after 15 years. The remaining 77% had some other service requirement for full vesting.

Defined benefits plans covering 41% of the participants had increased benefits for current retirees during 1980-84.

Of these, 51% of participants had one increase, 21% had two increases, 10% had three increases, 11% had four increases and 5% had five or more increases.

For most of these participants, however, the increases were made solely at the discretion of the employer and were not the result of any provision built into the plan to provide for adjustments for an increased cost of living.

In addition to those employees covered by defined benefit pension plans, many employees were covered by a variety of defined contribution plans, which are used solely or primarily for retirement income.

The most popular type of defined contribution plan identified in the 1985 survey was the savings and thrift plan: 27% of the employees surveyed participated in such a plan in 1985.

And, the level of participation was much higher among white-collar workers: Some 39% of professional and administrative employees and 33% of technical and clerical workers participated in a savings or thrift plan in 1985, compared with only 17% of production workers.

Under savings and thrift plans, employees contribute a predetermined part of their salary to a fund. Some 32% of the participants could contribute up to 16% of their earnings, 17% could contribute up to 10%, and 12% could contribute up to 12%. The remainder could contribute some other amount.

Employers also provide a contribution to savings and thrift plans to match at least a portion of the employee contribution. In 1985, the most-common employee match was 50% of the first 6% of earnings contributed by the employee.

Like defined benefit plans, savings and thrift plans have vesting provisions. However, the vesting is usually faster for participants in savings and thrift plans.

Continued on next page

The percentage of an employee's income that was replaced by pension benefits was higher among lower-paid workers, and that disparity was even more evident when Social Security income was figured into the total retirement income.

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Labor survey looks at variety of benefits

WASHINGTON—In addition to the major benefits of health, life and disability insurance and retirement income, less-common benefits are examined in the Labor Department's survey, "Employee Benefits in Medium and Large Firms, 1985."

For these miscellaneous benefits, the Labor Department's Bureau of Labor statistics noted only whether the benefit was offered to employees, and not whether the employees actually participated in the benefit.

For example, 33% of the employees surveyed worked for companies that offered some type of employer-subsidized recreational facility. Such facilities often are included in a company's wellness program, designed to improve employee health and thus cut employer health care costs.

Almost half—49%—of the employees could take advantage of plans under which the employer paid part of the costs of educational expenses. And, for 27% of the employees studied, the employer would pay the total cost, including books, tuition and fees. Such educational assistance was more likely to be offered for white-collar workers than for blue-collar workers, the study showed.

Full payment of expenses was available to 32% of the professional and administrative employees and the technical and clerical workers, compared with only 22% of the production employees.

And, partial defrayment of expenses was available to 54% of the professional and administrative workers and 52% of the technical and clerical employees, compared with only 46% of the production employees.

Employer-subsidized financial counseling was available to 11% of the employees surveyed.

This benefit also was more likely to be offered to white-collar employees: 13% of professional and administrative employees and 14% of technical and clerical employees, compared with 8% of production workers.

Prepaid legal services were available to 3% of the employees, and this benefit was more common for blue-collar workers: Five percent of the production workers had access to prepaid legal services, compared with only 2% of the other employees sampled.

Only 1% of the employees had access to child care benefits which included full or partial payment of the cost of care for employees' children. Two percent of professional and administrative employees had a child care benefit, compared with only 1% of the rest of the workers studied. ■

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Retirement plans

Continued from previous page

And, the vesting schedules apply only to the employer contribution; the employee contribution is fully vested immediately.

For 25% of the participants surveyed, there was immediate full vesting in the savings and thrift plan.

The most common type of vesting for savings and thrift plans was class year vesting, covering 37% of the plan participants. Under this system, the employer contributions for a particular year, or class, become fully vested after a specified number of years, usually two or three.

Twelve percent of the savings and thrift plan participants had cliff vesting, but for three-fourths of those employees, the period until full vesting occurred was five years or less.

Some 28% had graduated vesting, and for 71% of them, the period until full vesting occurred was five years or less.

Eighty percent of the participants in savings and thrift plans could withdraw the vested employer contribution prior to retirement, disability or termination of employment.

For 76% of those participants, they could make the withdrawal for any reason, although about half of them faced a penalty for such early withdrawals.

Twenty-six percent of all the employees covered in the survey participated in plans with a 401(k) feature, which allows employees to make pretax contributionsincome. For 88% of those participants, the 401(k) feature was part of an existing savings and thrift, profit-sharing or other defined contribution plan.

White-collar workers were more likely than blue-collar workers to participate in a 401(k) plan in 1985, the survey showed. Some 40% of professional and administrative employees and 34% of technical and clerical employees had a 401(k), compared with only 14% of production workers.

Some 18% of all employees covered in the survey participated in a profit-sharing plan. For 78% of those employees, the plan deferred benefits until retirement or some other specified condition was met.

For 6%, the plan paid benefits in cash to the participants, usually at the end of the plan year.

And, 17% of the participants were covered by a plan that combined the immediate cash and deferred benefits features.

In addition, 22% of the participants in profit-sharing plans could make a voluntary contribution to a 401(k) plan.

And one-fourth of all the employees surveyed participated in an employee stock-ownership plan.

In an ESOP, which is funded entirely by the employer, the employer pays a set amount into a fund, which then is invested primarily in company stock and makes benefit distributions either in company stock or in cash. ■

96% of workers receive life insurance benefit

By ALISON KITTRELL

WASHINGTON—The vast majority of employees at medium and large U.S. companies have life insurance coverage that is at least partly employer-paid, according to a recent study by the Labor Department's Bureau of Labor Statistics.

Employer-sponsored life insurance was provided to 96% of all these workers in 1985—the same percentage as was provided with employer-sponsored health insurance—according to the survey, "Employee Benefits in Medium and Large Firms, 1985."

The department's seventh annual survey of companies with at least 100 to 250 employees provides data on almost 4 million employees at 1,325 businesses nationwide.

For 90% of those workers with life insurance benefits, the full cost of their basic coverage was paid by the employer.

And, the survey authors note, "Life insurance coverage has kept pace with earnings since 1979, either through an increase in specified dollar amounts of insurance or through increased maximums in formulas linked to earnings."

For two-thirds of all life insurance plan participants, the amount of basic coverage was tied to earnings. White-collar workers were much more likely than blue-collar workers to have coverage tied to earnings: 84% of professional and administrative workers and 81% of technical and clerical workers with life insurance coverage had earnings-based limits, compared with only 48% of the production workers.

The most-common multiple of earnings, offered to 45% all such plan participants, was 100%. But, 33% had coverage equal to twice their annual salary.

Among those employees covered by multiple-of-earnings-based life insurance plans, 48% had no maximum amount of coverage.

The remaining 52% of these employees had coverage that did provide a maximum: The cap was less than $50,000 for 4%, $50,000 to $99,999 for 6%, $100,000 to $249,999 for 18%, $250,000 to $499,999 for 17%, and $500,000 or more for 6%.

Thirty-four percent of the employees with life insurance had flat amounts of coverage, including 3% for whom the amount of coverage was based on service.

Among the participants in plans with flat amounts of coverage not based on service, the most-common amounts of coverage were $5,000 to $9,999, offered to 36%, and $10,000 to $14,999, offered to 32%.

Other coverage amounts were: less than $2,000, offered to 1%; $2,000 to $4,999, offered to 12%; $15,000 to $19,999, offered to 9%; $20,000 to $24,999, offered to 5%; $25,000 to $29,999, offered to 3%; and $30,000 and over, offered to 1%.

More than half—53%—of the employees with life insurance had to fulfill a length-of-service requirement before the coverage took effect. For virtually all of the workers, the period was six months or less.

White-collar workers were less likely than blue-collar workers to have such a requirement: Only 42% of the professional and administrative workers and 49% of the technical and clerical workers had a length-of-service requirement, compared with 62% of the production workers.

Also, 96% of all the participants had extended life insurance during total and permanent disability, and 73% had coverage for accidental death and dismemberment.

Thirteen percent had coverage that included a survivor income benefit, which is a monthly benefit paid to surviving spouse or dependent children for a specified period after the death of an employee.

And 21% of those with life insurance also could purchase dependent coverage.

For 62% of the participants, coverage continued into retirement; for 60%, it continued for life, although the level of coverage was reduced at least once for all but 4%. ■

4 million people provide basis for benefit study

WASHINGTON—The data contained in the Labor Department's seventh annual survey of employees at medium and large U.S. companies were based on information collected on almost 4 million employees at 1,325 businesses nationwide, with the exception of Alaska and Hawaii.

And, the survey said, that information is representative of the 20.5 million workers employed at 42,696 such firms.

In compiling data for the survey, called "Employee Benefits in Medium and Large Firms, 1985," the Labor Department's Bureau of Labor Statistics divided businesses by type of operation.

Some 625 manufacturing companies were studied by the BLS, representing about 2.5 million employees. The manufacturing companies had a minimum of 100 to 250 employees.

Also, the survey studied 700 non-manufacturing companies, employing 1.5 million workers. Again, companies had at least 100 employees, except for accounting, auditing and bookkeeping services, where the minimum cut-off was 50 employees.

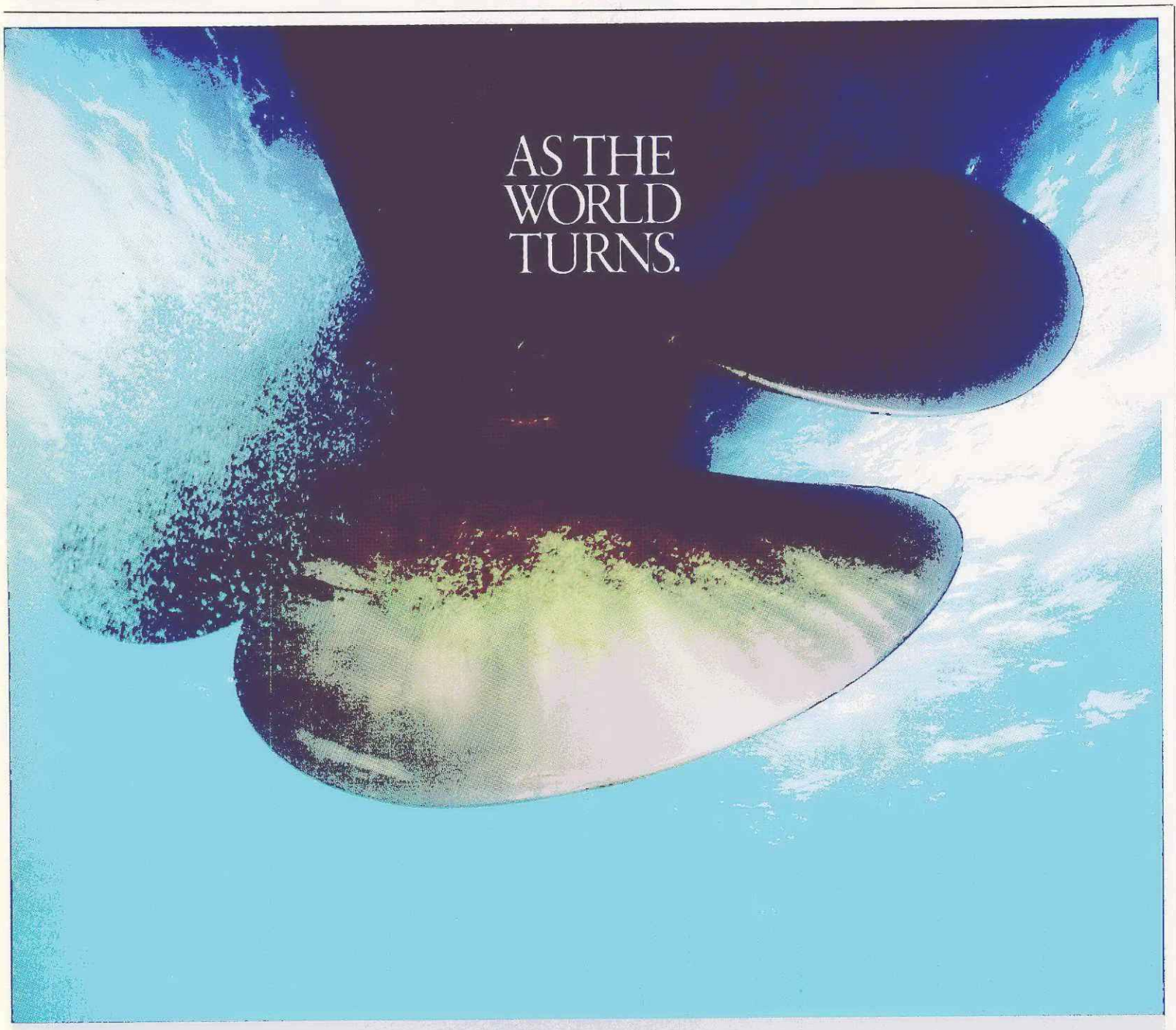
The employees themselves were assigned to one of three categories: professional and administrative, representing about 1.2 million of the employees; technical and clerical, representing 952,324 employees; and production, representing about 1.8 million employees.

According to the survey authors, professional and administrative workers are those in "occupations that require a foundation of knowledge in the theories, concepts, principles and practices of a broad field of science, learning, administration or management acquired through a college-level education or the equivalent in progressively responsible experience."

Technical and clerical jobs include "office and sales clerical, technical support, protective services, and other such occupations that do not require full knowledge of a professional or administrative field of work or the application of a high level of creativity, originality, analytical ability or independent judgment."

And, production occupations include "skilled, semi-skilled and unskilled trades; craft and production occupations; manual labor occupations; custodial operations; and operatives."

Employees that are not surveyed include executives; part-time, temporary and seasonal employees; and employees who travel constantly. ■



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SEPT. 26-27. Workers Compensation Lawyers Assn. Medical Seminar in Itasca, Ill.; $30 for arbitrators, commissioners, judges, professors, new bar admittees, law students; $50 for all others. Kenneth Gurber, Workers Compensation Lawyers Assn., 2 N. LaSalle St., Suite 1600, Chicago, Ill. 60602.

SEPT. 29. Association Captives: Answer to the Insurance Crisis seminar in Chicago, sponsored by Tillinghast, Nelson & Warren Inc.; $350. Conference Director, Tillinghast, Nelson & Warren Inc., 722 Post Road, Darien, Conn. 06820; 203-655-9791.

SEPT. 29-30. Strategic Planning for Organizing, Capitalizing and Implementing Industry-Owned Insurance Companies seminar in New York; $795; $695 for each additional registrant from the 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. 29-30. 1986 Casualty Loss Reserve Seminar in Chicago, co-sponsored by the American Academy of Actuaries and the Casualty Actuary Society; $300. Casualty Loss Reserve Seminar, 1720 I St. N.W., Seventh Floor, Washington, D.C. 20006; 202-223-8196.

SEPT. 29-30. Strategic Planning for Direct Marketing of Insurance Products Through New Distribution Systems in Boston, sponsored by Executive Enterprises Inc.; $795; $695 for additional registrant 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. 29-30. Association Captives: Answer to the Insurance Crisis? seminar in Chicago, sponsored by the Tillinghast division of Towers, Perrin, Forster & Crosby; $350; $50 for briefing, "Basics of Captives." Tillinghast, 722 Post Road, Darien, Conn. 06820-4798; 203-655-9791.

SEPT. 29-OCT.3. Managing Program Implementation course in Atlanta, sponsored by the International Loss Control Institute; $695. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-554-6001; within Georgia 404-466-2208.

SEPT. 30. Automating Risk Management for Profit and Survival seminar in Miami, sponsored by SOFTEC Inc.; free. **Also Oct. 1** in Tampa, Fla.; **Oct. 2** in Jacksonville, Fla.; **Oct. 7** in Livonia, Mich.; **Oct. 7** in Dallas; **Oct. 9** in Houston; **Oct. 14** in Chicago; **Oct. 16** in Minneapolis; **Oct. 21** Washington, D.C.; **Oct. 23** in Baltimore; **Oct. 28** in New York; **Oct. 30** in Boston; **Nov. 4** Kansas City, Mo.; **Nov. 6** in St. Louis; **Nov. 11** in Cincinnati; **Nov. 13** in Cleveland; **Nov. 18** in Los Angeles; and **Nov. 20** in San Francisco. Jack Bergers, SOFTEC Inc., 33063 Schoolcraft Road, Livonia, Mich. 48150; 313-261-4440.

SEPT. 30. Commercial Property Insurance course in Smithtown, N.Y., sponsored by the Professional Insurance Agents of New York; $55 for PIA members; $80 for non-members. **Also Oct. 1** in Mount Kisco, N.Y.; **Oct. 2** in Albany, N.Y. Professional Insurance Agents of New York, P.O. Box 98, Glenmont, N.Y. 12077; 518-434-3111.

SEPT. 30-OCT.2. Corporate Healthcare Management '86 conference in Chicago, sponsored by the Illinois State Chamber of Commerce; 3-day rate after July 31: $350 for ISCC members, $450 for non-members; one-day rate: $140 for ISCC members, $180 for non-members. Marsha Woods, Andry Montgomery & Associates. 101 N. Seventh St., Louisville, Ky. 40202; 508-582-1672.

OCT. 1-3. Establishing and Auditing an Effective Product Safety Management Program in Chicago, sponsored by the National Safety Council; $415 for NSC members; $520 for non-members. Russell E. Marhefka, National Safety Council, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800. Ext. 8130.

OCT. 2. Alcohol and Substance Abuse in the Workplace seminar in Miami, sponsored by the South Florida Health Action Coalition Inc.; $40. Dana L. Ferrell, Director of Health Resources, South Florida Health Action Coalition Inc., Suite 330, 7925 N.W. 21st St., Miami, Fla. 331126; 305-592-4936.

OCT. 2-3. Occupational Health Conference: Legal and Ethical Issues—Hazards at the Workplace conference in Sayre, Pa., sponsored by Guthrie Medical Center; $195. Donna Mundt, Employee Health Service Office, Robert Packer Hospital, Sayre, Pa. 18840; 717-888-666, extension 4608.

OCT. 2-3. Thirty-fifth Governor's Industrial Safety and Health Conference in Spokane, Wash., sponsored by the State of Washington Department of Labor & Industries; $15. Lucille Cooper, P.O. Box 207, Olympia, Wash. 98504; 206-753-9648.

OCT. 2-3. Product Safety and Liability Prevention: Successful Defense of the Products Liability Lawsuit course in Madison, Wis., sponsored by the College of Engineering, University of Wisconsin at Madison; $595. Professor Richard A. Moll, Engineering Professional Development, University of Wisconsin, 432 Lake St., Madison, Wis. 53706; 800-262-6243; 800-362-3020 within Wisconsin.

OCT. 2-3. International Insurance and Financial Services: A World View of Insurance Strategies and Operations seminar in Hamilton, Bermuda, sponsored by the Tillinghast division of Towers, Perrin, Forster & Crosby; $850; $725 for each additional registrant from the same organization. Tillinghast Seminars, 3340 Peachtree Road N.E., Atlanta, Ga. 30026-4301; 404-261-5420.

OCT. 6-7. Successful Financial and Legal Strategies for Recovering Uncollectible Reinsurance conference in New York, sponsored by Executive Enterprises Inc.; $795; $695 for additional registrant 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. 6-8. Annual Government Risk Management Seminar in Washington, D.C., sponsored by the Public Risk & Insurance Management Assn.; $300 for PRIMA members; $350 for non-members. Public Risk & Insurance Management Assn., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

OCT. 6-8. Seventh Annual Governor's Safety and Health Conference in Anchorage, Alaska, sponsored by the Alaska Safety Advisory Council; $200. Nancy Cannington, Alaska Department of Labor, P.O. Box 7-018, Anchorage, Alaska 99510.

OCT. 6-10. Management and Administrative Skills for the Occupational Health Professional course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; $700. Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 212-743-6523.

OCT. 7-8. The Bermuda Insurance Marketplace seminar in Hamilton, Bermuda, sponsored by Malcolm Butterfield Associates; $155. **Also Oct. 14-15, Oct. 16-17, Oct. 30-31, Nov. 4-5.** Malcolm Butterfield Associates, P.O. Box HM 2100, Hamilton 5; 809-295-5472.

OCT. 8. Workers Compensation for the Day-to-day User in Corono-Norco, Calif., sponsored by Xordium; $95. **Also Oct. 15** in Los Angeles; **Nov. 5** in San Fernando Valley, Calif. Karen Gillett, Xordium, P.O. Box 8422, Newport Beach, Calif. 92658-8422; 714-756-1707.

OCT. 8-10. Risk Management Information Systems course in New York, sponsored by the Risk & Insurance Management Society; $600 for RIMS members; $700 for non-members. Risk & Insurance Management Society. 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 9. Protecting Directors and Officers: Risk Management Alternatives seminar in New York, sponsored by the Risk & Insurance Management Society; $125 for RIMS members; $175 for non-members. **Also Oct. 24** in Anaheim, Calif.; **Nov. 7** in New Orleans. Risk & Insurance Management Society 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 9-10. Quality Control in Alternative Health Care Settings conference in Dallas, sponsored by the American Hospital Assn.; $325 for AHA member; $400 for non-member; $275 for each additional registrant from the same organization. American Hospital Assn., P.O. Box 98546, Chicago, Ill. 60693; 312-280-6083.

OCT. 9-10. National Institute on Workers Compensation in New York, sponsored by the American Bar Assn. Tort & Insurance Practice Section; $350 for ABA members; $325 for TIPS members; $375 for non-members; $300 for young lawyers; $75 for law students. American Bar Assn., Division for Professional Education, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

OCT. 9-10. Coping with Employee Benefits Reform seminar in New York, sponsored by the Practising Law Institute; $390; $40 for course handbook only. **Also Oct. 23-24** in San Francisco. Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

OCT. 12-15. International Assn. of Industrial Accident Boards & Commissions 72nd Annual Convention in Louisville, Ky.; $175 for active member or associate member; $240 for non-member; $100 for spouse or guest. IAIABC 72nd Annual Convention, P.O. Box 10103, Bowling Green, Ky. 42101; 502-223-4018 or 502-564-5575.

OCT. 14. The Risk Bearing Phenomenon—Alternatives to Traditional Insurance workshop in New Orleans, sponsored by the Society of Chartered Property Casualty Underwriters; $125 for CPCU members; $140 for non-members. **Also Nov. 17** in Washington, D.C.; **Nov. 19** in Los Angeles; **Nov. 21** in Seattle. Mari Jennings, Society of CPCU, Kahler Hall, 720 Providence Road, CB 19, Malvern, Pa. 19355; 215-251-2741.

OCT. 15. Cost Containment and Quality Assurance: The Impact on Today's Dental Profession symposium in East Rutherford, N.J., sponsored by Delta Dental Plan of New Jersey Inc.; $60. Delta Dental Plan of New Jersey Inc., 299 Cherry Hill Road, P.O. Box 222, Parsippany, N.J. 07054; 201-334-6300. Ext. 342.

OCT. 15-17. Fortieth Annual Fall Conference Council on Employee Benefits in Boston, sponsored by the Council on Employee Benefits; $300 for CEB member company or association (for each individual); $350 for non-members. C.S. Lazaroff, Goodyear Relief Assn., 1144 E. Market St., Akron, Ohio 44316; 216-796-4008.

OCT. 15-17. Meeting Your Responsibility for Worker Training and Right to Know course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; $400. Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 212-743-6523.

OCT. 15-17. Retirement Advisors Workshop in Chicago, sponsored by Retirement Advisors Inc.; $495. **Also Nov. 5-7.** Retirement Advisors

Continued on next page

"Wait until next year."

"When the recession really ends."

"When the lawyers come to their senses."

"I would say our reserves are adequate."

"Don't worry, we'll make it up on volume."

"The upturn is just around the corner."

"When the courts come to their senses."

"It can't stay this way much longer."

"The end is in sight."

Continued from previous page
Inc., 919 Third Ave., New York, N.Y. 10022; 212-421-2400.

OCT. 16. Risk Management: Challenges of Changing Times workshop in Northbrook, Ill., sponsored by Chicago, Wisconsin and Northeastern Illinois chapters of the Risk & Insurance Management Society; $75 for members of RIMS and prospective members. Patricia Benedick, Ameritech Corp., 30 S. Wacker Drive, Chicago, Ill. 60606; 312-750-5196.

OCT. 16-17. Buying Reinsurance in 1987 conference in New York, sponsored by Executive Enterprises Inc.; $795; $695 for additional registrant 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. 16-17. Risk Financing Alternatives: Coping With the Crisis in Coverage course in New York, sponsored by the American Management Assn.; $695 for AMA members; $800 for non-members. **Also Nov. 6-7** in San Francisco; **Nov. 24-25** in Chicago. American Management Assn., P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

OCT. 17. Managing the Health Care System symposium in Chicago, sponsored by Blue Cross and Blue Shield of Illinois; $95. Rosemary Longo, Blue Cross/Blue Shield of Illinois, 233 N. Michigan Ave, Chicago, Ill. 60601; 312-938-6155.

OCT. 17-18. Alternative Delivery Systems: Strategies for Physician Control conference in Washington, D.C., sponsored by the American Society of Internal Medicine; $350 for ASIM members; $425 for non-members. Teresa Crumpler, American Society of Internal Medicine, 1101 Vermont Ave. N.W., Washington, D.C. 20005-3457; 202-289-1700.

OCT. 18. Burns: Emergency Management for Occupational Health Nurses course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; $125. Office of Extension and Inservice Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 212-743-6523.

OCT. 19-22. Asia/Pacific Conference in Singapore, sponsored by the Risk & Insurance Management Society; $500. Risk & Insurance Management Society, Conference Department, 205 E. 42nd St., New York, 10017; 212-286-9292.

OCT. 20-21. How to Audit and Check Insurance Policy Costs and Coverage course in St. Louis, sponsored by the American Management Assn.; $675 for AMA members; $775 for non-members. **Also Oct. 27-28** in Philadelphia; **Nov. 6-7** in St. Petersburg, Fla.; **Nov. 13-14** in Dallas; **Nov. 17-18** in Bloomington, Minn.; **Nov. 20-21** in Boston; **Nov. 24-25** in Parsippany, N.J. American Management Assn., P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

OCT. 22-23. Strategic Planning for Raising Capital for the Insurance Industry conference in New York, sponsored by Executive Enterprises Inc.; $795; $695 for additional registrant 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. 22-25. Eighth Annual Educational Conference and Professional Trade Exhibition of the American Society for Hospital Risk Management of the American Hospital Assn. in Washington, D.C., sponsored by the ASHRM, Maryland Society for Healthcare Risk Management and the Risk Management Division, Hospital Council of the National Capital Area; $390 for ASHRM/MSHRM or RMD, Hospital Council of the National Capital Area member; $450 for non-member; $325 for each additional registrant from the same organization; $125 for full-time students. American Hospital Assn., P.O. Box 98946, Chicago, Ill. 60693; 312-280-6083.

OCT. 23. Employee Benefits workshop in Portland, Ore., sponsored by the Public Risk & Insurance Management Assn.; $110 for PRIMA members; $180 for non-members. **Also Nov. 7** in Binghamton, N.Y.; **Dec. 11** in Dallas. Public Risk & Insurance Management Assn., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

OCT. 24. Managing Police Liability workshop in Portland, Ore., sponsored by the Public Risk & Insurance Management Assn.; $110 for PRIMA members; $180 for non-members. Public Risk & Insurance Management Assn., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

OCT. 27-31. Self-Insurance Institute of America Inc.'s Sixth Annual National Educational Conference in Denver. Registration options are: section A (property/casualty and workers compensation issues) $425 for SIIA member, $525 for non-member, $75 for spouse; section B (employee benefits issues) $425 for SIIA member, $525 for non-member, $75 for spouse; and Section C (encompasses both A and B) $525 for SIIA member, $625 for non-member, $95 for spouse. Conference Registrar, SIIA 1986 National Conference, P.O. Box 15466, Santa Ana, Calif. 92705; 714-261-2553.

OCT. 28. ISO Commercial General Liability Rating workshop in Dover, Del., sponsored by the Insurance Society of Philadelphia; $65 for ISP members; $75 for non-members. **Also Nov. 13** in Philadelphia. Delaware Tech, Office of Continuing Education, 1832 N. DuPont Parkway, Dover, Del. 19901. For Philadelphia location: Insurance Society of Philadelphia, Public Ledger Building, Philadelphia, Pa. 19106.

OCT. 29-30. Insurance Industry Mergers and Acquisitions conference in New York, sponsored by Executive Enterprises Inc.; $795; $695 for additional registrant 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. 30-31. Public Agency Risk Pooling seminar in New Orleans, sponsored by the Public Risk & Insurance Management Assn.; $150 for PRIMA members; $250 for non-members. **Also March 5-6** in Clearwater Beach, Fla. Public Risk & Insurance Management Assn., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

OCT. 31. Managing and Controlling Asbestos Contamination/Exposure course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; $150. Office of Extension and Inservice Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 212-743-6523.

NOV. 3. Hedging with Financial Futures in the Insurance Industry seminar in New York, sponsored by Peat, Marwick, Mitchell & Co.; $400. Peat, Marwick, Mitchell & Co. Executive Education, 810 Seventh Ave., New York, N.Y. 10019; 212-603-3811.

NOV. 5-7. Marine Cargo Insurance and Ocean Cargo Claims seminars in New York, sponsored by the World Trade Institute; one day: $410, $365 for additional registrant from the same organization; two days: $640, $575 for additional registrant; three days: $815; $730 for additional registrant. (Marine Cargo Insurance seminar will be held Nov. 5-6. Ocean Cargo Insurance seminar will be held on Nov. 7.) Registrar, The World Trade Institute, One World Trade Center, Floor 55 West, New York, N.Y. 10048; 212-466-4044.

NOV. 6. Loss Control & Safety workshop in Portland, Ore., sponsored by the Public Risk & Insurance Management Assn.; $110 for PRIMA members; $180 for non-members. **Also Nov. 14** in Tampa, Fla. Public Risk & Insurance Management Assn., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

NOV. 7-8. Municipal Liability: The Search for Deep Pocket course in Orlando, Fla., sponsored by the American Bar Assn. Tort & Insurance Practice Section; $350 for ABA member; $325 for TIPS member; $375 for non-member; $300 for young lawyer; $75 for law student. American Bar Assn., Division for Professional Education, Department NI 438, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

NOV. 13. Self-Insurance and Other Risk Financing Techniques workshop in Tampa, Fla., sponsored by the Public Risk & Insurance Management Assn.; $110 for PRIMA members; $180 for non-members. **Also Dec. 12** in Dallas. Public Risk & Insurance Management Assn., 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

NOV. 13-14. Sixth Annual Occupational Health Nursing Principles and Certification Review course in Orlando, Fla., sponsored by the Occupational Health Consulting division of Fireman's Fund Risk Management Services Inc.; $275. **Also Dec. 4-5** in San Rafael, Calif.; **Jan.9-10** in Newark, N.J.; **Feb. 19-20** in Schaumburg, Ill.; **March 5-6** in Dallas; **March 19-20** in Philadelphia; **April 2-3** in Torrance, Calif. Annette B. Haag, Occupational Health Consulting, Fireman's Fund Risk Management Services Inc., P.O. Box 3890, San Rafael, Calif. 94911; 415-492-6646.

NOV. 14-19. Thirty-second Annual Employee Benefits Conference in Las Vegas, Nev., sponsored by the International Foundation of Employee Benefit Plans; $450; $150 for pre-conference institutes. Members only. International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

NOV. 17-18. Making the PPO Choice: A Purchaser's Guide to Assessing and Implementing the PPO Product conference in San Diego, sponsored by the American Assn. of Preferred Provider Organizations; $550 for general registration; $500 each for multiple registrants from same organization; American Assn. of PPOs, 101½ S. Union St., Alexandria, Va. 22314; 703-683-4918.

NOV. 30-DEC. 3. Corporate Health Care Cost Management Conference in Hollywood, Fla., sponsored by the International Foundation of Employee Benefit Plans; $530 for members; $605 for non-members. International Foundation of Employee Benefit Plans, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

DEC. 10. Personal Liability Risk Management workshop in Georgetown, Del., sponsored by the Insurance Society of Philadelphia; $105 for members; $120 for non-members. **Also Dec. 10** in Philadelphia. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306. ●

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Storms cause $20 million loss

NEW YORK—Insured losses as a result of wind and hail damage in North Dakota on July 29 and 30 are estimated at $20 million, according to C.E. Hermanson, vp-property claim services division of American Insurance Services Group Inc.

The heaviest damage occurred in the capital city of Bismarck and surrounding areas. The storm was assigned Catastrophe No. 15. ■

Industrial firms increase pension benefits

By JERRY GEISEL

WASHINGTON—The nation's largest industrial corporations are paying higher pension benefits than they paid a year ago, according to a new survey.

Salaried employees who retire this year at age 65 after 35 years of service at the 50 largest U.S. industrial corporations will receive an average pension benefit of $16,187, or 10.1% more than the $14,707 average pension benefit a worker who retired last year would have received.

When Social Security benefits are added to company-provided pension benefits, total retirement benefits received by employees retiring from the big industrial companies also are significantly higher in 1986 than 1985. The average combined pension and Social Security benefit a 65-year-old retiree can expect to receive this year is $25,283, up 8.6% from $23,287 in 1985.

The size of retirement benefits provided by major industrial employers is contained in a survey by The Wyatt Co., a nationwide employee benefit and risk management consultant.

Wyatt analyzed the pension programs provided by the nation's 50 largest industrial companies to their salaried employees.

In compiling the latest survey, Wyatt calculated the pension benefits provided by the 50 companies for employees retiring at age 65 after 35 years of service by assuming the employee started work with a salary of $4,659 and retired with a final average salary of $39,600.

Wyatt also assumes that the employee retired with an annual Social Security benefit of $9,096.

In its 1985 survey, Wyatt assumed that those employees who retired after 35 years started with a salary of $4,387 and retired with a final average salary of $37,000. Wyatt also assumed in the 1985 survey that the retiring employee received $8,580 in annual Social Security benefits.

Workers retiring at Georgia-Pacific Corp. will receive the highest benefits of the companies surveyed.

With these assumptions, Wyatt found that workers retiring at Georgia-Pacific Corp. this year will receive the highest benefits of the companies surveyed.

A 35-year employee at Atlanta-based Georgia Pacific can retire this year at age 65 with a benefit of $21,470; Georgia Pacific was not surveyed last year so the increase over 1985 is not known.

Other companies where employees who retire this year at age 65 with 35 years of service will receive large pension benefits include Dearborn, Mich.-based Ford Motor Co., $19,440, up from $18,359, a 5.9% increase; Detroit-based General Motors Corp., $19,280, up from $18,246, a 5.7% increase; and Houston-based Tenneco Inc., $19,075, up from $17,749, a 7.5% increase.

At the other end of the scale, Wyatt found below-average pension benefits among surveyed companies at Minnesota Mining & Manufacturing Co. in Minneapolis, $11,514, up from $10,795, a 6.7% increase; Dayton, Ohio-based Goodyear Tire & Rubber Co., $11,749, up from $10,082, a 16.5% increase; and Xerox Corp. in Stamford, Conn., $12,793 up from $11,846, an 8% increase.

When pensions and Social Security benefits are combined, retirees of many large industrial companies have a high percentage of their final pay replaced by retirement benefits, the Wyatt survey indicates.

For example, that 65-year-old who retires at Georgia Pacific after 35 years of service will receive combined pension and Social Security benefits of $30,566, which will replace 77.2% of final pay.

The Ford employee who retires this year at 65 with 35 years of service will receive combined pension and Social Security benefits of $28,536, which will replace 72.1% of final pay, while the GM employee will receive combined benefits of $28,376, replacing 71.7% of final pay.

Not all major industrial corporations, though, replace such a high percentage of salary with retirement benefits.

For example, a 65-year-old who retires this year from 3M after 35 years will receive combined pension and Social Security benefits of $20,610, which would replace only

Continued on page 38

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Pension benefits

Continued from page 36

52% of final pay, while his or her counterpart at Goodyear will receive combined benefits of $20,845, replacing 52.6% of final pay, according to the survey.

Since workers in the 1980s seldom stay with the same employer for 35 years, Wyatt also calculated retirement benefits for workers who retire this year at age 65 with 15 years of service.

In calculating benefits, Wyatt assumed a starting salary of $13,088, final average salary of $39,600 and an annual Social Security benefit of $9,006.

Under those assumptions, the 65-year-old General Motors Corp. employee who retires this year after 15 years will receive a pension benefit of $9,301 and combined pension and Social Security benefits of $18,397. Those benefits would replace 46.5% of final pay.

At Georgia-Pacific, the 65-year-old will receive a pension benefit of $9,073 and combined benefits of $18,169, which would replace 45.9% of final pay, while the 65-year-old at Ford will receive a pension benefit of $9,032 and combined benefits of $18,128, replacing 45.8% of final average pay.

The Wyatt survey also found 401(k) salary reduction plans are just about a standard employee benefit at big companies. Some 46 of the 50 companies offered their salaried employees 401(k) plans, compared with 45 last year, 32 in 1984 and 13 in 1983.

"You could say that 401(k) plans now are almost universal at big companies," said Sylvester Schieber, director of Wyatt's Research and Information Center in Washington.

The survey found that 31 companies have thrift plans with a 401(k) option, while a 401(k) feature is included in the profit-sharing plan at five companies. Ten companies have established separate 401(k) plans.

Employee participation rates in 401(k) plans varied widely at the 28 companies reporting participation information. Among the lower paid two-thirds of employees, the participation rate ranged from a high of 89% to a low of 17%; the average employee participation rate among the lower-paid two-thirds was 52%.

'Some companies have a long way to go to increase (401(k)) participation,' Mr. Schieber says.

Among the top-paid one-third, the participation rate ranged from a high of 99% to a low of 39%; the average rate was 74%.

"Some companies have a long way to go to increase participation," Mr. Schieber said, adding the effort a company puts into explaining its 401(k) plan to employees, especially the lower-paid, undoubtedly affects participation rates.

Of the 26 companies providing information on the level of earnings that separates the top-paid one-third to the lower-paid two-thirds, the average was $36,150. Earnings break points among the companies ranged from $21,360 to $47,800.

The survey also found that 31 companies now offer supplemental executive retirement plans to top executives, compared with 26 companies last year, 20 in 1984 and 16 in 1983. These supplemental plans are unfunded and are not tax-qualified because they are not offered to most employees.

Wyatt says supplemental plans have grown because of congressional cuts and freezes in the maximum benefits that can be paid by a qualified defined benefit plan and maximum contributions employers can make to defined contribution plans.

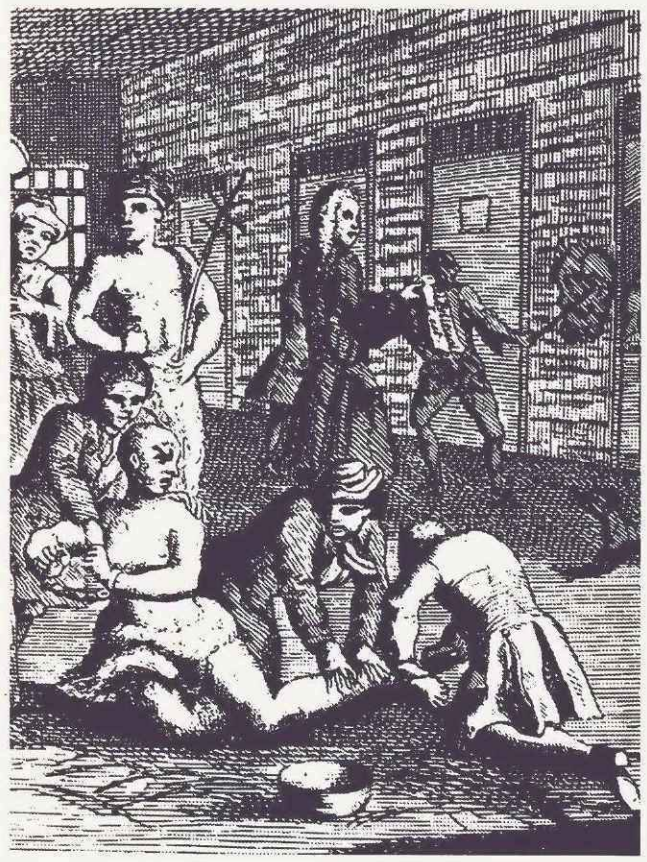
The current maximum annual benefit than can be funded through a defined benefit plan is $90,000; the maximum annual contribution that can be made to a defined contribution plan is $30,000.

Those limits were once as high as $136,425 and $45,475, but were lowered to current levels as part of the 1982 tax law and were frozen until 1988 by the 1984 tax law.

●

Free single copies of "Top 50: A Survey of Retirement, Thrift and Profit-Sharing Plans Covering Salaried Employees of 50 Large U.S. Industrial Companies as of Jan. 1, 1986," are available from any Wyatt Co. office or Wyatt's Research and Information Center, 1850 K St. N.W., Suite 400, Washington, D.C. 20036; 202-887-4600.

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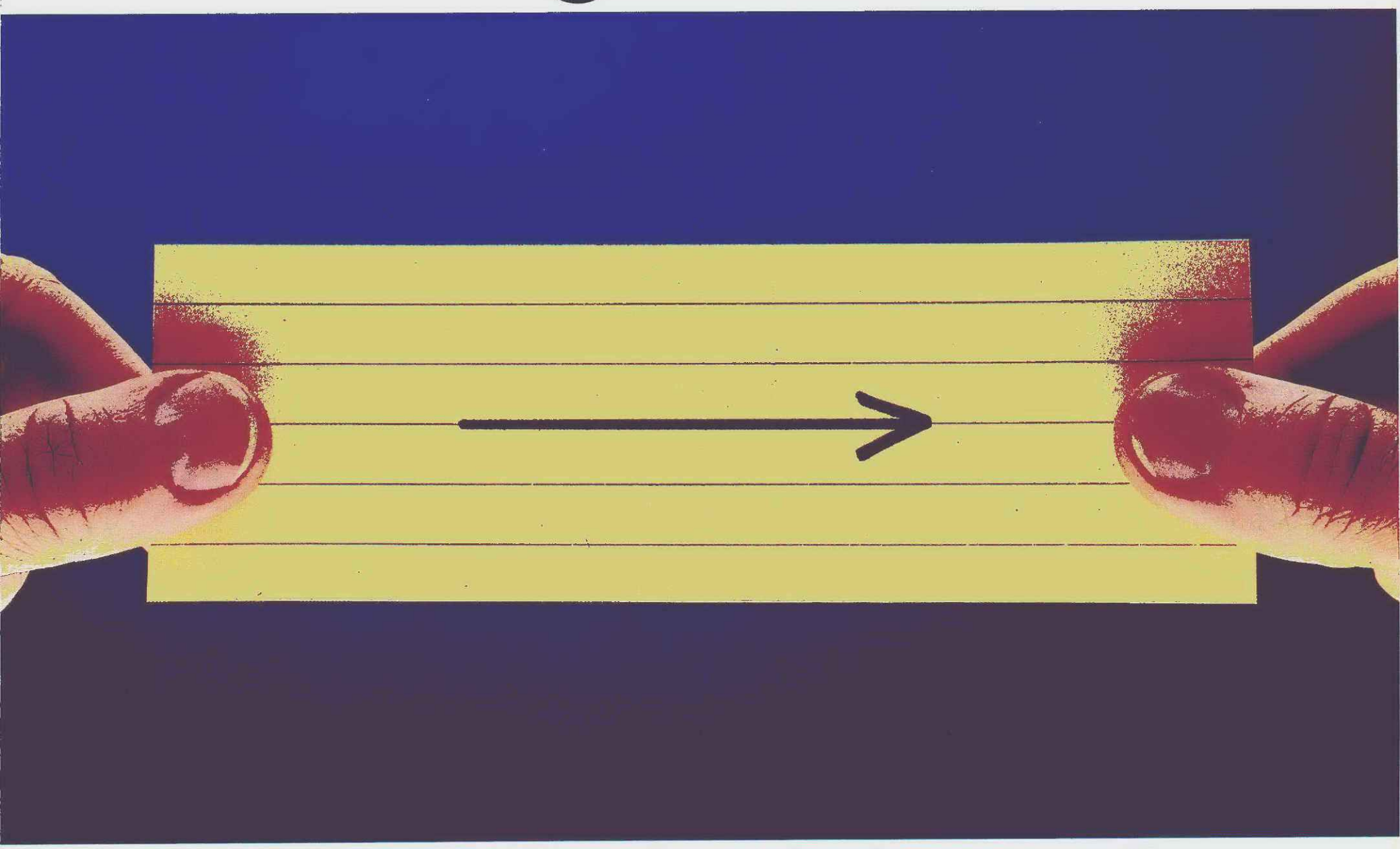
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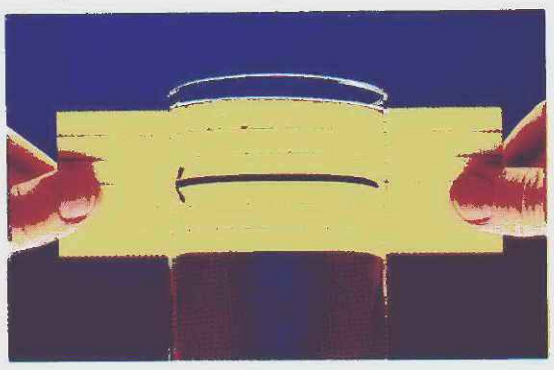
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Rand study finds HMO care costs less

SANTA MONICA, Calif.—Health maintenance organizations can reduce the cost of delivering medical care, according to a Rand Corp. study.

Rand researchers found that the cost of medical care provided by the Group Health Cooperative of Puget Sound, a Seattle-based HMO, was about 25% less than the cost of health care provided under the traditional fee-for-service health care delivery system in the Seattle area.

Researchers attributed this savings to the fact that hospitalization rates for people covered by HMOs were about 40% less than for those covered by fee-for-service plans.

"Physicians in HMOs practice a different style of medicine than private practitioners—one that is markedly less dependent on hospitalization," said Willard G. Manning, the Rand economist who directed the study.

"This results in real savings because hospital costs are the biggest single factor in the nation's medical bill. They account for half of everything that is spent on personal health care in the United States," Mr. Manning said.

The Rand study of the Seattle HMO is part of a 12-year, $78 million federally financed study of health care involving 7,700 people in six areas around the nation.

In this portion of the study, 2,362 people were randomly assigned to receive health care either at the Group Health Cooperative or from a fee-for-service physician of their choice.

Additionally, 733 existing members of the HMO were used as a control group.

The fee-for-service participants were divided into several groups: one in which individuals received health care services at no charge; one in which individuals had to pay 25% of their bills; and one in which individuals had to pay 95% of their bills.

However, health care costs for individuals in the fee-for-service plans were capped at $1,000 annually, no matter what level of copayments were required.

The group assigned to receive care at the HMO was virtually identical to that which received care under the fee-for-service plan in such personal characteristics as age, sex, race, family size, family income and general health.

According to the Rand study, parts of which have been printed in The New England Journal of Medicine, those selected to receive care from the HMO reported a hospital admission rate of 8.4 per 100 people, while those in the HMO control group similarly reported an admission rate of 8.3 per 100.

Individuals who received care under a fee-for-service arrangement but who did not contribute to the cost of the services provided reported a hospital admission rate of 13.8 per 100 people; those who faced a 25% coinsurance requirement reported a rate of 10.0 per 100 people; and those who paid 95% of their health costs up to the $1,000 cap reported an admission rate of 10.5 per 100 people.

Likewise, the number of hospital days among the HMO members were generally less than those who received care under a fee-for-service arrangement.

Those assigned to the HMO as part of the study reported 49 hospital days per 100 people, while those in the HMO control group reported only 38 days per 100 people.

But those who received care under the fee-for-service system and did not contribute to their health costs reported 83 hospital days per 100 people. Those who paid 25% coinsurance reported 87 hospital days per 100 people.

However, the individuals who paid 95% coinsurance only reported a rate of 46 hospital days per 100 people, about equal to the rate of those belonging to the HMO.

The reason the HMO members had a lower hospitalization rate was because the HMO acts both as a health care provider and insurer, Mr. Manning pointed out.

"We know that in an HMO the economic incentive is strong to keep patients out of hospitals," he said.

"This is because the HMO acts both as health care provider and insurer. Thus, the costs of hospitalization, which are high, have to be met from the HMO's own revenues from premiums.

"When hospital costs go up, premiums have to be raised to cover them and the HMO begins to lose members," he said.

While Rand notes that more research will be needed to investigate this hypothesis, "we conclude that GHC physicians are simply practicing a different style of medicine from that of fee-for-service physicians."

"Although our study is limited to a single, not necessarily typical, prepaid group practice, the general consistency between its results and (other studies) indicates that a less hospital-intensive style of medicine than that practiced by the average physician is possible," Rand said.

Mr. Manning noted that the lower hospitalization rates among those enrolled in the HMO were not caused by an increased amount of preventive care provided by the HMO.

About two-thirds of the preventive care visits reported by the HMO were for well-child care and gynecologic examinations.

"Because gynecologic and pediatric admissions account for a minority of hospitalizations, it seems unlikely that preventive care could account for much of the large difference in hospitalization rates," the authors of the survey say.

Rand notes it will continue to survey those individuals who participated in the experiment to make sure those who received care from the HMO do not suffer any health consequences. "We have taken extensive measures of the health status of our participants and future analysis of these data should detect any pronounced effects on the different style of medical treatment on health status," the researchers say.

However, they add that "prepaid group practices have existed for decades, and it seems unlikely that there can be large deleterious health effects that gave gone unnoticed."

The researchers do not foresee any wholesale replacement of physicians in the fee-for-service sector by HMOs in the near future, noting that many people resist joining HMOs even though prepaid plans may offer financial advantages.

•

For more information on the Rand study, contact Willard G. Manning, Rand Corp., 1700 Main St., Santa Monica, Calif. 90406-2138.

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Multiemployer plan funding improving

By JERRY GEISEL

NEW YORK—Multiemployer pension plan funding is on the upswing, according to a new survey.

About 80% of the 493 multiemployer pension plans surveyed earlier this year by New York benefit consultant Martin E. Segal Co. were fully funded, up from about 73% last year.

A pension plan is fully funded when it has sufficient assets to pay benefits promised to vested workers and retirees.

The average surveyed plan was 95% funded for vested benefits, up slightly from 94% last year.

Just 2.5% of the plans were less than 50% funded for vested benefits, an improvement over the 3% of the plans that were less than 50% funded in 1985.

"Multiemployer funds are in excellent financial shape with respect to the unfunded liability for vested benefits," said Segal President Robert D. Krinsky.

"The fears which have been associated with the economic impact of withdrawal liability assessment are, in most cases, unfounded," Mr. Krinsky added.

The amount of unfunded liabilities in multiemployer plans has been important to employers since 1980, when Congress passed the Multiemployer Pension Plan Amendments Act, which imposes major financial penalties on employers that withdraw from underfunded multiemployer plans.

Under that law, an employer that leaves a multiemployer plan is responsible for paying a share of the benefits that are promised to workers and retirees but are not funded.

Because employers' contributions to multiemployer plans—especially before 1980—haven't always matched promised benefits, the unfunded vested benefits can be substantial. Some companies that left underfunded multiemployer plans have been slapped with withdrawal liability claims that exceeded their net worth.

But as plan funding continues to improve, the potential that an employer will be hit with a large withdrawal liability claim is decreasing.

Segal surveyed 493—or about 25%—of the nation's 2,000 multiemployer plans.

The surveyed plans, all Segal clients, ranged in size from less than $1 million in assets to more than $1 billion in assets. The plans had an aggregate $31 billion in assets, up from $27 billion in 1985.

Some plans had less than 100 participants while others had more than 100,000 participants.

In the 1986 survey, 396 or 80.3% of the 493 plans were fully funded, up from the 355 or 73.5% of the 483 plans that were surveyed in 1985.

There are several reasons why multiemployer plans—which are most often found in the trucking, construction and clothing industries—have improved their funding. Those reasons, according to Mr. Krinsky, include:

- The assets of multiemployer plans have increased because of the stock market boom over the past several years.
- A slowdown in benefit improvements has occurred because of greater employer resistance to higher benefit costs.
- More union interest in wage increases than hikes in pension benefits.

A number of surveyed plans, though, were not well-funded. For example, 12 plans were less than 50% funded for vested benefits, compared with 14 plans in last year's survey.

While underfunded plans were not identified individually, Segal noted that plans covering workers and retirees in declining industries—such as retail milk delivery—tend to have a higher than average unfunded vested liabilities.

'Multiemployer funds are in excellent financial shape with respect to the unfunded liability for vested benefits. The fears. . .associated with the economic impact of withdrawal liability assessment are, in most cases, unfounded,' says Mr. Krinsky.

As these industries decline—most consumers today buy milk at grocery stores instead of having it delivered—there are fewer employers joining the multiemployer plan to replace companies that have gone out of business.

As a result, there are fewer employers to help finance benefits for a growing pool of retirees.

By contrast, in the construction industry, which has been booming in many parts of the country, plan funding is higher than in plans for many other industries, according to the survey. For example, 237 or 85.9% of the 276 surveyed construction industry plans were fully funded, compared with 80.3% of all surveyed multiemployer plans.

According to Segal, there was a modest correlation between the number of participants and the funding level of a plan. In general, larger plans were not as well-funded as smaller plans.

For example, some seven of the 12 plans that were less than 50% funded for vested benefits had more than 10,000 participants.

In addition, some 94, or 95%, of the 99 plans with less than 500 participants were fully funded, while 74, or 86%, of the 86 plans with between 500 and 1,000 participants had sufficient assets to pay all promised benefits.

By contrast, only 65% of the 55 surveyed plans with more than 10,000 participants were fully funded.

The reason larger plans, on the average, are not as well funded as smaller plans is probably their structure, Segal says.

"Larger plans often have multiple benefit levels and allow participants to move freely from a lower benefit level to a higher one," the study notes. "If the higher benefit level is applied to all service, as it frequently is, liabilities increase immediately, but it takes some time for the increased contributions to accumulate matching assets."

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Free copies of the "1986 Survey of the Funded Position of Multiemployer Plans," are available from Deborah Bohren, Director of Public Affairs, Martin E. Segal Co., 730 Fifth Ave., New York, N.Y. 10019; 212-586-5600.

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Third World nations pose great political risk: Survey

NEW YORK—U.S. companies doing business overseas face the greatest political risks in Third World, Arab and communist nations, according to the latest Political Risk Services Letter published by Frost & Sullivan Inc.

Frost & Sullivan, a New York-based political risk consultant, rates nations according to how much risk exists for three different types of business: financial transfers, direct investment and exports.

Ratings assigned to each nation vary from a high of A-plus to a low of D-minus.

According to the latest survey, the nations that pose the greatest risk—those with grades of C or lower—for financial transfers over the next 18 months are: Bolivia (C-minus); Chile (C); East Germany (C-minus); Greece (C); Guatemala (C-minus); Iraq (C-minus); Kenya (D-plus); Mexico (C); Nicaragua (C); Nigeria (C-minus); Peru (C); Poland (C-minus); Sudan (D-plus); Turkey (C-minus); Yugoslavia (C); Zambia (D); and Zimbabwe (C-minus).

The nations, according to Frost & Sullivan, that pose the greatest risks to foreign investment over the next year-and-a-half include: East Germany (C); Nicaragua (C-minus); Nigeria (C-minus); Poland (C); Romania (C); Syria (C); Soviet Union (C); Zambia (C); and Zimbabwe (C).

The nations that pose that highest political risks for exporting companies over the next 18 months include: Algeria (C); Argentina (C); Bolivia (C); East Germany (C-minus); El Salvador (C-minus); Greece (C); Guatemala (C-minus); Indonesia (C); Iran (C); Jamaica (C); Mexico (C-minus); Nicaragua (C-minus); Peru (C); Poland (C-minus); Sri Lanka (C); Syria (C); Turkey (C); Zambia (D-plus); and Zimbabwe (C-minus).

Interestingly, Libya's scores were not among the worst in any of the classifications.

Libya was assigned a B-minus for transfer risks, a B-minus for direct investment and a C-plus for export risks.

As usual, western democracies receive the highest political risk ratings in all three categories from Frost & Sullivan.

Those nations judged to have the most favorable climate—a rating of A or A-plus—for financial transfers over the next 18 months include: Australia (A); Canada (A); Denmark (A-plus); France (A); Hong Kong (A-plus); Kuwait (A); Netherlands (A-plus); Norway (A); Puerto Rico (A-plus); United Kingdom (A-plus); United States (A-plus); and West Germany (A-plus).

Frost & Sullivan gave A or A-plus ratings for risk to direct investments over the next 18 months to: Belgium (A); Canada (A); Denmark (A); Finland (A); Hong Kong (A); Ireland (A); Italy (A); Netherlands (A-plus); Norway (A); Portugal (A-plus); Puerto Rico (A-plus); Singapore (A); Sweden (A-plus); United Kingdom (A-plus); United States (A-plus); and West Germany (A-plus).

The nations rated as the most favorable to exporting companies over the next 18-months are: Australia (A); Belgium (A); Denmark (A-plus); Finland (A); Gabon (A); Hong Kong (A-plus); Ireland (A-plus); Norway (A-plus); Portugal (A); Puerto Rico (A-plus); Singapore (A-plus); Sweden (A-plus); United Kingdom (A-plus); United States (A); and West Germany (A-plus).

In addition to providing ratings for the three economic classes, Frost & Sullivan also grades each nation according to whether it has a "low," "moderate," "high" or "very high" likelihood of political turmoil.

According to the report, the nations with a high or very high chance of turmoil over the next 18 months include: Chile, Colombia, Ecuador, Egypt, El Salvador, Greece, Guatemala, Guinea, Haiti, Honduras, Iraq, Nicaragua, Nigeria, Peru, South Africa, South Korea, Sri Lanka, Sudan, Zaire, Zambia, and Zimbabwe.

Nations which are given a high or very high likelihood of turmoil in the next five years include: Bolivia, Cameroon, Chile, Colombia, Egypt, El Salvador, Guatemala, Guinea, Haiti, Jamaica, Kenya, Libya, Mexico, Nicaragua, Nigeria, Peru, South Africa, Sri Lanka, Sudan, Zaire, and Zimbabwe. ■

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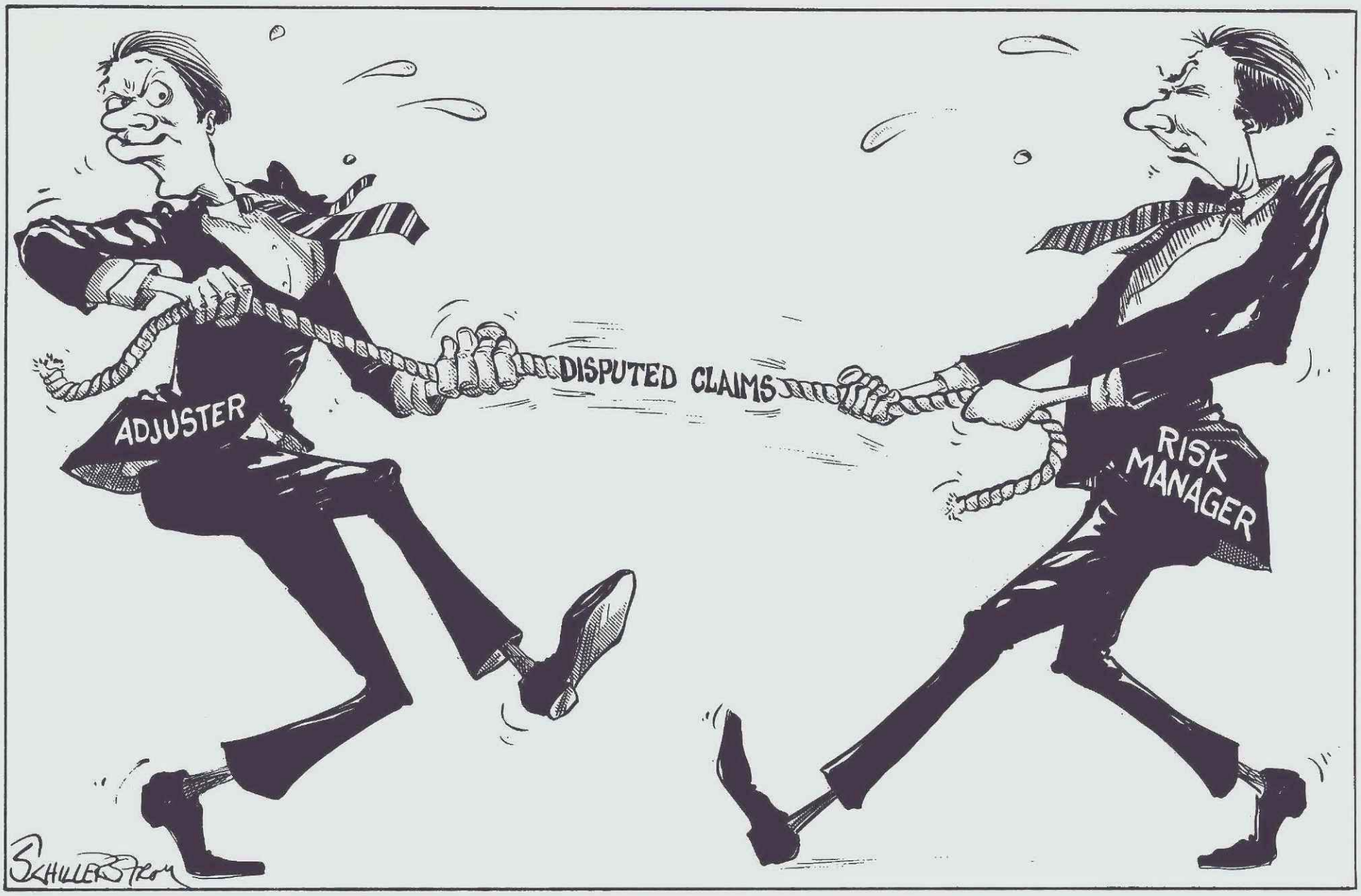
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Claims denial tug-of-war

Adjuster's initial decision needn't be final word in coverage

By Lester L. Lowenstein

THE COLLAPSE OF a drilling structure at the excavation site of a Midwestern mining company resulted in severe property damage and a serious disruption in production. When the claims adjuster reviewed the accident, he indicated that it was excluded from the mining company's all-risk policy and the damaged facility was not included on the schedule attached to the claimant's blanket policy.

Ultimately, however, the claim was paid in full—without legal action.

What should a company do when the adjuster says "no"? What steps should a policyholder take to present its case and contest the opinion of the underwriter?

While the parties embroiled in claims disputes often strive for "black and white" interpretations of a policy, veteran risk managers and insurance professionals realize the claims process is a highly subjective exercise fraught with numerous gray areas.

In today's increasingly complex business climate, the transition from insurance claim to settlement can be turbulent.

Many people, while realizing that an adjuster's denial of liability need not be taken as the final verdict, may be uncertain about how to proceed to protect their interests.

When an adjuster denies liability on a loss, it is because he believes the policy does not provide coverage for the location, the type of property or the peril involved. You as the policyholder may disagree.

If so, it will be on the basis of one of two points: Either you agree with the adjuster's interpretation, but believe something was intended to be covered that is not specifically reflected in the policy, or you disagree with the way the policy wording is being construed.

In the case of intent, some of the first questions that should come to mind are:

- Are the people who expressed the intent still available?
- Was the intent implied, stated orally or set down in writing?
- Is the policy wording a standard insurance company form—an Insurance Services Office form or broker's manuscripted form—or was the wording tailored for you?

Certainly in disagreements involving intent, your insurance broker, agent or sales representative should play a key role. Give him or her a good chance to resolve the problem before seeking outside help. If you have one, this may be a good time to alert your house counsel.

Because the original agreement may have involved as many as three separate groups—a broker, an underwriter and a buyer—it is not unusual for one of the key parties to be unavailable. Although the absent party may be willing to help, often the fact that they have moved on suggests that their input may no longer be desirable, even if obtainable.

Since "we never anticipate the unexpected" when the coverage was designed, there probably was little or no thought given to what now has occurred. If something was put in writing covering this situation, there would be no dispute. Still, double-check: You may be able to nip the problem in the bud.

If you have a standard policy form, chances are you are stuck with whatever it says. Your presumed acceptance of the policy when you received it can be difficult to argue against now. In spite of that, though, there may be factors that can work to your benefit, including:

- If the policy predating the one in question was different, how did it treat this issue?
- Did your broker or agent indicate limitations in the new coverage?
- Do the values you were reporting support inclusion of a location, type of property or valuation method not reflected in the wording?

A cautionary note regarding this last point: It is not true that "you collect like you report." Including values for an unsprinklered wood building on a blanket policy—even though it is not included in the schedule of locations—is not a recommended risk management technique. However, it will be helpful if your intent is supported by identifiable values.

If your coverage has been written under a manuscript form or has been custom-tailored, the news is both good and bad. The good news is that you may not be stuck with a standard insurance company interpretation. The bad news is that you can no longer claim that any ambiguity should be resolved to your benefit.

Actually, disputes arising over non-standard forms are usually a combination of intent and interpretation arguments. That is, the adjuster's interpretation of the wording doesn't match the policyholder's intent.

When this happens, these disputes

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Lester L. Lowenstein directs Coopers & Lybrand's New York-based Insurance Claims Services Group. He also is a member of the American Arbitration Assn.

perspective

A solution?

Would licensing make underwriters any wiser?

By James A. Robertson

RECENTLY I FOUND an article about the state of the insurance industry whose title proclaimed, "Worst Capacity Crunch Ever; Rampant Insolvencies Forecast." It was in a file that contained another interesting article titled, "Applied Knowledge Can Alter Loss Ratio by 30%."

The first article was dated Sept. 20, 1974, the second was from June 1974.

The "find" made me laugh at the ways we repeat ourselves—the truth that "there is nothing new under the sun" and the lesson on the cyclicity of the property/casualty insurance business that these articles demonstrated.

These things led me to reflect on what we know about underwriting and the setting of premiums for various types of risks. The actuarial science has come far in developing efficient, useable forecasting models for losses. When an actuary is not available, individual risk pricing techniques that I was taught as an underwriter in the early 1970s still provide a reasonably good estimate of the value of a risk with a loss history.

With all of the sophisticated tools we have available, underwriting cycles suddenly seem to be a very stupid phenomena. Since nearly everyone is now demanding reforms in reaction to the current insurance crisis, the insurance industry needs help to avoid restrictive state regulation or federalization.

To reduce the pendulum swing of future underwriting cycles, I have come to believe that it is time to license individuals who are property/casualty underwriters.

"Silly idea," you say? Let's talk about it before rejecting the suggestion.

Underwriters are the foot soldiers of an industry that collects more than $120 billion a year in premiums from American businesses. The 3,400 U.S. non-life insurance companies employ more than 470,000 people directly and 770,000 indirectly in agencies and brokerages.

From 1982 through 1985, this mammoth industry incurred an underwriting loss of more than $70 billion. The industry had a $5.5 billion operating loss in 1985 and lost $3.8 billion in 1984. These are the first operating losses since 1906, the year of the San Francisco earthquake.

Everyone now acknowledges that 1985 was the turning point of the most recent and most destructive underwriting cycle in history. It was also the longest downward cycle in the history of a business known for its cyclicity.

There were, of course, other economic factors that influenced the last underwriting cycle. Taking a longer view, the industry has had statutory underwriting profits in 12 years since 1960 (only eight years, if you use the underwriting results after policyholder dividends). But these results have been far exceeded by investment income in most of those 26 years.

The largest underwriting profit in history was $2.5 billion, in 1978. The largest investment income year was 1984, with more than $17 billion. Yet the industry sustained underwriting losses of more than $21 billion in 1984, producing a $3.8 billion operating loss.

These statistics are a sad indictment of underwriters, who apparently don't understand how to make a profit on the premium they charge for accepting risks. I've been told that underwriting profits have not exceeded investment income in this industry since the early 1950s.

speaking out

But why pick on the underwriters? Why not blame senior management, or even fate? Every business has fluctuations from year to year, and actuaries are no less fallible than economists and financial experts. If actuaries were perfect, every insurer would seek the ideal spread of risk and know exactly how much premium to charge for every risk, by class, to make a profit on the entire book of business.

Management certainly should be able to guide the business in the right direction, toward a more acceptable range of results than those posted between 1983 and 1985. That's what business plans and strategic planning should have done for the industry in the last 20 years.

Poor underwriting. . .helps continue the process of needlessly enriching attorneys who handle litigation over the policies that underwriters create.

But I hold underwriters responsible for the results because they are the people on the line who actually determine, in most cases, what price an insurer will charge for accepting a risk.

To paraphrase one insurance executive, underwriters are the checkers in a giant supermarket of insurance where each checker decides how much to charge for the groceries. When underwriters charge too little for accepting risks, it's the equivalent of knowingly selling rancid meat. When underwriters charge too much, the produce spoils on the shelf because no one will buy.

"Wait a minute," you say. "Those underwriters only do what management tells them to do." This point is valid. Management wanted them to write more business in the early 1980s when interest rates were the highest in memory. Management permitted them to use unsound rates and premium payment programs. Some of the programs on the "supermarket" shelves in the early 1980s appeared to be designed to produce an underwriting loss, so that the insurer's investment department would have more money to invest.

My negative impressions about the underwriting at most insurance companies have been reinforced too often over the years.

In order to continue writing business at depressed, inadequate rates, insurer managements even cut costs by reducing expenditures for training, seminars and outside contributions to insurance education, and stopped reimbursing the educational expenses of individuals who wanted to enroll in insurance courses.

It's hard to say who designed those programs and encouraged underwriters to use unsound techniques for pricing risks. Were the head underwriters of insurance companies the leaders or scapegoats of this movement? If they were scapegoats, then the blame totally rests at the feet of insurance company senior executive officers, and they bear responsibility for the fundamental changes we are now seeing in the industry.

But if heads of underwriting were the ones responsible for leading management and the industry into this mess, then they should be sent back for re-training or told to find employment more suited to their abilities.

Licensing would be one way to impose order and discipline on the underwriting process. It would not be perfect, but it could hardly be worse than the system we have now. Agents and brokers are licensed because they have a special position of trust and should be held accountable for knowing what they are selling. Why shouldn't the same standard apply to underwriters?

The integrity of insurance is too important to leave in the hands of untrained novices. The claims process requires intelligible coverage to function; many businesses now rely on insurance for their very existence; and the financial security of insurance allows people to create new businesses and stay in business. Poor underwriting thus damages the very infrastructure of our economy and helps continue the process of needlessly enriching attorneys who handle litigation over the policies that underwriters create.

If states license underwriters, there would have to be a stated professional standard for evaluating underwriting decisions. For example, when management wants to reduce rates on lines of insurance that are losing money, licensed professionals might be obliged to refuse. However, mere unlicensed underwriters have to do whatever they are told to keep their jobs, even when their orders are illogical. Licensing standards could help make underwriters more effective at avoiding both inadequate and excessive rates for particular standards.

The phrase "underwriting judgment" is often contradictory. When I was responsible for supervising other underwriters and reviewing the quality of their work, it surprised me to learn how many of their decisions were made because of fear and ignorance.

I found out that underwriters usually fear making a mistake or drawing attention to their work, and that they decline most risks because of this fear or because they are afraid to admit that they really do not understand risk or how to charge for accepting it.

When underwriters do not accept a risk, the decision often is unwarranted by the facts they have, but that's all right because the home office underwriting guide says they can write such accounts without referring them to the supervising underwriter.

My negative impressions about the underwriting at most insurance companies have been reinforced too often over the years. Line underwriting authority is diminishing. Because much underwriter training is poor, every experiment in increasing local underwriting authority fails, so management re-centralizes all underwriting decisions in the hands of the people who were promoted from within the failing system. These people remember their former oppression when they were line underwriters and so they release authority to the line underwriters again—until their superiors or successors decide that the experiment has, once again, failed.

It's a vicious circle! When companies want new blood, they go outside for people who have been promoted from within companies that may be in a worse mess.

Contrast the seeming chaos and caprice in the underwriting process of today with the title of the second article that I found. If knowledge of a risk can improve loss ratios by 30%, we need to focus on this knowledge. Knowing what the risk consists of,

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James A. Robertson, a former underwriter, is president of James A. Robertson & Associates and Insurance Litigation Consultants in Irvine, Calif. He is the author of "ISO Commercial Liability Forms: A Side-by-Side Comparison" and is well known for his work on "The Umbrella Book," which rates different umbrella liability policy forms.

perspective

Adjuster's interpretation needn't be final word

Continued from page 47
tend to fall into the second category: interpretation.

Interpretation problems are a natural result of the practical need to use a minimum number of policies to cover a maximum number of business operations. At best, the wording may be vague; at worst, it may be ambiguous.

Although case law can be built up over the years into a body that can serve as a guide for interpreting standard wording, states frequently rule in opposite ways, and unusual situations are always cropping up.

Therefore, if an adjuster tells you the "standard" way of dealing with a situation is thus-and-so, be cautious. Is what the adjuster says clearly implied, if not stated, in the policy?

Without being deliberately argumentative, consider whether there is a big gap between what actually is said in the policy and what you are being asked to accept. If there is, there may be more latitude in the policy than you are being led to believe.

At this point, you should ask yourself the following questions:

- How competent is and what is the authority level of the adjuster?
- Should I seek the involvement of a more senior or open-minded adjuster? If so, how?
- Do I threaten court action?
- Should I get an attorney to show I mean business?

At this juncture, it is well to remember that you are not dealing with a monolithic insurance giant. The adjuster operates with a fair amount of discretion, especially if he or she is at a senior level.

It is advisable to proceed as far as you can with whomever has been assigned to the claim. But, if an impasse is reached or if there is a personality conflict and you feel that a more knowledgeable review is called for, do not hesitate to appeal to higher authority.

Unfortunately, adjusters often are cast in the role of financial policemen trying to resolve complex, high-stakes issues. Furthermore, it is not unusual for different adjusters to interpret a given situation differently.

This suggests that claims work is not an altogether exact science. If the adjuster's initial evaluation is negative, it is also probably somewhat tentative. In dealing with a gray area, most of us tend to take a conservative approach.

The rule of thumb in the adjusting business is that you always can go back and accept liability, but it's tough to deny coverage once it's been accepted. So don't despair, and above all don't get angry. Keep the lines of communication open.

It is advisable to proceed as far as you can with whomever has been assigned to the claim. But if an impasse is reached or if there is a personality conflict and you feel that a more knowledgeable review is called for, do not hesitate to appeal to higher authority.

If you are working with an independent adjuster, request a review by a senior member of the insurer's claims department. If you are working with a staff adjuster, request a home office review. The best approach is a politely worded letter requesting "executive review of our differences and a meeting with your senior claims management to explore our respective positions."

By this time you probably will have sought the assistance of a knowledgeable claims specialist. If your broker has a claims department or someone especially knowledgeable about this type of claim, they will be helping you.

The only caveat is that occasionally the broker may be too involved with the problem to offer a totally independent opinion. Your outside legal counsel may be able to recommend someone.

It generally is best at this point to use your attorney as a resource but to keep him or her in the background unless you are especially uncomfortable in handling negotiations. Keep in mind that most disputes can be resolved through patient negotiations without the expense and additional delay of legal action.

The threat of a lawsuit usually only serves to escalate the disagreement and does not really intimidate the insurance company, which routinely hears these kinds of challenges.

Because you are dealing with a controversial situation, it may take a year or more before the issue is resolved. The delays will be frustrating.

Perhaps the adjuster will not conduct matters as professionally as you might wish. Perhaps he or she will not explain things to your satisfaction.

You should ask, "Where does it say that in the policy?" Do not be satisfied if the response is vague or if the cited wording is not clear or specific enough. Keep asking questions until you understand or decide that the point being made is fallacious.

Finally, keep good records and confirm, *in writing*, understandings or agreements on future action. Set target dates and follow up on them. If you are using a consultant or other outside help, make sure they have high standards and follow these same guidelines.

Do not let the situation stagnate. If it does, it will lose its importance in the eyes of the parties involved, and chances are you will lose also.

On the other hand, a pleasant, persistent and professional approach often can work wonders for your case.

Would licensing make underwriters any wiser?

Continued from page 48
and its past loss history, helps the underwriter to classify the risk correctly, rate it more credibly and determine whether to adjust the rate for past loss experience and other factors.

Only rarely have I observed an underwriter who declined a risk because he knew enough to say that the competition would do a better job—or provide more coverage or clearer wording—for the premium; applications were declined because because it wasn't worth the effort to set a price, or because the underwriter was overworked.

Mid-term cancellations don't usually result from sudden insight into the "correct" price for a risk or from a landmark court decision that changed the fundamental underwriting assumptions about a class of risk; they result from the orders of a middle manager of underwriting who fears for his job because his underwriters have been writing insurance for lousy risks that no one understood, at inadequate prices, based on inferior or non-existent loss information and intentional mis-classification, and on forms that gave away the store!

This does not mean there are not some good underwriters. Here are some of the things that good underwriters do:

- Good underwriters read and know about many types of businesses. They are curious about how things work and the behavior of people. Such knowledge helps them understand the fundamental nature of risk.
- Good underwriters understand the insurance business—how it works, where it came from and what's happening now. They follow key court decisions and understand how contracts work—and how sometimes they don't. They know about insurance products and procedures, especially in the area of their specialty. They have a sense of where the business is headed and take pride in their work.

Rarely have I seen an underwriter who declined a risk because he knew enough to say that the competition would do a better job—or provide more coverage or clearer wording—for the premium

- Good underwriters can think and write clearly, or know where to find competent help in drafting new coverage forms from scratch. They find the loopholes and illogical coverage provisions in forms they review.
- Good underwriters understand the meaning of value and can set a reasonable price for risk based on identifiable criteria. When they judgment rate a new risk, they visualize the risk and can recognize similarities with familiar risks by analogy.
- Good underwriters seldom, if ever, quote the lowest price for accepting a risk. They also examine the submission thoroughly before saying yes or no.
- Good underwriters are the people you call when you have a technical question about insurance.

Good underwriters must be a rare breed judging from the recent industry results.

Licensing underwriters would force regulators to determine the characteristics of competent underwriting and test for one's knowledge and skills before allowing insurers to give the pen to novices. Apprentices would be required to work under close supervision of licensed underwriters and successive underwriting responsibilities within companies would require successive levels of achievement, knowledge and skill.

If there were minimum standards under a licensing law for underwriters, then management could hardly refuse to support education required to retain their licenses or that improves their level of knowledge so they can qualify to supervise other underwriters. Companies that did not pay for education or train their own employees to advance would quickly lose good employees and find it difficult to attract qualified senior licensees to run the company.

The exercise of seriously considering whether to license underwriters might also lead us to ask whether regulators should be tested and licensed. If the judges of individual risks (underwriters) are so important, then how much more important are these gods (regulatory staffs) on whom insurers and the public rely to keep the insurance industry running responsibly?

If underwriters were prohibited from knowingly underpricing a risk, then regulators could be prohibited from denying (for political reasons alone) rate increases that are justified by changes in benefits or the scope of coverage. How many states now require their insurance department employees to pass courses in property, casualty, life or health insurance subjects? In how many states is the administration of rate reductions taken so seriously as rate increases? Would these cycles continue if regulation were taken seriously?

There must be a reasonable way to control underwriting cycles—to limit the amplitude of the periodic fluctuations in insurer results, without destroying the insurance industry's ability to develop creative risk handling alternatives. Is licensing underwriters, or regulators, or insurance company managers or claims adjusters the place to start achieving some sanity in this business?

If we don't do something, it's going to be impossible to be associated with the insurance business, because another cycle like the last one will kill it. Before that happens, you can bet we'll see much more insurance regulation than we've experienced until now.

Fully insured health plans less popular: Study

By ALISON KITTRELL

The trend in group medical insurance coverage is toward higher deductibles and co-payments and away from fully insured plans, according to a recent study by the Health Insurance Assn. of America.

The survey, "A Profile of Group Major Medical Expense Insurance in the United States," finds important changes in the makeup of group health insurance plans during the last several years, according to the Washington-based HIAA.

In fact, the HIAA notes that a similar survey was conducted in 1980 and that "plans were to update the study again by the late 1980s; however, significant changes in benefit plan design that have occurred since pointed up the need for more current information."

'Because of spiraling health care costs and a tightening of the money supply, insurance companies offered alternatives to the fully insured plans to employers who wanted to assume some or all of the risk,' the survey authors say.

As a result, the HIAA requested this interim study, based on data as of the end of 1984. Some 39 HIAA member insurance companies participated in the most-recent survey, providing information on 14.2 million covered employees.

The insurance companies that responded account for almost 40% of the total group health insurance premiums for fully insured plans written by health insurers in the United States in 1984, according to the HIAA.

The survey findings include:

- Only 56.4% of the employees reported in the 1984 survey were covered for medical care expenses through a fully insured financing arrangement.

This was down considerably from the 1980 survey, which found that 71.3% of employees were covered by fully insured arrangements.

In addition, in 1984 only 41.5% of the employees were covered for dental care under a fully insured program; in 1980, 60.9% of employees had fully insured dental coverage.

- Almost all—99%—of the employees had a maximum medical benefit of at least $50,000. And, almost 80% had $1 million or more in medical limits.

This continues a trend toward higher limits of coverage.

- Although the percentage of employees with some limit on their out-of-pocket expenses continues to increase, the amount of that limit also keeps growing.

In 1984, the most common cap on out-of-pocket expenses was between $1,001 and $2,000.

- There also is a trend toward higher deductibles.

This trend is most evident in comprehensive medical care programs, where the percentage of employees with a deductible of $250 or more rose to 18% in 1984 from 5% in 1980.

And, 83% of the employees covered under comprehensive plans had to meet a deductible for inpatient hospital expenses; only 17% had first-dollar coverage.

- Cost-containment features are a common part of medical care programs. In 1984, 62.6% of the employees had coverage for second surgical opinions, 53.5% had home health care benefits, and 40.2% had coverage for a birthing center delivery.
- More employees contribute to the cost of their health care coverage: more than 75% in 1984, compared with 55% in 1980. This includes employees who contribute toward their own and/or dependent coverage.
- More than 99% of the employees had coverage for inpatient treatment of mental and nervous disorders, and 97% had coverage for outpatient treatment for these disorders.

For almost two-thirds of those with coverage for inpatient treatment of mental disorders, the coverage provided the same level of benefits as provided for any other disorder.

But, only 5% of those employees with coverage for outpatient treatment of mental disorders had the same level of coverage as for other problems.

- Among employees with dental care coverage, 65% received benefits provided on a reasonable and customary reimbursement level, more than 60% had coverage for orthodontia and almost 45% had maximum annual dental benefits of more than $1,000.
- About 58% of employees had the option to continue group medical coverage upon retirement, regardless of whether they were eligible for Medicare. An additional 2% could continue coverage if they were under age 65 and not eligible for Medicare.

The trend toward employees assuming some of the financing risk for medical coverage is based on economic realities, the survey says.

"The traditional method (of providing coverage) is a fully insured program where none of the risk is borne by the employer. . . .

"However, because of spiraling health care costs and a tightening of the money supply, insurance companies offered alternatives to the fully insured plans to employers who wanted to assume some or all of the risk of funding their own employee health benefits," the authors of the survey said.

The survey shows that in 1984, 56.4% of the employees were covered by a fully insured plan, compared with 71.3% in 1980.

In 1984, 30.9% of the employees were covered by a minimum premium plan, involving some insurer-provided coverage and some self-insurance on the part of the employer.

In 1980, only 20.5% of employees were covered by a minimum premium plan.

And, in 1984, 12.7% of employees were covered by plans that were self-insured, with employers contracting only for administrative services. In 1980, only 8.2% of employees were covered by such self-insured plans.

The trend away from fully insured plans also occurs in dental

Continued on facing page



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Continued from facing page
coverage, according to the survey. In 1984, 41.5% of employees with dental coverage were covered under a fully insured plan, compared with 60.9% in 1980.

Some 41.6% of the employees with dental coverage were covered by a minimum premium plan in 1984, compared with 29.2% of the employees in 1980. And, 16.9% were covered under a self-insured plan, compared with 9.9% four years earlier.

The survey also notes a trend toward higher maximum benefit levels. In fact, the survey authors say, "A larger percentage of employees are covered for higher maximum benefit levels today than ever before."

In the HIAA's 1970 survey, only 15% of employees with major medical insurance had a maximum benefit of $50,000 or more. This percentage had risen to 90% in 1980.

And by the 1984 survey, 99.4% of employees had at least $50,000 in limits and almost 80% had maximum benefit levels of $1 million or more.

The 1984 survey also notes an inverse relationship between the company size and the maximum limits: For groups with fewer than 50 employees, 97.5% of the employees had at least $1 million in limits. But, that percentage drops to 90.4% among groups with 50 to 499 employees and to 71.6% for groups with 500 or more employees.

Out-of-pocket limits also are on the rise, both in terms of the number of employees that have such limits and in terms of the amount of the limits.

In the 1980 survey, 22.2% of the employees covered had no out-of-pocket limit, but among those employees that had a limit, the most common amount was $1,000 or less.

By 1984, only 1.6% of the employees had no limit on their out-of-pocket expenses, but the most-common limit had risen to between $1,001 and $2,000.

Similarly, the survey identified a trend toward higher deductibles and co-payments.

"A substantial shift toward higher deductible amounts in comprehensive medical plans occurred between 1980 and 1984," the authors of the study said.

In 1980, 34.7% of the employees covered under comprehensive medical plans had a deductible of less than $100, 60.5% had a deductible of $100 to $249, 2.5% had a deductible of $250 to $499, 1.3% had a deductible of $500 to $999, and 1% had a deductible of more than $1,000.

But, by 1984, only 9.9% of the employees covered under comprehensive medical plans had a deductible of less than $100.

Some 72.5% had a deductible of $100 to $249, 12.7% had a deductible of $250 to $499, 3.6% had a deductible of $500 to $999 and 1.3% had a deductible of $1,000 or more.

The growth in deductible amounts is less dramatic, although still evident, among those employees whose major medical coverage is provided by a supplementary plan to their basic medical coverage.

For example, the percentage of employees with deductible amounts of less than $100 actually grew among employees with supplementary plans to 17.3% in 1984 from 16.4% in 1980. And, the percentage with deductibles in the $100 to $249 range was 73.8% in 1984, compared with 83.3% in 1980.

However, the survey notes that, "The shift in these (supplementary) plans may not have been as great because other cost-containment features may have been incorporated into the underlying basic benefit program."

In fact, the survey shows a variety of cost-containment features being incorporated into all types of major medical expense plans.

The survey also notes a trend toward higher maximum benefit levels. In fact, according to the survey authors, 'A larger percentage of employees are covered for higher maximum benefit levels today than ever before.'

In 1984, 53.5% of the employees had coverage for home health care, 2.3% had coverage for mandatory second surgical opinions and 60.3% had coverage for voluntary second surgical opinions, 17.2% had coverage for periodic physicals for adults, 18.6% had coverage for well-baby care for children under 2 years old and 16.9% had coverage for well-child care for children aged 2 to 15.

In addition, 40.2% had coverage for birthing centers, 8.8% had coverage for hospice care, 1% were covered by plans that incorporated pre-certification for hospitalization, 0.9% were covered by plans that included concurrent review for hospitalization and 5.3% were covered by plans that included hospital audits by an outside agency.

The survey also showed that, by and large, these cost-containment provisions were more prevalent at smaller companies.

For example, 76.9% of the employees in groups of fewer than 50 had coverage for home health care, compared with only 43.2% of those in groups of 500 or more. And, 71.3% of those in groups of less than 50 had coverage for birthing centers, compared with only 23% of those in groups of 500 or more.

The survey also revealed that an increasing number of employees are being asked to contribute to the cost of their medical coverage, both for themselves and for their dependents.

In 1984, more than 75% of employees contributed to the cost of their coverage, compared with only 55% in 1980.

In 1984, 23.1% paid only for the cost of dependent coverage, while 52.1% contributed to the cost of coverage for themselves and their dependents.

And, employee contributions to medical coverage were most common in groups of fewer than 50 employees.

Continuation of group coverage after retirement was most common in larger groups, the survey showed.

Among all groups, 58.3% of the employees could continue their group coverage after their retirement.

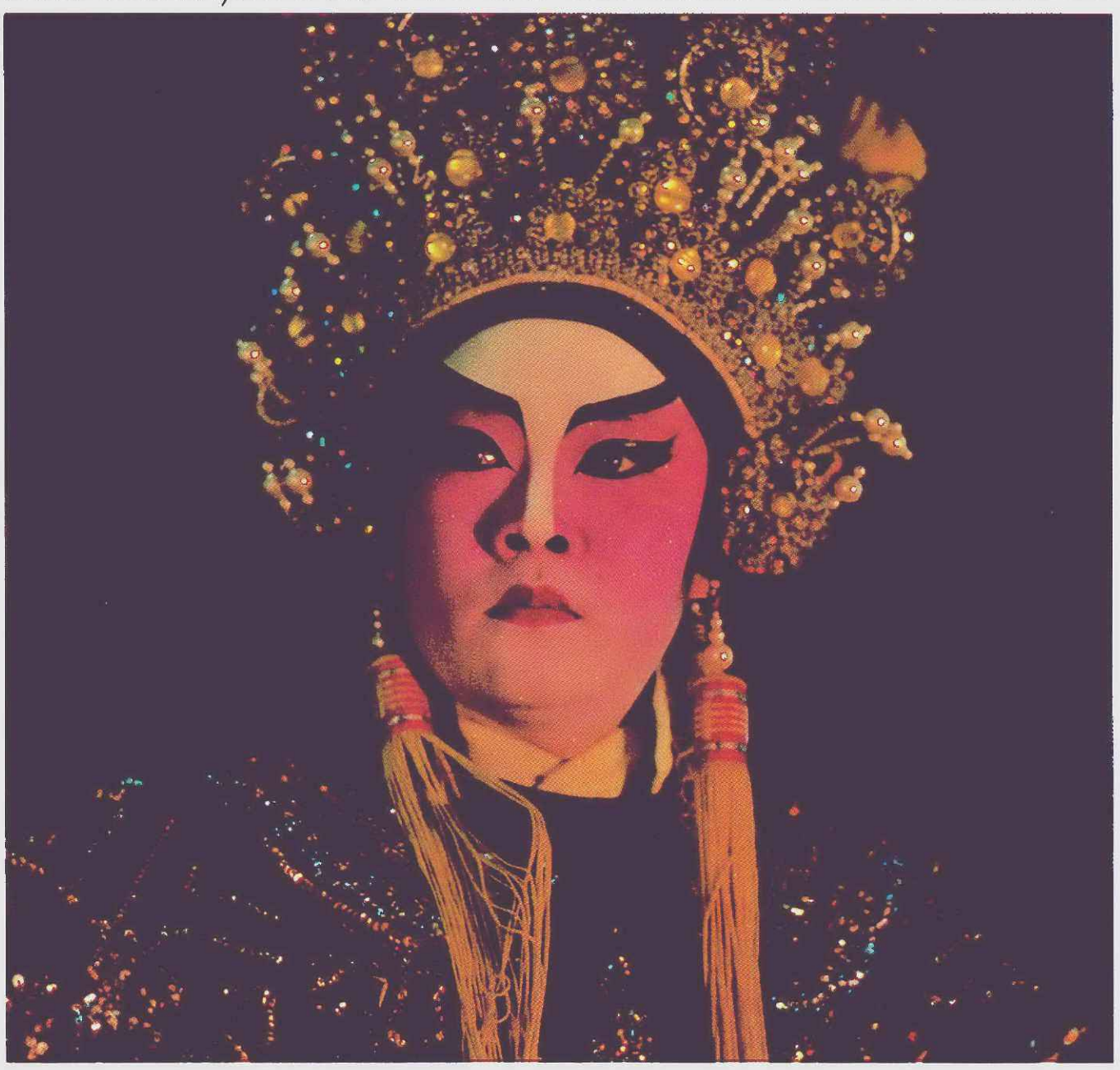
For an additional 2.2% of employees, continuation of coverage was available only if they were less than age and not eligible for Medicare. Continuation was available for an additional 0.4% of retirees who were only eligible for Medicare.

But, continuation of coverage after retirement was available for 89.1% of the employees in groups of 500 or more, compared with only 10.5% of employees in groups of fewer than 50.

●

Single copies of the survey, "A Profile of Group Major Medical Expense Insurance in the United States," are available free of charge from the Health Insurance Assn. of America, Department 1239, 1850 K St. N.W., Washington, D.C. 20006.

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Highlights of tax bill's benefit provisions

*Following are excerpts from a summary of the tax legislation now pending in Congress. The summary was prepared by the staff of the Joint Committee on Taxation (*BI, *Aug. 25).*

The material excerpted fron the summary includes provisions in the tax bill that will affect employee benefit managers.

The summary, prepared for the use of senators and representatives, is the most comprehensive guide to the tax legislation published to date, pending the release of the complete bill and the accompanying conference committee report.

As a general rule, the summary does not include actions by the conference committee to retain the current law on a particular issue.

Here are the provisions most likely to affect employee benefit managers:

Title XI. Pensions and Deferred Compensation; Employee Benefits; ESOPs

Treatment of Tax-Favored Savings

Individual retirement arrangements (IRAs)

Under the conference agreement, deductible IRA contributions are permitted as under present law (1) if an individual (or a married couple) has adjusted gross income (AGI) under a phaseout level, or (2), if the individual is not an active participant (or, in the case of a married individual, neither the individual nor his or her spouse is an active participant) in an employer-maintained retirement

THE NEW TAX BILL

plan for any part of the plan year ending with or within the individual's taxable year.

The phaseout begins at $25,000 for an individual and $40,000 for a married couple filing a joint return. For purposes of the phaseout, AGI is determined without regard to any IRA contributions.

For an individual who is an active participant in an employer-maintained retirement plan, the IRA deduction limit is reduced proportionately for AGI between $25,000 and $35,000. For married couples filing a joint return, the IRA deduction limit for each spouse is reduced proportionately between $40,000 and $50,000 if either spouse is an active participant in an employer-maintained retirement plan.

For purposes of determining whether an individual is an active participant in an employer-maintained retirement plan means (1) a qualified pension, profit-sharing or stock bonus plan (Section 401(a)), (2) a qualified annuity plan (Section 403(a)), (3) a simplified employee pension (Section 408(k)), (4) a plan established for its employees by the United States or a state or political subdivision, (5) a plan described in Section 501(c)(18), or (6) a tax-sheltered annuity (Section 403(b)).

The conference agreement provides that individuals may make non-deductible IRA contributions to the extent that they are not eligible to make deductible IRA contributions. Earnings on non-deductible IRA contributions are not subject to tax until they are withdrawn.

Under the conference agreement, the rules relating to spousal IRA contributions are amended to eliminate the requirement that the spouse have no earned income for the year in order to be eligible for the spousal IRA contribution.

The conference agreement also amends present law to permit the acquisition of IRAs of certain gold and silver coins issued by the United States.

The provisions are in effect for taxable years beginning after Dec. 31, 1986, except that the provision eliminating the requirement that the spouse have no earned income in order to be eligible for the spousal IRA contribution is effective for years beginning after Dec. 31, 1985.

Individual cash or deferred arrangements (Section 401(k) plans)

Under the conference agreement, effective for taxable years beginning after Dec. 31, 1986, the maximum amount that an employee can elect to defer for any taxable year under all cash or deferred arrangements in which the employee participates is limited to $7,000. The $7,000 cap is adjusted for inflation by reference to percentage increases in the dollar limit under a defined benefit plan (Section 415(d)).

Effective generally for taxable years beginning after Dec. 31, 1986, and, in the case of plans maintained by state or local government employers, for years beginning after Dec. 31, 1988, the conference agreement modifies the special non-discrimination test applied to qualified cash or deferred arrangements by (1) modifying the percentage tests, (2) clarifying the rules for aggregating elective contributions with certain non-elective contributions for purposes of the special non-discrimination test, (3) redefining the group of highly compensated employees and compensation to conform to the new uniform definitions used generally for purposes of the non-discrimination rules applicable to qualified plans and employee benefit programs (described below), (4) establishing a mechanism for the return of contributions that violate the special non-discrimination test, and (5) imposing an excise tax on contributions that are not returned (or forfeited) within a a special period of time.

Under the conference agreement, the actual deferral percentage for an employer's highly compensated employees may not exceed 125% of the actual deferral percentage of eligible non-highly compensated employees.

Alternately, the actual deferral percentage of an employer's highly compensated employees may not exceed the lesser of 200% of the actual deferral percentage of the non-highly compensated employees or the actual deferral percentage of the non-highly compensated employees plus two percentage points.

The conference agreement modifies certain present-law restrictions and imposes several additional restrictions on qualified cash or deferred arrangements.

First, qualifying total distributions may be made to a participant in a qualified cash or deferred arrangement on account of the sale of a subsidiary or substantially all

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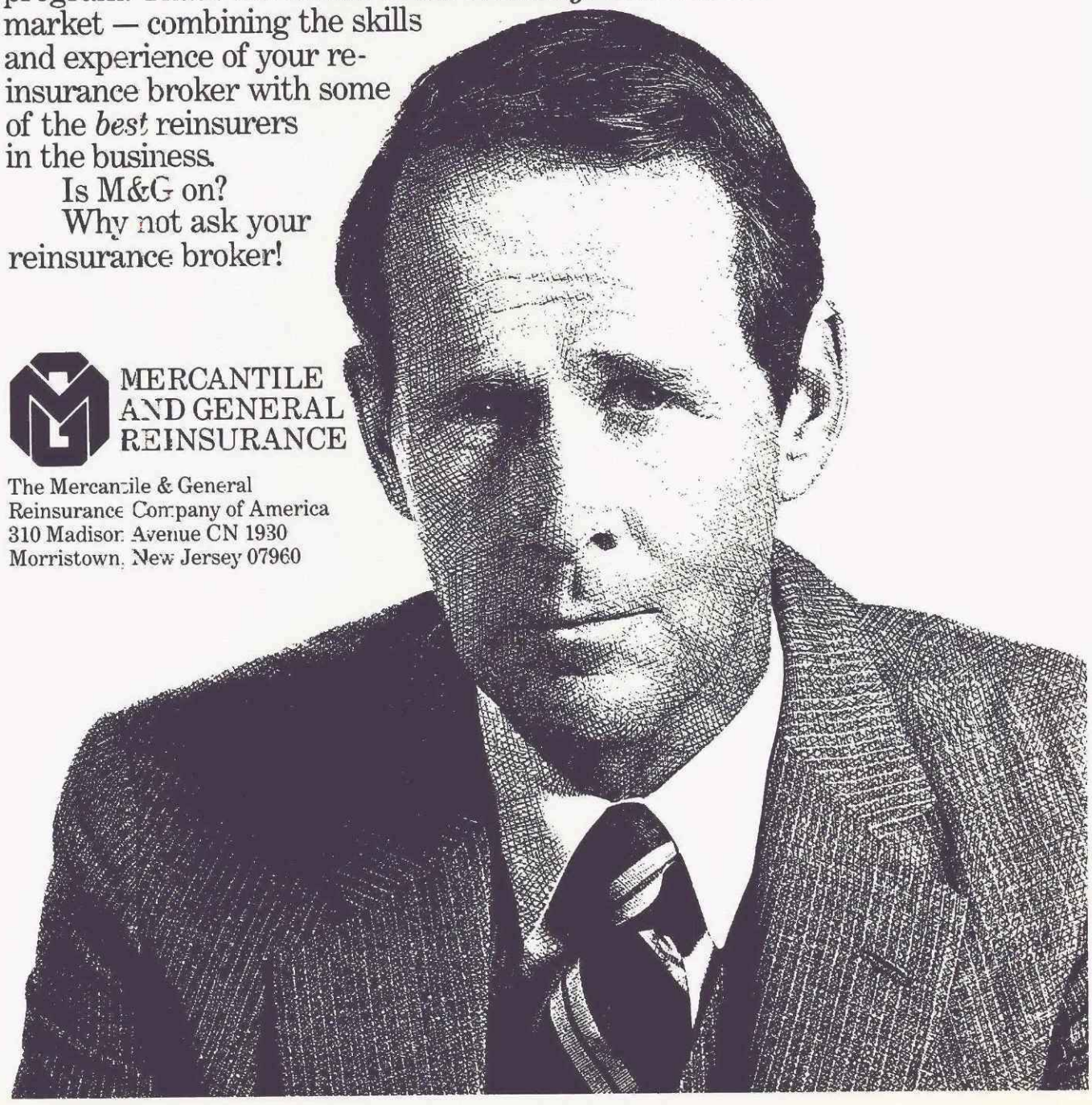
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the assets used in a trade or business or the termination of the plan in which the arrangement is a part, effective for sales or terminations occurring after Dec. 31, 1984.

Second, the conference agreement limits hardship withdrawals under a qualified cash or deferred arrangement to the amount of an employee's elective deferrals. In addition, the conference agreement provides that a qualified cash or deferred arrangement cannot require as a condition of participation in the arrangement, that an employee complete a period of service with the employer (or employers) maintaining the plan in excess of one year of service, effective for years beginning after Dec. 31, 1988.

Under the conference agreement, effective for years beginning after Dec. 31, 1988, an employer generally may not condition, either directly or indirectly, contributions and benefits (other than matching contributions) upon an employee's elective deferrals. An exception is provided for certain qualified offset arrangements.

The conference agreement provides that qualified cash or deferred arrangements are not available to employees of state or local governments, unless the plan was adopted before May 6, 1986, or to employees of tax-exempt organizations, unless the plan was adopted before July 1, 1986.

Employer matching contributions and employee contributions.

Under the conference agreement, a special non-discrimination test is applied to employer matching contributions and employee contributions under all qualified defined contribution plans and employee contributions under a defined benefit plan (to the extent allocated to a separate account on behalf of the employee).

This non-discrimination test applies in lieu of the usual non-discrimination rules applicable to the amount of contributions under qualified plans and is similar to the special non-discrimination test applicable to qualified cash and deferred arrangements under the conference agreement.

The provisions are generally effective for plan years beginning after Dec. 31, 1986.

Minimum Standards for Qualified Plans

Coverage requirements for qualified plans

Under present law, a qualified plan is required to cover employees in general, rather than merely the employees of an employer who are officers, shareholders or highly compensated. A plan generally satisfies the present-law coverage rule if (1) it benefits a certain percentage of the employer's work force (percentage test), or (2) it benefits a classification of employees determined by the secretary of the Treasury not to discriminate in favor of employees who are officers, shareholders or highly compensated (classification test).

The conference agreement modifies the present-law coverage rules to require that at least one of the following tests is satisfied: (a) at least 70% of all non-highly compensated employees are covered by the plan; (b) the percentage of non-highly compensated employees covered by the plan is at least 70% of the percentage of highly compensated employees covered by the plan; (c) the group of employees covered by the plan satisfies the present-law classification, test and the average benefit provided to non-highly compensated employees (as a percentage of compensation) is at least 70% of the average benefit provided to highly compensated employees (as a percentage of compensation).

For purposes of determining whether the average benefit provided to non-highly compensated employees is at least 70% of the average benefit provided to highly compensated employees, all employer-provided benefits and employer contributions, including elective deferrals under a qualified cash or deferred arrangement, are taken into account.

'Under the conference agreement, a plan is not a qualified plan unless it benefits as least (a) 50 employees or (b) 40% or more of all employees of the employer (if less). The requirement may not be satisfied by aggregating comparable plans.'

In addition, the conference agreement (1) clarifies the circumstances under which an employee will be treated as benefiting under a plan for purposes of the coverage rules; (2) modifies, for purposes of satisfying the new coverage requirements, the circumstances under which certain categories of employees may be excluded from consideration; (3) establishes a uniform objective definition of those employees in whose favor discriminatory coverage is prohibited; (4) permits satisfaction of certain of the coverage rules on a controlled group or line of business basis; (5) establishes a definition of a separate line of business or operating unit with a special safe-harbor rule; and (6) contains a special transition rule for certain dispositions or acquisitions of a business.

The provisions are generally effective for plan years beginning after Dec. 31, 1988. A special elective date applies to plans maintained pursuant to a collective bargaining agreement.

Minimum participation requirement

Under the conference agreement, a plan is not a qualified plan unless it benefits as least (a) 50 employees or (b) 40% or more of all employees of the employer (if less). The requirement may not be satisfied by aggregating comparable plans.

The requirement does not apply to all multiemployer plans. The multiemployer plan exception does not apply to plans maintained pursuant to collective bargaining agreements covering professionals (e.g., doctors or lawyers).

The provisions are generally effective for plan years beginning after Dec. 31, 1988. A special effective date applies to plans maintained pursuant to a collective bargaining agreement. In addition, the conference agreement contains a special transition rule under which plans that do not comply with the minimum participation rule must be merged or terminated by the end of the first plan year to which the rule applies. If a plan is terminated or merged under the special transition rule, (1) the present value of accrued benefits must be calculated using an interest rate no lower than a specified rate, and (2) the excise tax on asset reversions does not apply to such a termination or merger.

Non-discrimination rules applicable to tax-sheltered annuities

The conference agreement extends certain non-discrimination rules to tax-sheltered annuity programs other than those maintained by churches. With respect to employer (other than non-elective and matching) contributions to

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Tax bill excerpts

Continued from previous page

tax-sheltered annuity programs, the bill applies the general coverage and non-discrimination requirements applicable to qualified pension plans.

The conference agreement also directs the secretary of the Treasury to develop simplified comparability rules for purposes of applying the coverage and non-discrimination requirements.

With respect to elective contributions to tax-sheltered annuity programs (other than those maintained by churches), the conference agreement provides that an employer that offers any employee the opportunity to make elective deferrals is required to make the opportunity available to all employees, with no more than a de minimis contribution requirement.

The conference agreement also clarifies the definition of an employer for purposes of the non-discrimination rules applicable to both employer contributions and elective deferrals under a tax-sheltered annuity program. In addition, the conference agreement provides for the purposes of applying the non-discrimination rules that, students who customarily work less than 20 hours per week may be disregarded.

The provisions are generally effective for plan years beginning after Dec. 31, 1988.

Integration with Social Security

The conference agreement provides that a plan is not to be considered discriminatory merely because the contributions and benefits under the plan favor highly compensated employees if the plan meets the new requirements (i.e., the disparity limits) of the conference agreement relating to the integration of contributions or benefits under qualified plans.

Under the conference agreement, a defined contribution plan meets the disparity limits for integrated plans only if the contribution percentage under the plan for compensation over the integration level does not exceed the lesser of (1) 200% of the benefit percentage for compensation up to the integration level or (2) the sum of the contribution percentage for compensation up to the integration level and a specified rate.

In the case of an integrated excess defined benefit pension plan, the conference agreement limits the benefit percentage for compensation above the integration level to no more than 200% of the benefit percentage for compensation up to the integration level. In addition, the conference agreement further provides that the disparity between the benefit percentages for compensation above the integration level may not exceed an amount comparable to the disparity provided under present law and contains rules regarding the accrual of the disparity.

The conference agreement also requires that any optional form of benefit, pre-retirement benefit, actuarial factor or other benefit or feature provided by the plan with respect to remuneration in excess of the integration level specified by the plan for the year be provided with respect to remuneration that is not in excess of that level.

A defined benefit pension plan meets the requirements for integrated offset plans if it provides that a participant's accrued benefit derived from employer contributions (Section 411(c)(1)) may not be reduced by reason of the offset by more than 50% of the benefit that would have been accrued without regard to the reduction. The conference agreement further limits the size of the offset to an amount comparable to that permitted under present law and contains rules as to the rate at which the offset may accrue under a plan.

These provisions are effective for plan years beginning after Dec. 31, 1988. A special effective date applies to plans maintained pursuant to a collective bargaining agreement.

Uniform definition of highly compensated employees

The conference agreement provides a new uniform definition of the group of employees whose favor discrimination is prohibited ("highly compensated" employees) that generally applies for purposes of the non-discrimination rules for qualified plans and statutory employee benefit plans.

An employee is treated as highly compensated with respect to a year if, at any time during the year or the preceding year, the employee (1) was a 5% owner of the employer; (2) earned more than $75,000 in annual compensation from the employer; (3) earned more than $50,000 in annual compensation from the employer and was a member of the top-paid group of employees, i.e., the top 20% of employees by pay during the same year ; or (4) was an officer of the employer and received compensation greater than 150% of the dollar limit on annual additions to a defined contribution plan.

Treatment of an employee as a highly compensated employee under the last three categories is subject to the top-100 employee rules, as in both bills. If for any year no officer of the employer received compensation in excess of this level, the highest-paid officer of the employer is treated as a highly compensated employee.

The $50,000 and $75,000 thresholds are indexed in the same manner as the indexation of the dollar limitation under Section 415.

Vesting standards.

The conference agreement provides (under the Code and ERISA) that a plan (other than a top-heavy plan subject to separate vesting requirements) is not a qualified plan of an employer unless a participant's employer-provided benefit vests at least as rapidly as

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under one of two alternative minimum vesting schedules.

A plan satisfies the first schedule if a participant has a non-forfeitable right to 100% of the participant's accrued benefit derived from employer contributions upon the participant's completion of five years of service.

A plan satisfies the second alternative if a participant has a nonforfeitable right to at least 20% of the participant's accrued benefit derived from employer contributions after three years of service, 40% at the end of four years of service, 60% at the end of five years of service, 80% at the end of six years of service and 100% at the end of seven years of service.

A special rule is provided in the case of a multiemployer plan to require 100% vesting after 10 years of service.

The conference agreement also provides that a plan may not condition eligibility to participate in the plan on more than two years of service and that a plan with a two-years-of-service eligibility requirement must provide for full and immediate vesting after two years of service.

The provisions are generally applicable for plan years beginning after Dec. 31, 1988, with respect to participants who perform at least one hour of service in a plan year to which the new provisions apply. A special effective date applies to plans maintained pursuant to a collective bargaining agreement.

Treatment of Distributions

Uniform minimum distribution rules

The conference agreement establishes a uniform commencement date for benefits under all qualified plans, IRAs, tax-sheltered annuities, custodial accounts and unfunded deferred compensation plans of state and local government and tax-exempt employers. Under the agreement, distributions under a qualified retirement plan must commence no later than April 1 of the calendar year following the calendar year in which the participant or owner attains age 70½, without regard to the actual date of retirement.

In addition, the agreement also establishes a new sanction, in lieu of the plan disqualification, in the form of an excise tax for failure to satisfy the minimum distribution rules.

The provisions generally apply to distributions made after Dec. 31, 1988.

Treatment of distributions

The conference agreement (1) phases out capital gains treatment over six years beginning on Jan. 1, 1987, and (2) eliminates 10-year forward averaging for taxable years beginning after Dec. 31, 1986, and, instead, permits a one-time election of five-year forward averaging for a lump-sum distribution received after attainment of age 59½.

Under a transition rule, a participant who attained age 50 by Jan. 1, 1986, is permitted to make one election of five-year forward averaging or 10-year forward averaging (at present-law rates) with respect to a single lump-sum distribution without regard to attainment of age 59½, and to retain the capital gains character of the pre-1974 portion of such a distribution.

Under the transition rule, the capital gains portion would be taxed at a rate of 20%.

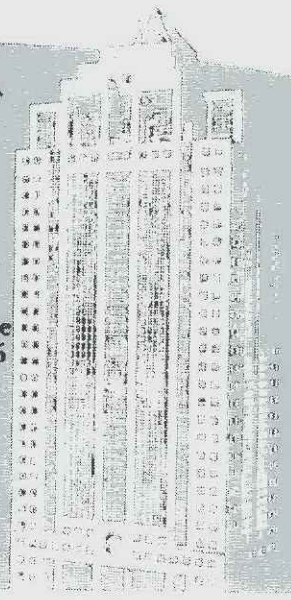
The conference agreement also (1) modifies the present-law basis recovery rules for amounts distributed prior to a participant's annuity starting date to provide for pro-rata recovery of employee contributions, (2) eliminates the special three-year basis recovery rule of present law, (3) modifies the general basis recovery rules for amounts paid as an annuity to provide that each distribution is treated part as recovery of employee contributions and part as payment of taxable employer contributions (until all employee contributions are recovered), and (4) restricts rollovers of partial distributions to distributions due to separation from service.

The new pre-annuity starting date basis recovery rules and the new restrictions on rollovers of partial distributions are generally effective with respect to distributions made after Dec. 31, 1986, with a provision preventing avoidance of repeal of the three-year basis recovery rule. Under a transition rule, in the case of a plan that, on May 5, 1986, permitted the withdrawal of employee contributions before separation from service, distributions are treated as made first out of employee nontaxable contributions made before

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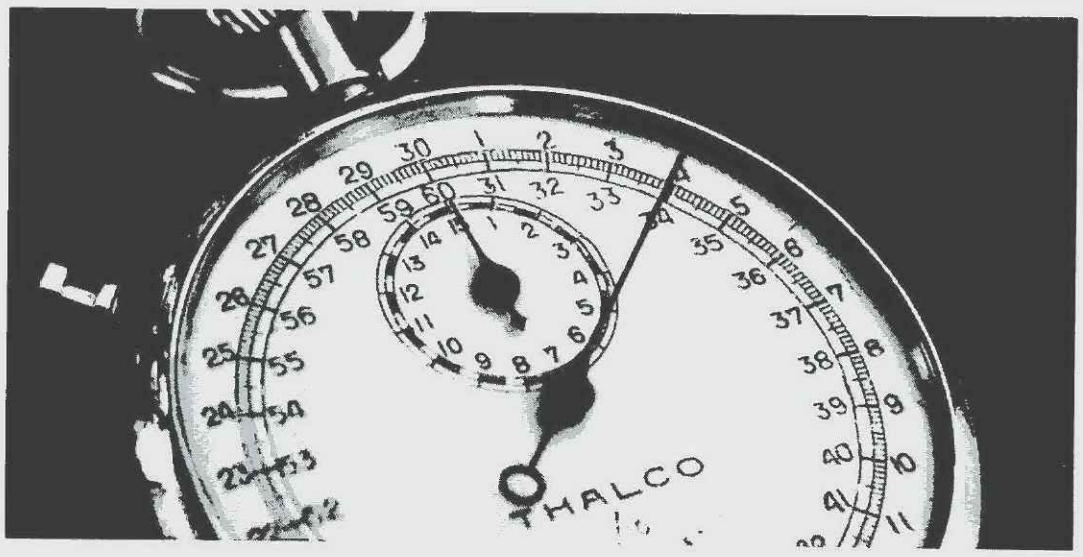
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Tax bill excerpts

Continued from previous page

Dec. 31, 1986. The post annuity starting date basis recovery rules are generally effective with respect to individuals whose annuity starting date is after July 1, 1986.

The conference agreement also provides basis recovery rules (effective Jan. 1, 1987) for distributions from an IRA to which nondeductible contributions have been made and permits rollovers from frozen deposits in bankrupt or insolvent savings and loan associations after the 60-day rollover election period.

Taxation of early distributions from qualified retirement plans

The conference agreement applies a 10% additional income tax to withdrawals from a qualified plan, qualified annuity, tax-sheltered annuity or IRA made before death, disability or attainment of age 59½. The additional tax does not apply to certain distributions (1) in the form of an annuity payable over the life or life expectancy of the participant (or the lives or joint life of the participant's beneficiary), (2) made after the participant and the participant's beneficiary has attained age 55, separated from service and satisfied the conditions for early retirement under the plan, (3) used for payment on medical expenses to the extent deductible under Section 213, (4) received from an employee stock ownership plan before Jan. 1, 1990, (5) received prior to March 15, 1987, if made on account of separation from service in 1986 if the recipient elects to be taxed on the distribution in 1986, or (6) to an alternate payee pursuant to a qualified domestic relations order.

The provisions generally are effective for distributions in taxable years beginning after Dec. 31, 1986.

Tax Deferral Under Qualified Plans

Overall limitations on contributions and benefits under qualified plans

The conference agreement makes several changes to the overall limits in contributions and benefits under qualified plans, tax-sheltered annuity programs and SEPs of private and public employers.

The normal retirement age, for purposes of the limit on benefits under a defined benefit pension plan, is conformed to the Social Security retirement age. If the retirement benefit under a defined benefit plan begins before the Social Security retirement age (presently, age 65), then the $90,000 limitation on annual benefits generally is reduced so that it is the actuarial equivalent of an annual benefit of $90,000 beginning at the Social Security retirement age.

Under transition rules provided by the conference agreement, benefits already accrued by a plan participant under an existing plan are not affected by the reductions for actuarial equivalence. The changes do not affect plans maintained by tax-exempt employers.

Under the conference agreement, the dollar limit on annual benefits under a qualified defined benefit pension plan is phased in over 10 years of participation. The agreement provides for rules under which non-abusive benefit increases are not limited by the phase-in.

The conference agreement provides for qualified cost-of-living arrangements. The agreement clarifies the terms under which an employee may obtain an employer-provided cost-of-living subsidy.

The conference agreement provides special rules for commercial airline pilots and participants in qualified police or firefighters defined benefit pension plan. The agreement clarifies the definition of a qualified police or firefighters plan and provides for indexing of the limit applicable under the special rules for those plans. In addition, the agreement clarifies the application of the special rules for pilots who retire before age 60.

With respect to defined contribution plans, the conference agreement adopts the rules of the House bill with respect to cost-of-living adjustments and clarifies the application of the limits for the defined contribution plans. Although cost-of-living adjustments will be made to the defined benefit pension plan limit beginning in 1988, no cost-of-living adjustments will be made to the defined contribution plan limit until the $30,000 defined contribution plan limit is equal to 25% of the defined benefit dollar limit. The cost-of-living adjustment will be determined by reference to the Consumer Price Index.

'The conference agreement applies a 10% additional income tax to (early) withdrawals.'

Under the agreement, contributions made by retired non-key employees for retiree medical coverage are not subject to the percentage of compensation limit on annual additions.

Under the conference agreement, the class of employers whose employees are entitled to the special catch-up elections for tax-sheltered annuities is expanded to include employers that are health and welfare service agencies. The agreement also provides a technical modification clarifying that the catch-up rules apply before separation from service.

The conference agreement provides for a 15% excise tax on benefit payments in excess of $112,500. Under the agreement, the tax does not apply to excess benefits accrued before Aug. 1, 1986.

The provisions generally are effective for plan years beginning after Dec. 31, 1986. Special rules are provided in the case of plans maintained pursuant to bargaining agreements.

Deductions for contributions to qualified plans

The conference agreement makes several changes to the limits on employer deductions for contributions to qualified plans. The agreement (1) repeals the limit carryforward applicable to profit-sharing and stock bonus plans, (2) extends the 25% of compensation combined plan deduction limit to any combination of a defined benefit pension plan and a money purchase pension plan, profit-sharing or stock bonus plan, and (3) applies a 10% excise tax to non-deductible employer contributions. The agreement includes a technical modification relating to fully insured plans.

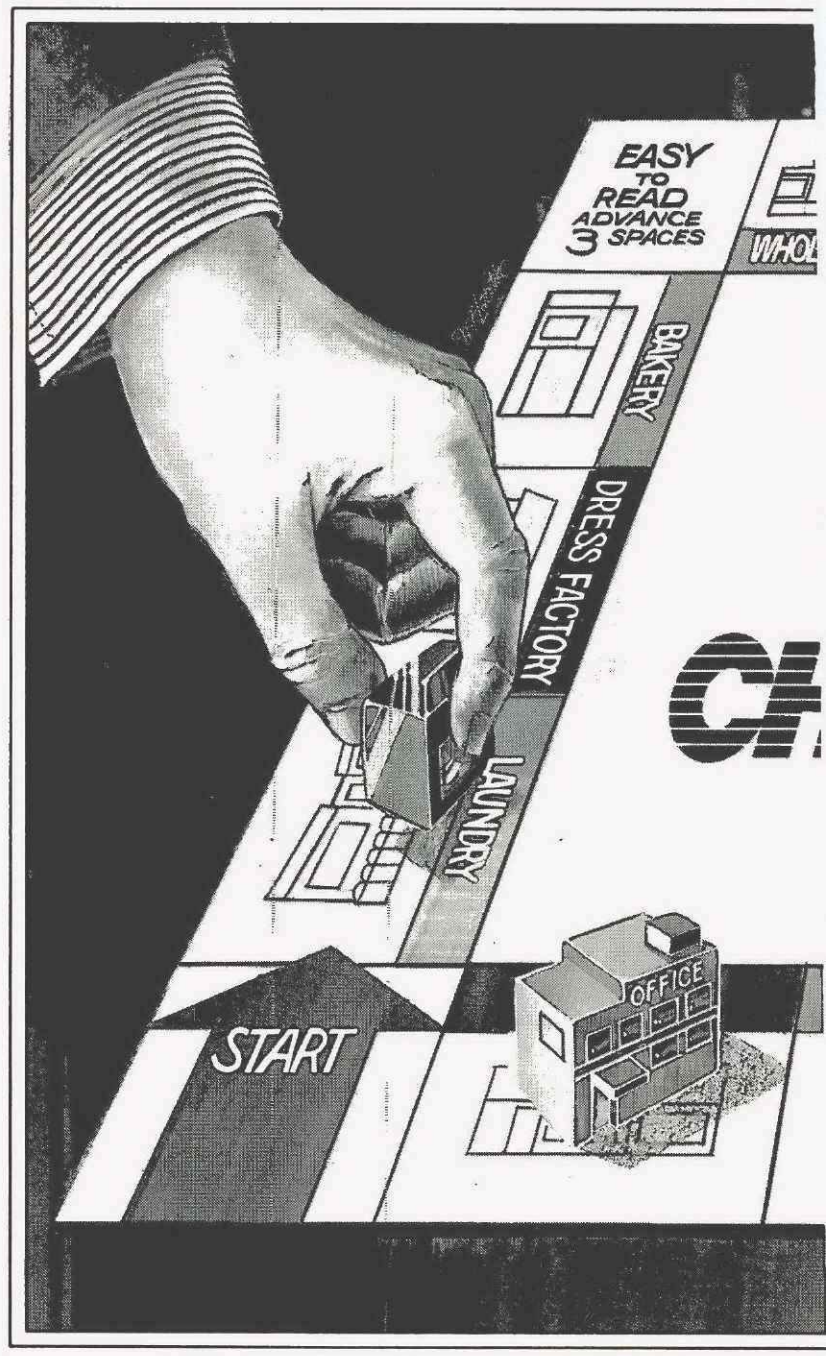
The provisions are effective for taxable years beginning after Dec. 31, 1986.

Excise tax on reversion of qualified plan assets to employer

The conference agreement imposes a 10% non-deductible excise tax on a reversion from a qualified plan. The tax is imposed on the person who received the reversion. The agreement provides that the tax does not apply to the portion of a reversion that is transferred to an ESOP under certain circumstances.

The provision applies to reversions received after Dec. 31, 1985, with an exception for a certain employer. The special provision for transfers to an ESOP expires for

Continued on next page



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reversions received after Dec. 31, 1988.

Miscellaneous Pension and Deferred Compensation Plans

Discretionary contribution plans

Under the conference agreement, an employer's contribution to a profit-sharing plan is not limited to the employer's current or accumulated profits. This provision applies without regard to whether the employer is tax-exempt. The provision applies for plan years beginning after Dec. 31, 1985.

Cashout of certain accrued benefits

The conference agreement amends the rules of the Code and ERISA relating to cashouts of accrued benefits to require that, for purposes of determining the present value of a participant's accrued benefit, a plan is to compute the first $25,000 of the present value of a benefit by using an interest rate no greater than the interest rate (defined or immediate, whichever is appropriate) that would be used by the PBGC (as of the date of distribution) upon the plan's termination.

The remaining portion of the present value of the benefit is to be determined by using an interest rate no greater than 120% of the PBGC interest rate.

(Also), the conference agreement clarifies that certain plan amendments adopting the provision will not constitute a cutback of a participant's accrued benefit.

The provision is applicable for distributions after Dec. 31, 1984. However, it does not apply to distributions. . .made after Dec. 31, 1984, and before the date of enactment, if such distributions were made in accordance with. . .regulations issued under the Retirement Equity Act of 1984.

Exemption from the survivor benefit requirements of the Retirement Equity Act of 1984

The conference agreement exempts a plan for the survivor benefits reuqirements of the Retirement Equity Act of 1984 if (1) the plan was established prior to Jan. 1, 1954, as a result of any agreement between employee representatives and the federal Government during a period of government operation, under seizure powers, of a major part of the productive facilities of the industry, and (2) under the plan, participation is substantially limited to participants who, before Jan. 1, 1976, ceased employment covered by the plan.

Employee benefit provisions

Non-discrimination rules for certain statutory employee benefit plans and cafeteria plans

The conference agreement established comprehensive non-discrimination rules for certain statutory employee benefit plans. Under the agreement, a highly compensated employee who is a participant in any discriminatory statutory employee benefit plan is taxed generally only on the value of the discriminatory portion of the employer-provided benefit under the plan if such a portion is timely reported.

The agreement (1) revises the non-discrimination rules applicable to group life term insurance plans and self-insured accident and health plans; (2) extends those rules to insured accident and health plans; (3) establishes a new non-discrimination test applicable to dependent care assistance plans; (4) applies the uniform definition of highly compensation employee, employer and compensation generally applicable under the non-discrimination rules for qualified plans; (5) permits satisfaction of the non-discrimination tests on a controlled group, line of business or operating unit basis; (6) contains a special transition rule for certain dispositions or acquisitions of a business.

Educational assistance and group legal services are not subject to the new non-discrimination rules because the exclusions for those benefits are schedule to expire, under the agreement, before the effective date of the new non-discrimination rules.

Under the new non-discrimination tests, employee benefit plans are subject to eligibility tests and a benefits test, applicable to each type of benefit. In applying the tests to health plans, employees with other health coverage can be disregarded, and family health coverage can be tested separately. In the case of group life term insurance, the non-discrimination rules can be applied to the value of coverage provided, expressed as a percentage of compensation (with the same cap on includable compensation applicable to qualified plans).

Generally, different types of benefits can be aggregated for purposes of satisfying the benefits test, except that health plans must satisfy the benefits test without aggregation with other types of plans.

(**Editor's note:** The complete non-discrimination eligibility and benefits tests are expected to be published in the conference committee report on the tax bill.)

Under the conference agreement, benefits provided under a cafeteria plan are generally subject to the new non-discrimination rules. (Also), the present-law cafeteria plan availability test continues to apply.

Under the conference agreement, full-time life insurance salesmen can participate in cafeteria plans, and employees of educational organizations may elect post-retirement life insurance coverage under a cafeteria plan. The agreement also provides that salary reduction under cafeteria plans is excluded from the FICA and FUTA wage bases.

The non-discrimination rules are generally effective for the later of: (1) plan years beginning after Dec. 31, 1987, or (2) the earlier of plan years beginning at least three months following the issuance of Treasury regulations or after Dec. 31, 1988.

Exclusions for educational assistance programs, qualified group legal services and dependent care assistance programs.

The conference agreement retroactively extends the exclusions from gross income for educational assistance and group legal services and the tax exemption for qualified group legal services organizations for two years through 1987.

In addition, the agreement increases the cap on annual excludable educational assistance benefits to $5,250 from $5,000.

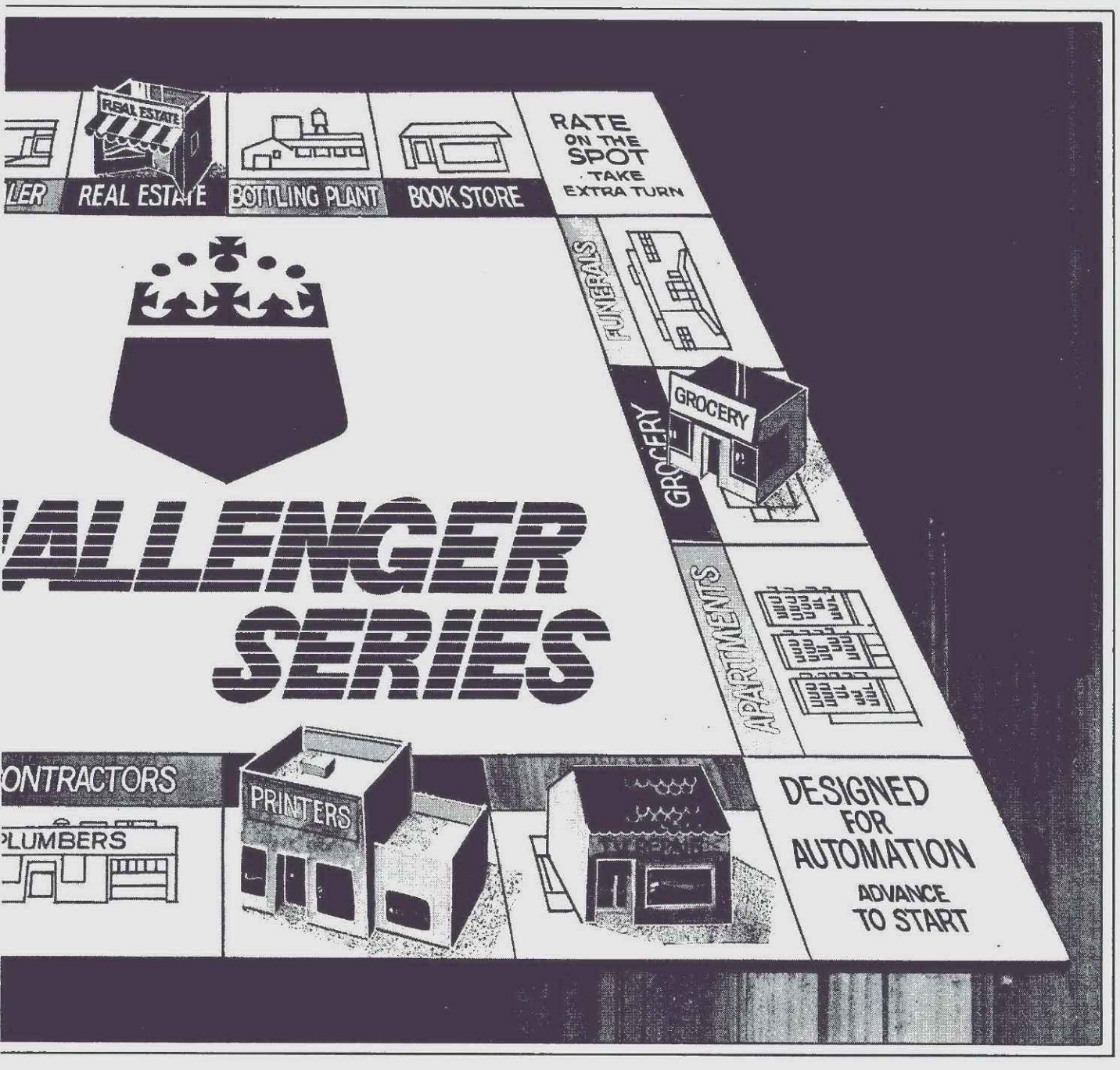
The provisions generally are effective (1) in the case of educational assistance benefits, for taxable years beginning after Dec. 31, 1985, and (2) in the case of group legal services benefits and the tax exemption for qualified group legal services organizations, for taxable years ending Dec. 31, 1985. A special rule is provided for group legal services benefits provided under a cafeteria plan.

The conference agreement imposes a $5,000 cap ($2,500 for a married person filing separately) on the exclusion for dependent care assistance. The provision is effective for taxable years beginning after Dec. 31, 1985.

Employee Stock Ownership Plans (ESOPs)

Repeal of employee stock ownership tax credit

The conference agreement repeals the special payroll-based ESOP tax credit for compensation paid or accrued after Dec. 31, 1986. A. . .transition rule is provided. ■



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Property/casualty aspects of tax bill noted

Here are the provisions of the tax bill approved last month by the congressional conference committee that affect risk managers and property/casualty insurance companies.

For taxable years beginning after Dec. 31, 1986, a property and casualty insurance company's deduction for losses incurred is reduced by a portion of the company's tax-exempt income and the deductible portion of dividends received.

Title XII. Foreign Tax Provisions

Treatment of Foreign Taxpayers

Excise tax on insurance premiums paid to foreign insurers.

The conference agreement does not contain the excise tax provision of the House bill. (Editor's note: A provision in the tax bill passed by the House would have increased the federal excise tax on premiums paid to foreign reinsurers to 4% from 1%).

Instead, the conference agreement adopts a provision that imposes current tax on each U.S. person who owns stock in any 25% or more U.S.-owned foreign insurance company with respect to income from insuring risks of U.S. stockholders and related parties, whatever the degree of ownership of the U.S. stockholder. An exception applies to insurance companies whose stock is publicly and freely traded. Similar rules apply to mutual companies.This income is separately boxed.

The provision is effective for years beginning after 1986.

The Treasury Department is to study the impact of treaty waivers of the excise tax on the domestic reinsurance industry.

Title IX. Financial Institutions

Property and Casualty Insurance Companies

Inclusion in income of 20% of unearned premium reserves

Under the conference agreement, 20% of the annual increase in unearned premiums is included in property and casualty insurance company income. Also, 20% of the unearned premium reserve outstanding at the end of the most recent taxable year beginning before Jan. 1, 1987, is included ratably over a six-year period commencing with the first taxable year beginning after Dec. 31, 1986.

In the case of insurance against default in the payment of principal or interest on securities with a maturity of five years or more (i.e., bond insurance), the percentage of unearned premiums included in income is 10%, rather than 20%.

If a property and casualty insurance company ceases to be subject to tax as a property and casualty insurance company, the remaining portion (if any) of the amount to be ratably included over six years is includible for the taxable year preceding the taxable year in which the company ceases to be taxed as a property and casualty insurance company.

Treatment of certain dividends and tax-exempt income

For taxable years beginning after Dec. 31, 1986, a property and casualty insurance company's deduction for losses incurred is reduced by a portion of the company's tax-exempt income and the deductible portion of dividends received (with special rules for dividends from affiliates). The portion taken into account is 15% of tax-exempt income and the deductible portion of dividends received from investments made after Aug. 7, 1986.

Treatment of loss reserves

The deduction for unpaid losses (i.e., reported losses that have not been paid, estimates of losses incurred but not reported, resisted claims and unpaid loss adjustment expenses) is limited to the amount of discounted unpaid losses. This provision applies to property and casualty lines of business reported on Schedules O and P of the annual statement approved by the National Assn. of Insurance Commissioners, to accident and health reserves (other than life insurance reserves subject to discounting under life insurance company tax rules) and to international and reinsurance lines of business. This treatment applies to loss reserves of both property and casualty insurance companies and life insurance companies to the extent such loss reserves are not subject to life insurance company reserve rules. Loss adjustment expenses of life insurance companies are not subject to discounting because they are not deductible.

In the case of title insurance companies, the agreement applies the discounting rules to the title insurance state law unearned premium reserves. The discounting period is the period over which the unearned premium reserves are deferred under state law, and the discount rate is the rate generally applicable to property and casualty insurers. Title insurance case reserves are subject to discounting under the same method as property and casualty insurance loss reserves.

The amount of the discounted unpaid losses as of the end of any taxable year attributable to any accident year is determined by using (1) the gross amount to be subjected to discounting (i.e., the undiscounted loss reserves), (2) the pattern of payments of claims, including the duration in years over which the claims will be paid and (3) the rate of interest to be assumed in calculating the discounted reserve.

The interest rate to be applied is 100% of the applicable federal midterm rate applied on a five-year rolling average basis. The loss payment patterns are to be promulgated by the secretary of the Treasury for 1987 and every fifth year thereafter, taking account of aggregate industry experience for each line of business.

A company may elect to use its own loss payment pattern experience. Special rules are provided for long-tail lines and for international and reinsurance lines of business. The provision is effective for taxable years beginning after 1986, with a fresh start provision and special treatment for reserve

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strengthening in taxable years beginning after Dec. 31, 1985.

Repeal of protection against loss account

Effective for taxable years beginning after Dec. 31, 1986, the deduction for contributions to the protection against loss (PAL) account for mutual property and casualty companies is repealed. Balances in the account are includible in income as under present law.

Revision of special treatment for small companies

Under the bill, property and casualty insurance companies (whether they are stock or mutual) with net written premiums or direct written premiums (whichever is greater) that do not exceed $350,000 for the taxable year are exempt from tax.

Property and casualty insurance companies (whether they are stock or mutual) with net written premiums or direct written premiums (whichever is greater) that exceed $350,000, but do not exceed $1.2 million, may elect to be taxed only on taxable investment income.

In the case of a controlled group, these amounts are determined on a group basis, applying 50% control test.

The provisions are effective for taxable year beginning after Dec. 31, 1986.

Study of property and casualty insurance companies

Under the agreement, the Treasury Department is required to conduct a study of the tax treatment of policyholder dividends of mutual property and casualty insurance companies for regular as well as minimum tax purposes and an examination of whether the property and casualty insurance industry meets revenue targets that are projected by the agreement. ■

California firms save with PPO

LOS ANGELES—Nine major employers in Southern California collectively saved $10.6 million in health care costs last year by using Met-Elect, the same preferred provider organization that helped benefit managers in Dade County, Fla. save $2.5 million during 1985 (*BI*, Nov. 11, 1985).

That $10.6 million figure reflects money the Southern California employers would have spent during 1985 had they not joined Met-Elect, according to Maureen Gutenstein, director of program management at Metropolitan Life Insurance Co. in New York. Met-Elect is marketed by Metropolitan Life.

The companies' total health care expenditure in 1985 was $111 million. Collectively, they spent about $1.1 million last year to use the PPO, according to Metropolitan Life.

The nine companies' results from use of the PPO during the first six months of this year are not yet available.

The nine companies are: Rockwell International Corp., the defense contractor located in El Segundo; Collins Foods International Inc., the restaurant manager located in Los Angeles; and Marshall Industries Inc., located in El Monte.

Also, Pioneer Electronics (USA) Inc., located in Long Beach; Bank of California, located in Los Angeles; and Zimmerman Holdings Inc., an aerospace and manufacturing holding company located in San Marino.

In addition, the Bechtel Group, located in Norwalk; Golden West Television, located in Hollywood; and Children's Hospital of Los Angeles.

These nine employers joined Met-Elect when it began operations in Southern California in January 1985; today a total of about 67 employers are enrolled in the PPO throughout Southern California, Ms. Gutenstein estimates.

The PPO has 43 hospitals and about 4,000 physicians in Los Angeles and Orange counties, she says.

About 80 employers are enrolled nationwide, using Met-Elect in about 16 cities.

Bechtel, for example, uses Met-Elect in Los Angeles, San Francisco and Miami, while Bank of America, which is one of California's largest employers, uses the PPO in San Francisco and Los Angeles.

The PPO now covers about 350,000 lives nationwide, including dependents. ■

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Orr named president of Union Mutual

James F. Orr III has been appointed president and chief operating officer of Union Mutual Life Insurance Co. in Portland Maine.


Mr. Orr

Mr. Orr was formerly executive vp and treasurer of Connecticut Bank & Trust Corp., responsible for the bank's investment functions and diversified financial services.

He will succeed **Colin Hampton,** who will continue as chief executive officer at Union Mutual while assuming the role of chairman.

Other insurer changes:

Colin O'Connor named president of Belvidere Insurance Co. in Bermuda, replacing Francis Carter who has left the company.

Joel O'Neal, 51, named senior vp in charge of commercial insurance underwriting for Fireman's Fund Insurance Cos. in Novato, Calif. Mr. O'Neal, who has been with the company for 29 years, was most recently a senior vp and regional executive.

Robert H. Whitehead, 53, elected executive vp of Industrial Indemnity Co. in San Francisco, Calif. He will continue to oversee all underwriting and actuarial operations. He joined the company in 1963.

comings & goings: industry

Thomas W. Devine named vp of The North River Insurance Co., a Basking Ridge, N.J., unit of Crum & Forster Underwriters Group. He was most recently assistant vp-financial analysis.

Jan Couch named vp-claims, eastern region for American General Insurance Co. of Florida, a subsidiary of American General Corp. She joined American General in 1979.

Also, **Martin Kreis** named field vp-cost containment at American General Group Insurance Co. in Houston. He previously was with Republic National Life Insurance Co.

Robert P. Aldorisio named actuary and vp of Selective Insurance Co. of America, a Branchville, N.Y.-based property and casualty insurer.

Peter J. Ilias appointed president and executive director of The Continental Insurance Co. Europe Ltd. and a regional vp of Continental's international department. Based in London, Mr. Ilias serves as chief operations officer for all of the Continental Brokerage and Special Operations Group's entities in Europe, the Middle East and Africa.

Also, **Bruce Hayden** appointed vp and manager of Continental's international department, headquartered in New York.

Brian Jessick, named senior vp and regional manager of the Southern California operations of Pacific Compensation Insurance Co. in San Jose, Calif. Mr. Jessick, who joined the company in 1963, had been vp and division manager.

W. Dean Dingman joined Reliance Insurance Co. as regional vp. Mr. Dingman will be responsible for managing the company's northeast region from Reliance's Northeast Service Center in King of Prussia, Pa. He most recently was a vp with Crum & Forster in New York.

Michael F. Magsig elected vp in the reinsurance division of the Lincoln National Life Insurance Co. in Fort Wayne, Ind. He had been director-reinsurance.

Charles M. Reynolds named executive vp of Star Insurance Co., a newly formed Michigan insurance company. Mr. Reynolds will be responsible for Star Insurance's operations, including underwriting, sales and finance. For the last three years, he was president of his own consulting firm, which specialized in developing markets for agents, brokers and financial institutions.

Reinsurers

Therese Arana named vp of the international underwriting department at American Re-Insurance Co. in New York. Ms. Arana will oversee underwriting policy and guidelines for treaty and facultative reinsurance in a newly formed department.


Ms. Arana

Randall M. Boyd (San Francisco), **G. Roger Greiner** (Stamford, Conn.), **Peter Lawrie** (New York) **and Ian McNeill** (Philadelphia) appointed vps at General Reinsurance Corp.

Agents/brokers

Corroon & Black Corp. in New York promoted **J. Bransford Wallace** and **John R. Lamberson** corporate executive vps. Mr. Wallace, who joined Corroon & Black in 1976, will continue as chairman and chief executive officer of the company's Brokerage Services Group. Mr. Lamberson, who joined the company, will continue to direct the activities of the BSG's construction services division. He will also move to the New York corporate office from San Francisco.

Robert C. Nevins, executive vp and chief operating officer of New York-based Fred S. James & Co. Inc., resigned "to pursue new areas of opportunity in the insurance industry," according to a James spokesman. Mr. Nevins, who formerly was president of San Francisco-based Dinner Levison Co., joined James' management as senior vp in charge of West Coast operations in 1983 when James acquired the brokerage. At the time of Mr. Nevins' departure, all officials in charge of operating and staff functions—except those responsible for strategic planning, national and international sales, government and public relations—reported directly to him.

Mr. Nevins could not be reached for comment on his future plans

George O'Gorman and **Donald J. Zuk** have been elected senior vps of Johnson & Higgins of California. Mr. O'Gorman is manager of the property and casualty operations, and Mr. Zuk is manager of the health care department in the firm's Los Angeles office.


Mr. O'Gorman


Mr. Zuk

Also at J&H, **Paul J. Kelley** and **Edward P. Kehoe** elected senior vps of Johnson & Higgins of Virginia Inc. Mr. Kelley, who joined J&H in 1974, had been a vp. Mr. Kehoe had been vp and manager of the property/casualty department.

Stephen D. Siragusa elected senior vp of J&H in New York. Mr. Siragusa, who is deputy manager of the casualty department, had been a vp.

Vp **Thomas F. Hartley Jr.** named manager of Johnson & Higgins of Arizona Inc. in Phoenix, succeeding **Thomas J. Bolton**, who retired July 1. He had been manager of the office's property/casualty department.


Mr. Hartley

Abid Kermani, Catherine E. Monahan and **Erik Severeid** named vps in Johnson & Higgins' New York international department.

Mary Marines elected vp of Pennock Insurance Agency Inc. in Upper Darby, Pa.

Robert L. Slaughter joined Great Lakes Agency in Chicago, Ill., as vp. He has been an agent since 1959.

Richard J. Schuessler named executive vp of CPI Insurance Group Inc. in Cedar Knolls, N.J. Mr. Schuessler had been vp of Jardine Emett & Chandler Inc.'s New Jersey office.

Harriet G. Jenkins promoted to vp at Associated Insurers Inc., a brokerage in Raleigh, N.C. She joined the company in 1981.

Howard Davis has joined Bayly, Martin & Fay Inc. of Georgia in Atlanta as president and chief executive officer. Mr. Davis, who had been vp-business development with Marsh & McLennan Inc., succeeds **Beach M. Clark,** who was promoted to chairman.

Matthew F. Coughlin III promoted to president and chief executive officer of Tulsa-based Frank B. Hall & Co. of Oklahoma Inc. Mr. Coughlin, who joined the company in 1981 as a senior vp, replaces **James M. Burdett** who was named president of Frank B. Hall of Texas and assumed responsibility for managing the Houston office.


Mr. Burdett

Brian C. Miller and **Christine Veator** named first vps at Frank B. Hall & Co. of Massachusetts in Boston.


Ms. Veator

David P. Maurer named managing vp of Alexander & Alexander Inc.'s New Jersey operation in Bloomfield, N.J. He had been a vp in A&A's Albany, N.Y. office.

Charles B. Crane named senior vp of Marsh & McLennan Inc. in Seattle. He joined M&M's Seattle office in 1970 and was most recently a vp.

Also at the Seattle office of M&M, **Robert C. Bale, John S. Emery and Jerry M. Wood** named vps.

Margaret J. Schumacher joined Rollins Burdick Hunter of Florida Inc. as vp.

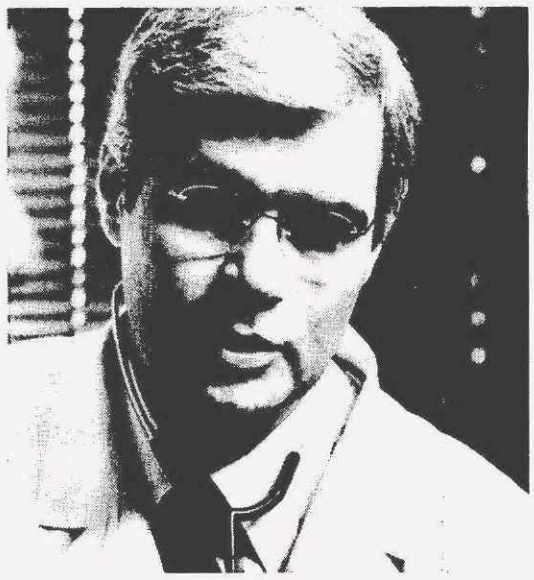
Also, **Bruce A. Hancock** has joined RBH of Arizona Inc. as senior vp. He is responsible for production, marketing and employee benefits operations in Arizona, New Mexico and southern Nevada.

Robert S. Weatherly joined RBH of Texas Inc. in Houston as vp.

In Chicago, **Raymond L. Hayes** named division manager and senior vp of the commercial brokerage division of RBH of Illinois Inc. Mr. Hayer, who is currently

Continued on next page

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Continued from previous page
president of the National Assn. of Insurance Brokers, will head the Chicago employee benefits, middle market property/casualty and commercial sales departments.

Excess/surplus

George P. Hilditch named senior vp and manager of the San Francisco office of Crump/H&W Insurance Services, the Crump Cos. Inc.'s excess and surplus lines brokerage subsidiary in California.

Keith J. Kenway appointed vp of C.I.S. Northwest Inc., another Crump unit in Seattle.

Laura S. Danoff, named vp-casualty brokerage in the San Francisco offices of Crump/H&W Insurance Services. She most recently was with Montgomery & Collins Inc.

Denis Cleavor promoted to president of Creative Insurance Specialists Inc. of Sanford, Fla., another excess/surplus lines Crump affiliate. He will continue as the company's general manager, a position he has held since 1984.

Stanley R. Kloszewski named senior vp in the national wholesale division of Poe & Associates Inc. in Tampa, Fla.

Donald F. Privett named vp of Swett & Crawford Group's national marketing division in New York. He most recently was vp at Glanvill Special Risk Brokers in New York, though he had earlier worked at Swett.


Mr. Privett

Brian Jarman named senior vp of underwriting for Swett & Crawford Group. He was previously president of AEGIS Insurance Services Inc. in Jersey City, N.J.


Mr. Jarman

At Stewart Smith West Inc., **Fred Anderson** named executive vp and **Lana Miller** named vp and manager of the professional and financial services department in Los Angeles, and **Terry Dwyer** named vp and manager of the San Francisco office.

At Stewart Smith Southwest Inc., **Andrew J. Herbert** promoted to senior vp.

At Stewart Smith East Inc., **Francis N. Grochowski** named vp and **Bart Allen** named vp and manager of the Philadelphia branch.

At Chicago-based Stewart Smith Mid America, Executive Vp **Arthur Judson** assumed additional responsibilities as manager of the casualty department, and **Alan Joseph** has been named vp and manager of the property department.

Philip J. See named vp-claims at Atwater McMillian Inc. in St. Paul, Minn., a surplus lines and special risk insurance subsidiary of The St. Paul Cos. Inc. He most recently was vp of underwriting services at Atwater McMillian.

Earl W. Routh named vp and branch manager of the Lincoln, Neb., office of Hull & Co. Inc., a Fort Lauderdale, Fla.-based excess and surplus lines brokerage. He was formerly vp of Empire Insurance Cos. of Omaha, Neb.

HMOs

John E. Graydon named president and chief executive officer at Canton, Mass.-based MetLife HealthCare Network of Massachusetts, an affiliate of Metropolitan Life Insurance Co. of New York. Mr. Graydon was formerly vp and general manager of Blue Cross &


Mr. Graydon


Mr. Hulsey

Blue Shield of Wisconsin's HMOs.

In addition, **James P. Galasso** named vp and actuary, a newly created position in MetLife HealthCare Network's St. Louis headquarters.

James C. Hulsey named president and chief executive officer of MetLife HealthCare Network of Georgia.

Michael Sheley, an executive vp at Philadelphia-based CIGNA Healthplan Inc., a subsidiary of CIGNA Corp., has also been named president of the HMO's western

Continued on next page

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comings & goings: industry

Continued from previous page
division. He joined a CIGNA predecessor company in 1977.


Mr. Sheley

Also at CIGNA Healthplan, **John W. Rohfritch** named executive vp and president of the north central region. He was formerly a senior vp at CIGNA Individual Financial Services Co.

Patricia A. Minicucci appointed senior vp of CIGNA Healthplan and president of the south central region. She was most recently vp-human resources for CIGNA's employee benefits and health care group.


Mr. Zurbach

John Zurbach named vp in charge of the new greater Pittsburgh region of U.S. Healthcare Inc. Mr. Zurbach, who has been with U.S. Healthcare affiliates since 1983, previously was the company's national sales manager.

Other suppliers

Ronald Rakich named senior consultant in the Newport Beach, Calif., home office of Warren, McVeigh & Griffin Inc.

John Erb joins the national health group division of Johnson & Higgins after resigning as executive director of the South Florida Health Action Coalition. Mr. Erb will be in charge of developing cost-containment programs for J&H clients.

Also at J&H **William F. Cantello** joined the San Francisco Employee Benefit Practice of Johnson & Higgins of California as a vp and senior consultant. He had been senior vp at Olanie, Hurst & Hemrich in San Francisco.

Ned Lucco named executive vp of Texas National Group Administrators, a subsidiary of Dun & Bradstreet Plan Services Inc. headquartered in Houston. He had been assistant vp-plan services.

Gerald L. Lenrow named head of Coopers & Lybrand's Central Region insurance operations and chairman of the Chicago insurance industry group.

Also at Coopers & Lybrand, **Vince Taormina** has been named a principal to head the actuarial, benefits and compensation practice in the west region. He also is now partner in charge of the Los Angeles actuarial benefits and compensation office. He had been head of the Philadelphia office of William M. Mercer-Meidinger Inc.


Mr. Taormina

Mitchell E. Frankel joins Coopers & Lybrand's Risk Management Group in Los Angeles as director, casualty claims consulting. He was formerly risk manager of the Los Angeles County Medical Assn.

Cathy Lowenbraun McKeon joined Coopers & Lybrand as a senior consultant with the New York risk management consulting practice.

Howard L. Wollner promoted to president and **Bicknell C. Robbins** named vp of Compensation Programs Inc., a Seattle-based actuarial consulting and pension administration firm, which is an affiliate of Corroon & Black Corp.'s Benefits & Specialty Sales Group.

Also at CPI, **Leroy J. Leavitt**, who joined the company in 1976 and most recently served as president, has retired.

Gregory L. Trout has joined Advanced Risk Management Techniques Inc. as consultant and manager of its new Sacramento, Calif., office.

Mark Schor appointed actuarial consultant for Frank B. Hall Consulting Co. specializing in benefits, compensation, employee communication and actuarial services. He was formerly a consultant with Coopers & Lybrand.

Marcia L. Hoover joined Alexander & Alexander Services Inc.'s Human Resource Management Group as manager of its defined contribution services unit. Prior to joining HRM, Ms. Hoover was a vp with Trilog Inc., am affiliate of CIGNA Corp.

Charles F. Royster, a member of Booke & Co.'s technical support group, has been elected a vp of the Winston-Salem, N.C., actuarial and consulting firm. He was previously an assistant vp.


Mr. Royster

Lawrence W. Sullivan named senior consultant at MBA Risk Management Services Inc. in Braintree, Mass. Mr. Sullivan had been president of Corroon & Black of Massachusetts Inc.

Hedy B. Foreman has joined New York-based Buck Consultants Inc. as national director of information systems/consulting.

Barbara Adolf has joined Buck as an associate benefits consultant in its group consulting services department. She was formerly vp of Adolf & Rose Associates, a company specializing in dependent care consulting services.

Also, seven others have been promoted at Buck: **Alice Bray** and **Michael R. Ryan** named benefit consultants; **Garry L. Haynes, Martin I. Shapiro** and **Edward J. Winterbauer** named consulting actuaries; **Diane L. Lotti**, named associate benefits consultant; and **James J. Merrick** named associate director of research.

Stephen Diser appointed president of Comspeq International Inc., a St. Petersburg, Fla, company that provides safety inspections in the amusement/entertainment industry. Mr. Diser joined Comspeq International in January 1985 as a safety consultant. ■



markets

Nobel Insurance acquires defunct Kentucky insurer

Nobel Insurance Ltd., a Bermuda-based reinsurer of coverages for companies in the explosives industry, has acquired Highlands Mutual Insurance Co. of Lexington, Ky., and has pumped $3 million in capital into the defunct insurer.

Highlands was placed into rehabilitation in 1980 by the Kentucky Insurance Department.

The company primarily wrote personal lines coverage for homeowners, according to a spokesman for the Insurance Department.

However, its financial condition began to deteriorate in the late 1970s when it began to take on "high-risk" business such as coverage for coal-trucking companies, the department said.

Nobel paid $50,000 for the defunct company, plus amounts for equities and securities the company held.

The insurer is now called North American Nobel Insurance Co. and additional capital will be added to the company as it becomes licensed outside the state of Kentucky, according to Richard Sprague, controller of Nobel U.S. Group in Dallas.

Mr. Sprague said management has not yet made a decision about what types of coverage the insurer will write.

Jack L. Zogg, chairman of Nobel, said, "In an unprecedented series of transactions, Highlands recently was converted from an assessable mutual form of entity to a mutual insurer and finally to an admitted stock company in less than two months' time."

The acquisition was Nobel's second in recent weeks.

Last month, the company bought Atlantic Casualty & Fire Insurance Co. in Columbia, S.C., for $3 million.

Atlantic Casualty & Fire Insurance Co. is A-rated by A.M. Best Co. and currently capitalized at $10 million. It will continue to write coverage for low-value dwellings while it is broadening its product base, according to Mr. Sprague.

Pittsburgh HMO

Employers in the Pittsburgh area now can offer their employees health care coverage through a new independent practice association health maintenance organization.

Physicians Health Plan of Western Pennsylvania includes 1,293 physicians and specialists, 25 hospitals and 109 pharmacies in five counties.

Originally developed by the Allegheny County Medical Society, the plan is now 75% owned by participating physicians.

Charter Med Inc., which is a subsidiary of United HealthCare Corp., owns the remaining 25% of the HMO and is retained as the management company for the new plan.

Initially, the plan will be offered to only employers, but the plan eventually will be offered to the public on an individual subscriber basis.

Physicians Health Plan's corporate office is at 5700 Corporate Drive, Suite 300, P.O. Box 101769, Pittsburgh, Pa. 15237; 412-366-9000.

Underwriting group

The International Underwriting Assn. Inc. is operating in Grand Turk with five insurance company members that will write coverage and eventually will share risks in the style of an insurance exchange.

Alan Teale, president and developer of International Underwriting, said the five companies that initially formed the association "don't all automatically appear on the same policy, but my guess is that eventually in most cases they will."

Mr. Teale said the association currently is capitalized at around $20 million, with individual investors in the companies contributing

Continued on page 66

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update

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markets

Continued from previous page
enough money to satisfy the requirements of the local regulators.

The insurance companies that currently are active in the association are American Trust Insurance Co. Ltd., American Trade Insurance Co. Ltd., Old American Insurance Co. Ltd., American Marine & General Insurance Co. Ltd. and American Transportation Insurance Co. Ltd.

The insurers are writing excess-of-loss reinsurance coverage above $250,000 retentions, according to Mr. Teale.

The insurers also will write excess liability coverage over $600,000 of primary coverage, he said.

Mr. Teale said that the association was formed in part because investors in high-level excess facilities—such as Marsh & McLennan's A.C.E. Insurance Co. Ltd. and X.L. Insurance Co. Ltd.—need coverage in "lower-level casualty areas."

The underwriters are taking a cautious approach to accepting risks at this point, according to Mr. Teale.

"We're being so bloody conservative it hurts," Mr. Teale said, explaining that the association plans to write at a 1-to-1 premium-to-surplus ratio during its first year.

"We're getting a lot of interest worldwide," he added.

"I suspect this is where most of the business will come from," he noted.

Member companies in the association will operate from the same facility, sharing administrative services and office equipment to hold down costs, says Mr. Teale. He expects the association to have around 12 members by the end of the year.

The association will operate in a manner similar to the Texas Lloyd's facility Mr. Teale helped put together in Dallas (*BI*, Sept. 2, 1985). In that company, which is named Lloyd's U.S., insurers use the same space and services and in some cases share risks.

The Texas Insurance Code allows for the formation of such "Lloyd's plan operations" in the state.

Mr. Teale said he acted as a consultant in the formation of Lloyd's U.S. and left when his contract expired.

The facility is operating with around $11 million in capital and is "doing very well," according to Mr. Teale.

Claims consultant

Professional claims consulting in the areas of primary insurance, reinsurance and excess/surplus lines is now available from a new consultant, Robert F. Ray & Associates Inc.

The firm's president and founder, Robert F. Ray, has held positions in the claims departments of The Travelers Insurance Co., of Hartford, Conn.; North American Reinsurance Co.; and New York-based American Treaty Management Corp.

The new consulting firm is located at 65 Parkdale Drive, North Babylon, N.Y. 11703; 516-242-9757.

Office expansion

EOI Service Company Inc., a Chicago-based firm that offers group universal life insurance plans to employees through their employers, is expanding its California office.

In addition to the company's founder, Jim Davidson, four other specialists will operate in the office at 2323 N. Broadway, Suite 300, Santa Anna, Calif. 92702; 714-558-1757.

The company currently serves 16 employers throughout California and has expanded the office to meet the growing demands for its optional life insurance plans, according to a spokeswoman for the company.

EOI brokers the plans to employers, who can offer employees the opportunity to purchase additional life insurance at their own cost, she said.

Mergers/acquisitions

Certified Claims Corp., a claims management division of Stewart Smith Holdings Inc., has been acquired from Stewart Smith by three of Certified's officers: Walter B. Kendall, president; and John Pasquini and Joseph Fanning, vps. The company, now known as **Certified Management Services**, will continue to provide a wide range of claims management and auditing services. Certified Management Services will continue to operate offices in St. Louis and Kansas City, Mo., with its headquarters remaining at 600 Central Ave., Suite 310, Highland Park, Ill. 60035; 312-433-2460.

Marsh & McLennan Inc. of New York, the nation's largest insurance brokerage, has acquired **Martin Hayes & Co.**, an independent insurance brokerage based in Nashville, Tenn. The broker specializes in contractor surety.

New York-based **Fred S. James & Co. Inc.**, the nation's fifth-largest insurance brokerage, has acquired **Rupert & Lutz Agency Inc.**, a privately owned insurance agency in Rochester, N.Y. Rupert & Lutz handles a wide range of property/casualty accounts and specializes in insurance programs for professional associations.

Twin City Group, a Minneapolis-based independent insurance agency, has acquired the **Stein-Carney Insurance Agency**. Stein-Carney will remain at 1944 N. Lexington Ave., St. Paul, Minn. 55133; 612-489-8891 and will be known as Twin City Group-Stein-Carney Agency.

AEGON Insurance Group, based in The Hague, The Netherlands, has acquired Baltimore-based Monumental Corp. Monumental markets individual and group health and life insurance and has total assets of almost $1 billion.

Insurance General Agency Inc. of Scottsdale, Ariz., has acquired **Allied General Agencies Inc.** of Denver and all of its subsidiary agencies: Allied General of Dallas; Kenneth I. Tobey Agency of Seattle; and Blackburn, Nickels & Smith of Minneapolis. Allied handles excess/surplus lines business. In addition, Insurance General Agency has also opened a new excess/surplus lines facility in Scottsdale. Insurance General Agency is located at 7975 N. Hayden, P.O. Box C5900, Scottsdale, Ariz. 85261; 602-483-3400; 800-352-7964 outside Arizona.

New offices

Delaware Valley Underwriting Agency of New York Inc., a managing general agency that specializes in brokering excess and surplus lines placements, has relocated to 59 John St., Seventh Floor, New York, N.Y. 10038; 212-227-8606; 212-227-8623.

Galaher Settlements, which provides structured settlement services nationwide, is relocating its corporate and western headquarters to 10681 Foothill Blvd., Suites 401 and 417, Rancho Cucamonga, Calif. 91730; 714-945-4740; 800-443-5112 outside Calif. The company is also relocating its eastern headquarters to 260 Franklin St., Suite 1510, Boston, Mass. 02110; 617-439-6260; 800-426-0385. ■

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Government proposes HMO 'user fees'

By JERRY GEISEL

washington

WASHINGTON—The Reagan administration wants to impose "user fees" on health maintenance organizations.

Under a rule proposed by the Department of Health and Human Services, a health maintenance organization that wants to become federally qualified would have to pay a fee of $34,600 to the federal government.

The fee for an HMO that already is federally qualified, but wants to expand its service area, would be $17,300.

Only federally qualified HMOs benefit from the "dual choice" provision of the federal Health Maintenance Organization Act, which requires that employers with more than 25 employees offer an HMO option to their employees if the employers are properly approached by the HMO.

HMOs derive a benefit from being federally qualified and therefore should pay part of the cost of qualification, explained Frank Seubold, deputy director of the federal Office of Prepaid Health Care.

The department says the user fees, which would generate less than $7 million in revenue next year, would have a negligible effect on HMO costs, growth and competitiveness.

"Our data show that. . .the fee would represent less than one-fourth of 1% of annual costs over the first five years of a new HMO's existence," HHS said.

As a result, the department says, a user fee would not create a significant financial barrier to access to HMOs. However, the Group Health Assn. of America, a Washington-based HMO trade group, charges that user fees will discourage HMOs from seeking federal qualification.

Insurance official

President Reagan has nominated Harold T. Duryee, a veteran insurance official, to head the Federal Insurance Administration.

Since 1984, Mr. Duryee, 56, has been special assistant to the FIA administrator.

In addition, from 1977 to 1984, Mr. Duryee, a graduate of Kenyon College, was deputy administrator of the Ohio Workers Compensation Bureau. For about 10 years prior to that, he was manager of the claims service division at Nationwide Insurance Co.'s northern Ohio regional office.

The Senate must vote on the nomination.

The FIA administrator's slot has been vacant since May, when Jeffrey Bragg resigned the post to join HOW Insurance Co. in Washington.

The FIA runs a number of insurance programs, including the National Flood Insurance Program and the federal Crime Insurance Program.

Tire safety rules

The Occupational Safety and Health Administration is proposing that general industry safety rules covering workers who service single-piece wheel rims be extended to marine terminal workers who service tires on large vehicles.

Under the proposal, the approximate 5,000 workers who service wheel rims at 400 marine terminals would be afforded the same protections as workers performing similar operations in general industry.

Those general industry standards protect employees—primarily at gas stations and garages—against the hazards of exploding rims, by requiring the use of barriers or other protective devices when servicing rims. In addition, workers must be trained in the safe handling of rims.

OSHA's 1983 marine terminal standard included similar protections for workers servicing multi-piece rims, but said standards for single-piece rims would be addressed later.

The current proposal simply would make the general industry requirements for both single and multi-piece wheel rims applicable to marine terminals.

Tax bill assailed

A provision in the tax overhaul legislation, H.R. 3838, that would increase tax liabilities on certain offshore captive insurance companies would deal a "devastating blow" to employers sponsoring captives, says the National Assn. of Insurance Brokers.

Under that provision, each shareholder that owns stock in any foreign insurance company that is 25% or more U.S.-owned would be liable for current year taxes on the income earned by the offshore insurer from underwriting risks of U.S. stockholders and related parties.

This tax would apply to all stockholders, regardless of the percentage of the ownership (*BI*, Sept. 15; Aug. 25).

An exception would apply to foreign insurance companies that are publicly traded.

The provision would go into effect for tax years after 1986.

By contrast, under current law, income earned by an offshore insurer is not subject to current taxation unless the insurer is considered a "controlled foreign corporation."

To escape being a controlled foreign corporation, an insurer needs to be owned by 11 separate entities, all of which own less than 10% of the insurer.

This change in the tax law will exacerbate the liability insurance crisis, argues NAIB President Raymond L. Hayes.

"In today's limited and costly insurance market, many small companies have been forced to operate without insurance. This provision will squeeze them harder," he pointed out.

Mr. Hayes also noted that the provision, in effect, "repeals previously negotiated tax treaty benefits without opportunity for due process."

"Many foreign governments will rightfully view this measure as a stab in the back," he added.

For instance, the United States and Bermuda signed a treaty in July that would exempt from federal excise taxes the premiums paid by U.S companies to Bermuda-based insurance and reinsurance companies (*BI*, July 21). However, that treaty has not yet been ratified by the Senate.

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Continued from previous page

A similar treaty with Barbados has already been ratified.

Mr. Hayes recommends that shareholders be given the option of paying all federal excise taxes on premiums paid to foreign insurers even if such taxes are excluded by tax treaties, or of complying with the new measure. Offshore captives also should be given more time to qualify for the tax exemption for foreign insurance companies whose stock is freely and publicly traded, he said. The tax bill, approved by a congressional conference committee Aug. 16, awaits final House and Senate approval.

Taiwan market

Taiwan has tentatively agreed to open up its insurance market to U.S. insurers.

Currently, only two insurers—CIGNA Corp. and American International Underwriters a unit of American International Group Inc. —are allowed to sell property/casualty insurance in Taiwan. And, they can sell only to businesses that are wholly or partly owned by U.S. parent companies

Under the agreement, any U.S. insurer that Taiwan licenses could sell coverage on the same basis as Taiwan-based insurers, including life and health insurance coverage. "This is a major step forward in terms of opening foreign insurance markets," said Gordon Cloney, director of the International Insurance Advisory Council at the U.S. Chamber of Commerce. ■

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Aging workforce presents benefits challenge: Study

By PAUL D. WINSTON

'The concerns of employers providing retiree health benefits arise from the uncertainties involved in assessing, managing, financing and predicting retiree health costs,' says Melody A. Carlsen of the ISCEBS research department.

BROOKFIELD, Wis.—Meeting the health care needs of the aging U.S. workforce poses great challenges to employers, according to the CENSUS, a poll of Certified Employee Benefit Specialists conducted by the International Society of Certified Employee Benefit Specialists.

"The concerns of employers providing retiree health benefits arise from the uncertainties involved in assessing, managing, financing and predicting retiree health costs," said Melody A. Carlsen of the research department of the Brookfield-based ISCEBS.

The 236 benefit specialists who responded to the poll rated inflation in medical care costs as the greatest of those employer concerns.

Medical care inflation was "of great concern" to 67% of the respondents, and "of moderate concern" to an additional 29%.

In addition to health care inflation, other areas of concern noted by the respondents were potential cutbacks in Medicare reimbursement and the potential for Medicare to assume a secondary payer status for all retirees.

Some 55% of the respondents said potential Medicare cutbacks were of great concern, and 41% said they were of moderate concern.

And, 56% expressed great concern over the potential for secondary-payer status for Medicare, while an additional 33% expressed moderate concern.

Uncertainties surrounding such factors as advances in medical technology and lack of a clear legal framework for managing retiree health benefits posed only a slight degree of concern for respondents.

Some of the CENSUS respondents indicated they have attempted to measure the costs of the retiree health plans with which they are associated.

To accomplish this, 53% of these respondents' plans differentiate the health costs of active employees from those of retirees.

And, 38% use experience-tracking systems to collect data and analyze costs, and 23% perform actuarial valuations of post-retirement medical benefits.

Only 23% said they perform actuarial valuations of post-retirement medical benefits. Some 39% of the respondents said they did not perform such valuations, and 38% either did not answer the question or said they didn't know whether or not they performed the valuations.

Ms. Carlsen observed that funding of the retiree health care benefits, especially in light of employers' concern over medical care inflation, is seen as a serious problem for benefit experts.

Almost half—47%—of the respondents said it was their opinion that "the current and future liability of retiree health benefits (is) an even greater problem than that of pension underfunding which led to the passage of" the Employee Retirement Income Security Act.

And, Ms. Carlsen said, it's not surprising that 82% of the respondents said the actuarial assumptions allowed under the Deficit Reduction Act of 1984, which establish funding limits for retiree medical benefits, should be modified to allow for health care inflation.

The survey also shows that most of the retiree health care benefits reported by the respondents are not prefunded.

Some 77% of respondents meet these obligations on a "pay-as-you-go" basis.

Thirty percent use a Voluntary Employee Beneficiary Assn., or 501(c)(9) trust. Only 4% fund retiree health benefits through a 401(h) trust.

Still, when asked if they would choose to prefund their retiree health care costs—if restrictions and tax disadvantages were not present in current prefunding options—only 40% indicated they would.

One respondent said that, because employers have little or no control over escalating health care costs, "prefunding would be an actuarial nightmare."

A New York actuarial benefits consultant said of prefunding, "Any such scheme, in order to be efficient and acceptable to employers—and ultimately, be beneficial to employees—should lean toward a defined contribution approach. The same problems inherent in a defined benefit plan would be exacerbated in any defined dollar benefit medical funding."

Noting that "court decisions to date lean toward 'automatic' employee vesting in retiree health benefits upon attainment of status as a 'retiree,'" the survey asked if eligibility for retiree medical benefits should instead be service-related.

Seventy-three percent agreed that such benefits should be service-related, while 22% find automatic vesting appropriate.

Nearly three-quarters of the respondents expect the Financial Accounting Standards Board to require that retiree health care costs be accrued over the active service life of employees, and 80% expect the FASB to make unfunded liabilities a balance sheet item.

One of the respondents, a group insurance analyst from Chicago, took a broad view of the question of retiree health care: "When all is said and done, rather than funding a system of health care for retirees, employers should be concerned with developing a health care delivery system that most people can afford."

CENSUS also asked several questions regarding pension issues as they relate to older employees.

On the issue of legislation mandating the accrual of pension benefit credits for active workers beyond age 65, Ms. Carlsen noted that "respondents are closely divided (49% favoring, 45% opposing) on mandating the accrual of pension benefits for workers beyond age 65.

"Most of those recommending legislation to that end suggest that accruals continue either to age 70 or until actual retirement," she said.

A 72% majority of respondents felt that it was inappropriate to consider mandating pension changes for retirees to reflect cost-of-living changes, while 20% felt it was appropriate.

In addition, 48% of the respondents expect that a system in which accrued non-vested pension benefits become portable might be created in the future; 35% do not expect such a system.

Finally, the survey asked respondents what lessons should have been learned from ERISA that could be applied to the issue of retiree health care benefits.

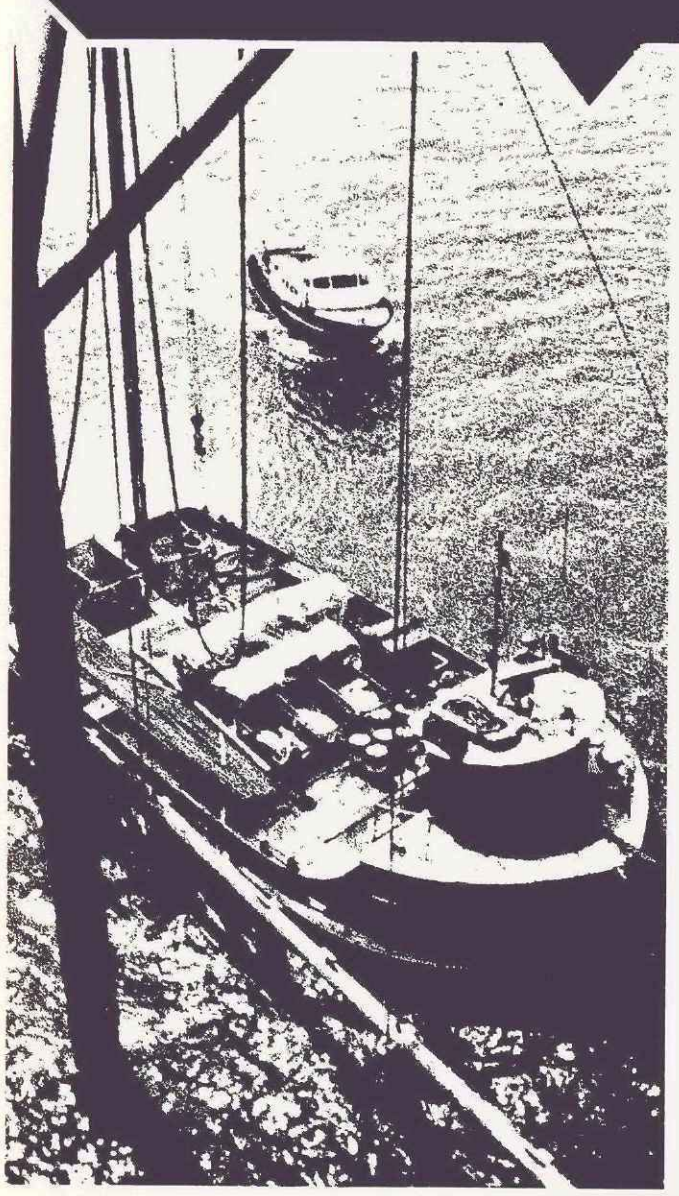
One benefit expert said, "We have learned that if a substantial segment of the private sector doesn't address this issue adequately, the government will mandate a less-flexible solution."

And, another respondent took a particularly pessimistic view of the situation, saying, "ERISA has taught us nothing of value, or the pending crisis would not exist."

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To obtain a free copy of the results of the CENSUS survey of Certified Employee Benefit Specialists, contact the International Society of Certified Employee Benefit Specialists, 18700 Bluemound Road, P.O. Box 209, Brookfield, Wis. 414-786-8771.

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Rendez-Vous

Continued from page 1

only for two years, but rate decreases last much longer.

"The market probably will be as difficult as ever," commented Peter C. Methley, chief executive of C.E. Heath (Insurance Broking Holdings) Ltd. in London. "It will not be easier. There is still more money to be put back into the kitty."

"I do not think we will see a lot of change from last year," added Wallace E. Winter, president of New York-based Intere Intermediaries Inc.

"Underwriters have accomplished what they wanted to accomplish-with treaty exclusions, higher retentions, better terms and prices. Now there may be some fine-tuning," he explained.

Mr. Winter said he does not expect the market to "harden further, although there may be some additional rate changes upwards."

"No one, though, should expect a movement in the opposite direction," Mr. Winter advised.

"The professional reinsurance companies will continue to demand strict terms like they did in 1986," affirmed Shlomo Jannai, general manager of Israel Reinsurance Co. Ltd. in Tel-Aviv.

Only a few sources suggested further upheaval in reinsurance markets will be in store next year —which would result in more changes in the capacity of ceding companies.

Don Smith, president of Kemper Reinsurance Co. in Long Grove, Ill., observed: "A lot of reinsurers are still re-underwriting their books of business. We will still see problems. They will not be as drastic as last year, but there will be some."

Perhaps the most pessimistic prediction was made by Christopher G. Rostron, managing director of recently formed Rostron Hancock Reinsurance Brokers Ltd. in London.

Specializing in reinsurance placements involving professional European reinsurers, Mr. Rostron predicted the marketplace "will be even tougher than last year. Terms and conditions will get harder."

He said he expects to see larger retentions by ceding companies, limited reinstatements adopted and ceding companies forced to retain their first loss that otherwise would have been covered by reinsurance.

But the general market analysis that the marketplace will remain about the same as it was during last year's renewals created a calm mood at the Rendez-Vous this year. At least people know what to expect.

That mood was markedly different from last year when reinsurers predicted—correctly—that the U.S. liability insurance market was careening toward its worst capacity crunch in history, creating worldwide reverberations.

European reinsurers abandoned U.S. liability business in droves last year, pulling the support from managing general agency programs and U.S. insurers and reinsurers. U.S. reinsurers that stayed in the market warned their capacity would be greatly reduced and what would be available would be sold at a much higher price.

Rendez-Vous attendees last year dashed from one meeting to the next trying to determine just how bad the crunch would be in 1986 and where they might find pockets of capacity.

This year, there was less dashing and, to all observers, fewer meetings.

Although the official attendance figure was released as 2,000—the same as last year—everyone agreed it appeared attendance was down, some saying by as much as one-third.

"The book (of registrants) looks thick, but the restaurants don't show it," observed Ward Gordon, chairman of Intere in New York.

"Companies are sending fewer representatives because there is less to talk about," observed Donald J. Greene, a partner with the New York law firm of LeBoeuf, Lamb, Leiby & MacRae. "There is just less business."

With not as much business to discuss, it was suggested that some of those attending the Rendez-Vous were "skiving" during the day, a British term for playing hooky, and gathering mostly at night for the social events (see story, page 77).

Certainly, the European reinsurers showed no interest in talking about returning to U.S. casualty business.

"Europeans have not changed their attitude toward U.S. casualty," said Wolfgang J. Buettner, president of Los Angeles-based American Intermediaries Inc.

"Some say there is a little opening up if there are aggregate limits and limited reinstatements, but I can't say that is true," Mr. Buettner said.

U.S. casualty markets are limited to London, Hannover Reinsurance Co. of Hannover, West Germany, and Ancienne Mutuelle Reassurance in Paris, he said.

And, some reinsurers, such as Union Reinsurance Co. of Zurich, Switzerland, are even leaving multiline treaties if they include U.S. liability business.

Mr. Smith of Kemper Re observed that the London market is interested only in providing coverage above the working layers, while U.S. reinsurers are writing the working layers where there is loss exposure.

"And the U.S. broker market is very slim for casualty risks," he added.

While a lack of renewed interest among Europeans in U.S. casualty business is bad news for U.S. commercial liability insurance buyers, it is good news to the U.S. reinsurers that continue to write casualty reinsurance.

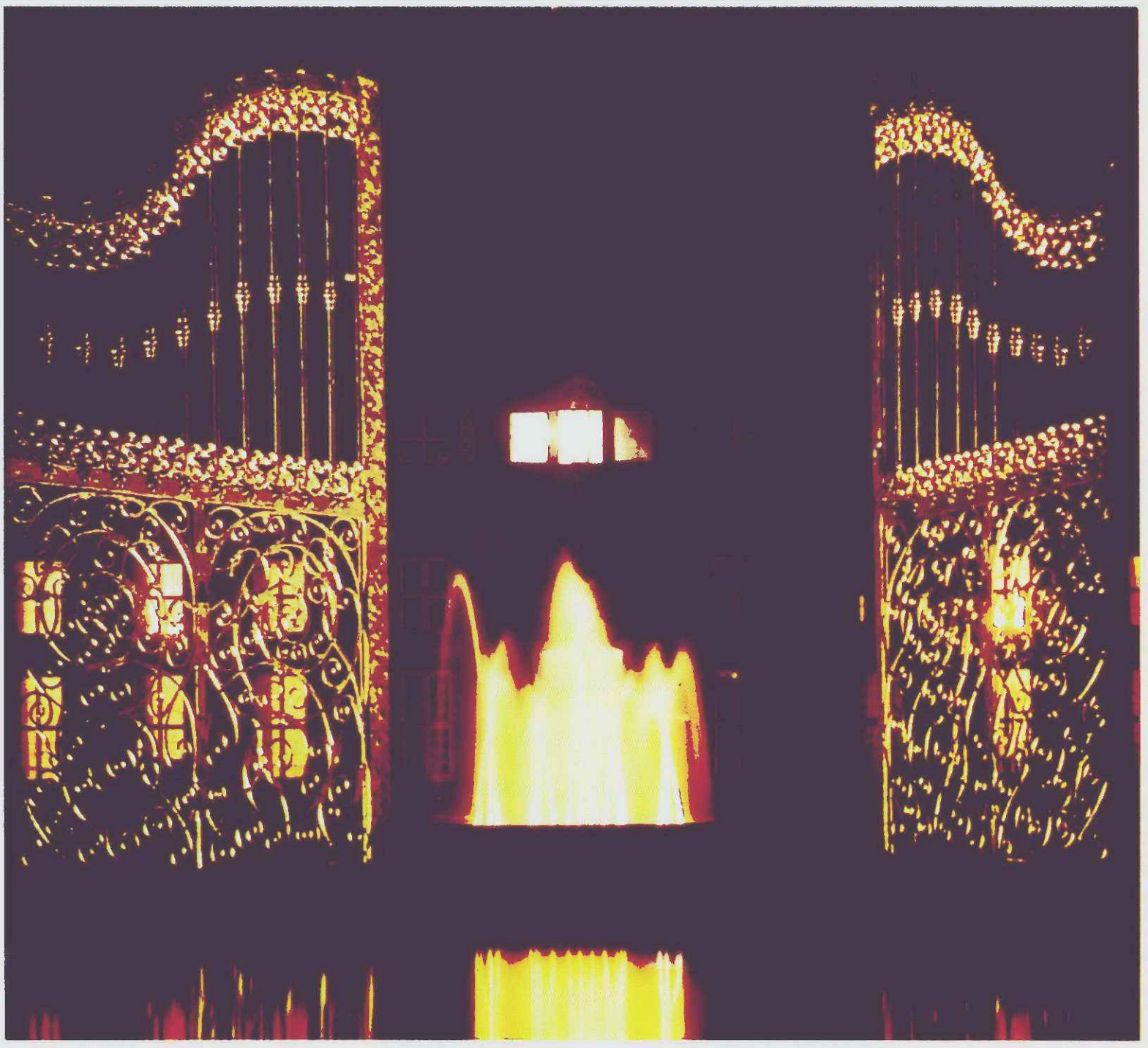
"That sustains the sellers' market, which we need," says James E. Dwane, senior vp of Prudential Reinsurance Co. in Newark, N.J.

"We're seeing continued strong pricing on casualty," said Edward B. Jobe, executive vp of American Re-Insurance Co. in New York.

Few observers at the Rendez-Vous, however, said they expect U.S. liability insurance to get much tougher to find or much more expensive in the coming year.

"The wrenching experience is over," according to James F. Dowd, president of reinsurer Skandia America Group in New York. "There will be less dramatic increases and more consistency

Continued on page next



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Rendez-Vous

Continued from previous page
and continuity."

Casualty reinsurance rate increases will fall in the 10% to 20% range, down from 50% to 100% last year, Mr. Dowd said, although casualty rates could rise higher than 20%.

"American casualty won't get much worse," predicted Raanan Ben-Zur, chief executive of Lloyd's of London broker PWS Group in London, which specializes in American casualty and international facultative reinsurance.

"Excess liability prices will rise again," Mr. Ben-Zur said, "but not 100% to 300%. Maybe 10% to 20%."

"Pricing seems to be reasonable now," observed Mr. Dwane of Prudential Re.

"The bottom line to the reinsurer is sufficiently improved results in pricing—both proportional and excess-of-loss," said Prudential Re President George S. Nimmo.

No one, however, was willing to say that current casualty insurance rates are too high.

"Insureds can't complain about casualty rates," Mr. Ben-Zur of PWS contended. Underwriters are in "business to make money and underwriters have lost their shirts on it. The spread is not there, compared with the unknown. It is very difficult to know if rates are right."

"We are still left with a feeling of unpredictability," said Mr. Dowd of Skandia America. "We're not sure rates will ever be adequate as long as (liability) conditions change.

"Long-term, tort reform will make a difference," Mr. Dowd added, "but no one state went far enough."

While U.S. casualty insurance rates will remain the same or rise, there will continue to be a shortage of capacity for casualty layers below $5 million, Prudential Re's Mr. Dwane said.

"The capacity shortage will be higher up on D&O and professional liability," Mr. Nimmo added.

"In the standard casualty market there will not be much of a shortage," Mr. Dwane said.

Certain classes of liability insurance are still not wanted by reinsurers, noted John Lock, general manager of Mercantile & General Reinsurance Co. P.L.C. in London and chairman of the Reinsurance Offices Assn.

Professional liability insurance and product liability insurance for chemical and pharmaceutical companies fall in this category, Mr. Lock said.

In addition, directors and officers liability risks will still be very difficult to place, noted Intere's Mr. Gordon.

General liability risks perceived to have a long-tail exposure also will be subject to claims-made policy forms, but not necessarily all liability business as some reinsurers would like.

"We can't sell it to Main Street risks," said one U.S. reinsurance company executive, requesting anonymity lest his reinsurers think he is falling back on implementing claims-made coverage.

"London is adamant that we adopt it across the board," he explained. But, he maintained, only Fortune 500 companies require claims-made forms.

Other reinsurers appear to agree.

Mr. Nimmo of Prudential Re said: "We want claims-made where it is needed," but not where the exposure is lighter.

"Mercantile and warehousing are not as vulnerable as manufacturing," added Mr. Dwane.

Munich Re, which writes U.S. casualty insurance on a "conservative basis," according to Mr. Luhrsen, "supports the occurrence form for the shopkeeper on Main Street where. . .occurrence isn't a problem.

"But," he added, "Munich Re has not supported occurrence forms in the professional liability areas in the U.S."

While reinsurers and brokers appear content that U.S. casualty marketplace conditions will stay the same, commercial insurance buyers will be left in tough bargaining positions and without desired liability coverage limits again next year.

To illustrate the extent of the sellers' market, one broker reported that some underwriters "are trying to push corporations to give up their rights on past claims or else they will get no cover now."

And there clearly is not enough capacity for U.S. casualty business today.

PWS, for example, places about $150 million in premiums related to U.S. casualty risks. "If we had a willing market, we could have five times that," Mr. Ben-Zur maintains. "We place only 20% to 30% of each order and there are tons of offers we cannot place."

The U.S. liability risks PWS can place in London and Europe are generally renewals of commercial general liability business written on a claims-made basis and excess of $5 million, Mr. Ben-Zur said.

"If it is a new risk," the chances of placing the business are "next to nil," he said, adding that one can forget about finding capacity for errors and omissions or medical malpractice insurance.

An exception to these rules—a $1 million primary product liability facility PWS has with Lloyd's—is completely used up, with the premium limit hit, Mr. Ben-Zur noted.

No one is predicting a speedy change to current market conditions for U.S. casualty business.

"The American casualty market will take more than two years" to loosen up, predicted Mr. Ben-Zur. "American casualty is the last line someone will go into. They are making a nice return on all other commercial lines. Why should they? It has the stigma of being loss-making and unpredictable," he explained.

Mr. Dowd of Skandia America predicts that the "upside cycle will be relatively prolonged—until 1990 or 1991—before the downturn and then it will not be as severe as what we went through."

Reinsurers are taking steps to be sure they do not allow themselves to write business at such inadequate prices again.

Prudential Re for example, is investing several millions of dollars in management information systems and actuarial techniques that will allow it "to anticipate the direction of rates and adjust our aggressiveness in marketing," according to Mr. Nimmo.

"I have a sense that other reinsurers are doing so as well," he added.

One promising sign of some stabilization in the casualty market was widespread discussion among reinsurers about fine-tuning their contract conditions.

"Last year everyone was so concerned about poor results that everyone tried to be a leader and put in every exclusion, whether it was appropriate or not," Mr. Nimmo observed.

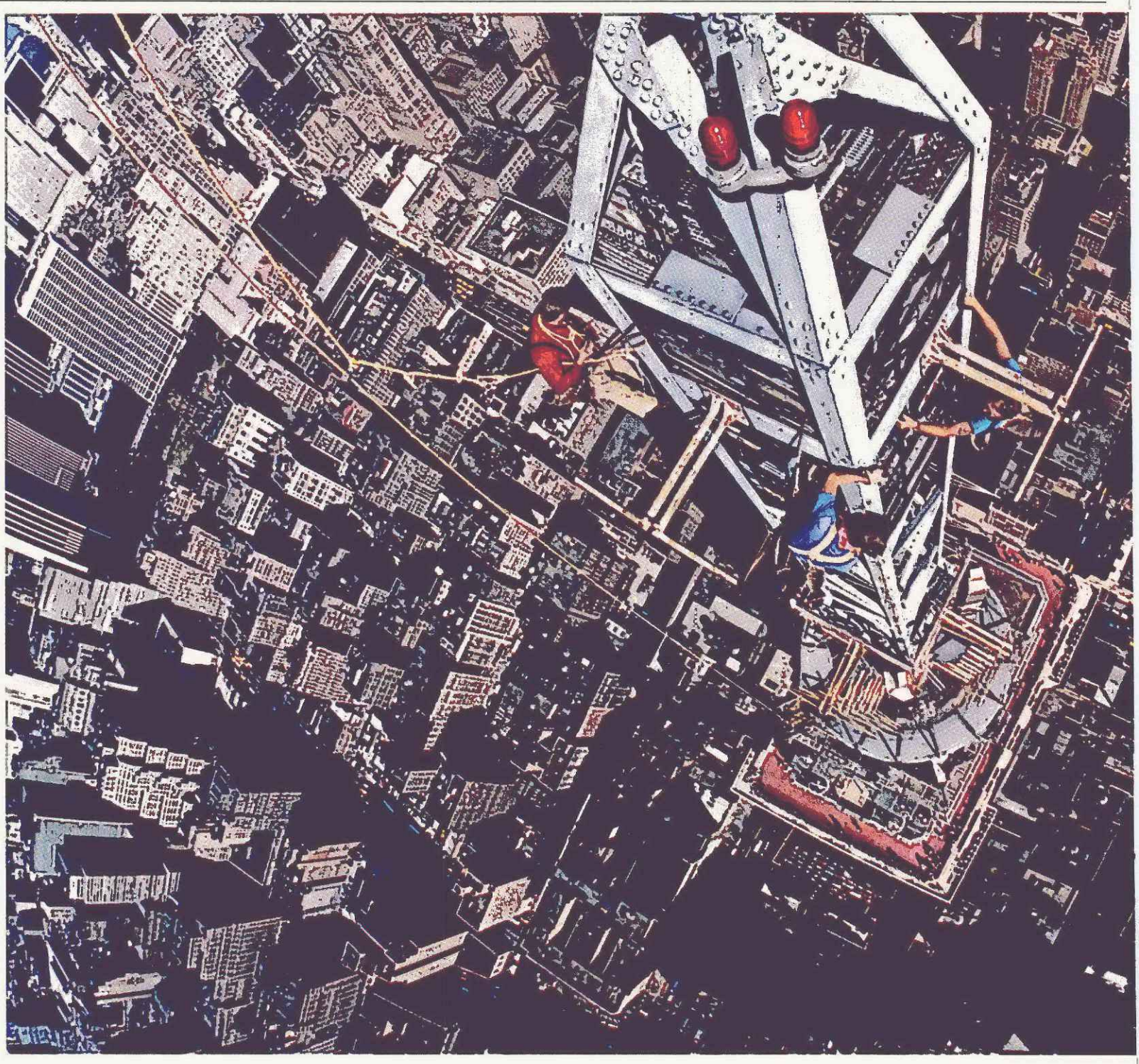
"It's been described as unprofessional, but it was not unprofessional, it was in disarray," he said.

Now, Mr. Dwane says, U.S. reinsurers are "trying to fine-tune and to be more uniform" on conditions imposed in their contracts.

But while tight U.S. casualty insurance market conditions are expected to continue, since European reinsurers don't want U.S. casualty business, competition is developing for U.S. property risks and rate increases should slow, stabilize and in some cases go down, observers say.

"Everyone wants it," Intere's Mr. Gordon said of property risks. "They are out of casualty and they want to fill the void."

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TECHNIQU

Chaloub sets his sights on American acquisitions

MONTE CARLO, Monaco—Henri Chaloub, founder and owner of the growing French-based underwriting agency and broker MEPA Group, has his eye on the United States.

Sitting at his cabana at the Beach Plaza Hotel in Monte Carlo during the Rendez-Vous de Septembre, Mr. Chaloub said he wants to expand worldwide, especially into the United States, by purchasing a U.S. broker.

"The United States is where we are looking," Mr. Chaloub said, adding "I am looking at the United States because you are not complete without a U.S. presence."

The MEPA Group, privately owned by the Chaloub family, was incorporated in 1976 in the United Arab Emirates, where Mr. Chaloub was the sole legal Middle East representative and general agent for France's largest insurance company, Union des Assurances de Paris, or UAP.

The group, with 350 people in nine countries—Saudi Arabia, Canada, Cyprus, United Arab Emirates, France, Italy, Jordan, Lebanon and Switzerland—now is based in Paris.

The group holds 18 active companies in insurance and reinsurance, with MEPA still the sole Middle East agent for UAP, handing more than 100 million French francs ($15.9 million) in premiums for UAP, according to Mr. Chaloub.

The group's three insurance companies include Societe Liberale Francaise, half-owned by UAP; Allied Insurance & Reinsurance Co., with capitalization of $5 million; and Pancyplian Insurance Co. in Cyprus.

MEPA has brokerage offices in the Middle East, Switzerland, Italy and France.

Recently, MEPA purchased French reinsurance broker Plas-Negre & Co., which is an authorized French agent for 16 insurance and reinsurance companies based in Europe, South America and Africa.

Together, MEPA and Plas-Negre handled more than 700 million French francs ($111.1 million) before their merger, according to Mr. Chaloub.

"For 1987, we forecast over 1 billion French francs ($158.7 million) will be handled by our company," he said.

MEPA also has a policy of investing in insurance companies, including a 5% share in the only publicly quoted company in France, Societe Generale Co. Assurance, in addition to a 10% share in an unidentified Swedish company, Mr. Chaloub said.

Mr. Chaloub will not reveal MEPA's gross revenues; however, the blue Rolls-Royce that sat parked in front of the Beach Plaza waiting for his call and the no-expense-spared party MEPA threw for more than 200 people during the Rendez-Vous suggest prosperity.

Mr. Chaloub says he started in the insurance and reinsurance business "accidentally."

"I was in Egypt and it was a rainy day. I was passing under a shade (awning) and I noticed on the window of the building the name of a man who I knew who was in insurance.

"I was 18 years old and I became interested in insurance."

—By Stacy Shapiro

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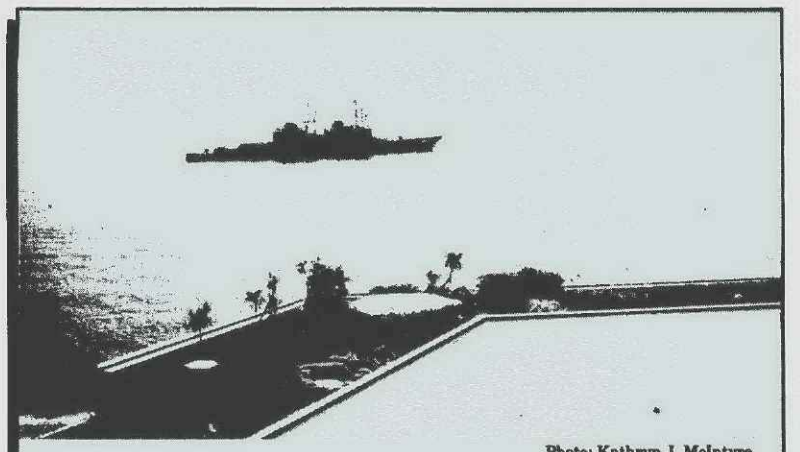


Photo: Kathryn J. McIntyre

U.S.S. John Rodgers dropped anchor off the coast of Monaco

U.S. destroyer fires imaginations in Monaco

MONTE CARLO, Monaco—There is nothing like an American destroyer anchored just outside the harbor of Monte Carlo to spark the imagination of those attending the Rendez-Vous de Septembre.

"Whilst the British and Continental reinsurers were here in force, only the Americans brought their own yacht," quipped an underwriting executive from London.

"U.S. reinsurers brought their own protection to Monte Carlo," declared Kenneth D. Biersack, retired vp-general manager of GTE Reinsurance Co. Ltd. in Bermuda and now president of the newly formed consulting firm Curtis International Ltd. in Bermuda, an affiliate of Curtis International Inc. in New York.

"The ship gives a whole new meaning to 'American offshore protection,'" commented a U.S. lawyer.

A U.S. reinsurance company executive used the ship, the U.S.S. John Rodgers, as a symbol to explain his management philosophy: "Imagine that the destroyer out there was a large reinsurance company," he said. "It would be much more difficult to turn that around 180 degrees than it would to turn, say, that motorboat right there," he said, pointing to a boat dwarfed by the warship.

"I'd rather have a reinsurance company the size of the motorboat to manage," he said.

And, one British citizen wanted to claim the John Rodgers for his own: David Springbett, who is chairman of PWS U.S.A. Inc., the U.S. subsidiary of Lloyd's broker PWS International Group and known for dreaming up apropos ditties based on the initials PWS, said he wanted to paint PWS on the side of the John Rodgers.

While PWS was dubbed to stand for "Protection With Security" for this year's Rendez-Vous, PWS on the side of the ship would stand for "My Personal WarShip," he said.

The ship was on a routine port call for rest and recreation, according to a Navy spokesman in Washington.

Silhouetted in the sunrise each morning over the Mediterranean Sea during the weeklong conference, the John Rodgers could be seen from anywhere in Monte Carlo with a view of the sea. At night, her anchor lights brightened the sky.

The only signs of movement on the ship visible from land were sailors running laps on the deck and the occasional takeoff and landing of a helicopter. Otherwise, the John Rodgers swung quietly on her mooring, with the American flag streaming off her stern.

-By Stacy Shapiro

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Lloyd's underwriter blames market crisis on five factors

MONTE CARLO, Monaco—The international insurance and reinsurance business is in a state of turmoil that affects its credibility due to five factors, a Lloyd's of London underwriter says.

Michael Payne, who underwrites an estimated 75 million pounds ($112.5 million) in premiums on behalf of 2,750 names at Michael Payne & Others, lays the blame for reduced capacity and higher rates on:

- Cash-flow underwriting, in which underwriters expected investment income earned on reserves to cover increasing losses.
- A lack of professionalism in underwriting standards.

"A lack of professionalism leads to sloppy and careless underwriting," Mr. Payne said. However, he added that "buyers and brokers have something to answer for" in shopping for the cheapest prices.

- The role of the professional reinsurer.

Reinsurers provided too much capacity to "even the most inept direct writers," Mr. Payne charged. "The market was saturated with capacity where little was required in underwriting judgment. Surely now reinsurers can judge who is the real pro and who is not," he said.

- Inadequate loss reserving.

"It is no more apparent than in the United States," Mr. Payne said, but also is a problem worldwide.

- Changing attitudes of consumers.

"In almost every country the populace is more litigious, mostly in the United States," Mr. Payne said. "I don't believe any of us could have foreseen how far-reaching these changes were going to become," he commented. "Nor could we anticipate that the liability business would be so greatly affected, regardless of whether or not there was any involvement in the United States."

Mr. Payne, who has underwritten reinsurance for 40 years, says he has kept U.S. liability risks at an "absolute minimum."

He acknowledged it is "much more difficult for the major insurance buyer to understand why suddenly and almost overnight he can only buy limited cover and at a far higher price.

"I almost—but not quite—feel sorry for brokers who have to explain why this is happening."

-By Kathryn J. McIntyre

Tort reforms need uniformity: Attorney

By KATHRYN J. McINTYRE

MONTE CARLO, Monaco—Tort reforms adopted in the United States to date "are not perfect, but they are a step in the right direction," an attorney with a U.S. insurance holding company says.

Because the tort reforms enacted vary so much from state to state, "we are winding up with a hodgepodge of law," observed Patrick Foley, vp and associate general counsel of American International Group Inc. in New York.

States enacting tort reforms are targeting different areas, but even when states address the same issue, the reforms take different approaches (*BI*, Aug. 25).

For example, some states have eliminated joint and several liability entirely, while others have only eliminated it as applied to non-economic damages, and still others have only modified the application of the theory, Mr. Foley said.

"The quality and quantity of tort reform must be improved," Mr. Foley advocated.

The American public is aware of the need for tort reform, Mr. Foley said, citing the passage of Proposition 51 by California voters. That successful referendum, put on the ballot after the California Legislature refused to pass tort reforms, eliminated the application of joint and several liability to non-economic damage awards.

However, Mr. Foley also noted that the reforms enacted will be "subject to judicial review." Until that review is complete, "we cannot be certain we have reform."

Mr. Foley also called on "judges to do their jobs." Judges, he said, "appear to have decided to abrogate long-accepted principles of legal thought to achieve social goals. They have done away with legal theories of causation and fault. The doctrine of negligence has almost been obliterated.

"We need to structure the system so that the liabilities of the parties are understood and enforced in court based on those understandings," Mr. Foley suggested.

In the meantime, U.S. insurers are trying to price their products at a "more realistic level" than they did during the competitive market, Mr. Foley commented.

"The pendulum had been allowed to swing too far toward rate inadequacy and must be allowed to swing back," he said.

However, some states are trying to control rate hikes, he noted, and in some cases have associated liability reform with insurance reform, including restrictions on cancellations and non-renewals.

"These restrictions appear to be punitive in nature, to get even with insurers out of the distorted notion that insurers want insureds to bear the brunt of excess verdicts.

"They've lost the real understanding of what insurance is about. They fail to understand the unpredictability of the court system that causes companies to raise rates and walk away from risk.

"Insurance companies exist to distribute losses, not to absorb them," Mr. Foley stressed.

"If state governments or the federal government intervenes to prevent this—or to compel insurers to assume risks at unreasonable terms—it will be disastrous to the insurance market," he warned.

In addition to raising rates, insurance companies are becoming more selective in their underwriting, requiring larger deductibles and claims-made policy forms, Mr. Foley said.

Businesses that retain more risk are encouraged to "exercise greater care," he noted. ■

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Heath executive disputes rumors of revenue losses

MONTE CARLO, Monaco—Rumors flying in the London market that Lloyd's of London broker C.E. Heath P.L.C. may lose up to 8 million pounds ($12 million) in North American brokerage revenues following the defection of three top U.S. casualty brokers are not true, a Heath executive says.

"Heath will retain most of its business," said Peter C. Methley, chief executive of C.E. Heath (Insurance Broking Holdings) Ltd., during an interview at the Rendez-Vous de Septembre.

"We have 120 people in that division of our company. The fact is only three directors walked out," he said.

"It is ridiculous to think that the North American account will close down," he added.

The North American accounts handled by Heath generated about 7 million pounds of Heath's 32 million pounds of profit last year, he said.

The three directors, including Nigel Chamberlain, chairman of the North American division, joined Stewart Wrightson P.L.C. earlier this month.

Since they left, Mr. Methley noted, U.S. broker Rollins Burdick Hunter, which generates much of Heath's U.S. business, "said that we wouldn't lose their account. They said, 'Why wipe out 60 years of doing business together?'"

Heath has lost about 10 senior executives since former Chairman Frank Holland retired about two years ago and was succeeded by Derek Newton.

Among others who left was Keith D. Gillies, a 31-year veteran of Heath who had been chairman of Heath's reinsurance division and a board member.

Mr. Gillies last fall joined U.S. reinsurance broker Towers, Perrin Forster & Crosby in Philadelphia as a vp and was supposed to move to the United States.

However, for "personal reasons" he decided not to make the move and left TPF&C after six months.

Mr. Gillies is now chairman of reinsurance broker Golding Stewart Wrightson Holdings P.L.C.

Others, however, have been hired, including Mr. Methley, who joined Heath last year after working 23 years with Leslie & Godwin Ltd., a subsidiary of U.S. broker Frank B. Hall & Co. Inc.

Mr. Methley said he was recruited by Heath and accepted the job because, "I felt Heath was an independent company with a small board at the top."

There are only four people on the Heath board, Mr. Methley said.

'We have 120 people in that division of our company. The fact is only three directors walked out,' Mr. Methley says. 'It is ridiculous to think that the North American account will close down.'

Some London analysts suggest that Heath is ripe for a takeover bid, as Heath's profits dropped last year and its stock price is falling.

But Mr. Methley disagrees.

"We are an aggressive company in terms of takeovers. What companies we find to build our company, we will buy. We are asset-rich and we want to remain independent," he said.

Mr. Methley predicted that Heath will increase its profits to 50 million pounds in next three years, with acquisitions.

"We are looking at profitable companies to improve our base," he said.

Heath earlier this year considered buying Lloyd's broker Dewey Warren, but backed out.

"We had a look at Dewey Warren, but the profit base just wasn't there. I do not need to buy 70 people," Mr. Methley said.

—By Stacy Shapiro

Rorer Group names Lewison director of risk management

comings & goings: buyers

Thomas D. Lewison, 44, has been named director of risk management at Rorer Group Inc. in Fort Washington, Pa. In this newly created position, he will be responsible for risk assessment, loss prevention and control, risk financing and insurance for Rorer's worldwide operations. Mr. Lewison reports to William S. Harrington, treasurer. Prior to joining Rorer, a pharmaceutical company, Mr. Lewison was corporate risk and insurance manager of Degussa Corp. in Teterboro, N.J. He received a bachelor of arts degree in business administration from New York University. In addition, Mr. Lewison is a member of the governmental affairs and nominating committees of the Risk & Insurance Management Society.

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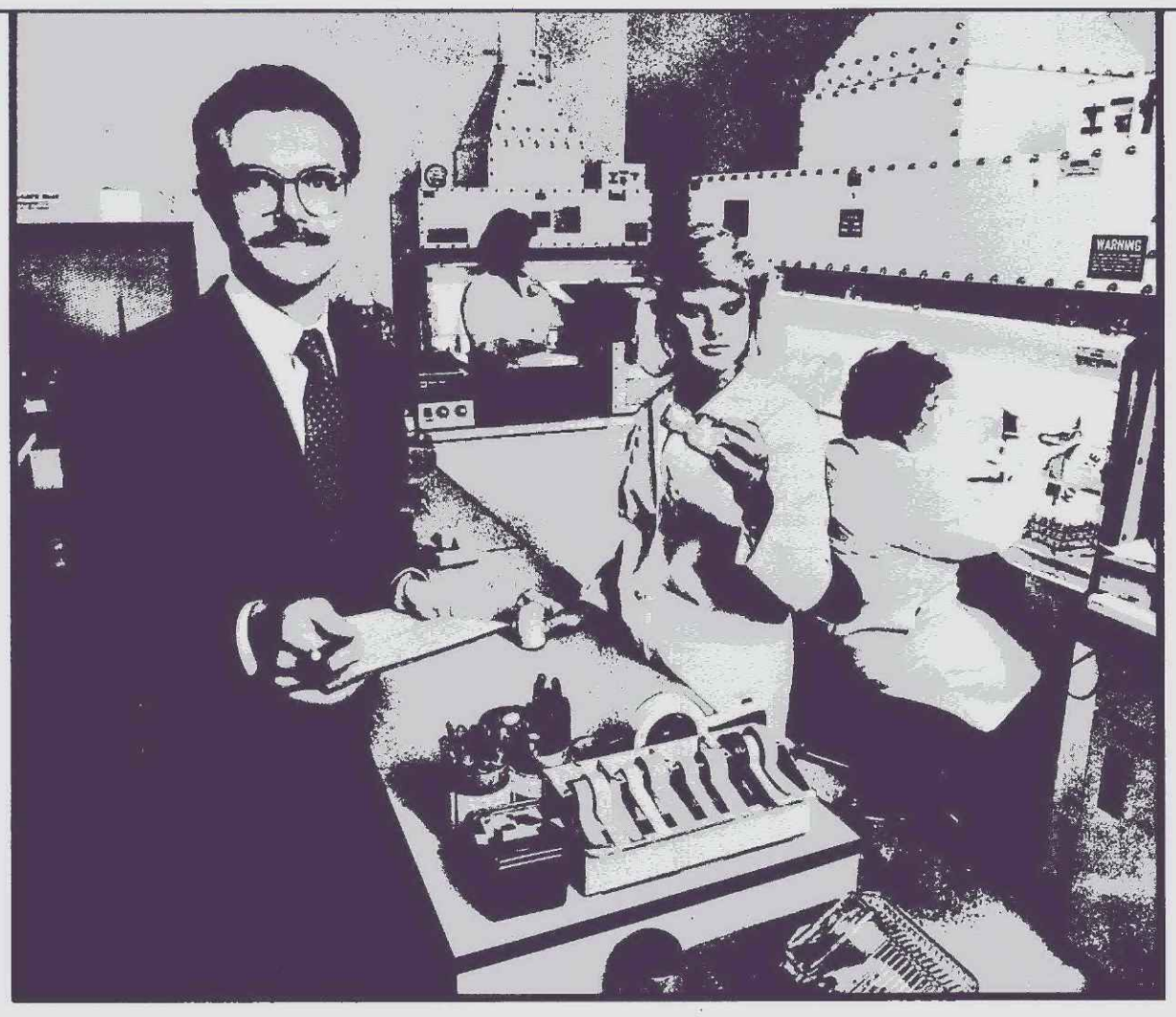
Edwin R. Hall, 38, has been named assistant director of the American Bankers Assn.'s Risk Management Center/Security and Risk Management Division in Washington, D.C. In this position, he is responsible for developing programs, products and services that address key risk management issues faced by banking professionals. Mr. Hall replaces **Mark Stevens**, who has left the American Bankers Assn., and reports to Roger Wentz, director of internal banking services. Before joining the American Bankers Assn., Mr. Hall served as an analyst at the Coastal Corp. in Houston. Mr. Hall received a bachelor of arts degree in psychology from Oklahoma State University in Stillwater and a master of business administration degree from Golden Gate University in San Francisco. In addition, Mr. Hall holds the Associate in Risk Management designation.

* * *

Margaret Morehouse, 36, has been named director of compensation and benefits for the city of Seattle, where she will be responsible for developing and administering both salary and benefit programs for approximately 9,000 city employees. Ms. Morehouse replaces **John McLeod**, who has left the city government, and reports to Tracy Phelan, employee services administrator for the city. Prior to joining the city of Seattle, Ms. Morehouse served as director of human resources for the University of Alaska system in Fairbanks, which is composed of 11 community colleges and three universities. Ms. Morehouse received a bachelor of arts degree in psychology from the University of Alaska and a master of science degree in industrial and labor relations from Purdue University in West Lafayette, Ind.

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• **The basics of risk management and insurance from the perspective of construction companies** is provided in a new booklet published by Associated General Contractors of America and the International Risk Management Institute Inc. The 35-page "Guide to Construction Insurance," covers a broad range of subjects, including automobile workers compensation, builders risk and contractors equipment coverages. All insurance chapters in the booklet focus on the Insurance Services Office's new commercial lines policy forms. Copies of the guide may be obtained for $15 ($23 overseas) from International Risk Management Institute Inc., 10300 North Central Expressway, Building III, Suite 208, Dallas, Texas 75231-3390; 214-363-9656.

• Changes in **the new 1986 business income insurance policy** are explained in a new book from BJ Publications. The book, written by James R. Jorgenson, provides descriptions of how coverage is broadened and simplified under the new form, in addition to including limit-setting and pricing guides, to keep track of underwriting requirements, rates and rating procedures for the new forms. For a copy, send $9.95 to BJ Publications, P.O. Box 16791, San Antonio, Texas 78216.

• **"Topics in Association Benefits Management-1986"** is the title of a new book from the International Foundation of Employee Benefit Plans. The 89-page book is a collection of texts presented at the 1986 Association Benefits Management Conference held last April. Topics covered include association professional liability insurance, underwriting association plans, selecting professionals and retiree health benefits, among others. Cost of the book is $23 for IFEBP members and $25 for non-members. Write to Publications Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069.

• Living with new federal laws affecting employee benefits can be a headache for employers, so the Illinois State Chamber of Commerce has published a new folder, **"How To Cope With COBRA."** The pamphlet contains suggestions, safeguards and tips on dealing with the health care coverage provision in the Consolidated Omnibus Budget Reconciliation Act. For a free copy write Pam Mitroff, Manager, Health Care Cost Management Department, Illinois State Chamber of Commerce, 20 N. Wacker Drive, Chicago, Ill. 60606.

• Metropolitan Life Insurance Co. has a new booklet, "Take Control of Your Future with Metromatic," which contains information of special interest to employers who are looking for **opportunities to supplement existing employee benefit plans on a voluntary payroll deduction basis** using universal life insurance. The booklet is free of charge and can be obtained by contacting Metropolitan Life Insurance Co., 208 S. LaSalle St., Suite 1232, Chicago Ill. 60604; 312-726-8452.

• The HMO Advisory Group, a committee of the Washington Business Group on Health, has produced a new report on **"The Future of HMO Regulation: A Need for Reassessment."** The report discusses the federal qualification process, the community rating system and current employer contribution regulations, among other topics related health maintenance organization rates, levels of benefits and quality of care. Copies of the report are available for $10 from the Washington Business Group on Health, 229½ Pennsylvania Ave. S.E., Washington, D.C. 20003; 202-547-6644.

• "Risk Identification: The Foundation of Effective Risk Management" is the title of a **detailed examination of the risk identification process** in the latest issue of Betterley Risk Management Commentary, a publication of D.A. Betterley Risk Consultants Inc. Sections of the study include a review of risk identification methods, techniques, who is involved and how it varies among organizations. In addition, a probability/severity matrix also is included as part of the study. To order a copy, send $25 to D.A. Betterley Risk Consultants Inc., Department RI, 446 Main St., Worcester, Mass. 01608; 617-754-1704.

• "International Benefits—1985-1986" is the title of a collection of texts published by the International Foundation of Employee Benefit Plans. Topics covered in the 130-page book include **international employee benefits, compensation and benefits strategy, U.S. Social Security and totalization agreements.** The texts in the booklet were presented at IFEBP International Benefits conferences in 1985 and 1986. Cost of the book is $10 for IFEBP members and $18 for non-members. To order contact Publications Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

• The National Assn. of Professional Insurance Agents has produced an 18-page booklet, **"CGL in the Marketplace: Implementation Guidelines For the Insurance Industry."** The booklet provides an 11-point plan for using the new Insurance Services Office's commercial general liability forms. In general, the PIA guidelines stress cooperation between insurers, agents and consumers in using the new forms. To obtain a copy of the free booklet, contact Richard C. Bourne, Director of Industry Affairs, National Assn. of Professional Insurance Agents, 400 N. Washington St., Alexandria, Va. 22314; 703-836-9340.

• Andrew Barile, chairman of reinsurance intermediaries and consultant Andrew Edwards & Co., has authored two new insurance-related books. **"Reinsurance. . .A Practical Guide"** is designed to give the reader a basic understanding of the reinsurance industry, discussing topics such as treaty and facultative reinsurance, functions of reinsurance and the U.S. reinsurance market. The second book, **"The Captive Insurance Company—An Emerging Profit Center,"** examines the growth and potential of captives and, in addition, covers specifics such as conducting a feasibility study, reinsuring captives and the role of captives in the conventional insurance market. Cost of the reinsurance text is $9.95, and the captives book is $12.95. For a set of both books, the price is $22.90. To order contact Interstate Service Corp., Box 1725, Oklahoma City, Okla. 73101.

• The American Society of Safety Engineers has published an 80-page **"Safety Manual for Municipalities."** The book provides a general look at loss control procedures, in addition to safety measures for various administrative departments, including: waste treatment/pollution control, police, fire and public works. Single copies are available at the rate of $20 for ASSE members and $25 for non-members. Only prepaid orders for the book will be received by Department F, American Society of Safety Engineers, 1800 E. Oakton Blvd., Des Plaines, Ill. 60018-2127.

• The International Foundation of Employee Benefit Plans has published a book by Richard E. Johnson, a principal in the Seattle office of benefits consultant William M. Mercer-Meidinger Inc., entitled "Flexible Benefits—A How-To Guide." The book provides an approach for **developing a benefit plan structure** that serves the interests of both the employer and employee. It describes types of cafeteria benefit plans, Internal Revenue Service regulations and a step-by-step plan for successful phase-in of a flexible benefits program. Copies are available at $15 for IFEBP members and $25 for non-members. Contact the Publications Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069.

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HMO office changes name after transfer

WASHINGTON—The U.S. Department of Health and Human Services Office of Health Maintenance Organizations has changed its name to the Office of Prepaid Health Care.

The OPHC was transferred to the federal Health Care Financing Administration from the Public Health Service Office of HHS earlier this summer, said Frank Seubold, director of the OPHC.

He said the office has also been divided into four divisions: the Office of Financial Management, the Division of Qualification, the Office of Compliance and the Office of Policy Planning.

The change was made because as Medicare recipients were offered the option of enrolling in prepaid health plans, the OHMO became more involved in qualifying HMOs—and other prepaid plans—to receive payments from HCFA. Therefore, plans had to deal with OHMO on qualification matters and with HCFA on payment matters.

In addition to the qualification of HMOs, the Division of Qualification now will be responsible for contracting with prepaid plans to provide health care to Medicare recipients.

The Office of Financial Management will be responsible for tracking the enrollments of and determining payments to Medicare prepaid plans by the HCFA, Mr. Seubold said.

Workers comp litigation increasing in California

SAN FRANCISCO—Every ninth workers compensation claim in California is litigated, according to second-quarter statistics recently released by the California Workers' Compensation Institute.

An "alarming increase" in litigation is reflected in the results of the latest survey, the CWCI notes.

Statewide, the litigation rate climbed to 11.2% of total new reportings between April and June, which is an increase of 26% from the corresponding quarter in 1985, when only 8.9% of new claims were litigated.

And, according to the CWCI, the 11.2% figure represents the largest year-to-year increase in the 15-year history of the statistical series.

This incidence rate—the highest on record—means every ninth work comp claim, everything from medical-only claims to death claims, is litigated, the CWCI reported.

And, if the comparison base is limited to disabling work injuries, then 40% of all lost-time claims result in the filing of an "application for adjudication," the institute claims.

Southern California, with about 60% of all claims, accounted for 71% of new applications filed from April to June. And, claims filed during this period produced a record 28% increase in the region's litigation rate, the CWCI reported.

Northern California had a 14% increase in new claims that were litigated. But even though this litigation pace was slower than in Southern California, the CWCI notes it also set a record.

The second-quarter statistics also show that dispositions as a percentage of applications continued to decline. The number of resolutions during the quarter actually increased slightly, but the influx of new filings pushed the disposition rate to 68% of applications, a new low, according to the CWCI.

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NAIC panel

Continued from page 3

we are going to take some time getting out of it," Aetna's Mr. Bailey said "But the process inevitably had to be an abrupt reversal, rather than trying to save the past.

"If we want a competitive system, and I hope we continue to do so, then we must reasonably pay some price for the excesses of those in the competitive marketplace. For unlike any other business that anybody is in, this industry sets its price and determines its cost, rather than the other way around.



Mr. Bailey

"Our objective ought to be to take the extremes out of this (cyclic business) and not try to eliminate" the cycle, Mr. Bailey said.

Mr. Byrne noted that, for the short term, the industry's capital position "is improving."

"But I already see enormous amounts of naive capital flooding back into the business in the nooks and crannies and that's the way it starts. And the next thing that will happen is reinsurance deals will be set up that people never intended to perform on. Will we get another run of captives out of Bermuda? All these industrial companies set up captives and the minute they hit a storm they say, 'Well, that's enough for us,'" Mr. Byrne said.

Hallmark's Mr. Heydinger, however, criticized the insurance industry's past performance and defended alternative risk financing mechanisms, like captives, that have been established by employers.

"I think that there was no underwriting science practiced during the soft market, and I don't think it's being practiced now during the hard market. I think they (insurers) have gone from protecting market share to sort of 'what will the market bear?' And that's what is determining prices and forms today," Mr. Heydinger said.

"My own personal belief is that marketplace forces are going to do more to improve the lot of the commercial buyer than will tort reform and insurance reform," Mr. Heydinger said.

He specifically referred to alternative facilities being developed for excess and professional liability coverages, pointing out these facilities are "permanent changes" and "have played a significant role in confronting the unavailability problem for commercial risks."

"I believe that these new facilities have a better chance of success than a lot of their predecessors. And I certainly agree with Jack (Byrne) that a lot of them washed their hands and walked away when times got tough. But I think the latest variety are a lot better focused on their real mission in life, and that is to provide consistent, reliable, fairly underwritten risk-sharing.



Mr. Heydinger

"At least that's my hope, and I hope that's not just wishful thinking," Mr. Heydinger said.

Hallmark has been a "consistent leader in many of these facilities," said another panelist, David D. Holbrook, executive vp of broker Marsh & McLennan Inc.

M&M specifically was involved in the formation of three facilities, Mr. Holbrook said: A.C.E. Insurance Co. Ltd., X.L. Insurance Co. Ltd., and American Excess Insurance Assn.

The insurers on the panel were somewhat critical about the formation of these facilities.



Mr. Byrne

"This is great. You take this product line that we've been losing. . .on and you gather capital from the policyholders and you pool the capital out there and you come with your fancy projections," Fireman's Fund's Mr. Byrne said.

"What is it that is going to make the business any better residing in A.C.E., other than maybe bookkeeping differences, than it was heretofore? Is it going to be underwritten better, priced better—what's going to make it better?" asked Mr. Byrne.

"It's all of those things," Mr. Holbrook responded.

"I'm glad it was created," said Aetna's Mr. Bailey, referring to A.C.E. "I'm delighted that it's in existence. It's relieved me of a whole bunch of responsibilities. . .But I find it terribly naive to suggest that they can make 100 cents on the dollar any different than professional people."

State insurance regulators also are concerned about the various risk financing alternatives recently established.



Mr. Yancy

Utah Insurance Commission Harold C. Yancey asked whether the insurers on the panel expect the business to ultimately come back to the commercial market.

"And I'm not just talking about this $50 million-type risk. But I'm talking about the business that has gravitated to the pools, the municipal business, that kind of business. Do (insurers) expect to get that back soon?" Mr. Yancey asked.

"Yes, we certainly will," said Mr. Byrne. "We certainly will get that business back. Some of the pools cannot pay the claims because they try to make a dollar do the work of $1.20. That will be 15 years from now," he said.

Hallmark's Mr. Heydinger, however, defended the stability of newly created captives and pools. They were created, he said, because insurers left policyholders with no choice.

"These facilities represent to me, as a policyholder, some chance of stability. I think A.C.E. is going to be there in 1987. As I start planning what my liability program's going to look like in 1987, about the only piece I can identify right now is A.C.E. The other $100 million, I don't know where that's going to come from," Mr. Heydinger said.

Referring to Hallmark's liability insurers, whom he did not identify, Mr. Heydinger said: "I don't know whether they're going to give me $20 million next year, or $5 million, or what it's going to be, but I know what A.C.E. is going to give me. I know what. . .X.L. and the rest of them (will give me) because them guys is us. And unless we decide to pull out and fold up our tent, we know what's out there," Mr. Heydinger said.

More of the participants in today's captives and pools understand the need for a long-term commitment, Mr. Heydinger added, saying that management could change their minds, but he's hoping that the commitment remains.



Mr. Hager

Iowa Insurance Commissioner William D. Hager also raised questions about participants in these new pools.

"I have no concern with respect to the pools where the participants are sophisticated insureds. That does not trouble me at all. I am troubled in instances where the participants are unsophisticated, and I think the next wave of pool participants that we're going to see are precisely that," Mr. Hager said.

The public perception now being created, according to Commissioner Hager, is that there's "a mecca in these pools."

He asked for advice, to help regulators educate the public about the pitfalls of these mechanisms.

Mr. Heydinger agreed that the next wave of buyers joining pools will be small groups, probably without full-time sophisticated risk managers.

"But isn't that the role of the agents and the brokers, and don't you have to rely heavily on that?" Mr. Heydinger asked.

The NAIC itself also has a role to play, Mr. Heydinger said, calling on it to develop standards for pools.

Fireman's Fund's Mr. Byrne surmised that the real concern of regulators is how they can tell buyers that "the check may not clear" from these new alternative mechanisms.

He recommends agents producing business for such facilities to obtain some kind of waiver from buyers.

"I would print on that waiver, 'Mr. Client, I tell you the check may not clear, and you've got to acknowledge that, before you agree to buy this coverage from this source,' " Mr. Byrne said.

Besides alternative insurance mechanisms, state insurance regulators and others in the audience also wondered about changes in the reinsurance market.

"To me there is a new problem growing and it's going to be a much more serious problem, and that is, reinsurers simply being unwilling to follow the primary pattern," Mr. Byrne said.

"It used to be we had a handshake, where what happened to the primary capital happened to the reinsurer. It was a wonderful way. . . .That's not the way it is today."

"The new Lloyd's (of London) contracts for U.S. casualty business, for example, all have sort of a five-year sunset clause in them and they (the buyers) scream and they yell and they say 'how in the world can we live with a five-year sunset. We can't have a five-year sunset.' And I say, 'take it or leave it.' And they take it," Mr. Byrne said.

"Now if I were a commissioner, or a deputy commissioner, I guess I would worry a lot about that. I would want to know how many of my domestic companies have a reinsurance contract that actually expires before my company's primary contract expires," he said.

"The folks in England are bringing enormous pressure on us. . .all of which are very good reasons to not do business with Lloyd's," Mr. Byrne said. "And if they hang us out to dry again, why would we ever continue to allow all those reinsurance premium dollars to flow over to Lloyds is beyond (me)."

Robert T. Guyer, president of Winterthur Inc. U.S. in New York, a unit of Winterthur Swiss Insurance Co., agreed with Mr. Byrne that "there are reinsurers in this business that don't belong."

The reinsurance marketplace, according to Mr. Guyer, is "extremely unsettled."

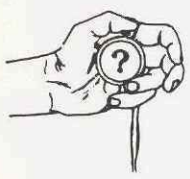
Insurers on the panel were asked by state insurance regulators if they would keep their promise and return to the market in those states in which tort reform was enacted.

Aetna's Mr. Bailey said insurers already have returned to these states, but he warned buyers and regulators not to expect a dollar from insurers in exchange for 10 cents worth of tort reform.

"Don't expect that from a business that has been badly hurt. . .that has already started to sweat about how long this improving marketplace is going to last. Don't expect us to give the store away on the cuff. I just don't think that is realistic," he said.

Hallmark's Mr. Heydinger said he believes that business hasn't done its share in picking up the tort reform banner. "We have thrust it right in the center of this whole insurance availability problem. . .There is a lot that needs to be done with the tort system irrespective of insurance and whether it is available. . .We have let the insurance companies carry the banner," he said.

Also on the panel was Richard B. Baker, president of Myers, Baker & Co., a Chicago-based broker. ■



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Tylenol recall

Continued from page 1

appeal, we will be successful on appeal," said James McGuire, an attorney with the New York law firm of Mendes & Mount, which represents four of the liability insurers.

Johnson & Johnson lawyers are still studying the decision, but will probably appeal to the 3rd U.S. Circuit Court of Appeals in Philadelphia, according to Gregory L. Diskant, a lawyer representing the company with Patterson, Belknap, Webb & Tyler in New York.

Seven Chicago-area residents died in September 1982 after taking cyanide-laced Extra-Strength Tylenol capsules.

Johnson & Johnson has denied liability in lawsuits stemming from the Tylenol deaths, claiming that the tampering did not occur while the product was under J&J's control.

Those lawsuits are still pending, a J&J spokesman said.

Following the poisonings, J&J recalled and tested Tylenol capsules still on store shelves and remarketed the product in tamper-resistant packaging.

The re-marketed product eventually exceeded its share of the analgesic market before the poisonings.

J&J undertook the recall without consulting its liability insurers, and in November 1982—without ever having filed a claim—sued the eight insurers and Affiliated FM Insurance Co., an all-risk property insurer, to recover recall-related losses (*BI*, Jan. 10, 1983).

The eight liability insurance companies sued by J&J are: North River Insurance Co., Transit Casualty Co., Employers Insurance of Wausau, Aetna Casualty & Surety Co., American Centennial Insurance Co., Granite State Insurance Co., First State Insurance Co. and Northbrook Excess & Surplus Insurance Co.

Middlesex Assurance Co. Ltd, a Bermuda-based J&J captive insurer, wrote the first $5 million combined single limit in liability coverage on the program. The eight insurer defendants provided excess liability coverage in four layers:

- A first excess liability layer of $5 million was split evenly between Middlesex and North River.
- A second $20 million excess layer, of which North River wrote $12.4 million; Middlesex wrote $2.5 million; Employers of Wausau wrote $4.6 million; and Transit Casualty—currently in liquidation in Missouri—wrote $500,000.
- A third excess layer of $25 million, of which Aetna wrote $7.5 million; American Centennial wrote $5 million; Granite State wrote $4.9 million; North River wrote $5 million; and an insurer not named in the suit wrote $2.6 million.
- A fourth excess layer of $25 million, of which Aetna wrote $5 million; Granite State wrote $6 million; First State wrote $5 million; and Northbrook wrote $9 million in coverage.

Johnson & Johnson, 'having failed to convince this court that the explicit wording of the policy affords the coverage it claims, seeks not only to force an ambiguity into the contract after the fact, but seeks to interpret the purported ambiguity contrary to its own admitted intent,' the opinion states.

North River, Transit Casualty, Employers of Wausau and First State moved for a summary judgment dismissing the J&J complaint, and later were joined by the other four liability insurers. J&J then filed a cross-motion for summary judgment in its favor.

The suit against the liability insurers was stayed while U.S. District Judge Frederick B. Lacey presided over a "minitrial" on the liability of Affiliated FM. J&J claimed it was entitled to recover lost Tylenol profits under the Affiliated FM policy's business interruption clause.

However, Judge Lacey ruled against J&J last year, and the ruling was upheld by the 3rd Circuit Court of Appeals in June (*BI*, Sept. 2, 1985; June 23, 1986).

Judge Barry took over the case against the liability insurers after Judge Lacey retired from the bench earlier this year.

In its complaint, J&J argued that it was entitled to collect recall expenses from the insurers because the recall was undertaken to prevent additional deaths and thus additional claims against the company and its insurers.

To support this argument, J&J lawyers pointed to two previous cases in which policy wording similar to that used by the J&J insurers was found to include coverage of costs incurred to mitigate damages that otherwise would have been covered by the policies.

Judge Barry, however, noted that J&J has argued "from Day One" that it is not liable for the Tylenol deaths.

"Not believing it was liable, Johnson & Johnson could not have believed that it was mitigating damages," the judge's opinion reads.

Ruling, in addition, that the cases cited by J&J's lawyers did not apply, Judge Barry pointed to the J&J policy language, which provided coverage for "sums which the insured shall be obliged to pay by reason of the liability. . .for damages" stemming from, among other things, personal injuries.

"The recall in the present case was not caused by liability for the seven deaths; it was at best merely related to the seven deaths in that they served as notice to the plaintiff that the Tylenol remaining on the shelves was potentially harmful. The recall was thus prompted. . .by the possibility of future liability for possible future poisonings," the opinion says.

Judge Barry concurred with the liability insurers' argument that recall coverage—a first-party coverage—is not included within the scope of third-party liability insurance policies.

Even if recall coverage generally could be found in such policies, though, Judge Barry concluded that there are "grave doubts" about whether the coverage would be included in this case, since the premium paid by J&J "was substantially less than it would have been had recall and recall-related expenses been included."

"Again we return to one rock hard fact: Johnson & Johnson knew it could purchase recall insurance and elected not to do so," the opinion says.

Judge Barry noted, among other things, that annual reports to J&J's board of directors stated that the company had no recall insurance and that, one month before the recall, J&J had turned down an offer from broker Johnson & Higgins for product integrity/product impairment coverage—coverage that J&H testified would never have been offered had anyone believed that recall expenses were included in the liability program.

In addition, the liability insurers charged that during coverage renewal negotiations after the poisonings, Frederick B. Molineux, J&J's director of corporate insurance, told H.S. Weavers (Underwriting) Agencies Ltd., North River's London reinsurer, that aside from the seven death cases no claims from the incident would be reported.

The liability insurers charged that Mr. Molineux made this statement to obtain a premium reduction, which was subsequently obtained.

However, J&J denied that Mr. Molineux ever promised that no further claims would be made.

Even if the J&J policies did not clearly include coverage for recall costs, J&J lawyers argued that the policy language was ambiguous on the point, and that the ambiguity should be construed in its favor.

Judge Barry, however, dismissed this argument.

"Courts will not strain the language of the policy to find an ambiguity where there is none in order to grant coverage that does not exist," the judge wrote.

The opinion adds that J&J, "having failed to convince this court that the explicit wording of the policy affords the coverage it claims, seeks not only to force an ambiguity into the contract after the fact, but seeks to interpret the purported ambiguity contrary to its own admitted intent."

Judge Barry also concurred with the insurers' argument that the Tylenol recall costs were not incurred "unexpectedly and unintentionally" by J&J and, therefore, were excluded from coverage under the policies.

J&J had argued that the insurers' failure to modify "unexpectedly and unintentionally" with "from the point of view of the insured" meant that "unexpectedly and unintentionally" referred to the point of view of potential victims and that the expenses were therefore covered.

Judge Barry noted that "it makes no sense" to interpret the recall as being intentional or unintentional from the point of view of the potential victim.

Judge Barry's ruling also rejected the conclusion reached in previous cases that mitigation expenses should be allowed for public policy reasons where the policy language is ambiguous to encourage policyholders to contain damages that otherwise would be covered by insurance.

To apply this doctrine properly, the judge concluded, would require mandatory coverage of mitigation expenses in all liability policies.

If this coverage were not mandatory, a policyholder with an ordinary liability policy found to be ambiguous would reap a windfall in collecting mitigation expenses while other policyholders will have paid extra premiums for the same coverage.

"Such a windfall would not, and could not, be a form of encouragement to undertake mitigation efforts but, to the contrary, a reward for having made such efforts," the judge wrote.

To make mitigation coverage mandatory, on the other hand, would "compromise the important public policies of freedom of contractual choice in the marketplace and the reduction of premium costs to the consumer." ■

British Issues

Sept. 16 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High-Low pence	pence
Comml Union	287	22.1	18.3	6.4	302	287
Genl Accident	837	14.7	37.7	4.5	862	837
Gdn Royal Exch	810	15.6	46.5	5.7	842	810
Royal	837	11.8	42.2	5.0	862	837
Sun Alliance	705	20.1	29.5	4.2	730	705
Brokers						
CE Heath	472	8.4	38.0	8.1	490	472
Hogg Robinson	318	11.0	16.2	5.1	333	318
JH Minet	248	9.5	14.1	5.7	264	248
Sedg Grp	330	13.8	18.3	5.1	347	330
Stew Wrightson	425	13.5	19.0	4.5	440	420
Wills Faber	435	15.5	15.5	3.6	437	423

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

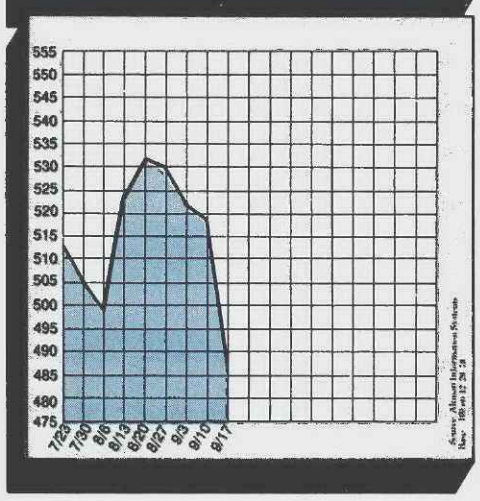
BI Industry Stock Report

September 17, 1986 9/11/86 thru 9/17/86

		Price	% Chg.	P/E	$ Div.	% Yld	High	Low	Vol.(000)
Brokers									
Alexander & Alexander Svcs	NYSE	36.50	-3.3	243.3	1.00	2.7	36.88	35.25	446.9
Baldwin & Lyons Inc	OTC	24.00	0.0	30.8	0.16	0.7	26.00	24.00	1.1
Corroon & Black Corp	NYSE	33.00	-5.0	16.6	0.65	2.0	33.00	31.75	571.8
Crump E H Cos Inc	OTC	32.25	0.4	31.0	0.25	0.8	32.25	32.13	895.4
Gallagher Arthur J & Co	OTC	28.00	-8.2	22.6	0.20	0.7	29.50	28.00	464.9
Hall Frank B & Co Inc	NYSE	19.88	-0.6	0.0	0.00	0.0	20.38	19.88	258.5
Marsh & Mclennan Cos Inc	NYSE	64.00	-1.9	22.5	1.50	2.3	64.75	62.50	781.6
Poe & Assoc Inc	OTC	14.25	-1.7	0.0	0.32	2.2	14.50	14.25	6.1
AGENTS/BROKERS	AVERAGE			-60.5		1.6			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	57.88	-6.5	11.0	1.36	2.3	59.00	57.50	4,949.1
Anderson Clayton(Ranger/PanAm)	NYSE	55.88	0.0	31.9	0.00	0.0	0.00	0.00	0.0
Armco Inc	NYSE	6.88	19.6	0.0	0.00	0.0	6.88	6.38	1,423.5
Berkley W R Corp	OTC	29.25	-8.6	22.2	0.24	0.8	31.50	28.00	738.4
Berkshire Hathaway Inc Del	OTC	2675.00	-10.5	650.9	0.00	0.0	2725.00	2625.00*	2.7
CIGNA Corp	NYSE	54.75	-6.8	0.0	2.60	4.7	57.88	54.75*	1,921.7
CNA Finl Corp (CNA)	NYSE	53.00	-12.9	14.7	0.00	0.0	54.88	53.00*	489.2
General Re Corp	NYSE	58.13	-6.6	25.3	0.88	1.5	60.75	55.63	1,271.2
ITT (Hartford Group)	NYSE	49.00	-6.7	23.2	1.00	2.0	50.38	48.75	4,410.6
Sears Roebuck & Co. (Allstate)	NYSE	40.50	-8.5	11.6	1.76	4.3	41.50	39.75	6,760.8
Teledyne Inc (Argonaut)	NYSE	315.63	-4.1	11.5	0.00	0.0	317.50	314.00	187.8
Transamerica Corp (Occidental)	NYSE	33.88	-6.6	14.9	1.68	5.0	33.88	33.63	915.2
CONGLOMERATES/HOLDING COS.	AVERAGE			91.9		0.3			
Insurers									
Aetna Life & Cas Co	NYSE	57.13	-5.8	11.4	2.64	4.6	58.63	56.50	2,630.2
American General Corp	NYSE	39.50	-6.5	11.8	1.12	2.8	40.13	38.63	1,674.6
Amern Heritage Life Invt Co	NYSE	39.50	-3.7	14.3	1.32	3.3	40.25	39.50	23.8
American Indty Finl Corp	OTC	16.50	-8.3	0.0	1.12	6.8	17.00	16.38*	34.2
American Intl Group Inc	NYSE	124.25	-6.8	20.3	0.44	0.4	128.50	119.75	1,147.3
Aneco Reins Ltd	OTC	2.25	-14.3	0.0	0.00	0.0	2.25	1.75	22.0
Avemco Corp	NYSE	27.50	-9.1	14.5	0.50	1.8	28.13	27.25	32.8
Business Mens Assurn Co Amer	OTC	27.50	-2.7	22.5	1.10	4.0	28.38	26.75	149.4
Chubb Corp	NYSE	63.50	-7.0	47.4	1.56	2.5	63.63	62.50	980.7
Combined Intl Corp	NYSE	53.88	-3.4	10.4	2.24	4.2	54.50	52.13	204.4
Continental Corp	NYSE	43.00	-5.2	0.0	2.60	6.0	44.75	43.00*	1,004.0
Crown Life Ins Co	OTC	350.00	2.9	0.0	6.40	1.8	350.00	340.00	1.7
Durham Corp	OTC	42.50	-5.6	11.9	1.36	3.2	44.00	42.50	14.1
Farmers Group Inc	OTC	42.00	-4.0	14.6	1.00	2.4	42.00	41.00	541.4
Fairmont Finl Inc	AMEX	17.38	-4.1	17.9	0.00	0.0	17.38	17.13	208.1
Fireman Fd Corp	NYSE	34.13	-7.8	0.0	0.30	0.9	35.38	34.00	914.1
Fremont Gen Corp	OTC	20.75	-9.3	0.0	0.48	2.3	22.38	20.63*	190.2
Great West Life Assurn Co	OTC	790.00	0.0	0.0	18.00	2.3	790.00	790.00	1.5
Home Group Inc	AMEX	18.75	-10.2	89.3	0.00	0.0	20.38	18.75*	682.6
Hanover Ins Co	OTC	61.00	-9.6	17.6	0.56	0.9	65.50	61.00	96.6
Hartford Steam Boiler Insptn	OTC	40.50	-9.5	22.8	0.84	2.1	42.75	39.88	99.2
Kans City Life Ins	OTC	28.75	-7.3	11.3	0.87	3.0	30.25	28.50	19.6
Kemper Corp	OTC	28.00	-11.1	12.7	0.60	2.1	30.13	28.00	1,424.1
Liberty Corp S C	NYSE	38.00	-4.4	14.0	0.72	1.9	40.00	38.00	37.4
Lincoln Natl Corp Ind	NYSE	49.63	-5.0	10.8	2.00	4.0	50.25	49.00*	518.7
Mission Ins Group Inc	PAC	3.63	0.0	0.0	0.00	0.0	4.38	2.88	3.2
Monumental Corp	OTC	55.63	0.0	18.8	0.00	0.0	55.63	55.63	1.1
Nac Re Corp	OTC	31.00	-6.1	0.0	0.00	0.0	31.50	29.50*	127.9
Nobel Ins Ltd	OTC	13.88	-14.6	0.0	0.37	2.7	15.50	13.50	110.9
Northwestern Natl Life Ins	OTC	28.25	-10.3	10.4	0.86	3.0	30.50	28.25	240.1
Ohio Cas Corp	OTC	74.75	-6.6	15.9	3.00	4.0	78.00	74.25	165.7
Old Rep Intl Corp	OTC	34.38	-5.5	11.5	0.78	2.3	35.00	34.38	172.7
Orion Cap Corp	NYSE	29.50	-10.6	0.0	0.76	2.6	31.25	29.50	87.4
Protective Corp	OTC	22.00	-5.4	11.8	0.70	3.2	23.25	22.00	1,009.4
Provident Life & Acc Ins Co	OTC	23.75	-5.0	8.7	0.84	3.5	24.75	23.75*	314.4
St Paul Cos Inc	OTC	37.75	-6.2	22.5	1.50	4.0	38.50	36.25*	1,283.1
SAFECO Corp	OTC	57.25	-7.7	13.6	1.68	2.9	60.50	56.50	634.2
Seibels Bruce Group Inc	OTC	15.25	-4.7	0.0	0.80	5.2	15.75	15.00	124.1
Selective Ins Group Inc	OTC	20.75	-5.7	0.0	0.92	4.4	21.38	20.25*	160.2
Statesman Group Inc	OTC	5.38	-4.4	59.7	0.05	0.9	5.38	5.00	133.5
Tokio Marine & Fire Ins Co	OTC	525.50	-11.8	99.0	1.66	0.3	582.00	521.00	14.9
Torchmark Corp	NYSE	27.25	-4.4	11.0	0.60	2.2	27.25	26.00	588.8
Travelers Corp	NYSE	44.00	-4.9	11.0	2.16	4.9	45.38	43.63	1,871.4
Trenwick Group Inc	OTC	18.50	-8.6	0.0	0.00	0.0	19.25	18.50*	204.4
United Fire & Cas Co	OTC	29.25	-9.3	15.3	0.80	2.7	30.00	28.50	23.4
United States Fid & Gty Co	NYSE	38.88	-3.1	0.0	2.32	6.0	39.25	38.63	3,642.3
Uslife Corp	NYSE	43.63	-4.1	11.4	1.12	2.6	47.50	43.13	398.8
Washington Natl Corp	NYSE	31.75	-2.7	14.3	1.08	3.4	32.00	31.25	64.7
Zenith Natl Ins Corp	OTC	24.00	-9.4	41.4	0.80	3.3	24.00	22.50*	300.7
INSURANCE COMPANIES	AVERAGE			47.7		2.1			

System design: Altman Information Systems

BI Insurance Index



The *Business Insurance* index of insurance industry stocks took a nose dive last week, closing at 488.3 points on Sept. 17, down 30.5 points from 518.8 points on Sept. 10. A total of 54 stocks posted losses, while only two climbed and five were unchanged. Stocks that posted the biggest losses were: Nobel Insurance Ltd., down 14.6%; Aneco Reinsurance Co. Ltd., down 14.3%; CNA Financial Corp., down 12.9%; Tokio Marine & Fire Insurance Ltd., down 11.8%; and Kemper Corp., down 11.1%. The only two gainers were Crown Life Insurance Co., up 2.9%, and The Crump Cos. Inc., up 0.4%. The *BI* index's 5.9% drop was on a par with that of the major market indicators: The NYSE composite dropped 5.8% and the Standard & Poor's 500 index fell 6.2%.

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